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TRAUMA AND REPETITION

An Intersubjective Perspective

BY

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A minor dissertation submitted in partial fulfilment of the requirements
for the award of the degree of Master of Arts in Clinical Psychology

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DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signed by candidate

University of Cape Town

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ABSTRACT

This research study employed the single case-study method with the aim of illustrating how extraordinarily difficult it can be within a South African context to name racial, gender and class differences and their concomitant painful histories within the therapeutic space. The evolution of trauma is followed with particular emphasis on its relationship to gender. This case study focuses particularly on the intersubjective space generated between a White, male intern psychologist and a Coloured, female survivor of gender based violence. Material gathered over an eleven-month treatment period highlighted a resistance of both parties to acknowledge and engage with issues, such as race and gender, which threatened both client and therapist with early traumatogenic repetitions within the therapeutic space. During the therapeutic contact, empathic failures occurred when issues relating to power were not adequately discussed and processed within the therapeutic space. Clinical vignettes illustrate the narcissistic transformation which occurred within the therapist from the initial contact, through the process, to the here and now. Finally, recommendations are made in an effort to offer both institutions and trainee psychologists suggestions which could facilitate working with the complex intersubjective dynamics of therapy within a South African context.

“Therapists face a paradox. They must remember the past, and hold hope for the future, but sit lightly to both memory and desire; they must be authentic but self-effacing; they must own authority but refuse domination; and they must have the capacity to immerse themselves in the experience of their patients but also recognise the ways in which their own subjectivity has constructed that experience. Always, in every minute, this paradox makes a spider-web against the sun. In negotiating the web, the possibilities for false inane, ignoble weightless speech multiply endlessly. There are no technical ways to avoid occasional clumsiness that tears filaments of spun silk to float away in the air.”

(Swartz, 2004, pg 16)

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CHAPTER ONE

INTRODUCTION

1.1: ORIENTATION TO THE STUDY

This introduction section briefly describes the aims, background and rationale which provided the impetus for a study of the complex intersubjective field generated within the therapeutic space between myself as a White, male, intern therapist and my client, a Coloured¹, female survivor of gender based violence. The study developed in response to a consideration of the therapeutic dangers of failing to acknowledge the ongoing salience of traditional systems of racial, cultural and gender privilege (Frosh, 2002) within a South African context.

1.2: AIMS OF THE STUDY

Material for this dissertation was gathered over an eleven- month treatment period. A retrospective investigation of specific material which emerged during therapy, highlighted an ambivalence and, at times, resistance enacted by both parties within the therapeutic space, which seemed to be related to particular material. Initial resistance encountered during the exploration of traumatic elements of the client's past appeared to be particularly entrenched when material related to gender based violence entered the therapeutic space.

¹ I use the term *Coloured* as this is the descriptive category the client used to describe her experience of racial discrimination during apartheid. Racial categories such as 'White', 'Coloured', 'Black' and 'Indian' were used during the apartheid regime in an effort to ascribe inherent potentialities in different population groups. Coloured identity remains a complex area within the South African context.

This resistance seemed, in part, to be influenced by the impact of socialised, patriarchal values about a woman's role in relationships, as well as the view of men as responsible for perpetuating gender based violence. A further resistance was encountered within the therapeutic space, by both parties, when issues relating to race entered the space.

The continual threat of repetition weighed heavily upon the therapy. As the resistance grew, engaging with and acknowledging *difference* within the therapeutic dyad became difficult. The space that was generated *between* us is explored theoretically by adopting a Psychoanalytic Self Psychology and an Intersubjective approach.

1.3: BACKGROUND AND RATIONALE OF THE STUDY

South Africa's history has been characterised by the salience of race, class and gender in relation to power and access to material resources (Dawes, Donald & Louw, 2000) .

Historically, many people within South Africa have been deeply traumatised by the legacy of apartheid policies. As a member of a privileged minority during the time of apartheid, I viewed the painful struggling of a birthing nation from the comfort and fear of high-walled suburbia. It was during this time that I internalised a sense of somehow being complicit in the traumatic legacy of apartheid. The legacy of these internalisations still un/consciously manifests within my interactions with the macro social milieu of the "new" South Africa, but they have also manifested within my work with the client. This dissertation is an exploration of how and why the silence in the therapeutic space in relation to these salient issues were both addressed and avoided.

Therapy with a woman who was disadvantaged as a direct result of the apartheid policies of the past, had an effect upon the way I listened to her painful narrative. It was necessary for me to understand the complex space that was generated between us, particularly with regards to trauma and the ever present possibility of retraumatisation.

Swartz (2004), argues that the interactions marked by race, class and gender difference as well as the repetitions which are directly linked to these issues are seldom addressed within the analytic dyad. In therapy with my client it soon became apparent that no matter how much both parties tried to circumvent issues related to power, the intersubjective space was constantly informed by our socially constructed expectations of each other. It therefore became necessary to explore the effect which our commonly held social constructions had on the material that was being explored within the therapeutic space, through the adoption of Self Psychology and an Intersubjective perspective.

During the course of the therapy with the client my expectations as to what would inform the therapeutic space hampered the process and littered the space with silence. During certain phases of therapy, I reflected on how the client's traumatic experience in her relationships with men could be understood theoretically through the psychodynamic concepts of trauma and retraumatisation and how my being a white, male therapist might have reinforced this in therapy.

My concern that being a male therapist would somehow, inadvertently retraumatise the patient due to her history of sexual abuse, constantly dogged my heels, and I was often

aware of my own discomfort when the patient discussed how she was oppressed by men and apartheid.

What became evident throughout therapy with my client was that with the critical levels of child abuse and gender based violence within South African society, it was extremely difficult to acknowledge my position as a conscientised male voice within the therapeutic space. The disempowerment I experienced within therapy, as well as the narcissistic transformations which occurred as a psychologist in training, have prompted me to consider the Intersubjective nature of the therapeutic space more fully.

1.4: THE STRUCTURE OF THE DISSERTATION

The dissertation is divided into the following chapters:

- Chapter 2: The literature review charts the course of the evolution of the study of psychological trauma, a particular focus being on the historical links between trauma and gender. The tenets of Self Psychology and Intersubjectivity are then outlined in the hope that these particular theoretical paradigms might be used to broaden the understanding of specific patient-therapist *dynamics* evoked within therapy.
- Chapter 3: Methodological issues are considered. In particular, the salience of the qualitative single case study with reference to the psychodynamic approach is explored within this chapter.

- Chapter 4: This chapter presents the details of the case material. Relevant background information, a description of the patient, as well as a brief review of therapeutic process with the patient is presented.
- Chapter 5: Clinical vignettes are discussed and linked to the specific areas covered within the literature review. This chapter explores how specific theoretical constructs have ‘translated’ within therapy with the client.
- Chapter 6 presents a conclusion which draws the key elements covered within this dissertation together and offers particular recommendations for trainers of psychologists, when dealing with the complex Intersubjective dynamics generated within a South African context.

CHAPTER TWO

LITERATURE REVIEW AND PROPOSED FRAMEWORK FOR ANALYSIS

2.1: INTRODUCTION

The first part of this chapter provides a brief review of the literature which addresses the chimera-like evolution of the concept of hysteria in an effort to illustrate how women's experience of trauma became *gendered* as far back as the 19th Century. Men's traumatic wartime experiences are then highlighted. The review then argues that with the rise of the feminist movement in Western Europe and America during the 20th Century, a deconstruction of women's narratives of trauma led to the expansion of the pre-existing (predominantly male orientated) diagnostic category of Post Traumatic Stress Disorder (PTSD) in an effort encapsulate women's experiences of sexual abuse (Battered Woman Syndrome, Complex PTSD).

The review focuses on how feminist commentators have attempted to highlight the experience of a more chronic, insidious form of trauma so often experienced by survivors of childhood sexual abuse and gender based violence. The review then examines how trauma and gender interact within the South African context; a particular focus being on the 'culture of violence' experienced by women and children. The review then considers Attachment theory as a possible avenue for exploring the impact of chronic, insidious trauma on development. The effect of insidious trauma on the formation of personality structure is explored with particular reference to Borderline Personality Disorder (BPD).

The focus of the review then looks specifically at the theoretical paradigms of Self Psychology and Intersubjectivity, which are employed to make meaning of the complex presentation of *trauma and power* in relation to gender, race and class within the therapeutic space. The review concludes by asking whether a delivery of grief is possible intersubjectively when the multiple layers contributing to past trauma are not adequately acknowledged within therapy.

2.2: HYSTERIA AND THE EVOLUTION OF GENDERED TRAUMA

Mitchell (2000) states that “of all the psychic, mental, emotional or behavioural conditions known to humankind, it is hysteria which has been bound with bands of steel to femininity, and hence very largely to women” (p.ix). Hysteria is often viewed as the alternative or other side of the coin to what is regarded as *normal* behaviour. All human emotions, psychic states, and indeed even organic illnesses, take place within specific social contexts (Gergen & Gergen, 2000). They cannot exist outside of them. Yet discussions of hysteria are remarkable for a particular sort of unawareness of this self-evident fact (Herman, 2001). Every context which describes hysteria links it to gender. Sometimes it is a medical diagnosis, sometimes an insult. Mitchell (2000) challenges the assumption that there is an equivalence between femininity and hysteria, arguing instead that hysteria has been feminised.

In ancient Greece hysteria was described as the 'wandering womb', in the middle ages it was explained as seduction by the devil, and in the eighteenth century as a touch of 'the vapours' (Mitchell, 2000). It was only during the late nineteenth century that the *disorder* known for its "incoherent and incomprehensible symptoms, proper to women and originating in the uterus" (Herman 2001, p.10) became a major focus of serious enquiry.

In France, Charcot's meticulous, respected gaze focused on hysteria which restored dignity to a subject that was considered beyond the scope of serious scientific investigation. Spurred by Charcot's findings, Janet, Freud and Bruer pursued what they viewed to be a major scientific discovery (Van der Kolk, 1996). All three arrived independently at strikingly similar formulations, "hysteria was a condition caused by psychological trauma" (Herman, 2001, p.12). The traumatised psyche was thus conceptualised as an apparatus for registering blows to the psyche outside the domain of ordinary awareness. The hysterical female epitomised the shattering effects of trauma on the mind (Mitchell, 2000).

By 1896 Freud wrote a report on eighteen case studies, entitled *The Aetiology of Hysteria*, in which he put forward the claim that the cause of hysteria was seduction during early childhood, around the ages of 3 or 4 (Leys, 2000). The child, usually a girl, played a passive role as she was approached by an older person, usually the father.

Freud's findings, however, had radical social implications, for if they were true, he would be forced to conclude that what he called "perverted acts against children" were endemic, not only among the proletariat of Paris, but also among the respectable bourgeois families

of Vienna (Freud, 1896 in Mitchell, 1974, p.21). The only potential source of intellectual validation and support for this position was the nascent feminist movement, which threatened Freud's cherished patriarchal values (Herman, 2001). Freud was therefore on the horns of a dilemma which eventually caused him to repudiate his earlier findings. Instead he adopted the position that when patients were discussing childhood sexual experiences, these were not actual experiences but fantasies, often wish-fulfillment fantasies (Giovacchini, 1992). Freud's turnaround marked the end of this line of enquiry and for almost a century the exploitative social contexts within which sexual relations occur became invisible and were silenced (Brown, 1995).

Herman (2001) argues that the late nineteenth-century studies of hysteria focused on the question of sexual trauma without acknowledging that violence was a routine part of many women's sexual and domestic lives. Women's experience of trauma had effectively been erased from social discourse and the focus shifted onto a form of trauma particular to the lives of men. Mitchell (2000) states that it is the "repression of the male hysteric that has partly led to a misdirection of psychoanalytic efforts from looking at the symptoms of hysteria to trying to replace them with an understanding of femininity in general" (p.214).

2.3: TRAUMA AND WAR

A form of trauma which claimed to be particular to men's experience was that of 'shell shock' or combat neurosis which began to be recognised during the First World War (Herman, 2001). Many men under conditions of unremitting exposure to the horrors of trench warfare began to break down; began to act like hysterical women (Herman, 2001). The emotional stress of prolonged exposure to violent death was sufficient to produce a neurotic syndrome resembling hysteria in men.

In the military (and in society at large) however, it has not been acceptable for men to scream and weep uncontrollably and military authorities often attempted to suppress reports of psychiatric casualties because of their demoralising effect on the public (Leri, 1919 as cited in Herman, 2001). The virtual epidemic of war neuroses threatened the war effort and authorities were pressured by the sheer weight of numbers to pursue a cure which would enable traumatised soldiers to return to the front. The focus of the 'talking cure' for combat neuroses was on the recovery and cathartic reliving of traumatic memories in an effort to deliver grief (Herman, 2001). As a result of World War I, hysteria moved from the domestic sphere onto the battlefield, it had been subsumed by 'shell shock' and trauma had become linked to war. Men became traumatised, not because they were like women, but because of the psychological effects of war related trauma (Young, 1997).

On the surface, it appeared that men's experience of trauma adopted a different socially constructed discourse to that of women in that, during combat, a group of largely psychologically 'healthy', adult males entered situations of untenable stress and were 'afflicted' by a syndrome that was later recognised as Post Traumatic Stress Disorder (Brown, 1995). However, after World War I, interest in the syndrome declined and was only revived in the 1940's by Abram Kardiner, an American psychoanalyst who had treated traumatised veterans during the 1920's (Young, 1997).

Despite Kardiner's achievements, the psychiatric establishment ignored the classification until 1980, when PTSD was included in the third edition of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM- III). This inclusion followed a political struggle waged by activists on behalf of the large number of predominantly male, Vietnam War veterans who were then suffering from the undiagnosed psychological effects of war related trauma (Young 1997; Lifton, 1974).

Herman (2001) argues that the study of psychological trauma has, to a large extent, been driven by political expediency during the past century and that the most recent to emerge is that of sexual and domestic violence, which is closely affiliated with the feminist movement of Western Europe and North America.

2.4: FEMINISM AND TRAUMA

According to Herman (2001), it was not until the woman's liberation movement of the 1970's that it was recognised that post-traumatic disorders belonged not only to men's experience in fighting wars, but were in fact also salient to women's experience in civilian life.

The real plight of the abuse women and children suffered in personal, private lives had been obfuscated for almost a century by a silence precipitated by, what many argue was, Freud's surrender of the seduction hypothesis, which marked the discontinuation of a line of enquiry pertaining to the exploitative social contexts within which sexual relations occurred (Masson, 1988). Freud has been criticized for having given up his so-called seduction hypothesis and for putting forward the hypothesis that his patients were reporting fantasies as opposed to facts (Herman, 2001; Mitchell, 2000; Giovacchini, 1992). Leys (2000), however, maintains that what many critics fail to acknowledge is that even at the height of his commitment to the seduction theory, Freud problematised the originary experience of the traumatic event by arguing that it was not the experience itself which acted traumatically, but its delayed revival as a memory after the individual had entered sexual maturity and could grasp its sexual meaning. Thus, from the beginning Freud rejected a straightforward causal analysis of trauma according to which the traumatic events assault the subject from the outside (Leys, 2000). With Freud's turnaround and the supremacy of the psychological model came the belief that, having been 'understood', hysteria had simply disappeared.

