

COUNTER-TRANSFERENCE PHENOMENA IN THE WHITE CLINICIAN:  
A HERMENEUTIC INVESTIGATION OF CROSS-RACIAL  
PSYCHOTHERAPY IN SOUTH AFRICA

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(ii)

ABSTRACT

This is a psychodynamic study of the white clinician's counter-transference in cross-racial psychotherapy. Available evidence indicates that racial conflicts, despite their salience in South Africa, are rarely addressed in psychotherapy practice, training or research. The research that has been conducted is reviewed and the limitations of the natural scientific paradigm are discussed. Hermeneutics - the art of interpretation - is presented as a more appropriate methodology for the study of human beings.

The researcher conducted one unstructured interview with each of seven 'liberal', white therapists (six clinical psychologists, three of each sex, and one female psychiatric social worker) regarding their experience of cross-racial psychotherapy. The interview protocols are reflected upon and the common themes explicated and described. Three primary themes emerge, regarding, amongst other phenomena, the participants' feelings of 'white guilt' and their inhibition of the expression of 'black anger', feelings of helplessness and sexual conflicts. General defensive approaches adopted by the clinicians include the use of their professional role and of patient characteristics, the adoption of directive approaches and the practice of overcompensation. Defence mechanisms employed include those of intellectualisation, displacement, denial, rationalisation and projection. The need to make reparation is pervasive. A Kleinian analysis of 'white guilt' is presented and the researcher's role as interviewer is reflected upon. Implications of the results for practice, training and research are discussed. Amongst these are the need for formal training and self-reflection, suggestions with regard to attuning oneself to counter-transference and with regard to the handling of cross-racial therapy, the presentation of research possibilities and a discussion regarding the clinician's political role. It is concluded that, in many cases, cross-racial psychotherapy can be effective and that the chances of its success are enhanced by the tackling of counter-transference and other racial barriers.

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## CHAPTER ONE

### PSYCHOTHERAPY IN THE SOUTH AFRICAN CONTEXT

#### 1.1 INTRODUCTION

##### 1.1.1 RATIONALE AND SCOPE OF THE STUDY

This is a psychodynamic study of the feelings evoked by race in the cross-racial psychotherapeutic relationship. In particular, the emotions experienced by white therapists working with patients of colour, and the consequent behavioural manifestations of these feelings within the context of psychotherapy, are examined.

The study has been initiated by the informal observation that, while logic dictates that the differing race of therapist and patient must often be an important issue in psychotherapy (especially in South Africa), it appears to receive little, if any, attention during the course of therapy or during supervision or training sessions. To date, this topic has received relatively little space in the professional literature of this country, while studies carried out abroad are usually on the level of comparing treatment outcomes of various mixed race therapist-patient pairs (e.g. Jones 1982), studying bias with regard to assignment to treatment procedures (e.g. Kuhlman et al, 1982) and with regard to diagnosis (e.g. Allon 1971), and the effects of race on the perception of process variables in counselling (e.g. Sladen, 1982). Studies do exist which have explored both the therapist's and the patient's feelings about race (e.g. Gochros, 1966) but these are few and far between and seldom provide a framework within which to analyse and interpret these feelings.

A fair amount of attention has been given to the study of racial attitude development in young children (e.g. Porter, 1971; McDonald, 1973) and several theories have been put forward to explain adult racial prejudice (e.g. Adorno et al, 1950; Bettelheim and Janowitz, 1964), but the link between these areas and the added dimension of a complex psychotherapeutic relationship remains mostly unexplored.

It has been shown by numerous researchers (e.g. Goodman, 1964) that children, from an early age, become aware of race and experience anxiety and conflict in that regard. Race, like sex, is an integral factor in the development of a child's self-identity. Erikson (1977) has suggested that the process of ego development requires polarisation of group prototypes. A "dichotomy of evil and ideal prototypes provides orientation for the emergent self" (Gregor and McPherson, 1966, p.219). This procedure is simultaneously complicated and made more salient by the nature of South African society. Here there exists *de jure* segregation and intergroup behaviour is regulated by widely-held norms and values. This inevitably results in the subjugation of one, or in the case of South Africa, several, racial (and other) groups by another, which in turn results in strong interracial feelings. Hence, one would expect a marked intrusion of race-related feelings into the social reality and, consequently, an increase in the saliency of the racial aspects of each individual's identity. Albeit a controversial point, Milner (1975) has stated that, in these instances, the racial aspect of a child's identity may even be more important than fundamental ones such as sex.

That there exist strong interracial feelings in this country is beyond doubt. At the time of writing, South Africa is in a state of emergency.

Violent demonstrations have left hundreds of people dead, thousands wounded and over two thousand detained by police. Most commentators cite *apartheid* as the cause of the present civil unrest. What Beyers Naudé calls "the anger of the voteless" (quoted in Iyer, 1985, p.7) is all too apparent. Many whites, on the other hand,

"fear the authoritarianism prevalent in much of black Africa. They fear the thought of undereducated blacks in control. They are afraid of being wiped-out"  
(Iyer, 1985, p.12).

Motlana (ibid) describes the relationship between whites and blacks as a "sort of love-hate relationship" (p.14). One might expect that whenever there is contact between individuals belonging to different ethnic groups, certain feelings are bound to be evoked, both conscious and in the unconscious, purely due to the stimulus of the other's race. In South Africa, where interracial contact is loaded with such heated issues, there can be few people who do not experience these feelings.

It would therefore be surprising to find in the behaviour of many South African mental health professionals (of all races) the implication that these feelings are left outside the consulting room. If this is indeed the case, then it is by some process that the mental health service, like many liberal universities, becomes a pseudo-enclave in which colour difference is over-compensated for, paid lip-service to, or denied.

Many psychotherapists in this country, following Freud (1958), emphasize the need for the patient to work through his *transference* feelings toward the therapist, whereby "transference" we mean "feelings which really belong to someone in the patient's past" (Malan, 1979, p.20), i.e. past feelings which have been re-evoked by the person of the therapist. Indeed, within the psychodynamic framework, the transference provides the field within which the patient may achieve resolution of past conflicts in the here-and-now.

However, just as it is important to take cognisance of the transference, so attention needs to be paid to the therapist's *counter-transference* feelings. In the counter-transference it is the therapist who "projects onto the patient revived elements of attitudes, misconceptions, fears and impulses derived from his own emotionally significant past relationships" (Wolberg, 1954, p.488). It is likely that many therapists in South Africa have unresolved feelings with regard to race and, if unattended to, these feelings may play themselves out in therapy in a number of ways. For example, guilt is often seen to be a source of conflict in the "liberal" white therapist. The question then arises as to how this manifests in therapy. One possibility is that it may result in the therapist bending over backwards to help his black patient. If so, this may lead to a tendency to be more directive (and consequently encourage dependency in the patient), or even to embark upon an erroneous form of treatment, one which the therapist hopes, unrealistically, will help his patient but for which the latter is, in reality, poorly suited.

Another area is that of sex. Writers such as Fanon (1968) and McDonald (1973) hypothesize that racial and sexual conflicts are by no means mutually exclusive. If it indeed exists, this sexual quality of racial attitudes will no doubt influence the nature of the transference and counter-transference relationships. Hoch (1979) outlines an aspect of the problem:

"...in a white civilization which considers many forms of sexuality to be immoral - and consigns them to the dark dungeons of the unconscious - the 'devil', dark villain or black beast becomes the receptacle of all the tabooed desires, thereby embodying all of the forbidden possibilities for ultimate sexual fulfillment and becoming the very apotheosis of masculine potency" (p.44).

Sexual intimacy between the black man and white woman, or black woman and white man, was, until recently, forbidden by law in South Africa. Nevertheless it remains, as Harry Stack Sullivan says, the "master taboo of society" (in Hoch, 1979, p.44). Psychotherapy, however, is a very intimate situation. The patient's desires, often sexual, are stripped naked, and commonly a sexual transference and/or counter-transference arises.

Sartre's statement in the preface to Fanon's "The Wretched of the Earth" (1968) introduces a further hypothetical example of counter-transference, this time in an all-male therapeutic pair: "...the European has only been able to become a man through creating slaves and monsters" (p.26). The white therapist, in his unconscious, might need to keep the black patient 'in his place'. If he threatens to get out of it, "his threatening sexual aspect must be removed, by any means necessary" (Hoch, 1979, p.56).

The point being made is that the white therapist who has unresolved conflicts with regard to race, especially if these are unconscious, will be led by his anxiety to defend himself against these feelings. The way in which his conflicts become manifest in the cross-racial therapy situation will depend upon the nature of the conflict, the type of defence mechanism utilised, and the nature of the psychotherapy process. The *aim* of the present study, therefore, is to explore the emergence of unconscious racial feelings in the psychotherapeutic relationship, feelings which have their origins in childhood and are entrenched in the adult who provides psychotherapy.

A further point of clarification regarding the scope of this study is that the notion and manifestations of racial transference are only of importance

insofar as they affect the counter-transference. An example of interest would be the way in which the therapist responds (i.e. his/her counter-transference) to the coloured patient who harbours angry feelings toward, and who feels little trust in, whites.

Another aspect concerns that of the various degrees of racial prejudice. It is not the present intention to study overt levels of prejudice, or even prejudice which would normally be measured by a rating scale. The aim is to explore the more subtle forms of prejudice or "racial anxiety", that which is present in apparently "liberal" or "radical" South African psychotherapists and which might become manifest in the form of, for example, slips of the tongue, passive-aggressive behaviour, or reverse discrimination.

There are many more related issues which are beyond the scope of the present research. For example, the focus on the white therapist excludes discussion of the racial feelings of the therapist of colour. Furthermore, the present emphasis on mixed-race therapeutic relationships by no means implies that race cannot become an issue when the therapist and patient are of the same race. For instance, the coloured patient may see his coloured therapist as being a collaborator and a deserter. Reticence on the part of the therapist to deal with this issue may be taken, by the patient, as collaborative evidence therefor.

Race may also be an issue outside the transference. Here one is reminded of Hegel's notion that "the dominator is himself narrowed and dominated by his compulsion to dominate" (Hoch, 1979, p.18). Hence, when the therapeutic pair is white, it might become necessary to recognise the defensive and restrictive quality of the patient's prejudice and need to dominate and to work through these. A therapist who is unaware of his own need to dominate (both blacks and his patients) might sabotage his own work.

### 1.1.2 A NOTE ON GENERAL PROCEDURE, METHODOLOGY AND TERMINOLOGY

In order to provide a point of departure, the relevant empirical and theoretical literature on racial attitudes per se, as well as the literature on racial attitudes in psychotherapy, will be reviewed. The limitations and methodological problems of the natural scientific positivistic paradigm when applied to the study of human beings will be demonstrated and an alternative methodology, *hermeneutics*, will be presented. Hermeneutics, which is the art or science of interpretation, provides the general methodological approach of the present study.

In keeping with this approach, certain comments regarding variables and terminology are in order. Firstly, little attempt to operationalize variables has been made. There are problems regarding the basic concepts in the field of race relations because they are "ideologically based and time-bound" (Kinloch, 1974, p.49). Thus, no rigid definitions of, for example, "race" or "racial prejudice", are attempted. A proviso must be added, however. Tobias (1972) has pointed out the alarm caused by "the rise of political doctrines based upon racial differences and by the enormities and excesses committed in the name of race" (p.20). In contrast, the present study places emphasis on the understanding of race as a social concept rather than a biological one. Thus, the terms used to denote groups in South Africa, viz. "white", "black" (or "African"), "coloured" and "Indian" are adopted on the basis of their colloquial usage within the population under investigation (i.e. white South African clinicians who do not display overt racial prejudice). These are definitions imposed by, amongst other things, State legislation, and do not necessarily reflect true physical or psycho-social groupings. However, they "have been operative for over thirty years and so undoubtedly have had psychological sequelae with respect to perceptions of groups" (Foster, Friedman and Wilson, 1984, p.7).

Since "black" has not been used here in the Black Consciousness sense, that is, to denote all those who are oppressed, coloured, Indian and black patients, in order to avoid confusion, have been referred to collectively as "patients of colour". An exception to this rule arises in the discussion of research conducted elsewhere (especially in America) where "black" often refers to a very wide range of people, including those designated as "coloured" in South Africa. Thus, apart from the usual problems of comparing this research to research conducted in South Africa, there exists confusion as to which specific group of people participated in the particular study.

Furthermore, the use of the term "race" rather than "ethnic group" represents the researcher's efforts to narrow down the scope of the enquiry. To the extent that this represents a presupposition regarding the notion of what is meaningful to the participants of the study will be discussed in the concluding section. Similarly, a further presupposition may be evident in the author's attempt to focus on race rather than social class. This is based on evidence accumulated by researchers such as MacCrone, who has stated:

"In a society organised upon the basis of two mutually exclusive white and black groups, it will be the individual's race membership which will be of far greater importance in determining his attitudes and behaviour than his membership of any particular class within his racial group" (in Lever, 1979, p.195).

A further note regarding terminology has to do with the use of the words "clinician" and "therapist". While recognition is given to the semantic differences and issues involved herein (for instance, some critics maintain that South African universities are producing clinicians rather than psychotherapists), for convenience, these terms are used interchangeably. Unfortunately, limitations of space preclude an in-depth discussion on this point.

As discussed above, the hermeneutic paradigm will be offered as an alternative to the natural scientific positivistic paradigm. The specific *tools* (in terms of language and field of reference) of the enquiry, however, will be borrowed largely from the field of psychodynamic psychotherapy. The fact that psychodynamic language is to be used to analyse the data does not imply that psychodynamic *therapy* is the only modality under consideration. It seems clear though, that if the race-related feelings under consideration do exist, they will occur regardless of the orientation of the therapist, the setting of the therapy, or the mode of therapy (individual, group, family, etc.), although not without influence from these factors.

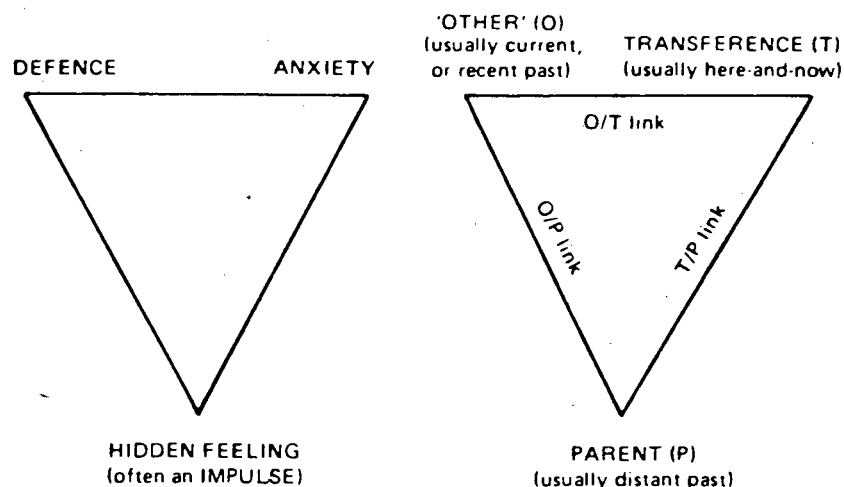
The data of the study is in the form of in-depth clinical interviews conducted by the researcher with seven white therapists regarding their experience of cross-racial psychotherapy. It was the aim of the researcher to enter into research devoid, as far as possible, of pre-conceived notions and theory. Thus, while the interviews are analysed psychodynamically (and, hence, certain presuppositions cannot be avoided), this is more in terms of *process* than theoretical (psychoanalytic or otherwise) *content*. Presuppositions are primarily limited to the central notions of psychodynamic psychotherapy, as outlined in the following section.

## 1.2 PRINCIPLES OF PSYCHODYNAMIC PSYCHOTHERAPY

Malan's (1979) synthesis of the basic principles of psychodynamic psychotherapy provides the basis for the analysis of the interview material. Particularly important is the notion of the two triangles (of conflict and of person) and their related concepts. These are briefly outlined below. For further elucidation of the principles of psychodynamic therapy, the reader is referred to Malan.

### 1.2.1 THE TRIANGLES OF CONFLICT AND OF PERSON

The two triangles represent the understanding and aim of psychodynamic psychotherapy. The therapist's goal is to reach beneath the patient's *defence* and *anxiety* to find the *hidden feeling* (see *Triangle of Conflict*, Fig. 1), and then trace this feeling back from the present to its origins in the past, which is usually related to the patient's parents (see *Triangle of Person*, Fig. 1).



(i) TRIANGLE OF CONFLICT

(ii) TRIANGLE OF PERSON

Figure 1. The Two Triangles (reproduced from Malan, 1979, p.80).

The first triangle is related to the second by the fact that the hidden feeling in the triangle of conflict is directed towards one or more categories of the triangle of person. Almost every intervention made by a therapist can be represented on the two triangles. A significant part of the therapist's job "consists of knowing which parts of which triangle to include in his interpretation at any given moment" (Malan, 1979, p.80). These principles may also be adopted by the researcher wishing to conduct a hermeneutic analysis along psychodynamic lines.

By making use of *interpretations* the therapist attempts to deal with the patient's anxiety, defences and hidden feeling. The patient *resists* the coming to consciousness of hidden feelings which are often *ego-dystonic*. He feels anxious and he defends himself against these hidden feelings. A principle of psychodynamic therapy is that the anxiety and the defence should usually be interpreted before the hidden feeling.

Anna Freud (quoted in Laplanche and Pontalis, 1980, p.110), has pointed out that defence mechanisms may be directed not only against instinctual demands but also against everything else which might give rise to anxiety: super-ego demands, emotions, situations, etc. She cites several defence mechanisms: repression, regression, reaction-formation, isolation, projection, introjection, turning against the self, identification with the aggressor, etc. Melanie Klein (*ibid.*) adds others, which she describes as being very primitive in nature: splitting of the object, projective identification, denial of psychic reality, etc. Other defence mechanisms mentioned in the psychoanalytic literature include rationalisation and intellectualisation. For definitions and explanations of each of these mechanisms, the reader is referred to Laplanche and Pontalis (1980).

The transference/parent (T/P) link shown in the second triangle of Figure 1 represents the area in which the most important psychodynamic interpretations are made. The term 'transference' has come to be used loosely for *any* feeling that the patient may have for the therapist (Malan, 1979). Classically defined, however, it is the experiencing of feelings, drives, attitudes, fantasies and defences, by the patient towards the psychotherapist, which are (i) *inappropriate* to the latter and (ii) a *repetition*, i.e. a displacement of reactions originating in regard to significant persons of early childhood (Greenson, 1965).

S Freud (1921) distinguishes between two different kinds of transference: a *positive* transference denotes affectionate feelings towards the person of the therapist, while a *negative* transference refers to the transference of hostile feelings. 'Positive' and 'negative' refer to the nature of the affects transferred and not the unfavourable or favourable effects of the transference on the psychotherapy. For example, the transference of positive feelings may have negative effects and vice versa.

The transference, both in its positive and negative form, may be used as a weapon by the resistance; the "transference-resistance" is that which reactivates the mechanism of a past repression (Laplanche & Pontalis, 1980).

However, the transference also provides the therapist with his most powerful therapeutic instrument. Freud (1958) stresses the importance of remembering previously repressed material, as opposed to acting it out, or repeating it, in therapy. The transference (itself a piece of repetition) is used to create an intermediate, artificial and provisional region, the "transference neurosis", which replaces the ordinary neurosis and is accessible to intervention. The transference neurosis is "an artificial neurosis into which the manifestations of the transference tend to become organised...its elucidation leads to the uncovering of the infantile neurosis" (Laplanche & Pontalis, 1980, p.462). Thus, as pointed out by Malan (1979), "every therapist must be prepared to recognize transference the moment it arises, to accept it uncritically, to interpret it to the patient when appropriate, to perceive the relation in which it originated and to interpret this to the patient as well" (p.66).

Greenson (1965) has separated the patient's reactions to the therapist into two (imprecise) categories, both of which are essential to psychoanalytic-type therapy. The one is the transference neurosis discussed above, the other is what he terms the "working alliance". This term designates the "relatively non-neurotic, rational rapport which the patient has with his analyst" (p.157) and emphasises the patient's capacity to work purposefully in the treatment situation.

The principles of relevance to the person of the patient and the job of the psychotherapist have been briefly covered. The therapist as a person - the feelings he or she experiences with regard to the therapy process and toward the patient - are usually discussed under the heading of "counter-transference".

#### 1.2.2 THE NOTION OF "COUNTER-TRANSFERENCE"

For some, *counter-transference* refers to everything in the therapist's personality that is liable to affect the therapy; others restrict it to those unconscious processes which are brought about in the therapist by the transference of the patient (Laplanche and Pontalis, 1980). For the present purposes, the former broader definition will be adopted, i.e. the counter-transference includes the conscious and unconscious feelings held by the therapist about the patient and the therapy process.

On the one hand, the counter-transference is to be used as a guide for making transference and other interpretations; on the other, it is an interference and its manifestations need to be reduced.

Regarding the controlled exploitation of counter-transference manifestations for the purposes of the work of psychotherapy, Freud (quoted in Laplanche and Pontalis, 1980, p.93) has remarked: "Everyone possesses

in his own unconscious an instrument with which he can interpret the utterances of the unconscious in other people". Interpretations made by the therapist may be guided by his counter-transference reactions, i.e. by the emotions he experiences in response to his patient at that particular point in therapy.

The second aspect, that of interference, is no less important. Freud (ibid.) stressed the fact that no psychotherapist can go beyond his own complexes and internal resistances. Wolberg (1954) agrees:

"The more insight (the therapist) has into his interpersonal operations, the more capable he is of exercising any necessary control. Where the therapist has little understanding of his unconscious dynamism, he is most apt to respond with unmanageable counter-transference" (p.488).

It is the very rare therapist who can respond with completely therapeutic attitudes towards all patients. The specific display of counter-transference will depend upon the particular problems and personality of the therapist. Wolberg (ibid.) presents various examples:

- (i) The therapist who needs to be authoritarian and directive might pander to dependency strivings in his patient and/or nurture rebellious tendencies in him.
- (ii) Pompousness in the therapist may lead him to make too early and too deep interpretations (in an effort to impress his patient), or to force the patient into actions which are premature.
- (iii) Submissive and passive traits in the therapist render him unable to offer guidance or firmness when appropriate.
- (iv) The therapist may become detached as a defence against entering into close contact with some patients, and therefore make it very difficult for his patients to relate to him.
- (v) Perfectionistic impulses may cause the therapist to drive the patient compulsively toward goals which are beyond the patients' capacities or, if they are appropriate, at an inappropriately rapid pace.

- (vi) Guilt or anxiety about certain of his own impulses, such as those concerning sexuality, hostility and assertiveness, may lead the therapist to inhibit their expression in the patient.
- (vii) Transference may become extreme and perhaps insoluble if the therapist, under pressure of his own neurotic drives, sets up a situation in treatment that parallels closely the traumatizing environment of the patient's childhood.
- (viii) Certain patients may evoke strong feelings of rejection and intolerance in the therapist and hence the emotional climate so important for personality growth will be absent or even destructive.
- (ix) An openly antagonistic patient may precipitate counter-hostile attitudes in the therapist.
- (x) A seductive patient may stimulate sexual feelings in the therapist.

Counter-transference may become more pronounced during different phases of therapy, such as during periods of resistance, or during the termination phase, when the therapist's own feelings of loss might be evoked.

The aim, therefore, is to reduce the anti-therapeutic manifestations of the counter-transference so that the psychotherapeutic situation may ideally be structured exclusively by the patient's transference. It is for this reason that many psychotherapists are advised to undergo personal psychotherapy. Counter-transference may result in therapeutic failure and must therefore be given the appropriate attention as soon as possible.

It should be pointed out, though, that the issue as regards counter-transference is not the existence of fantasies in the therapist but whether his situation is so emotionally desperate that he is prevented from analyzing his reactions and consequently acts them out.

Having outlined the principles of psychodynamic therapy, let us turn our attention to the second primary aspect of the study, viz. that of racial attitudes - their development and manifestations, and the theories that have been put forward in order to account for them.

CHAPTER TWO  
RACIAL ATTITUDES

A review of the empirical studies on the development and manifestations of racial attitudes per se will be followed by a review of the literature, empirical and otherwise, on cross-racial psychotherapy. Following these two sections will be a further review, that of the more popular theories of racial prejudice.

The present chapter has been included at this point for the following reasons:

- (i) To provide the reader with general background knowledge regarding the work that has been done in the field of racial attitudes and its relationship with psychotherapy.
- (ii) To provide direction for the present study (regarding both methodology and content) by taking note of the limitations of previous research.
- (iii) To provide a point of reference, not to be used a priori (as noted, it is my intention to enter into dialogue with the data with as few presuppositions as possible), but a posteriori, that is, for comparative and explicatory purposes following the completion of the study's primary task, which involves the interpretation of the interview material.

## 2.1 A REVIEW OF THE EMPIRICAL LITERATURE

### 2.1.1 'STUDIES OF RACIAL ATTITUDE DEVELOPMENT IN YOUNG CHILDREN

There is general agreement amongst researchers that children become aware of racial differences at a very early age. Goodman (1964), using a doll-preference task, found that racial awareness was present in most three and four year olds taking part in her study. Investigations involving children of various races by Clark and Clark (1939; 1940) and Stevenson and Stewart (1952), amongst many others, support these general findings. In fact, Ammons (1950) found manifest racial awareness in many children as young as two years.

Katz (1976) has proposed a theory of racial attitude development which encompasses eight overlapping steps, spanning about ten years of the child's life approximately concomittant with the anal, through to the latency phases. These steps are as follows:

- (1) early observation of racial cues;
- (2) formation of rudimentary concepts;
- (3) conceptual differentiation;
- (4) recognition of the irrevocability of cues;
- (5) consolidation of group concepts;
- (6) perceptual elaboration;
- (7) cognitive elaboration; and
- (8) attitude crystallization.

### 2.1.2 PARENTAL FIGURES AS SOURCES OF RACIAL INFORMATION

Berger and Luckmann (1967) have stated that the child internalizes the world of his significant others as, not one of many possible worlds, but as the only existent and conceivable world. Using attitude scales, Foster, Friedman and Wilson (1984) found high positive correlations, ranging from 0.38 to 0.91, with a mean of 0.53, between the anti-black attitudes

of young white English-speaking middle-class South African children and their parents. Weaker positive correlations have been reported by, for example, Harris, Gough and Martin (1950) and Mosher and Scodel (1960).

Contrary to these results, Diamant (1969) and Pushkin and Veness (1973) found no relationship between children's and their parents' attitudes. However, given the findings of child-parent associations in general attitudes (e.g. Murphy, Murphy and Newcomb, 1937), it is likely that parental figures hold some degree of influence upon the developing child's racial attitudes. The salience of race in South Africa may explain the remarkably high correlations obtained in Foster, Friedman and Wilson's study and is suggestive of a stronger parental influence in this country.

The importance these findings have for the present research may be gleaned from the fact that the discovery of the source of attitudes is a necessary part of the process of psychotherapy. This aspect is also inextricably bound up with the nature of the transference and counter-transference.

### 2.1.3 SKIN COLOUR AS A RACIAL CUE

Goodman (1964), in her studies on racial awareness, found skin colour to be the main focus of concern. Hair quality, eye colour and other cues, although important, were secondary. McDonald (1973) agrees:

"According to our findings it is especially the difference in skin colour which is at the root of a racial prejudice" (p.95). In a South African study, Melamed (1968) found that "skin colour...was the cue most utilized for discrimination" (p.5) and that this was learned by the age of six. Using a paired associates test, Melamed also found that subjects learned the colour cue faster than the cues of curly hair, thick lips and large nose. This is in accordance with the Cieutat et al (1958) finding that the most meaningful stimulus is learned quickest in paired associates learning.

In South Africa, one would expect the features of speech and language to be of some importance. To date, however, these cues have not been studied with regard to racial attitudes.

#### 2.1.4 THE CONNOTATIVE MEANINGS SURROUNDING COLOUR

In Western-orientated, white-dominated cultures negative emotional attitudes have come to be associated with particular darker colours, viz. yellow, brown, or black, which tend to be associated with notions of dirtiness, destructiveness or unpleasant smell. Light colours, on the other hand, especially white and pink, tend to be associated with ideas of cleanliness, purity, innocence and chastity (McDonald, 1973).

The attitude of Europeans coming in contact with Africans in the sixteenth century was that "black was the colour of the devil and all that was base, bestial, sensual and evil" (Hoch, 1979, p.50). That these attitudes have not changed much can be seen in such contemporary creations as the immensely popular film *Star Wars*, where the prototype of the good hero is the blue-eyed blonde Caucasian Luke Skywalker and the villain is Darth Vader, a monstrous figure dressed in black.

The association of white and black with the polarities of good and evil may be further exemplified by examining the Bible and English literature. Isaacs (1972) cites several Biblical examples, such as Job crying out in self-arraignment, "my skin is black", using this figure of speech to "show how heavy was his burden of sin" (p.146). Indeed, for many years, the negative references to black in the Bible provided the architects and supporters of apartheid with pseudotheological arguments in support of their views.

Apart from the actual English language, which contains many examples of negative connotations to the colour black (e.g. blackmail, blacklist, black magic), the great writers and poets such as Shakespeare, Blake and Milton sustain this theme. The villain in Shakespeare's first tragedy, *Titus Andronicus*, for instance, is a black man.

The manifestations of these negative colour connotations in young children have been well recorded in the literature. Goodman (1964), for instance, found that many of her Negro children called their skin colour "dirty" and wanted to scrub it off; Lasker (in McDonald, 1973) describes the case of a five year old white boy who exclaimed to an approaching Negro child: "Look out, little black child, don't breathe your black breath on me!" (p.178); while one of McDonald's (1973) white children remarked to a peer: "Don't worry I found out that it won't rub off!" Landreth and Johnson (1953), using picture completion tests, found that children as young as three know that skin colour is important and are capable of regarding white as desirable and black as undesirable. Williams et al (1967, 1971, 1975) have studied the acquisition of evaluative colour concepts in pre-school children and have used operant theory to explain their results. They found that most of the children tested (on, for example, the Preschool Racial Attitude Measure (PRAM)) associated positive adjectives with white persons and negative with black people. These investigators hypothesise that infants have innate preferences for lightness over darkness and that these preferences then generalise to skin colour. This is then reinforced by the linguistic symbolism discussed above, i.e. the association of "white" with "goodness" and "black" with "badness".

### 2.1.5 SELF-CONCEPT AND RACIAL PREJUDICE IN CHILDREN

Many investigators have described the feelings of inferiority, self-hate, submissiveness, persecution, withdrawal and general low self-esteem of the black children in their studies (e.g. Clark, 1963; Goodman, 1964; Horowitz, 1939; Porter, 1971). Impaired identity formation in the black or coloured child is attributed to a state of conflict about his colour.

It appears that identity formation in the white child is also distorted by racial conflicts. Brody (1964), for instance, found that white children's perceptions of Negro figures contributed to their own sense of identity in that (a) "the perceptions may have helped in the establishment of an identity as 'white' meaning privileged, dominant, good and happy in contrast to an identity as 'black' or 'Negro' meaning underprivileged, subordinate, bad, sad and lonely" (p.359); and (b) "the 'white identity' of a child raised in an atmosphere of racial tension contains within it partly conscious fragments of 'Negro identity'" (p.359), i.e. blacks represent the white child's fearful or unacceptable aspects.

South African studies, on the whole, support these findings. Gregor and McPherson (1966) found that both black and white children showed a preference for and attempted an identification with the 'valued white ideal'. Melamed's (1970) group of English-speaking white children manifested a similar ethnocentric attitude. Hudson et al (1966) found that, despite the early relationships formed by most white children with a black nanny, from approximately five years of age, "there is a conviction of the superiority of the white man" (p.36). Stressing another aspect, Bloom (1974) writes:

"The dominant feature in the development of the white self-concept is the increasing insulation of the white individual and the consistent pressing sense of the blacks as a threat and a danger to the whites" (p.152).

In a study by Van der Westhuyzen (1967), white senior school girls were found to have higher self-esteem than their coloured counterparts. The use of skin lighteners and hair straighteners and the phenomena of "passing for white" (Watson, 1970) is further evidence of a need for increased self-esteem through a desire for whiteness.

Logan (1981) objects to what she calls "this noxious labelling of black children and youths" (p.48) and cites American research showing either no differences between the self-concepts of white and black children, or more positive self-concepts of the black child. Momberg and Page (1977), in a South African study, concluded that "generally white and coloured self-esteem is the same" (p.197) and attribute this change to the rejection of the negative stereotype by blacks and the growing emphasis on Black Consciousness.

Thus, two conflicting views emerge from the research literature. The truth probably lies somewhere in between. There may well be an increase in the self-esteem of black children over recent years due to the growing popularity of Black Consciousness. However, it seems unlikely that oppressed and denigrated groups, especially in South Africa where polarisation is so extreme, could escape identity impairment caused by racial prejudice. It is this researcher's view that results such as those obtained by Momberg and Page, which show no difference between whites and coloureds regarding self-esteem, are biased due to their subjects' self-esteem having been measured in a social vacuum. In other words (as is hypothesized), if the behaviour and feelings of the coloured or black individual were measured in the context of him interacting with a white individual, one would still find an overall discrepancy in self-esteem across racial groups.

#### 2.1.6 OUT-GROUP ATTITUDES OF SOUTH AFRICAN ADULTS AND ADOLESCENTS

"The best way of describing South African society", writes Feit (1967), "is to say that it consists of groups of peoples thrown together by history, all hating each other, but not enough to want to end their relationship. South Africa is, in other words, the same as everywhere else - only more so" (p.403).

MacCrone (1938) found that the stereotype of the coloured was the most unfavourable of all ethnic groups in South Africa. He also found that Africans were most hostile towards Afrikaans-speaking whites. The attitudes of whites towards blacks he considered to be a complex compound of superiority, hostility, dislike, contempt and fear. Lever (1979) confirms part of these findings: "There is sufficient evidence to indicate that most whites tend to think of blacks as inferior" (p.186).

Ashmore and Del Boca (1976) have reviewed studies of "perceived racial threat", which is conceptualized as different to racial prejudice in that it has a "larger fear and a smaller contempt component and involves beliefs that blacks are trying to usurp the position of whites...rather than notions about black inferiority" (p.102), and have found preliminary evidence for the existence of this syndrome.

Bloom (1960) writes of the "extreme hostility" of his coloured subjects towards whites. Gerhart (1978) explores and documents the anger of the black, coloured and Indian groups from a historical point of view.

Studies on "tokenism" or reverse discrimination, an increasingly more evident phenomena in South Africa, have been conducted in America and Canada. Allied to this is the finding by Ashmore and Del Boca (1976) that middle-class whites who value egalitarianism and who have little contact with blacks, bend over backward for the black in an interracial

encounter in order not to appear prejudiced (to themselves and/or to others). Dutton and Lennox (1974) found evidence for the hypothesis that once middle-class whites have demonstrated their non-racist, egalitarian values by "token" altruisms, they are less likely to make more significant contributions to the minority group progress.

Research on guilt and ambivalent racial attitudes indicates that guilt which follows an aggressive act towards an outgroup member is dealt with by denigrating the victim and hence justifying the aggressive act (Katz, Glass and Cohen, 1973). These researchers do point out that the possibility of other guilt-reducing means is not precluded. For instance, altruistic behaviour, which was not allowed in their experiment, has been shown to reduce guilt (Freedman, 1970).

#### 2.1.7 SEXUAL STEREOTYPES AND MYTHS

In the introduction to this work, mention was made of the sexual aspect of racial attitudes. Indeed, many researchers stress the importance of the role that sex plays in racial hostility. As early as 1937, MacCrone, reporting on South Africa, wrote:

"The idea of a white woman in the arms of a black man, especially if she is there of her own free will, is enough to give rise to the most phenomenal emotional reactions in the white man" (p.310).

The scope of this study precludes an in-depth analysis of "sexual racism". However, some of the basic stereotypes and myths are presented (see Fanon, 1967; Bastide, 1972; Stember, 1976; Hoch, 1979):

- (i) The black man is a wanton, sexual beast with an oversized penis;
- (ii) His sexual drives are greater than those of the white man and his desire harder to satisfy;

- (iii) White women are in ever-present danger of being raped by black men;
- (iv) Blacks suffer from sexually transmitted diseases far more often than whites due to their sexual promiscuity.

Stember (1976) found that, from most blacks' point of view, their supposed super-sexuality is a myth of the white man's imagination. The same researcher could find only one experimental study which directly investigated the sexual racism theme, that of Schulman's. Using a variation of Milgram's method, Schulman found that the "sexual hostility of the white male (towards the black) is not limited to some special group of males but extends even to those whom, on traditional grounds, one might expect to be free of such hostility" (in Stember, 1976, p.34).

#### 2.1.8 CONCLUSION AND CRITIQUE

The above research provides several points of interest with regard to the study of white therapists' racial attitudes: the early development and entrenchment of racial attitudes; the significance of parental figures as sources of racial information; the primary importance of skin colour as a cue for identification; the entrenched connotative meanings surrounding colour, not only within western society but across time; the existence of feelings of hostility, fear, guilt, and so on, between the various race groups in South Africa; and the existence of a strong sexual component to racial attitudes.

A major criticism pertaining to many of the above studies regards their use of survey questionnaires. According to Wellman (1977), "people who disagree with the ostensibly prejudiced statements found in questionnaires are not necessarily less ethnocentric or prejudiced or more tolerant than

the people endorsing them" (p.32). Factors such as economic security (and, therefore, distance from racial problems) and inability to tolerate ego-alien feelings (e.g. the white liberal who feels too guilty to acknowledge anti-black feelings within himself) may be distorting the data.

A second difficulty relates to the focus of most of the above research, which is on overt forms of prejudice. While some studies hint at more subtle levels of prejudice in the "liberal" individual, the empirical methodologies are inadequately suited to an in-depth analysis of this phenomenon.

Both the above criticisms will be discussed in more depth at a later stage.

While it may be possible, by means of conjecture, to imagine what the manifestations of these underlying attitudes will be in the work of the white therapist, it is clearly of more benefit to examine the actual studies of cross-racial psychotherapy.

## 2.2 A REVIEW OF THE LITERATURE ON CROSS-RACIAL PSYCHOTHERAPY

Most researchers agree that the subject of race is hardly ever explored during psychotherapy; while the theory of the importance of racial factors is readily accepted by clinicians, "there is often extreme resistance to practical application of the idea" (Gochros, 1966, p.28). Mathabe (1983) suggests that this resistance may underlie a good deal of the difficulty in cross-racial psychotherapy.

Kadushin (1972) notes that the "participants are keenly aware of the (racial) difference between them" (p.91) and agrees that the issue is rarely discussed openly. However, he feels that it is not clear whether this is because both therapist and patient agree to a conspiracy of silence about a potentially threatening issue or whether it is because

race is considered irrelevant to the work at hand.

In spite of this attitude, there has been a fair amount of research in the area of race and psychotherapy, representing essentially four types of investigations:

- (i) Outcome studies of actual psychotherapy;
- (ii) Epidemiological studies regarding types of disorders, patient numbers, and method and length of treatment;
- (iii) Analogue studies consisting of laboratory investigations of same and differing race interviewer-interviewee interactions; and
- (iv) Clinical impressions of experienced cross-racial therapists.

Transference and especially counter-transference phenomena are discussed relatively seldomly. When these issues are explored they generally form part of category (iv) above.

The present section reviews the main issues explored by the various types of studies. These are examined under two general headings:

- (a) the effectiveness of cross-racial psychotherapy, and
- (b) process variables in cross-racial psychotherapy.

#### 2.2.1 THE EFFECTIVENESS OF CROSS-RACIAL PSYCHOTHERAPY

It is generally acknowledged that racial groups differ in their therapeutic needs (Westbrook, Miyares and Roberts, 1978) and expectations (Yuen and Tinsley, 1981). Although several investigators have questioned whether a patient can actually be helped by a different race therapist,

the overwhelming consensus is that, provided racial differences are taken into account and the therapist has an understanding of his patient's racial and cultural background, cross-racial therapy can work (e.g. Mathabe, 1983; Dawes and Davids, 1983). Grier (1967), noting the necessity of establishing a working alliance, finds differences "to be no serious problem once the hidden and highly individualistic meanings that the patient imposes on the racial differences are exposed" (p.1587).

