

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

UNIVERSITY OF CAPE TOWN
GRADUATE SCHOOL IN HUMANITIES

**DECLARATION BY CANDIDATE FOR THE DEGREE OF
MASTER IN THE FACULTY OF HUMANITIES**

I, Catherine Filippa Srubisky, of # 6 Blackrock, 221 Mainroad, Three Anchor Bay, Cape Town, do hereby declare that I empower the University of Cape Town to produce for the purpose of research either the whole or any portion of the contents of my dissertation entitled: An Analysis of Therapeutic Failure in Psychotherapy with a Deaf client: A training psychologist's experience in any manner whatsoever.

CANDIDATE'S SIGNATURE

DATE

An Analysis of Therapeutic Failure in Psychotherapy with a Deaf client

A training psychologist's experience

by

Catherine Srubisky

SRBCAT001

Supervisor:

Debra Kaminer

A minor dissertation submitted in *partial fulfillment* of the requirements for the award of
the degree of Master of Clinical Psychology

Faculty of the Humanities

University of Cape Town

2011

COMPULSORY 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.

Signature: _____

Date: _____

ABSTRACT	5
1. CHAPTER 1: INTRODUCTION	6
1.1. Aims and Rationale	7
1.2. Structure of the dissertation	8
2. CHAPTER 2: LITERATURE REVIEW	9
2.1. A social constructionist perspective on Disability	9
2.1.1. Deaf with a capital D	12
2.1.2. The therapeutic process with Deaf clients	15
2.1.2.1. Holding similarities and differences between disabled and non-disabled clients	15
2.1.2.2. Communication issues	18
2.1.2.3. Theory of mind	20
2.1.3. Recommendations for therapist working with Deaf clients	22
2.2. Relational psychology and intersubjectivity	25
2.2.1. Intersubjective space in a therapeutic context	28
2.2.2. Place of the Third	29
2.2.3. Surrender	29
2.2.4. Breakdown	31
2.2.4.1. Key features of breakdown	32
2.2.5. Restoring the intersubjective space	34
3. CHAPTER 3: METHODOLOGY	36
3.1. Aims of the research	36
3.2. Research Design	37
3.3. The clinical setting and background information	41
3.4. Description of case material	43
3.5. Approach to data analysis	43
3.6. Confidentiality and ethical aspects	44
4. CHAPTER 4: ANALYSIS	47
4.1. Forms of therapeutic failure	48
4.1.1. Over-talk	48
4.1.2. Not asking pertinent questions	52
4.1.3. Putting words into the client's mouth	60
4.2. Theoretical understanding of breakdown	63

4.2.1.	Nature of therapist’s assumptions and anxieties	63
4.2.2.	Failure to hold differences and similarities.....	66
4.2.3.	Communication ruptures	69
4.2.4.	Theory of mind.....	70
4.2.5.	Breakdown.....	72
4.3.	Conclusion.....	77
5.	CHAPTER 5: CONCLUSION	79
5.1.	Summary of findings	79
5.2.	Limitations.....	83
5.3.	Recommendations	85
6.	REFERENCE LIST	86

University of Cape Town

ABSTRACT

This mini dissertation attempts to understand the early stages of a psychotherapeutic process between a trainee psychologist and a Deaf client. Both a social constructionist perspective of the experience of being disabled / Deaf, and an intersubjective lens, have been utilized in order to understand the nature of the therapeutic failures that occurred and how they functioned. A psychoanalytic case methodology was used to analyse the first eight sessions in the psychotherapeutic process with a Deaf client and members of her family.

Three forms of therapeutic failure were identified during the early stages of the therapeutic process with a Deaf client: 1) over-talking, 2) not asking therapeutically pertinent and relevant questions, and 3) putting words into the clients' mouths. The therapist's assumptions and anxieties regarding Deafness, which have been influenced by social constructions of Deafness, had a significant impact on the development of these therapeutic failures. An intersubjective lens suggested that these three therapeutic failures occurred through the mechanisms of breakdown, complementary relationships, and failure to surrender to the position of the third. Ultimately, the function of these failures was to cause the therapeutic relationship to break down so that the therapeutic relationship could shift into mutual recognition. The implications of this case analysis for therapeutic work with Deaf clients and for working with difference in the therapeutic relationship in general are discussed.

An Analysis of Therapeutic Failure in Psychotherapy with a Deaf client

A training psychologist's experience

1. CHAPTER 1: INTRODUCTION

This mini dissertation attempts to understand the nature of, and reasons for, breakdowns in the therapeutic process between a deaf client and a training psychologist. In order to achieve this, the literature on Deafness within psychotherapy, together with the theoretical framework of intersubjectivity, will be used as dual lenses through which to understand the development of therapeutic ruptures.