Mitchell (2000) however, argues that Hysteria has never disappeared but has merely been transformed. She argues that currently women appear to be affected by the many different aspects of Western Hysteria such as eating disorders, multiple personality and 'borderline' conditions (Mitchell, 2000). Although Bollas (2000) does not believe that Hysteria is necessarily gendered, he argues that Hysteria has disappeared from contemporary culture only insofar as it has been subjected to repression through the popular diagnosis of BPD. Librecht in Mitchell (2000) appears to concur and states that "the hysterics of the past have become the borderlines of the present" (p.61).

However, the idea that Hysteria has been *absorbed* by the diagnostic category of BPD remains contentious (Herman, 2001). Women patients with a complex presentation borne out of childhood sexual abuse and insidious, chronic trauma are often given what Herman (2001) calls "troublesome" (p.123) diagnoses such as Somatization disorder, Borderline Personality Disorder, and Multiple Personality Disorder. Herman (2001) posits the argument that all three of these diagnoses may be seen as variants of *Complex Post-Traumatic Stress Disorder* which is characterised by denial, psychic numbing, self-hypnosis, dissociation, and alterations between extreme passivity and outbursts of rage. Herman (2001) maintains that each of these disorders derives its characteristic features from a form of adaptation to the prevailing environment and that women's experience of psychological trauma is an "affliction of the powerless" (Herman, 2001.p33).

The notion that traumatic events were at one time believed to be relatively rare events stemmed primarily from men's experiences of war and when PTSD was first included in the Diagnostic and Statistical Manual of the American Psychological Association in the

1980's , traumatic events were described as “outside the range of usual human experience” (Young, 1997, p.34). The APA's definition of PTSD was undeniably limited in that many women's experience of chronic sexual abuse and domestic violence was overlooked and such experiences, one may argue, are hardly outside the range of usual human experience. It was only with the introduction of the DSM IV in 1994, that the PTSD diagnosis was refined and the term “outside the range of usual human experience” dropped (Young. 1997, p. 34). However what remains painfully evident is that the current diagnosis of PTSD is still limited and does not fully acknowledge the chronic presentation of trauma within many women's lives (Brown, 1995).

2.4.1: Insidious trauma in women's lives

The rise of the Feminist Movement helped to shift the focus and understanding of trauma from that of a traumatic event often experienced by men in war, to that of a more *insidious*, chronic experience of trauma, which commentators argued many women often experienced within domestic contexts, often on a daily basis, for many years (Herman,2001; Mitchell 2000; Terr,1990). It appears that people subjected to prolonged, repeated trauma develop an insidious, progressive form of post-traumatic stress disorder that invades and erodes the personality (Giovacchini, 1992). Terr (1990) differentiates between “Type I” trauma, i.e. the effects of a single traumatic blow from that of the effects of prolonged, repeated trauma or “Type II” trauma (p.67).

Her description of the Type II syndrome appears to reinforce Herman's concept of Complex Post-traumatic stress disorder. Type II trauma includes denial and psychic

numbing, and dissociation. In addition to Complex PTSD and Type II trauma, feminist commentators have highlighted the limitations of current diagnostic categories relating to women's experience of trauma by elucidating symptoms related particular traumas experienced by women such as Rape Trauma Syndrome (Burgess & Holstrom, 1974) and Battered Women Syndrome (Walker, 1979), but these 'syndromes' have yet to be legitimised by the DSM.

2.4.2: Child Sexual Abuse

The current discussion on women's experience of trauma would not be complete without considering the early abuse that many girl children are subjected to. It is hypothesised that many women who currently experience symptoms related to Complex Traumatic Stress Disorder, have experienced a long history of Type II trauma beginning in early childhood (Herman, 2001).

Herman (2001) states that in many instances, children in incestuous relationships will not disclose the abuse to parties within the family, regardless of the tumultuous atmosphere that characterised family interactions and no matter how much they were suffering, because they do not want to disrupt family system. Lewis (2002) offers another possibility, he claims that many girl children may find it difficult to disclose abuse to the authorities as many positions in legal institutions are filled predominantly by men. The argument here being that a child's disclosure to a male authority figure and subsequent disbelief may bring about secondary trauma (Russell, 1986).

Giovacchini (1992) puts forward the hypothesis that many patients are afraid of revealing what happened to them in their families, as many of these patients were threatened as children with violence or stigmatisation if they discussed, or admitted that they had been abused (Russell, 1986). It is possible to argue that in many instances, disclosure of chronic abuse is equated by survivors with stigmatisation, due in part to a failure of the psychiatric establishment to recognise and validate the pervasive nature of women's experience of trauma.

Survivors of childhood abuse, like other traumatised people, are frequently misdiagnosed and mistreated in the mental health system. Due to the number and complexity of their symptoms, their treatment is often fragmented and incomplete (Herman, 2000). As a result of their characteristic difficulties in close relationships, they are particularly vulnerable to revictimisation by care givers. They may become "engaged in ongoing, destructive interactions, in which the medical or mental health system replicates the behaviour of the abusive family"(Herman, 2001, p.123).

Giovacchini (1992) posits the view that a lack of psychic unity can be the outcome of faulty development or a defensive, as well as disintegrative, reaction against chronic, multiple trauma. There appears to be a reciprocal relationship between these two states in that the less organised the psyche is, the more it will fragment when traumatised.

Health care services and clinicians are being confronted with an ever increasing number of patients, especially women, who report episodes of incest and other types of sexual abuse during childhood, adolescence and adulthood (Giovacchini 1992; Herman 2001),

this trend is particularly evident within the South African context (Marshall & Herman, 2000).

2.5. TRAUMA WITHIN A SOUTH AFRICAN CONTEXT

In coming to a deeper understanding of the study of trauma and the historical disempowerment of women and children in a South African context, it is necessary to examine how Apartheid and the violence inherent to it has impacted on individual lives. Many children from previously disadvantaged sectors of the population in South Africa find themselves in a society where Apartheid policies have left them with a legacy of severe socio-economic disparities. The circumstances in which the majority of families have lived appears to have impacted negatively on their capacity to meet the most fundamental needs of children. Disempowerment and fragmentation have been aggravated by deprivation, violence, malnutrition, poor health, inferior education and discriminatory social security systems (Dawes et al. 2000). The current social and economic milieu of South Africa is still heavily influenced by the legacy of Apartheid. Migrant labour and limited resources still force husbands and wives from their homes in rural areas. Children are still separated from their parents due to socio-economic factors and access to social services is still limited (Dawes et al. 2000). Apart from the legacy of overt, political violence which tore the very fabric of society, many lives appear to have been affected by a more chronic presentation of trauma i.e. trauma incurred by poverty, separations, substance abuse and domestic violence.

Women's experience of gender based violence in this country has only recently come to the fore and has historically been compounded by an entrenched patriarchal society which posits men as the head of a household (Richter, Dawes & Higson-Smith, 2004). The historical development of a culture of violence is currently fuelled by an overloaded and largely ineffective justice system and the subsequent perception that there will be no serious consequences for domestic violence (Hamber, 2000).

It is estimated that one in three women are being abused in relationships with male partners (Angless & Schaffer, 1997, as cited in Dawes et al. 2000). Similarly, Richter (1996) found in her Soweto- Johannesburg study that there was violence in the homes of one third of 1615 families sampled. Angless and Shefer (1997) note that the impact on children witnessing violence varies with age and gender. However, the range of behavioural and emotional problems reported by researchers and practitioners is similar; emotional, cognitive and behavioural disturbances appear to be commonplace.

According to Dawes et al. (2000) many millions of children's lives have been affected by political violence and chronic poverty within South Africa. Poverty is well known to compromise a wide range of developmental outcomes (Mcloyd & Wilson, 1996 as cited in Dawes et al. 2000) and is accentuated by disruptive relationships with caretakers, such as those associated with migration from rural areas to cities. Under such circumstances, proximal relationships are likely to be unstable and children are frequently exposed to alcohol abuse, domestic violence and other adverse conditions associated with chronic poverty (Dawes et al. 2000).

Dawes et al. (2000) argues that self-regulation is a key attribute that begins to develop during the early period of life. Self regulation enables the child to improve impulse control and delay gratification, characteristics which are ideally reinforced by consistent, empathic caregivers. In the following section, the development of self regulation is explored using particular elements of attachment theory, in order to explore the effects which inconsistent proximal relationships may have on the formation of adult psychopathology such as that of Borderline Personality Disorder.

2.6: TRAUMA, ATTACHMENT AND THE BORDERLINE PERSONALITY DISORDER

A basic psychoanalytic definition of trauma is: 'An event in the subject's life defined by its intensity, by the subject's incapacity to respond adequately to it, and by the upheaval and long-lasting effects that it brings about in the psychological organisation' (Laplanche & Pontalis 1980, p.465). The focus in the definition is on trauma that is unconsciously active, and that does not necessarily reside in an event, but may lie in the ratio of difficult to soothing events accumulated over critical periods of development, or times of particular vulnerability, within a particular context (Swartz, 2003; Fonagy, P., Target, M., Gergley, G., Allen, J., and Bateman, A, 2003).

Traumatic experience incurred during critical times of development is viewed by many Psychoanalytic authors (Fonagy 2001; Russell; 1998, Stern, 1985) as being a contributing factor in the formation of the primary defect inherent to BPD, i.e. the failure to achieve object constancy or of a failure to form reliable and well integrated representations of

trusted people. Ongoing early trauma incurred by separation, sexual abuse or domestic violence may result in a relative developmental failure in the formation of introjects that provide the self with a sense of being soothed and secure (Fonagy, 2001).

Fonagy et al.(2003) hypothesise that the capacity to think about the self and others in mental state terms (i.e. to attribute intention, beliefs, and attitudes to significant others) is anchored in secure attachment relationships which can enhance ones resilience in the face of later trauma. The quality of resilience generally refers to those factors and processes that interrupt the trajectory from risk to problem behaviours or psychopathology and thereby result in adaptive outcomes even in the presence of adversity (Zimmerman & Arunkumar, 1994 as cited in Dawes et al. 2000). Factors that promote resilience and protect children from negative outcomes include capacities that are part of the child's physical and psychological makeup, as well as features of the social ecology in which the child is involved. Fonagy et al. (2003) discuss trauma in later development, arguing that the extent of the impact depends on how well early attachment relationships facilitated the capacity for the internal representation of relationships.

Fonagy et al.(2003) argue that there are specific consequences for the representation of the internal world if the individual is made vulnerable by genetic predisposition or disorganised early attachment. They argue that a failure of mentalisation may occur as a result of disorganised early attachment and links the failure of mentalisation to the clinical presentation often associated with Borderline Personality Disorder.

Turning then to the therapeutic dyad, it is possible to hypothesise that specific psychic vulnerabilities, such as the inability to adequately regulate affect, may be precipitated by enactments, within therapy, which evoke repetitions of early traumatogenic failures (Fonagy, 2001). Bowlby (1975 as cited in Fonagy, 2001) fully intended that the concepts of attachment theory would illuminate the understanding of more severely disturbed narcissistic, and borderline patients and their treatment. He hypothesised that just as the availability of a secure base in childhood facilitates the child's exploration of the external world, so the therapist and the therapeutic situation serve as a secure base from which the patient can engage in self exploration. Bowlby (1975) wrote that the chief role of the clinician was to "provide the patient with a temporary attachment figure" (p.291). Like all attachment relationships, the therapeutic one was thought by Bowlby (1975) to be inherently bi-directional, with attachment-seeking behaviours (smiling, proximity seeking etc) tending to evoke corresponding adult attachment or caretaking behaviours (soothing, protective etc).

Psychoanalytic theorists see the analytic relationship as a powerful catalyst in retraumatising the patient in that painful thwarted developmental yearnings are believed to be activated in the transference. Kohut (1971) acknowledges that it is important to address traumatogenic developmental failure in the transference with the insight that "the analyst is not the screen for the projection of the internal structure... but the direct continuation of an early reality that was too distant, too rejecting or too unreliable" (Stolorow, 1991, p.31).

In Bowlby's view (1975), the attachment behavioural system inevitably contributes to the configuration of transference and countertransference dynamics, for it is activated throughout the life cycle in situations where an individual who is ill and in distress seeks protection from or contact with someone deemed older or wiser. Frank (1997) suggests that the best treatment outcomes and overall ratings of treatment alliance occur when patients and therapists attachment state of mind is complementary as opposed to concordant. In such an alliance the therapist is more likely to challenge the client's characteristic ways of regulating affect and distress in interpersonal contexts, leading to better therapeutic outcomes. There have been numerous debates, by various psychoanalytic schools, around how to establish the most effective therapeutic alliance, as well as the role of the therapist within the alliance (Freud, 1920; Winnicott, 1971; Natterson and Friedman, 1995; Stern, 1995). Self Psychology theory has, however, foregrounded the role of the therapist within the therapeutic alliance and was, for the purposes of this research, deemed to be the most appropriate theoretical position from which to describe both the therapist's and client's experience.

2.7. SELF PSYCHOLOGY

While Frosh (2002) acknowledges the impossibility of a complete understanding of human experiences, he argues that psychoanalysis represents an approach which attempts to make sense of otherness by actively engaging with difference. This has particular relevance to the Self Psychology perspective; the Self Psychologist, through the adoption of an empathic stance, allows him/herself to experience and be effected by the client's

experience (Wolf, 1988), and this in turn provides insight into the client's subjective world.

In attempting to penetrate the heart of the client's experience, the therapist must make an attempt to avoid defensive racial and gender dynamics. Self psychology, because it emphasises disruptions in the empathy process (Wolf, 1988), suggests that such disruptions are therapeutic opportunities. By working with such disruptions within an environment where the salience of gender and cultural difference is extremely marked, it is theoretically possible to adequately discuss and process these disruptions within the therapeutic space. The process of engaging with and attempting to repair the rupture in the therapeutic relationship requires that the patient and therapist engage in an authentic manner, which explicitly acknowledges each of their contributions to the therapeutic dyad. According to Wolf (1988), many analysts have been tactful and sensitive to their patient's needs for a therapeutic alliance and have avoided the harshly unresponsive ambience that resulted from an overly strict application of the rule of 'abstinence'. The emphasis, however, usually remained on technical neutrality and on the concept of unconscious conflict, which required confrontative interpretation. In Self Psychology, the self is conceived of as a psychic structure that, like all structures are made up of parts that either fit well together i.e a self that is cohesive or at other times, of a self that is fragile and easily fragments. Selfobjects are the intrapsychic experience a person has of objects in their environment which are evoked in the process of self formation. Affirming, nourishing and strengthening responses are required for the development of a cohesive self and are termed selfobject experiences (Wolf, 1988; Kohut, 1977). Kohut (1977)

referred to the other as a necessary self object and studied the effect of the self object upon the other self in need, that is the patient.