Some investigations though, have indicated that racial homogeneity enhances therapeutic effectiveness (e.g. Fry, Kropf and Coe, 1980). Porché and Banikiotes' (1982) and Grantham's (1973) studies suggest that patients prefer racially similar therapists. Banks (1972) compared the variables of race and experience and found the former to be of greater importance in working with black patients. Bryson and Cody (1973) showed that blacks were better understood by black therapists. Rosen and Frank (1962) maintain that the counter-transference of the white therapist can lead to, at worst, traumatizing the black patient still further, or, less dangerously, to impeding the effectiveness of treatment.

Jones (1978) has criticized some of the above studies on several methodological counts: "therapists" were often not professionals; "patients" were often college students taking part as research subjects; "therapy" often consisted of a single, initial interview; and many studies used client-centered therapy, an approach entailing specific conditions which might not have the same relevance for other modes of therapy (as demonstrated by Bergin and Jasper, 1969).

Other investigations have revealed contrasting findings. Proctor and Rosen (1981) and Jones (1978, 1982) have found that patients benefitted approximately equally regardless of racial matching, while Grier (1967) feels that the use of race-differences in therapy can lead to enhanced effectiveness. The different-race therapist, says Grier, offers the patient

"an additional element of external reality - one heavily charged in this society. The patient makes use of this element in expressing or representing precisely those aspects of his neurosis which are highly cathected, providing the therapist often with a unique opportunity to trace complex, intensely experienced conflicts by means of the brightly coloured thread of race" (p.1591).

Niemeyer and Gonzales (1983) also found no differences in effectiveness of the therapy as measured by therapist and patient ratings of perceived relief, understanding and coping. However, these investigators, in reviewing the literature, conclude that American blacks have been dissatisfied with traditional therapy, reflected in underutilization and premature termination. They also found, in their study, that relative to other treatment dyads, white patients seeing white therapists attributed their change more to therapy than to other outside factors. X

The studies indicating no difference in overall therapeutic effectiveness may be criticised on a number of points.

Firstly, Jones' studies did not include those patients who dropped out in the first eight sessions. Bearing in mind that, as Jones (1982) himself points out, it is precisely in this early phase of treatment that race difference is likely to have its greatest effect, this is an important point. Secondly, making use of therapists as raters of their own effectiveness brings in the variable of counter-transference and this may bias the results.

Furthermore, the above studies were conducted in multiracial settings in the United States, one result of which may be that the therapists involved in these studies may have a higher sophistication with regard to racial issues. Indeed, some therapist subjects were self-selected, thus introducing a further bias. Another facet is the difficulty of generalising these findings to South African conditions where the racial situation is that much more overdetermined. Unfortunately, there appear to have been no empirical studies comparing treatment outcome of homogeneous and heterogeneous therapeutic dyads conducted in this country.

### 2.2.2 PROCESS VARIABLES IN CROSS-RACIAL PSYCHOTHERAPY

While the evidence concerning the effects of racial differences on treatment outcome is inconsistent, the literature is consistent in its assertion that there are clear differences in therapy process when the treatment dyad is racially mixed as opposed to being racially homogeneous.

For instance, Vontress (1971) expresses the extreme view that the transference when the therapist is white and the patient is black is almost always negative, even though this is not always overtly expressed.

The literature has been reviewed, although not exhaustively, and process variables have been split up into logical units. For convenience, the manifestations of both the counter-transference and the transference have been included under each heading. At this stage, information regarding therapists of colour and white patients has been included, although these individuals are somewhat excluded from the focus of the interviews analysed later in this study.

#### 2.2.2.1 IMPEDIMENTS TO THE ESTABLISHMENT OF TRUST AND RAPPORT

The widely noted phenomenon of black patients dropping out in the very early phases of therapy (Sue, 1981) is evidence of problems in establishing effective rapport and building a therapeutic alliance. As noted above, Jones

(1982) has remarked that it is precisely in the early phase of treatment that race difference is likely to have its greatest impact.

Edwards (1982) states that it is problematic for a black patient to identify with and trust the white therapist who is seen as an oppressor. Indeed, Banks (1972) found increased rapport and self-exploration in homogeneous (black) treatment dyads. With the white therapist there is an unwillingness on the part of the patient to reveal weakness for fear that this will be capitalised upon, distrust having developed due to continued exposure to discrimination (Rosen & Frank, 1962). Beck (quoted in Tukulu, 1983) writes that

"A feeling of trust is an impossible achievement in a white dominated milieu where there is a history of degradation of blacks by whites and an equally apparent insensitivity to the presence and needs of blacks" (p.16).

According to Beck, blacks develop "suspiciousness of their environment" (ibid.) and test the therapist to see if they will receive the accustomed rejection from a person in authority. Tukulu (1983) states:

"They keep aloof; they smile, they nod, but they do not trust; they say 'yes' even when they should say 'no' - they will not open up until they have satisfied themselves that it is safe to do so" (p.16).

Communication and rapport is impeded: in the everyday black/white relationship the "white talks and the black listens", making it difficult to adopt the "communicative equality" (Van den Berg in Manganyi, 1973, p.12) so necessary for a therapeutic relationship. The black patient expects to be responded to in the customary master-servant mode and "would definitely be thrown off-balance by a white who accepts him on a 'man-to-man' basis" (Tukulu, 1983, p.16).

Several other authors (e.g. St. Clair, 1951) also report experiencing special difficulty in establishing rapport with black patients due to the latter's suspiciousness and submissiveness which arises out of a basic distrust.

A further impediment is the common belief that a white's interest in a black is due to ulterior motives, either because he has a need to be seen as a care-giver, or because he achieves neurotic satisfaction from playing "one-upmanship" (Tukulu 1983).

The manifestations of a lack of trust are numerous. An example quoted by Rosen and Frank (1962) deals with a misunderstanding in which a black patient, who has been told by his white therapist that he must learn to live with his symptoms, attributes this to anti-black prejudice rather than psychiatric reality. Other problems arising out of distrust include the diminished effect of the therapist's empathy or interpretations; the fact that anger may only be expressed passively; the possible emergence of transient signs of paranoid feelings; etc.

In addition, Vontress (1971) has found a strong tendency for therapist self-disclosure to be decreased the less the patient resembles the therapist. X

A further difficulty for the therapist lies in the fact that different race patients may present with different problems. Although the American experience often appears to be that blacks present with the same disorders as whites of the same class status (Rosen and Frank, 1962), it may well be that the picture in South Africa is somewhat different.

An important area, addressed by, for example, Sue and Sue (1977) and Dawes and Davids (1983), is that of idiosyncratic cultural factors impeding cross-racial communication. They discuss variables such as language; non-verbal communication; idiosyncratic rituals and culture-bound values; and idiosyncratic ways of dealing with emotional distress. These authors show how each of these variables can act as a source of conflict and misinterpretation in psychotherapy.

Dawes and Davids (1983) cite the example of a young, educated Muslim person who addresses an elder from his community in English (as opposed to the vernacular Afrikaans). He might be making a statement that he wishes to distance himself from the community and its values. The therapist who does not recognize this is at a disadvantage.

Kruger (1980) points out that, although a white therapist and his black client might be speaking the same language, "it is not, however, entirely the same language because the verbal communities from which they come differ extensively" (p.26). X

Another problem of communication, writes Kruger, might arise when a white therapist attempts to elucidate the feeling aspects of his black client's existence when the "traditional life of blacks in South African tribal life hardly calls for the expression of purely personal feelings" (ibid.). Kruger's experience, however, was that optimal conditions could be created, partly by the therapist "opening up", in which the black client might express his feelings about his being-in-the-world.

The differences between the white and black regarding the desirability of, and their ability to assert, their personal autonomy represents another communication problem (Kruger, 1980). For instance, personal autonomy is not, according to Kruger, a valid category of being for the traditional Xhosa. X

#### 2.2.2.2 ACQUIESCENCE, DEPENDENCY AND OVERAFFABILITY

The black patient often conceals his hostility by a submissive attitude which then results in a pseudodependency upon the therapist (St. Claire, 1951). Pinderhughes (in Tukululu, 1983, p.17) makes the observation that blacks often relate to therapy as something done to them, rather than with them. Many blacks, especially those of lower class status, tend to defend themselves against anticipated demands from whites by assuming an exaggerated air of stupidity or indifference (Rosen and Frank, 1962). Similarly, overaffability is often quoted as a defence of the black patient (ibid.).

These responses may not only result in the white therapist misunderstanding his patient, but in his fostering of these defensive reactions. This, in turn, may be interpreted by the black as an attempt by the white man to ensure the former's sense of inadequacy (Gochros, 1966). In this way, an unfortunate self-perpetuating cycle is set up.

#### 2.2.2.3 SELF-HATRED

Rosen and Frank (1962) have found that attitudes of self-hatred are particularly difficult to reveal in the presence of a white therapist but "eventually do appear if therapy is sufficiently prolonged" (p.457). Feelings of self-hatred may manifest in envy of the more "assimilated" black or patronisation of the less "assimilated" black (i.e. into white culture).

Grier (1967) speaks of the white patient, who, because of his own feelings of inferiority, identifies with the black therapist whom he sees as being castrated. Negative feelings toward the therapist are bound up with negative feelings toward the self and both are repressed under the guise of love and admiration for the therapist. These people, Grier points

out, avoid the topic of race and become annoyed when it is brought up - as it must in order to expose the self-destructive core of the neurosis. X

#### 2.2.2.4 ANGER AND PASSIVE-AGGRESSION

Anger and hostility may arise out of idiosyncratic social and individual factors or as a result of racial discrimination. Often these etiological factors cannot be separated. St. Claire's (1951) observations may well apply to many South African coloureds and blacks. He frequently found in Negro families the presence of a harsh, rejecting and unstable father, an insecure mother, and the existence of a matriarchal home. This resulted in excessive hostility toward the father and other male authority figures, and a concomittant strong dependency and unconscious hostility towards maternal figures.

It is widely noted (e.g. St. Claire, 1950; Tukulu, 1983) that the black patient has a great deal of difficulty in expressing direct anger towards his white therapist. Often hostility towards various situations and people (including whites) is freely expressed, but the patient usually suppresses and attempts to disguise his hostility toward the therapist. X

Pinderhughes (in Tukulu, 1983, p.17) lists the following behaviour as representing the indirect expression of aggression: silence, resistance, claims of being a passive victim of circumstances that interfere with therapy, lateness, non-payment of bills, missed appointments, and termination of therapy. Sullenness is another manifestation of passive-aggression (Rosen and Frank, 1962).

Grier (1967) presents the case of a white Jewish businessman who projected his own anger onto a racial screen. He expected to receive punishment from his black therapist for all the wrongs he felt Jews had done to blacks, X

thereby projecting a feeling of having been victimised onto the therapist. Elaboration of this theme in therapy revealed the patient's fear of a castrating father.

Other white patients, writes Grier, need to see the therapist as depreciated or castrated so that their own hostile impulses may find a vulnerable target and they may feel safe from counter-attack. X

As regards the counter-transference, passive aggression in the clinician may take the form of subtle rejection of black patients so that they stop coming to see him. The clinician's anger may have entirely idiosyncratic origin, or it may, for instance, be in response to passive aggression on the part of the patient (Rosen and Frank, 1962). X

Gochros (1966) cites fear of unleashing "uncontrollable" and "irrational" anger directed by the black patient towards the white therapist as one reason for resistance of the latter to explore this area. Even with therapists who treat most other instances of anger as a transference phenomenon and handle them relatively comfortably, the case of racial anger presents difficulties. This appears to be because of the guilt felt by the white therapist due to his membership of the exploiting race. Furthermore, if he is honest with himself, he will realise that he, as a white, could not have escaped becoming imbued with some prejudice. This may result in a defensive reaction to prevent ego-alien attitudes from being revealed.

#### 2.2.2.5 GUILT, REVERSE DISCRIMINATION, PATRONISATION AND REJECTION

Counter-transference may be evidenced by the white therapist's over-zealousness to help. This reverse discrimination represents an attempt to assuage guilt due to unconscious prejudice towards blacks and to atone for the sins of the white race. The clinician may provide extensive or intensive treatment - "leaning over backwards" - when neither is indicated (Harrison and Carek, 1966). In the realm of social work, the worker might provide extra payments (Gochros, 1966).

Kruger (1980) reports that he came to realize that the problem

"...was not the client but myself as the therapist. I had to work through my own anxieties and guilt feelings in this regard. It became quite clear that I could not merely hide behind the façade of a professional relationship without accepting my client as a fellow human being" (p.29).

Vontress (1971) refers to "the great white father syndrome" whereby the therapist needs to communicate to his black patient that he is both omnipotent and well-meaning. The unconscious communication is that if the black patient does not depend upon him, he (the black) will be doomed to catastrophe.

The phenomena of patronisation represents a further example of counter-transference. This may take the form of oversimplification of the patient's concerns, or a tendency on the part of the therapist to view racial and cultural conflicts as being at the root of all 'his patients' problems, i.e. a failure to see blacks as human beings first and black second (Adams, 1950).

Burns (in Kadushin, 1972, p.91) points out that black children (and no doubt, adults) have learned how to manipulate the guilt feelings of their white therapists.

Reparative needs may be manifest in the patient depreciating his therapist in order to act out the fantasy of rescuing a damaged or endangered parent (Grier, 1967).

Intermittent school attendance, frequent change of job, illegitimate children, jail sentences, drug abuse and other signs of antisocial behaviour may have different implications for the black and white patient or clinician (St. Clair, 1951; Gochros, 1966; Rosen and Frank, 1962). This may have negative implications for the counter-transference in that it may result in the clinician disapproving of, or even rejecting, her patient.

#### 2.2.2.6 MATERNAL FEELINGS

Grier (1967) describes the transference of the white patient who has been reared by the "ever-indulgent" black nanny. The black therapist (male or female) is perceived as the all-forgiving, totally uncritical, idealized maternal object. Interpretation of this projection reminds the patient that he cannot act on every instinctive impulse simply because his therapist is black, and this evokes an intense and persistent hostile response. Often the patient protests that he had tried to be fair and liberal but now he finds himself in the hands of an embittered black. Grier writes:

"This reaction must be blunted by the tactful interpretation of the initial positive transference and its repeated identification as a projection onto the therapist of all those qualities the patient wanted to see in his own mother and the specific prediction that surely the day would come when the therapist will become the bad mother endowed with an equally unrealistic set of negative characteristics" (p.1590).

#### 2.2.2.7 SEXUALITY AND BODILINESS

Fanon (1967) offers his observation that many whites, especially white women, perceive the black as a phobogenic object. Vontress (1971) notes that many white female therapists experience great anxiety when dealing with a black male, particularly if he is between the ages of sixteen and thirty and if the female therapist is about the same age as her patient and, Vontress adds, "especially if the door is closed" (p.9). X

Grier (1967) notes that patients who tend to sexualise the transference also tend to introduce the racial factor in order to intensify the process of sexualisation. He illustrates his point with the example of a white woman who projected onto her black therapist the fantasy of a "dark lover with no impulse control" (p.1589). This patient's feeling of shame at having a Negro therapist was due to her own guilt and disapproval of the content of her erotic fantasies. X

Jones (1978) states that an erotic transference "appears to develop most readily in racially congruent pairings, and is relatively subdued, perhaps even suppressed, in racially dissimilar pairings, particularly in the white therapist - black client dyad" (p.235).

Kruger (1980) feels that the underlying taboo which surrounds sexual intercourse between black and white necessarily extends to social intercourse in a wider context. In discussing the distance between a white man and a black woman in South Africa, he points out that there is not only a difference in skin colour, but also a difference in "bodiliness" not meant in a physiological sense but rather "in the sense of our being a body in the world...the body that has an 'outside' as well as an 'inside'... the body that is capable of body language" (p.29). In his work with a black female patient, Kruger found that his acceptance of her at the "non-verbal bodily-communicative level" was crucial to the success of the therapy.

#### 2.2.2.8 CONCLUSION AND CRITIQUE

The nature of the findings regarding the effect of race on psychotherapy are, on the whole, contradictory. Many conclusions are made tentatively and methodologies have often been shown to be deficient. Those studies using a natural scientific positivistic framework are subject to criticism regarding their inappropriate application to the study of human beings. The overwhelming majority of studies which have been reported from a phenomenological point of view are problematic in that the authors explicate their own experiences of therapy without being self-reflective. This lack of self-reflection makes it difficult to ascertain whether, for instance, the statements made by some therapists regarding their enhanced efficacy due to their different race do not represent a need for reparation or a wish-fulfillment. Allied to this point is the fact that most researchers focus on the transference, rather than the counter-transference. In addition, little work has been conducted in South Africa, and there are problems concerning the generalisation of overseas studies.

Nevertheless, certain tentative conclusions can be drawn. In many instances, effective treatment does not rely on racial homogeneity, while in some cases race-difference may be used to enhance efficacy. In other cases racial homogeneity appears to be therapeutically desirable and perhaps even essential. The problem is thus a complex one. What seems to be apparent from the literature is that in most instances race alone may not be the single critical factor for a successful therapeutic outcome. Rather, that it is one of a number of important patient and therapist characteristics, and that its importance varies according to the particular therapist-patient dyad.

One finding which appears to be beyond reasonable doubt is the necessity of taking the racial factor into account (because of its effect on the therapy process) especially when race is overdetermined in the society to which the treatment dyad belongs.

The research that has been reviewed up to this point has been mostly descriptive in nature. In order to explore the explanatory level, the following section will examine some theories that have been posited regarding racial prejudice per se.

### 2.3 THEORIES OF RACIAL PREJUDICE AND THEIR LIMITATIONS

Jones (1972) has aptly stated that "the theory of prejudice is as complex as the society which houses its phenomena" (p.104). Reviews have been attempted by Allport (1954), Kinloch (1974), Milner (1975), Ashmore and Del Boca (1976), amongst others. The present review is not exhaustive but presents the main areas of emphasis. Ashmore and Del Boca (1976) have divided the area into two levels of explanations: societal and individual.

### 2.3.1 SOCIETAL-LEVEL EXPLANATIONS OF PREJUDICE

The theories included in this category "seek to account for how properties of relationships between groups shape the attitudes of the individuals comprising these groups" (Ashmore and Del Boca, 1976, p.75).

#### 2.3.1.1 EXPLOITATION THEORY

Jones (1972) puts forward Cox's view: "race prejudice is simply a social attitude perpetuated to maintain and justify the superior, advantaged position of the upper class in relation to the underclass" (p.105). While political and business leaders, in many instances, no doubt use, and thus perpetuate, intergroup conflicts to further their own ends, there is little direct evidence to say that "conscious propagation of racism by elites is a significant determinant of individual attitudes" (Ashmore and Del Boca, 1976, p.75). Furthermore, it seems clear that the exploiters do sincerely (on a conscious level, at least) believe in their racial superiority.

#### 2.3.1.2 NEGATIVE INTERGROUP RELATIONSHIPS

This theory holds that "positive intergroup interdependence (e.g. allies in wartime) promotes favourable intergroup attitudes, while negative intergroup interdependence leads to hostile intergroup attitudes" (ibid.). Van den Berghe (1980) has identified two "ideal types" of racial prejudice: "paternalistic" and "competitive". With the former type, where there is an exaggerated dominant-subordinate interdependence, the most congruent image of blacks is that of an inferior being in need of care. The "competitive" type sees blacks and whites competing for economic and political power and produces an image of blacks as aggressive and threatening. Both these types exemplify negative intergroup interdependence.

This theory (as do all the others) rests on the perennial "chicken-and-egg" problem, i.e. did the intergroup relationship shape individual attitudes or

vice versa? Since the argument between sociology and individual psychology is beyond the scope of this thesis, the problem shall not be tackled here. However, it does seem that if one is to explain the mechanism by which the decrease in prejudice in the individual that is hypothesized in the "positive intergroup interdependence" situation, is brought about, one must resort to one or other "individual level" theory.

### 2.3.2 INDIVIDUAL-LEVEL EXPLANATIONS OF PREJUDICE

#### 2.3.2.1 SOCIALIZATION AND CONFORMITY

This explanation assumes that racial prejudice is learned in the same way as other attitudes and values, viz. through interaction with the sociocultural environment. The four major "sources of information" are: parents, peers, schools and the mass media. The influence of parents has been covered in a previous section (see Section 2.1.2).

Most whites in South Africa invoke internal factors to explain the present situation. Thus, rather than place an emphasis upon discrimination, poor education, poor health care, etc., blacks are labelled as "lazy", "stupid" and "incompetent". South African political socialization plays down internal conflict and cloaks the status quo in a pseudo-moralistic, pseudo-Christian respectability. Thus, many whites and some blacks, Indians and coloureds see the real danger as external (e.g. the "Communists") while dissident groups and individuals inside the country are seen as agitators and extremists, who are perceived to be intrapsychically disposed towards violence. In this way, real reasons for change can be denied.

In summing up the evidence concerning the factors of socialization and conformity, Ashmore and Del Boca (1976) point out the inconsistent findings and the fact that much evidence is correlational. Although it seems clear

that these factors can explain a large proportion of the variance in prejudice, "it is not clear exactly how these cultural patterns are transformed into the prejudice of individuals" (p.97).

#### 2.3.2.2 COGNITIVE PROCESSES

Tajfel (1973) has proposed three cognitive processes essential to the acquisition of social attitudes:

- (a) "Categorization", which refers to those cognitive activities that shape the perception of groups;
- (b) "Assimilation", refers to the learning of the content (provided by social values and norms) of social categories; and
- (c) The "search for coherence", which describes how attributions regarding the causes of changes in intergroup relations are made. He cites some impressive research findings in support of this theory (see Tajfel, 1973).

Ashmore and Del Boca (1976) present three criticisms: the fact that the results of the reported studies may be paradigm specific; the confinement of the studies to English subjects and hence the dubiousness of generalising findings to other cultures; and, finally, there are alternative explanations regarding the norm of ingroup bias - it need not necessarily be rooted in the need to establish a social identity in a given situation, as maintained by Tajfel.

#### 2.3.2.3 PERSONALITY PROCESSES

Three major psychoanalytic theories have been postulated, viz. the "projection", "frustration-aggression", and "authoritarian personality" theories.

(i) The "Projection" Theory

In this theory, as with the frustration-aggression hypothesis, an attempt is made to account for prejudice in terms of a single defence mechanism. An anxiety-arousing impulse is defended against by projecting it onto some other person or group. Most commonly, unconscious tabooed sexual impulses of the white man are seen to be projected onto the black. In this way the white can maintain an image of himself as "moral" and "clean", while seeing the black as the uninhibited, insatiable sexual beast who deserves the white's scorn and degradation.

The general view of proponents of this theory is that the white, feeling shame and guilt because of his sexual desires, projects them onto the black and attributes the latter with the sexuality he finds morally unacceptable in himself. The black becomes the embodiment of the id.

Stember (1976) places a slightly different emphasis. He feels that it is projection, not of guilt, but of desire: "It was *because* the white man viewed the white woman as the epitome of sexual attractiveness that he was convinced that the black must do so, too" (p.42). The white woman is idealized and thought to be degraded by sexual relations aimed at anything other than procreation. Thus, a white woman is seen to be defiled by an interracial sexual union and hence the anger of the white man is activated.

Little research has been conducted to test this theory. Ashmore and Del Boca (1976) cite one study, "the only methodologically adequate investigation", by Pompilo, that "found no support for a link between projection and prejudice" (p.78).

(ii) The "Frustration-Aggression" Hypothesis

Popularly known as the "scapegoat theory", the line of thought proceeds as follows:

- (a) Frustration accumulates due to the limits set on id impulses by the society;
- (b) It is dangerous to express this frustration against the actual frustrators because they are more powerful and might retaliate (e.g. parents) or because the actual frustrator cannot be identified (e.g. social norms);
- (c) Aggression is hence repressed and a pool of "free-floating aggression" is created;
- (d) Anxiety due to this repression is partially relieved by displacing aggressive feelings onto an out-group in the form of prejudice; and
- (e) This hostility is rationalized by finding fault with the particular out-group. (This latter point subsumes the "projection" hypothesis because it includes the projection of the individual's undesirable impulses. However, the defence mechanism primary to this hypothesis is that of *displacement*).

Research findings are conflicting. Bettelheim and Janowitz (1964) review a number of studies which indicate that people experiencing downward social mobility (and who are therefore assumed to be more frustrated) are more highly prejudiced than those whose social status is stable or upwardly mobile. Ashmore and Del Boca (1976) cite a few studies which show correlations between various indices of self-reported dissatisfaction with one's condition in life and ethnic prejudice.

Contrary to the above, Allport and Kramer (1946) found that Jews, although very often discriminated against (which is assumed to be frustrating), were lower in anti-black prejudice than Protestants or Catholics. Furthermore, Morse and Allport (1952) found little consistent correlation between anti-Semitism and self-reported feelings of frustration.

(iii) The Authoritarian Personality

Adorno, Frenkel-Brunswik, Levinson and Sanford (1950) argue that authoritarian methods of childrearing and accompanying attitudes tend to develop in the child a personality which is disposed toward certain types of ideology, ethnocentrism and authoritarianism. The original study and theory has generated a great amount of research, some supportive, some contradictory, as well as many methodological objections. Methodological flaws include the fact that all of the items on the attitude scales used to measure ethnocentrism and authoritarianism were positively keyed and thus responses may be contaminated by the acquiescence of the respondent. (For a review of methodological problems, see Christie and Jahoda, 1954).

In summing up an area of the research, Ashmore and Del Boca (1976) write:

"...harsh parental discipline and dominance may predispose children to be prejudiced, but...the weakness and inconsistency of the relationship suggests that it depends on a number of variables (e.g. parental prejudice, community norms). The relationship between prejudice and child-rearing practices must at this point be regarded as unsupported" (p.82/3).

In South Africa, correlations between authoritarianism and prejudice have been found to be somewhat lower than elsewhere (Colman and Lambley, 1970; Orpen, 1971; Pettigrew, 1974), leading these researchers to conclude that, in a society which reinforces intolerant attitudes, deep-

seated personality factors are less relevant. As Pettigrew (1974) points out, "conformity to South African mores is associated with racial intolerance while deviance from these mores is associated with racial tolerance" (p.89). Milner (1975) states:

"While it has been established beyond doubt that prejudiced attitudes are often found in persons with this sort of 'abnormal' personality (as described by the Authoritarian Personality), this explanation cannot account for the currency of these attitudes among large populations of apparently 'normal' people" (p.29).

Nieuwoudt and Nel (1974), however, found a significant relationship between authoritarianism and prejudice and point out that the country's prejudiced norms might fulfill an "important personality function for the authoritarian person by supplying him with an appropriate group on which to displace aggression" (p.100). They suggest that former results may have been confounded due to English-speaking authoritarian subjects suppressing their prejudice because of the more liberal norms of that group.

In any case, it appears that all these South African studies have utilised university students as subjects, hence casting doubt upon generalisations made to the broader population.

#### 2.3.2.4 CONCLUSION AND CRITIQUE

Apart from specific criticisms that have already been levelled at each of the above theories, there are others regarding the theories in general.

The psychoanalytic theories of prejudice, particularly that of the Authoritarian Personality, concentrate on individuals with very high levels of prejudice and, as stated above, the "abnormal" personality. The ability to these theories to account for racial anxiety in the

"liberal" or less overtly racist individual is thus impaired.

Secondly, the theories, because of the social context in which they have arisen, inevitably explain anti-black prejudice, and cannot be easily applied to explain black's attitudes toward whites. Although this aspect is beyond the scope of the present study, the criticism pertains to any future work that might be recommended.

The following methodological criticism is related to the first objection made above. All the theories make a priori assumptions about the existence of overt levels of prejudice. This fact alone is capable of sabotaging research of the present nature. One cannot assume that the white therapists participating in this study are prejudiced, just as one cannot make a priori theoretical judgements regarding the etiology of their racial attitudes. In fact, what is being questioned here is the appropriateness of the natural science model to the study of human beings.

Thus, the theories, if adhered to at this point, would probably be of nuisance value. It is therefore my intention to enter into dialogue with the interview material *sans* theory and then, afterwards, to reflect upon the usefulness, if any, of the theories.

Throughout this chapter, while reporting studies and theories grounded in the natural scientific positivistic paradigm in order to document their findings for a posteriori reflection, I have been sceptical about the appropriateness of this paradigm for the study of human beings. It remains for this argument to be bolstered by further evidence and for the argument to be given regarding the use of hermeneutics as an alternative paradigm, this being the task of the following chapter.

CHAPTER THREE

RATIONALE AND METHODOLOGY

3.1 RATIONALE FOR A HERMENEUTIC PARADIGM

3.1.1 METHODOLOGICAL PROBLEMS IN PSYCHOTHERAPY AND RACE RELATIONS RESEARCH

The present work involves exploration into two fields of study, viz. psychotherapy and race relations, whereby racial attitudes represent the *content* of the various psychotherapy *process* variables (in particular, counter-transference).

Both fields of research have had to address significant methodological problems, the primary one of which is whether the natural scientific positivistic paradigm, which has provided the framework for much of the research conducted in these areas, is a valid model to use in the study of human beings.

Strupp (1981), in appraising scientific psychotherapy research, concludes that, although controlled experiments can be of value, "they cannot replace creative and insightful thinking" (p.216). This applies to a significant proportion of the research cited in the previous chapter. In an earlier study, Bergin and Strupp (1970) concluded that large-scale multifactorial projects in the natural scientific positivistic mould do not justify the required expense and manpower.

Kruger (1983) examines several myths that have pertained in the research of psychotherapy, e.g. the myths of the uniformity of patients and of the uniformity of therapists, and the myth that theories provide an adequate research paradigm. He concludes, from a phenomenological point of view, that

"attempts to operationalize variables or to quantify meanings will always have to cope with the fact that the therapist and client cannot be operationalized without violating the experience of psychotherapy as such and that, since intersubjective truth can be reached in ways which are more adequately descriptive than numbers, the dogma that research must necessarily be of a quantitative nature need not be upheld" (Original manuscript, p.13).

The phenomenologists, according to Cargill (1985), dispute the prerogative of natural science to decide upon the nature of reality and, in particular, the latter paradigm's claim to objectivity:

"The Cartesian notion of duality, viz. that the world can be perceived as an object by a subject (who is presumed to be capable of objectivity) is philosophically unsound, since the basic nature of man's being-in-the-world precludes the possibility of man stepping outside of himself to view, evaluate and judge the phenomena of his world" (p.9).

Man cannot observe objects without viewing them within their context and in terms of their significance for him. "This unity can only be broken to the detriment of the parts, so that both the world view and methodology of natural science can never do justice to the study of the nature of man" (ibid.).

In a review of the literature, Cargill concludes that "the case study has increasingly come to be regarded as the research design most appropriate to the study of psychotherapy". As Steele (1982) points out, case studies do not provide scientific proofs following the hypothetico-deductive model of predictive causality. The narrative causality inherent in a case study approach, however, is ideally suited for the presentation of interpretive evidence. It combines the particulars of an individual life (the idiographic) with general theoretical presuppositions about human nature (the nomothetic). The other advantage of a case study approach is that it "integrates incidents by establishing amongst them a matrix of interconnections" (Steele, 1982, p.7).

The research into race relations has been plagued by the same methodological issues as discussed with regard to psychotherapy research.

Stember (1976) presents the limitations of a quantitative approach to race relations research, arguing that the underlying dynamics of inter-group attitudes cannot be explicated by such an approach. He comments as follows:

"It was difficult, without prolonged in-depth interviewing, to get beneath the surface of intergroup attitudes; certainly any motivations not at a level of awareness were unlikely to emerge at all. It appeared to many that given its commitment to quantitative methods, sociology was moving towards analysis of the trivial, tending to restrict its attention to issues amenable to its established techniques" (p.xii).

Since the more subtle forms of prejudice are of interest to the present study, Wellman's (1977) point, that traditional instruments used in large-scale surveys are not sensitive to these less overt manifestations, is an important one. He writes that

"the structured questions asked in highly systematic (natural scientific) research designs also assume a great deal of knowledge about the subject *before* the questions are posed. Since we know relatively little about that face of racism that I am exploring, traditional sociological methodologies are not much help; in fact they probably get in the way of understanding" (p.xix).

Furthermore, evaluating racial sentiments independently of the contexts within which they occur renders only the most obvious kinds of racism detectable.

In a discussion of the validity of the natural science model for research into race relations, Wellman writes that many social scientists, in their research efforts, ignore the conflict between acts of inquiry and acts of writing. They present their research as if it occurred in a linear fashion in order to establish proof and predictability within the natural

scientific paradigm. However, the act of research is often not linear: theory does not always precede research.

In conclusion, it appears that the natural scientific paradigm, although it can be of some value, has its limitations with regard to the study of human beings - it cannot adequately be used in the study of psychotherapy and nor in the study of race relations, especially if we aim to explicate the more subtle and deeply-hidden dynamics of human emotions.

### 3.1.2 THE HERMENEUTIC PARADIGM

A non-quantitative approach, and one which provides a viable and appropriate alternative to the natural scientific model, is the hermeneutic paradigm.

"Hermeneutics", writes Steele (1982, p.3), "is the art or science of interpretation". It is, in fact, a combination of science and art, a "systematic interpretative method whose goal is the creation of understanding" (p.343). It views texts as carriers of meaning and as subjects capable of answering our questions. Its task, therefore, is to aid communication in order to facilitate understanding.

Dialogue is an integral part of hermeneutics, the paradigm's sole presupposition being that of communication, i.e. that humans talk with each other. This is also, as Steele demonstrates, the methodological base of both psychoanalysis and analytical psychology.

The act of interpretation in research requires one to enter into a relationship with one's data. One dialogues with the data and allows it to disclose its meaning. As Kruger (1983) puts it, the "truth requires a patient communion with the phenomenon to let all its dimensions emerge"

(Original manuscript, p.28). The phenomenon must be free to speak to the observer as that which it is.

The data reveals phenomenon which must be reflected upon by the interpreter. In turn, the hermeneutic practitioner "must be self-reflexive, coming to know him or herself through encounters with others" (Steele, 1982, p.350).

This model denies the possibility of one absolute truth. Rather, it "celebrates the power of individuals to inquire and to construct replies which, within a context, answer their questions" (p.5).

Several key notions are important for the hermeneutic practitioner to adhere to (from Steele, 1982, pp.347 - 349):

- (i) There is no presuppositionless knowledge and no unprejudiced inquiry.
- (ii) In attempting to understand texts or other people we must try to do so on their own terms.
- (iii) Prejudices must give way upon exposure; there must be a movement towards greater understanding through successively revised interpretations. If each new interpretation of an element fits with an emerging conception of the whole, then a wider understanding is emerging. If it does not, then revisions are needed, either of the partial interpretations, or the emerging holistic view, or both.
- (iv) The process of understanding involves a continuous movement back and forth from the part to the whole and back again from the whole to its parts.

- (v) The goal of interpretation is to arrive at a set of meanings which maximize the understanding of the parts in terms of the whole. Such constructions are evaluated by their consistency, coherency and configuration - the harmony of the parts with the whole.
- (vi) Understanding can always be improved upon. New meanings will eventually become old, superseded meanings. The passage of time brings reflection on experience and reflection should bring new understanding. The goal of interpretation is to make meanings manifest that have been uncalculated, unseen, or hidden by misunderstanding disguised as comprehension.
- (vii) Through interpretation we can know more about a text than the author knew, or more about an event in a person's life than the person knew at the time of the episode or may know before reaching an understanding of it with the interpreter.
- (viii) The interpreter must attempt to minimize his or her distortions of the past; operations must be checked within the historical dimension.
- (ix) As historical and cultural differences between an interpreter and that which is interpreted increase, the need for vigorous application of hermeneutics also increases.

For the present purposes, several notions addressed by Kruger (1983) are useful. In his advocacy of a methodology that is analogous to the therapeutic process itself (regarding a phenomenological model of psychotherapy research), he stresses the importance of a third as witness in order to avoid the danger of solipsism. While we must be

close enough to the phenomenon to let its dimensions emerge, there must also be a sufficient distance in order to communicate one's findings in a compelling fashion. One can reflect upon one's reflections in dialogue with a third as witness which is also oneself, but this, Kruger points out, is very difficult. Thus, one can take oneself as a subject and explicate one's own experience.

The best way to achieve 'human-scientific' proof, according to Kruger, is to ask a number of subjects to explicate their experience of a specific phenomenon, extract the common themes, reflect upon these, and then arrive at an essential description which can make a claim to general validity.

## 3.2 METHODOLOGY

### 3.2.1 THE DESIGN

The design encompasses a multiple case-study approach in which, in the first stage, seven mental health professionals (six clinical psychologists - three female, three male - and one female psychiatric social worker) each participated in one in-depth interview with the interviewer.

The second stage involved the analysis of the interviews by the researcher. Each interview text was split up into units or themes. The interviews were then compared to one another and the themes common to them were explicated. The three major themes were then analysed hermeneutically and an essential description of each was arrived at. It is the explication and description of these major themes that comprises the primary focus of the study.

The interviewer was the present author. Although, as discussed, it is desirable to have a "third as witness", this was not a practical possibility given the scope of the present study. Although unavoidable, this factor is

clearly a potential source of bias. The issue will be discussed more substantially in a later chapter, especially with reference to Kruger's option of using oneself as a "third as witness" and the consequent need for self-reflection. Thus, while an intrinsic part of the design is the constant self-reflection of the researcher, this is only brought into written form in the final chapter, as part of an evaluation of the study.

### 3.2.2 THE PARTICIPANTS

The participants volunteered to take part in the study after the researcher had informed them that he required qualified clinicians to interview. As such, the sample is not a random one. However, this does not compromise the hermeneutic approach and, in fact, is an advantage in that the interviewer was known to each of the participants. A certain measure of trust and rapport was therefore evident prior to each interview.

Included here (see Table 1) is some information regarding each participant.

It was decided not to include more identifying data for two reasons:

- (i) Ethical considerations require that all possible precautions be taken in order to keep the identities of the participants confidential; and
- (ii) The study is primarily concerned with interview *texts*, and in explicating the feelings experienced and defences utilised by the participants from these texts. It is beyond the scope of the study to understand each participant's experience of cross-racial psychotherapy in terms of their particular life events and personality development.

For convenience, I have labelled the four female participants Therapists A - D, and the three male participants, Therapists E - G.

TABLE 1  
PARTICIPANTS' IDENTIFYING DATA

Therapist	Profession*	Sex	Present Work Setting	Years experience in cross-racial Therapy
A	Clin. Psych.	F	Private Practice	2
B	Clin. Psych.	F	Out-pt. Clinic	2
C	Psych. S.W.	F	Out-Pt. Clinic	6½
D	Clin. Psych.	F	Out-Pt. Clinic	4
E	Clin. Psych.	M	Private Practice	12½
F	Clin. Psych.	M	Private Practice	4
G	Clin. Psych.	M	Out-Pt. Clinic/ Private Practice	10

\* Clin. Psych. = Clinical Psychologist

Psych. S.W. = Psychiatric Social Worker

The participants all work in major centres in South Africa (the majority in Cape Town). Each can be described in general terms as coming from a middle-class, "liberal", white South African milieu. All have English as their home language, apart from one who is an Afrikaner. All have worked with black, coloured and Indian patients in a variety of settings, both in-patient and out-patient, the exception being the psychiatric social worker who has never worked in an in-patient unit. While all have conducted in-depth therapy with coloured and Indian patients, and have all worked on an assessment and short-term management level with black patients, only three have attempted to treat black patients on an in-depth level. Most of the participants have worked with patients of colour within a variety of therapy modalities: individual, group, family, marital therapy, projective art, and so on. The schools of psychotherapy within which the therapists work in-

clude psychodynamic, behavioural, gestalt and client-centered-therapy.