South African statistics indicate that the prevalence of various forms of disability for the total population constituted 6.5% in the 1996 Census (2 657 713 individuals); 5% in the 2001 Census (2 255 982 individuals) and 4% in the 2007 Community Survey (1 916 219 individuals). Of the total disability population (1 916 219 individuals), 9.4% had some form of hearing disability in the 2007 Community Survey

(<http://www.statssa.gov.za/publications/P0301/P0301.pdf>, accessed 15 October 2010).

These statistics suggest that although the prevalence of disability in South Africa appears to be decreasing, the proportion of disability, and specifically of hearing disabilities, remains significant. Importantly, however, the consequences and experience of being disabled cannot be adequately understood through statistics alone.

The limited amount of literature regarding Deaf and / or disabled clients in therapeutic processes further suggests that investigating such contexts is a meaningful and much needed endeavour. Understanding the context of engaging therapeutically with disabled or Deaf clients has the potential to be constructed as a human right's issue, particularly in the context of training clinical psychologists. Generally, clinical psychologists in training are faced with a number of different anxieties as well as a general lack of experience and knowledge pertaining to clinical work. Such anxieties may not only be narcissistic in nature, but may also be rooted in difficulties engaging with difference including

disability. It is for these reasons that an adequate understanding of the fundamental concerns and elements in working therapeutically with a Deaf or disabled client need to be developed.

1.1.Aims and Rationale

The aim of this dissertation is to develop a theoretical understanding of the experience of a training clinical psychologist in providing a therapeutic intervention for a Deaf client. This experience involved feelings of great incompetence, feeling overwhelmed, and being 'stuck' within the therapeutic process. In order to fully understand this experience, the context of not only Deafness, but of Deafness within a psychotherapeutic process, needs to be explored. At the same time, relational psychoanalytic theory may also illuminate the nature and functions of breakdowns in the therapeutic relationship. The work of Jessica Benjamin has therefore been selected as a second lens through which to view the therapeutic process.

Exploring the experience of Deaf clients within a therapeutic process is a significant and meaningful endeavour in itself, yet there is little literature on this subject. This area may well be regarded as a human right's issue in terms of equal access to services for all individuals (Raifman and Vernon, 1996). As Fusick (2008) discusses, there are few mental health professionals who have adequate knowledge of Deaf culture or are proficient in an appropriate form of communication with Deaf clients. Consequently, exploring and understanding the experience of Deaf clients within a psychotherapeutic process may provide insights that could be applied to improve equal and fair access to psychological health services and to enhance the quality of service that Deaf clients receive from mental health professionals.

Another potential contribution of this study may be to provide guidance and understanding for future training therapists in working with not only Deaf clients, but in managing impasse's with clients with any form of difference

1.2. Structure of the dissertation

Chapter 1 covers the introduction, aims and rationale of this mini-dissertation; Chapter 2 comprises the literature review which entails a discussion of the disability / Deafness literature as well as an exploration of Jessica Benjamin's intersubjectivity theory. Chapter 3 follows with the methodological approach and specifies the aims, research design, clinical setting and background information, description of case material, approach to data analysis and concludes with issues surround confidentiality and ethical aspects. Chapter 4 deals with the analysis of the material and provides examples of the three forms of therapeutic failure. Chapter 5 is the concluding chapter and provides a summary of the integration of findings as pertaining to both the disability / Deafness literature as well as Benjamin's intersubjectivity theory.

University of Cape Town

2. CHAPTER 2: LITERATURE REVIEW

This literature review has two aims. Firstly, it aims to review existing literature about psychological aspects of Deafness and about the therapeutic process with Deaf clients. Secondly, it provides an overview of the relational intersubjective approach proposed by Jessica Benjamin. The first part of this review examines literature about what the psychological experience of being Deaf may entail. This is contextualised within an understanding of a social constructionist perspective on disability, and of the concept and meanings of Deaf culture. Literature regarding the therapeutic process with a Deaf client is then discussed in terms of three main components: understanding the differences and similarities between disabled and non-disabled clients in psychotherapy; communication issues in psychotherapy with Deaf clients; and the implications of theory of mind in psychotherapy with Deaf individuals. This first section concludes with recommendations that have been offered for therapists working with Deaf clients. The second portion of this literature review explores the intersubjective perspective as theorised by Jessica Benjamin, with specific reference to understanding the place of the third, surrender, breakdown (which includes exploring the meaning of agency and the position of the third) and lastly how to restore the intersubjective space.

2.1.A social constructionist perspective on Disability

Perhaps the most common understanding of disability is rooted in the bio-medical model. This model defines physical disability in terms of the physical loss or lack of capacity of one's body. Disability, in this model, is therefore defined through incapacity, inability and loss (Crisp, 2002; Marks, 2002*a*; 2002*b*). In this sense, disability is a pathology and the disabled individual is consequently pathologized (Crisp, 2002). Significantly, as Marks (1999) points out, it is only through diagnosis and medicalisation that people will receive treatment within this biomedical framework of disability.