Wolf (1988) highlights the dependence of the self on a 'selfobject matrix', i.e. the self does not develop without the other. Kohut's psychoanalytic approach focused on the 'self' and the absolute necessity for the development of the self in relationship to another self or selves (Natterson & Friedman, 1995). The very emergence and maintenance of the self as a psychological structure depends on the continuing presence of an evoking-sustaining-responding matrix of selfobject experiences. Wolf (1988) argues that in therapy, once a selfobject transference has become established, any disruption of the continuity of the bond between analyst and analysand is experienced by the analysand as a threat. Disruptions in the continuity of the sustaining self object experience result in symptoms characteristic of disruptions of the continuity of the self.

With the growing acknowledgement of the interpersonal processes in psychoanalysis, it has become difficult to retain the view of the therapist as a neutral presence (Mitchell & Black, 1998). Self psychology has been instrumental in developing the idea of the therapist as an active participant in the therapeutic context, and in highlighting the importance of the empathic stance of the therapist to the therapeutic process.

According to Wolf, (1988): "For the psychoanalyst to have some idea about an analysand's inner experience, he must sense it by putting himself imaginatively into another's experience, that is by vicarious introspection" (p.35). According to Kohut (1977), vicarious introspection essentially indicates that, through empathy, "the therapist self object can replicate and extend the patient's experience within his or her own mind".

In this way the therapist's identification with the patient is intensified, resulting in an increased effective empathic understanding. A by product of this process of vicarious introspection is the strengthening of the cohesion of the analysand's self and an increase in the analysand's self esteem and feeling of well being. Through the adoption of an empathic stance, the therapist allows him/herself to experience and be effected by the client's experience (Wolf, 1988), this in turn provides insight into the client's subjective world.

Some theorists, however, question whether empathic immersion is sufficient, Swartz (2004) views empathic immersion as a form of subjugation to the subjectivity of another and that this state allows patients to use the therapist as an object as opposed to relating to the therapist as a subject (Benjamin, 1990). According to Schwaber (1983) there are many examples from the psychoanalytic literature which demonstrate how therapists, of all theoretical persuasions, have been obstructed in their listening and understanding of their patient's material by failing to take into account the influence of their theories and their own personal approaches on the patient's material. What appears to be limited within the theory of Self Psychology is the recognition of the therapist's own subjectivity and its impact on the therapeutic space. Intersubjective theory offers an avenue for the acknowledgement of sometimes very different subjectivities within therapy and explores the space that is generated *between* as opposed to *within* subjects.

2.8: INTERSUBJECTIVITY

It appears that definitions of Intersubjectivity in Psychoanalysis vary according to the theoretical contexts within which they reside, however, all share an interest in subjectivity as central to our experience of the world and problematise the possibility of analytic neutrality or objectivity (Swartz, 2004, Ogden, 1994; Benjamin, 1990).

Within Intersubjective theory there also appears to be a unanimous acceptance of a sense that the material of the therapeutic encounter is “deeply affected by mutual adaptation and influence” (Swartz, 2004, p.7). The term *intersubjectivity* then refers to the field of intersection between two subjectivities; the interplay between two different subjective worlds which define the analytic situation (Atwood & Stolorow, 1984; Stolorow, Brandschaft, & Atwood 1987, in Benjamin 1990).

Stolorow and his associates (Atwood & Stolorow 1984, Stolorow, Orange & Atwood 1997) have linked their intersubjective perspective to Self Psychology. They see Intersubjective analysis as the detection of the conjunction or disjunction of the two subjectivities, thus enabling the therapist to become a more effective self-object. They have developed a theory of the self as being fluid, multi-dimensional and context-sensitive (Stolorow, Orange & Atwood, 1997). In their view, both patient and therapist co-create the self anew in each session, within “an intersubjective field, a system formed by the reciprocal interplay between two (or more) subjective worlds”(p.4.).

Intersubjective theory postulates that the other must be recognized as another subject in order for the self to fully experience his or her subjectivity in the other's presence (Benjamin, 1990)

2.8.1: The recognition of difference

One of the central tenets of Intersubjective theory is that we bring to every case our own subjective ideas about whatever is under consideration. Patient and therapist do not, however, simply bring to the therapy two separate and very private lives, with the only result being that the therapist and patient come to understand the patient's private world. Rather, the two people understand and change each other during the process of co-creating the therapy. Even as this approach considers how the therapeutic process is co-created by two equally valid subjectivities, it also takes into account how broader contextual issues may impact on subjectivity (Natterson & Friedman, 1995).

In the past, cultural difference had been emphasised in order to legitimise racism (Harvey, 1990) and some authors have wondered whether this has subsequently led to what seems like an avoidance of notions of race/gender and class issues between subjects within therapy (Flax, 2004). Yet in a South African context, race/ gender and class continue to form an integral part of our identities (Gibson., Swartz & Sandenbergh, 2002), and to not acknowledge this runs the risk of ignoring a significant aspect of our experiences in relation to each other. In the South African context, with a history of entrenched racial discrimination, the avoidance of talking about cultural difference can be understood in terms of a reluctance to create difference between people, and a resistance

against perpetuating the historical racist perspective which saw Black, Indian, Coloured and White people as fundamentally different and incompatible (Gibson, Swartz & Sandenbergh, 2002). Ridley (1995), however, comments on how it is possible for therapists to inadvertently engage in unintentional acts of racism due to their own unexamined, and often unconscious beliefs about individuals from cultural backgrounds which are different to their own.

In engaging in what Ridley (1995) calls 'cultural ambivalence', and ignoring the exploration of cultural difference in therapy, one runs the risk of "an inadequate understanding of the individual and an inability to maximally assist them in achieving therapeutic goals" (p.92). Race/ gender and class permeate South African life in every dimension and Flax (2004) posits that there is no ungendered, raced subject and no unracial gendered space. Flax (2004) goes on to argue that "suspending the reality question or rejecting construing objective/ subjective as binary enables us to hold in mind the complexity of race and gender; it is a social fact, a socially constructed category, a possible site of intensely subjective fantasy" (p.6). In addition, race relations remain so charged and obdurately malignant partially because they are simultaneously intra- and intersubjective (Flax, 2004).

Swartz (2004) posits that Intersubjective therapy foregrounds mutual recognition and survival of difference, and paradoxically in this is contained the possibility of negotiation beyond the "dynamic of domination" (p.14). Talking about the 'persistence of splitting and gender polarity in our structure of individuality', Benjamin comments: "To uncover this persistence is to confront the original sin of denying recognition to the other, and to

rediscover the lost tension between self and other. This tension, a fragile balance, to be sure, can only be sustained through the lived experience of recognition, the meeting of separate minds” (Benjamin 1990, p.84). Swartz (2003) states that the “recognition of difference creates the possibility of two separate subjectivities” (p.3). However, the discourse around ‘culture’ and “cultural ambivalence” (Ridley, 1995) appears to be a euphemism employed as a defence against naming the painful and complex issues of race, gender, class and power which inevitably enter the therapeutic space.

Thus Swartz (2004), argues that feminists and intersubjectivists may have legitimate grievances pertaining to perceived theoretical omissions, for example feminists may accuse many intersubjectivists of ignoring dynamics pertaining to race, gender, class and power, whereas intersubjectivists may accuse feminists of the reification of specific aspects of the relational construction of reality such as gender-power dynamics.

In an attempt to reconcile African feminism and intersubjective theory, Swartz (2004) posits the view that it remains the challenge of these two paradigms to, engage in a relationship that “acknowledges gender, race, class and power relationships, is mindful of the effects on colonialism on subjectivity, is aware that colonialism has deeply affected access to voice and is therefore attentive to silence, accepts that the negotiation of the intersubjective space will be shaped by histories of oppression and the abuse of power, and yet will also assume that unique moments of meeting are not only possible, but essential to change” (p.7).

2.8.2: Intersubjectivity and Attachment Theory

Whilst Attachment theory illuminates traumatogenic developmental failures in the transference, Intersubjective theory suggests that the recognition of difference is also critical in the therapeutic encounter. Thus, the groundbreaking work of Stern (1985), Beebe (Beebe and Stern 1977; Beebe 1985; Beebe and Lachmann 1988) and Fonagy (2001) have illuminated how crucial the relationship of mutual influence is for early self-development. However, Benjamin (1990) points out, that in the mother-infant relationship, the mother is not simply an “object” who meets the infant’s basic needs. As the child develops, he or she comes to recognise mother as a separate subject with her own needs and desires, this often forgotten step is heralded by Benjamin (1990) as a major developmental element with profound implications for future relating. Beebe and Lachmann (1988) have also shown that self-regulation is achieved at this point through regulating the other: “I can change my own mental state by causing the other to be more or less stimulating. The joy of intersubjective attunement is: This *Other* can share my feeling” (Benjamin, 1990, p.67).

Benjamin’s (1990) intersubjective theorising argues that it is not only object usage that is important, but also object relating. She states that traditional intrapsychic theories fail to elaborate the difference between the object and the real other. She goes on to illustrate how Object Relations theory elucidates the relationship between other and self where the other is made object which, she states, fails to recognise the fact that the other is used as object without its own subjectivity given due recognition, a process which interferes with the ability to relate intersubjectively (Benjamin, 1990).

Benjamin's intersubjective theorising is predicated on mutual recognition, which is essentially an attunement to each other. With the premise that mutual recognition is important for future relating, trauma can then be understood to be the result of a failure to be related to, or the failure to relate to the other as a subject.

2.8.3: Intersubjectivity and Trauma

Intersubjective theorists, Stolorow and Atwood (1992) have elaborated on Kohut's understanding of trauma by suggesting that what is considered traumatic for the child is not the nature of the event, but the failure of the environment in being able to help the child manage the intolerable affect states. Atwood and Stolorow argue that "the essence of the trauma lies in the experience of unbearable affect" (1992, p.52).

Stolorow & Atwood (1992) view the analytic relationship as a powerful catalyst in the retraumatisation of the patient in that painful, thwarted developmental yearnings are activated in the transference. As Beebe and Lachmann (1988) have proposed, one of the main principles of the early dyad is that relatedness is characterized not by continuous harmony but by continuous disruption and repair (Beebe and Lachmann 1988). The patient's efforts to disengage from his/her "affective yearnings" for a connection with the analyst is always "evoked by perceptions of qualities or activities" (1992, p.59) of the analyst that resemble or call up the patient's fears or expectation of childhood trauma. The constant interplay between the twin subjectivities involved in the intersubjective dance determines "the passage of trauma" (Swartz, 2004, p.7). There is a range of options; retraumatization, an attack on the listener, or the possibility of healing through a

delivery of grief. Power, and in particular the dynamics of domination and subordination, in narratives of trauma, are crucial, and may intervene to subvert the course of healing. Swartz (2004) argues that unconscious trauma is expressed in relationships and that these relationships carry with them the possibility of a re-experiencing of particular elements of the past trauma.

2.9: REPETITION AND THE DELIVERY OF GRIEF

Russell (1998) argues that repetition is unavoidable. With the threat of repetition comes the possibility of change as well as a fear that “hope will again be crushed’ (Swartz, 2004, p.11). It appears that repetition, particularly within relationships, illustrates “we have not yet found a way to feel differently” (Russell 1998, p.21). Both Russell (1998) and Stern (1994) suggest that the more traumatic an experience has been in a patient’s life, the more likely the patient is to be wounded by the event(s) and the more likely the patient is to compulsively, if unconsciously repeat. The idea that repetition can be used to heal is posited by Russell (1998) as the great paradox within therapy; in order to facilitate healing, the patient faces the challenge of changing, while remaining the same. Swartz (2004) argues that trauma is always and forever available, that trauma will repeat is unavoidable, but it is in the shaping of successive repetitions that it may change its dimensions and offer an element of reparation.

Ornstein (1991) argues that when the therapist inadvertently repeats an element of a patient’s past trauma, even in a relatively well established transference, disruptions may occur. She goes on to argue that it is specifically at the time of these disruptions that the defences and anxieties around elements of past trauma may become visible to the therapist, and through interpretation, to the client. Ornstein (1991) states that

interpretations that focus on both the dynamic (here and now) as well as genetic (there and then) sources of vulnerability “ facilitate the reestablishment of empathic attunement, deepen the analytic process and provide insight which facilitates the acquisition of psychic structures that increase self cohesion so as to make habitual defences and symptomatic behaviour less necessary” (p.384). According to Stolorow (1991) retraumatisation occurs under two conditions; either a close replication of the original trauma occurs or a loss of a viable alternative mode of organising experience occurs.

Russell (1998) argues that retraumatisation can lead to resistance, both by the patient and therapist. What appears necessary, however, is that the resistance be granted saliency through recognition and in the interpretation made by the analyst, with particular attention given both to the intersubjective conjunctions and the intersubjective disjunctions. That the intersubjective space between therapist and client can breakdown as a result of disjunctions, is viewed as a common feature, what facilitates the delivery of grief however is the ability to restore or repair the relationship (Thomson, 1991).

Herman (2001) suggests that “the descent into mourning is at one the most necessary and the most dreaded task of recovery” (p.188). She goes on to argue that survivors of chronic childhood trauma face the task of grieving for the loss of the foundation of basic trust; the belief in a good parent. Secure, reparative relationships facilitate mourning and healing, after many repetitions, the moment comes when the telling of the traumatic narrative no longer arouses affects which threaten the self with fragmentation and the narrative becomes part of the survivor’s experience, but only a part of it. The delivery of grief therefore appears to be possible when the survivor “no longer devotes her life to

remembrance and mourning and begins to find her attention wandering back to ordinary life” (Herman 2001, p.195).

Flax (2004) uses the term ‘melancholia’ to describe how the historically privileged suffer from the denial of the full acknowledgement of the harm and losses they inflicted. This denial and the use of denigration as a defense against guilt for the historical context within which White subjects find themselves, blocks access to the delivery of grief.

It is not however only white South Africans who have blocked access to the delivery of grief, it is also the historically oppressed who have had to bear the projections of their oppressors. Swartz (2004) argues that within therapy there is an underlying wish to transmit traumatic experience so that it may be understood, but that within the relationship there is also defence against hope and against re-entering old realms of pain.

CONCLUSION

In this literature review I argue that women’s experience of trauma became *gendered* as far back as the 19th Century. The review highlighted that the rise of the feminist movement in Western Europe and America during the 20th Century precipitated a deconstruction of women’s narratives of trauma, which led to the expansion of the pre-existing of Post Traumatic Stress Disorder (PTSD) in an effort encapsulate women’s experiences of sexual abuse. It was argued that the current description of PTSD is still limited in that it does not currently acknowledge the experience of more chronic, insidious forms of trauma so often experienced by survivors of childhood sexual abuse and gender based violence. The review then examines how trauma and gender interact

within the South African context. Attachment theory was offered as a possible avenue for exploring the impact of chronic, insidious trauma on development with particular reference to BPD. The review utilised the theoretical paradigms of Self Psychology and Intersubjectivity, to explore the complex presentation of *trauma and power* in relation to gender, race and class within the therapeutic space. The review concluded by exploring whether a delivery of grief is possible intersubjectively if the multiple layers contributing to past trauma are not adequately acknowledged within therapy.