### 3.2.3 THE INTERVIEWS

As noted, the interviewer held one in-depth interview with each participant. The interviews ranged from 40 to 50 minutes in length and were held in a variety of settings, although always on the participant's "home ground" - either in their consulting room or their home. Each interview was tape-recorded.

The only information given to the participants prior to the interview was that the researcher was interested in conducting a study on psychotherapy. The aim and focus of the research was kept purposefully vague at that stage so as to facilitate the spontaneity of the interviews.

The aim of the interviewer was to enter into each interview devoid, as far as possible, of presuppositions and hypotheses. The extent to which this was possible is discussed in a later chapter. The plan was to hold unstructured (although not non-directive) interviews with the interviewer asking open-ended questions and making use of the psychodynamic technique of interpretation in order to elicit unconscious material. The interviewer attempted, where possible, not to introduce new themes into the interview. However, no claims can be made regarding the interviewer being a benign figure in the interview. On the contrary, it was the interviewer's express intention to guide and help the participants verbalize material which was below their level of awareness.

At the outset of each interview the participant was asked whether they objected to the interviews being tape-recorded for the purpose of quoting verbatim passages and confidentiality of identity was ensured. They were then asked by the interviewer to explicate their experience of cross-racial therapy in the following manner:

"I'm interested in racial issues in psychotherapy and, in particular, what you, as a white therapist, experience when working with a coloured, Indian or black patient".

The flavour of the interviews was generally relaxed and informal, a fact helped in no small measure by the previous good rapport between the interviewer and each participant. Other factors which were of help in this regard include the fact that several participants share a common background with the interviewer in terms of training. Some participants also share, with the interviewer, an understanding of psychodynamic psychology and/or of the South African milieu. A few of the clinicians shared further similarities in terms of personal factors, such as religion. These factors are stated with a view to reflecting, in retrospect, upon the ways in which the broader context of the interviews affected the texts which emerged.

#### 3.2.4 THE PROCEDURE

Following the completion of all the interviews, a verbatim transcript of each one was made from the audiotape (the interview protocols are presented, in full, in the appendices to this study - see Appendices A - G). Each transcript was then analysed in turn. The transcript was read through two to three times in an attempt to rid the researcher of as many preconceptions as possible and so that a "feel" of the interview as a whole could be obtained. The researcher then broke the protocol up into meaningful units (or themes) and an attempt was made to see how each unit related to other units and to the whole protocol. Much of this process represents the preliminary work and is not reported in detail.

Once the above procedure was conducted with all seven protocols, the three primary themes upon which this study focuses were chosen on the basis of their commonality (across interviews) and their emphasis (within each interview).

It is important to note that no claim regarding the exclusive significance of the chosen themes is being made. There may be other themes which are just as or even more essential than these but which were either not captured by the researcher or not chosen for a focussed analysis.

Each of the major themes were then analysed. Each protocol's unit or units reflecting the particular theme was situated in the context of the interview and explicated in detail. The feelings of the therapists, and the ways in which they dealt with them (in terms of their anxiety and defences), were reflected upon within the context of the group of participants. General descriptions and conclusions regarding each theme was then made by the researcher. Lastly, the researcher reflected upon his participation as interviewer and explicated his own experience of the research.

The following chapter demonstrates both the method and the results of the analysis. A general word of warning is given regarding the inclusion of certain strong swear words in the verbatim quotes. This was done to convey the affect of the participant at that time and not for sensational effect.

Due to the detailed nature of the analysis, a summary of the various counter-transference phenomena explicated herein will follow.

A cursory perusal of the interview transcripts is sufficient for an understanding of the importance of 'white guilt' and its relation to anger. This theme emerged spontaneously within each interview, as can be seen in the analysis below.

#### 4.1.1. GUILT, ANGER AND THE DEFENCES AGAINST THESE EMOTIONS

For Therapist A, the theme of guilt emerges early in the interview, following a discussion based upon her feelings of impotence, frustration and alienation when confronted with coloured and black patients. This earlier transaction will be analysed under the theme of "helplessness".

The theme of guilt linked to anger becomes overt towards the end of the interview. It is useful to examine the text just prior to this. Therapist A cites an example of a patient with whom she worked psychodynamically and reports that a "good mother transference" arose. She says:

"Now that's interesting because a good mother transference doesn't arise with all my white patients, but with all the coloured - and one black guy - the good mother transference arose very much more easily than with white patients. With the white patients I was often the father and the bad mother".

Her explanation for this phenomenon is that "their blackness and my whiteness is influencing it" and that the coloured and black patients, because of the race difference, relate to her more dependently than whites do: "And the way it manifests is that they start having good mother feelings about me". A tentative interpretation at this point is that this therapist might be discouraging the expression of hostile feelings (which might be part of an underlying negative transference) with her coloured and black patients and that she rationalises this state of affairs by positing the existence of dependency needs in these patients.

Therapist A does feel that, if she "was really working in depth with them for a long time" (and here, again, she may be defending herself by denial and rationalisation), she would have to pay attention to the negative transference. She says that her "whiteness would facilitate working with that" and presents a theory on how the fact that there is an *actual* "good white mother in the therapy room" and a "bad black mother at home" will be an advantage in creating "wholeness and an integration" (see Appendix A, p.163).

While her theory may be a good one, it could also perform a defensive function for her whereby her whiteness, which makes her anxious in the cross-racial therapy situation, is reversed into something good, something which might actually aid the therapeutic process. In this way she could avoid any underlying feelings which would make her feel bad about being white and/or fulfill her need to make reparation for the damage she has done (in fantasy and/or in reality).

The above interpretations, made only tentatively, receive reinforcement from the remainder of the interview text, when it becomes clear that Therapist A is defending herself against her patient's anger and her own feelings of guilt and anger.

At this point the interviewer, sensing Therapist A's defensiveness, points out that there exists the apartheid structure of which her patients are a part and asks, "is the bad black mother just at home?".

Therapist A recognizes that "the white woman is a bad woman - she's the oppressor" but persists in stating that this cannot be faced in therapy until her patient feels "safe enough".

"They must get to the stage where they're not actually feeling that they need me so much any more, i.e. their immediate crisis must be over and we must be working with bigger things now".

It is probably true that the majority of her patients fear expressing anger towards her as a white authority and therefore need time to build up trust and to feel less vulnerable. However, it could also be that Therapist A is unconsciously saying that *she* does not feel ready to handle "black anger" and that she is projecting this feeling onto her patients, whose own fears provide a ready hook for this projection. She then rationalises about the patients' feelings in order to hide this from herself.

When the interviewer again tried to pin her down regarding her feelings about receiving her patients' 'black anger', she says:

"Their mother has oppressed them - it's the anger against oppression - against not being allowed to be who I am".

Here, as before, she uses her professional role as a defence and labels the patient's anger as a transference phenomenon. The interviewer attempts to neutralize A's defences by asking her more directly to look at her position as a member of the oppressive white race receiving a black's anger. Therapist A again gives as a rationale for never having to face that anger in therapy the fact that she has been working with "crisis resolution type methods - short, intensive admissions - that its never got to the stage where I've actually had to cope with that". Although she says that she would acknowledge the anger as justified, she attempts, at first, to distantiate herself from any culpability:

"I think I personally don't feel the guilt of the oppressor insofar as I don't feel I've ever taken any active role in oppressing. The guilt I feel is that I've benefitted from their loss..."

She attempts to minimise her feeling of guilt by intellectualising about different forms of guilt. When confronted by the interviewer's suggestion that they might be one and the same guilt, she replies:

"Ja ja, it is. But there must be a difference. Because I don't feel like someone who's said 'vok off, jou swart kaffir'...and I know that in my interpersonal relationships as well...the fact that someone is black has never...no, that's not true, I mean, it has...it has influenced me... but (sigh)...ja, no, I would feel guilty...and you know what else I would feel - and this is actually what I'd feel a lot more strongly than guilt - I'd feel so angry towards the powers that have damn well got me into this situation".

She acknowledges her feeling of white guilt but then becomes angry, directing this anger towards the country's authorities. Given her acceptance of her own responsibility, this outward direction of anger represents, at least partly, a defensive displacement.

Several of the above phenomena are echoed in the interview **with Therapist B.** For this therapist, the notion of guilt arose after discussing her feelings of impotence and depression with regard to working cross-racially (see later for in-depth analysis). This line of thematic development is similar to that found in Therapist A's interview.

Let us examine B's interview from the point (Appendix B, p.168), where she states that she identifies just as strongly with people of another colour when they are of a similar socio-economic class to her own, and that she does not have a strong feeling of difference when working cross-racially (a similar denial to that shown by Therapist A). However, B then questions her own honesty, saying that she feels there "should be a difference". Exploring this further, she states that her "consciousness" of, and "sensitivity" to, racial issues should "theoretically" influence the therapy situation, as should the political situation influence how the patient feels in therapy. Asked what she would expect, theoretically, to find, she replies:

"I would expect me to feel guilty and then to feel resentful or...um...resentful, for want of a better word...and...um ...cynical of my seeming indifference to social issues or seeming empathy with the situation. I'd expect them not to believe it".

B is hesitant and somewhat anxious about her choice of the word "resentful", which is perhaps, for her, a euphemism for anger. The interviewer, at this point, ascertains that B feels guilty, *outside therapy*, as a white South African, and asks her what she thinks becomes of these feelings in the therapy situation.

"Gee, that's funny, maybe in a way that absolves me... that here I'm doing my duty - I'm actually being empathetic and helping but I mean I don't believe that I am really, but maybe in a sense, I hide behind my professionalism, in that situation...(...)\*..if my maid at home were to tell me about what was happening - like certain things a patient would tell me - I would feel absolutely awful...I mean, I would just really for days feel terrible".

Like Therapist A, she uses her professionalism as a defence against her underlying feelings. However, unlike A's intellectualising about the transference, she isolates herself within the role of the professional and thereby alienates herself from her patient. She also uses the fact that she is providing a service as a defence against feelings of guilt.

"...somehow the professionalism of the situation, that I'm a professional there and I'm actually not there to really feel it...".

A further use of her professionalism is demonstrated by this quote:

"I think I'd feel worse if I wasn't in the situation of being a therapist because you know I've got a list of what to do...I've got to get through the history...(...) ...and it really does defend me against feeling it too much".

In this way people are transformed into answers to various questions (e.g. father's age, wife's occupation) on a psychiatric history schedule and the affect of the meeting is neutralised.

The focus of B's interview shifts onto black anger of patients. She defends herself in a very similar way to Therapist A. First, she perceives their anger as being "because of the whole situation...(...)"

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\*Note: This sign has been used to indicate that certain dialogue has been edited out.

...angry about the whole situation that makes a difference between us". The "whole situation" thereby becomes the target of anger, rather than herself; like Therapist A, she distantiates herself from the cause of the trouble. When the interviewer presses her to comment on how she would respond to anger directed at her, she reacts anxiously:

"I'd feel - first of all I'd feel (laugh) - professionalism already comes in - I'd think, well, what's beneath that sort of thing...and what's the transference on something like that (laugh). Actually my immediate reaction would be - he's *right!* I *am* guilty...".

Here, like Therapist A, she intellectualises about the transference as a defence against her deeper reaction, which is to feel guilty.

The process and content of Therapist C's interview regarding the guilt/anger theme is somewhat different to that of Therapist A and B's interviews, although there are certain similarities. From the outset C mentions that she "tends to get angry" with her lower-class coloured patients, although she claims to react no differently to her white lower-class patients. With her middle-class coloured patients, she says that, in the past, she was "afraid of the black/white issue coming up" and was also afraid that she would not be able to identify with, or to understand these patients. She feared that if she spoke about the racial difference she would lose her client.

The passivity of her clients appear to elicit frustration in Therapist C:

"...it is because I am the superior race in this country and I don't understand how they live and perhaps I don't understand that they can't be actively involved in changing the situation - they're passively waiting for the situation to change - I can't understand this. And why can't they rise above it?"

She says that she now points out how she feels to the client, even though she doubts whether this is ethical because

"it's almost as if I'm inciting him to do something - which might be against the law...(...)...or giving him the confidence to do what he really wants to do".

A little later the interviewer offers her the interpretation that her uncertainty about doing this might be related to anxiety arising out of dealing with a client who would become increasingly assertive *in therapy*. After a pause, she replies:

"What would they do in the therapy situation? No, because I'd turn the tables right back onto them - I'd say: 'Right, you've got the problem, you can decide whether you're going to keep your problem or not, so its up to you - you have the authority now, not me! And they respond to that by not coming for the next interview and then I 'phone them and then they come back...".

It is clear from this that C defends against assertiveness and aggression in her patients by "turning the tables right back onto them", and it is therefore not surprising that they do not return for their next session. Their fantasies of destruction (of themselves and their therapist) are realised - the therapist shows that she cannot cope ("you have the authority now, not me") and becomes aggressive toward the client. It appears that this therapist is still struggling with the issue of black anger and, although she has indeed made progress, she still experiences anxiety that negatively influences her therapy. Further on she provides reinforcement for this interpretation. Regarding her patients' anger in general, she says:

"I'm sure there is anger but I don't pick it up - I don't make the effort to pick it up (with patients she refers on)...but with those I keep - it is there but they haven't got there - I think we're all pussyfooting around".

Her defence is very similar to that in Therapist A's case; she also rationalises **her reticence** to explore angry feelings by using the patient's discomfort as an excuse.

"I think it would take time...(....)it'll take time before I pick it (anger) up because they feel comfortable with it. I don't think I'd want to make them feel uncomfortable before I've really engaged them".

The interview content changes to the theme of sex (see later for analysis), and C brings up a transference issue, i.e. the subservience of many of her coloured patients. She also feels that they project an authoritarian attitude onto her (Appendix C, p.184). Asked how she feels about this, she replies:

"I haven't handled it...(....)It actually makes me go on this whole white guilt trip 'Now look what I've done to you' and I feel like saying - 'it's not me, I don't vote Nat, I want you to have equal opportunity, I want you to have equal pay'".

Her defence against the guilt elicited in her by her patients' attitude, like A and B's, is to distantiate herself from the oppressor, to deny any responsibility.

Furthermore, she says she feels like expressing this (her distantiation from the oppressor) to the client but does not, because:

"...I think to myself, Jesus Christ, do I need to have a guilt complex - you know, whose problem is this - yours or mine? Whose got the guilt over here? Are you laying your guilt onto me? If I didn't want to see you, if I didn't want to help, I would've said so - but give me a chance!"

It appears that another defence of C's is to project her guilt onto her clients: "Are you laying your guilt onto me?" Following the above response, the interviewer reflected that C sounded "quite exasperated". This was accepted by C:

"Ja, give me a chance and then I will do a thorough assessment, I suppose more thorough than I would do with anybody else. So that they can see I care and I want to help and don't look upon me as being a white authority, I'm a white professional...(.)...I want to turn around and say: 'Well, what the fuck do you want me to do?! Should we go to the State President right now and talk about it?' Oh, so I get angry, but I've got to contain it because it's not going to be functional or beneficial for either of us".

C, like Therapist A, becomes angry following her feeling of guilt. She defends against these feelings by overcompensating (reaction-formation) and by using her professional role (as seen with the previous two participants). In addition, as can be seen in her subsequent responses (Appendix C, p.185) she becomes more authoritarian and more directive in therapy.

The interplay between C's feelings of anger and of guilt is not clear and further discussion with this participant could have been aimed at clarifying this dynamic. For instance, C's anger emerges once again, later in the interview, in response to the interviewer asking her how she reacts upon discovering that her client is coloured:

"Sometimes I just think: oh fuck, not again. Do I have to go through my feelings again, because every time I have to go through my fucking feelings and I doubt if they do...(.)...and it is very disturbing for me, to keep going through it and through it and...".

As an aside, the fact that she experiences these feelings repeatedly indicates that there has been insufficient conflict resolution and that a significant trend in her dynamics remains hidden from her. C also uses displacement: "...and then (my husband) gets it in the neck when I get home" (Appendix C, p.186).

Towards the end of the interview, in response to a feeling of her patients expecting her to "fix" them, she becomes markedly angry: "*fuck them!*, it's not my responsibility and it's not my fault..." (Appendix C, p.187).

The trend of the interview regarding guilt and anger is as follows: Initially C admits to becoming angry with lower-class coloured patients but then defends against the racial aspect of this by saying that (a) she also gets angry with lower-class whites and (b) she has changed her attitude toward middle-class coloureds. Later on, whilst discussing her patient's subservience she expresses feelings of guilt and only then does her anger re-emerge. A tentative thought, and one that would need further explication, is that C might, at times, use her feelings of guilt as a defence against her feelings of hostility.

The "one-down" position of patients of colour, which we have already witnessed as a provoking agent for white guilt, is active in eliciting guilt in Therapist D. This theme emerged approximately one third the way through the interview, following exploration of the themes of sex and of helplessness (see later for analysis). The interviewer reflected D's feeling of helplessness upon being confronted with a patient presenting a problem related to his skin colour (Appendix D, p.191). D said she felt this quite often, that the "resources for coloured people are (not) as good as for white people". She feels part of the "white system that actually provides all the resources" and feels "guilty about that". Asked how she deals with those guilt feelings she becomes defensive, rejoins with the question, "do you mean they might come out in a therapy situation?", and then denies that her guilt would emerge in therapy.

However, if we understand her guilt to be the underlying feeling in this case, then the contradiction in her reasoning becomes clear:

"...I don't try to suppress (my guilt feelings). I think they probably end up as anxiety because I think that most white people in South Africa are very anxious about the situation...(...)...I'm seeing how they really feel - how angry and frustrated they are..."

D herself makes the link between her underlying feeling (guilt) and her manifest feeling (anxiety) and thus, it is not the case, as she tries to make it, that her anxiety is simply a derivation of a realistic, perceived racial threat (that is, devoid of personal guilt). In this way D presents with pseudo-insight which allays some of her anxiety.

In the following passages D talks about her feeling that coloureds have less respect for whites than fellow whites would have, and that "they expect to be not treated as well". She admits that she has to "prove a bit more to make sure that that doesn't happen" but, one response later, contradicts this: "I don't overcompensate. I just treat them the same".

In response to the interviewer's probe about angry feelings, at that point in the interview, she denies that she feels "much against them" and, although she recognizes that "coloured people have a lot of anger against whites", she says:

"I haven't really experienced it that much - sometimes... (...)...I can sense their anger but I can also sense at that time that they are pleased that a white person is listening to them. That somebody's listening to them but I think it makes it better that a white person is listening to them - so there is some anger there but I think it's being dealt with appropriately".

D states that she senses black anger but, in order to explain to herself why this does not emerge in therapy she rationalises and, possibly, projects a feeling opposite to that of anger onto her patients - a feeling of appreciation for the white therapist. While her patients probably do have feelings of appreciation for her, it appears that she is focussing on this aspect in order to ignore the anger of her patients. This manoeuvre is also reminiscent of the previous participant's feeling

of absolution for her guilt, having rendered a service. D's anxiety is also shown by her attempt to cut off further discussion by issuing a closed-ended statement: "there is some anger there but I think it's being dealt with appropriately".

In the proceeding interview passage D gives further evidence of her anxiety. She cites the example of the patient's father who became angry and she sensed that it was because he felt discriminated against. She became angry with him because " I *don't* discriminate - he was implying that I *was* discriminating..." When asked if she expressed her anger, she laughed anxiously and replied that she had tried to pacify him instead. It seems that she felt her own anger to be bad and, at the same time, made an attempt to neutralise his as quietly as she could.

What appears to be happening with this therapist is that she resists the expression of both her own and her patients' anger, for fear of it becoming uncontrollable.

Therapist E uses several of the defences already explicated. For him, the theme of guilt and anger emerged after he had been talking about cultural and linguistic barriers and the fact that he feels "there's almost an extra pressure on me to try to prove that I'm not viewing her (a patient) as a racial threat" (Appendix E, p.199).

Given an interpretation that he overcompensates in order to prove something to his coloured client, E opened up with the fact that he needed to prove something to himself as well. This is connected to his awareness of his South African prejudiced upbringing and his feeling that when he gets angry with a black person he's prone to be prejudiced about it - "you bloody kaffir", he offers as an example.

Asked how his prejudice affects his work, he gives an example of a statement made by an aggressive patient and his response to it:

"... 'Whitey, you know the revolution is coming and you're going to be chopped up with all the rest of them'. Of course, I had a very strong impulse at the time to kind of dis-identify myself with the oppressor. At the time that this happened I thought to myself - that this is more a situational thing than white guilt because I don't have any conscious feeling of guilt - at all, about being white in South Africa".

His first defence against the patient's anger is to deny any responsibility - to "dis-identify...with the oppressor". He then denies having any conscious awareness of a feeling of guilt and presents an explanation which is ego-syntonic, i.e. he distinguishes between "white guilt" and a "situational thing", upon which he does not elaborate (cf. Therapist A's two forms of guilt). His rationalisation for not having white guilt (i.e. that coloured people were treated as equals in his home), however, contradicts his earlier statement somewhat: "Look, I'm very aware of being a South African and having the...segregation input in my upbringing".

Another interesting phenomenon in E's case are his feelings of rejection following the termination of the angry client referred to above.

Therapist F mirrors some of the above phenomena. Early in the interview he states several times that he sees the issue as a class or cultural one, rather than racial in nature. However, he had given some conflicting messages in this regard, viz. that he feels less alienated from his *white* patients at the outset and that he finds himself, at times, being startled by the *blackness* of his Indian client (Appendix F, pp. 209-210). The interviewer links these points in a subtle interpretation of F's anxiety and defensiveness. In a rather sudden remembering, F replies: "...You know, I've just remembered a dream I had last night", and then says to himself: "how relevant is this?" With encouragement he relates a dream in which four

black men, representatives of the United Democratic Front, arrive at his "brand new flat", for which he has just paid cash. F, in his dream, finds himself excusing himself to the black men, making apologies, saying: "I'm just a small businessman, don't hold me too responsible for what's going on in this bloody country at the moment". In analysing the dream, he finds that he was afraid of the black men, whom he saw as "uprighteous sort of people and very bright" (and apparently representing his superego). Hence, he says:

"I felt that feeling of guilt. I'm talking about the old shame and doubt sort of level of development. Quite low level stuff...shame, I felt ashamed and s-scared, of course".

His anxiety is a persecutory, paranoid anxiety - "low level", as he says - he anticipates punishment for his crimes and feels guilty and "s-scared"! (In recalling the dream he makes the proverbial stutter). F's repression and resistance becomes evident in his next statement: "I can't tell you much more than that, unfortunately. Only a segment of the dream". However, he does go on to say that he felt "quite alienated from them - they were definitely a different group" and that he experiences this feeling increasingly with blacks. When he had close contact with his black ex-girlfriend and other blacks, he "had no problem there. But now they're starting to recede into what becomes a body - the essence of *racism* is that you have no contact with that group" (my italics).

He talks about feeling guilty and not wanting to be held responsible, not wanting to be accused. His guilt, he feels, has "to do with ripping people", with aggressing against people. In his dream, he pleads: "I'm just a small offender in the bigger unit. Please don't kill me". In relating his dream, he backtracks: "No, they weren't going to kill me, they were going to hold me responsible for something or other".

The dream and its interpretation provide eloquent evidence of F's underlying racial anxiety and his feelings of white guilt and of alienation.

The interviewer attempts to get F to examine the influence of these feelings on his work, in particular with coloureds and Indians (Appendix F, p.211). He replies that, with Indians, these feelings do not affect him as much because, being Jewish, his "rating for the world is money, status, social influence". The case of coloureds he says, is a "bit different". He then introduces an example of a black alcoholic school teacher but does not relate his own feelings about working with him. When pinned down by the interviewer, he again resists: "I don't know...tricky question. We're getting into very latent areas, aren't we?"

He then opens up and admits that he has to be careful not to offend the patient's ethnicity. With his Indian client, he is "super-cautious perhaps, a bit liberal". Once again, the need for white clinicians to overcompensate arises. In F's case, this honest look is indication of his prior resistance and rationalisation. Nevertheless, F then returns to his former position but makes a slip of the tongue:

"...but I maintain very strongly that once you get to know your client as a human being all the other variables pale into *significance*" (my italics).

F excludes Africans from this statement. To be fair, his statement may be accurate, "*once* you get to know your client..." (my italics).

However, it appears that there are feelings within F that need to be attended to as part of the process of getting to know his client.

With specific regard to blacks, F says:

"I'd have big problems taking in an Af at the moment, especially at the moment, because what might evolve is stuff very much like in that dream...apologising to the client. In fact, I don't know what effective therapy I could do".

He gives an example of a black student he saw and with whom his "brief was to invent a work program for him". He recognised the need of this patient to deal with deeper personal issues but "never succeeded in getting into" this area. F's statement that "I think I was trying to be very careful not to hurt his feelings" indicates that his use of a behavioural approach might have been, partly at least, a defence against exposing himself to the feelings inherent in insight therapy (cf. Therapists A, B and C's use of this defence).

In the next part of the interview, further aspects of F's defences become clear. He admits a need to apologise to his black client but feels that

"...my radicalness helps me through situations like that because I genuinely *don't* feel that apologetic because I know *I* wouldn't do something like that to a black person and that gets me off the hook".

In other words, having a radical political attitude defends him against feelings of guilt. A tentative interpretation, and one which might have been explored, is that F's "radicalness" represents a reaction-formation.

F goes on to say that "it's more of a paranoia thing that's set up: maybe he'll hate me for being white". Like Therapist E's "situational thing", this statement alludes to a perceived racial threat, rather than a white guilt phenomenon. However, given that F has admitted to harbouring feelings of white guilt, this feeling of perceived threat could be used defensively.

His reaction to the interviewer's question regarding how he would deal with anger directed at him as a white is typical of most of the

respondents. He says:

"Ah yes...well, I hope I'm enough of a psychoanalyst to see it through. Have to use all the tricks of the trade".

After this initial reference to using his professionalism, he opens up more:

"...personally I would feel a bit put upon, ja, because there's no defence against that. It's true, I am white...".

However, he immediately starts searching for a defence again: "...of course you could argue that it's a transference issue", and launches into an intellectual discussion of "culturalised transference". However, in using his relationship with his black ex-girlfriend as an example, he appears defenceless again: "Me, little me"; and later, with respect to therapy and being accused and called a "bloody bastard":

"I'd feel quite alienated, I'd feel hurt. I'd feel more hurt than in an individualised transference. You see, an individualised transference is very easy to live down..."

Remembering the dream, he continues later: "So he'd (the patient) get to me and I'd be doing bad therapy at that moment". After this, the pattern repeats itself: he again attempts to defend with psychoanalytic technique, and then says that he doesn't feel personally accountable and pre-empts further discussion by putting a general, impersonal question into the conversation (Appendix F, p.213).

What appears to be happening with this therapist is that he does not feel comfortable with his defences against his racial anxiety and his feelings of shame and guilt. He tries them out, drops them, and then tries them out again when his feelings become too threatening. The only comfortable way out of this ambivalence is to avoid the conflicts altogether - to do behaviour therapy with blacks, as opposed to a more in-depth insight therapy, to ignore the racial aspect of his Indian client and rather see

him as a dark Jew, to analyse anger in terms of a "culturalised transference", and so on.

For further evidence of F's guilt and underlying racial prejudice, the reader is referred to Appendix F, pp.214 to 216. Here he talks more openly of treating black patients "like shit", being patronising towards them and "feeling bloody guilty you don't speak Xhosa. So then you project: 'Fuck him, he doesn't speak English, so he must be dirt'". He feels his private practice represents a "fool's paradise" and he talks about "salving" his conscience by getting a black friend a job.

Therapist G's transcript demonstrates how, for him, guilt is related to anger as well as to feelings of sadness and of helplessness. For the present, I will concentrate on the guilt-anger axis.

The interview with Therapist G began with his feelings about relating to black as opposed to coloured patients, his feelings of impotence and alienation regarding the language barrier with a black patient and an example of him working very successfully on a non-verbal level with a Portuguese patient. He says he communicates non-verbally with black patients as well and points out the necessity of respecting the patient and avoiding acting out the 'superior white doctor' stereotype. He denies that he falls foul of this and gets angry at doctors who do: "...it angered me to watch some of the doctors who come in and walk over people".

Shortly thereafter, the interviewer asks G whether he ever experiences difficulties in therapy with a coloured patient because of their colour difference. He replies in the negative and says that perhaps it "may have been problematic if I didn't have my (overseas) experience".

G talks about the process of change he had undergone, from adhering to overt attitudes of prejudice (in childhood) - regarding blacks as "inferior", to sharing friendships and work relationship with blacks on an equal basis: "...And discovering their friendship and their loyalty and the...*human being*".

The interviewer asks him to elaborate on his process of change with regard to how he had dealt with his prejudice, to which he replies:

"I think a lot of my prominent feeling was guilt...and I had to deal with that in therapy (his own)...(...)... I remember how I cried...(...)...a lot of the sadness that comes out is sadness because of your own people and because of the system in which you are...And sadness about the helplessness of people who are inferior, who are kept down...(...)...if I'm honest, I get that tremendous sadness very often, still...I don't think I've cried all my sadness away. Guilt, sadness...and the anger, too.

G starts to talk about guilt, which leads him into talking about sadness and then, later, anger. It is interesting that he makes a statement about "people who are inferior" and in the next phrase changes the meaning of this: "who are kept down". Could this be his unconscious speaking, saying that he has not yet rid himself of that childhood feeling that blacks were the "agterryers" (Appendix G, p.222), the inferior non-human beings? On the other hand, one might attribute this slip to the respondent's occasional language difficulty (due to English being his second language).

There follows an attempt to explore his anger, which appears to be directed at the system because (i) it destroys any good G feels he does in therapy, and (ii) it hurts the patient, with whom G feels he identifies (Appendix G, p.223). Asked how his guilt relates to his anger, G begins by denying that he still feels guilty: "I don't think, right now, I mean, in the beginning there was a lot of guilt,...uh...I don't think I feel as guilty anymore". He reports that he had a period of "penance", indicating

that his guilt led him in the past to inflict some form of punishment upon himself. He then reaches an insight which results in him accepting that "perhaps there's still a lot of guilt". The insight is that he overcompensates when working with people of colour and feels a need to make reparation:

"...When I get the opportunity I try to ...(...)...  
I'll go *beyond* - very often - beyond what I'd normally do...(...)...in that way, perhaps, still dealing with guilt. Almost doing, what's the word, restitution?"

G says that, whilst doing therapy, he has to continuously remind himself of this dynamic so that he does not

"carry more of (the patient's) burden than is therapeutically good for (the patient)...(...)...in subtle ways, these things pop out and...and one can easily...I can easily fall into the trap of overplaying or overdoing my role as a psychologist".

The interviewer asks how he responds to patients getting angry at him as a white person and he replies that, although he believes there must be anger towards him, he's never encountered it in therapy

"although I'm not scared of raising the issue, 'how do you feel about me being white?' but I haven't, in therapy, actually, I can't remember that I worked - perhaps they didn't have the courage because they're dependent or they feel dependent - they're in a hospital situation and all the people there who can help them are white. Perhaps they're afraid to verbalize their anger..."

The question arises as to what has happened - surely, during the course of ten years of cross-racial therapy, he must have encountered black anger (this he acknowledges himself). Given that this is true and examining the above extract, one can see that, in searching for an explanation as to why he has never encountered black anger, he begins to theorize about the patient population. This appears to be a defence of rationalisation. He had already stated that he is *not* scared of this issue and to accept that he might have some anxiety in this regard would

be ego-dystonic. Thus, in order to master his anxiety, he attempts an intellectual discourse which, at the same time, deflects attention from himself onto his patients. Furthermore, the nature of his intellectualising indicates a possible further defence, that of *projection*, whereby he cannot accept his fear of the anger and locates it (the fear) in his patients.

This last interpretation requires further explication. However, given that at least two of the other participants (cf. Therapists A and C) used a similar defence, it would not be surprising to find this in G. It would be interesting to explore with G in what ways he might be discouraging the expression of black anger in therapy.

For further examples of G's guilt and anger, the reader is referred to Appendix G, pp. 224 to 226 .

In conclusion, it is interesting to note the way in which G handles the fact that he is an Afrikaner. He appears to dissociate himself from the stereotypical right-winger (e.g. he says, "somebody...who has not had overseas experience"). Given the salience of an Afrikaner identity, it is even more interesting that both participant and interviewer colluded in steering clear of direct exploration of this issue!

#### 4.1.2 HELPLESSNESS AND THE DEFENCES AGAINST THIS EMOTION

At least five of the seven participants reported feeling helpless and impotent when dealing with many patients of colour. The analyses of four of these protocols, Therapist A, B, D and G's, are presented here.

Therapist A's first response of the interview reflects this theme:

"...having to deal with the social problems as a psychologist - which I'm not equipped to deal with - my whole interest is - I feel impotent when confronted with social problems, so that my whole perception and conception of myself as a therapist is affected by the frustration that I come across".

The extent to which her perception of herself as a professional is negatively influenced by this feeling of impotence is evident in her degradation of the mental health service, of which she is a part:

"I know the patient is getting this kind of treatment because he can't afford any other kind". The political status quo that limits a lot of her black and coloured patients gives rise to the frustration in her.

Therapist A categorizes different types of patients of colour, originally assigning her feelings of impotence to her first category, i.e. those with social problems. However, it emerges that patients from her second category - the "yuppie coloured" - also make her feel impotent. Other similarities between the categories emerge and she eventually drops this idea, indicating that it was a defence of intellectualisation against underlying feelings, of which impotence is one.

Let us examine the second example of Therapist A's feeling of impotence.

In this instance she talks about a coloured female patient who, she feels, "related to me only in terms of my externals". She became fixated with the therapist's very Caucasian attributes, viz. her blue eyes, blonde hair and white skin and, because of this, attributed education and intelligence to the therapist. The aim of the treatment "was to get her to go out and find this elusive job". The patient wanted the therapist to find the job for her and Therapist A's comment is that "she endowed me with a lot of power". At the same time, the therapist felt that the patient stood

"that much less of a chance because there are so many more people like her looking for jobs - but now she says that if she were white - I don't understand - I can't actually help her - that I must go out and get the job for her - that was what she literally said...I could get the job for her. So she endowed me with a lot of power".

In reply to the interviewer's query as to how this made her feel, she said, "very, very impotent". In order to cope with these feelings, by her own admission, Therapist A "got sucked in" and became very directive, giving the patient concrete steps to follow. She also "started using myself much more as an example so that I couldn't remain as objective as I could with a white".

A further probe regarding her underlying feeling elicits this response:

"Guilt...feeling responsible, feeling guilty about the fact that, yes, I probably do stand a better chance of getting a job than she does because I'm white, because I've had the advantage of a white education...and feeling that I must take some responsibility for that and feed something back in this little way".

Feelings of impotence are related to feelings of guilt and both are defended against by making reparation.

In an interesting parallel, Therapist B also categorizes her patients (albeit in a different way to Therapist A). Once again, the helplessness theme emerges at the beginning of the interview, where B categorizes her patients into those who are "very complex in a psychodynamic sense" (and who are usually white) and those who are "in a sense less complicated than white patients" (and whose "issues were clearer to me"). She is aware of feeling "terrible" about saying this, perhaps because she feels she is patronising the patients in her second category.

B later comments that the "sort of philosophical issues of doing psychotherapy at a much more complicated level are done away with".

She takes a supportive, behavioural approach and says that

"...in a way it's simpler because you're getting given more concrete issues. But in a way it's much more depressing because you just feel that the social issues are just too big for you to handle at all...so although you can hide from it by feeling that you're doing something ...(...)...You're given a sense of power in that situation. You are the white therapist who is sorting all that out - but it's a complete myth".

In comparing how she feels with white patients, she says that "there's not that feeling of terrible stark reality". With patients of colour, however, her feelings of depression and helplessness are, as she realises,

"...overcome by acting on the concrete reality...and grasping hold of the things that you can do...and also really there's a whole feeling in that we're really doing something...(...)...I don't believe that it's really there. You make yourself think that because the situation is so desperate".

In reality, the problems of her coloured patients are so complex and overwhelming that B defends herself against her anxiety and underlying emotions by isolating aspects of the situation - she acts on the "concrete reality", thereby neutralising the affect of the situation. Thus, she can only relate to part of her patient's existence. The sense of "power", "reassurance" and "usefulness" obtained by doing this is, as she realises, false - it's a "myth". B's underlying feelings are distressing enough for her to say:

"...I think that's why I don't really like working with people of another race - because I ultimately feel that I'm not doing anything".

Towards the end of the interview (Appendix B, p.174) B talks more directly about her avoidance of racial issues in psychotherapy:

"...we de-emphasize it because of our inadequacy. We're feeling inadequate already in the situation and to actually look at it and scratch at it and see how inadequate we are in that situation we're really going to feel useless...(...)...you can bring out the most intimate details about the person but the one thing that you shy away from is the race issue. I mean, it's the most painful issue".

In contrast to the openness and insightfulness of the above statements, Therapist D's feelings of impotence emerge in parapraxes. During her first response of the interview she says that the language problem with blacks makes working with them a total "impossibility". It appears that she then meant (consciously) to make a distinction between these "non-workable" cases and coloured people with whom she shares a common language:

"I've done quite a bit (of work) with coloured people, um, and there I think to some extent the racial thing makes a bit of a difference but I think it's *always an insurmountable problem*, I think that's just one factor which makes a person more or less workable" (my italics).

Clearly, what she meant to say was that "it's *never* an insurmountable problem". This slip highlights her anxiety about cross-racial therapy, which she evidently unconsciously feels less able to cope with than she wishes to acknowledge.

D's second slip of the tongue occurs in the context of replying to a question regarding how she feels when confronted with a new coloured male patient (Appendix D, p.190). She reacts with what she calls a "very spontaneous racial reaction", i.e. that she assumes there'll be a communication problem, that the person will be less educated and less cultured, etc. And then she adds:

"So, basically I'll just have more doubts about my, not my ability, but that person's ability to communicate with me".

It appears that she was going to say "my ability to communicate with the person" but defended against this admission of self-doubt by projecting her fear onto the patient.

Further on in the interview she presents an example of a coloured man who felt that if he were white he would be more likely to be loaned money by white friends,

"whereas being coloured it's more difficult, nobody wants to help you and if you want to get a, if you wanted to get a car, you know, because you're coloured you can't get it like a white person".

It seemed to the interviewer that this patient was making an indirect communication to the therapist regarding his anxiety about *her*, a white person, helping him, a coloured person. This interpretation was presented to D and appeared to elicit the expression of some deeper feeling:

"Oh, really, I didn't think of it that way. Um, no, it made me a bit uncomfortable because I felt that I couldn't really give him any response that would satisfy him. I mean I listened to it reflectively, you know, and I questioned the reality of his beliefs because they weren't actually completely accurate - the way he viewed white society, that people just hand money out to each other... but it made me a bit uncomfortable because I felt that I *couldn't give him a satisfactory answer*, I couldn't satisfy whatever need was coming from there" (my italics).

The interviewer reflected D's feeling of helplessness and her attempted solution (viz. to point out the fallacy of the patient's beliefs).

However, she then becomes flustered:

"Ja, and to reflect on, he was, frustration...just to make him feel understood, I couldn't really - a practical solution of how he could change his behaviour by becoming..."

And here she stumbles, looking for words. The therapist's anxiety appears to come from the fact that she is feeling tested by the patient (and, perhaps, the interviewer!) and that she feels responsible for providing a "satisfactory answer" but cannot do this, probably because her patient's claim has more than a measure of truth to it - it would be more difficult for him as a coloured to get finance for a car. As seen with other participants, she then attempts a "practical solution" as a defence.

In fact, her underlying feeling of guilt emerges two responses later, in the context of being part of the "white system" that provides poorer resources for coloureds. Thus, her patient's assertion of the white's easier living conditions, as well as his testing of D, raised her anxiety and she attempted to defend by, firstly, denying the accuracy of his statements and, then, offering practical solutions. Her underlying feelings, as shown, are helplessness and guilt.