There have, however, been numerous critiques of this perspective on disability (Crisp, 2002; Marks, 2002*b*). These critiques have argued that disability, defined in the bio-medical sense, is singularly and reductionistically perceived as a physical impairment, which limits a more comprehensive understanding of what the experience of disability might be from the perspective of the individual (Finkelstein, 1996; French, 1996). The implication of a physical impairment being defined as a physical incapacity / loss / inability, is that the individual is constructed as being 'less than', vulnerable, incapable and / or unable (Oliver, 1995). In other words, physically disabled persons become uniformly defined as the physical loss of their bodies, and this loss then comes to represent the entire meaning of the individual's experience.

It has been argued that disability in this bio-medical model tends to ignore the social, political or psychological dimensions of what disability can represent to people (Harvey, 1987; Marks, 1999). This definition of disability can only but function to construct people in terms of deficit rather than actual experience (Williams & Abeles, 2004). Ultimately, it is argued, the physical impairment experienced by disabled persons cannot be equated with the psychological, emotional, political or social experiences of being disabled. In this sense, the bio-medical model of disability is not only reductionist but may also be prejudicial in that it assumes that disabled people have particular qualities that are in fact not inherent to their persons, nor to their disabilities. These qualities may include being excessively vulnerable or fragile, lacking agency, lacking independence, lacking the ability to make decisions, or lacking the capacity to engage in sexual or intimate relationships (French, 1996; Oliver, 1995; Zola, 1982*a*). Fundamentally, the critiques of the bio-medical model argue that this model cannot account for the disabled person's humanity or represent an appropriate portrayal of their person-hood and day-to-day lived experience (Finkelstein, 1996; French, 1996).

Disability is therefore more than merely the sum of the physical impairments involved (French, 1996). The experience of disability, as taken from a more social constructionist perspective, is not about the impairment per se, but rather about how the physically impaired person's social environments have responded to them as disabled people

(French, 1996). It is these responses, and the individual's experience of these responses, that can be argued to define 'disability'. A person's experience of disability may represent the accumulation of experiences (throughout their childhood and even into adulthood) of how people have defined their disabilities and consequently responded to them. These may have included anxiety-filled projections from society based on people's primal fears and discomfort about death, illness and difference (Kemp & Mallinckrodt, 1996). As mentioned, the effect that these social constructions may have for disabled people may be to attribute features to them that are actually not inherent to the impairment or to their own psyches per sé. The significance of this process is that although these qualities are not innate, there is the potential that these qualities shape and become integrated into the disabled person's internal representations of themselves and consequently become how they define themselves, and their disability (Kemp & Mallinckrodt, 1996). Social constructions of disability may also include the assumption that all disabled people experience trauma and emotional distress based on their physical loss. It is assumed that there is a sense of loss in the first place and that such a sense of loss would warrant an emotionally distressed response. This is not to say that a disabled person may not experience emotional distress; however the root of this emotional distress may be the responses of others in the disabled person's social environment and how these have defined them as embodying a loss of agency, strength, autonomy and the potential for being an active member of society (Oliver, 1995).

As a result of these social constructions (rather than because of the actual impairment itself), the experience of many disabled people has been one of discrimination, alienation and / or a struggle to develop their independence (Harris, 1995). The lack of a healthy sense of independence may inhibit the development of appropriate coping skills, healthy separation and individuation from family members, and the development of a healthy self concept (Kemp & Mallinckrodt, 1996). Social constructions of disability may further include that the degree or quality of the individual's limitation is overestimated, which may lead to the individual being over-protected, rejected or even avoided due to people's discomfort or anxiety regarding the disability (Kemp & Mallinckrodt, 1996). This process may result in the disabled person being exposed to, and thus experiencing, fewer

opportunities that could contribute towards helping them develop to their fullest potential (Kemp & Mallinckrodt, 1996).

Understanding disability must therefore include understanding how disability has often been constructed as loss and incapacity, and how this construction may have negatively influenced (and become integrated into) the experiences of the disabled individual (Leigh, Corbett, Gutman & Morere, 1996). Additionally, one is obliged to consider what the actual lived experience has been of the disabled individual and how these experiences have been influenced by (and incorporated) the social constructions that the individuals been embedded within (Oliver, 1995).