In the next chapter I will present methodological considerations, with a focus on the application of qualitative methods to this research which foregrounds the subjective experiences of its participants.

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CHAPTER THREE

METHODOLOGY

This chapter is a brief outline of the rationale for the selection of the single- case study methodology employed by this dissertation.

3.1: QUALITATIVE METHODOLOGY

The adoption of a qualitative research methodology in this dissertation enabled me to explore the critical conversations between the client and myself which centre around issues of race, gender and class. According to Denzin (2000) qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive practices that make the “world visible” (p.3). These interpretive practices transform the world, and are recorded through various methods, such as case notes. Understanding is central to qualitative research, under which the case study is subsumed, and is contrasted to the emphasis on explaining, characteristic of quantitative research. While understanding is not exclusive to the former, it does lend itself to a more thorough in-depth and open-ended process. Stake (1995) emphasises an empathic stance that is enabled through “thick description” (p.39) made possible by this methodology, which also permits the reader an empathic entry into the case. In foregrounding empathic relating and understanding, Dilthey (1994 in Stake, 1995) believes that the case study methodology correctly cautions against a search for fixed causes to human behaviour.

3.2: THE CASE STUDY

A case study is “a case-based research project that examines a single case, usually in considerable depth” (Edwards, 1998, p.37).

3.2.1: Limitations of the case study

This methodology is not without controversy in that the case study, as a research method has struggled over time to acquire the status associated with other forms of research (Yin, 1984). The case study’s struggle for legitimacy appears to centre on two key issues. The first concerns the recognition that because the “therapist herself is so embedded in the process (in influencing it both directly and indirectly and also in terms of understanding what is taking place), it is difficult for current scientists to regard the analytic situation as a kind of laboratory or the analyst as simply a neutral observer” (Mitchell & Black, 1995, p.225).

Alderfer (1984 in Stake, 1995) has responded to this criticism by labelling the inclusion of the researcher as “self effects” and argues for an acknowledgement that while the personal and professional identity of the researcher is often blurred, it remains suppressed and hidden by conventional positivist methodologies. Thus, the critique that researchers are embedded within the process should not be limited to case study research alone.

As Donmoyer (2000) points out, whatever type of research methodology is employed, discussion of the “role of paradigms in research reminds us that researchers must inevitably rely on an a priori conceptualisation that is not determined by the data but, rather, determines what the data is” (p.51). Donmoyer (2000), goes on to argue that when clinicians use social scientists’ cause and effect findings, “they are also influenced by social scientists’ a priori conceptions of social action and social relationships” (p. 52)

The second critique of case studies focuses primarily on the notion of generalisation, and how it applies to case study research. As a case study is often thought of as a “constituent member of a target population”, and since “single members poorly represent whole populations, one case study is seen to be a poor basis for generalisation” (Stake, 2000, p.23). This view stems from the nature of accepted paradigms of research methodology, which, modelled on physics holds that the task of research of any phenomenon is concerned with the “identification and measurement of its key predictors and the mathematical functions that link them” (Edwards, 1998, p.11). This prevailing view, however, is itself open to criticism. For example, even “statistically significant findings from studies with huge, randomly selected samples cannot be applied directly to individuals in particular situations, skilled clinicians will always be required to determine whether a research generalisation applies to a particular individual” (Donmoyer, 2000, p.50-51).

3.2.2: Strengths of the single case study

In response to the criticism levelled at the case study methodology, researchers (Edwards, 1998; Lincoln & Guba, 2000; Schofield, 2000 in Stake, 2000), have made the claim that the case study method is not simply “a somewhat secondary tool for the serious work of scientific hypothesis testing” (Mahrer, 1988, p.697). Arguing rather that case study research has a “central place in the development of systematic and valuable knowledge” (Edwards, 1998, p.12).

Edwards (1998) highlights the validity of the case study by arguing that the “intensive, largely retrospective study of individual cases can be as rigorous and informative as the extensive, prospective study of samples of people, whether in survey or experiments. One can generalise from individual cases, and many important real- life problems cannot be studied effectively, or at all by experimental methods of enquiry”(p.13).

Furthermore, Edwards (1998) argues that “in the field of psychotherapy, careful and systematic observation and description of individual cases has been the cornerstone on which the development of scientific knowledge has been built”(p.10). In motivating for the case study over other methodologies, Yin (1984) illustrates its value in exploring material that will explore an understanding of ‘why’ and ‘how’ a subject behaves and engages in a particular way within real-life contexts (Yin, 1984). Case studies appear to be particularly useful when describing the context within which an intervention has occurred and to explain causal links which are too complex for surveys or experimental designs.

The case study has grown into prominence as a research method and has been lauded for its value in being able to provide an in-depth and thorough study of a single case (Yin, 1984). The case study method aims to probe, in an effort to grasp realities that are sometimes elusive, often complex and always personal. Stake (1995) maintains that when we study issues we are attempting to understand dynamics that are intricately and sometimes disturbingly wound up within political, social, economic, historical and personal contexts.

An immediate advantage of this methodology is that “case studies can take us to places where most of us would not have an opportunity to go” (Donmoyer, 2000, p.61). This method of research is one which requires self-reflexivity, allows for qualitative depth and incorporates an attention to the research context, which includes the researcher as part of that context (Yin, 1984). The case study, unlike other research methods, is not overly concerned with the general, but with the specific, that is the particularities of a single case and an interest in understanding what is happening (Stake, 1995). Intrinsically related to understanding is the interpretation made by the researcher who reminds mindful of its impact on the material.

3.3 WHY USE THE CASE STUDY TO STUDY TRAUMA?

The qualitative case study is a method whereby attention may be drawn to the relevance of the *subjective* experience of trauma, and has for that reason often been the preferred choice for research in the psychodynamic arena.

Armsworth and Holaday (1993) posit the argument that the number of trauma-related symptoms not currently incorporated in the diagnosis of PTSD, increases the importance of research that focuses on the qualitative importance of these symptoms. In addition, the degree of variance in response to traumatic events may be lost in quantitative analysis. Another important reason for selecting the single case study methodology is found in Stolorow and Atwood's (1992) definition of trauma which highlights that the essence of trauma lies in the subjects *experience* of unbearable affect. It was therefore deemed appropriate to select a methodology which would enable me to explore the subjective experience of trauma not only of the client, but of the therapist as well.

Russell (1998, p.9), suggests that the unconscious elements of transferences and defenses such as splitting and dissociation come to be the "personal stories of tragedy, trauma and loss". He adds that the management of these elements, which are often traumatic repetitions within the psychodynamic context, is crucial for the recovery process. A psychodynamic understanding and management of a trauma case, therefore, allows the subjective reconstruction of the memory that has adversely affected the survivor's inner sense of self.

3.4. THE CURRENT CASE STUDY

The case study design was considered appropriate for this case as it afforded me a rich opportunity to work with the unique constellation of a multilayered presentation.

In the case under discussion one sees that the client's personal dynamics, as well as the intersubjective dynamics within therapy are inexorably linked to the socio-political milieu within South Africa. Utilising the case study methodology provides an opportunity to explore the client's as well as the therapist's experience from multiple vantage points, including the social and psychological.

During the analysis of the material presented within this dissertation, I, as the therapist, have attempted to adopt a stance of self reflexivity in order to acknowledge my own experiences as far as possible with regard to the influences which they may have on the interpretation of the material. Rather than adopting the view that the therapist's subjectivity was an unhelpful hindrance to the research (and therapeutic) process, I argue that my self reflexivity and impact on the therapeutic process is a key focus of the research.

Case studies appear to range from those designed to challenge and test developed theories to largely descriptive accounts. The rich material generated through understanding can be conveyed through testimonies, key episodes and/or narratives, as opposed to quantitative methods that draw on scales and measurements. The basic method employed in this research study, which describes the complex nature of the intersubjective space between a male therapist and female survivor of gender based violence, is hermeneutic-psychoanalytic in nature. The reason for the adoption of the hermeneutic-psychoanalytic perspective, is that it tries to incorporate the inevitability of the impact of the researcher. This position allows for an acknowledgement of how the interpretative lenses which researchers bring to the research material are formed out of their cultural ideological

climate (Kincheloe & MacLaren, 2000) and how those interpretative lenses are shaped by their individual unconscious processes (Hollway & Jefferson, 2000). Thus in this case study, I am able to acknowledge how the decision to include or exclude certain material in this dissertation was undoubtedly shaped by both my conscious and unconscious processes and would no doubt differ from that of other researchers. The un/conscious processes that shaped this dissertation will undoubtedly impact on the findings, which once again highlights the impossibility of adopting an *a priori*, or objective understanding of a subjects experience of trauma.

3.4.1: Analysis of the case

In the case under discussion I have chosen to present the material as narrative vignettes. Key episodes are highlighted with the purpose of not only illustrating the presentation of the material, but with the more important purpose of demonstrating the potentialities generated within the psychotherapeutic space between two subjectivities.

Therapy was conducted at a university clinic in 2003 during my 1st year of training as a clinical psychologist and from an out patient facility during my intern placement in 2004. Extensive, detailed therapy notes were kept and written directly after each session from the researcher's memory of the events that transpired during the session.

The sessions were then presented to my supervisor each week, which allowed for a psychodynamic-intersubjective interpretation of the case material. Hollway & Jefferson (2000) point out that in qualitative research, meanings evolve out of the particular

intersubjectivist context made up by the researcher and the research participant, and are not objectively 'found' by the researcher.

For the purpose of this case study, certain material has been extracted from the 37 sessions and have been presented as clinical vignettes which illustrate specific themes relating to the patient's longitudinal history of trauma and how this trauma inhabited the therapeutic space.

3.5: ETHICAL CONSIDERATIONS

Multiple issues pertaining to the ethical nature of the research were considered and discussed within supervision. I chose to inform the patient of my wish to write the case material up for the purposes of this dissertation. Although certain authors (Stake, 1995) caution against informing patients of research undertaken due to the impact it may have on clinical material, consent was requested from the patient to write the case up in order to acknowledge issues related to power, with respect to domination and subordination, which could have un/consciously been repeated by omitting to seek the patient's permission. The patient granted permission to write up her case within my dissertation as long as I took every care to conceal her biographical details and protected her confidentiality. The effects of the patient's permission to write about her case allowed us to discuss openly whether specific themes would be included within the current text. This proved therapeutic with regard to our exploration of themes which the patient was anxious to have documented. The patient has been informed as to the argument put forward in this dissertation and has given full consent for the use of the biographical data

contained within. The following research complies fully with the American Psychological Associations ethical principles in the conduct of research with human participants (Christensen, 1980, pp.332-340).

The procedure adopted in this study enabled the therapist to arrive at the deeper understanding of the intersubjective space generated during 37 sessions which stretched over an over an eleven month period. The sessions began in June 2003 and will culminate in a termination in December of 2004. Sessions were held once a week, there were numerous missed sessions and the reasons for this will be explored in the analysis section.

CONCLUSION

For the reasons outlined above, it was considered appropriate to employ a single case study design to illuminate particular aspects of the client's narrative and enabled the researcher to focus on both the client's, as well as the therapist's multi-layered experience of trauma. In conjunction with the selection of the case study methodology, the use of clinical vignettes enabled an exploration of the intersubjective space generated within therapy.

CHAPTER FOUR

CASE HISTORY

The following chapter describes the case history and the course of therapy with the client. The chapter concludes with a formulation and diagnosis made during the early stages of our therapeutic contact.

4.1: INTAKE, COUPLE COUNSELLING AND PSYCHOMETRIC ASSESSMENT

Chantelle is a thirty-five year old woman who referred her son to a clinic (where I was completing the first year of my clinical psychology training) for a psychometric assessment. She arrived with her husband, Ron², her 10 year old son, Miguel and her youngest child, Brad. Chantelle was neatly dressed with short, curly, copper coloured hair and of average height and weight. During the initial intake interview her affect appeared slightly anxious and she answered questions put to her with short, almost curt answers, this was, however, counterbalanced by an almost adolescent, playful air on occasion when her son was not present. In the interview, she attempted to conceal her underlying anxiety with the aforementioned playfulness, but her description of the presenting problem evidenced that she was finding it increasingly difficult to manage her outbursts of anger and was struggling, on a host of different levels, in dealing with her son as he matured. She claimed that Miguel was not doing as well as he should academically and that despite her attempts to work with him on his school work he was “*very slow and irritating*”.

² I have used pseudonyms throughout in order to protect identity.

She felt that she was becoming increasingly frustrated and angry with him, and during the intake after asking Miguel to leave the room, she revealed that she feared that his poor academic performance may in some way be linked to the circumstances of his conception. Miguel had been conceived during a rape. It soon became apparent that besides this and other significant experiences of trauma in Chanelle's life, her marriage to Ron was also in distress. During the intake, her husband Roy attributed their marital difficulties to Chantelle becoming "*hysterical*" normally in the context of what was reported as rageful attacks directed towards Ron and Miguel

In supervision it was decided that an intervention which focused primarily on strengthening the couple subsystem would positively affect the family system. A further option for individual therapy was offered to Chantelle once the couple therapy was completed. Her son Miguel was referred to another intern during this time for psychometric and emotional assessments.

The psychometric assessments revealed that Miguel had significant learning difficulties and emotional problems. Collateral gathered from his teachers at school sketched a child who was socially isolated from his peers, and would often exhibit somatic complaints on the morning of class tests. A particular teacher also flagged that Chantelle had only recently begun showing an interest in her child's academic development. The same teacher also referred to there "*being something emotionally wrong*" with Miguel as she had often found him crying in the past weeks for no apparent reason. A Thematic Aperception Test (TAT) carried out in conjunction with his psychometric assessment revealed "*the prominent presence of a 'forbidding' woman who prevents the following of*

personal intention. The feeling is that everything will be disallowed or disapproved of. There was a single occasion where forceful expression of aggression occurs, which is directed at a woman, although only when the restraining woman is not about"

(psychometric report, 30 September 2003). According to the intern who assessed him Miguel often referred to his mother as a critical woman who would beat him whenever he did not perform well at school, or do his chores at home. Miguel was placed on the waiting list for a learners support group in 2004 and is currently enrolled in the programme.

In an effort to strengthen the couple subsystem, which appeared to be severely compromised, a period of six couple therapy sessions was contracted with Chantelle and Ron. Initially, both parties appeared to agree that the primary precipitant for the distress within the couple system centred around Chantelle's rageful attacks on Ron and Miguel. Ron claimed that the attacks directed towards him by Chantelle centred primarily around his role as a father to Miguel, as well as his role as a husband, which left him feeling frustrated and 'impotent'.