Therapist G, like Therapists B and D, cites the language barrier with his black patients as inducing feelings of helplessness and alienation in him (beginning of the interview):

"If I have to work through an interpreter which happened to me, I felt totally helpless, I feel very distant and... almost as if I cannot reach and touch the other person... (...)...even the personal...the eye contact...he looks at me, and then he looks at the interpreter. Every time there's a break in the relationship".

With coloured people, however, he does not experience this helplessness and alienation: "...I find it quite easy to work with coloured people". Nevertheless, towards the end of the interview, feelings of helplessness as regards coloured people do emerge, albeit in a somewhat different context. Following exploration of his feelings of anger, guilt and

sadness (see earlier analysis) and a short discussion on the theme of gender differences, G responds to a general request for comment on cross-racial therapy by talking about the double bind many of his younger coloured patients are in. They have pressure from parents to get an education and conflicting pressure from political activists to boycott school.

"...that makes me feel very helpless...I mean, it's wonderful to keep them in the hospital for some time but once you send them out and then you realise - that's where the discrepancy between what my children have and these children - where they're actually not safe on the streets. Some of the coloured suburbs where kids are being raped...it makes me feel very helpless".

How does he attempt to deal with these feelings? In the example he gives, of coloured mothers approaching him for help, he attempted to use prayer (he was involved in faith counselling at the time), but this did not work:

"...And then *my* feeling of...helplessness. You can say, 'OK, let's pray', but it's actually *shit*, because of...they needed the support and they needed someone to listen to them but...what can I do about their situation?"

He tries out practical solutions - wanting to advise the parents to send their children away to a safer place but, realising that there is a lack of facilities and finance, he says: "...it's futile - that makes me feel very helpless and, again, angry". His feeling of helplessness is related to feelings of guilt (his children have, and their's don't) and he becomes angry.

#### 4.1.3 SEXUAL CONFLICT AND THE DEFENCES AGAINST IT

This theme arose overtly and spontaneously in the interviews with Therapists B, D and F and these analyses are reported here. In other interviews, where it was initiated by the interviewer, the participants' responses indicated that significant conflicts were involved herein. Of this latter category,

Therapist C's interview analysis has been included here. More weight has been given to the analyses of the aforementioned three participants although one could argue that silence about the issue is indicative of repressive forces at work.

For Therapist B, it is her anxiety about her competence and her role as a female authority figure that provides an entrée to this theme. Towards the end of the interview, after discussing her feelings of helplessness and of guilt, she talks about the transference of a coloured female patient who saw her as a model female figure (Appendix B, p.172). The interviewer asks her about the gender factor (whether she feels it to be important) and she resists somewhat. She says that it is difficult to separate it from the socio-economic factor and that, although she feels there must be a difference, she is not aware of one.

When the interviewer attempts to explore B's work with coloured males, this clinician again becomes defensive. She asks, "Why do you ask about males rather than females?" and laughs anxiously when the interviewer parries her question. The interviewer interprets that she has some anxiety in this regard and presses on. B talks about her feeling with men in general:

"...that anxiety about competence and about looking in control of the situation, which is certainly related to my relationship with my father which - never really having credit for competency - never feeling that I'd made it".

She again states that she wouldn't feel different with a coloured of the same socio-economic status and then she brings in her feelings of guilt, which had been exposed earlier in the interview:

"...there'd be my anxiety in relation to my own feeling of guilt and as to how that patient was actually seeing me as a white female psychologist. So that would be the added anxiety. You know, am I...I don't know...am I - sort of able to show concern that can be taken purely as concern and caring for somebody or is that being - sort of looked at in the context of the social issue and - ach, I don't know it's totally mixed up. I mean, my guilt comes into that just as strongly".

A very tentative interpretation at this point could be the following:  
B is anxious that her concern and caring might be misinterpreted and taken as a manifestation of her racial guilt. However, she is confused about this - "ach, I don't know it's totally mixed-up. I mean, my guilt comes into that just as strongly". But which guilt? Could it be Oedipal guilt - which arises in relation to working with men (note her dynamic with her father) - and here being defended against by her racial guilt? And is she afraid that her "concern and caring" will be misconstrued in a *sexual* way? These questions would need further exploration with this participant.

With Therapist C, it was the interviewer who initiated the theme of sex. Her response nevertheless indicates that this is a significant issue for her. Asked whether there is a difference between seeing a white as opposed to a coloured male, she initially says, "No, apart from the issues we've discussed, no" (Appendix C, p.181). The issues up to that point covered the themes of anger and alienation. However, C immediately hints at a difference not yet discussed:

"I'm very aware of my own sexual feelings towards somebody of another colour - but - it doesn't affect me in my relationships with them".

When the interviewer asks her to explore this issue she becomes markedly anxious and, to relieve some anxiety, laughs, expresses a need for a cigarette and then says, "What?", as if her defences had blocked out the interviewer's request. She then responds:

"By that I mean I know where the line is drawn for myself (lights up cigarette) - you know at times you'd get a nice good-looking white client and you'd think - this could've been somebody who you could've had a relationship with, but I've had these thoughts about - see, I'm starting to hyperventilate! (anxious laughter) - I've never discussed this with anybody - I don't have these thoughts about a coloured person because it's not somebody I would have a relationship with - no matter how nice he is".

At this point she attempts to use *isolation* as a defence. White clients she could feel sexually attracted to but not coloured clients. However, a parapsix indicates an unconscious conflict. After saying that she "could've had a relationship with" (a "nice good-looking white client") she says: "but I've had these thoughts about -" Here, she clearly meant, on a conscious level, to say: "but I've *never* had these thoughts about -". However, she unconsciously omits the "never" and her anxiety about the possibility of being attracted to coloured men becomes very apparent; she breaks off her sentence to remark on her anxiety: "- see, I'm starting to hyperventilate! (anxious laughter) - I've never discussed this with anybody -" and, having brought her anxiety under control by this manoeuvre, she finishes her sentence as she had meant it (consciously) to be: "I don't have these thoughts about a coloured person..."

Whilst talking about the etiology of these feelings - in relation to her family upbringing - she says:

"everybody was always equal and my home was always open - always encouraged - but the limit was unconsciously set for us - that is as far as it goes - you cannot marry them or engage in a relationship with them - the same way as I would never have a relationship with a person of another religion..."

Picking up on this last point of C's, the interviewer asks whether the racial factor is a bigger taboo than the religious one. C initially says that "they carry the same weight" but then contradicts herself - she might feel attracted to a white Gentile but "wouldn't even think that far with a person of another colour". Thus, it seems that C is using her Jewish injunction not to marry outside the faith as part of a rationalisation aimed at warding off ego-dystonic ideas.

Therapist D also presents with doubt about her role as an authority figure. She initiates the theme of sex when, after her second response of the interview, she is asked to clarify what she meant by "racial thing" (Appendix D, p.189).

"...maybe there's certain, um, like different cultural beliefs,...(...)...now I'm a female psychologist, maybe that to them, that would be a problem".

She feels that the "sex of a person doesn't matter" within the white culture ("maybe not entirely"):

"...but maybe with coloured people, that would be a problem to them if they are quite traditional in viewing the woman as the inferior...I mean I think some coloured cultures do see it that way".

Asked whether this would matter regardless of whether the patient was male or female, she replies:

"but maybe it would be worse if I'm seeing a male - for him it's a complete reversal which he's maybe not comfortable with, not accustomed to, you know".

The interviewer asks whether this had ever been an overt issue in therapy and D replies that, although no patient has ever said anything, she has

"felt it now and then; that because a male, a coloured male has like resented my position of authority, experienced it as a resistance and I thought maybe it's that, but I mean I'd never ask them I'm just too scared to do that. I can't really think of any other things except that we..."

And she goes on to a different subject, a theoretical discourse about different religions which could be a block. When the interviewer attempts to bring her back to her feelings about dealing with men, she drops the male gender and talks about "a coloured person".

Let us examine the above process. In reality, it may well be that certain sections of the coloured population are patriarchal. However, the same can be said about the white culture. Indeed, many coloured families are matriarchal in nature.

D cannot substantiate her feeling about the cultural norm that she posits as the cause of resentment in her clients. It is possible that she is picking up anger directed at her for other reasons - perhaps as part of a negative maternal transference, or racial anger. In any case, it appears that her labelling of this resentment as due to a cultural norm is used by her, at least in part, as a defence against the fear she harbours in relation to men of colour. This interpretation gains evidence in her statement: "I'd never ask them I'm just too scared to do that".

Later on, the interviewer returns to the question of sex. This follows the theme of anger and a general discussion regarding the effectiveness of cross-racial therapy (Appendix D, p.194). The interviewer asks whether there were differences for D regarding the gender variable across race groups. She replies that she would expect to encounter sexual transference and counter-transference when working with a white male, but that this is not as "likely" with a coloured male. Asked to expand on this point, she becomes anxious:

"because I think that - I don't see - um - I don't really see (laugh) non-white men as attractive as white men - OK - so, I wouldn't be as worried, like maybe I'm going to get into this guy".

She also wouldn't expect a sexual transference to arise with a coloured patient although

"with a lot of white guys they very quickly misinterpret... (...)...I think they fall in love with me very easily - the white male clients - and I wouldn't expect that to happen nearly as easily with a coloured client".

Here she appears to be denying the possibility of sex (reality or fantasy) with a coloured man:

"You're socialized into not seeing another race as potential sexual partners...(.)...it's not acceptable. For me, it's like, not really acceptable to me, if I was to fall in love with a coloured guy, there'd be big problems for me. Or for any white woman".

She projects her internalized taboos onto coloured men as well as white women. With these powerful taboos, it becomes necessary for her to defend herself against any impulse to have sex with a coloured man by denying both her feelings and his, and those of all other white women.

In order to further explore her feelings of cross-racial sexual liaison, the interviewer asks her how she feels about seeing a mixed couple - a coloured man and a white woman - in a social situation. This immediately elicits anxiety, which D relieves by laughing. She says she cannot "identify with that", that it would "embarrass" her and then she begins to get angry:

"And very strongly I question it because I wonder - I don't think this applies to a lot of situations, but it sometimes does apply - that people do that to create an impression. I experienced that at (my university) a lot because there were mixed racial groups there. A lot of white girls who wanted to prove how liberal they were would go to *bed* with a guy who was black. And the black guys knew that they could screw a white girl anytime. And that makes me angry because that's again reverse racial discrimination".

D is angry and, apparently, disgusted with these "white girls", but is it because they are practising "reverse racial discrimination" or is it because their cross-racial sexual practices elicits deeper feelings in her?

Earlier she said that this "is not acceptable...for any white woman" but here are these white girls who freely go to "*bed*" with black men. It seems that she is offended at a deeper level than that implied by an intellectual concept such as "racial discrimination". Perhaps she feels that these white girls are betraying their race, that they are dirtying themselves and, by implication, her, too.

The interviewer places the emphasis back onto the therapy situation and D is adamant that she has never felt that a coloured man has been sexually attracted towards her (unlike Therapist C who felt that people of colour do not share her taboos regarding miscegenation - Appendix C, p.182).

The interviewer offers D the interpretation that the notion of cross-racial sex elicits anxiety in her and that she might be defending against this by denying the existence of sexual transference feelings in her patients. She admits that this is "a possibility". The interviewer asks D how she would feel if the sexual transference became evident. Rather than express how she would feel personally, D tells the interviewer what she would do professionally: "I would try to deal with it as professionally as I could, in the same way as I would with a white guy".

Therapist F's interview presents some interesting possibilities. The first hint of a sexual theme emerges early on. F was talking about a 19-year-old male Indian client of his and how he had dealt with their racial difference in therapy. F felt his attitude had relaxed the client but then he says:

"...He's very dark by the way...black! black! I sometimes catch myself, about once every four sessions, 'Jesus, you know, this is weird!' Just the old cultural conditioning of South Africa. Black! But I sometimes catch myself making this fuck-up. I haven't taken adequate account of his cultural background. Like girls...now he took this girl to a...plebs dance (laugh.), what do you call it? Debs! Debs ball...plebs, huh! um...and, you won't believe this, but his lady friend was chaperoned by her parents. Freaked! I mean, I laughed".

Without further evidence, only tentative interpretation of this excerpt can be made. In examining the process, we can see that his associations move from an emphasis on the patient's race and, specifically, his skin

colour ("black! black!") with reference to ingrained racial prejudice ("the old cultural conditioning of South Africa"), to the therapist's feeling of, at times, not taking "adequate account of his (the patient's) cultural background". His first association to this limitation is a sexual one - his patient's dating - and here he makes a slip of the tongue: referring to a deb's (debutante's) ball, he accidentally calls it a "pleb's dance". "Pleb" is a derogatory, demeaning term, short for plebeian, which refers to someone belonging to the common people, of low birth or of doubtful breeding. Thus, F's unconscious prejudice slips out. At the same time, he reports laughing at the fact that the girl was chaperoned. Although he reports apologising to the patient and saying, "I'm not trying to insult you, it's just a bit weird to me", his later remarks tend to indicate that his feelings are not quite that benign:

"...I always get him to teach me - he loves it. Asked him how he feels about her being chaperoned. He said he really wanted to take her outside and kiss her - very sweet, you see, this kid's fourteen".

The "pleb's" slip, F's therapeutically inappropriate laughter, his reference to his 19-year-old patient as "very sweet, this kid's fourteen" add up to an unconscious message: "this person is of low breeding and he is *not* a man, he's a boy". One could tentatively conclude that it has a patronising, emasculating flavour to it.

The sexual theme becomes more overt towards the end of the interview (Appendix F, p.216). In discussing his guilt, his fear of black anger and his ambivalent feelings of alienation and closeness with blacks, he uses his relationship with a black ex-girlfriend as a reference point. He talks about his inability to confront her when he knew she was taking advantage of him. He says this was because of his "*pure* shame and guilt" and, because of the "white man's burden", he "owed her one". He was afraid that if he said something, she "would have ranted and raved".

In exploring his attraction to her, he discloses that the first woman he ever slept with was black. "She was very good to me". He feels that "some of my shadow side (is) involved here as well - part of it is revolutionary, a wish to offend the system which I very strongly rebelled against". What emerges later is that the "system" he refers to is both the political one and his family of origin.

However, before he elaborates on this aspect, he provides two more hypotheses:

"...On a slightly dirtier level you can talk about the master-servant relationship. When I originally went for black women I didn't feel that white women would accept me. In other words, I was being a strong racist as well as a sexist. I accept all that about myself. I'm terribly attracted to Indian women...beautiful princesses walking on the street. Can't get access, they're a very closed group. I don't know what to say, it's the Jewish genetic streak in me, the dark side. Arabs are pretty dark. I've never paid much attention to those taboos that's perhaps why I can't answer your questions about the therapy issue. I work on a different system".

These last words appear to be both true and a piece of resistance. It is true, his sexual impulses towards black women are not inhibited by societal taboos, rather the opposite - because of the taboos, black women provided ammunition in his rebellion against his system. However, the resistance is there when we consider that this issue is heavily loaded for F; black women are very significant to him.

Further exploration shows a powerful libidinal cathexis to black women from an early age. F remembers being "dumped" by his parents:

"I must have been 3½ - quite an early memory - I remember doing some *very* sexual things with this woman - looking up her dress, massaging her feet. I remember massaging this woman's gnarled African nanny's feet...a very touching memory. I wasn't massaging out of servitude, I was massaging out of pure sexuality".

F presents a picture of a strong need for a "substitute black mother", one who is "sexually extremely open", big breasted, warm and has a "lovely dark skin, not like Mom's skin". He shows a history of feeling far more accepted by black women than he does with white women.

The only conclusion that can be made with certainty is that, for F, his racial feelings may have a significant effect on his therapy, especially in terms of a sexual counter-transference. The precise manifestations of his particular racial dynamics in therapy would require further dialogue with F.

The above analysis of the three central themes has divulged many examples of the participants' anxiety, defence mechanisms and underlying conflicts. The following section draws this material together in a summarised and descriptive form.

#### 4.2 SUMMARY AND DESCRIPTION OF THE THEMES AND DEFENCE MECHANISMS UTILISED

As noted, this section provides a summary of the defence mechanisms explicated in the analysis of the interviews as well as a brief description of each of the three themes. The information contained herein is not exhaustive but includes many of the salient points that have emerged from the analysis. In common with psychodynamic psychotherapy practice, the defences will be analysed first and, following this, the underlying feelings (i.e. the themes).

##### 4.2.1 DEFENCE MECHANISMS

There are common attitudes or approaches taken by the therapists which each involve several of the defence mechanisms recognised by the literature. Among the most salient of these attitudes or approaches are:

- (i) use of professional role;
- (ii) adoption of a more directive and/or behavioural approach;
- (iii) use of patient characteristics; and
- (iv) overcompensation.

The first of these, using the *professional role* as a buffer against underlying feelings, is evident throughout the analysis. Therapists commonly label patients' sexual or hostile feelings (towards them as whites) as transference phenomena (e.g. "maternal transference", "culturalised transference") and in this way avoid having to take responsibility for their own actions or having to respond on a personal feeling level. In addition, psychodynamic or other techniques are often used defensively, e.g. interpretation of the patient's dynamics. It appears that the defence of *intellectualisation* is being used here in order to neutralise the affect of the situation.

A related aspect is the tendency of some therapists to *isolate* themselves within the role of the professional and thereby withdraw and alienate themselves (on a feeling level) from their patients. In this instance, the concept of the defence of isolation is meant in a broader sense than its use in, for example, obsessional neuroses, where it relates more to a withdrawal of cathexis (decathexis) from the therapeutic relationship. This mechanism is evident in several aforementioned examples of participants responding differently to a similar situation outside of therapy. Related to this is the attitude, expressed explicitly by one therapist, of wanting to be seen as a "white professional" rather than a "white authority". Inherent in this defensive posture, as well as in several others, is the defence mechanism of *denial*.

The second broad defensive approach mentioned above, viz. the *adoption of a directive and/or behavioural approach*, is used very often. Related to the use of the professional role is the use made of schematic history-taking in order to neutralise affect. Other phenomena range from a general attitude of *authoritarianism* and/or directiveness (e.g. the giving of advice) to the adoption of specific behaviour therapy procedures (e.g. work schedules). Supportive approaches, rather than in-depth work, are assumed and problems of patients are simplified. In this way, therapists can avoid having to deal with deeper, more disturbing feelings (both the therapist's and the patient's) and a sense of achievement is fostered. The result, however, is that aspects of the patient are isolated and he or she is related to only as a part object (in Kleinian terms). While behaviour therapists and others who take directive approaches do more than they purport to do, this is not on a conscious level and, hence, these approaches may be used defensively.

The third broad attitude, that of *making use of patient characteristics* as a defence, is also used fairly regularly. The positing by therapists of a particular transference has already been discussed. In particular, patients' feelings of dependency and vulnerability are used as excuses to avoid tackling threatening material. The defence mechanisms most commonly related to this attitude are those of *rationalisation* and *projection*. While interpretations regarding this latter mechanism have at times been made tentatively, it is clear that the participants project their own feelings of guilt, self-doubt, mistrust, prejudice, fear of hostility and their own sexual taboos, onto patients.

The fourth general phenomenon is that of *overcompensation*. Most of the therapists feel pressurized to present a liberal image to their patients

and feel that they must be especially careful and sensitive to their patients' feelings. It appears to be common practice amongst the participants to provide, or to be tempted to provide, an additional service to their patients of colour - for example, the completion of a "more thorough" assessment. The most salient defence mechanism at work here appears to be that of *reaction-formation* whereby repressed wishes or conflicts are defended against by the adoption of a diametrically opposed attitude. Another specific manifestation of this might be (and this is a tentative statement) the adoption of radical (left-wing) political attitudes.

Related to this phenomenon is a common need amongst the participants to engage in *reparative acts* with their patients. While the need to make reparation is not, essentially, a defence mechanism, it appears to perform a defensive function in some cases. (Reparation will be discussed more fully under the theme of guilt). For instance, one therapist felt her whiteness might actually help the patient. While this may be accurate it also appears to represent a reaction-formation and a need for reparation. Reparative needs are further evident in, for example, Therapist A's wish to "feed something back" and Therapist G's admission of dealing with his guilt by doing "restitution".

There are several other defence mechanisms commonly used by the participants. One which has hardly been mentioned because of its universality as a mental process is that of *repression*. There are many examples of this defence mechanism, i.e. of participants keeping threatening material from coming to consciousness (for instance, as shown in the dream extract of Therapist F). Another, which I shall label "*dis-identification with the oppressor*", is explicitly mentioned by several therapists and entails some kind of statement distancing themselves from the attitudes and actions of the governing authorities. This state-

ment is usually made in response to the therapists' own feelings (e.g. of guilt) or hostile accusations or black anger on the part of the patient. The defence mechanisms of *rationalisation* and *denial* are often involved here, whereby the therapist states that, for example, because he does not vote for the government he is not responsible in any way for the plight of the oppressed. This defence may be compared to that of the recognised "*identification with the aggressor*" in that the therapist, faced with the criticism (perhaps emanating from his or her own superego in conjunction with an external authority) that he is an oppressor, identifies with the aggressors who, in this case, would be in opposition to the South African government.

The mechanism of *intellectualisation* has manifestations other than those attributed to it above. For instance, different forms of guilt and feelings of perceived racial threat are intellectualised about whilst some therapists put forward various theories categorizing patients.

*Rationalisation*, a mechanism comparable to that of *intellectualisation*, is used by therapists to explain to themselves why they have not tackled certain threatening aspects of their patients' therapy, why they are *not* prejudiced (e.g. two Jewish therapists give their religion as reasons for this) and to defend against other ideas which may be ego-dystonic.

*Denial*, another mechanism previously mentioned, is used pervasively to ward off awareness of race differences and the consequent threatening feelings of guilt, sexuality, prejudice, anger, and so on. Several participants initially denied experiencing problems in cross-racial therapy (other than with blacks) but later in their interviews, through insight, came to accept the existence of several problematic issues. Therapists denied aspects of their patients (e.g. the existence of anger) and of the therapy process (e.g. the existence of a sexual transference).

Feelings of anger appear to be *displaced* quite commonly. *Isolation*, again meant in a general sense, is used by a few therapists to separate the threatening sexual aspects of their patients of colour from the therapy relationship. A tentative interpretation was that *guilt* itself might be used at times for a defensive purpose - either to defend against anger or in the case of racial guilt being used to defend against Oedipal guilt. Patients appear to be *patronised* on occasion as a defence against an underlying feeling. What I have termed "*pseudo-insight*" seems to be used by at least one therapist as a defence.

The majority of the explicated defence mechanisms have been summarised. What follows is the essential description of each of the three themes, which are not mutually exclusive. The generalisations inherent in these descriptions are based on the analysis of the interviews and thereby make their claim to a general validity amongst liberal white South African psychotherapists (while recognising, at the same time, that there is no one absolute truth). It should be noted that the descriptions are limited by the fact that an idiographic analysis has not been undertaken with each participant.

#### 4.2.2 GUILT AND ANGER

All seven participants appear to have a lot invested in the perception of themselves as liberal- or radical- minded people who have the minimum of racial prejudice or racial anxiety. However, the analysis shows the existence of several deeply-felt ego-dystonic psychodynamics within each participant. There are feelings of hostility and rejection held toward people of colour; some overt evidence of deeply ingrained prejudice came to light; many of the therapists mistrust and fear their black, coloured or Indian patients; and all, without exception, experience marked discomfort and/or feelings of guilt in relation to being white in South Africa.

Several factors appear to provoke a feeling of guilt in the participants. Some respond with guilty feelings to black anger in their patients. In a few, guilt is elicited by patients' subservience, passivity or projection of authority. In others, white guilt appears to be such a sensitive issue that the colour of the patients' skin or the fact of their different race might be enough to provoke this feeling.

Several participants became aware of feelings within themselves of helplessness which then evoked a feeling of guilt. It thus appears that the precipitants of white guilt are numerous and that the importance of any one factor depends upon the particular make-up of the individual.

The feeling of white guilt is a very uncomfortable one and is vigorously defended against by the therapists (see the preceding summary of defence mechanisms). Of the precipitants of white guilt, black hostility and anger, especially, appears to be avoided at all costs. In addition, it became clear that clinicians collude with patients in keeping the race issue out of therapy - for fear of its explosive and damaging potential.

The feeling of guilt entails acceptance of some responsibility for causing damage and misery to people of colour in South Africa - for being the cause of unemployment, inequality, dangerous situations in the townships, poor education and so on. White guilt also entails a feeling of "we have *because* they don't have" and that "we, as members, are responsible for the sins of the white race - we have aggressed against others so that we can possess the spoils".

Most of the participants eventually showed at least some acceptance of this feeling. Acceptance for the sins of the white race then entails a feeling of being deserving of punishment; one therapist did "penance" (i.e. he meted out punishment to himself) while another had a nightmare

of being killed by black men. For other clinicians, being punished by a patient's premature termination or being accused of being a white oppressor left them feeling hurt and rejected. Several participants spoke of their anxiety about a racial threat. Incidentally, while the notion of perceived racial threat was used defensively, it is clearly a valid entity and exists side by side with that of white guilt.

Feelings of responsibility elicited the need in most of the participants to make reparation to people of colour, to apologise to them, to somehow make up for the damage they feel they have caused.

A few of the therapists became angry about having to experience this guilt, directing the anger toward the government, the patient and, in one case, the therapist's husband. Another therapist became angry at colleagues in the medical profession who showed little regard for patients of colour. A point of interest is that the sadness and depression reported to be linked to feelings of guilt is perhaps indicative of anger turned toward the self.

The vicious circle of "oppression of blacks - feeling of white guilt" was attributed by several therapists to the political system of South Africa, i.e. to apartheid.

It emerged that only a minority of the participants had given the issue of race in psychotherapy much conscious thought. Two, however, stated that they had spent time in their own therapy working through race-related issues. Even with these individuals, the repetition compulsion regarding guilt and its related feelings and behavioural manifestations was evident and thereby indicative of insufficient conflict resolution.

#### 4.2.3 HELPLESSNESS

In the four interviews cited in the analysis this theme emerged spontaneously at the outset of each one, suggesting that feelings of helplessness are uppermost in the conscious minds of the majority of the participants.

Precipitants of these feelings of impotence and helplessness are reported to be: social problems of patients of colour; the socio-political status quo; the language barrier and the necessity of using interpreters; the dependency of the patient; and the endowment of power (onto the therapist) by the patient.

The clinicians described several feelings related to that of helplessness, ranging from a generalised feeling that race problems in cross-racial therapy is a "painful" issue, that it causes discomfort and feelings of futility and uselessness, to feelings of doubt about their professional competence and feelings of personal inadequacy. One therapist's very honest statement appeared to sum up an extreme view on this theme: "I don't really like working with people of another race - because I ultimately feel that I'm not doing anything".

The participants make use of various means to defend against these feelings (see preceding summary on defence mechanisms). A general phenomenon appears to be the "great white doctor" syndrome where the therapist assumes a position of power, becomes directive and prescriptive and in this way avoids being overwhelmed by a feeling of not being able to cope. Several participants recognised that they get "sucked in" in this manner and that the feelings of usefulness and power derived therefrom are false.

Allied to this adoption of a directive approach are the therapists' feelings of guilt and their consequent reparative needs. Feelings of helplessness are also related to feelings of depression and alienation (which, apart from being an underlying feeling also appears to be used in a defensive manner). In some therapists anger is elicited by feelings of impotence (see sections 4.2.1 and 4.2.2).

#### 4.2.4 SEXUAL CONFLICTS

Three of the four female participants presented very significant dynamics in relation to the theme of sex, whilst only one male participant's interview was thought to be interesting enough to be included in the analysis. Thus, generalisations about female sexuality are more validly made, especially since some striking similarities emerged.

Firstly, it was the interviewer's subjective impression (which seemed to gain validity in the analysis) that the female participants' anxiety was at its highest when discussing sexual conflicts. Anxiety about their competent fulfillment of the role of female authority figures for men of colour was evident. One therapist linked her anxiety in this regard to her relationship with her father and a tentative interpretation was made in the analysis with respect to a dynamic between Oedipal and racial guilt. Further dialogue is clearly needed in order to further explicate this issue.

Nevertheless, some clear dynamics did emerge. There was a general repression and denial of any feelings of sexual attraction across the colour line. Internalized taboos regarding miscegenation appear to be very powerful, leading to their projection, by the therapists, onto all white womankind and, by one therapist, onto all men of colour. These taboos were attributed by the therapists to their socialisation within their families of origin and society. One therapist became very angry with

"white girls" who have sex with black men. This dynamic appears to have deep roots, possibly arising out of a fear of being contaminated, in fantasy, by men of colour and/or by her own id impulses. Again, this interpretation represents an extrapolation of the given facts and would need further explication. However, the depth of the therapist's anger and disgust, in this case, indicates the presence of a powerful conflict along the lines already described.

In sharp contrast, the male therapist showed a strong attraction to women of colour, the etiology of which appeared to be bound up with an early libidinal cathexis, which seemed to be related to a "substitute black mother" dynamic, as well as a wish to offend his family and the wider social system. On the other hand, this therapist's relationships with men of colour appeared to be, on a behavioural level, patronising and emasculating. Unconsciously, he seemed to see blacks as powerful superego-type figures. In fact, the foregoing description hints strongly at the dynamic fusion of racial and Oedipal conflicts. In this participant, and we cannot generalise here, black men are representative of the father, black women of the ideal mother. Perhaps the Oedipal triangle in the therapist's family of origin was too threatening to cope with (his mother was described as unloving, perhaps his father was deficient in his own way) and the entire conflict was displaced onto blacks.

In conclusion, specific generalisations, especially with regard to male sexuality, are made tentatively. Nevertheless, there can be little doubt that the theme of race-related sexual conflict is a valid one and affects the individual's handling of and feeling of comfort within the cross-racial therapy situation.

The overlapping nature of the above descriptions show that the separation of the themes, although convenient and useful, is an artificial measure. Feelings of anger, guilt, helplessness, their consequent defences, the need to make reparation and sexual conflicts are all intimately related.

Whilst the descriptions have been limited by the evidence generated during the present study, the following section presents the application of one well-known theory - that of Melanie Klein's - to the interpretations (regarding white guilt) that have been made by the researcher. Reference will also be made to the theories of racial prejudice reviewed earlier in the present work. It should be noted that the choice of Kleinian theory is not meant to imply that it represents any absolute truth.

#### 4.3 A THEORETICAL DISCUSSION ON WHITE GUILT

A brief description of Klein's theory as it relates to guilt is presented. Due to space limitations several aspects of her theory are not detailed in this analysis (e.g. the notions of the paranoid-schizoid and depressive positions and of envy and gratitude). The interested reader is referred to Klein (1975a; 1975b), Segal (1964; 1979) or Salzberger-Wittenberg (1970).

Klein (1975a) demonstrates how the human infant both loves and hates his first love object, that is, his mother. When his needs for nourishment are satisfied and she gives him sensual pleasure (at the breast), he loves her. When his desires are not gratified or he feels pain or discomfort, hatred and aggressive feelings are aroused and the infant is dominated by impulses to destroy the very object of all his desires. Thus, the struggle between love and hate within the infant, with all the conflicts to which this gives rise, sets in in early infancy and, according to Klein, is active throughout life.

Various phantasies accompany these feelings: destructive phantasies, which the baby feels have really taken place - he feels he has actually destroyed the object of his destructive impulses; and omnipotent phantasies of a restoring kind, which he also believes really take place.

Herein lies the root of an unconscious sense of guilt for, if we detect in ourselves impulses of hate towards a person we love, we feel concerned or guilty (ibid, p.309). A feeling of sorrow is also associated with awareness of these impulses. The feeling of guilt is repressed because of its painfulness and is expressed in disguised ways. For instance, feelings of unworthiness are always associated with unconscious feelings of guilt and arise from the unconscious fear of being incapable of really loving others and of not being able to master aggressive impulses towards others.

During the course of the child's development, the sensual craving for the mother's nipples diminishes and genital feelings come to the fore. For the little girl, her interest, mostly unconscious, is in her father's genital, which becomes the object of her libidinal wishes and phantasies. She desires her father and has phantasies of taking her mother's place as his wife. She is also jealous of her mother's children and wishes that her father would give her babies of her own. Thus, concomitant rivalry, aggression and hatred felt toward the mother are added to earlier grievances which the little girl felt because of frustrations at the breast. Sexual desires and phantasies are nevertheless still actively felt toward the mother.

There exists a corresponding development in the little boy. He has genital desires towards his mother and feelings of hatred against his father (as a rival), although he also has genital desires towards his father. Klein (1975a) writes:

"The situations give rise to many conflicts - for the little girl, although she hates her mother, also loves her; and the little boy loves his father and would spare him the danger arising from his - the boy's - aggressive impulses. Moreover the main object of all sexual desires - in the girl, the father, in the boy, the mother - also rouses hate and revenge, because these desires are disappointed" (p.310).

There also exist strong conflicts between aggressive impulses and feelings of love with regard to siblings. While they arouse intense jealousy because they are rivals for the parents' love, and the child wishes to deprive his brothers and sisters of everything they have, they are also loved by the child.

Clearly, if the child's destructive wishes were to come true, he would experience intense feelings of guilt. Klein writes that "even the realisation of much less far-reaching destructive desires is apt to arouse deep conflict" (ibid, p.316) and gives the example of the child who becomes his mother's favourite and feels guilty because other family members are correspondingly neglected.

Klein argues that feelings of guilt and distress arising from the conflicts between love and hate become an essential part of love, influencing it both in quality and quantity.

Another fundamental element in love and in all human relationships is the need to make reparation. A profound urge to make sacrifices exists in order to repair loved people who in phantasy have been harmed or destroyed. Reparation is linked to the depressive position and the establishment of a relation to the whole object (see Klein, 1975a, 1975b).

Thus, the urge to make people happy is associated with feelings of responsibility and concern for them. This manifests in feelings of sympathy with people and an ability to understand them. For genuine consideration, though, an ability to identify with people is a necessity; and, since we identify with them, we share the help or satisfaction that

we give them. In this way we regain in another way the sacrifice we have made. Furthermore, in acting towards another person as a good parent we re-create, in phantasy, the wished-for love of our parents and also undo (in retrospect) all the harm we've done them in phantasy. Guilt and despair arising out of destructive feelings of hate and revenge are thereby dealt with.

The need for reparation has a more specific sexual aspect. For the little girl, her jealousy and hatred gives rise to a wish that her father's penis be an evil thing which would destroy her mother. This, in turn, arouses phantasies of healing her father's genital. The girl also has feelings of her own genital being dangerous. Similarly, the little boy regards both female and male genitalia as being dangerous, and this gives rise to reparative phantasies.

According to Klein (1975a), many people attempt to resolve these conflicts by "lessening their capacity for love, *denying* or suppressing it, and by avoiding strong emotions altogether" (p.322).

Let us now apply the above to the problem of the psychotherapist and his white guilt.

With regard to guilt in general, there appears to be no difficulty in applying Klein's theory to the psychotherapist's situation. The therapist's satisfaction gained from furthering the patient's development is greatly enhanced by his ability to identify with the patient and thereby gain from whatever help he affords the patient. The therapist's phantasies of doing for others what he wished his parents to do for him, or what they actually did for him, increases this satisfaction. By means of the mechanism of reparation he also makes up for the harm, in phantasy, he has done his parents and siblings and in this way lessens his feelings of guilt. Protective feelings, also stimulated by guilt, find expression

in doing psychotherapy. By distributing help, caring and love to his patients, the therapist gains comfort and satisfaction for himself.

A problem arises, however, in applying this theory to the specific guilt of the white South African therapist. The powerful nature of white guilt demonstrated in this study requires an explanation - for, on the surface of things, black people appear to be quite removed from the dynamics of the white person's nuclear family. If black people are distant objects (in comparison to mother, father and siblings), how do they come to be such significant recipients of the white therapist's guilt? The logical answer appears to be that, if they ever were distant objects, they do not remain so. There are several possible explanations for the black man taking such an important role in the white man's psyche.

To this researcher's mind, the most plausible of these explanations is one or other variation of the displacement theory. The reader will recall the "Projection" and "Frustration-Aggression" theories reviewed earlier. With the help of Kleinian theory we may use the ideas behind these two theories to posit a more complete explanation for the presence of white guilt in the therapist who does not show overt or quantifiable signs of prejudice.

In view of the above application of Klein's theory to the position of the psychotherapist, it is possible that, within the therapist (and for that matter other white South Africans) conflicts arising from destructive wishes held toward original family members remain somewhat unresolved, threaten to overwhelm the ego and, as a defensive mechanism, are displaced onto people of colour.

In Kleinian terms, the mechanisms of this "scapegoat"-type theory would be along the following lines: The child is at first attached to his or her parents. An over-strong attachment would give rise to frustrated greed and hatred and, hence, a fear of losing the all-important love-object. This fear of dependence, together with the intellectual and emotional growth of the child (which enables him or her to find other objects of interest and pleasure), result in the ability to displace or transfer love (and hate) from one's parents to other people and things. (In a similar way, sexual impulses get disconnected from the first loved people. At the same time, the child acquires the ability to love in a tender, affectionate way which is dissociated, to a certain extent, from sexual feelings).

However, this turning to other people and things does not resolve the individual's conflicts, for they are transferred from the first-loved people in a less intense degree to the new love - and hate - objects (which stand partly for the old ones).

At this point, let us add a further facet to the argument. The individual is in conflict about hating a loved person and finds it too threatening to separate love and hate within the family circle or, for that matter, a wider circle of significant others. However, it is relatively safe to hate people who are further removed than to hate those closest to one. In South Africa, people of colour are easy targets for displaced hostile feelings. They are removed from the "inner white circle", they are "them". It is not only socially acceptable but it is the norm to be prejudiced towards them (cf. "Socialisation and Conformity" theory).

So, by displacing feelings of hate onto people of colour, the white person maintains the security of his or her loved people (they are safe from his phantasies of destruction). The feeling that love can be kept unspoilt is

fostered by this separation of love and hate. Along the sexual theme, an example could be that of the female therapists who had to deny the sexuality of their male patients of colour, possibly because they had displaced onto these patients feelings of their fathers' genitals being dangerous.

At the same time, "we so much dread the hatred in ourselves that we are driven to employ one of our strongest measures of defence by putting it on to other people - to project it" (ibid, p.340). A vicious circle is set up: hate displaced onto people of colour as well as projected - and we expect them to hate us. In this way, black anger becomes that much more powerful because it contains, for whites, elements of their own projected hate.

There remains a thorny problem: the liberal therapist does not freely admit his prejudice, which emerges only in covert ways. This throws doubt on the anxiety-reducing motivation of the displacement and projection mechanisms outlined above. It appears, then, that liberal whites are just as anxious to repress hostile feelings towards blacks as they are with regard to hostile feelings towards members of their family circle. One tempting solution would be to posit the existence of some other target for displaced hostile feelings in the liberal white - the most obvious being the conservative and ultra-conservative white groups (i.e. the most blatant oppressors). While there is no doubt some validity to this notion, it cannot alone address the fact of white guilt.

It is posited that the white liberal, when he was a young child, displaced and projected anger onto people of colour who, at that period of his development, provided the most distant (and therefore safest) target. At that early age the infant can discriminate between white people ("us") and people of colour ("them"). This group polarisation is made easier by cues

such as skin colour and language. He does not yet possess the intellectual capacity to discriminate between liberal and conservative whites. Later, however, during and after the course of moral development, a conflict arises in relation to the individual's liberal ideals and, because phantasies of destruction toward the first objects of displacement and projection (i.e. people of colour) become too threatening (due to the obvious injury people of colour have received in South Africa), intense feelings of guilt are provoked. It therefore becomes less threatening to direct overt anger towards the "haves", the well-to-do white ruling group, who by no means appear to be suffering from anyone's destructive phantasies.

The liberal white therapist is thus led to defend against his ego-dystonic feelings towards people of colour (which have developed at an earlier age than his feelings towards the white government) by the various mechanisms explicated in the present analysis.

Let us look at the special case of reparation. Klein, referring to the individual's transference of feelings from the first significant people, writes that

"just because his feelings towards these new people are less intense, his drive to make reparation, which may be impeded if the feelings of guilt are over-strong, *can now come more fully into play*" (ibid., p.327, my italics).