2.1.1. Deaf with a capital D

Significantly, the literature on understanding what it means to be deaf has in fact distinguished between the social and cultural understanding of what Deafness may represent and the bio-medical framework which defines deafness purely in terms of physical impairment (Leigh, Corbett, Gutman & Morere, 1996). In the literature on Deafness, this distinction can be found in the use of Deaf (with a capital letter 'D') relative to deaf (with a small letter 'd'). Deaf (with a capital letter D) refers to the cultural, social, political and psychological experience of deafness, which goes beyond the physical impairment to include the lived experience of how a deaf person's social and political environments have constructed their disability and consequently their identity (Crown, 2008; Freeman, 1989; Harvey, 1987; Jampel, 2010; Williams & Abeles, 2004). Deaf culture represents not only the Deaf person's unique experience and their own personal meanings of disability, but also includes the experience of the social constructions stemming from their environments. Acknowledging that the experience of being Deaf is actually a cultural experience and not purely a physical one reconstructs the Deaf person with a sense of agency, independence, authority and strength (Harris, 1995).

The literature suggests that Deaf people have been treated as 'less than', 'unable to understand', or even 'childlike' (Harris, 1995) by their hearing environments. Deaf

persons may be perceived by the hearing world as lacking in agency, and consequently as lacking in their ability to make decisions and as being “passive” (Harris, 1995). As suggested under the discussion of disability, these responses to the physical impairment of hearing loss may be attributed to society's unconscious projections of anxiety, fear and discomfort regarding death, illness and difference. The discriminatory consequences of these anxious projections can be seen in how Deaf individuals have been perceived as having to be managed or fixed (Harris, 1995; Harvey, 1987; Kemp & Mallinckrodt, 1996). This perspective has been supported through the bio-medical model and proposes that Deaf individuals need fixing or management through fixing their hearing loss, helping them to adjust to a hearing world or even helping to adjust to the loss of their physical capacities. However, it has been argued that these impulses to fix, rehabilitate or manage the Deaf individual are social constructions and represent the fears and anxieties of the non-disabled, hearing community (Harris, 1995). As with disabilities in general, a significant concern regarding these social constructions of deafness is that they may become integrated into the identities of deaf individuals. If Deaf individuals have not had the opportunity to be exposed to a social environment that is supportive and constructs them as powerful, independent and non-pathologised, their identities may not have integrated these representations. Therefore in order to understand what Deafness / deafness may mean, one must understand these social constructions as well as acknowledge the lived experience of the Deaf individual and how their identity has integrated their social, psychological and emotional experiences.

A helpful point of reference in understanding these social constructions and how they may have become integrated by the Deaf individual is to focus on the family of the Deaf individual. Altshuler (1963) conducted an early study to ascertain more clearly the relationships between family members in which one or more members had hearing impairments. The results of this study suggested that participants with the greatest degree of psychological pathology (including both internalizing and externalizing disorders) were in effect those who had been treated differently by their family members (that is, were rejected or overprotected) based on their hearing impairments. Significantly,

Altshuler (1963) found that children who had hearing impairments, yet came from families in which they were treated as equals, reported fewer, if any, signs of pathology.

Another context to consider in understanding the experiences and social constructions of Deaf individuals is the health care industry of which mental health services form a part (Harvey, 1987). As previously noted, Deaf individuals are most often constructed as needing to be fixed or managed, rejected or overprotected, within this health care context (Kemp & Mallinckrodt, 1996). The experiences of Deaf people in relation to receiving assistance, whether it be for medical or mental health purposes, has often added to or exacerbated their previous experiences of discrimination and limitation (Finkelstein, 1996; French, 1996; Kemp & Mallinckrodt, 1996). The bio-medical model assumed by the health care profession, as previously discussed, has constructed the physical impairment as the most significant aspect in understanding Deafness. Interventions have been focused on 'fixing' and rehabilitating the individual, in order for them to adjust to their 'loss' or to allow them to mourn the loss of their physical abilities (Finkelstein, 1996; French, 1996).

There are few other perspectives currently in use to provide psychological support for disabled people (Halgin & McEntee, 1986). Understandably then, the experiences of the Deaf community in dealing with health (including mental health) services have often been negative ones, as such interventions have been based on the underlying bio-medical / medico-tragic models (Oliver, 1995). It has been suggested that many clients with disability perceive 'mainstream' mental health services as being unable to assist them, as these services lack an accurate understanding of the concerns pertinent to a person with disability (McKenzie, 1992). According to Marks (2002a), therapeutic and rehabilitative services have endured a negative reputation with disabled societies, as these services have tended towards ignoring the underlying challenges of what disability actually means in a lived experience for the person with the disability. This negative perception, coupled with the limited number of appropriate services provided, means that many members of the Deaf community may not seek out mental health services. As such, mental health services may be another site of systematic exclusion for Deaf persons and persons with

other physical impairments. The review will now turn to the issues that may arise in the therapeutic process with Deaf clients who do seek psychotherapy.

2.1.2. The therapeutic process with Deaf clients

Understanding what deafness means within a therapeutic context requires consideration of a multitude of elements, which interact with each other. Three elements commonly identified in the literature include: the tension in holding the ways in which Deaf clients may be similar to or different from non-hearing impaired clients; issues of communication; and theory of mind in Deaf clients.