The couple had not had sexual relations for a number of months and Ron attributed their lack of intimacy to Chantelle's unresolved 'issues' pertaining to her history of sexual abuse. At first Chantelle appeared to agree with Ron's views as to the cause of the disquiet, however, by the third couple session, Chantelle was able to offer differing view, she became more animated and at times directly oppositional to both Ron and myself. My countertransference response during this time was to feel helpless, as I was often anxious not to be seen to be in a gendered alliance with Ron. Chantelle began to use the space

afforded to her in therapy during this time to voice criticism regarding Ron's treatment of Miguel. She portrayed Ron as an unloving father who ostracised Miguel due to him not being Ron's biological son. Within the couple sessions, Ron began to withdraw and became guarded.

According to Chantelle, Ron would not attend subsequent sessions after the couple had discussed Chantelle's perception that Ron was not an adequate father figure. Six couple sessions took nine weeks due to numerous cancellations. As we approached the termination of the couple sessions, Chantelle expressed a desire to continue therapy on her own. It seemed that Ron was relieved at the prospect and great pains were taken during termination to put forward the hypothesis that 'fault' did not lie in Chantelle and that any resolution of the couples difficulties would have to be addressed and negotiated equally by both parties.

The focus of this dissertation will, however, remain on the individual therapy sessions conducted between Chantelle and I.

4.2: INDIVIDUAL THERAPY

Chantelle entered individual therapy in an attempt to explore the conflictual nature within her close interpersonal relationships. She felt that elements of her traumatic past may in some way be contributing to the irritability and frustration which characterised her interactions with men, with her husband and son in particular.

She stated that she had ambivalent feelings towards men after her rape and was reluctant to marry, but felt that her son needed a father. Ron has two sons aged 12 and 8 from two previous relationships. Each of the children lived with their respective mothers and Ron had intermittent contact with them, primarily due to what he termed, Chantelle's "*emotionally violent*" reaction towards him when he would make contact with his sons.

4.2.1: Early upbringing and childhood experiences

Chantelle's rape was not an isolated, unusual traumatic occurrence in her life. The physical and emotional abuse that Chantelle experienced as a result of her rape, represented a continuation of a common theme in her life, i.e. that of chronic trauma. Chantelle's childhood experiences appear to be characterised by extreme feelings of powerlessness and helplessness in the face of ongoing sexual abuse and emotional neglect.

Chantelle is the eldest of eight children and one of two daughters born to her parents. Chantelle was the result of an unplanned pregnancy. Her earliest recollection, at around three years of age, is of her father waking her and taking her and her brother to stay at her maternal grandmother's house in the dead of night, in an effort to protect them from her mother's drunken rage. Soon after that night, her father returned to collect his son, but left her with Chantelle's grandmother for a year and a half, during which time she had irregular contact with her parents. She recalls that the time spent with her paternal grandmother and aunt was a nourishing time, that she was treated as "*someone special*" and that she felt "*safe*".

Due to a prolonged separation between Chantelle's mother and father, Chantelle's mother wanted her children close to her and Chantelle was placed back in the care of her mother when she was between five and six years of age. She describes how traumatic the separation from her grandmother was; she clung to her grandmother's skirt, screamed and begged to remain with her, she recalls feeling terribly betrayed by her grandmother.

Once she returned home she remembers these early years as being filled by terror, particularly because she would often witness her mother being physically assaulted by numerous lovers and was often subjected to physical abuse when she attempted to intervene. She cried in sessions and spoke in depth of how she had often been shamed in front of her mother's lovers by her mother and that during a time when her mother went to the '*smokkelhuis*' (shabean), a naked man had asked Chantelle to massage his genitals. Chantelle often wept when she recounted her mother's inconsistent reactions to her attempts to rescue her when Chantelle's mother was being physically abused by her lovers. After her mother had been beaten, Chantelle would often be beaten by her mother whereupon Chantelle would run back to her grandmother's house to seek solace. Whilst Chantelle's grandmother lived in the same neighbourhood and tried, at times, to be a source of support for her, she was powerless to prevent Chantelle's ongoing exposure to and experience of violence. Chantelle recalls how her mother would often come and find her at her grandmother's house and would drag her from underneath her grandmother's bed, where she hid from her mother's rage. Her grandmother never protected Chantelle from her mother's rage. As a result, she felt that there was no one that she could turn to, since everyone, including her grandmother, seemed to be afraid of her mother.

During the early 1970's Chantelle's mother and her young siblings were subjected to particularly harsh socio-economic conditions, primarily due to the limited employment opportunities afforded Coloured people during Apartheid. The family lived in one room at the back of a relative's home and would often go to sleep hungry. Chantelle recounts how they often had to rely on the goodwill of her father's friends and neighbours to feed and clothe them.

On rare occasions when her father would return home, he would seek Chantelle out and produce a marshmallow fish from his pocket, Chantelle still sees these fish as a source of comfort and often eats them when she is feeling 'low'. After spending some time with her, her father and mother would invariably drink, argue and then physically assault each other whilst Chantelle hid in the cupboard praying that her father would remain and protect her. She states "*he always left, but he wasn't only leaving my mother, he was rejecting me*". Throughout the above experiences, Chantelle indicated that her father did little to protect her from her mother's rage and that he too, on occasion, had beaten her when he had been drunk.

Her relationship with her other siblings appears to have been largely distant. As the eldest sibling, Chantelle would often find that she would be responsible for the care of her younger siblings, particularly when her mother had been drinking. Chantelle remembers feeling that this was a burden that "*was too much for a child to bear*". She recalls how her younger siblings would cower around her when her mother became enraged, but that she had nowhere to hide and no way to protect them or herself.

During the course of therapy it emerged that Chantelle had been chronically sexually abused by her mother's brother between the ages of 7 and 10, when her uncle often slept over in the cramped living conditions. She recalls how he often used to take her walking in the veld and would ask her to perform fellatio on him in exchange for “*about 50 cents*”, she would often take the money and buy marshmallow fish and would phantasise about how her father would come and kill her uncle.

Chantelle did not tell anyone about the abuse because her uncle had told her “*that something terrible would happen*” if she disclosed. She recalls that the only person she felt she could trust was her grandmother, but that her grandmother had always been fond of her uncle and Chantelle did not want to destabilise the fragile alliance she had with her grandmother. When Chantelle was approximately 6 years old she began school. She remembers hoping that going to school would provide some solace from her domestic circumstances, but this was not to be. At school Chantelle recalls how she was often denigrated by other children who accused her and her mother of being prostitutes. She wept when she described how other children called her a ‘*kaffir*’³ because she had no shoes and could speak Xhosa. She stated “*It got so bad, I wanted to kill some of them, especially the teachers for not protecting me*”. Chantelle recalled feeling isolated and being taunted with racist slurs on the playground.

³ ‘Kaffir’ is a highly offensive term used mainly by segments of the White South African population to refer to Black people.

Soon after Chantelle reached highschool her parents reconciled and although they were both still drinking heavily, she says her parents made inconsistent attempts at winning her favour. Her isolation continued in high school until she was befriended by a group of young men. She recounts that she never felt threatened by them as they protected her from others, she soon began to adopt their style of clothing and began to use their colloquialisms. During this time she says that she felt empowered for the first time in her life and often wondered what it would be like to be a man.

During her matric year, Chantelle's parents joined a charismatic church group and subsequently stopped drinking. During this time, her mother imposed the church's strict belief system on her children and Chantelle was drafted into the service of the church as a peer counsellor. A fellow male counsellor invited her on a date during which time he made sexual 'overtures' towards Chantelle. She recalls how this left her feeling confused and angry regarding her sexuality in that she did not view herself "*as a sexual person*", she recounts how she was "*angry that he saw me in that way that I wanted to kick him where it really hurt*". As a result of the conflict between her and the counsellor she was prohibited from attending the matric dance which she cites as the biggest regret of her life as it served to confirm for her that she was "*different*".

4.2.2: Adulthood

When Chantelle matriculated she went to study Social Work at a University. She began a friendship with a man named Ibrahim, she says that she spurned his sexual advances as she was afraid of having sex because of her past "*abusive*" sexual experiences with men.

During this time Chantelle was still living at home and although the family had moved to more spacious accommodation she felt that her mother was “*always in my business*” and that she had changed from being the absent mother into an overwhelming, overinvolved presence in her life. Chantelle “*dropped out*” of university due to a lack of funds, which her father had promised to provide for her. She claims that the lack of financial support she received from her father was akin to the emotional neglect she experienced as a child, it reinforced her feeling of “*not being worth the investment*”. Shortly thereafter Chantelle went to work for a non governmental organisation working with gender based violence as she said that she wanted to help people who had been in similar situations to her mother and herself.

When Chantelle was 24 years old she was raped by Ibrahim upon her return home from church one evening, she was a virgin at the time. During therapy she disclosed that she had actually been raped twice by Ibrahim on two separate occasions and that she believes that not disclosing the rape to the police the first time led to the second rape. The level of violence used during both rapes was extreme and Chantelle had almost lost consciousness during the second rape due to Ibrahim’s use of a leaden pipe in the attack. She did not disclose to anyone on either occasion as she was afraid that people would believe that she had been complicit in the rape. After the second rape, Chantelle attempted suicide on three separate occasions. She recalls that after drinking alcohol and taking pills during the second attempt, she was hospitalised and it was at this time that she discovered that she was pregnant. She unsuccessfully attempted to abort the foetus in her second trimester, she said she felt “*dirty, as if there was hate in my belly*”.

When it became evident that Chantelle was pregnant, she informed her mother and was subsequently blamed for the rape by her mother who said that she must have “*brought it on [herself]*”. Chantelle fled to her grandmother and her son, Miguel, was born later that same year. After his birth Chantelle refused “*to become involved in his life*” and turned over his care to her grandmother. She began work in an optical suppliers firm three weeks after his birth.

During this time Chantelle was still, however, subjected to what she calls “*vicious rumours*” from within the community which prompted her to approach the police and lay a charge against Ibrahim. Chantelle says that the charges were never followed up by the police and she eventually chose to “*forget that it had ever happened*”.

Chantelle recounts how during this time she began to argue with friends and family “*over everything*” and feels that her family withdrew from her. She moved out of her grandmother’s house and went to seek accommodation with a friend who also took over the care of Miguel. When Miguel was three years old Chantelle began to re-establish closer contact with her family and returned to live with her grandmother. She says that her grandmother was a healing influence in her life during this time and was responsible for fostering a closer relationship between herself and Miguel. She often saw Ibrahim in her neighbourhood and a year later was successful in establishing paternity through a DNA test.

She claims that she pursued the paternity test in order to “*make Ibrahim pay for what he had done*”. She has, as yet, received no financial assistance from Ibrahim. After the DNA test proved that Ibrahim was Miguel’s father, she says that she felt “*validated*” by the result, and began to socialise to a greater extent. It is at this time that she met her current husband, Ron, and married him four months later as she felt that her son “*deserved a real father*”.

4.2.3: Chantelle’s relationship with Ron

The relationship between Ron and Chantelle was described by Chantelle as being stable and secure, if not passionate, during the first five years until Miguel began school. At this time Chantelle reports that there was a conflict over Miguel’s surname, as he still held Chantelle’s maiden name. According to Chantelle, Ron stubbornly refused to adopt Miguel as he felt that Miguel “*was not good enough to be a [Ron’s surname]*”. Chantelle claims that Ron’s refusal brought back a lot of memories of being excluded at school and she was unable to contain her anger at Ron and would often “*shut him out of my life for days*”. Miguel struggled at school and failed grade 2 twice at different schools. Chantelle reported that Miguel’s poor performance at school during this time may have been related to what she termed as “*Ron’s inability to accept him as his own*”.

In 2000, Chantelle claims that her relationship’s with Ron and Miguel began to deteriorate significantly. She was unable to link the precipitous deterioration with any particular event, but states that “*just looking at them would make [me] so angry*”. Other relationships during this time also appear to have been a source of conflict, for example,

Chantelle moved Miguel to three different schools in 2000 due to conflicts with his teachers over his performance. Chantelle felt that his poor school performance was linked to them being poor teachers.

During this time, Chantelle reports that she often fought with members of Ron's family as she felt that they were excluding her and Miguel from "*their hearts*". Although Chantelle was exhausted by her constant conflicts with those around her, she fell pregnant in 2000, she claims that she fell pregnant to demonstrate to Ron's family and to the mothers of his children, that she was "*here to stay*". Soon after the birth of her second son, Brad, Chantelle initiated contact with Ibrahim through her grandmother in an effort to forge a link between Miguel and his biological father. Chantelle claims that she did this due to Ron's inability to be a "*real*" father to Miguel. She stated that she also initiated Miguel and his father's first meeting as she had "*known what it was like to have a weak father*".

Chantelle organised the meeting through her grandmother as she states that she did not want to encounter Ibrahim "*face to face*" as she was afraid that she would not be able to contain her rage towards him. Soon after Miguel's met his father, he began to ask Chantelle for more visits. Currently, Miguel sees Ibrahim intermittently, an arrangement, which she claims places great strain on her marriage. Chantelle claims that Miguel's poor academic performance, her marital difficulties as well as her difficulties in managing her anger towards her husband and Miguel, prompted her to bring Miguel to the clinic in June of 2003.

4.2.4: Chantelle's understanding of why she was coming for treatment

Chantelle's pattern of ambivalent relationships towards men due to the pattern of violence and abuse that had been prevalent in her life was one of the reasons she presented her son to the university clinic for an assessment. She complained that men had always wanted "*something from [me]*" and that she was "*sick and tired*" of being taken advantage of. She said that her resentment towards men was beginning to affect her relationship with her husband and two children and that as her immediate, nuclear family were all men, that she felt that she needed to gain insight into why she felt so overwhelmed by her feelings of anger. Chantelle commented that prior to coming to therapy she had often phantasised about what life would be like without her son Miguel and during one session said "*sometimes I wish he were dead... God forgive me*".

Not surprisingly, Chantelle felt that in the midst of all of this she was "*coming to pieces*". Chantelle stated that she often felt disorganised and described herself as being scattered. She did not have the subjective experience of feeling herself as a synthesised whole. In this mental state she tended to polarise her surroundings and persons in terms of good and bad, although most of them were in the bad category.

She was struggling to restrain her temper at work, especially with her male supervisor whom she felt was overtly sexual in his dealings with her, although she was unsure if this was the case or whether she was interpreting the situation in a negative light due to her past experience. Chantelle stated that "*other people*" had often commented that she appeared to be depressed.

She complained of feeling “low”, constantly fatigued, with reduced appetite and social withdrawal. While not being actively suicidal, she entertained thoughts of death on occasion, particularly when she had thoughts of harming her son. She stated “*sometimes I feel so guilty for wanting a different life, for wanting to be free from my responsibilities, but I know that I will never escape and I’m sick of it*”. Chantelle’s re-establishment of contact with Ibrahim, in an effort to provide her son with a father figure, had also left her feeling confused and shamed.