This was certainly borne out by the present analysis, where therapists commonly felt that they had to do more for their patients of colour.

However, Klein also states that making reparation should provide the individual with a feeling of comfort and satisfaction and should lead to a reduction of guilt. The analysis demonstrated the repetition-compulsion of the white therapists in this regard - while there appeared to be a diminished feeling of white guilt during the course of some therapists' development, for most, it appeared to be just or almost as powerful -

regardless of whether the therapist had been making reparation for two or for ten years. There is a necessity, therefore, to explain why making reparation does not afford significant, meaningful relief from the feeling of guilt.

According to Klein, we share the help or satisfaction that we give to people because of our identification with them. The qualities of the mixed race relationship, however, are such that identification with the different race person is problematic. The analysis shows this clearly. The therapists were, on the whole, quite alienated from their patients of colour (especially blacks) and it appeared that they often were withdrawn from patients of colour as a defensive manoeuvre. Thus, while the therapists' displaced feelings of hostility appear to evoke guilt and the need to make reparation, they are also overwhelming enough to result in withdrawal and alienation and a consequent lack of identification with the patient. This combination of problematic identification and reparative acts results in a relative lack of conflict resolution. Hence, the observed repetition-compulsion and the perpetuation of the feeling of white guilt.

Perhaps the problem in identification lies in the therapists' denial of their displaced hostility and of their white guilt. The individuals' original solution to his family dilemma becomes a problem itself because of similar reasons: the difficulty of accepting that one harbours feelings of hate for people one feels one should love.

Another idea, although tentative, is that white radicals feel more comfortable (or so it appears) with people of colour than white liberals do because they have more successfully displaced their hostile feelings onto another group - the Government and its allies. Similar reasoning could pertain regarding the relative lack of white guilt in the overtly prejudiced individual, i.e. a more successful displacement of anger, consonant with their ideas of morality, has taken place.

A somewhat different way of explaining the presence of white guilt, but one which is compatible with the above argument, is the following: Klein herself writes about the process by which love for the mother's breast can be transferred onto things. One "thing" which can come symbolically to stand for the mother's "ever-bountiful breast", and for the whole mother, is one's country. Hence, "we speak of our own country as the 'motherland'... it can be loved with feelings which borrow their nature from the relation to her" (Klein, 1975a, p.333). Taking this further, it is possible that the different racial groups then come to stand, symbolically, for the individual's siblings. Since the white group is clearly the "motherland's" preferred "child" and much harm and neglect has befallen its "siblings" (i.e. the black, coloured and Indian groups), it stands to reason that whites would experience intense feelings of guilt in this regard.

A third, entirely different explanation and one which would be compatible with the "Exploitation Theory" reviewed earlier on, is that, for economic reasons, whites oppress blacks and *then* feel a generalised kind of guilt because of the aggression per se. This explanation appears to be too weak and simplified in the face of the powerful and complex interracial dynamics that have emerged during the course of this study.

Finally, Klein's theory is of interest in the case of the colonial. Open aggression and ruthless cruelty on the part of colonials against native groups might be partly motivated by the individual's early phantasised attacks against siblings and imaginary babies in the mother's body. Reparation is then expressed in the repopulation of the country with people of the colonials' own nationality.

In conclusion, it can be seen that Kleinian theory can be very useful in explaining the origins of white guilt. Furthermore, the fact that an in-depth object-relations theory such as this one can be related, not only to other psychoanalytic theories, but to, for example, the theories of "socialisation and conformity" and "exploitation", is perhaps indication of the fact that all these theories are merely explaining the same phenomena in different language and on different levels.

Having completed the analysis and theoretical discussion of the participants' counter-transference phenomena, there remains the necessity of tackling the tasks of self-reflection (on the part of the researcher), of discussing the implications, recommendations and limitations of the present research and of summing up the major findings of the study.

CHAPTER FIVE

DISCUSSION AND CONCLUSIONS

5.1 MAJOR FINDINGS OF THE STUDY

Three primary themes emerged from the analysis of the interviews.

The major theme, which was labelled "Guilt and Anger", was concerned primarily with the participants' feelings of white guilt arising out of an awareness (sometimes unconscious) of deep-rooted feelings of prejudice and hostility toward people of colour and of feelings of responsibility. Intimately associated with these emotions was a universal fear, amongst the participants, of black, coloured and Indian patients' anger and hostility, the expression of which appeared to be avoided at all costs.

The second major theme concerned the feelings of helplessness, professional and personal inadequacy, futility, sadness and depression experienced by the cross-racial therapists. Sexual conflict, the third theme, involved anxiety on the part of the female therapists, whereby the sexual aspects of their male patients of colour were often denied. Therapists' feelings of attraction across the colour line were repressed.

Other counter-transference feelings emerged, for example, feelings of alienation, rejection, sexual attraction (in the case of one male therapist) and power. General anxiety and frustration with regard to working with people of colour was pervasive.

Participants used a **v**ariety of defence mechanisms in attempts to ward off these ego-dystonic impulses and ideas. Most of them hid behind their professional role and expertise, using particular approaches or techniques in order to avoid experiencing anxiety-producing race-related

feelings in therapy. The mechanisms of intellectualisation, isolation, displacement, denial, rationalisation and reaction-formation, amongst others, were utilised. Fears and prejudices were projected onto patients; therapists showed a common need to make reparation for the harm perpetrated by the white race; and efforts were made to dis-identify with the oppressor. Patients were patronised and their problems simplified.

Without any doubt, different-race patients elicit an idiosyncratic anxiety, which is often marked, in the participants of this study. The manifestations of this anxiety appear to be, on the whole, specific to the cross-racial therapeutic situation. Racial counter-transference exists and often intrudes unnoticed into the therapy process. Clearly, liberal attitudes are no guarantee that these variables will not emerge in the therapists' work. While some participants appear to explore the subject of race with their patients and in their own reflection upon their work, the majority seem rather to avoid this, especially as regards discussing race with patients.

Comparison of the present findings with those reviewed earlier in the study show a general agreement. Kadushin's (1972) uncertainty regarding the absence of race-related dialogue in therapy - he is unsure whether this is because the issue is felt to be irrelevant to the therapy process or because its threatening nature leads to avoidance - is addressed. Given the threatening racial material that has emerged the issue is clearly not irrelevant to the work at hand and it appears that, generally, therapist and patient have a non-verbalized agreement to remain silent about their potentially explosive racial difference.

Although this study did not directly address the issue of the efficacy of cross-racial therapy, it appears that, on the whole, the participants

felt that, although a same-race therapist could achieve better results, they could help coloured and Indian patients. Participants were far more sceptical regarding their efficacy with black patients, some feeling that they could not help blacks at all, especially in the present political climate. One therapist reported a general feeling of not being able to help patients belonging to *any* of the race groups. This somewhat mixed set of responses reflects the state of the empirical literature on the subject (see Section 2.2.1).

Other phenomena reported in the literature were found to be present in the study. For example, the various impediments to the establishment of trust and rapport (patients' suspiciousness, the master-servant social matrix, idiosyncratic cultural and language barriers, etc.) and patient transference phenomena (passivity, subservience, dependency, difficulty in expressing hostility, etc.). Some of the counter-transference phenomena already noted (guilt, reverse discrimination, rejection, repression of sexual feelings, and so on) have been reported in the literature.

One point which has emerged from this study and which is of essential relevance to the research is the tendency of therapists to use patient transference phenomena in a defensive way and, in some cases, to project these phenomena onto patients. Given that several studies on transference rely solely on therapists' reports, their results need to be reassessed.

A general point which has not received much attention is the distinction, made by several participants in this study, between the feeling of white guilt and that of perceived racial threat. While the latter notion was at times used in defending against feelings of guilt, it is clearly a valid entity in a country where people are not safe from a racially-motivated attack. The counter-transference phenomena of therapists avoiding their

patients' hostile feelings might, in part, be due to a perceived racial threat. However, it seems unlikely that people brought up in apartheid society could experience a racial threat devoid of any feeling of personal guilt.

A further point of interest, and one already alluded to, is the fact that different race groups appear to have different meanings for each of the study's participants. For instance, Indians have a particular meaning for one Jewish therapist. On the whole, though, blacks were perceived as being more socially distant than both coloureds and Indians.

A related issue concerns the question of class and culture. While only one therapist objected to the researcher's emphasis upon racial differences per se, several participants had difficulty in separating out the variable of class. It was shown, though, that even the class issue could be used as part of an intellectual defence against underlying racial feelings. While class is an important issue it is unlikely that, in a racially segregated society, it could be separated from, or that it could be as important as, the issue of race.

Before discussing the implications of the above findings, let us consider the limitations of the study and evaluate the researcher's role as interviewer.

## 5.2 EVALUATION OF THE STUDY AND OF THE RESEARCHER'S ROLE AS INTERVIEWER

The study's methodology and design can only be evaluated from the hermeneutic perspective; no attempt was made to conduct natural scientific research and therefore the principles of positivistic science do not apply. The key notions of hermeneutic research, as set out in Section 3.2.2, have been adhered to as far as was possible. Just as the researcher came to know more about the dialogue of the participants than they themselves, so the reader will no doubt have seen and understood phenomena to which the researcher might have remained blind. Such is the nature of hermeneutic enquiry:

understanding can always be improved upon and there is no one absolute truth.

While the researcher attempted to minimise his prior prejudices and pre-suppositions, it is clear that these do exist and should be examined. This is especially relevant given that the researcher was interpreting dialogue of which he was himself a participant. A brief self-reflection follows.

The first question any researcher might ask himself is, "why am I interested in this particular field?" Briefly, I have been aware of experiencing many of the feelings, counter-transference phenomena and behaviours that I have identified in the participants of this study and found that these greatly influenced my work with people of colour. As such, I can make no claim to unprejudiced enquiry; I expected to find conflicts regarding white guilt, anger, sexual feelings and so on, in therapists who share a similar social and political milieu and hold similar political ideals to myself. Being aware of these biases I attempted to avoid introducing them into the interviews. I began with a standardized, open-ended, non-directive question and attempted to take my cue from the participants' responses. Examination of the interview protocols will show examples of where I have failed to do this. For instance, at times, usually where the interview had reached an impasse, I introduced themes into the discussion. Mostly, though, the themes emerged spontaneously and the majority of my responses in the interviews were cued by the participants' prior response. Nevertheless, each participant response might cue any one of a myriad interviewer responses. The flavour and content of the interviews were therefore very much influenced by my personality. Thus, one criticism might be that the analysis of the interviews did not include the *person* of the interviewer. It was felt, though, that the primary aim of the research could be fulfilled without complicating the picture by including this aspect.

In the role of researcher I had to be cautious not to let my own counter-transference towards patients of colour invade my interpretation of the material and had to constantly remind myself to allow the text to 'speak' to me without my own past dominating my dialogue with it.

Another aspect which I became acutely aware of whilst interpreting the interview material were *my* feelings towards the participants of the study. I was impressed and felt gratified by the honesty of many of the participants; on the other hand, I felt angry with and irritated by the defensiveness, particularly the denial, of one of the therapists. Thus, while I wanted these feelings to inform me, I had to be constantly aware that they would not prejudice my interpretations.

My prior relationships with each participant influenced the interviews in no small part. In general, the good rapport shared with each therapist prior to the interview was advantageous in that it decreased the anxiety inherent in the interview situation, thus allowing the participants to be less defensive. Defences that did emerge were therefore more validly attributed to anxiety induced by the topic of discussion rather than to the interview situation itself.

Respondent acquiescence, always a variable to consider when conducting research with human beings, did not appear to overly bias the interviews. Only on the rare occasion did it appear as if participants were keen to respond with information they thought was sought after by the interviewer. When participants agreed with an interpretation or observation made by the interviewer, and this excerpt was used in the analysis, it generally adhered to the criteria set out by Malan (1979) for genuine acceptance as opposed to acquiescence (i.e. there existed a "deepening of rapport").

Other variables inherent in the interviews were probably influential. For instance, the fact that many of the participants and the interviewer share a common psychological language probably resulted in certain pre-suppositions being made. For instance, when one participant spoke of his "shame and doubt" he probably felt that he did not need to elaborate on what he meant by this, having assumed that the interviewer was familiar with this Eriksonian concept. This process of assuming common meanings is something which goes on continuously and forms a cornerstone of our ability to communicate with one another. As such, it is also something which might conceivably lead to misunderstandings.

Another example of an interview variable which might not have been fully explicated is the factor of non-verbal communication. The importance of this variable becomes apparent when reading certain textual excerpts and experiencing difficulty in following them. Clearly the written word does not capture the full meaning of the interview.

Reading and studying the interviews in retrospect it has become apparent just how much I, as the interviewer, was blind to whilst conducting them. While this is an unavoidable fact of interview-based research (meaning and understanding are dynamic variables), it does highlight a particular limitation of the present research, i.e. that a single interview with a person can produce only a certain amount of information. Several times during the analysis it has been pointed out that interpretations have had to be made tentatively and that further explication on the subject would be necessary.

Another point of criticism might be the choice of orientation. In reply to this, it must be stressed that no claim has been made regarding the absolute truth of psychodynamic and, in particular, Kleinian theory. The choice was a subjective one and therefore represents the researcher's bias. The phenomenon of white guilt, for instance, could have been situated within a

phenomenological understanding of guilt. Similarly, the interviews might have revealed different results, or ones that at least might have appeared *semantically* different, had the analysis been conducted according to a theory of socio-economic class structure.

In this regard I found some self-reflection a necessity: "was my attempt to explain white guilt in Kleinian terms a defence against taking political responsibility?" According to Klein the original hate-objects are within our own family. Nevertheless, we transfer and displace our feelings and must take responsibility for this fact; in this way, I cannot avoid owning my feelings of prejudice, fear, guilt, etc.

Regarding an earlier point, in retrospect, it is apparent how often I, as the interviewer, was fooled by the defences of the participants. The uncovering of some of these defences had to await the luxury of many hours of examination. There are two points to be made here. Firstly, the defences of the participants are both subtle and powerful. Secondly, even though I was on the look-out for them, I was often oblivious to these defences. The description of the themes and the many defence mechanisms utilised is ample evidence of how much the process of reflection has taught this researcher and how important it is to pay attention to what we do not see in ourselves:

"Even in ourselves we must now try to help the other speak, to understand the foreign language of the unconscious and look at conscious reflection with an eye to seeing what it does not see. We have become distorted texts in need of interpretation and although we can never escape ourselves, we are capable of thought and reflection and so we can take up different analytic perspectives on ourselves" (Steele, 1982, p.350).

A final, somewhat different point, concerns the fact that the themes were artificially separated and were not exhaustive. This has been noted. While it may provide a point of criticism, it was a practical necessity. Interpretation is a self-perpetuating, ceaseless endeavour and artificial boundaries must be drawn in order to complete a task.

Let us go on to examine the implications of the themes and defence mechanisms explicated in this study for the white therapist and his or her patient of colour and thereby give further credence to the necessity of a self-reflective, introspective approach to cross-racial psychotherapy.

### 5.3 IMPLICATIONS FOR CROSS-RACIAL PSYCHOTHERAPY PRACTICE, TRAINING AND RESEARCH

Each counter-transference phenomena probably has its own unique influence on the patient and the therapy process. It is not the present intention to be exhaustive and list every implication, but to indicate, by means of examples, how the therapist's feelings might influence his work.

One of the major findings concerns the suppression of sexual issues in therapy (in the case of female therapists and their male patients of colour). Not only would this obstruct the process of psychodynamic therapy (by preventing the working through of the transference) but in any therapy it might result in the reinforcement of an anti-therapeutic feeling within the patient that his sexual feelings are bad and need to be repressed.

The tendency of white therapists to be directive as a defence may foster dependency needs in their patients. In more extreme cases one may see the emergence of the "great white doctor" syndrome where therapists relish the feeling of power they get because it combats their feelings of helplessness. The sexual aspect of this (hinted at with one male participant) is that the male clinician's sense of ultimate manhood - of being a "white hero" in Hoch's (1979) terms - is linked to him "winning victory over the

'dark beast'" (p.10). While this may be an extreme view, it does serve to highlight the effect of this attitude upon the patient, who will end up with a feeling of being powerless, dependent, defeated and, perhaps, castrated.

The fact that race itself appears to be seldomly discussed might influence the process in several ways. The patient may feel that part of his identity is being denied, and he may feel rejected by the white therapist. He may sense the therapist's discomfort about the racial issue and this may have an effect on his ability to trust the therapist with other, less painful, issues. Whatever the reasons, and they are likely to be multi-factorial, race appears to be a likely candidate to precipitate the patient's fixation in therapy.

Probably one of the most destructive of all the counter-transference phenomena is the white therapist's fear of handling black anger. The consequent discouragement of the expression of the patient's anger and hostility can only be counter-therapeutic. In effect, what white therapists are doing here is to only relate to patients of colour who agree to wear what Fanon (1967) has called "white masks", i.e. to those who will think and behave as whites and who will not be angry about their oppression as blacks. The message to the patient is that black anger is inappropriate, irresponsible and destructive. The therapist will care for the patient as long as the latter continues to deny and, in fact, hate an essential part of himself. Sarte, in the preface to Fanon's "Wretched of the Earth" (1968), has commented:

"...and the first action of these oppressed creatures is to bury deep down that hidden anger which their and our moralities condemn and which is however only the last refuge of their humanity" (p.18).

It is because of his fear that the white therapist cannot accept the constructive force of black anger. If one agrees with Fanon's philosophy, one can see that violence and anger is used by oppressed people of colour to recreate themselves, to regain their manhood. To deny the patient the expression of his anger is to do him an injustice, and also to serve to perpetuate the master-servant relationship.

A large part of the white therapist's fear could be of his own making. If Klein is correct and we project onto others the hatred within ourselves, endowing others with malevolent qualities, then it may be that the white therapist stands more in fear of his own projected hostility than of his patients' angry feelings. This thought offers hope, for the more resolved are our own prejudices and conflicts, the less we will project and, consequently, fear the anger of others. The more resolved cross-racial therapist will be better able to experience his patient's anger without censoring him and therefore render a more balanced therapy. Incidentally, the attitude which allows the projection of these feelings onto people of colour will probably reinforce the patient's suspiciousness and mistrust of the therapist.

Traumatic experiences which the person of colour has experienced, as a direct or indirect result of discrimination, may become intertwined with his personal neurotic difficulties. The patient's experience of a rejecting, frustrating socio-political order may revivify emotions he has experienced during his infancy and early childhood. The therapist thus needs to be aware of this fact lest he inadvertently set up a situation in therapy which reflects the patient's socio-political milieu.

This brings us to the possible advantage of cross-racial therapy. As posited in the literature (St. Clair, 1951; Grier, 1967) and by one participant in this study, the use of the contrasting therapist-patient

race membership may actually enhance the therapy process. If characteristics of the therapist allow for a more intensive transference (e.g. the whiteness of the therapist eliciting feelings of rejection in the patient) this may well be the case. The danger lies in this process going unrecognized and hence resulting in unresolved transference and reinforcement of past trauma.

The defence of reaction-formation used by many therapists may result in the implementation of an inappropriate management plan. For instance, rather than feel that he is discriminating, the therapist might embark on a course of psychotherapy with a patient who is not suited for this.

The presence of unresolved feelings of prejudice and discomfort in the therapist can only lead to the perpetuation of a vicious cycle, resulting in a conscious or unconscious sense of resentment for, and dislike of, working with people of colour.

Just as the racial experience and conflicts of the patient are intertwined with his personal difficulties, so it is with the clinician. The literature on racial attitude development (Section 2.1.1) and the Kleinian analysis (Section 4.3) demonstrate the early roots of racial feelings and conflicts. The following discussion shows how a personal neurotic tendency of many therapists might affect their cross-racial work: Storr (1979), in discussing the personality of the psychotherapist, has pointed out that many people who take up this profession have an "anxious awareness of what may upset (their) parents" (p.174). The effect of this attitude in the potential therapist is that aggressive feelings are repressed. During their training, Storr says, "many of those in the 'helping' professions have, reluctantly, to face and accept an aggressive aspect of their personalities which they might not have realised existed"

(p.175). Thus, according to Storr, the tendency to repress aggressive feelings is part of the type of personality predisposed to enter the helping professions. This may account, in part, for the fact that each of the participants in this study had difficulty with the expression of black anger.

Storr goes on to recommend that psychotherapists undergo therapy themselves. At the very least, the psychotherapist needs to be aware of his own psychopathology and how it has contributed to his choice of profession. I would add that, in the realm of cross-racial psychotherapy, the therapist needs to be aware of how his neurotic conflicts and his racial conflicts are intertwined and how they affect his work. Of course, absolute self-understanding is an unattainable ideal. Constant reflection and introspection, however, is not.

Storr also refers to what Jung has called "unconscious infection" (p.183), whereby the therapist's own equilibrium is threatened by particularly disturbing material that emerges in his work with patients. In South Africa the racial issue alone is disturbing enough to most people. The patient's particular pathology can only add to this. Storr suggests that the therapist who finds himself feeling threatened should talk it over with a colleague, or "he might find that further analysis for himself was called for: on the other hand, he might have to recognise his own limitations" (p.184).

Wolberg (1954) suggests ways of sensitizing oneself to manifestations of counter-transference (in general) by self-examination throughout the course of therapy. Some questions the therapist might ask himself are the following (from Wolberg, p.491):

1. How do I feel about the patient?
2. Do I anticipate seeing the patient?
3. Do I overidentify with, or feel sorry for the patient?
4. Do I feel any resentment or jealousy toward the patient?
5. Do I get extreme pleasure out of seeing the patient?
6. Do I feel bored with the patient?
7. Am I fearful of the patient?
8. Do I want to protect, reject, or punish the patient?
9. Am I impressed by the patient?

With regard to racial counter-transference, several more specific questions might be added. Taking our cue from the themes explicated in this study, we might ask: Does the patient elicit guilty feelings in me? Do I avoid talking about race in therapy? Do I adopt an inappropriately directive approach with the patient? Do I feel alienated from the patient? Do I inhibit the patient's expression of anger? Do I need to overcompensate with the patient? Do I patronise the patient? Do I simplify the patient's problems?

Sensitivity to the issues inherent in cross-racial psychotherapy will naturally guide the formulation of several other relevant questions. Should answers to any of the above questions indicate a problem, the therapist may need to explore the etiology of such feelings and attitudes: Is it something about the patient which is eliciting the feeling? Is the patient angry, or overly-dependent, or is his skin colour alone the provocative factor? Am I scared of the patient's hostility? Why do I feel guilty? What is the nature and origin of my racial attitudes? Wolberg writes:

"Mere verbalization to himself of answers to (his) queries, permits of a better control of unreasonable feelings. Cognisance of the fact that he feels angry, displeased, disgusted, irritated, provoked, uninterested, unduly attentive, upset or attracted, may suffice to bring these emotions under control. In the event untoward attitudes continue, more self-searching is indicated" (p.491).

Wolberg points out that the clinician need not be a paragon of personality virtues but that, provided a working relationship exists and the clinician is reasonably flexible, empathic and objective, he may indulge in a variety of spontaneous emotional responses without harming the patient or the therapeutic process.

In addition to the foregoing, the results of this study indicate, in agreement with previous work, specific ways in which the white therapist might approach cross-racial therapy. The therapist needs to show an attitude of respect. He must demonstrate his serious and sincere offer to listen and help.

As clinicians, we need to "guide against the assumption that the client operates within the same world view as we do" (Dawes and Davids, 1983, p.7). Problems in understanding the client's communication might arise. Thus, it is the professional's responsibility to become familiar with the history, culture and ways of thinking and feeling of his patients. Rituals, such as shaking hands, introducing oneself, referring to clients as "Mr, Mrs or Miss (Ms)" rather than by first name, might be particularly important for people who have been consistently denied the elementary symbols of civility and courtesy. One needs to understand the cultural context of conveying respect. In this researcher's experience, it is common practice in Provincial and State in- and out-patient settings for professionals to call patients by their first names while the latter refer to the professionals by their surnames. In fact, professionals are often called 'Doctor' or 'Sister' even when the 'Doctor' may have been a psychologist (non-Ph.D) and the 'Sister' a doctor! The importance of titles is clearly evident, as is the sexual discrimination on the part of patients. It is also for reasons of respect and status that many black and coloured nursing sisters in the hospitals continue to call each other by their titles and surnames, even though they may be close friends.

It is important to show a sincere acceptance of the clients, and to overcome interpersonal distance. Kruger (1980) adds that this needs to be "not only in the spiritual or psychological sense, but as an embodied being" (p.31). Differences clearly need to be acknowledged in a non-judgemental way. Patronisation of the client, simplification of his problem, or denial of significant parts of his identity are problematic ways of dealing with the issue.

Fibush and Turnquest (in Steere, 1984, p.111) suggest that, if a race-related resistance arises in the patient, the therapist should introduce the topic of race and attempt to elicit the patient's feelings and fantasies regarding the different race of the therapist. They feel that this is generally appropriate at an early point in the therapy.

When patients point out attitudes or behaviours inherent in the therapist or the therapeutic situation, these need to be examined and, if appropriate, responsibility needs to be acknowledged. The fact that the therapist has been socialised within the apartheid society and the consequent effects of this might need to be admitted and accredited. The admission of responsibility by the therapist may alone give the patient a feeling that he is not dealing with the usual intransigent white authority and this may lead him to question his defences.

When a patient spontaneously or is assisted in expressing black anger, it could be problematic to then point out that this is being unfair to the therapist, or for the therapist to dis-own any culpability. Rationalisations and intellectualisations will only serve to label the therapist as insincere. Nevertheless, Gochros (1966) does point out that intellectual discussion may be quite useful in two ways:

- "(1) in providing a less threatening opening into an area that is uncomfortable for both (therapist) and client; and
- (2) in setting up ground rules, a technique that is already used in such areas as confidentiality" (p.32).

If intellectualization is engaged in, though, it must be with complete honesty. Therapists must not promise a total lack of prejudice or total understanding when they can produce neither. Nevertheless, they can make a statement regarding their willingness to increase their understanding of the client.

Tukulu (1983) points out that "it rarely occurs to (whites) that the black man is constantly shifting gears. In the oppressive white environment he exhibits a permanently bowed head and emits excessive 'yessirs'" (p.17).

Manganyi (1973) has this to say:

"The doctor remains in the experience of the black patient a white doctor. This qualification is of the utmost importance since it carries so much of the behaviour which goes on below the verbal level...I have had the experience of patients saying 'Baas' and 'Master' to white doctors. Never have I come across any doctor who appeared shocked by this scandalous suggestion!" (p.55).

Can we expect patients of colour to express their feelings, especially hostile ones, when they are otherwise (outside of therapy) not allowed to do so? When the expression of black anger is so often met by whites with attitudes of disapproval and with detention, punishment and even death? The therapist must therefore be open to subtle signs of anger in the patient and be able to interpret these. Just as with any other dynamic, the therapist must first explore the patient's anxiety and his defences before labelling the underlying feeling or impulse. If appropriate, this must be linked to the racial issue. If the patient denies feeling angry, it need not mean that the therapist's interpretation was incorrect. While it may be poorly timed, the interpretation still serves to show the

patient that the therapist is not afraid to handle the issue. It may take much testing on the part of the patient before he will trust the white therapist enough to become angry at him or her. The therapist therefore needs to resist taking the 'soft option' of entering into a conspiracy of silence with the patient about black anger.

While it has emerged that more directive therapy techniques are often used defensively by the therapist, this does not mean that these techniques are not warranted. Certain aspects of therapy might be antagonistic to the values held by the client and techniques therefore need to be tailored to the client's needs. It is likely that many unsophisticated clients are unsuited for insight-orientated therapy and that a behavioural approach is the appropriate choice. Nevertheless, the attitude of the behaviour therapist, for instance, is no less important than that of the psychoanalyst and counter-transference remains an essential issue.

The therapist may need to be more flexible in scheduling appointments in order to take into account unreliable transport services, or those which have been interrupted by political unrest in the patient's neighbourhood. While he should avoid overcompensating, the clinician needs to understand that, for instance, missing an appointment may have been due to factors entirely out of the patient's control.

The clinician needs to avoid forcing his or her own values or goals upon the client, particularly when working with a client whose cultural system is vastly different to that of Western society.

The particular diagnostic system used by the clinician may not be appropriate for certain clients. Steere (1984) cites studies by Cheetham and Griffiths and by Bührmann which point to the "disproportionate number of black patients who are diagnosed as schizophrenic within mental

institutions" (p.119). These researchers suggest that this state of affairs may reflect errors in diagnosis which arise out of an inability to distinguish between cultural communication patterns and symptoms of schizophrenia. In addition, Steere mentions a Xhosa psychological condition known as 'thwasa' which is difficult to categorize within Western nosology.

Theoretical orientations may need to be examined and adapted according to the client's cultural dynamics. While psychoanalytic theory might suit European man, Africa may call for a different understanding. This, of course, is a huge topic of its own and is beyond the scope of this thesis.

The stage of therapy will affect both the transference and counter-transference. For example, the termination phase might elicit feelings of rejection in the patient and the therapist needs to be aware of a possible racial flavouring to this.

It is this researcher's experience that racial discrimination is sometimes used by patients to defend against other dynamics. For example, some patients blame their unemployment on discrimination when they have in fact done little to find themselves a job (perhaps due to marked dependency needs, or passive-aggressive traits). The handling of mixed neurotic and racial conflicts such as this is very tricky. If one does interpret the defence in this example, the patient might experience it as a minimising of the racial issue and become alienated from the therapist. It might be better, especially in brief psychotherapy, not to interpret this particular defence, to rather acknowledge the racial issue and deal with it, and find another way to work with the patient's dependent and passive-aggressive traits.

There are two aspects of the training of cross-racial therapists which need to be addressed. Firstly, in situations where the supervisor and the trainee are members of different race groups, there appears to exist the same avoidance of racial issues as exists in the cross-racial therapy situation. This is reported in the literature (e.g. Gochros, 1966), by a participant of this study (Therapist C) and is certainly in agreement with the experience of the present researcher. Similar problems pertain within interracial groups such as the staff of a hospital ward or outpatient clinic and at workshops, institutes and conferences. Many of the issues relating to cross-racial therapy pertain to these situations. Trainee therapists are therefore 'socialised' within this milieu and perpetuate the problem once they enter practice.

The implication of the present research is that racial issues need to be tackled in the training environment, both informally in the interracial setting and as a formal part of the training curriculum. The curriculum might be designed to help the cross-racial therapist understand the cultural and emotional idiosyncrasies of his patients as well as the psychological, socio-political, physical and economic implications of being black, Indian or coloured in South Africa.

After pointing out the requirement that therapists must understand themselves, Vontress (1971) recommends further "sensitivity training" in the form of experiencing "at first hand the agony and frustration of being black in a white society" (p.12). He suggests that therapists receive direct exposure to the environment of their clientele by living and working in black communities. While this is still an impossibility in South Africa, therapists could find other ways of gaining exposure, for example, by visiting black townships.

Supervisors could prescribe appropriate reading material. Interracial training groups could be used to explore issues of race. Trainers could tackle the issue on a one-to-one level with their trainees. Live supervision of a trainee doing cross-racial therapy could be used to good advantage.

For the clinician to work effectively with the patient he needs to understand the latter's language and the idiosyncratic way in which it is used (e.g. use of metaphors). This presents a problem in a country where so many different languages are spoken. However, the English-speaking clinician, for example, might find that a significant number of his patients are Xhosa- or Afrikaans-speaking, in which case it would certainly be preferable that he speaks the particular language.

Before proceeding to a discussion of research needs, another important issue will be addressed. It is possible that therapist-patient racial matching is a more desirable ideal to strive for. Firstly, though, while there is an urgent need for therapists of colour (especially black therapists), and the training of these people is something which needs to be lobbied for, at the present time racial matching is unrealistic because there are so few therapists, and so many patients, of colour. Secondly, it is not clear whether racial homogeneity always leads to better results (see Section 2.2.1) and it may be that in some cases an 'enlightened' cross-racial therapist is as successful with a client as a therapist of the client's race may have been.

Turning now to the question of research, it can be seen that the present study has opened up several possibilities. For instance, research of a similar nature could be conducted with politically more conservative and more overtly prejudiced white therapists. The nature of the themes and defences used

may be somewhat different in another group. The same applies to research with therapists of colour regarding counter-transference towards whites as well as other oppressed groups.

The relationship between race, culture and class is something which requires much explication while research into optimum methods of training cross-racial therapists is another area requiring attention.

The design of future research might be different. For instance, mixed-race therapy groups might be studied regarding group dynamics. In-depth case studies with a single therapist might be attempted, so as to explore the link between early racial attitude development and individual and family dynamics. In order to get the other side of the picture, patients could be interviewed and asked to explicate their experience of cross-racial therapy.

More extreme phenomena might be studied. For instance, white therapists who have had experience counselling detainees and alleged torture victims might be interviewed. There are many new possibilities open to the researcher in this field due to its hitherto virtually unexplored nature in this country.

Before concluding let us examine what is perhaps the most controversial aspect of this field of research. I am referring here to the interface between psychotherapy and politics. Kruger (1980), while acceding to the limitations of concrete reality, questions whether, for the client, "psychotherapy is relevant at all or whether the most appropriate approach is not perhaps political action" (p.26). Fanon (1968), on the other hand, has emphatically advocated political action for the oppressed person.

The position of the white clinician in South Africa, though, is what I want to examine. With regard to the white cross-racial therapist's clientele, Pinderhughes (1980), commenting on behalf of the APA Committee to Visit South Africa, argues that apartheid is an etiological factor in the genesis of psychiatric disorder:

"The committee believes that frequent and intense life stress is an important etiological agent and precipitating factor for mental and emotional disorders and sometimes for psychosomatic and somatic disorders. In South Africa the committee observed conditions of deprivation, loss, fear, conflict, depression, loss of freedom, discrimination, disruption of family, absence of protection and frequent encounters with separation, illness and death. The committee considered these conditions pathogenic, causing great stress to human systems and often depriving these systems of important support" (p.867).

Examining how black people fare on Maslow's hierarchy of needs, Steere (1984) comes to the same conclusion. Pointing out that there exists a tension between the ethical principles of the psychologist and the manifestations of the South African socio-political system, she states that "it may well be an ethical obligation of the South African psychologist to bring this to the attention of the authorities" (p.109). She suggests that research be conducted to demonstrate the extent of the detrimental influences of discrimination and that psychologists press for reforms within the institutions in which they work.

Some professionals have found another way out of this conflict. In a study of emigrant South African psychologists, Louw and Foster (1984) cite apartheid as the primary motivating factor for leaving the country. These researchers conclude that "apartheid will have to be opposed to prevent further loss of these sorts of skills and to encourage full development of an adequate and responsible psychology in South Africa" (p.24).

For some psychologists, perhaps including some of this study's participants, it may well be that their feelings of guilt mitigate against them leaving the country. In Kleinian terms, by remaining close to the 'mother' (or 'motherland'), she is preserved in phantasy and the process of making reparation can continue unhindered.

Obviously, the decision regarding political involvement is a personal one. In the real situation of psychotherapy, though, intellectual arguments about whether one should or should not be conducting cross-racial therapy are not practical. As long as one is practising psychotherapy in this country and one is approached by a person in need, regardless of the colour of his skin, one is ethically obliged to help in the best possible way.

The bottom line as regards the white cross-racial therapist is that, although there are many impediments to conducting effective therapy, it is possible in many cases to procure a significant positive change in the client. The more aware the therapist is of counter-transference and the various racial barriers, the better the chances of success. While there will always be some clients who will require a therapist of their own race for a successful treatment, for the rest, authentic efforts on the part of the white therapist to accept and come to understand his client, as well as his own feelings about the client, can only lead to an enriched therapeutic relationship with an optimum chance of success.

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APPENDICES

INTERVIEW PROTOCOLS\*

- \* The protocols represent complete verbatim transcripts of the audiotape of each interview. Only identifying data, such as names of individuals and places, have been changed in order to protect the anonymity of the participants and people referred to by the participants. Laughter or significant pauses are indicated by a "(laugh)" or a "(pause)". When the respondent was, for example, clearly embarrassed or anxious, I have taken the liberty to indicate this. An attempt has been made to punctuate the protocols so as best to convey the meaning and expression of the respondents.

APPENDIX A

INTERVIEW PROTOCOL : THERAPIST A

(Female Clinical Psychologist)

- Interviewer: I'm interested in racial issues in psychotherapy and, in particular, what you, as a white therapist, experience when working with coloured, Indian or black patients.
- Therapist A: Well, it is different, but the difference varies from patient to patient. I could probably describe it in terms of four categories. Just off the cuff, one of the categories would be: having to deal with the social problems as a psychologist - which I'm not equipped to deal with - my whole interest is - I feel impotent when confronted with social problems, so that my whole perception and conception of myself as a therapist is affected by the frustration that I come across; and the type of patient who induces that kind of feeling in me... always there's a financial problem involved in that I know the patient is getting this kind of treatment because he can't afford any other kind of treatment and I know that the financial problems that he or she has to deal with contribute markedly to the fact that he's presenting at all.
- Interviewer: So are you making a link between the patient's race and his financial problems?
- Therapist A: Yes, but you see the thing is there are white patients with financial problems *but* the white patients I have seen with those kind of problems are those that have degenerated to the state where they have these financial problems because of their illness perhaps where they have become less and less able to cope socially...where they can't find or keep jobs and they've become dependent upon disability grants. So, amongst the whites I also feel that frustration but amongst the blacks it's more marked - amongst the non-white population there're some of them that fit into that category because they've degenerated but most of them haven't. They're in that category because they just were there - in fact the direction of the causality is an opposite one.
- Interviewer: So how does that affect your feelings of frustration. Is it more marked in the blacks' case?
- Therapist: Yes, of course, because there are more blacks like that that I've had to deal with. Whereas in my white population there might be 1 in 10, in the black you can be sure of four. But that's the one category I was talking about. Another category - the "yuppie" coloured - and there are lots of them. I was amazed at the affluent homes from which many of my patients come - and these patients are presenting with problems that can be dealt with completely differently. I don't need a social worker to help me - I don't need to think so much in terms of social problems.
- Interviewer: So they're more like the majority of your white patients?
- Therapist: That's right - and there's a large group like that.

Interviewer: And for that group...is there a difference to working with the equivalent socio-economic status white?

Therapist: Yes - partly because of their attitude towards me - like often in therapy the fact that I was white influences our interaction...I remember one young lady who felt that because I was white and had long blonde hair I was just the epitome of everything she wanted to be and she related to me only in terms of my externals and it was hard for me to get through to her as a person because all she saw were my blue eyes and my blonde hair.

Interviewer: So she became fixated with your physical attributes?

Therapist: Ja.

Interviewer: And how did the issue arise in therapy?

Therapist: She spontaneously told me that she thinks I'm so beautiful and so obviously I explored what's so beautiful about me, thinking that maybe there was some inner light that was shining through. But it was my blue eyes and blonde hair.

Interviewer: Did she say anything about the colour of your skin?

Therapist: Um (affirmative). Yes - I asked her whether she thinks to have blue eyes and blonde hair is really beautiful...she said "yes and the white skin"...and she said I'm clever because I'm white, as well - and I've got the education. Her whole issue was that she needed to separate from her mother and go out and find a job - she was young - seventeen - and she just failed Std. 9 and then left and presented at the OPD where they diagnosed schizophrenia and her mother wanted to apply for a d.g. - so you see the social problems come in here as well. They wanted an accurate diagnosis to put on the form - so she came in for diagnostic assessment - she'd never ever been schizophrenic before - there was nothing. And so the aim of her treatment was to get her to go out and find this elusive job, you see...and there the social problems come in again, you see, because I knew she stands that much less of a chance because there are so many more people like her looking for jobs - but now she says that if she were white - I don't understand - I can't actually help her - I must go out and get the job for her - that was what she literally said... I could get the job for her. So she endowed me with a lot of power.

Interviewer: And how did that make you feel?

Therapist: Very, very impotent.