2.1.2.1. Holding similarities and differences between disabled and non-disabled clients.

Perhaps one of the most significant points to consider when engaging with a Deaf / deaf client is that, as Oliver (1995) states, such clients should be seen as people before their disability features. This statement suggests that people (disabled and non-disabled) cannot be defined in an appropriate and comprehensive manner simply in terms of their physical attributes, including physical impairments, and that the emotional conflicts for hearing impaired clients may stem not only from their physical impairments per se but also from the same sources as for non-disabled persons. This perspective emphasizes the similarities between Deaf and non-hearing impaired clients.

Furthermore, there is no single psychological approach to Deafness (Clark, 1998, cited in Williams & Abeles, 2004) and the Deaf community is not a homogeneous group (Leigh, Corbett, Gutman & Morere, 1996; Oliver, 1995). This implies that each Deaf client and what they bring into the therapeutic context should be considered as unique (Oliver, 1995), and therefore the actual lived experience of the Deaf client is essential in understanding and contextualizing the concerns and meanings that Deaf clients bring into therapy.

In considering the issues regarding mental health provision for the Deaf community, there is a tension between having to hold, on the one hand, that the emotional concerns of the Deaf client may be the same as for non-Deaf clients, yet on the other hand, that there are certain elements that are pertinent and specific to a Deaf client's experience. These experiences include the social constructions that may have resulted in the client feeling marginalised, pathologized and lacking in agency. In other words, this tension lies in acknowledging that whilst the issues for disabled people are in fact often the same as for non-disabled people (Kemp & Mallinckrodt, 1996; Pelletier, 1985), and that deaf clients are likely to seek therapeutic interventions for many of the same reasons as hearing clients (Williams & Abeles, 2004), their experiences have most likely been influenced by a common thread of discrimination, prejudice and marginalization. As Marks (2002b) suggests, in order for disabled persons to truly gain any real benefit from a therapeutic process, therapists need to have not only an understanding of the unconscious dynamic of disability, but also an understanding of the cultural and political constructs of disability, thus suggesting that the *differences* between the hearing and hearing impaired communities are in fact also important to bear in mind (Kemp & Mallinckrodt, 1996).

However, there are a number of elements that the therapist may bring to the relationship which may hinder his or her capacity to hold this tension. For example, therapists may assume that their Deaf clients have entered therapy because of their physical impairment (Kemp & Mallinckrodt, 1996). This bias may inhibit the therapist's ability to accurately assess, conceptualise or formulate the client's actual concerns, which will most likely impede implementing a suitable and appropriate treatment. Instead a pattern of overprotective and controlling counseling, which under-estimates the client's capacities, may develop, which may be reminiscent of the client's previous experiences of the hearing world to date (Kemp & Mallinckrodt, 1996). If not resolved and worked through, this rupture in the therapeutic process may result in the client leaving therapy without receiving the help they were originally seeking. Consequently, the client's concerns and conflicts remained unresolved and their previous experiences of prejudice are simply confirmed.

Kemp and Mallinckrodt (1996) suggest that these biases and assumptions may lead to specific mistakes being made by the therapist. These include errors of omission and commission. The main aim of any psychodynamic therapeutic experience would be to understand the conflicts of the client in order to assist them to be able to work through and ultimately resolve these conflicts (Crisp, 2002; Marks, 2002*b*). As would be for any client, this process would necessitate curiosity, which would propel the therapist to inquire and gain insight into the culture and life of the client. The error of omission entails that the therapist does not ask the client critical questions about themselves. These questions could include asking about sexuality, experiences of alienation or interpersonal relationships. This could be due to the therapist experiencing an excessive amount of anxiety in engaging with the client's disability, or the therapist may have assumed that such information is not valid or necessary to gain from the client. The effect that this error of omission has is to subtly communicate to the client that in fact the therapist holds certain negative stereotypes of the Deaf client and therefore does not perceive the value in asking these important and significant questions. The client may then perceive their experiences as being unimportant and once again marginalised (Halgin & McEntee, 1986). Gaining insight through asking such questions is critically important in order to fully understand (or fully 'hear') the client.

An error of commission may occur when the therapist assumes that a particular concern is pertinent and significant for the client, based on the therapist's perception of disability – when in fact such concerns are not important to the client (Kemp & Mallinckrodt, 1996). This may communicate to the client that the therapist is focusing too much on the disability and disregarding what is actually of importance to the client (Kemp & Mallinckrodt, 1996). This shifts the focus away from the client's underlying concerns, diminishing their own meaning and perspectives (Kemp & Mallinckrodt, 1996).