4.3: DIAGNOSIS AND FORMULATION

4.3.1: Diagnosis

The following provisional diagnosis was made soon after the history taking conducted during individual therapy. This diagnosis was however questioned during the course of her individual therapy for reasons which will be discussed in the following section.

Axis I: Dysthymic Disorder

Axis II: Borderline Personality Disorder

Axis III: None

Axis IV: Problems with primary support group

Axis V: GAF 60-70

4.3.2: Formulation

A rudimentary formulation of the case was made during the initial stages of therapy which led to a provisional diagnosis.

“Chantelle has experienced multiple trauma’s from an early age as a result of being born into a dysfunctional family. Separations, abuse by her mother, a largely absent father and childhood sexual abuse all contributed to Chantelle’s often distressing world and emotional turmoil. Unable to receive the containment so crucial during critical developmental periods, Chantelle had no-one to soothe her affective states. As a result she developed particular mechanisms such as splitting and projection to compensate for a world which was often chaotic and disempowering. The childhood sexual abuse further intensified her feelings of helplessness and her internal world came to be constructed in split-off polarities, aggression from subservience, isolation from pain and shame. Her early experiences also affected her ability to trust men, this trust ‘deficiency’ (Brothers, 1995) is currently evident in her inability to view men such as her husband and son, as trustworthy providers of secure, nourishing experiences. Chronic trauma has also stripped Charmaine of her ability to regulate her outbursts of rage towards others, her rage is utilised as a defense to protect her shattered self” (first formulation, August 2003). This formulation has, however, evolved and grown as my understanding of the case, as well as my impact on the material, has deepened.

CONCLUSION

In retrospect, we initially followed an unusual route i.e. from a family intake, through the six couple sessions, to individual therapy. This process has, however, provided me with valuable information regarding Chantelle's relationships which I may have been unable to access through Chantelle's narrative alone. The following chapter moves on to explore the intersubjective dynamics which were evoked between Chantelle and myself within therapy and how these dynamics were informed by both of our histories.

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CHAPTER FIVE

THERAPY AND ANALYSIS

5.1: INTRODUCTION

The following chapter has a dual purpose. It will present and discuss selected clinical material which argues that psychotherapy is mutual; that it is an exchange occurring between two people and about two people (Natterson & Friedman, 1995). The material selected illustrates that each individual is constructed both by him/herself and by the other during the process of interaction, this is of particular salience when working psychodynamically within a South African context. The way in which particular discourses constructed the therapeutic space will also be explored, with particular emphasis on the twin discourses of race and gender. The chapter also outlines how particular developmental traumas were re-enacted within the therapeutic relationship and how the opportunity for change was often missed by not mutually recognising each other within therapy (Swartz, 2004). Furthermore, this chapter argues that the intern therapist's attempts at empathic immersion alone, has as yet, proved unsuccessful in providing the 'delivery of grief' which the client desperately seeks within therapy. In order to illustrate how unconscious processes were evoked within and *between* the client and myself, particularly with regards to trauma and power, Self Psychology and Intersubjective perspectives have been adopted.

I have also chosen to focus on my own subjective experience as an intern psychologist working psychodynamically, with a woman who has a chronic history of multiple traumas.

5.1.2: Outline of the analysis

The material presented in this chapter is divided into particular themes which emerged during therapy with the client. These themes are divided into the following subheadings:

1. The inevitability of empathic failure and subsequent repetition of past trauma.
2. The impact of race and gender on the therapeutic space.
3. Narcissistic transformations of the therapist.
4. Repetition and the delivery of grief.

5.2. THE INEVITABILITY OF EMPATHIC FAILURE AND SUBSEQUENT REPETITION OF PAST TRAUMA

As an inexperienced intern desperately defending against a history of institutionalized prejudice and racism, and recognising both the gender, race and class differences between Chantelle and myself, I quickly equipped myself with Kohutian ideals of empathic attunement (Kohut, 1977; Wolf, 1988) in an effort to overcome the disparities which existed between our experiences. I readily accepted the supposition that attending to Chantelle's traumatic narrative with sufficient, intense empathy would result in the strengthening of the cohesion of the client's self and an increase in her self esteem and feelings of well being (Wolf, 1988).

However, what my understanding of Self Psychology theory failed to address was the impact of my own subjectivity on the therapeutic process (Natterson & Friedman, 1995). It soon became evident, that being a white male in a country saturated in a discourse of historical oppression and gender based violence, evoked particular countertransference enactments brought about by my desperate attempts to distance myself from particularly sensitive issues. Many conflicting emotions related to race, gender and class were evoked within me by Chantelle's painful retelling of her experiences of chronic sexual abuse, gender based violence and socio-economic deprivation as a result of Apartheid.

In the time between the termination of the couple sessions and the first one on one session with Chantelle, I had made a brief mental psychodynamic formulation which linked Chantelle's difficulties within her interpersonal relationships with the men in her family, to her own attachment history as well as to her chronic experience of trauma. In supervision it was decided to focus the intervention on her experience of past trauma, in an effort to explore the dynamics which played themselves out in her current relationships and to link her defences with an underlying anxiety.

I eagerly awaited the beginning of our individual sessions as I had spent a great deal of time reading key texts on trauma and self psychology. I had also read widely on theory pertaining to psychic defences, boundaries, projective identification, repetition and a host of others. My expectations as to what would unfold during the therapeutic process were largely informed at this stage by my omnipotent phantasies as to how a client and therapist should 'behave' within therapy.

The following vignette illustrates how these omnipotent phantasies were challenged during the first session as I was attempting to ‘take’ a comprehensive history ‘from’ Chantelle.

5.2.1: “I don’t really know how this is supposed to work?”

C: I feel a little uneasy being here.

J: What is it that is making you feel this way?

C: I don’t know, maybe it’s because we are alone... I feel like I’m naked you know, exposed...

J: I wonder if that has anything to do with...(Chantelle interrupts)

C: It’s weird being here, I mean I don’t really know how this is supposed to work?

J: It sounds as if you are a little anxious about being here, how is this different... (am interrupted a second time)

C: It was easier when [Ron] was here... even if he is weak...

Chantelle’s anxiety was marked during our first session. Her anxiety almost immediately elicited a defensive reaction on my part as is demonstrated by my asking her what was making her feel anxious. My private reflections (not included in my case notes) on the session at the time, reveal that I interpreted her anxiety as somehow being as a result of my lack of empathic attunement, or lack of experience. Chantelle’s use of the words “naked and exposed” also raised my anxiety within the room as I became acutely aware of the unspoken spectre of repetition with regards to gender based violence.

Chantelle demonstrated her own exquisite unconscious attunement when she verbalised my own unconscious anxiety regarding my therapeutic ability, as can be seen in the statement “*I don’t know how this is supposed to work*”. In retrospect, this statement was both a veiled attack and a plea reminiscent of the polarities of affect often demonstrated by the borderline patient (Kernberg, 1984). The effect was almost instantaneous, my countertransference was heavily laden with anxiety, which I attempted to contain through illustrating my newfound understanding of psychodynamic interpretation. Once my attempts at interpretation were frustrated, the intersubjective space became saturated with the anxiety and uncertainty of both parties. Chantelle’s evocation of her perception of Ron as being a “*weak*” man felt punitive, and I experienced it as a commentary on my failure to provide her with a new facilitating selfobject experience (Stern, 1995), much in the same way as her selfobject experiences had failed her in the past. During the session I felt like the weak man, a position I have struggled to extricate myself from throughout the therapeutic process with Chantelle.

During this session I was unaware of being transferentially acted upon, the anger and anxiety which was present within Chantelle’s narrative was ignored, partially due to my unrelenting efforts to forge an empathic link with her. In retrospect, her use of the words “*weak man*” could refer to numerous proximal relationships with men in her life, ranging from her father, to the rapist, to her husband and ultimately to me. Chantelle cancelled the following two sessions which further undermined my idealised professional self and precipitated a narcissistic wounding which will be discussed in more depth in a later section on narcissistic transformations.

In supervision it was agreed that I attempt to ‘penetrate’ into the heart of her experience through vicarious introspection (Wolf, 1988), thereby attempting to avoid any enactment of defensive gender dynamics which had begun to take root within the therapeutic space. I distinctly remember how the use of the words ‘penetrate into’ by my supervisor further heightened my anxiety regarding the possible threat of retraumatising Chantelle, due to her prior experience of rape. It was this threat of retraumatisation that precipitated my decision to redouble my efforts in forging an empathic connection with Chantelle when she returned to therapy two weeks later.

During this session neither of us chose to address the therapeutic derailment and Chantelle went on to express how Miguel was a primary cause of her problems and that she experienced him as being “*just another man waiting to hurt someone*”. It was during this session that I became increasingly aware of my own masculinity and of the space it occupied within the room. The session was thick with Chantelle’s descriptions of Miguel as being a constant source of stress and disappointment; she consistently used words in ways which constructed him as something deserving of her rage. During the session she vacillated between extreme passivity and outbursts of rage. The following vignette illustrates examples of the anger and frustration which characterised large segments of her narrative.

5.2.2: “Do you think that he’ll grow up to be like his father?”

C: He is such a clumsy, stupid child, he drops things and gets in the way. At school his is just dof (stupid) you know...he frustrates me so much...sometimes I really just want to klap (hit) him...

(a silence follows) ...maybe it's his father you know, its strange, but often when I see [Miguel] walk from behind I see "the creep" [referring to his father]. I wonder ...do you think that he'll grow up to be like his father?

J: It sounds like you are really frustrated with Miguel at the moment and that maybe you are afraid that as he grows he will represent what you fear most in men?

C: Why do you people always answer with a question, I mean I've heard that people who abuse become abusers, I need to know so that I can prepare myself, so I can look for the signs...

This session served to illustrate how Chantelle had developed particular, largely rigid defences, such as displacement and rage which habitually protected her from retraumatisation which became evident through her selfobject transference. However, my limited experience left me ill prepared with regards to managing and understanding her experience of rage.

I struggled to remain empathically attuned to Chantelle, as she relentlessly extolled how she experienced her son as being "stupid" and how she often wanted to hit him. I was aware during the time of feeling great empathy for the plight of her son, even in his absence. As a father myself, I found it difficult to understand her constant expressions of rage towards her child. In retrospect I have become aware of her attempt to transmit elements of her traumatic experience, such as her experience of gender based violence, during the session. During the session her experience of trauma was always present, always available, particularly through the evocation of her experience of her child, due to the traumatic nature of his conception. "Do you think he will grow up to be like his

father” held within it the dread that history would in some way repeat, this dread hung heavy in the air, unanswered by me.

It appeared that by her asking me this question the responsibility for the trauma in Chantelle’s life was somehow being pinned to me, as if I would be able to exorcise the pain, or that by withholding an answer I was actively causing psychic trauma that had resulted from a much earlier experience (Swartz, 2004).

During this phase of the therapy, however, I was more aware that Chantelle’s affective reactions to my inevitably non attuned responses, was often experienced by me as being extreme and at the time, reinforced my diagnosis of pathology at the level of personality. In an effort to manage my rising anxiety evoked within the therapeutic space as a result of Chantelle’s perceived attacks upon her husband, her son and ultimately myself, I attempted to understand Chantelle’s experience of rage directed at men, through her presentation of symptoms. It became urgent for me to corral her rage, to deflect it from me, to make sense of it through diagnosis.

Chantelle’s use of primitive defences, her unstable affects and her unstable relationship and attachment history appeared to reinforce the diagnosis of a Borderline Personality Disorder (BPD), provided by the DSM-IV (APA, 1994). It is important to note that the adoption of BPD has done little to broaden my understanding of Chantelle’s inner world within therapy as I often came in ‘armed’ with theoretical understanding which compromised my ability to remain sensitive to the mutual interplay between our two subjectivities. The gathering of symptoms did, however, enable me to contain my own

anxieties in dealing with the nature and intensity of the traumatic material which had begun to permeate the therapeutic space.

At times during therapy with Chantelle, when her traumatic narrative threatened to overwhelm my defences I would once again revert to the search for symptomatology which would reinforce my diagnosis and garner the sympathetic ululating of my colleagues. However, in retrospect, it was impossible to diagnose the borderline condition without first observing the transference during therapy. The provision of a diagnosis prior to the development of the relationship between us obscured particularities which defined the singularity of her presentation.

In formulating the case to present to my supervisor after the initial few sessions, I put forward the hypothesis that Chantelle's struggle to form a secure attachment with Miguel echoed her own traumatogenic selfobject experiences of childhood. I further posited that her previous disengagement from the therapeutic process, as demonstrated by her infrequent attendance, mirrored her difficulties in forming a secure therapeutic attachment which would possibly threaten her defences. During our subsequent sessions, I planned to focus on the range of selfobject failures which had precipitated a self state which relied on organizing principles designed to protect her from further loss (Leavy, 1998; Kohut, 1997; Brothers, 1995).

Chantelle's rageful affective responses to the inevitability of empathic 'failures' appeared to evoke the spectre of repetition within the therapeutic space. A powerful determining factor in Chantelle's life had been Chantelle's early experience of a distant unsupportive mother who did not provide adequate opportunities for effective mirroring of her experiences.

I gradually became aware that Chantelle's rage at men was one of her only available forms of self expression and that my silence in response to her rage and lack of self disclosure enacted a repetition of her distant, unresponsive mother. The following vignette from Chantelle's graphic construction of her rape during the 7th session, illustrates an intersubjective moment which facilitated the re-enactment of a past selfobject failure which significantly influenced the course of therapy.

5.2.3: "It makes me so angry when I think about it I could kill him, hell, I could kill everyone"

C: He hit me with a short metal rod until I was almost unconscious...then he dragged me into the bushes... I was so scared (she is silent for a long while)

J: ...(I remain silent)

C: He smothered me with his hand, I couldn't scream... it makes me so angry when I think about it I could kill him, hell, I could kill everyone (her voice is raised, she looks directly at me for what seems an eternity). My mother didn't help me, she ignored me and told me it was my fault...

(Another long silence, during which I feel pressured to respond...)

J: (I shake my head...)I don't know what to say Chantelle... it sounds frightening (I fall silent again, overwhelmed, avoiding eye contact, my hand over my mouth)

Chantelle's retelling of the event caused a visceral reaction in me which took me quite by surprise, my breathing quickened, my mind was invaded by vivid terrors and it was only during supervision that I was able to make sense of Chantelle's communication through the complex interweaving of transferences, countertransferences and modulating phenomenon.

The reaction within my body precipitated by Chantelle's traumatic narrative, was one of the first indicators that a deconstruction of our reified positions as client and therapist, was underway.

During this session, I felt bludgeoned, violated and exhausted. Chantelle's selfobject transferences saturated the therapeutic space with rage and terror, which evoked a particular countertransference enactment i.e. *silence*. While I struggled to manage my countertransference feelings of therapeutic impotence and emasculation, a 'thick silence' developed around acknowledging the violence and trauma precipitated by men in her life. At times during the session I was so deeply affected by Chantelle's selfobject transference of rage, that my ability to remain empathically immersed in her inner world was compromised as I was unable to decentre from my own affective state (Lichtenberg, 2000).