Interviewer: How did you deal with it in the session?

Therapist: I got sucked in a bit and made her a list of steps she must take...number one: get the Argus, no. two: phone for appointments, no. three: go for your appointments, no. four: don't get discouraged if you get turned down thirty times, I myself have been turned down many times for jobs...and I started using myself much more as an example so that I couldn't remain as objective as I could with a white, so to speak.

Interviewer: Why was that?

Therapist: Guilt...feeling responsible, feeling guilty about the fact that, yes, I probably do stand a better chance of getting a job than she does because I'm white, because I've had the advantage of a white education...and feeling that I must take some responsibility for that and feed something back in this little way.

Interviewer: So in a way you took on the power she was giving you.

Therapist: I tried to, ja.

Interviewer: And then what happened?

Therapist: She was discharged with my list (embarrassed laugh) and I haven't had any follow-up...but her mother, for example, said to her: "If they're not going to give you the disability grant then tell the doctor to find you a job". Ja, because of my guilt I actually think I overstepped the limits of white objective psychotherapy.

Interviewer: How many times did you see her?

Therapist: She was an in-patient at (a coloured unit) for perhaps eight to nine weeks. I was seeing her in groups more and just occasionally I'd get her in for something that needed to be discussed and it was in these private sessions with her that her feelings about me manifested.

Interviewer: So that didn't come out in the groups?

Therapist: No...I think the only way I felt my whiteness in the groups was that...I was definitely seen as the boss and in control... the authority...and often they would say - "if you say so, then it's right".

Interviewer: Did they ever say why?

Therapist: Yes, no...in the groups it would only come out from the point of view of my training...I'm the doctor, so to speak. But I think groups are a completely different issue - shit, I haven't really given this much thought at all...I think the same things manifest differently when there's more than one person - when you feel you're being watched by the others - and I think the patients probably felt that inhibition.

Interviewer: How did you feel in the group when they treated you as this authority?

Therapist: Again, sort of frustrated - and I would cope with it by asking someone else: "and what do you think of that? - do you think I've got so much authority?"...and they would all agree.

Interviewer: And then?

Therapist: I have to drop it in the end...because without someone in the group to present the antithesis I can't create the synthesis and I didn't feel that I should present the antithesis - it would've been too directed for my way of working.

Interviewer: What would the antithesis have been?

Therapist: The antithesis...OK, they're saying - "you are right because you have the education"...the antithesis would've been: "you're wrong...despite your education you don't know everything about me because I'm a separate person"...and no-one would ever dare to present that antithesis...and how could I present it? By saying to them...you're wrong, I don't know everything about you (laugh)...you know - it would've been too contrived.

Interviewer: How much do you feel that they were giving you all this power and knowledge - how much of that was due to the fact that you were white and -

Therapist: And how much was due to my personality? - 'cos that's also a factor.

Interviewer: Yes, but leaving your personality out for the meantime - say you were coloured - same as them - do you think it would've been different?

Therapist: See, I was never in a fortunate position of having a coloured co-therapist, so I've got no point of comparison.

Interviewer: How did they relate to the nurses?

Therapist: No, but you see the nurses are a different category altogether... they're just...the psychologists, social worker and occupational therapist just formed a completely different category...and they would tend to ignore the nurses in group. In fact, because they were wanting to relate to the most powerful person - or who they perceived was the most powerful person.

Interviewer: Let's go with that - what do you think they wanted from you - in relation to you being white?

Therapist: Miracles!...it's to do with this helplessness they've been raised with, you know, the white person's always going to solve..."we can be dependent on the white person"...as whites we've made them dependent on us and now we're screaming when they relate to us as dependents...and we've made them - all through our history - we've made them dependent on us. And now we're sitting with these hundreds of dependents that we don't want. What was your question? What did they want from me? They wanted me to solve their problems because that's what the white man is in South Africa for - "to solve all our problems". But then there was also another category - I don't know how I can describe them...they also related to me dependently, but only as dependently as my white patients did relate to me - they were prepared to take more responsibility - now these were the people who had a bit more education...and that had somehow in their personalities developed a bit of independency and were able to see themselves. With them, interestingly enough, I never got the feeling that I was white - not with this particular category.

- Interviewer: When they came into your office, did you ever have the feeling that they were brown?
- Therapist: No...no - it just didn't become an issue - those were also the ones that I found that I could touch more easily...
- Interviewer: And you could identify with them more easily?
- Therapist: Yes.
- Interviewer: So the racial difference never became an issue with any of these people?
- Therapist: No...I'm thinking of two patients in particular. The one was a guy who was having a battle to get, was in matric and he was a lovely person. Very sensitive young man that was obviously battling with homosexual issues - and he had...I could do the same kind of therapy with him as with my white patients. I couldn't do the same kind of therapy with the other people that I'm talking about.
- Interviewer: Did you work in-depth with him?
- Therapist: I saw him at least 100% more than the others and I worked with him more - when I was in group. I worked with him more... but there was a whole group of them that I worked with more.
- Interviewer: And with this patient, did you do psychodynamic work?
- Therapist: Yes.
- Interviewer: What sort of transference arose?
- Therapist: A good mother transference. Now that's interesting because a good mother transference doesn't arise with all my white patients, but with all the coloured - and one black guy - the good mother transference arose very much more easily than with the white patients. With the white patients I was often the father and the bad mother.
- Interviewer: How do you explain that?
- Therapist: It ties in with what we were saying about the previous group that I was talking about...that their blackness and my whiteness is influencing it. In fact, but much more unconsciously - it's the dependence, you see, that's still coming through, ja, it's got to do with that. They're still relating to me dependently but more independently than this other group. And the way it manifests is that they start having good mother feelings about me.
- Interviewer: So...if you had to continue over quite a long period with that kind of patient, what would you imagine would come out?
- Therapist: I think if I was really working in-depth with them for a long time...certainly the shadow aspect of the bad mother would have to be addressed and I'm sure it would manifest - and that would be very good - In fact my whiteness would facilitate working with that.

Interviewer: Say more.

Therapist: The whole issue of...look, in neurosis...you know Jung says that the reason we present for psychotherapy is because we're leading a one-sided existence and that we're focussing on consciousness instead of digging up the unconscious and balancing consciousness with the unconscious. Now, here we've got this consciousness of a good white mother and in the unconscious somewhere is the bad black mother and the fact that I am so overtly a good white mother to them and they are going to so emphatically relate to me as a good white mother is going to facilitate me actually presenting to them the difference, the contrast. If I can present to them the contrast, the bad black mother and show them the good white mother and the bad black mother, that is, their own mothers are the same in themselves, then I'm creating wholeness. So they've got this good white mother in the therapy room - *literally*, and the bad black mother at home, *literally*, so they've got to find those two parts in their own psyches and coalesce them to create a wholeness and an integration...So what you can actually do in therapy is, when they start talking about the feelings about me, I can actually say to them, now how do I compare to your own mother - give me an image of your own mother and I bet you it would involve: "well you look differently, to start with", you know, and so on, "she's not as educated as you and she's not as sensitive as you"...and all the badness would come out - the comparison would come out. So the striking contrast between the coloured bad mother and the real - in inverted commas - good mother, the therapist, is so striking that the thesis and antithesis are presenting boldly - you can't miss.

Interviewer: Alright, you're looking at it on an individual, family neurosis level - what about the social aspect - all these coloured kids you're seeing are part of the community - part of the apartheid structure - so you've got bad and good images floating around out there - how does politics come into it and the fact that you're white? Is the bad black mother just at home?

Therapist: Now...this ties up in fact with what I was saying beforehand - if they're experiencing me in therapy as the good white mother - but have got the image of the bad black mother in general social terms - the white woman is a bad woman - she's the oppressor - or she's affiliated to the white male oppressor - and, sure, it depends which sex I'm working with as well because if I'm working with a coloured woman - she's always had a white woman to oppress her and boss her around, but because the patient in therapy needs me so much, because they're in so much distress they can't afford to see me - at the moment - as the bad black mother and therefore that has got to be repressed in some way and they relate to me as a good white mother. But in the course of therapy as one starts working more and more with the issues I certainly feel that one of the ways that would facilitate him in getting to address the bad black mother in me is the fact that I come from the white power structure. But the person must be feeling safe enough and they must be feeling...they must get to the stage where they're not actually feeling that they need me so much any more, i.e. their immediate crises must be over and we must be working with bigger things now.

- Interviewer: You're talking about their anger to do with being black in a white world...How would you feel about dealing with that anger?...Because it's different to the anger you're talking about with regard to their mother.
- Therapist: Well is it? Their mother has oppressed them - it's the anger against oppression - against not being allowed to be who I am.
- Interviewer: OK, but if you're going to conceptualize it in terms of... this is anger directed at me...and it's source is being black in a white world and I'm part of that white world...
- Therapist: Yes...I see what you mean...I must think about that now... You see, I think two things would happen here - the one is - what I would feel inside myself and the other is what I would do in therapy. I've never had to address that anger in therapy because I've been working with people in such immense crises and we've been working with such crisis resolution type methods - short, intensive admissions - that it's never got to the stage where I've actually had to cope with that. So it's really - I'm having to really think how it hits me - I know that probably in the therapy session itself I would receive the anger and interpret it and acknowledge that it's justified. I'm sure I would do that - I would empathise. And inside myself - how would I feel because this would influence how I would respond in future to that person. (pause) See, I think I personally don't feel the guilt of the oppressor insofar as I don't feel I've ever taken any active role in oppressing. The guilt I feel is that I've benefitted from their loss - that's the guilt I feel.
- Interviewer: Isn't that the same thing - the guilt of the oppressor?
- Therapist: Ja...Ja, it is. But there must be a difference. Because I don't feel like someone who's said "vok off, jou swart kaffir"... and I know that in my interpersonal relationships as well... the fact that someone is black has never...No, that's not true, I mean, it has...it has influenced me...but (sigh)... ja, no, I would feel guilty...and you know what else I would feel - and this is actually what I'd feel a lot more strongly than guilt - I'd feel so angry towards the powers that have damn well got me into this situation.

APPENDIX B

INTERVIEW PROTOCOL : THERAPIST B

(Female Clinical Psychologist)

- Interviewer: I'm interested in racial issues in psychotherapy and, in particular, what you, as a white therapist, experience when working with coloured, Indian or black patients?
- Therapist B: There's a couple of things, first of all - this is a terrible thing to say, but in a way it's reassuring, generally, well, certainly in my hospital internship year - for 90% of the different race patients were not as intelligent as a lot of the white patients that I saw and I think that's because they were coming to a hospital...some of them were very intelligent, professional people but they were definitely in the minority, so a lot of the other patients that I've seen were - it sounds terrible and I feel terrible about saying it but I think it's true, were...in a sense - less complicated than a lot of the white patients. For example comparing those I saw at (a psychotherapeutic ward). At least that's how it seemed to me to be...that the issues were clearer to me...I think it's complicated by the issues of socio-economic class, 'cos you've worked, well at (coloured/black/Indian ward) with patients usually of a lower socio-economic class...a lot of whose problems are related to society rather than very complex in a psychodynamic sense.
- Interviewer: So what sort of problems would you be talking about there?
- Therapist: Marital problems that had to do with finances and drinking and beating up...not for a moment that that is simple - but it's more clear-cut, it's something you can get a hold of. I'm not sure I'm talking about what you want to know, which is race.
- Interviewer: Let's go with it...so the actual symptoms would be more overt?
- Therapist: Yeah.
- Interviewer: They'd be more behavioural?
- Therapist: Yeah.
- Interviewer: As opposed to a more sophisticated client coming to you and saying: "I lack self-confidence".
- Therapist: Yeah, that's right, not that those same things are not there, they're very much there - the lack of confidence and that sort of thing...but in a sense it's not what the patient brings to you...and because they bring you something that's concrete, you know the other things are there but it's not your position to alert them to the fact that they are there. You deal with what the patient actually brings you. That's easier in a sense because it's more concrete, you can actually get a hold of what the patient is saying...and you do a lot...sort of philosophical issues of doing psychotherapy at a much more complicated level are done away with.
- Interviewer: What sort of approach would you take, dealing with that level of client?

- Therapist: I would take a lot more of a supportive and behavioural approach to them. That doesn't necessarily mean I'd be doing behaviour therapy with them, but supportive, first of all, because a lot of the problems arise out of lack of social support, not that I'm able to redress the balance, but that is another thing about it...in a way it's simpler because you're getting given more concrete issues. But in a way it's much more depressing because you just feel that the social issues are just too big for you to handle at all...so although you can hide from it by feeling that you're doing something - OK, you get the husband in, you see him, you refer him for treatment of alcohol addiction or something like that. You feel like you're doing something and you're given a sense of power in that situation. You are the white therapist who is sorting all that out - but it's a complete myth and if you keep yourself on that level of thinking that you're actually doing something - and the patients are all very grateful...and that sort of thing...it's fine but there's always that sense of knowing you're not meeting the problem at all...much more so than with a white patient, where even though the problem they bring you is much more so...subtle...or complex in a psychodynamic sense - and - there's that feeling of... understanding it for one thing - and identifying it - and there's the feeling of - it's not a life or death problem, too...you know,...sometimes it is but...there's not that feeling of terrible, stark reality and of not being able to get away from that, which is absolutely depressing... I hate that.
- Interviewer: So, what you're saying is that the kind of problems which most black or coloured clients come to you with make you feel quite depressed, impotent and helpless.
- Therapist: Yes...yes...which I think is overcome by acting on the concrete reality...and grasping hold of the things that you can do...and also really there's a whole feeling in that we're really doing something.
- Interviewer: At the same time you're saying that that feeling is really a false one?
- Therapist: Yeah...I don't believe that it's really there. You make yourself think that because the situation is so desperate.
- Interviewer: So it's a defense against our feelings of helplessness -
- Therapist: Yes. (pause) I mentioned the word reassuring in the beginning...I think it's reassuring on the surface because they bring you a concrete problem...they look up to you... in a sense - and expect you to be able to sort it out... and acting on that level is reassuring because you feel more that concretely you've got something to work with - but ultimately it's not...it's terrible...I think that's why I don't really like working with people of another race - because I ultimately feel that I'm not doing anything.

- Interviewer: Let's focus in on one thing you've said, where the person of the other race comes along and he or she looks up to you as somebody who is going to help them with their problem... taking somebody of an equivalent socio-economic status but white, what difference would there be for you, if any?
- Therapist: Immediately I'd feel there wouldn't be much difference... but...that's my immediate reaction. In fact, there wouldn't be, just thinking of the patients I've treated.
- Interviewer: Do you feel that that patient also comes along and looks up to you?
- Therapist: Yeah, bringing the same sort of problems. Relationship problems and that sort of thing.
- Interviewer: And do you have the same sense of hopelessness about that situation?
- Therapist: Yeah, for example Ben (a patient known to the interviewer). At the beginning I felt I could handle this...quite a simple problem, it's not complicated. I mean I know what should be done in that situation...whereas if you're seeing a middle-class white person, you don't always know what should be done because the issues are not clear. The rights and wrongs of the situation are not clear whereas in a sense the rights and wrongs of the situation are clearer and more simplified in this white or non-white situation...but there's not really room to do anything about it.
- Interviewer: And something else you've mentioned, in terms of identifying with the patient, do you feel there's a difference there - whether they're white or black, taking out the variable of socio-economic class?
- Therapist: Um...again, I don't really feel there's so much difference - like compare some of the middle-class coloured patients that I saw (in the coloured ward), teachers, etc. I felt it was certainly very similar to the middle class white patients I've seen. I don't have a strong feeling of difference - although, I'm not sure that that's true - that there's not a difference.
- Interviewer: What makes you say that?
- Therapist: Because I feel that there should be - and there must be - and it's not quite honest of me to be saying that there's not a difference - OK, but at the moment I can't really feel the difference.
- Interviewer: Why do you say that there *should* be a difference?
- Therapist: It's my consciousness of the social issues and the sensitivity of the racial issues - saying - like I know this and I'm sensitive to them - and I feel, theoretically that they must come into the therapy situation - and the very political issues of the country. I mean, they cannot not be present, surely. I'm talking theoretically - in this situation - and yet, my feeling is not really in that - well, I'm thinking about specific patients. I can't really pin point any particular difference.

Interviewer: What sort of things would you expect from the black or coloured patient because of the political situation? What sorts of things would you expect to come into the relationship between you and them?

Therapist: I would expect me to feel guilty and them to feel resentful or...um...resentful, for want of a better word...and...um... cynical of my seeming indifference to social issues or seeming empathy with the situation. I'd expect them not to believe it. I can't really remember the situation where this has ever been an issue - but perhaps that's been just because I haven't been focussing on it. I can't say that because I can't feel that feeling now - that it's not happening - but that's what I'd expect to happen.

Interviewer: Would you say, focussing on your side of things, you'd expect yourself to feel guilty - is that something that you're aware of walking around as a white South African - outside therapy?

Therapist: Ja, it's not necessarily as a psychotherapist.

Interviewer: Ja, so you're aware of feeling guilty as a white South African.

Therapist: Um (affirmative).

Interviewer: What do you think happens to that when you get into a therapy situation?

Therapist: Gee, that's funny, maybe in a way that absolves me...that here I'm doing my duty - I'm actually being empathetic and helping but I mean I don't believe that I am really, but maybe in a sense, I hide behind my professionalism, in that situation. But actually, you know, like if my maid at home were to tell me about what was happening - like certain things a patient would tell me - I would feel absolutely awful... I mean, I would just really for days feel terrible. I mean... the gardener the other day came - a story about his kids - they were staying in Crossroads - and his kids had gone off to the Transkei and then they'd come back to Crossroads... and they were obviously living in a really terrible situation and I felt guilty about it - felt terrible, felt absolutely depressed and sad about the whole situation for days after... whereas a patient could have told me something much worse. OK, about a much worse situation - and yet somehow the professionalism of the situation, that I'm a professional there and I'm actually not there to really feel it to the last degree of the feeling. I'm naturally there to see if there's anything I can do about it or anything that can be done about it rather than anything I can do about it.

Interviewer: So there's a distance between you as a person and what that client, as a person, is going through.

- Therapist: Yes, there's some distance. I feel it. You know, I wouldn't say that I don't feel it at all, I certainly do, but in a way it's sort of alienated by the situation. I think I'd feel worse if I wasn't in the situation of being a therapist because you know I've got a list of what to do...I've got to get through the history and that sort of thing and it really does defend me against feeling it too much - or feeling my own inadequacy too much.
- Interviewer: You feel if you had to - like with your gardener - feel that way with your client - it would make you feel so helpless and guilty - or the other way round - feeling guilty and helpless and defending against this by getting through a structured interview and by doing concrete steps.
- Therapist: Well, I think it's working both ways.
- Interviewer: Let's take it from the other side, the patient who you'd expect to feel resentful and cynical about your help - at the same time you feel you're not picking this up in the session.
- Therapist: It's not an immediate thing for me when I think about that situation. But thinking about it for a while I can see that I would expect it to be there and - ja - I can start to feel it as well.
- Interviewer: You feel their resentment?
- Therapist: I don't know if it's there really - but I think there have been certain situations where I've felt both those feelings - guilt about the situation I'm in as a white South African and resentment on the part of the patient. Resentment in the sense that I'm sort of...talking from a situation which is so unlike that situation, really.
- Interviewer: Do you feel that they would be envious and very jealous of your position as a privileged white?
- Therapist: No, I don't think really jealous or anxious in the sense of wanting what I've got - not as simple as that. I think it's sort of - anger because of the whole situation - not just wanting what I've got - but angry about the whole situation that makes a difference between us.
- Interviewer: How would you feel if a coloured or black patient had to really get angry with you in a session and get angry with you because you're white - which he'd actually stated: "you white pig, you don't understand".
- Therapist: I'd feel - first of all I'd feel (laugh) - professionalism already comes in - I'd think, well, what's beneath that sort of thing...and what's the transference on something like that (laugh). Actually my immediate reaction would be - he's *right!* I *am* guilty and that sort of thing.

Interviewer: How would you respond to him?

Therapist: I don't know...I suppose there's two responses, and I don't really...Y'know, I think I could use both of them at different times, depending on what kind of relationship I'd had with the patient before...um...the one would be to respond professionally and...you know the thing of saying - not necessarily to the patient, but to myself - what I'd say is this: "it's not actually me, it's the transference, or he's deflecting from another issue". That kind of issue - and then interpret that - although - I don't think I'd interpret it straight away, it would look so cowardly (laugh). - But the other reason would be to say: "You know, I can understand - I feel it as well". That would be reacting on a personal level - and it would depend - I think most of the time I'd respond on a professional level - but I could see there being a situation where I'd respond on a personal level, depending on the patient and the relationship.

Interviewer: Do you think that in the same way that we as white therapists might defend ourselves against feelings of guilt and so on by being professional - the patients defend themselves against feelings of anger by doing something else?

Therapist: Yes - I certainly had a situation in which I was very sure that the nature of my being white and the patient coloured was an issue and that they were very angry about it. I really felt that it was very important to get to that and get it out but the patient defended against it by being very subservient, **actually** - and - well, saying: "You must be right" - not saying, "you're the white therapist" but that was the implication.

Interviewer: Did you initially try to bring it out?

Therapist: Yes, it was in a group situation and I'd tried on a number of occasions to bring out the anger but it was that subservience and defense - and the denial of anger.

Interviewer: How did you try to bring it up?

Therapist: It was...I can't remember exactly, but some of the patient's responses - or I would have said, perhaps, I think it was a projective art situation - it ran through a whole stack of groups - in which this patient, it was the only patient who gave me a picture representing herself - none of the other patients did. Now she saw herself as being unattractive, obese, uneducated, that sort of thing and gave me a picture that was very white, very clear, very educated sort of thing - which said a lot to me about how she was seeing - the issue had already been brought up in previous groups about anger and that sort of thing - about my position and you know, I think I said to her: "with the kind of things that you've been sharing about yourself and how you feel about yourself - if I saw somebody else as being like you've shown me here, I'd actually feel very angry with that person". I tried to bring it out in that kind of a way.

- Interviewer: But she was being subservient and - do you think she was maybe idealizing you? Seeing you as her ego-ideal?
- Therapist: Yes, definitely - so there were both sides of it there - the idealization as well.
- Interviewer: You were a model female for her. Generally speaking, do you feel that a gender factor is important here?
- Therapist: Yes.
- Interviewer: In what way?
- Therapist: I just think that, personally, my reaction to a man and to a woman - patient or not as a patient - is different. The anxieties that it arises are different.
- Interviewer: Looking across race groups - keeping sex constant - could you talk about the coloured vs. white males?
- Therapist: You know it's difficult to separate it from the socio-economic issue - keeping that stable as well - I have the same feeling that I talked about earlier - of feeling - I'm sure there must be a difference but I actually can't feel it - I feel as though it would be the same.
- Interviewer: Taking it into account, what sort of feelings arise, working with a coloured male?
- Therapist: Why do you ask about males rather than females?
- Interviewer: I'll get to the females.
- Therapist: (anxious laughter).
- Interviewer: I think we have some anxiety here. Coloured males, generally, what sort of anxieties do they elicit in you?
- Therapist: As different from white males as patients - I think the anxiety that arises in relation to men as patients - it also arises in relation to some women patients, but I think it's certainly more prevalent with me with men, is that anxiety about competence and about looking in control of the situation, which is certainly related to my relationship with my father which - never really having credit for competency - never feeling that I'd made it. So those are the anxieties that arise in relation to men. Now, I don't really feel that there's a difference in relation to coloured and white men, if they were of the same socio-economic level. Competence - there'd be my anxiety in relation to my own feeling of guilt and as to how that patient was actually seeing me as a white female psychologist. So that would be the added anxiety. You know, am I...I don't know...am I - sort of - able to show concern that can be taken purely as concern and caring for somebody or is that being - sort of looked at in the context of the racial issue and - ach, I don't know it's totally mixed-up. I mean, my guilt comes into that just as strongly.

Interviewer: Do you ever worry that your concern and caring might be taken advantage of by a patient and that you might end up being physically or sexually threatened?

Therapist: That's really hard to say. I don't think so at all, if you're talking about - ach, I'm using so many terms that have so little meaning - a middle-class white or coloured person, male, OK - now, certainly, some of the patients that you might see at (a psychiatric hospital) I certainly would feel a bit anxious about my physical safety - not necessarily rape but just wondering if that patient is dangerous - making sure that I sit next to the door - that kind of anxiety - I must say I've never really seen...I don't think...I certainly have not felt that nearly as often with a white male patient. OK, that sort of, wondering about my physical safety but then again, I haven't really been in those situations much. But in terms of sort of - D'you mean a patient sort of - me wondering whether a patient was fantasizing about raping me in that situation? I've never been particularly aware of that. I don't think it would be an issue for me more with a coloured man than with a white man - if it was a particular situation - a particular content of therapy.

Interviewer: Is there anything in particular about women then?

Therapist: Say, a nonwhite woman to a white woman. Well, certainly the issue of identification. My identification with a white is probably the closest identification that I could have with somebody in therapy and somehow that didn't spring to mind in talking about coloured and white men in therapy - I think because my identification with a woman is much stronger, so I'm more aware of it being stronger with a white woman than with a nonwhite woman. You know, I find it quite difficult to separate the issues of race with socio-economic issues because it's probably still there with a non-white - for want of a better word - woman who is of similar economic standard to a white woman who I'm seeing but I'm not really nearly as much aware of it. Whereas if I was seeing somebody who was of a lower SES, <sup>cost</sup> then the identification with that patient is obviously lowered - by issues that are related to race but are not directly race.

Interviewer: How do you think that affects your therapy?

Therapist: My identification? Well I think, for me a patient that I feel a close identification with, there's a strong possibility that they feel a close identification with me as well but they don't know nearly as much about me. But they probably - I mean - another white woman can probably have a much closer understanding and idea of my background than a woman of another race has. Possibly a woman of another race might fantasize about my background in anger and resentment - or whatever - so, ja, I certainly feel that because the identification is closer on the patient's part as well as on my part - um - my therapy with a white patient is going to be much more effective.

Interviewer: Given your experience, is that generally true - with men as well?

Therapist: Yes (pause) I don't know. In a way I feel that my therapy with non-white men has been more effective than with white men, but then I haven't seen all that many white men in therapy - gosh, I don't know how you're going to analyse this material - (laugh) it's so - actually now that I've thought about it, I could give it to you a lot more coherently.

Interviewer: Is there anything else that comes to mind about the whole racial issue?

Therapist: I just think that it really brings in so much. I mean, it really does make a difference in your therapy. I mean, even looking at it from the therapist's point of view, it makes a lot of difference because of my feelings about the situation. And from the patient's point of view you've got their feelings about the whole issue. So I just think it definitely makes a big difference to your therapy. I don't think it necessarily means that you can't do effective therapy, but I think if I take it in general I probably do better therapy with whites than with non-whites.

Interviewer: In your experience, how much emphasis is placed on racial issues in psychotherapy by colleagues and supervisors?

Therapist: Not nearly enough. I don't think it's given nearly enough emphasis. I think, again, we de-emphasize it because of our inadequacy. We're feeling inadequate already in the situation and to actually look at it and scratch at it and see how inadequate we are in that situation we're really going to feel useless. I think that's why it's not given much attention but I think it has to be because we are doing therapy in that situation. Maybe we shouldn't be. OK, but we are doing it and if we're going to do it I think we must be much clearer about the issues and also much more honest with ourselves about bringing out the issues in group. I mean, it's amazing in a psychotherapy group like that you can bring out the most intimate of details about that person but the one thing that you shy away from is the race issue. I mean, it's the most painful issue.

Interviewer: Why do we shy away?

Therapist: It's avoiding our own feelings about it and it's also possibly not understanding what the patient feels or not knowing and having incredible fantasies about what the patient feels about the race issue in relation to me. So, I don't know what the patient's sensibilities are about it and I'm very weary of tapping it - ja.

Interviewer: Given two patients with similar economic status, coloured and white, who would you prefer to work with?

Therapist: White (pause). You know, whenever you first say hallo to a patient who's non-white and who's going to be your patient, the first thing you notice about them is whether they're male or female and what race they are. Or maybe what race they are and then whether they're male or female. And if you're not - if that issue is never opened - and most of the time it isn't - if we're not being honest about that on that most immediate level, they're not going to be honest with us about their feelings of that and also about their feelings about many other things 'cos we betray a sort of image of - oh, I *hate* it, but it sort of - benevolent image, of really understanding what it is and I don't believe that they really believe that we do understand - precisely because we don't bring up the issue of race, the feeling is that, if we don't address that issue then we don't understand that it's such a big issue. So how can we understand anything else?

APPENDIX C

INTERVIEW PROTOCOL : THERAPIST C

(Female Psychiatric Social Worker)

Interviewer: I'm interested in racial issues in psychotherapy and, in particular, what you, as a white therapist, experience when working with coloured, Indian or black patients?

Therapist C: The blacks are out...language problem number one, which is a big problem and I don't think I'd be able to do psychotherapy with them because I don't understand them. With the Indians it's OK because somehow I can identify with them as I identify with the white patient. So it's a little easier although I do prefer the middle class. With the coloured people...with the lower-class I tend to get angry with them. I tend to get...I want to do the assessment and get it over with because I know I'm not going to see them for psychotherapy, but I get a little irritable... impatient, very impatient - but I'm aware of it and I try that it doesn't come across. With the middle-class coloured person it's different - then I'm feeling that I'm relating to them more and more and a sign of that is that I'm actually taking some of them on for therapy and they're responding to it.

Interviewer: So let's take the first part of what you were saying - the lower class patient...you get angry and irritable. What's that in response to?

Therapist: I think it's to do with intellectual functioning - you know with the lower class white patient I'd be exactly the same. You know, I enjoy an intelligent person that you can work with and that you can get into things with. And I'm intolerant of those that aren't.

Interviewer: Have you seen a lot of lower class white patients?

Therapist: Ja.

Interviewer: Are there differences between those and the coloured lower-class patients?

Therapist: No...

Interviewer: You respond in the same way.

Therapist: Yes.

Interviewer: The middle class coloured patient - you intimated that there's been a change in your attitude?

Therapist: Yes - before, I would do the assessment and hope that I could refer them somewhere because I think I was afraid...

Interviewer: Afraid of?

Therapist: I think I was afraid of the black/white issue coming up, which has been coming up with the ones that I've kept. I think I was also afraid that I wouldn't be able to identify with them and I wouldn't be able to understand them. I never gave myself the chance and now that I'm doing assessments thoroughly I'm giving myself a chance.

Interviewer: Would you talk a bit more about the black/white issue...  
What you're afraid of.

Therapist: Ja, I didn't want myself to be put into the position of  
therapist saying that...negating that the issue is there...  
I wanted to talk about it but on the other hand I was  
afraid that I would lose the client if I expressed my view.  
I didn't want to just accept his point of view and I felt  
if I gave my point of view I would lose him - he wouldn't  
come back.

Interviewer: What would your point of view be?

Therapist: That there is a difference and yes that it's something to  
look at and maybe that the two of us can try and get some  
rapport and some understanding between us because it's  
different. Whereas before I would've said: "No it's not  
different, it's a therapeutic situation - I'm not judging  
you and you mustn't judge me"...I wasn't honest and now  
I'm being honest.

Interviewer: Before - were there other things you were afraid of?

Therapist: No - I just felt uncomfortable in that I wasn't honest with  
them and I think I sensed that they knew that.

Interviewer: And now? How does the difference come out in therapy?

Therapist: It comes out in that - how can I really understand his need  
to smoke when he's living with six other people and doesn't  
have his own privacy whereas when he smokes he actually  
deceptively has his own privacy.

Interviewer: How does that link to the social issue?

Therapist: The socio-economic conditions, that is, he's forced to live  
in a house with six other families.

Interviewer: You've initially labelled that as a racial difference.

Therapist: Ja, it is because I am the superior race in this country  
and I don't understand how they live and perhaps I don't  
understand that they can't be actively involved in changing  
the situation - they're passively waiting for the situation  
to change - I can't understand this. And why can't they  
rise above it? And they talk about it more because I'm  
expressing - I get more feedback and more understanding going.

Interviewer: So, do you actually express that to them?

Therapist: Yes, lately. I never have before. I don't know if it's  
ethical or not but it's the only way I can work with them.

Interviewer: Why are you not sure about the ethics?

- Therapist: Because by saying "why can't you be active by changing your situation?" - it's almost as if I'm inciting him to do something - which might be against the law or - putting thoughts into his head, or giving him the confidence to do what he really wants to do but what he's not allowed to do.
- Interviewer: So that's a dilemma you face then. If you help to increase the assertiveness of your coloured client it might get him into trouble. Let's go back to something you're picking up - that is, passivity in the client. How does it relate to what you mentioned earlier about the superiority - inferiority thing? Is it part of them feeling inferior in the therapy situation?
- Therapist: I don't think inferior, I think threatened. Particularly when one's trying to elicit some kind of information from them. Particularly if they have a drug problem - you know, "I'm telling this white person and she's telling me she's not going to the police but do I really know?" You know, "many white people have promised me many things but then the tables have been turned against me".
- Interviewer: So there is a general feeling of being let down by white people and they're projecting that onto you?
- Therapist: Yes.
- Interviewer: Do you think that out of your uncertainty of what's happening - part of your anxiety might be - that if you encourage assertiveness - what might they do in the actual therapy situation?
- Therapist: (pause) What would they do in the therapy situation? No, because I'd turn the tables right back onto them - I'd say: "Right, you've got the problem, you can decide whether you're going to keep your problem or not, so it's up to you - you have the authority now, not me". And they respond to that by not coming for the next interview and then I phone them and then they come back - but they don't express gratitude that I haven't let them down, they just come back and keep coming back.
- Interviewer: What's happening there?
- Therapist: I think it's an acceptance by them of me and I also think they tested me and I passed the test - one of the tests.
- Interviewer: Do you ever pick up anger towards you as a white?
- Therapist: Only once...he started taking drugs in the army because he was being discriminated against because of his colour. But he carried on and on and on about it and I said to him: "Well, actually I'm white and what you're really saying to me is that I'm white and you're angry because it's my people who've done this to you and I'm also taking your drugs away from you. And I think we should put it that way rather than keep on telling me what the whites have done to you in the army". He wasn't very happy.

Interviewer: - What did he say?

Therapist: That he wanted to leave, that I could offer him nothing and he didn't know why the hell he came here in the first place.

Interviewer: What happened?

Therapist: But he stayed and I told him why he came in the first place - that we're actually looking at the drug issue but it could be related to his anger.

Interviewer: And subsequently?

Therapist: I haven't seen him yet. But I said to him - please phone me after he's been to (the doctor for medication). He's phoned. His girlfriend has phoned to say that he's doing okay. You know, it was also a heavy issue to pick up in the first interview. But - that is the message I thought he was giving me and I was right.

Interviewer: With other clients, is the anger there and being regressed or not there?

Therapist: The other ones that I keep?

Interviewer: Or others.

Therapist: Well, I think those that I don't keep - I'm sure there is anger but I don't pick it up - I don't make the effort to pick it up...but with those that I keep - it is there but they haven't got there - I think we're all pussyfooting around.

Interviewer: Why's that?

Therapist: No, I don't like to bring it up, unless I can pick it up from what they've said, so I wait.

Interviewer: How do they generally come across? If you're saying that the anger is there, and they're not letting it out, then they must be defending against their anger by presenting in some other way?

Therapist: One way is by telling me what they think I want to know - what they think I want to hear - very much so.

Interviewer: How do you feel about that?

Therapist: (pause) I can understand it - that's the way they've been brought up - I think it would take time - if I think of some of them - it'll take time before I pick it up because they feel comfortable with it. I don't think I'd want to make them feel uncomfortable before I've really engaged them.

- Interviewer: Do you think, generally, that it takes a longer time for a coloured person to bond with you, compared to a white of similar socio-economic status?
- Therapist: Yes, it does because I allow them to test me for themselves whereas the white person doesn't need to test me in that way.
- Interviewer: Is there a difference for you in terms of the sex of the patient. Say, taking a coloured male and a white male?
- Therapist: No, apart from the issues we've discussed, no. I'm very aware of my own sexual feelings towards somebody of another colour - but - it doesn't affect me in my relationships with them.
- Interviewer: Do you mind talking about that?
- Therapist: I need a cigarette (anxious laughter). What?
- Interviewer: You're very aware of your sexual feelings towards people of another colour?
- Therapist: By that I mean I know where the line is drawn for myself (lights up cigarette) - you know at times you'd get a nice good-looking white client and you'd think - this could've been somebody who you could've had a relationship with, but I've had these thoughts about - see, I'm starting to hyperventilate! (anxious laughter) - I've never discussed this with anybody - I don't have these thoughts about a coloured person because it's not somebody I would have a relationship with - no matter how nice he is.
- Interviewer: And no matter how good looking or attractive he is?
- Therapist: Ja.
- Interviewer: Where does that come from?
- Therapist: I think it's also...um...I think it comes from my upbringing, it was very, it wasn't - for my parents, everybody was always equal and my home was always open - always encouraged - but the limit was unconsciously set for us - that is as far as it goes - you cannot marry them or engage in a relationship with them - the same way as I would never have a relationship with a person of another religion - I just wouldn't, no matter how exciting he was.
- Interviewer: But at the same time, is the racial factor an even bigger one than the religious factor?
- Therapist: I'd say for myself they carry the same weight - but yes, if I met a black Jew it would be very difficult - I don't think I could.
- Interviewer: And if a very attractive white Christian came to see you, might you respond with a sexual countertransference feeling?

- Therapist: No, I'd think, well goodness, he is nice and maybe he has a lot to offer, but no thanks, I wouldn't want to get involved. But I wouldn't even think that far with a person of another colour.
- Interviewer: Ja, so in other words the racial thing is a bigger block?
- Therapist: Ja.
- Interviewer: What do you feel that these guys of different races feel towards you in terms of the sexual transference?
- Therapist: (pause) I had one case actually where he turned around to me and said to me: "You know, you're very nice" and I actually asked him, I said: "If I wasn't your therapist and I was very nice and the laws weren't here -" and he said: "Yes, I would take you out". That was the first time. I thought about whether they affected me - and I think some of them do - and I think that was the first time but I've never discussed it - that was the first time - it took a lot of courage - a helluva lot of courage because I think, if I were younger, I would probably have changed him to another therapist. But I don't think that the way I feel it stands for them as well - I think they're very open.
- Interviewer: Some people would go further than that and say that people of colour are oversexed. Does this hold true for certain people you see?
- Therapist: No, I don't think so. If a girl was raped by a coloured - I wouldn't say, well what can you expect? I mean, it could just as well have been a white person that she was raped by - um -
- Interviewer: And in terms of, say, working after hours, being the only person around here - and seeing a white compared to seeing a coloured guy?
- Therapist: I'm scared all the same, if I don't know the person. If it was a coloured or white person I'm seeing on a regular basis it would be fine. But if it was an initial assessment I could be frightened. In the same way in the example where I was frightened with this other man - if it had been a white person who came with the same record, I would be afraid. In fact, I think I would be more afraid with the white person because he's equal. I think the coloured person would be more cautious because of my colour.
- Interviewer: Moving on to females of a different race. Any differences for you?
- Therapist: No.