The consequence of making either of these errors is that the social construction of the Deaf person as being 'sick', less than, vulnerable, fragile, lacking in agency, dependent and childlike, is reinforced in the therapeutic space. Making these errors may also have a profound influence in constructing the relationship between the client and therapist in

terms of 'therapist = rescuer' and 'client = vulnerable and sick' (Miller, 1992, cited in Kemp & Mallinckrodt, 1996). Furthermore, the therapist may be avoiding engaging with the client's disability and therefore be unable to explore the client's perspective about their previous experiences and what ultimately their disability has meant to them (Miller, 1992, cited in Kemp & Mallinckrodt, 1996). Deaf clients may experience mistrust for their therapists; they may feel unsupported and lacking in autonomy and may well have confirmed their expectation that their therapist will take control of or reject them, or even that they themselves lack the control and authority to care effectively for themselves (Hoyt et al., 1981; Oliver, 1995). It should be borne in mind that a Deaf person's environment may have largely taught them that they are unable or unworthy of communicating their needs (Finkelstein, 1996; French, 1996). Furthermore, they may have internalized that they do not actually know what their needs are and thus cannot communicate these (Loera, 1994). The Deaf client may therefore feel unable to engage in an open discussion of what their concerns are.

2.1.2.2. Communication issues

In the therapeutic process, or what is colloquially referred to as the “talking treatment”, Marks (2002*b*) suggests that a shared language as a mode of communication is necessary to allow the therapist to understand the cultural meanings of the client. Simultaneously a shared language will enable the disabled client to share their own meanings and representations with the therapist. Freeman and Conoley (1986) found that Deaf clients were more inclined to rate counselors in a positive light when they used Sign language (manual language) relative to using a Sign interpreter. This suggests that the common use of a shared language is important in order to assist the development of a bond within the psychotherapeutic process.

Children who have access to a Deaf culture and socialization process also have access to a shared language with which to communicate effectively and appropriately (Loera, 1994). However, Altshuler (1963) found that most hearing families preferred that their

deaf children used spoken / verbal communication as opposed to using sign language. Williams and Abeles (2004) have suggested that Deaf children may even experience punishment from their families and other social environments for using Sign language. The family of Deaf children may not learn to Sign and are therefore not able to provide a “language model” for their children (Schirmer, 2001, cited in Williams & Abeles, 2004, p. 643). These development contexts may result in Deaf children not being able to use Sign language and consequently being prohibited from accessing a cultural identity as Deaf individuals (Leigh, Corbett, Gutman & Morere, 1996). Meadow (1980) states that, while growing up, deaf children may have fewer experiences of social interactions as a consequence of reduced language development. Repeated thwarted experiences of attempting to communicate with their environment can often result in negative feelings for Deaf individuals, which ultimately results in social isolation and difficulties with entering and navigating the social system effectively (Loera, 1994; Meadow, 1980). In terms of how this may affect the process of therapy, Deaf clients entering the therapeutic process may not have the skills to express themselves in a way that a non-signing therapist will understand. Furthermore, the concerns and difficulties that deaf clients bring into the therapeutic context could be exacerbated by their limited ability to communicate with their environments, including with the therapist (Meadow, 1980).

These communicative difficulties are of prime significance in understanding both the general experience of Deaf individuals, but also the experience of Deaf clients in psychotherapy (Harvey, 1986; Leigh, Corbett, Gutman & Morere, 1996). These communication barriers may even result in Deaf individuals being labeled as “low functioning deaf...severely disabled, underachieving, minimal language skilled, multiply handicapped, traditionally underserved, high risk, psychologically unsophisticated and language and learning challenged” (Glickman, 2009, p.356). Significantly, as Glickman (2009) discusses, the term ‘traditionally underserved’ best describes the communication contexts of many Deaf individuals as this concept refers rather to the lack of adequate services and support that Deaf persons may have received, which has in turn influenced their diminished social functioning / integration and communication capacities.

Another key element in understanding the prime importance of communication processes within the therapeutic context is the tendency for some families of Deaf clients to ignore or diminish the impact of their child's (or family member's) disability (Mendelsohn & Rozek, 1983). If the family denies the child's (or family member's) disability, they ultimately ignore and disregard the child's (or family member's) experience, as well as their developmental and psychological needs. This can be replicated in the therapeutic process when the therapist ignores or diminishes the Deaf client's experiences of disability. Instead, acknowledging and trying to understand what these experiences have been may ultimately result in raising psychological concerns and also validating the client's experiences (Mendelsohn & Rozek, 1983). This necessitates the therapist acknowledging and exploring the client's disability through effective methods of communication (Mendelsohn & Rozek, 1983).