During the session I felt smothered by my silence which left me feeling helpless. According to Russel (1998), trauma is that which gets compulsively repeated and only through reliving the past, can there come a kind of understanding which facilitates a positive shift, a delivery of grief. Chantelle's previous attempts to relive the past through her construction of a coherent narrative of the traumatic experiences in her life, had often been met with derision and indifference by significant others particularly her mother, and within therapy, as I became paralysed by the 'dread to repeat' my silence carried the promise of repetition with it.

Without an opportunity for an internalization of a response from her mother which mirrored Chantelle's distress, she struggled to develop a cohesive internal state. It can be hypothesised that her retelling of the violence she experienced through her relationships with men became

traumatic, when the mirroring that she needed from the therapist to assist in its tolerance, containment, and integration was interpreted by her as being absent. It appeared that the failure of mirroring of a proximal relationship was repeated and evoked within therapy, and that soon afterwards an empathic rupture/ intersubjective disjuncture (Teicholz, 1999) developed within therapy.

Kernberg (1984, as cited in Herman, 2001), argues that the therapist's task is to "identify the actors" in the borderline patient's inner world. He identifies representative pairs of actors that may make up part of the client's inner world which include the "destructive bad infant" and the "punitive, sadistic parent", "the unwanted child" and the "uncaring, self-involved parent", "the abused victim" and the "the sadistic attacker" or "rapist" (p.147). It is possible to postulate that during the session I mirrored many of the actors which made up part of Chantelle's inner world. Through my experience of "being smothered by silence" I experienced what it felt like to be the abused victim. I was, however, in such fear of becoming the sadistic attacker that I attacked my own ability to remain empathically attuned to her experience and thereby became the uncaring, self involved parent. Chantelle's reference to the inability of her mother to adequately soothe her after this event, seemed to reinforce Chantelle's perception that her inner experience of trauma could not be understood or soothed by anyone.

After her disclosure of the rape and the concomitant feelings of rage and terror which it evoked within both of us, Chantelle cancelled the following three sessions. I was once again plunged into a narcissistic crisis about my ability as a therapist, which prompted a tireless reworking of my formulation of the case in an effort to contain my compromised, idealised professional self.

Chantelle's subsequent disengagement from the therapeutic process can be viewed not only as an empathic rupture which occurred during therapy, but also as a communication of her experience of profound selfobject failure, repeating and echoing damaging, developmental failures (Ornstein, 1991). Chantelle's frequent cancellations were interpreted by me as a loss of trust in my ability to provide a safe, holding environment, which on my part led to a precipitous loss of self esteem. However, in retrospect, her disengagement can also be understood as an attempt to protect her threatened self, to differentiate herself, to distance herself from a 'distant mother'. During this time I also hypothesised that Chantelle's early pathogenic relationship experiences in conjunction with numerous traumatic experiences i.e. a combination of Type I and Type II trauma (Terr, 1990) had compromised her normal developmental processes, particularly with regard to her ability to adequately regulate her affect (Fonagy, 2001).

Stolorow (1991) argues that the patient's efforts to disengage from his/her "affective yearnings" (p.59) for a connection with the therapist is always "evoked by perceptions of qualities or activities" (p.59), of the therapist that resemble or call up the patient's fears or expectation of childhood trauma. As an intern with an appropriately limited level of experience, I was unable to recognize the repetition of a central developmental trauma which set into motion the activation of unconscious defenses designed to protect the self from threatened fragmentation.

Chantelle's tendency to experience and respond to me as if I were similar to self object failures of the past correlated with my tendency to identify and comply with these projected role expectancies, usually through an unconscious withdrawal from her (Stern, 1994). This unconscious withdrawal can be illustrated by my often 'forgetting' to call her to reschedule

missed appointments, or by my avoiding talking about the break in supervision during the therapeutic derailment.

When Chantelle returned to therapy after the break, I attempted to link Chantelle's narrative of rage directed towards her husband and son to her history of chronic sexual abuse and gender based violence at the hands of male role players in her life. My initial attempts at drawing links between her experience of sexual violence and her difficulty in forming a secure attachment with Miguel were met with either silence or rage. I quickly became unsettled and overwhelmed by the duration of the silence or the intensity of her rage, which I felt was no longer confined to the members of her family or the rapist. Her rage was expressed in passive aggressive statements such as "*why are you asking me, aren't you the expert?*", or "*I don't have money to waste on this now...*" and finally in session 11 "*you men are all the same...*". The effect of these exchanges was that I was battered into an almost dazed silence. I became painfully aware of my being male and was soon preoccupied with an avoidance of appearing racist or sexist.

Our intersubjective 'dance' was often characterised by us stepping upon each other's toes.

Within the 'therapeutic' space it was often difficult to decipher exactly what Chantelle *needed* within the therapy in order provide in some measure, what was missed in early traumatogenic relationships and to facilitate Chantelle's experience of myself as a male therapist as a different and more self-facilitating object (Stern, 1994).

After the session in which she constructed a narrative around her experience of rape, I became convinced that Chantelle's traumatic experience would never intersect with my experience, this conviction was a source of alienation; the unbridgeable gulf separating her experience from my

understanding. It was as if Chantelle and I inhabited different worlds that could not be bridged by empathic attunement alone.

5.3: THE IMPACT OF GENDER AND RACE ON THE THERAPEUTIC SPACE

5.3.1: The impact of gender on the therapeutic space

A 'therapeutic paralysis' developed within therapy after her construction of a narrative around her rape. This *paralysis* appeared to centre around my struggle between the disorganization of my own affect, or 'self state' (Ornstein 1991) and my desperate attempts to remain empathically attuned. The disorganization of my self state, as well my difficulties in remaining empathically attuned were gradually acknowledged as being linked to the interplays between our two subjective worlds (Beebe & Lachmann, 1988). The fledgling recognition of the impact of my own subjectivity is illustrated in my reflections on session 11.

5.3.1.1: "I can't help feeling complicit in some way"

Chantelle crosses her legs whenever we speak of the abuse she suffered at the hands of her uncle. I can't help feeling complicit in some way, as if by being a man, I am partially responsible for the violence she has suffered, I become enraged at the men who have done this to her but silenced by my masculinity. I become trapped in thick, empathic 'quicksand', wondering if my silence is punishing her further. My therapeutic impotence tackles my very sense of self, of who I am, as a male, as a therapist, I wonder if this is what she wants me to be, impotent, emasculated. The threat of retraumatisation hangs heavy in the air, waiting, daring me to put a foot wrong.

I experienced the space generated between us during these initial sessions as being chaotic and disempowering, particularly when I focused on the impact of gender within the therapeutic space. It was during these initial linguistic “skirmishes” (Swartz, 2004, p.11) that I often wondered if I were in some way being made to feel elements of Chantelle’s often chaotic and disempowering experiences in relation to men. However, instead of acknowledging and naming the experience I would remain silent, often agonizing over whether or not I was “a good enough therapist” as I struggled with my own idealised professional self (Bacal & Newman,1990).

Within supervision I began to question whether empathic immersion alone, was sufficient. My attempts at remaining empathically attuned in the face of Chantelle’s heightened affectual states was often experienced by me as a being a form of subjugation (Swartz, 2004). I had begun to feel as if I were merely a vessel designated to hold her unprocessed affect, I felt that I was being used as an object as opposed to being related to as a subject (Swartz, 2004; Benjamin, 1990). During this time I began to struggle around how I would acknowledge and recognise my own subjectivity and its impact within the therapeutic space. I viewed my own subjectivity as an impediment to the therapeutic process, something which needed to be overcome. However, in retrospect, it was the burgeoning recognition of my own subjectivity which actually began to undo the paralysis which had characterised the space between us.

5.3.2 The impact of race on the therapeutic space

During therapy with Chantelle, I gradually became aware of an oppressive sense of guilt and failure evoked by my own selfobject needs, which had arisen as a result of my feeling indirectly responsible not only for the trauma she had experienced as a result of gender based violence, but also the insidious trauma she had experienced largely due to the draconian policies of apartheid. The notes from session 14 illustrate how our subjective historical milieus had begun to impact on the intersubjective space.

Chantelle was silent for the first five minutes of the session, initially, instead of breaking the silence I too remained silent, attempting to emulate my own internal classical psychoanalytic role models. The silence was excruciating, almost painful. I noticed that her eyes were brimming with tears when she eventually related her experience of the previous day.

5.3.2.1: I had a fight with the boy at work

C: I had a fight with the 'boy' at work, he walked past me and brushed against me... I felt so angry, it wasn't a mistake, I know their kind, one of the girls at work was raped by them, I'm telling you it's not going to happen to me, not again...

J: I'm not sure I understand who you are referring to Chantelle, could you be a little more specific?

C: Ag man, you know... black people.

J: And are you saying that you felt threatened by this man? (I emphasise the word 'man')

C: I always feel threatened by people, black, coloured it doesn't matter, but I still don't trust that boy...he gives me the creeps.

The extract illustrates my emerging awareness of the particular impact of race in relation to power in the intersubjective field. I was aware within the session of our particular use of language to differentiate between racial groupings. I found her use of the word “*boy*”, in describing a black man at work, to be in stark contrast to my liberal sensibilities with regards to race. This is demonstrated by my consciously asking her for clarification of whom she was talking about and then referring to the “*boy*” as a “*man*”.

Stake (2000) argues that all understanding involves interpretation. Interpretation, in turn, can only be from a perspective embedded in the historical matrix of the interpreter's own traditions. It stands to reason therefore that understanding is always from a perspective delimited by the history which has formed the interpreter's own organising principles. Even though as a White South African who's interpretive perspective is still heavily laden within the historical matrix of liberal guilt for the oppression caused by apartheid, the acknowledgement of my own subjectivity and it's impact on the intersubjective space within this session is marked through my re-emphasis on the word “*man*”.

The defensive racial dynamics and their relation to power between myself as a White male therapist and Chantelle as a Coloured woman are particularly marked within this session as can be exemplified by her omission of the racial category of ‘White’ when describing the myriad of people (broken into racial groupings) that she felt threatened by. I did not draw

her attention to her omission, due in part to my own defensive racial dynamics in not wanting to be perceived as a possible source of threat.

Chantelle's re-emphasis of the word "*boy*" again challenged my ability to be able to understand Chantelle from the vantage point of her experiential frame of reference and to recognize how her experiences are tied to her cultural upbringing (Toukmanian & Brouwers, 1998). Chantelle's statement that her colleague "*gives me the creeps*" also appears to have been an unconscious reference to her rapist, whom she had often referred to during the course of therapy as being "*the creep*". However, instead of emphasizing the disruption in the empathy process (Wolf, 1988) brought about by our different subjective experience of race, and engaging with the obvious unnamed issues of power and trauma, I avoided the issue in an effort to contain my own anxieties about engaging with the issue of race.

The defensive racial dynamics illustrated above have particular relevance within a South African context, as the socio-historical-economic disparities of the past (and present) make it exceedingly difficult to acknowledge and engage with difference within the intersubjective space (Swartz 2004).

In the South African context, with a history of entrenched racial discrimination the avoidance of talking about cultural difference can be understood in terms of a reluctance to create difference between people, and a resistance against the perpetuation of a historical racist perspective (Gibson, Swartz & Sandenbergh, 2002). Ridley (1995)

describes how it is often tempting and possible to ignore the uncertainty inherent in addressing difference within therapy.

Stolorow (1994) argues that the analysis of a resistance is made possible through recognition, inquiry and in the interpretation made by the therapist, with particular attention given both to the intersubjective conjunctions and the intersubjective disjunctions. However, during this particular session I found it exceedingly difficult to engage with race openly as I was afraid that any simple, possibly inadvertent misunderstanding, would quickly re-evoke painful memories of our racialised histories (Swartz, 2004).

The intersubjective field generated by two subjectivities led to a shared experience not only of significant loss and trauma evoked by our subjective socio-historical milieus, but also of trauma related to “insidious unnoticed ‘innocent’ acts of cruelty, ‘minor’ neglects and disappointments, that added together form intolerable or overwhelming experience” (Swartz, 2004, p2).

The intersubjective field generated between two subjectivities can lead to an infinite range of possible outcomes. In the following section I will outline one of these outcomes namely the narcissistic transformations which occurred within me, as a therapist, as a result of a therapeutic relationship characterized by the absence of the mirroring of my own particular selfobject needs.

5.4: NARCISSISTIC TRANSFORMATIONS OF THE INTERN PSYCHOLOGIST

Stolorow and Atwood (1992) argue that the analysand’s fear of retraumatisation by the analyst underpins the expression of resistance in the analytic space. I would argue,

however, that the threat of retraumatisation is twofold, in that it is not only the analyst's fear of retraumatising the analysand which underpins resistance, but also the threat of the analyst being retraumatised her/himself which constantly stalks the therapeutic space.

When 'pathology' is no longer viewed in terms of processes located solely within the client (Teicholz, 2001), as in this case, I was no longer protected from the various ways in which I myself and the theories I ascribed to were implicated in the enactments I observed. During therapy with Chantelle I often experienced a sense of disappointment and disempowerment and while it is possible to disavow these feelings as being a result of Chantelle's selfobject transferences, these feelings may also be understood as an (evolution and) dissolution of my own narcissistic omnipotent fantasies during my first year of training as a therapist. The following vignette demonstrates Chantelle's attempts to communicate her distress about the perceived lack of attuned mirroring during her disclosure of traumatic, unintegrated material in previous sessions.

5.4.1: "I don't feel better, I feel worse..."

C: I often wonder why I come to you here... I don't understand how this works? Aren't I supposed to be feeling better by now? I don't know what it is that you want from me?

J: It sounds as if you are wondering why you are here Chantelle? I don't know if I can necessarily answer that question for you.

C: But then what's the use, if you can't help then I may as well deal with all this on my own, I've done it for so long anyway.

J: I didn't say that I couldn't help...It sounds as if you are very angry with me Chantelle, can you tell me why?

C: Aren't you supposed to know? You're supposed to have the answers, I'm gatvol [fedup] with everything, I don't feel better, I feel worse...(falls silent).

J (feeling pressured once again to provide a response)...I don't necessarily have the answers Chantelle (long silence).

This vignette illustrates a moment in which I felt that my own self-organisation, with regards to my idealised, professional self, was under threat and a mutual feedback cycle ensued. I comment on this vignette in terms of the intersubjective field, with emphasis on my own input because the intersubjective space generated between Chantelle and myself broke down as a result of a disjunction caused by a threat to my own self-organisation. That the space *between* therapist and client can breakdown is accepted as a common feature, what counts however, is the ability to restore or repair the relationship (Benjamin, 1990).