- Interviewer: Any differences for the patient - the kind of transference that arises - is there anything in particular that you've picked up there?
- Therapist: The only feeling I pick up is one of, you know, I've been through it all, what do you know, who are you as a woman who's only got one man in your life and I've had to have many - that kind of thing - also from the sexual side - and I deal with it with both. And of course if they're bisexual - that kind of thing as well. Sometimes you get a female patient who has bisexual relationships and she kind of likes you and she knows that you're not that kind of person and she maintains the distance because she feels that you're actually judging her and it's hard stuff for her to bring up to you.
- Interviewer: So is there a difference between coloured and white bisexual, on the whole?
- Therapist: Ja, because I think the white bisexual would feel - probably more safe, once I encourage her to talk about it and then understanding whereas the coloured one would think, well she's not only judging me because of that but she thinks - that's what she can expect because I'm coloured - you know, I've got no principles, there's a word that you'd use - you know, that's what you'd expect from them - you could expect nothing better.
- Interviewer: So, what you're picking up there is that coloured people, because you're white, are more easily projecting their own feelings of badness onto you. So that if part of themselves judges their bisexuality as bad or immoral, they'll project it onto you and feel you're judging them because you're white.
- Therapist: And a white person wouldn't do that kind of thing - and so they actually are bad because do white girls actually do that? They question that.
- Interviewer: So there's quite a split then - in that your whiteness as a therapist might - the client tends to polarise the situation because you're white - you're good and up there and they're bad and down there. Have you ever actually dealt with this in therapy?
- Therapist: Ja, in the one case where she's actually asked me: "Have you ever had any white girls who do this?"
- Interviewer: And how did she respond?
- Therapist: Well, it was only the one incident. I don't think I could generalise and say that would happen every time. She said: "You're just saying it to make me feel better" - and - "well, what have I got to gain to make you feel better?" and then after that - well, I think it's actually a good response because maybe I am doing it to make her feel better - if somebody said that to me I'd say the same thing and afterwards when I said: "well what do I stand to make you feel better?" it was OK.

Interviewer: When you're saying that you might be doing that, might be saying that to make her feel better?

Therapist: Ja, I know I'm not doing that but I can understand why she would think so. The other thing, though, now that I'm thinking of it, it's a small thing, but, you know, when they 'phone in, first of all, they don't know who they're seeing - it's the luck of the draw - I assume they think we are white - once they've spoken to you on the phone - and they come in and say, "hullo, I'm so-and-so - and who are you" - and you walk - I always like to walk together with them - but it doesn't work that way - I always land up walking in front, with them at the back. With my white patients I walk together with them - it's very interesting - and my white patients will sit in the chair closest to me - near my desk - my other one will sit to the one furthest, although I'll say, take a seat and will point to that seat, they'll sit on the other side.

Interviewer: What's happening there?

Therapist: I think they're threatened, particularly in this kind of work that we're doing - OK, what am I going to do to them - I'm not going to give them any choice in anything - I'm going to say, you must do this and that.

Interviewer: So they're projecting an authority thing onto you?

Therapist: Um, not a professional one, an authority one.

Interviewer: How do you feel about being put in that position?

Therapist: I haven't handled it. I haven't spoken about it, you know, in the first session. It actually makes me go on this whole white guilt trip: "Now look what I've done to you" and I feel like saying - "it's not me, I don't vote Nat, I want you to have equal opportunity, I want you to have equal pay. You know, let's talk about it, let's forget about the (presenting problem), let's look at this", that is my gut reaction.

Interviewer: But something stops you from doing that?

Therapist: I don't...because, you know, I think to myself, Jesus Christ, do I need to have a guilt complex - you know, who's problem is this - yours or mine? Who's got the guilt over here? Are you laying your guilt onto me? If I didn't want to see you, if I didn't want to help, I would've said so - but give me a chance!

Interviewer: You sound quite exasperated.

Therapist: Ja, give me a chance and then I will do a thorough assessment, I suppose more thorough than I would do with anybody else. So that they can see I care and I want to help and don't look upon me as being a white authority, I'm a white professional - which is maybe better to start off working with - if I have to be classified as white.

- Interviewer: Their doing that elicits guilt in you -
- Therapist: You know, I want to turn around and say: "Well, what the fuck do you want me to do?! Should we go to the State President right now and talk about it?" Oh, so I get angry, but I've got to contain it because it's not going to be functional or beneficial for either of us.
- Interviewer: So, how do you contain that anger?
- Therapist: By doing one helluva assessment (laugh). And in the end I always say, "Fine, I'll see you for psychotherapy"- talk about what it is -"but I'm not going to do all the work - *you're* going to work"and I know I do that and I know I hit them harder than I would with somebody who didn't do that.
- Interviewer: Could you say more about hitting them harder? Would you tell a white about what psychotherapy is all about?
- Therapist: Ja, but I would say that "psychotherapy is like this and that, you keep all your appointments, you do 75% of the work and I try and give you insight". Whereas with the other person I say: "*Right!* You better keep your appointments! Otherwise there'll be problems because I have other patients to see and *you* are going to do all the work. I'm going to try my best but I'm not going to work". It would be on the same lines but my tone would be very different - maybe they elicit a more authoritarian tone from me - maybe that's what they're wanting - sometimes I give them what they want from me, sometimes I don't - those that I give what they want from me are those that come back - set structure, finished!  
"It's up to you to come back" - sometimes they do, sometimes not. And my relationships with those where I've hit a harder line have turned out to be very nice.
- Interviewer: So your guilt and your anger has two reactions: you are more authoritarian and more directive and at the same time, there's an overcompensation in terms of the work you do because you do a more thorough assessment.
- Therapist: Ja.
- Interviewer: Where does the relationship change then - you say they "turn out" to be quite nice.
- Therapist: ...I can't pinpoint, it's just a gradual thing where I soften up and they start working - I can't pinpoint because with each one it's been different - there have only been four, one of which was Indian.
- Interviewer: Let's switch tracks here slightly. How conscious are you of the person's colour?

- Therapist: Very - I'm very conscious because they make me conscious.
- Interviewer: When you walk into the waiting room and you're not sure of the race of the person, how do you react when you find out?
- Therapist: Sometimes I just think: oh fuck, not again. Do I have to go through my feelings again, because every time I have to go through my fucking feelings and I doubt if they do - you know what I mean - and it is very disturbing for me, to keep going through it and through it and through it. That's the only - that's why I prefer to know what colour they are because it's exasperating to start all over again. You know, the same thing again, he's going to walk behind me, I can say it like a parrot - he's going to sit in the wrong chair - and it doesn't matter how hard I try, I'm going to go through the same thing (laugh) - and then (my husband) gets it in the neck when I get home - and some of them I would say, I had to work harder than I do with my white patients because of the whole guilt trip. And, in fact with this one girl, I said: "you know, I've worked fucking hard with you - but I'm not getting anywhere, you're not doing anything". She said: "well, I didn't know what to do". So I said to her: "well, should I be like a white madam and tell you what to do?" No response. I said to her, "well, I'm not going to be a white madam. You are going to do what you want to do". So we sat quietly and then I said: "fine, if you're not going to talk and tell me how you feel, you can sit here for the rest of the time and you can do what you want, but I'm going to do what I want to do". And I turned around and did some work and she sat - and then she went. And when she came back I said: "well, you did what you wanted to do, you left, how did you feel?" So she said, well, she felt a bit shit. In the (particular local multi-racial) scene there's a colour differentiation. Even there there is a bit of distinction which I think is pathetic.
- Interviewer: How do they feel about that?
- Therapist: I don't know - I didn't touch it with them - my issue was whether I was being passive or active - or whether I take the white madam approach. Because if that was what she wanted, afterward I would give it to her, if that was what she felt she needed.
- Interviewer: What happened the next session?
- Therapist: We went straight into it. I said to her: "how do you feel - you did what you wanted to do and I did what I wanted to do". So she said she felt shit because she had disappointed me and I had to point out to her that she wasn't disappointing me but disappointing herself.
- Interviewer: And did she go for that?
- Therapist: Ja, she did. She didn't like it because that would mean she'd have to take responsibility for herself and why should she if she has a white therapist. Why can't I do it for her? OK, that's not what we spoke about, but that's what...and I thought it was a good session. She didn't think it was a good session. She just said that I was mixing her up...I was confusing her.

Interviewer: They are putting responsibility onto you. You're the white therapist, fix it?

Therapist: Not only fix it but it's because of you that I'm like this and that's why, it's your responsibility to fix it and *fuck them!*, it's not my responsibility and it's not my fault - and that's why they're going to work that much harder - that's what it does to me.

Interviewer: Anything else that comes to mind?

Therapist: Uh-uh, I think I've said enough (laugh). I've had therapy because of this shit (laugh). No, I have - because I couldn't - you know, either I was going to do therapy and do it with everybody or not at all. I didn't go specifically for that reason, I went for another reason, but it became a big issue. And actually, my therapist - *she* couldn't handle it...because she didn't see that, she just saw upper-class whites who could pay R30 per session.

Interviewer: In your experience with colleagues you've worked with elsewhere, how recognized is this whole issue?

Therapist: I don't think - that's why I was actually surprised when (a colleague) came and said what he did - he stated a preference, that he'd rather work with whites - it's the first time anyone's been honest enough with me to state a preference and so I haven't been able to talk to anybody about it because they're not and they don't want to discuss it. It's their job and if somebody of another colour comes to see them they'll see them and that's it.  
And in your training situation, where it should be an issue, it's not. It's not touched on at all. And if one of your coloured colleagues happens to touch on it - then they're just told that this is not a political platform - lets carry on...if you can't do Melanie Klein with a coloured patient of limited capacity then that's your baby, you find something else, I'm teaching you Melanie Klein, I'm not teaching you something that's going to help them.  
And for that matter, from the coloured's point of view, they try to get into a position, make a move for themselves, they're educated but are always under the white person. Have they ever gone to discuss it or for therapy? I think it's very important - they haven't, it's not encouraged at all - and it needs to be because that's where the start is, for them.  
Maybe you should open up a private practice for that.

APPENDIX D

INTERVIEW PROTOCOL : THERAPIST D

(Female Clinical Psychologist)

Interviewer: I'm interested in racial issues in psychotherapy and, in particular, what you, as a white therapist, experience when working with coloured, Indian or black patients?

Therapist D: Ja, well, I mean, well to start with there's obviously the language problem. If there's quite a real language problem then it's a total impossibility um - otherwise I think it varies. I've never really done that much - with black people; I've done quite a bit with coloured people, um, and there I think to some extent the racial thing makes a bit of a difference but I think it's always like an insurmountable problem, I think that's just one factor which makes a person more or less workable and I mean things like their ability to verbalize and their intelligence and different things like that count equally as much. Like I mean, you know, you might get a white person that's not workable for whatever reason.

Interviewer: OK, lets focus then on the racial things which you're saying is one factor.

Therapist: Oh, you want to know what I mean by that. Um - I don't know; it's not very clear in my own mind; maybe there's certain, um, like different cultural beliefs, things like, I don't know, um, OK now I'm a female psychologist; maybe that to them, that would be a problem, because I think in, with white culture it's more acceptable if you go see a professional, doesn't really, I mean, the sex of a person doesn't matter - you can still view that person just as much as a professional, maybe not entirely, but you would - but maybe with coloured people, that would be a problem to them if they are quite traditional in viewing the woman as the inferior...I mean I think some coloured cultures do see it that way.

Interviewer: So do you feel that that would matter, regardless of whether the person you were seeing was male or female?

Therapist: But maybe it would be worse if I'm seeing a male - for him it's a complete reversal which he's maybe not comfortable with, not accustomed to, you know.

Interviewer: Is that something that's ever come out - has somebody ever said anything to you about it?

Therapist: Nobody's ever said it anything to me about it; I think I've felt it now and then; that because a male, a coloured male has like resented my position, of authority, experienced it as a resistance and I thought maybe it's that, but I mean, I'd never asked them I'm just too scared to do that. I can't really think of any other things except that we - I don't think that this has got anything to do with it but, like a lot of coloured people are like belong to different religions and I think that could be a block if you belong to a different religion that is often a problem; you know if coloured people have...they come from a different religious background. It could be something that maybe I don't understand them as well because like their fasting time is important and is a whole different thing for them and how they come to see me during their fast and it's something

very important and I don't know the importance of that; but that's more religious than...

Interviewer: What sort of feelings would you go through personally. Say a booking's made for you and you just know the name; you walk into the waiting room and you see a coloured man sitting there as opposed to seeing a white man sitting there.

Therapist: Ja, well, what will go through my mind is, um...I'd immediately think now, I'll be more, if I see a coloured person sitting there, I'm more likely to think that I might have a communication problem with that person, because I think that, well that's actually a gross generalisation, but I think automatically what comes to mind is maybe if it's a white person they've got a better education, a better cultural background, and you're gonna have more in common with them and be able to verbalise better than a coloured person. That's a very spontaneous racial reaction. So basically I'll just have more doubts about my, not my ability, but that person's ability to communicate to me. Communication is so important that I can understand that problem, so immediately I'm thinking that maybe this will be more difficult than if it were a white person. I think that's all, but I mean, as soon as I can see that that person can, I mean, if they are a person that can communicate well, then I feel that the racial thing becomes very insignificant during the course of whatever treatment you give.

Interviewer: In therapy, does the racial difference ever come up?

Therapist: Ja, even when it's with a person that I've only seen a couple of times - that person themselves have raised the racial issue, and they've viewed it as complicating whatever other problems they've got.

Interviewer: In what way, would they raise it as an individual fact for themselves out in the world or as a problem between the two of you?

Therapist: No, not in the treatment situation. As one of their problems in the outside world which intensifies whatever psychological problem they have.

Interviewer: Could you think of an example?

Therapist: Um, yes, a guy I saw the other day, I was seeing him a couple of times with his drug problem and, um, he was just telling me how difficult his life was in general. I mean that was one of the reasons why he was using drugs, his life was so difficult, and one of the things was because he felt that, he had financial problems and the reason why he had financial problems was that because he was coloured, he said that if you were white that any of your friends would lend you money without question, whereas being coloured it's more difficult, nobody wants to help you and if you want to get a, if you wanted to get a car, you know, because you're coloured you can't get it like a white person.

- Interviewer: So he was saying that because he's coloured he has problems eliciting help, especially from white people. How did that make you feel - that's exactly the therapy situation?
- Therapist: Oh, really, I didn't think of it that way. Um. No, it made me a bit uncomfortable because I felt that I couldn't really give him any response which would satisfy him. I mean I listened to it reflectively, you know, and I questioned the reality of his beliefs because they weren't actually completely accurate - the way he viewed white society, that people just hand money out to each other...but it made me a bit uncomfortable because I felt that I couldn't give him a satisfactory answer, I couldn't satisfy whatever need was coming from there.
- Interviewer: So did it make you feel a little bit helpless?
- Therapist: Ja, very helpless...
- Interviewer: And your response to him in that situation was to point out that his beliefs about white society were not quite correct?
- Therapist: Ja, and to reflect on, he was, frustration...just to make him feel understood, I couldn't really - a practical solution of how he could change his behaviour by becoming...
- Interviewer: Is that something - you've given your example now of feeling somewhat helpless in relation to a client saying that they have a problem because of the colour of their skin. Is that something that you have felt more often with coloured people than with white people?
- Therapist: Do you mean white people saying that because of the colour of their skin?
- Interviewer: No, let me re-phrase the question. Is that something that you've felt quite often with coloured people?
- Therapist: Feeling that I couldn't help them because of the colour of their skin? Ja - especially in this job because I'm made more aware of it. Like I don't think that the resources for coloured people are as good as for white people - like I've got a white person and a coloured person both with the exact same problem and I've got less to offer the coloured person in real terms of what is available in the community and that makes it difficult. 'Cause you're part of the white system that actually provides all the resources. I feel guilty about that.
- Interviewer: So what do you think happens with those feelings of guilt?
- Therapist: What happens to them?
- Interviewer: How do you deal with them?
- Therapist: Do you mean they might come out in a therapy situation?
- Interviewer: I don't know. I'm asking you.

- Therapist: I don't think so because I'm aware of them, you know. So I don't think that they could sneak into the therapy situation by me trying to suppress them; I don't try and suppress them. I think they probably end up as anxiety because I think that most white people in South Africa are very anxious about the situation. The anxiety that I've already got about the political situation; just makes me much more aware of it because not a lot of white people come into close contact with non-white people and I am doing that through my work so I'm seeing how they really feel - how angry and frustrated they are - I think it ends up being anxiety.
- Interviewer: So the anxiety you're talking about there is like a general anxiety? Would that be connected to a black threat? Do you ever feel threatened by black men?
- Therapist: Do you mean in a therapy situation? No, not really. I think if I was gonna feel threatened by a black man, I'll be more likely to feel threatened in another situation; in a situation where I was, in a dark street, if I saw a black man coming towards me or if I saw any man coming towards me, but I think in a therapy situation I feel quite secure, I never feel that my patients are going to attack me.
- Interviewer: What about seeing a black or coloured guy after hours, alone?
- Therapist: Ja, I'd be a bit scared to see any man after hours, particularly if he was coloured. I feel very anxious about a particular white patient that to me looked dangerous, I can't say exactly what it was. I didn't feel safe with *him*, but that was a white so it can happen with whites as well; but I think I might feel more like that with blacks...or coloureds.
- Interviewer: What's that connected to - is it the threat that you might be attacked - a violent attack or a sexual attack or...?
- Therapist: I think that it would be - like this is a free association 'cos I haven't thought about it - it's more that I think coloured people - sort of - don't have respect for white people - I mean, I'm not saying that they should have respect, maybe they shouldn't, but I'm just saying - I don't think they have as much respect for white people as white people have for each other. So, because of that he might attack me.
- Interviewer: Why would you say that they don't have much respect?
- Therapist: I think because of the way that in those situations they're not treated in a fair way by white people - so that if someone doesn't treat you fairly you can't respect that person. They don't see them as a human being - as having value because they don't treat you like that.
- Interviewer: Besides that feeling that coloured people have less respect for you as a white person, what other feelings do you think they have towards you as a white person?

- Therapist: My patients? Well, I just think that their expectations of me are influenced by the fact that I'm white. I think they expect to be not treated as well because they're coloured and because I've got to prove a bit more to make sure that that doesn't happen - that they don't perceive that happening.
- Interviewer: So, you're feeling that they feel that they're going to be let down by you.
- Therapist: Because I'm white.
- Interviewer: And you respond to that by -
- Therapist: I don't overcompensate. I just treat them the same.
- Interviewer: Yet you feel at the same time that you must prove to them...?
- Therapist: I feel that that expectation of being treated less well is there...and I make sure that I don't treat them less well but I don't treat them better - I mean, I treat them all the same, as best as I can. I don't go overboard for the coloured person because they're coloured - I think that that is racial discrimination in another sense.
- Interviewer: What about anger?
- Therapist: Against them?
- Interviewer: I don't know.
- Therapist: I don't think I feel much anger against them - I think maybe - I think if I was to generalise I'd say that coloured people have quite a lot of anger against whites in general because of the situation in the country and maybe some of that comes into the therapy situation from their side. I haven't really experienced it that much - sometimes when something comes up where they bring social things into it then I can sense their anger but I can also sense at that time that they are pleased that a white person is listening to them. That somebody's listening to them but I think it makes it better that a white person is listening to them because white people don't normally listen to them - so there is some anger there but I think it's being dealt with appropriately.
- Interviewer: And the anger you felt as being towards white people in general and not towards you specifically because you're white?
- Therapist: On the odd occasion it has - I just thought of one example where like a referral took a long time because it would take a long time anyway - I mean, they just happened to be coloured people and there was a lot of anger coming from the father because he felt that it wasn't happening fast enough. And it was never said but I just felt that he thought it was happening slowly because he was coloured and I actually - that was the only time I felt anger towards the patient because I *don't* discriminate - he was implying that I *was* discriminating - why was it taking so long, and so on. That made me angry.

Interviewer: What were you picking up there that made you feel that his anger was because he felt discriminated against?

Therapist: No, I can't say that he said that, maybe it was me, maybe I thought that he was angry - I can't say that he said anything - I mean, he was angry about the whole thing - that it was taking so long - but he never ever said to me that it was because he was coloured that it was taking so long - but I don't know, he - he sort of sounded quite indignant about the whole thing - and when I tried to explain why it was taking so long he didn't want to accept my explanations - he said, "yes, but we've got a big problem here" - as if I didn't know that already. I can't say it was that but I think it was.

Interviewer: Your response to that, though, was to get angry at him.

Therapist: To feel angry, yes.

Interviewer: So you didn't express that to him?

Therapist: No, no, I tried to pacify him, but I don't think (laugh) there'd be anyway I could actually say to him: "it's not because you're coloured that it's taking a long time". I don't think that would've helped. I didn't express it, no.

Interviewer: Do you think that cross-racial therapy can be effective?

Therapist: Yes, I think it can be effective but I think - what do you call it when it's the same patient - within culture therapy is better, but sometimes - I don't know, there aren't that many coloured psychologists around - so, I think it's better than nothing. It's better to have a white therapist than no therapist but I think if you could have a coloured one it might be more effective.  
I think that if - maybe with black people who can speak a better English but not much - it's going to be ineffective - but with coloured people it can because there's a language thing - their home language is Afrikaans - speak Afrikaans to them and they're contactable. With a black person - who of us can speak their language? - even if they're proficient in English or Afrikaans it's not going to be the same and I think with therapy - language is so important - all the nuances of language and that - it's the tool that you work with.

Interviewer: Is there anything else that comes to mind when you think about factors which could impede cross-racial therapy?

Therapist: Ach, not much, no, just that I think that none of us can really know what it's like to live in a coloured situation. That's a real difference - socio-economic background.

Interviewer: Makes it difficult to empathise?

- Therapist: Yes...there's nothing else really.
- Interviewer: Do you feel any difference, getting back to what you originally spoke about - say, bringing in the factor of gender, seeing a coloured male or female as opposed to seeing a white male or female? Are there any differences that come in there for you?
- Therapist: Yes, very much so. If I see a white male I'd be more likely to expect transference and countertransference, and not with a coloured male - to that extent.
- Interviewer: Would you say a bit more about that?
- Therapist: Because I think that - I don't see - um - I don't really see (laugh) non-white men as attractive as white men - OK - so, I wouldn't be as worried, like maybe I'm going to get into this guy, too much - I mean that doesn't happen a lot with white clients but it's a possibility - and I'd also expect the reverse.
- Interviewer: You wouldn't expect them to find you sexually attractive?
- Therapist: Not as easily, no. I mean, the therapy situation - with a lot of white guys they very quickly misinterpret that.
- Interviewer: What do you mean, "misinterpret"?
- Therapist: I think they fall in love with me very easily - the white male clients - and I wouldn't expect that to happen nearly as easily with a coloured client.
- Interviewer: Why is that?
- Therapist: I think, the same as what applies to me. You're socialised into not seeing another race as potential sexual partners. That's about it, ja.
- Interviewer: Why do you think we are socialised into that?
- Therapist: You mean because it's prohibited, it's not acceptable. For me, it's like, not really acceptable to me, if I was to fall in love with a coloured guy, there'd be big problems for me. Or for any white woman.
- Interviewer: How do you feel about seeing - in a social situation - a mixed couple. Say, a coloured guy and a white woman?
- Therapist: (laugh) Um...I don't mind, I just feel that I can't identify with that. I just feel that I wouldn't like to be in that situation. It would embarrass me. And very strongly I question it because I wonder - I don't think this applies to a lot of situations, but it sometimes does apply - that people do that to create an impression. I experienced that at (my university) a lot because there were mixed racial groups there. A lot of white girls who wanted to prove how liberal they were would go to *bed* with a guy because he was black: And the black guys knew that they could screw a white girl anytime. And that makes me angry because that's again reverse racial discrimination. And when I see a couple like that it does

enter my mind - whether they're doing that to create an impression. If they're not, if they're really in love, then that's lekker, I can't judge that.

Interviewer: But your feeling is that it's not natural because we're not socialised that way?

Therapist: No, I think that any relationship between two people can be natural. I think that in certain situations, when you meet a person of another race and he...the circumstances are such that you get close to him before you know it - but I think the opportunities for that to happen are much less than for your own racial group. Also, I think, things like your background, upbringing and that, orient you towards a certain type of partner, which is normally of the same racial group, so I think it's there in practical terms that you're less likely to get involved with somebody of a different race. It can happen, though.

Interviewer: Let's take it back to the therapy situation: you and a coloured guy. Have you ever felt that a coloured guy has been sexually attracted towards you?

Therapist: No.

Interviewer: But with a white guy?

Therapist: It has happened. Not every one, but occasionally, but never with a coloured guy.

Interviewer: Do you think that it might be heppening but you're not picking it up because, for you, it would be an unnatural state of affairs, it would cause anxiety to feel that a coloured guy is sexually attracted towards you?

Therapist: Could be. But if I'm not picking it up then I'm not aware of it. I mean, it's quite possible, it's a possibility.

Interviewer: How would you feel if it had to happen?

Therapist: I would try to deal with it as professionally as I could, in the same way as I would with a white guy. Where - at the appropriate time - I'd confront the...transference 'cept - 'cept - confront it - not make the person feel rejected and also, I'd be quite aware to make it - to approach it in exactly the same way as I would a white person.

Interviewer: Let's move on. Doing therapy with a coloured woman as opposed to a white woman.

Therapist: I think there're less problems. I think...just that she's also a woman...quite easy to understand her. OK, there are still all the same differences but you've got that commonness that you're both females. I think it would be easier, definitely.

Interviewer: And coloured women - is there any comment that you would make on the transference that arises there?

Therapist: I find them, generally, to ...um...see you very much as a professional...like it would be a different relationship to that with a white woman. I think it would take a bit more time for the bonding to work - to bond with the person. Because I think they see you more as a professional. I think they'd accept easier than a coloured male would. They'd be more comfortable with you being like that - maybe even more so than you being like on more of a level with them. But to actually bond with that person is going to take longer.

Interviewer: Do you find it frustrating that the bonding is slower?

Therapist: A bit...just a bit.

APPENDIX E

INTERVIEW PROTOCOL : THERAPIST E

(Male Clinical Psychologist)

Interviewer: I'm interested in racial issues in psychotherapy and, in particular, what you, as a white therapist, experience when working with coloured, Indian or black patients?

Therapist E: In a nutshell, it's very difficult, much more so than working with people of the same cultural beliefs and similar background. I think that the great difficulty lies in the fact that the linguistics are shaded. Cultural beliefs and practices are also different. What we might take as being positive and healthy and normal, other cultural beliefs take as being dangerous, or wrong or sick or threatening...A very good example I think is the way we might approach a white woman in therapy - say a problem with her husband - you might use an interpersonal communication model to try and solve that. But we couldn't do that with a Moslem woman. She firstly would not be able to handle the fact that she's allowed to talk to her husband.

Interviewer: And with a coloured woman who's very westernized?

Therapist: I think the job becomes easier but then one has to be careful because a helluva lot depends on where they live. If they live out in the sticks - wh...they tend to put very different values onto words that we take for granted - I'm trying to think of an example that bothered me - that gave me quite a bit of trouble. It's to do with an interpretation I made of a description given to me by a husband of his wife's behaviour. He said something to the effect that she'd been disloyal to him - I took it up as not meaning particularly much because to me it didn't seem like there was any kind of disloyalty. She'd apparently said something about his drunkenness to some woman - apparently she had meant it as a sexual barb towards him and when I mentioned to him that she had said this, he got very angry and said: "There's nothing wrong with our love-life" - so I'd got it completely mixed up, without even realising - I screwed it up completely.

Interviewer: Apart from the cultural barriers, when comparing doing therapy with a white vs. coloured woman - any differences?

Therapist: Certainly for me, ja. Something I feel - there's almost an extra pressure on me to try to prove that I'm not viewing her as a racial threat *or* rather that I'm not being perceived as a racial threat - I try to neutralise that. I think obviously what it means is that I'm very aware of that and I'm adopting a very different strategy.

Interviewer: What kind of strategy?

Therapist: I think that I try to show that I don't want to be seen as some kind of boss figure because I certainly perceive from my experience - most of the time I am perceived as a boss - "wit man se boss" type figure who's got all the answers but who's also in a sense very arrogant and is very demanding. I think that what happens is that I anticipate that they're not going to open up because of that - Rather they're going to try and feed me with what they think I want.

Interviewer: So what do you do to counteract that?

Therapist: Well I try to show that I'm aware that there's a cultural and colour difference between us and I'm trying to not let that make a difference. I think it works with some people and it doesn't work with others.

Interviewer: In a way you work a lot harder to prove something to your coloured client.

Therapist: ...or to myself - sure - both ways.

Interviewer: What are you needing to prove to yourself?

Therapist: Look, I'm very aware of being a South African and having the... the segregation input in my upbringing - I'm very aware of it - I often feel myself, when I get angry with somebody - I look for differences to get angry about and with a black person - I might think - you bloody kaffir - or something like that. It's so ingrained, it's so there - it is a prejudice, it's an impersonal prejudice and I don't want it to have too much of a destructive input in my therapy - where we're dealing with personalities rather than stereotypes - but some of the stereotypes tend to creep in if I'm watching out - they definitely creep in, even in something as subtle as tonal quality - which is very important in therapy...

Interviewer: How do you feel about being a white South African and having prejudice as part of your make-up? How does this affect your work?

Therapist: ...I can certainly remember an occasion when it did...um... that was with someone who was particularly militant and particularly...aggressive - said something to me like: "whitey, you know the revolution is coming and you're going to be chopped up with all the rest of them". Of course, I had a very strong impulse at the time to kind of dis-identify myself with the oppressor. At the time that this happened I thought to myself - that this is more of a kind of individualistic thing - the white guilt - more a situational thing than white guilt because I don't have any conscious feeling of guilt - at all, about being white in South Africa - I didn't grow up that way - certainly not where - where coloured people are concerned. They were in and out of my house all the time. So as a child I used to go out with them. I think possibly because my father worked so closely with coloured artisans that I was never really particularly aware until - maybe I was about 15 or 16 at the time - the kids on the block made a comment: "why do so many coloured people come to your house" - and up until then I never really thought of it as being abnormal in any way. They used to come in and sit down and talk business, have some tea and then leave - because the house doubled as an office.

- Interviewer: To get back to this particular instant in therapy. Your first impulse was to dissociate yourself from the oppressor - did you actually do that?
- Therapist: Probably, as far as I remember - this was several years ago - I know that at one point towards the end of a session I got very hung up on the polemics of the situation - and I said: "listen, I'm not one who particularly agrees with violence on any level". I think it was already happening at the stage when I could sense that the guy was already giving up because of the white experience - maybe because of his anger and his depression. He needed it, he couldn't give it up, certainly not to people he saw being responsible in the first place. He was a guy who lived in a community where there's actually quite a bit of militancy brewing out there - um - and he was sent by a doctor to a psychologist. I think in retrospect it was the wrong move for him because he was angry with the whites and to work through his anger with a white man would be like too much of a surrender for him. And of course the therapy didn't work.
- Interviewer: Did he drop out?
- Therapist: Ja.
- Interviewer: And how did you feel about him dropping out?
- Therapist: Well, I felt very rejected because I said to myself - well, look I'm willing to put down the hatchet on a personal level - and - uh - overcome hatred. Months later I could begin to see that this was his balls. He was perceiving me as taking them away.
- Interviewer: So, presumably for him, resolution had to be a symbolic or actual overthrow of the white man?
- Therapist: Well, possibly for him therapy would have been for him to have dondered me, but I'd never stand still for that.
- Interviewer: Do you think there's anything particular to a private practice situation, with respect to doing cross-racial therapy?
- Therapist: Ja, there is something peculiar to a private practice situation with respect to doing *any* kind of therapy...um - in private practice - I...it's largely a question of acculturation and money - in any private sector - you don't really see a helluva lot of the *heavy* pathology you see in the hospital or that one sees in the streets that never get to hospital. One sees people who've been able to integrate an idea that they are part of a kind of an international brotherhood of man, rather than an insular tribal thing.
- Interviewer: So the coloured people who end up in private practice are a self-selected bunch?

- Therapist: Yes, I think that they are, in the sense that they're firstly, westernised enough to accept that they can take their problems out of a tribal thing - or out of a religious thing - they're big enough to say: "look, my minister just doesn't help me with this, or my boss isn't helping me with this, or my wife, or my father, the patriarch of the family is not helping me, I must realise I must come and get some of the white man's medicine. I think the kind that make it in therapy are the ones who are not necessarily saying that we use the white man, we know he is the aggressor and we use him to get our way and then we fuck off when we've got the goodies. I don't think those are the ones that succeed. I think the ones that succeed get through that kind of thing. They recognize that we're all in the same boat together, like it or lump it. The pathology that strikes you strikes me and strikes everybody else - it's just a question of degree and extent. I think discomfort and misery and despair are universal.
- Interviewer: With those kind of people then, who make it in the end, does the racial thing ever become an issue in therapy?
- Therapist: I think it does never become *not* an issue. I think one is always aware that there are similarities and there are differences.
- Interviewer: Is it ever a verbal thing, something that's spoken about? In what way does it come out?
- Therapist: That's a tough one. It comes down to a question of individuals - I must accept there that the person I'm dealing with is coloured and I'm white and that there are always going to be differences. As much as we might know each other personally, there are differences - that we can talk about and accept that there *are* differences. They're not changed - not suddenly becoming pigmented white men and I'm not becoming an albino black - and that's spoken about. I dunno - that's not quite answering your question. It's very difficult to be particularly specific. How would you and I speak in therapy? I mean we would enter flow as two individuals and it would always be acknowledged that you are you and I am I - you wouldn't really want me to be a token you and I certainly wouldn't want you to be a token I - of course, there's a certain amount of maturity there - because maybe if I were a kind of father figure I would like you to be a token representation of what I'm about - possibly, just a thought - there may be a lot less of that with somebody of a different culture. I have difficulty determining whether that's a cultural thing or a transference thing.
- Interviewer: Do you think that there is a difference?
- Therapist: Probably not.
- Interviewer: Are you saying, then, that there's less of an identification that goes on with somebody of a different colour?

- Therapist: I've never thought about it that way - yes, sure. No, perhaps there's more of a - ja, OK, there's less of an identification and there's more of an acceptance of differences without animosity - without any kind of wish - there's not somebody who I could identify as perhaps being part of me.
- Interviewer: So, there ends up being more distance between you and your coloured clients, generally?
- Therapist: Ja.
- Interviewer: How do you think that affects the therapy?
- Therapist: That's a good question - from certain points that's very good because it makes separation and termination a lot easier. But that's really taking it out of context because I think that in a sense we never get past the idea that you're seen as an authority figure. I think part of the ingrained life-long coloured cultural thing is that, no matter how grudgingly, they *still* look up to you as being a leader and they put a distance there as well. So, of course that automatically makes them a lot less resistant to many of your probes, which means you can get the job done less personally.
- Interviewer: Are you saying that perhaps the authority of the white man is an advantage in that it leads to less resistance on the part of the client?
- Therapist: Yes, but one must be specific here and say that - with the kind of client that's going to succeed in therapy with a white man.
- Interviewer: And the kind of client that doesn't succeed?
- Therapist: It's a disadvantage, it's a barrier you never get through and they drop out. They want to destroy you anyway or they need to destroy you. See, that's part of bitterness. If you're cross with me, you don't want to just give up that anger - you want to beat me up with it. And - and that's where we're accepting similarities. Look, I still honestly feel that from a therapy point of view, we never get away from the principle that the best person to treat a drug addict is a converted drug addict - and I'll never maintain that I as a white clinical psychologist am the best person to deal with that kind of person - I'll do it, but always really knowing that they'd be better off with somebody who - look the best is literally the psychologist who would be the person who grew up next door and will understand the lingo and the inflection and the culture, regardless. So, I don't think we're ever the best.
- Interviewer: But with some we can do the job?

Therapist: Ja - my experience is not all that many. But perhaps the whole thing is summed up very nicely by a friend of mine who - who did a helluva lot of cross-cultural work in the medical profession. He was made very very welcome by the black doctors at Baragwanath. He spent a good couple of years at Bara. He was saying: "you know, to talk to these civilized African doctors is one thing but then when you get onto a personal level, a lot of them are still witchdoctors at heart and want to be witchdoctors at heart - because it's so deeply ingrained and they believe in the sleight of hand and the suggestion that goes with. And where the interface comes with Western medicine, they say: "well, listen - it's only where our mumbo-jumbo doesn't work that we're interested in the white man's medicine. We know it's more powerful than ours - and, has a wider range - but we still like it". And perhaps that sums it up for the psychological profession as well. Very adaptive idea.

Interviewer: You're talking about belief-systems...what about your prejudice in therapy?

Therapist: Therapy is a growing thing...a lot of the time we're also treating ourselves and we're growing through our treatment of our clients. I've noticed for myself that it's an ongoing thing. There've been a lot of situations where I've started out being very prejudiced against a client and have known it and perhaps have said: "look, I'm prejudiced against you - it's not the best thing that we work together". Circumstances being what they are - and there are certain circumstances like, for example, when you're about to do marital therapy and you've just heard the husband's side of it and he's got a very positive bonding with you and he's trusting you after years and years of batting around and fucking around with various other psychologists - and he's found somebody he can trust and you know you've got to do marital therapy - and you've heard all about this horror of a wife - and you know that you're biased but you've got to see them - and you already sometimes want to smash them on behalf of this poor downtrodden husband - and in walks a very innocent and demure lady who's just nothing of the kind. You see, that's on a very simplistic level. To come back to the colour thing I think that we have to grow out of our prejudices because we've got them anyway. I'm sure that at times you feel very negative towards certain of your clients. You'd like to reject them or criticize them or jump on them from a dizzy height, just something about them pisses you off and sometimes it takes a bit of time for you to connect with it and you say: "this is ridiculous, it gets to me, but it's ridiculous". Now, as a therapist you have to accept that this is something that's going to happen to you, I think from the time you start out until the time when you retire.

Interviewer: Professionals seem to feel OK about feeling angry with or even sexually attracted to clients. How do you think they feel about feeling racially prejudiced against their client?

- Therapist: I think that to give them their credit they are maybe trying to overcome the roots of the prejudice that has been instilled in them. Maybe they *do* know that they have these feelings. So they will say: "OK, I've got these feelings and I know it's ridiculous. Now, I don't think we should work together because of this". And the client will say: "Well, thank you for being honest - I would like to try because you're being honest with me". I don't think that's a fairy tale, it happens to me often, when I might say to somebody: "Listen, there's something about you that I'm not handling too well - it's my prejudice". And they say: "Well, what is it" and I tell them and they say: "hey, on a personal level, that's something other people feel the same way about me. I couldn't bear it if you rejected me because of that". And now sometimes, I'm not saying often - it's very rare - say: "OK, I know that I'm prejudiced against you and you're probably prejudiced against me - OK". Look, let's keep in mind that there's a difference between the white liberal and the genuine liberal - i.e. the pink liberal - who's going to be pretentious about his feelings. He's not going to own up to a dark-skinned person who walks in and they say: "You're dark-skinned, I'm not prepared to see you because of your dark skin". I think that the genuine liberal - liberated person is going to be able to say that.
- Interviewer: So in some cases it remains a buried issue?
- Therapist: Ja, it is a buried issue but I think also because it happened at grass-roots level that it can stay buried - and you're immersed in it all the time so you stop seeing differences. It's like having an ugly friend and as you spend more time with them you don't see it anymore.
- Interviewer: Ja, but why don't you see it anymore?
- Therapist: Isn't it something to do with a human thing of accommodation - that if you receive enough shocks often enough you're going to stop feeling any pain.
- Interviewer: The problem is that in a hospital - you might be accustomed to it - but the new trainee coming into the ward is not.
- Therapist: Right!
- Interviewer: And then you don't pick up on the racial issues.
- Therapist: You don't.
- Interviewer: The other thing is that it counts on a systems level - that the system's accommodated to it and new registrars or interns go into the system and get accommodated to it without being individuated in any way and then the whole thing becomes a screw-up because you're not dealing with the racial issues.
- Therapist: I'm inclined to agree with you - it could become explosive if you stuck around long enough. But listen there's another side to this - there's a discrimination in the hospital system that's being made on the basis of who you are - this huge segregation between staff and patient and I think that the social issue becomes very, very obscured because you've already got a natural barrier. I'm the white - I'm the *doctor* and I think the "white" gets dropped very quickly because you realise

there's so much work that anybody who's sharing the load with you, if you happen to be that kind of person, is your equal. They're an "us" - and - and they don't become a "them" until we get out of uniform. The "them" is the patient. Like when I worked at (a mental hospital) - those psychologists and God-knows how many nursing staff and we shat off, we worked. From start to finish, every day, and I never thought about anything, other than the fact that it was "us" against "them". Afterwards, weeks later, I said: "hey, you know- I'm actually working with coloured people but - why haven't I noticed it?" Basically I think because of the other segregation... Perhaps that's where the fuck-up is. That there is this huge distance between patients and staff. You see, again, you know, you're going to get yourself into hot water because in private practice, generally speaking, you're not meeting many people of different cultures because we tend to have the market cornered on people who are intelligent and earn well, who have been able to maximise their opportunities and with the stratification...