2.1.2.3. Theory of mind

Theory of mind is a fundamental part of development and involves the ability to understand the mental states of others as well as oneself (Hindley, 2005; Meristo et al., 2007). These mental states include beliefs, desires and intentions. Furthermore, theory of mind involves understanding how other mental states may differ from one's own. In order to develop a theory of mind, the individual must have access to a more mature mind with whom they can interact – developing a theory of mind must consequently originate through language input (Peterson & Siegal, 1999)

Peterson and Siegal's (1999) research found that deaf children may battle with being able to hold others in mind, as such processes depend on "conversational experiences and awareness" (Peterson & Siegal, 1999, p.126). Deaf children who have had limited access to the means of communication will have had limited access to opportunities to learn and develop their ability to hold other people's minds in their own, at least until they learn a more accessible means of communication, such as Sign language (Meadow, 1980; Peterson & Siegal, 1999). Petersen and Siegal (1999) suggest that Deaf children from

signing families have a better theory of mind relative to Deaf children from hearing or 'oral' (speaking in verbal English) families (Peterson & Siegal, 1999).

Meristo et al. (2007) explored the question of how access to an appropriate and accessible form of communication may influence or affect children's ability to develop theory of mind. Having access to a language through which one is able to understand others and express oneself provides children with the opportunity to access their significant care-giver's mind and be able to interact with this more mature mind. This accessibility to others establishes the foundations necessary in order to develop a theory of mind. The appropriate mode of communication provides the opportunity to develop a sense of other people's minds as well as being able to monitor other people's mental states appropriately. The study by Meristo et al. (2007) conveyed that children who have early access to an appropriate language (i.e. Sign Language versus verbally spoke English) have more opportunities for being exposed to other people's beliefs as well as being able to develop an understanding of how these beliefs can be different or even false. These children's performances on tasks that measure theory of mind thus reflect the children's "cumulative and constant" exposure to conversation (Meristo et al., 2007, p.1166).

Moeller and Schick (2006) found that conversations about mental states were also highly important for the development of theory of mind in Deaf children with hearing mothers, and that the quality (and not quantity) and accessibility of communication about mental states was highly significant for the development of theory of mind. Woolfe, Want and Siegal (2002) found that children who had access to Sign language from birth, as well as a family member who used Sign language, outperformed late signers and even seemed equal compared with hearing children in terms of theory of mind capacity.

Meadow (1980) adds that social interaction involves the ability of both parties, to a greater or lesser degree, to be able to assume the other's role. This social exchange of meaning requires that each party is able to 'hear', understand and offer an appropriate response. Deaf children seem to demonstrate a depressed ability to take on another's role

(i.e. empathy), which is however *not* related to general intelligence (Meadow, 1980). One explanation could be that Deaf children have not had the same opportunity as hearing children to develop their perceptual skills and must read facial expressions as opposed to understanding language. Meadow (1980) suggests that deaf children have had fewer opportunities to develop the skills related to receiving emotional interpretations.

A point that may also be considered is that the Deaf child's inability to respond effectively in social situations affects not only their own experiences but also the responses of the people they are interacting with – be it parents, friends, family members or even members of the mental health system (Meadows, 1980). This may add to an already potentially difficult communication experience for both parties.

Consequently, within the context of therapy or mental health services, the counselor / therapist should hold and explore with the client issues concerning communication; theory of mind as well as hold any differences or similarities the client may bring or experience within the therapeutic context. These elements are vital components in providing an appropriate mental health service for Deaf clients. Ultimately the client should be equipped with the skill of being able to have a better understanding of their emotional experiences, their desires, intentions and beliefs (i.e. theory of mind) and other relative psychological processes (Hindley, 2005).

2.1.3. Recommendations for therapist working with Deaf clients

Considering the above review of what being Deaf may entail, both out in the world and in the therapeutic space, what could a hearing therapist (who has never had access to a Deaf individual) actually do within the therapeutic context? Firstly, it could be suggested that therapists should not only learn Sign language, but also familiarize themselves with Deaf culture; however, this may not always be practically feasible. Halgin and McEntee (1986) have alternatively suggested that therapists should at least have an *openness* to multiple forms of communication as well as exploring their own and their client's anxieties. Similarly, therapists should learn to be able to acknowledge their own

stereotypes, theoretical approaches and methods of communication (Wright, 1983). Harris (1995) highlights the importance of co-constructing a *shared* means of communication – a format in which both participants are able to access each other's meaning, whatever system this may entail.

Some authors have suggested that these linguistic or communication (or even cultural) differences may be additionally managed by the therapist taking the initiative in conversation, being more active and directive with the client, as well as accepting that perhaps the client will initially only provide short and simple responses that may lack the richness in content that therapists would like (Hoyt, Siegelman & Schlesinger, 1981; Williams & Abeles, 2004). Furthermore, the therapist can also be more active in helping the client to label and describe their emotions and experiences, both past and present, thereby exposing them to conversations about mental states (Williams and Abeles, 2004). However, Oliver (1995) suggests that therapists need to recognise that the client is ultimately the expert on what *their* concerns and needs actually are, and it is therefore logical to accord the client their own 'voice' in therapy (however this 'voice' may be communicated). Similarly, Deaf clients should be provided the voice to be able to state what type of treatment they need in order to best resolve their concerns. The significance of this, even if the client has difficulty in communicating, is to re-construct the Deaf client as having agency, the capacity to make their own decisions, as well as validating them and their experiences (Kemp & Mallinckrodt, 1996; Oliver, 1995; Williams & Abeles, 2004). Furthermore, not adopting the role of expert, and acknowledging the knowledge and understandings of the client may encourage the therapist to be more inquisitive, enquiring and curious about the client. This may then function to help the therapist enquire about the client's experience rather than apply their assumptions about Deafness or disability in general.