I experienced this session as being particularly stressful, I was dimly aware that my countertransference reactions were particularly pronounced when I became narcissistically wounded, when I perceived that my ability as a therapist was being questioned, as in the statement "*aren't you supposed to know?*".

Other criticisms during the session were that I was a student whose only interest was using her as a learning experience. The 'truth' of these statements provoked the threat of a narcissistic rage within both parties which was only barely restrained. The accuracy of her statement, that I was

using her and would somehow discard her once I had completed my allotted time with her, carried the very real threat of repetition of her past selfobject failures and I quixotically defended against my part in it's inevitability .

Although I had been trying to be compassionate and reflective, the intersubjective field had already been influenced by my silence in previous sessions. The silence was finally broken by my feeling pressured to provide a response, "*I don't necessarily have the answers...*", Chantelle was then able to experience me, to use me, once again as a repetition of a past self object failure.

If selfobject transference is understood as a striving to organize experience and create meanings, it may, therefore, be assumed that the analyst's countertransference must represent his own attempts to organize her/his experience of the client and of the psychotherapeutic relationship (Ornstein, 1991). As the therapeutic relationship continued I became aware of the need to tolerate and understand my countertransference. However, I also became aware that I was experiencing Chantelle as a selfobject who failed to affirm my own idealized professional self.

Her experience of rage and disconnection precipitated my own disruption, which in turn greatly affected her experience of me as an attuned, empathic selfobject. Although it is tempting to place the responsibility for initiating 'pathological' reenactment on Chantelle and while I may argue that I was pressed into the role of an early inattentive mother, I also have to acknowledge my fear of fulfilling this role due to my own unmet archaic selfobject needs. Kohut (1971, as cited in Stern, 1994) believed that patients actively (if unconsciously) seek archaic selfobject relational configurations in order to 'cure' previously unmet selfobject needs, i.e. the "fantasy, selfobject relationship". However, one could argue that this may also be true of the therapist when their own particular self object needs are evoked by material within therapy. (Stern,1994).

Through the process of self- reflection I have begun to recognise that my need for being acknowledged as a compassionate, sensitive, liberal thinking person arose from early experiences. The very notion that Chantelle experienced me as being a selfobject, which did not mirror these qualities, threatened my basic self image, it also threatened to undo my defences against another self image, which contained elements of guilt and shame associated with growing up under and feeling complicit with the Apartheid regime.

Bacal et al. (1990) argues that narcissistic issues may be assumed to occupy some position of prominence in the personal psychology of the psychotherapist. As psychotherapists there appears to be an idealised professional self which he argues “contains elements of the all loving healer, the warrior, a fusion of the best of scientist and artist setting forth to battle and vanquish the dark forces of the human soul” (p. 26).

In supervision I continually denied my feelings of helplessness, since such feelings challenged my idealized, professional self. My attempts to be a source of nurturance and compassion were soon foiled by an intensification of the therapeutic relationship, with its components of disillusionment, provocation and countertransference enactments. The empathic countertransference which characterised the initial weeks of therapy soon faded into disappointment and anger. These confrontations and contradictions to my idealised professional self image led to a precipitous loss of self esteem and set in motion mechanisms by which I defended against narcissistic trauma. Initially the preservation of my self esteem was sought by the denial of any data which contradicted this idealised professional self-image, this was characterised by being “overly intellectual” about the case and being preoccupied with dry facts and theory. I glamorised

intuition and extolled the benefits of immersion in affect. Troublesome feelings such as frustration, aggression and even rage which conflicted with my narcissistic aspirations of what a therapist should be/ or could be allowed to feel, were simply denied. It was exceedingly difficult as an intern to acknowledge the unrealistic expectations of myself and of therapy as a neophyte therapist. The attempt to maintain my self esteem in the face of the disparity between my realistic and appropriately rudimentary level of skill and my grandiose narcissistic aspirations undoubtedly impacted on the intersubjective field generated between us.

Bacal et al. (1994) maintain that although many therapists gain much from their personal analyses, none of us is entirely free from sensitivities, vulnerabilities and longings that arise from personal and professional injuries, both past and present. During the course of therapy with Chantelle, I have often attempted to defend myself from the repetition of disruptive experiences and their disturbing effects, particularly that of shame. Wolf (1980) recognized the bidirectional nature of selfobject neediness in the analytic process. Furthermore Bacal et al. (1990) observed that when a therapist has a countertransference reaction the therapist's selfobject needs, which are ordinarily being met by the client during therapy, are then frustrated and his sense of self is concomitantly threatened. The selfobject disruption in the therapist will affect the therapist's ability to remain optimally attuned to the client. During therapy with Chantelle I have become increasingly aware of my own selfobject needs i.e. to be recognized as a 'good enough therapist', and have begun to explore how these selfobject needs contribute to particular countertransference reactions and reflections within this therapy.

5.5. THE DELIVERY OF GRIEF

The question remains however, how do South African therapists working within a complex socio-historical matrix, engendered, to a large degree, by the legacy of Apartheid and create conditions whereby the intersubjective space, with its continually shifting elements of race, gender and class, can be acknowledged and attached to words within therapy?

During session 27, I had asked for Chantelle's permission to write up this case for the purposes of my dissertation. She had agreed on condition that I disguise her biographical details. This session marked an unnamed shift in the power dynamics within the intersubjective space brought about by my request to use the clinical material. During this and subsequent sessions, I became increasingly aware that I was influencing the interchange in order to fill out chronological information which would aid my research.

As I became aware of my influencing the course of the exchange, I defended against my own selfobject needs by convincing myself that my eliciting the information was necessary for her recovery; that I would use the information to explore her dynamics which would deepen my understanding of the case. What I was not acknowledging, however, was the repetition of the dynamics of power and subordination which were being enacted within the therapeutic space. The shift in power dynamics carried with it the threat of repetition of our racialised past. However, the shift of power within therapy has also highlighted positive aspects that facilitate a delivery of grief, my request to write

about her has framed her experience as being worthy of deep reflection, and her narrative as being important.

The writing of this dissertation may be seen in itself as a provision of sorts, of new facilitating selfobject experiences, for both parties, which carries with it the possibility of an alternative way of organising both past and current experience. Prior to penning this dissertation my own struggles with Chantelle centred around my ability to acknowledge my own subjectivity within therapy. The therapeutic process has invited me to reflect upon my own experiences relating to gender, race and class. The deconstruction of these experiences, has led me to believe, that my subjectivity is not an impediment to be overcome, but is rather valuable data which affects how the client is heard and responded to. Through the 'labour pains' of this dissertation, I have been able to contribute to the reshaping of our experience in therapy which has contributed to a delivery of grief for both parties.

The feedback (which was spontaneous and unplanned) occurred during session 34 and is an excellent example of how the writing of this dissertation has influenced my own process of development as a therapist. The acknowledgment of my own subjectivity within the session challenged the habitual intersubjective therapist-client relationship and required responses which were too specific and personal to be technical manoeuvres.

5.5.1: "I will never be able to know exactly what that felt like for you"

C: I was so surprised to see you at the clinic[where her son attends the learning support group] yesterday, being all professional

J: It sounds like it was a little strange to see me in that environment?

C: Yes man, I mean you walked up and shook my hand like a salesman...

J: Are you interested to know what I was selling at the clinic?

C: [laughs], I mean I know that you speak to [supervisor's name]

J: Are you worried about what I tell her about this case?

C: No, not really...

J: Would it help you if I told you some of the issues that are raised in what I am writing about?

C: Ja, I suppose so...

J: Well, one of the issues that I am focusing on, is on my experiences of being a man within therapy while talking to you about the violence of men...

C:[Silent]

J: Another example is that of race, of your experience of apartheid, of how I will never be able to know exactly what that felt like for you because... well, because I am white...

C: Ja... you're right, but it's like I won't know what it's like to be a man...

J and C: Both laugh

The above vignette illustrates how the use and acknowledgement of my own individuality facilitated a brief moment within the space generated between us, where we met as two persons relatively unhidden by our usual therapeutic roles. While this moment carried

with it the threat of past trauma for both of us, a repetition, and although there were still defensive dynamics at play, the moment felt different, it felt as if we really caught a glimpse of each other.

Swartz (2004) argues that the mechanism whereby the client's delivery of grief is enabled, ultimately occurs through the therapist adopting "a state free from a desire to be dominating or coercive in order to help patients reach their grief" (p. 2). Theoretically, intersubjective therapy foregrounds mutual recognition and survival of difference, however, what previous material demonstrates, is how exceedingly difficult it is to acknowledge race, gender and power dynamics within the therapeutic space, and how that difficulty can ultimately frustrate the delivery of grief on a multitude of different levels. It is a common misconception of intern psychologists that their subjectivity needs to be denied, that a therapist can exist apart from their race and gender. I propose that it is this very assumption which blocks the delivery of grief, for it is specifically at the node where therapist and client engage with issues raised by gender, race, class and power that the work actually happens.

CONCLUSION

As Chantelle and I approach termination, it is both an end and a beginning on many different levels. It is the ending of a therapeutic relationship, which although it repeats a primary trauma for the client i.e. that of being used (as a source of information and training) and then left (my moving on to Community service), has also offered an alternative through the use of mutual recognition and respect. It is this alternative way of

organising past experience which offers a delivery of grief, a way of breaking repetitive cycles of painful relating.

Although I have (inevitably) not always been the attuned mirroring therapist, I have been useful to Chantelle through my hopefulness, my engagement and my innocence. We have been useful to each other. The delivery of grief has been mutual, it is a constant, unfolding process as opposed to a final destination.

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CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1. CONCLUSIONS

That trauma is an affliction of the powerless (Herman, 2001) cannot be denied, however, how trauma is engaged with, repeated and hopefully metabolised, remains the challenge within therapy. Throughout the literature review of this dissertation, I argued that the construction of particular diagnoses, such as that of the 'difficult to manage' borderline patient have evolved through gendered constructions of trauma. I have argued that the use of pejorative diagnostic categories undermine the very real social milieus within which women, particularly within South Africa, struggle. That 'difficult to manage' patient's are difficult to manage specifically because of their histories, child sexual abuse, gender based violence, the legacy of racism and discrimination makes women's histories difficult. I am not arguing that diagnosis is not relevant, but rather that intern's not use diagnosis as a way of disavowing uncertainty, or of placing pathology firmly within the patient as opposed to looking to the contributions of their own subjectivity to inform what transpires within therapy. For as long as we posit ourselves as experts the possibility of re-enacting patterns of exploitative relationships is present.

All therapist's have their own selfobject needs (Bacal et al.1990), particularly intern psychologists who desperately cling to their analytic authority/ theory in an effort to stave off being overwhelmed by their client's traumatic narratives.

Through the therapeutic process with Chantelle I have begun to challenge and deconstruct my idealised professional self, attempted to acknowledge my own selfobject needs facilitated by omnipotent phantasies about an idealised professional self, but throughout, I have attempted to remain open and curious. My increasing awareness of and sensitivity to the unconscious has delivered this dissertation as a way of releasing myself from my own demons, as a way of delivering my own grief.

This dissertation has also showed that we fail to acknowledge the other at our own peril. By not acknowledging the very real differences that exist between people we fail to engage with each other within therapy in an honest 'real' manner. Our assumptions about difference handicaps empathic connection and reinforces our defences around issues of race, gender, class and power. I have also argued that empathic attunement alone is not sufficient as it denies the subjectivity of the therapist and is a form of subjugation in itself (Swartz, 2004).

The first part of this analysis focused on how the, conscious and unconscious expectations of the intern therapist were activated and frustrated by the client. The meeting of two very different subjective worlds, each of which had different traumatic experiences led to numerous defensive tactics being employed by both parties in an effort to defend against repetitions of trauma. Understanding how these defenses were enabled became paramount to the negotiation of a way through the repetition which cast its shadow over the therapeutic process. The second part of the analysis highlighted the impact of gender and race on the intersubjective field generated between us.

It is still unclear whether my being a male therapist facilitated or hindered the therapeutic process, however, that my defences around issues of masculinity impacted on the therapeutic space cannot be denied. Empathic immersion alone was unable to provide me with access to the client's experience of trauma and it was only through me actually experiencing her traumatic narrative viscerally, that I began to question acknowledge the impact of my own subjectivity within the therapeutic process. Before I was able to process and accept the role of my own subjectivity, however, I had to undergo a deconstruction of my narcissistic, idealised, professional self.

The third part of the analysis outlined the impact which empathic breaks and therapeutic derailments had on the self organisation of the therapist. The struggle between empathic attunement and the countertransference enactments precipitated by defenses against a narcissistic wounding of the therapist was explored. The therapist's own self object needs and experiences were explored as being influential on the repetition of specific past selfobject failures, of both therapist and client.

The analysis asks how grief can be delivered if we do not actively engage with difference. Theoretically, intersubjective therapy foregrounds mutual recognition which ensures the survival of difference. It is argued that a denial of the impact of race, gender and power dynamics on the intersubjective space ultimately frustrates the delivery of grief on a multitude of different levels. I have also explored how writing this dissertation has influenced the therapy, broadening my understanding. The broadening of my understanding has lead to brief encounters which have challenged and further

deconstructed my idea of therapeutic authority, this deconstruction has enabled me to respond and listen to Chantelle's narrative in a more authentic manner.

6.2: RECOMMENDATIONS

The final section is intended to offer both institutions which train intern psychologists, as well as intern therapist themselves, a few recommendations which have arisen through my own subjective experience as an intern psychologist working psychodynamically, with a woman who has a chronic history of multiple traumas. It is hoped these recommendations will assist in the continual development of training techniques for trainee psychologists, which acknowledges the complex intersubjective dynamics of therapy within a South African context.

- Instead of focusing on and isolating issues of race, gender, class and power in clearly delineated teaching blocks, it would be beneficial for the entire M1 year to be permeated with a discourse that highlights and demonstrates their saliency in every context.
- Supervision could be employed to challenge and evoke trainee- therapists expectations of working with these complex issues. This could be done by focusing on the intersubjective space generated between two very different subjectivities.
- Experiential e.g. group therapy techniques could be used to evoke the trainee's own material with regards to these issues.

- It is recommended that trainee therapists be encouraged to be reflexive with regards to the impact of their own subjectivity on the therapeutic space, and to foster the notion that the acknowledgement of one's own subjectivity within therapy is not a hindrance to be overcome, but is a valuable resource in understanding and fostering an empathic, authentic connection with the client.
- The trainee therapist's colleagues are a valuable, instructive resource, perhaps if a climate were engendered within the training which fostered sharing as opposed to competing, an environment could be created wherein authentic intersubjective moments between the trainees could be explored.
- The use of Self Psychology and in particular Intersubjective theory has been useful in broadening my understanding of how to engage with and acknowledge difference, I recommend that a greater emphasis be placed on Intersubjective theory/ therapy in the curriculum
- Finally, trainee therapists need to be encouraged to be open to the experience and inevitability of failing both themselves and their clients, for it is in these very experiences that learning occurs.

"No matter, fail again, fail better"

Samuel Beckett

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