Interviewer: There are a lot of, for example, wealthy Indians and coloureds, where are they going to?

Therapist: A lot of them are going to their minister. Bear it in mind that there's much more of an extended family still in operation and their religious ties are a lot more powerful - um - and I think also that a lot of them have a greater veneration for their quality of life than we have, with a result that there's not necessarily all that much damage coming through. I'm maybe speaking out of turn here, for I know that in terms of your (client population) that you're seeing a helluva lot of coloureds and Indians. But I - ok, you're also seeing a helluva lot of Jews. Five years ago we were saying - "what's happening to the Jews now?" - it's all falling apart and it is because our cultural links are changing - we no longer want to see ourselves as being victims of the matriarchy, where Mama is everything. We're saying, "no!"

APPENDIX F

INTERVIEW PROTOCOL : THERAPIST F

(Male Clinical Psychologist)

- Interviewer: I'm interested in racial issues in psychotherapy and, in particular, what you, as a white therapist, experience when working with coloured, Indian or black patients?
- Therapist F: Well, currently I only have one patient of another race - a young Indian, 19 years old, university material, fairly aculturated. But I've come up against some very interesting specifics of the Indian culture. I don't see it as a racial issue at all, it's very much a cultural issue with this particular chap. He's a chap who's suffering from an extended adolescence - he comes from what I would regard as a white western model person - very overprotective parents, give him lots of money but he has no autonomy. He presented with inability to talk to girls, shyness, very controlled...being a **phenomenologist** myself I started drawing this picture for him of two worlds - of the teenager and of the parents. And what emerges is that the world of the parents is actually the *Indian* world...and the world of the teenager is the *Western* world...but, he had to educate me. I started making some comments...how valid is this...and he told me, "extremely valid, most Indian parents are like this...conservative", he tried to explain.
- Interviewer: So you got him to fill you in on cultural details.
- Therapist: Absolutely...how does it feel to be at home? And if I ask your father? Here we have the old issue - how much of it is family specific and how much is culturally relevant.
- Interviewer: Let's look at this: you as a therapist, what sort of feelings did you have in relation to him being an Indian?
- Therapist: Hmm...difficult question. When he came in I was a trifle... I wouldn't say anxious, what is a better word? Um...it was new, novelty, you know, how am I going to handle this guy? I was very aware that there *might* be some *insurmountable* barrier...I was very interested to find out...because I actually have a lot of trust in myself across colour lines. I saw his was upper-middle. I realised that there wouldn't be any problem. But, I started thinking about it from his point of view. He doesn't mix with white people, how is he going to feel, coming to this *white* therapist. In fact, why didn't they refer him to one of my Indian compatriots? So, ja, there was a bit of tension on both sides. There were a lot of confounding variables, though...the very nature of his problem was that he couldn't talk...so it was a long time before we could talk comfortably. He spoke very softly and I was very confronting with him: "I don't hear you", force them to speak up. I never actually bothered to make it a therapeutic issue.
- Interviewer: The racial difference?
- Therapist: Ja, it's not quite my style. Ultimately, I did speak to him about it a bit, when I got to know him better, after a few sessions.
- Interviewer: Tell me about that.
- Therapist: I didn't really get into it, unfortunately. It's a pity because then I'd have more info for you...um...

I just said to him, "ja, you know, you don't mix with many whites, how does it feel"... "oh, it's a bit strange"... "why is it strange?"... "well, I've never met many white people, just don't talk to them about personal issues". Very interesting, you see, he was drawing the dichotomy between business and personal issues. So I said to him, "how does it feel?" and he said: "no, no, it's quite OK now". See my attitude relaxed him quite a lot, I just talked to him like anybody else... He's very dark by the way... black! black! I sometimes catch myself, about once every four sessions, "Jesus, you know, this is weird!" Just the old cultural conditioning of South Africa. Black! But I sometimes catch myself making this fuck-up. I haven't taken adequate account of his cultural background. Like girls... now he took this girl to a...plebs dance (laugh), what do you call it? Debs! Debs ball...plebs, huh! um...and, you won't believe this, but his lady friend was chaperoned by her parents. Freaked! I mean, I laughed. So he laughed very embarrassedly and I said, "I'm sorry, I'm not trying to insult you, it's just a bit weird to me". I'm very honest with him, I just ask him to explain, I always get him to teach me - he loves it. Asked him how he feels about her being chaperoned. He said he really wanted to take her outside and kiss her - very sweet, you see, this kid's fourteen.

Interviewer: Why do you think - just going back - why do you think you never got more into the racial thing with him?

Therapist: In transference, so to speak? Um...either I'm avoiding it, I don't know, or I don't think it's particularly important, because he's a highly aculturated person. I feel very much at home with this guy - the Indians are very very much like Jews (laugh) - all the dynamics about mommy and daddy, they're all the same. Plenty of money but no real freedom. So I've worked very well with the guy, it's like talking to myself. I don't know, I didn't think it was important. Now, the question is, am I fucking up there, did he think it was important?

Interviewer: You felt you could identify closely with him?

Therapist: Ja, so he's probably a bad example. If we talk about blacks that's a different story. Big problems there. I had the opportunity to work with a lot of blacks in (a particular mental institution). Saw lots of coloureds there as well - had an interesting coloured girl who was highly aculturated - not a very good example. I felt very close to her. Now, what about Africans? With some of them we had to work with an interpreter - in a sense that fogs what you're asking about.

Interviewer: To go back to the coloured girl, why do you say she's not a good example?

Therapist: Well, she was also highly aculturated. Bright girl who had a matric. Had gone a bit downhill since then. Histrionic personality disorder, was in for fraud. She was very sweet - for me there was no racial barrier, that's what I'm trying to tell you. Very sweet, her parents, both school teachers. This issue of class, I'd freak about this but I'm not interested in questions of race. This class issue here,

this kid I see in (therapist's hometown), his parents are shopkeepers, like my parents were shopkeepers. He's got this Escort XR3, very much like me at his age. This woman...middle-class really, I felt very sorry for her, they wanted to put her in jail. (My superior) thought I was showing favouritism, which I was. She shouldn't have been an observation case in a black ward.

Interviewer: When you worked with her, were you *aware* of her colour?

Therapist: Yes and no. You see, this is the beauty of my work. When I start with a new person - it doesn't matter what colour they are - I'm *always* alienated from them. OK, that's my particular hang-up, but phenomenologically we all go through that, it's an approach-avoidance gradient. You get closer as you learn more about them. I feel very alienated from my client during the first session. That's why I do a quick, incisive, fact-taking. This woman, I saw for 4 sessions and by the fourth we were quite close - we'll come back to that - with Africans it takes a lot longer. Coloureds and Indians, no problem. I ceased to see her as a coloured by the third session.

Interviewer: Generally speaking, that alienation process, would there be a difference between whites and coloureds and Indians, of the same socio-economic status?

Therapist: Yes, quicker to get in touch with white patients on the whole. Class issue very important. I'm sorry to keep coming back to this, but it's a big issue for me. To me, personally, the class issue is possibly a bigger issue than the colour issue.

Interviewer: Would you say that the struggle in South Africa is a class or racial one?

Therapist: I wouldn't call it a race struggle at all. I don't want to sound like a Nat but I think it's a culture struggle - an ethnicity struggle. And I feel that as much with a Greek or Portu (sic) or French-Mauritian - they're white, but I feel very alienated from them. Working-class people on the whole. I feel - "Oh, God, you've got to watch it" - I'm not sure of the norms.

Interviewer: You've been stressing the importance of class and culture rather than race - for you. Yet you do feel, on the whole, less alienated from white patients at the outset, and you find yourself being startled at times by the *blackness* of your Indian client - this confuses me.

Therapist: ...You know, I've just remembered a dream I had last night. How relevant is this? (to himself).

Interviewer: Tell me, anyway.

Therapist: (A particular black activist) and three compatriots came to my flat, representatives of the local UDF, I guess.

Interviewer: All black guys?

Therapist: Oh, yes, definitely. African blacks. Um...what I was trying to do was to excuse myself to them, basically. I was making ...apologies, that's the correct word. I was saying, "listen, I'm just a small businessman". I don't know why I was saying this stuff, I don't know why they had come. They were obviously some representatives of the black community en masse...and I was saying, "I'm just a small businessman, don't hold me too responsible for what's going on in this bloody country at the moment", you see, this is what I was saying to them...in my new flat which I had just paid cash for - important point, I'm negotiating for this flat, you see - very important point. My new flat they came into, oh, yes. Brand new flat which I visited twice to look at. And I don't know how that is all leading up...something to do with therapy as well...um..."I'm just a small businessman". What was happening in this dream? Unfortunately I don't remember what they said.

Interviewer: What were you feeling when they came in?

Therapist: I was quite scared of them. Uprighteous sort of people and very bright. I felt that feeling of guilt. I'm talking about the old shame and doubt sort of level of development. Quite low level stuff...shame, I felt ashamed and s-scared, of course. I can't tell you much more than that, unfortunately. Only a segment of the dream. I felt quite alienated from them - they were definitely a different group. I'm beginning to feel that more and more about Africans. Whenever I get out of touch with individual Africans - it's the old story. When I knew (therapist's black ex-girlfriend) and these people I had no problem there. But now they're starting to recede into what becomes a body. The essence of racism is that you have no contact with that group.

Interviewer: The shame and doubt and guilt?

Therapist: Well, it had to do with ripping people I suppose. I was saying, "don't really accuse me". I know what we're doing in this country, man. It's a massive, fucking, rip-off. Great, huge, very powerfully structured. I was saying, I'm just a small offender in the bigger unit. Please don't kill me". No, they weren't going to kill me, they were going to hold me responsible for something or other.

Interviewer: And you were feeling guilty of this "something"?

Therapist: Ja, and trying to get off the hook as well because I know bloody well that I am guilty, you know, this has all come out for me in the last few weeks. I know I'm guilty. I feel ashamed, but what can you do.

Interviewer: OK, now bring that kind of feeling into the therapy situation. How do you think it affects you doing therapy? And do you have that kind of feeling with regard to other oppressed groups in this country - coloureds and Indians?

Therapist: Well, no, not so much with the Indians, you see. You see, I'm Jewish. My rating for the world is money, status, social influence - they're all the same. Class, therefore ethnicity - where do you fall on the Western-Eastern

continuum or the Western-African continuum. I'm a typical capitalist in that instance. Coloureds...bit different. Blacks, we're getting quite alienated there, ja, they're very different. I had this one case in (my training hospital) - long term, alcoholic - look, I know a lot about African culture, thank God, so I was able to talk quite openly about it, "yes, he should go and make the necessary sacrifices..." But, he didn't do it. Messed up, he was an alcoholic - same dynamics, no matter what the colour of his skin. But it was difficult communicating with him. He spoke a good English. School teacher.

Interviewer: In that kind of situation, how do your feelings of guilt affect you in therapy?

Therapist: I don't know...tricky question. We're getting into very latent areas, aren't we? ...Look, I have to be careful. I have to be on guard. Careful not to offend that person's ethnicity. I have to be careful with my Indian client. When I laugh I immediately have to say, "I'm not laughing at you", which I wouldn't say so quickly to a white client. I feel this chap might be a bit more thin-skinned. So, you watch it, you're a bit more cautious. Super-cautious perhaps, a bit liberal. So, yes, I am a bit careful with this chap...but I don't let it compromise my work. I said to him, "look, I don't really care what background you're coming from, the question to me as a psychologist is, what do you really want in your life". And he told me. He wants to leave home and have a job. But you have to bear in mind the culture - because it would offend his parents more if he left home than, say, Jewish parents. So, I can't push him too hard. I'm not too scared of offending the guy, I'm a bit more cautious...but I maintain very strongly that once you get to know your client as a human being all the other variables pale into significance. I can't apply that so much to Afs, let's be fair; I don't know if we'll ever bridge the cultural gap. And I speak from rather intimate experience.

Interviewer: Keeping in mind your dream, how would you feel doing therapy with a black client now?

Therapist: - I'd have big problems taking in an Af. at the moment, especially at the moment, because what might evolve is stuff very much like in that dream...apologising to the client. In fact, I don't know what effective therapy I could do. I had a kid when I was at (university clinic). (white colleague) took him over after me, worked with him quite well. Oh, no, I'm talking shit - (black colleague) took him over, which is much more relevant. Sorry, getting confused here. (Black colleague) took him over, worked very well with him. They got into areas which I never succeeded in getting into, much more personal stuff. He wouldn't talk to me about his family. He'd talk to me about his loneliness at varsity - I was on quite a behavioural thing with him, my brief was to invent a work program with him. I think I was trying to be very careful not to hurt his feelings...careful about questions of money and motivational issues. I didn't understand why he was at varsity, parents weren't wealthy, but they weren't starving... earning a fair amount of money.

- Interviewer: Do you recall having the need to apologise to him?
- Therapist: To a small extent, ja, definitely. Like he would tell me about instances of racism on campus. Difficult you see... I'm a sort of white liberal, a *genuine* white liberal - well, I'm actually a radical - in the sense that my radicalness helps me through situations like that because I genuinely *don't* feel that apologetic because I know I wouldn't do something like that to a black person and that gets me off the hook, you see. But I still do feel, whoops! - it's more of a paranoia thing that's set up: maybe he'll hate me for being white when he's telling me this story, you see, and that starts fuelling it up.
- Interviewer: So, your fantasy is that he'll be angry with you and hating you?
- Therapist: Absolutely! Those are my fantasies, very clearly. It would be the same with my Indian client. If we had heavy shit with the Indians I'd start thinking that he was perhaps anti-me.
- Interviewer: Take that fantasy through..what effect would it have on you, your client being angry with you for being white?
- Therapist: Ah, yes...well, I hope I'm enough of a psychoanalyst to see it through. Have to use all the tricks of the trade, you see... But, personally I would feel a bit put upon, ja, because there's no defence against that. It's true, I am white... of course, you could argue that it's a transference issue. Culturalised transference...transference between race groups... he's transferring onto me his old experiences of *white* people. And we're going right into the internal objects here because this is what his parents have told him about white people - especially with Afs. I mean, (black girl-friend) and I lived through the whole bloody thing...the dreams she used to have. I was beautifully represented in her dreams: this *huge* oppressive white man. Me! Little me. Culturalised transference. And I would have to throw that back..."you're actually putting onto me what you're feeling about all the whites in South Africa...what is really going on here?" "You bloody bastards..." I'd feel quite alienated, I'd feel hurt. I'd feel more hurt than in an individualised transference. You see, an individualised transference is very easy to live down, because you know very well you're not that woman's father. But, in view of this dream I was talking about, if this guy says to me: "you fucking whites are all the same" (laugh) to a certain extent I have to admit because I have this shame about being white in this country. So he'd get to me and I'd be doing bad therapy at that moment. As I say, I'd have to find the right interpretation: "yes, you know, what you're doing here" - heavy projection in there - "is asking me to accept all the badness for the whole white group in this country". He wouldn't admit it, of course. I don't think I'm as available for that kind of shit as some people would be. I don't feel personally accountable...I suppose your next question would be, maybe white therapists don't think about this kind of issue enough. Interesting area you're opening up here.

Interviewer: What do you think?

Therapist: Well, I would say that this is the first time I've *really* got into this. I like these phenomenological interviews, they force you to explore latent areas.

Interviewer: That's interesting, that you've never really thought about it after working closely with people of colour.

Therapist: Look, we treat them like shit at (a psychiatric hospital). The way we communicate with them is different, it's not an "I-them", it's an "I-it", more a positivistic scientific experience. Observation cases: "And then what did you do? Can you prove it?" (Stern intonation).

Interviewer: Sounds like an interrogation.

Therapist: Ja, I caught myself being an interrogator. To be fair, I worked with whites in that section the same way - had a diagnosis in the back of my mind - maybe some of those weren't psychopaths. Some of them were schizos. Tend to interrogate a black schiz. like a psychopath. Ja, we do tend to clump the black patients into certain groups, because we're not treating them as human beings. You can't, you don't have enough contact with them as people.

Interviewer: Why does it manifest as treating them like shit?

Therapist: Because, number one, you're feeling bloody guilty you don't speak Xhosa. So then you project: "Fuck him, he doesn't speak English, so he must be dirt". I'm talking about essential colonialist mentality, racist. And with a working-class Indian or coloured I'd also be dealing with them in a slightly patronizing way. I feel *terrible* about this. You see, for me, it's not really a race issue, I'm sorry, it's a class issue, I have "railway cases", now I hate railway cases, because they're dik, they have no money. Now, I couldn't give a fuck if you send me an Indian, a coloured or an African - problem with Africans is that they tend to be railway cases... For me, the race issue is a bit of a red herring. I'm talking now about private practice, I don't know about the hospitals. These people are being so fucked around in the wards before they come to you. A mental hospital essentially run by whites, is a micro-cosm of society. I would claim, this is very unfair, you can confront me about this, I would say that my private practice is not really such a micro-cosm. I could play the devil's advocate and contradict this.

Interviewer: What's the difference for you?

Therapist: Oh, because they're fitting into a structure there which has rules very similar to the larger structure. The wards are quite different. Coloured wards are crowded, coloured patients are shat upon more often than white patients, it's obvious, it's like a prison. When you walk into my practice, you pay the same fees - I'm not saying I'm happy about this, by the way - and they are treated as people. So, I don't see it as being as big a variable in private practice.

Interviewer: Doesn't this leave begging the whole question of your feelings of guilt?

Therapist: Look, if I was a community worker this would all come out a lot stronger. The kind of black people I get in my practice are going to be bourgeoisie, by definition. The fact that they've gone to a white doctor in the first place is very weird.

Interviewer: Does that let you off the feeling of guilt?

Therapist: Yes, to a large extent, absolutely. I'm excluded from the *real* situation in this country, I'm living in a fool's paradise. My definition, that is what private practice is about. It's blatantly elitist. I think I'm not the right person to interview about this kind of thing. We haven't seen a single Af. this whole year, needless to say, and we never will. I don't know about this question of shame and guilt. I think it depends upon what sector of the public health service you're working in. And that would beg the question, "why would I go into community work in the first place?" Basically, because I'd have plenty of shame and guilt and, let's hope, some honest civil commitment. I don't have that, I'll leave that to others. I have no comment about that, I just went into private practice for my own selfish reasons. I'm an elitist psychotherapist. I don't think I can help railways people. (Another colleague) does, but then he's a behaviourist... I don't care whether they're black or white. It has to do with the quality of the material. But, as I say, I'm putting in this proviso about Afs. I don't know what would happen if an upper-middle class Af came in. I'd still have a problem there. I'd have to be very careful. I'm not talking about a family from Soweto, I'm talking about one from (a rural township). I'd be very careful about my interpretations, especially at the moment. We must be political about this. If someone came in at the moment, they wouldn't just come in with depression. They'd come in with depression because their shack has been blown up and they can't sleep at night - I've got this black friend Jonathan - and I feel a bit shit when he says to me he couldn't sleep for the last few nights because there're petrol bombs blowing up around his house. He keeps on saying: "it's terrible, you know, it's terrible". And I just look at him with wide eyes and say: "I just can't identify with what you're saying". I'm honest with him, "but tell me anyway". And that's the same attitude I'd adopt with a client. I'm honest, not this bleeding heart liberal - "oh, that's terrible". I'd be pretty phenomenological - it's the *only* way you can work - you don't make interpretations. That's probably the way I'd get off the guilt to a certain extent. I wouldn't prescribe.

Interviewer: How did you feel when your friend came to you?

Therapist: I felt very shit. I salvaged my conscious by getting him a job. So I did my bit as a white person.

Ja, I do feel terrible. Handing ten rands now and then to him - it's essential to keep him alive. But I'm not a pseudo-sympathiser. But what if Jonathan came for therapy, he's radical. If a guy came to me complaining about the social situation at the moment I would feel a bit put upon. It's different...when a white patient says to you: "Oh, God, you remind me of my father when you say that or...the way you laugh, it reminds me of my older brother". When a black guy says to you: "you fucking whites are all alike", I mean, you can make an interpretation, "yes, how do you know we're all alike", the point is he'll never get a chance, well, he might get a chance to find out with you. But then he'll say to you: "Yes, you're going home to your flat in your posh white suburb and I'm going home to my ghetto". See, you've lost the game. I think humanism doesn't work across the African-white colour line. I tried it with people like (therapist's black ex-girlfriend). We got quite close, but we still lost it.

Interviewer: Do you mind talking about that?

Therapist: No, not at all. It's a source of great confusion to me. It didn't work, she had to make a choice. I don't know what happened. First she tried to use me. She wanted to stay in my room (after their relationship terminated). I moved out. I never confronted her about it. *Pure* shame and guilt. I didn't want to freak her out. If it was a white person, I would've said: "you're taking advantage of me, what's going on here, Jane, that's not nice". From being very close, and the price she had to pay for that was to give up the black world and come into the white world. When she was getting ready to marry this black guy, she had to get back into the black world. And while she was in the transition period she used me. I thought I was getting all these trips laid upon me. White man's burden, you know. Using my house, getting me out. Why? Because I owed her one. I was terribly afraid that if I said something about it - I'm not sure what she would've done - my fantasy is that she would've ranted and raved in some way or other - she was so beautiful, this is the problem. I was very attracted to her.

Interviewer: What was your attraction about in the first place? And in the context of the taboo against this, I mean, living in South Africa, there are prohibitions about being attracted to a black woman?

Therapist: So I hear. I don't suffer from those, you see. I'm a very weird guy. The first woman I ever slept with was black. She was very good to me. You can make your interpretations from that - she was the first woman, she was beautiful. So, I don't know what to say. Oh, there's some of my shadow side involved here as well - part of it is revolutionary, a wish to offend the system which I very strongly rebelled against. Certainly with the first one, I mean I was eighteen, for Christ's sake...On a slightly dirtier level

you can talk about the master-servant relationship. When I originally went for black women I didn't feel that white women would accept me. In other words, I was being a strong racist as well as a sexist. I accept all that about myself...I'm terribly attracted to Indian women... beautiful princesses walking on the street. Can't get access, they're a very closed group. I don't know what to say, it's the Jewish genetic streak in me, the dark side. Arabs are pretty dark. I've never paid much attention to those taboos. That's perhaps why I can't answer your questions about the therapy issue. I work on a different system.

Interviewer: How did you come to have a "different system".

Therapist: I was very reactionary...I always loved African music. I don't know...Blackness...perhaps I have a black soul. People have made various interpretations to me...who knows. I'm deeply attracted to black women. Vibrances, communality. The dynamics of my family suggest that I would be drawn to a warm family network. I never had that at home.

Interviewer: Were you drawn to say, a black nanny, from early on?

Therapist: I suppose so, I don't remember too well. Oh, I remember being dumped by my parents. I must have been 3½ - quite an early memory - I remember doing some *very* sexual things with this woman - looking up her dress, massaging her feet. I remember massaging this woman's gnarled African nanny's feet...a very touching memory. I wasn't massaging out of servitude, I was massaging out of pure sexuality. In the unconscious there is stirring...substitute black mother, mother of the soil. Definitely, definitely. (Black ex-girlfriend) was a great motherly type for me...big breasts... sexually extremely open...I've yet to meet a black person with sexual hang-ups - I'm sure they have. Coloureds, different story. I've got a value in Afs, that's why I don't have the usual South African alienation. I started young - screwed this woman at the age of 18½ - and she *liked* me. It was quite an interesting experience because I was so scared of white women. And I'm not saying that it was just because - consciously speaking - I thought they were inferior, because, believe me I was already moving to the left at the age of 19. But it was actually that this woman gave me *warmth*, in the quiet way that Africans have. They hug you...I'm talking about deep stuff. Kleinian stuff... that white mothers couldn't give. Could see it that way.

Interviewer: So, black women became good objects?

Therapist: Absolutely. Lovely dark skin, not like Mom's skin. You're alienated from your mother, you move for a libidinal satisfaction towards the opposite, which would be seen as black - I'm talking very symbolically - but it's very useful in this country that there are these blacks around. Nicely polarized for us. So, you move away into an object

cathexis which is very foreign to your own family experience. You get fully involved in that area - you sleep with the women and get friendly with the men. You see it's overdetermined, because you find a lot of things that were lacking in your own home - communality, warmth, spiritualism, they're soft people, they actually love. Whites...we're an essentially oralistic culture - I'm generalizing - Afs are essential oral, phallic - a bit of both. They do both very well, they sing very well, they fuck very well. Sensual beings. It's Pan-African... They also offer you the possibility of rebellion against the family because the family *hate* you hanging around with Afs. Famous connection we have - Jews and blacks - Saul Bellow writes about this. I'm not sure - part of it, identify with the underdog. Also, we come from a communalistic culture. So we're more like Afs than your uptight WASPs who will never relate well to Afs. That's why the Afrikaaner gets along better than the English-speaker with the black. Within certain limits, but they're a lot more open with each other.

APPENDIX G

INTERVIEW WITH THERAPIST G

(Male Clinical Psychologist)

Interviewer: I'm interested in racial issues in psychotherapy and, in particular, what you, as a white therapist, experience when working with a coloured, Indian or black patient.

Therapist G: If I think about the medical field right now...people coming in with heart attacks...people trying to commit suicide...there was a time **when** there were no patients in cardiology in the coloured side...we didn't deal with suicides...for instance...and, as the years went by it just increased to a point where right now they're overflowing. At (the therapist's ex-hospital) it's incredible, they have three times the suicide rate. Now, personally, I find it quite easy to work with coloured people, not as easy to work with black people. Um...I feel I understand the language, I understand the background. If I have to work through an interpreter which happened to me, I felt totally helpless, I feel very distant and...almost as if I cannot reach and touch the other person.

Interviewer: Did that feeling ever come to you when working with coloured and Indian patients, feeling that you couldn't touch them?

Therapist: No, no. Working through an interpreter - I'm not quite sure how he understands what I say. Even the personal... the eye contact...he looks at me, and then he looks at the interpreter. Every time there's a break in the relationship. If I would've been young and I knew what I know today, I would definitely have taken up a black language. I think it's very necessary for anyone working in the therapeutic field in this country.

Interviewer: So, language is an extreme example of a barrier between you and a black patient -

Therapist: Physically, I don't have any problems touching a person and holding a person physically, which in my work often happened. When you have a dying patient, for instance, there were times when language was totally ignored and... I did my therapy only through touching. When the whole thing...there was a Portuguese woman who couldn't speak a word of English or Afrikaans and the general thing of the staff was that it was hopeless for you to even go in there because there's no way of you communicating. She couldn't read, either. And I remember so very well how I went in... and I had to say to her that I was the counsellor...there was a Bible on the shelf and I made the cross and pointed to the Bible and she understood it. And...and she started - she was like an animal walking up and down, pacing in front of the window - she - she had cancer, was there for radiotherapy... and when she realised that I represented something spiritual for her, she just started crying. And all I did was to hold her. And then, eventually I said to her, I want to pray... and she prayed as I prayed, in her own language...and I was very touched, something happened between us which is very difficult to describe in words. And when I went out the matron and sisters asked what in heavens had I done. And I asked them to come into the office and told them about the distress I had experienced in this woman...and how they avoided her because they couldn't communicate with her verbally. And

I thought the therapeutic communication at that point was purely a physical kind of containment.

Interviewer: Could you imagine that kind of thing happening with a black patient?

Therapist: Ja...and it did, with dying patients, often. The only thing I did - I think it's important for the patient to understand who you are, whether you are a psychologist or a doctor - for them, representing a spiritual dimension for the person. What is important is not to physically overwhelm the patient. The patient would either pull back or...I tried to respect - I mean, it's very easy for a white person to *intrude*, especially because of our - almost a feeling of *superiority*, to intrude into the black person's world. "I know how, and I will do my thing" - and, basically, because I respect the person as a human being...where I cannot communicate verbally I'm very tuned in to non-verbal reactions. Hands...when I do touch, is there a response? That kind of thing.

Interviewer: Did you ever find yourself in trouble with this feeling that "I am the superior white doctor"?

Therapist: I wouldn't say, personally. I'm very much aware and sensitive...and to move as fast as the person allows me to move. And even to wait until I feel the patient invites me to walk with him or her. But it *angered* me to watch some of the doctors, who come in and walk over people. And I feel... they will never handle a white patient in the same way... It's a very difficult thing to generalise, I don't think it's fair. But often, just watching, I would say: "Heck; I wouldn't do it that way". Some doctors do it with white patients. I mean, they come in, they don't even sit down, they just do their thing and walk off. That feeling of... really power, especially in the medical field. In psychiatry I think it's different, because you cannot read a medical chart and prescribe on what you have in front of you. You have to make contact. So, I think we have to separate the two fields in a sense.

Interviewer: We've spoken about the language barrier and also your feeling of other professionals acting superior...taking, say a coloured patient, were there any other barriers for you there...the fact that they were coloured and you white in South Africa...did that have any difficulties for you?

Therapist: Not for me, but I...I think may have been problematic if I didn't have my overseas experience. I think I'm perhaps not representative of the typical Afrikaans-speaking clinical psychologist. My very first patient overseas when I started my internship was a black - and - even after all these years - I believe this was set up for me in the hospital. I still remember his name. And I had to work...in therapy overseas - a lot of time in group therapy was spent on how - also, pressure from the other people - how I feel about it, about my patients.

Interviewer: Your overseas experience changed you then?

Therapist: I would say, ja. For instance, we got a coloured student in the Masters degree program at (therapist's ex-hospital) and, for many of the white students, I mean, it was a - we had a group exercise were...milling around and touching - that kind of thing...and, for (sigh)...I think there were about five white guys and he was the only coloured present and for many of them it was the first time in their life that they'd touched a coloured guy and...and even for him, to be touched by an Afrikaans-speaking person was - it was just a moving experience. And in terms of group dynamics, it was just an incredible amount of material that came out during that session and afterwards. We worked very creatively.

Interviewer: Let's go back to your own experience overseas - looking at the process of change, what sort of things did you have to look at in yourself when you were confronted with having to work with black people?

Therapist: (pause) I would say, Graeme, you know, in the way I grew up and I grew up really in the country...uh...and I very often went out and spent weekends on farms. My friends were kids from farms. And we lived in an area where every weekend I had I went out. Although we played with - even as a little child - with black kids, there was - *they* pushed - they did the work...they pushed the cart or the pram and...they were sort of the "agterryer". Uh...and always in terms of a person regarded as...as...inferior. And I think my biggest discovery was to come to a point where I could start to see the person behind the colour...behind the skin. Um...and discover the friendship and the equality - and the amazing thing, I think, about overseas is - eventually, overseas students, whether they come from Ghana or Zambia or from South Africa...there's something binding them because they're foreign - and because you're in a different situation and sometimes feeling very threatened, you start to take care of each other.

Interviewer: So you found yourself bonding with a lot of black people.

Therapist: And discovering their friendship and their loyalty and the... *human being*, which is nothing different from what I am. Even my children...(my son's) best friend was a Zulu guy from South Africa...a kid in school...and his tragedy was... "if I go back, we cannot relate in the same way". There they were like this. Here, in South Africa, he would never have had the opportunity to accept his friend on an equal level.

Interviewer: You came to discover that they were human beings...what happened to all those *old* feelings that you were talking about, e.g. having as a child...feeling superior?

- Therapist: I think a lot of my prominent feeling was guilt...and I had to deal with that in therapy. We were forced into individual therapy...in group...but basically, guilt of... I remember how I cried...and...and that was not the first time, that was later, when I went back into therapy. Later on, a lot of the sadness that comes out is sadness because of your own people...and...and sadness because of the system in which you are...and existing. And sadness about the helplessness of people who are inferior, who are kept down, who have ceilings all the way. I mean, (my wife) could tell you how much I cried - I mean, I cried about my own pain but later on it becomes a universal kind of thing and you cry for your people, for your country, and everything. I think for about six months in therapy I didn't do anything but cry...um...and...and... if I'm honest, I get that tremendous sadness very often, still...I don't think I've cried all my sadness away. Guilt, sadness...um...and then anger, too. I don't think you can keep anger away from that.
- Interviewer: How did the anger come in, for you?
- Therapist: Um...anger because of...I mean, if I start to work with a patient...anger because of the system, anger because of what I think we achieve in therapy, like at (therapist's training hospital)...you have the patient there for about eight weeks. But you know, sending him back, he's not only up against family and social problems but he's up against a system, he's almost in a non-win situation. And...then I feel angry, I think, because I identify...*for* the patient but also *against* the system. And...and angry for myself because I invest and eventually you're up against a wall...if that makes sense.
- Interviewer: Ja, I can understand that...How does your guilt then relate to your anger?
- Therapist: Uh...I don't think, right now, I mean, in the beginning there was a lot of guilt,...uh...I don't think I feel as guilty anymore - I mean, there's for me - there was a time of - almost - penance...a time, ja, perhaps there's still a **lot of** guilt because...when I get the opportunity I try to...what's the word to...almost like...I'll go *beyond* - very often - beyond what I'd normally do...um... I find that even with paying (my gardener) for instance, I would pay above other people - although I can't even afford it. But, in that way, I think, perhaps still dealing with guilt. Almost doing, what's the word, restitution?
- Interviewer: Reparation?
- Therapist: Reparation! That's the word...uh.
- Interviewer: So, you overcompensate when dealing with black people - doing more than you would with a white?
- Therapist: Ja, I think, often...not...ja, that's difficult to say - I find myself at times doing it...and I have to - in therapy - to keep reminding myself - this is back to the old story where I said: "intruding"...also respect the

other person and saying, "OK, you needn't do that, you needn't. Because he's black and because of the system you needn't...make the reparation for him or...carry more of his burden than is therapeutically good for him". I think that's the danger I have to be aware of all the time...I mean, it's easy to say: "I respect you as a black person" but, in subtle ways, these things pop out and...and one can easily...I can easily fall into the trap of overplaying or overdoing my role as a psychologist.

Interviewer: In getting back to the anger...how would you respond to a black or coloured patient getting angry at you, as a white in the system?

Therapist: You mean, in the therapeutic situation? I haven't...thinking back...I haven't encountered...I believe there must be anger towards me because I represent the white group. I haven't in therapy, although I'm not scared of raising the issue, "how do you feel about me being white?" but I haven't, in therapy, actually, I can't remember that I worked - perhaps they didn't have the courage because they're dependent or they feel dependent - they're in a hospital situation and all the people there who can help them are white. Perhaps they're afraid to verbalize their anger. Verbalizing anger against the system I think is easier than to verbalize anger against the therapist who may represent the system. Um - I don't find that threatening. As a matter of fact, I...I can...I could allow a patient to be very angry with the political system and - and deal with it. I can understand some of that.

Interviewer: You feel that the anger is often there but the patient can't verbalize it...how do you think it manifests - in other ways - if it does?

Therapist: That's a difficult one...I'm speculating...perhaps by sabotaging the process or themselves, by...inflicting...or turning the anger onto themselves, perhaps try to commit suicide...perhaps some possible ways...uh...I'm trying to think of the patients we're seeing...some of them tried to commit suicide and ended up there. I would say, very often because of hopeless living conditions and a feeling of being suffocated by, perhaps the political system but also the... which actually incorporates...it involves my family, my working situation, it involves my marriage often, it involves my children...perhaps because of...eventually, the only way you can handle this tremendous anger is to turn it onto yourself. Either start drinking or using drugs or walk in front of a car or...

Interviewer: Acting out in some way...for you, is there any comment that comes to mind with respect to a sex difference, say coloured compared to a white woman?

Therapist: At this stage, past couple of years - and I think again back, especially when you start talking about coloured women I think about...about the (therapist's ex-hospital) context - with dying patients you automatically counsel...the word sounds empty...and I never felt threatened or different in touching either a man or a woman - and this is true for me too, in terms of white people.

Interviewer: Before your overseas experience, did you feel the same way?

Therapist: I can't talk about that, before, the years I spent at (a university)...very much protected years...I didn't work with people in need. I was fortunate to graduate and immediately go overseas.

Interviewer: Did you work with black women overseas?

Therapist: Ja...quite a lot. Black women, yes. Men, (another culture), the whole overseas scene, which is very mixed up. And especially in some of the hospitals...my first experience at (a particular hospital) was in a slum area and the majority of the patients were blacks - where I spent a year doing an internship.

Interviewer: Is there anything else that comes to mind about doing cross-racial therapy?

Therapist: If we take, when I worked at (a coloured, black and Indian in-patient unit) - you have a kid...because of the present political situation - on the one hand, for a coloured kid, there are more possibilities...he could go to school, he could matriculate...he could at least get a degree - and I feel there's a lot of pressure from the parents to say to the kids, "OK, go to school, do it" but then there's the pressure from the political activists, saying: "If you dare go to school, if you don't boycott" and in between, we've got this kid. On the one hand the family situation and on the other...and sometimes because of tremendous fear and anxiety they end up in hospital. Now, just as an example, I would spend some time helping this kid deal with his anxiety or his fear or his phobias or what-have-you - or his depression. Once he lifts, he's back into the system, back into the world where he would still be terrified going out onto the street, still want to please his parents but cannot because of...and that makes me feel very helpless... I mean, it's wonderful to keep them in the hospital for some time but once you send them out and then you realise - that's where the discrepancy between what my children have and these children - where they're actually not even safe on the streets. Some of the coloured suburbs where kids are being raped...it makes me feel very helpless. I remember at (ex-hospital) one morning about three or four of the cleaning women waiting for me at my office and they said they wanted to talk to me because of fear for their girls, their children being raped - where, in the hospital we had about four or five rapes in that area...within about two, three days and it was kids, 13, 14, 15 years old and these mothers were working full-time and during school time it was OK, they knew their children were being protected - but after school hours...And then *my* feeling of helplessness. You can say, "OK, let's pray", but it's actually *shit*, because of...they needed the support and they needed someone to listen to them but...what can I do about their situation? They still live in a slum area. Their children *are* in danger. I can't even say to them "OK, send them away to this place or that place, let them attend a hostel"...

it's futile - that makes me feel very helpless and, again, angry. And I compare. I compare the safety with which my children go to school...it's not two percent of the situation in the townships.

Interviewer: It makes you angry

Therapist: It makes me very angry...because I have a feel for their crisis ...and helpless. Even if I had direct advice to offer, it's stupid...there is no advice to offer. What can you say, you can just say, "that's the situation. It's tragic, that is the situation, your children are in danger, your little girl may be raped tomorrow"...(pause) I think actually it would be quite a good thing if you could get somebody from the Afrikaans-speaking community who has not had overseas experience and just ask them how they feel.

Interviewer: How would you imagine that they'd react?

Therapist: ...Well, I...some of the students I've had...and how difficult it was for them to go into the Coloured wards and work with coloured people. My fantasy is that at this stage some of them may feel extremely threatened. You know, I talked about a feeling of supremacy of...of...power but I think the opposite is also true. My fantasy is that some might feel totally threatened to work, for instance, on a Saturday night in the emergency services.

Interviewer: What part of that do you think threatens them?

Therapist: I think the enormous amount of power and energy that is coming out...that is available in the black society and especially, like in the emergency services when people come in less inhibited because they've had one or two drinks too much. And they are very verbal and very aggressive...it's on a human level that you have to make contact and respect the person but also not become overwhelmed by the anger and the hostility. But in counselling sessions where somebody would come to you...my fantasy is that that may not be as overwhelming.

Interviewer: How would they handle being a part of the system that's oppressing these people and yet counsel them at the same time?

Therapist: - They don't...I think we have to realise that there are very clear polarities. There are a group that realise that there is just one way...through communication. But, on the other hand, you have very conservative people. These different groups would react totally differently. Some would say, "OK, there's just one answer, and it's through violence and control and keep the lid on the pot and...use every means... in war and love, everything is fair". The other group would say, "there's no future unless we communicate". So, it would be very difficult to generalise. And to do empirical kind of research on this you need to get people on both sides.