Part of co-constructing Deaf clients as their own experts is to also acknowledge their strengths. Deaf people have (most likely) had to consistently confront the negative attitudes of others, which may have included negative and hurtful stereotypes such as that Deaf individuals are helpless, fragile, vulnerable, burdensome, asexual, passive and / or

childlike. Acknowledging that Deaf clients have had to endure such experiences can help the therapist to recognise that Deaf clients also have the strength and coping skills to manage these adversities. Halgin and McEntee (1986) highlight the importance of acknowledging the positives of Deaf client's experiences that may well include their ability to deal with society's projected anxieties and stereotypes.

Of prime importance to acknowledge and work through are the therapist's own anxieties, biases, assumptions, misconceptions and concerns regarding disability and Deafness, as well as their own sense of competency (Williams & Abeles, 2004). The therapist has both a professional and personal identity, and both identities are involved in the therapeutic process in times of success and failure (Hinshelwood, 1999). Thus acknowledgement not only of the patient's transference but also of the therapist's countertransference is essential in understanding the therapeutic space. Also to be kept in mind is the tendency for beginning therapists to experience countertransference in the form of narcissistic injuries. These include moments during the therapeutic context in which the therapist's 'ideal self' is at risk for feelings of shame and a depleted self-esteem. The training therapist is particularly at risk for experiencing narcissistic injuries which reduce the perception of oneself as a competent and adept therapist, and these feelings may lead the beginning therapist to act in ways that may not necessarily be facilitative for the therapeutic process (Mollon, 1989). Work with Deaf clients may therefore be particularly challenging for beginning therapists, compared with more experienced therapists.

Fusick (2008) suggests that mental health professionals working with deaf clients should engage in self-analysis in order to identify countertransferences and potential biases that may stem from a lack of knowledge and experience. Fusick suggests that mental health professionals may benefit from acknowledging and understanding their own thoughts and feelings regarding deafness. Given the anxieties and insecurities often experienced during training in clinical psychology, this kind of careful self-analysis may be particularly important for trainee therapists who are working with deaf clients.

In conclusion, the literature cited above reflects the sensitivity that clinicians and health care workers should exercise when working with Deaf clients. Furthermore, the culture of Deaf clients is an essential component that should be acknowledged during the therapeutic process, as well as the anxieties that the therapist may themselves experience in response to disability. There are, however, a variety of guidelines which can inform therapeutic work with a Deaf client seeking psychotherapy. Ultimately, the literature points to the urgent need for mental health care service providers who are competent in providing interventions for Deaf clients, highlighting the complexity of such work and the insight and empathy that should be demonstrated throughout such a process.

2.2. Relational psychology and intersubjectivity

Although using the literature on disability and Deafness is undoubtedly essential to understanding a therapeutic process with a Deaf client and the therapeutic failures that this may have entailed, intersubjectivity theory seems to add further depth in understanding **how** these therapeutic failures functioned, and **why** they were seemingly an integral part of the therapeutic process. In particular, Jessica Benjamin's theory provided a comprehensive understanding of the experiences of shame and therapeutic impasse which were prominent for the clinician / researcher during this therapeutic process.

As Aron (2006) acknowledges, the theory of intersubjectivity cannot be restricted to a specific or unitary definition. Intersubjectivity is located within the broad spectrum of relational psychoanalytic theories stemming from the post-Freudian psychological approaches (Benjamin, 1995). The theory of intersubjectivity could be used to refer to a multitude of theoretical concepts or ideas including object relations, self psychology, intersubjective theory, interpersonal trends or perhaps even "relational perspective" (Mitchell, 1993, cited in Benjamin, 1995, p. 2). Notwithstanding the unique and nuanced differences between these approaches, the common element in each refers to the "internal representations of relations, unconscious as well as conscious" (Benjamin, 1995, p. 2 – 3). What these approaches share is the belief that the human mind is interactive rather

than monadic and that the psychoanalytic process should therefore be understood as occurring between subjects rather than within the individual (Benjamin, 1995). These relational models emphasize the idea that a sense of self cannot be developed or exist in isolation, but rather that the meaning of experiences that contribute towards developing the self, in part, stem from recognising the 'other' in relation to the self (Miehls, 1999). Therefore in order for the infant to develop their independence and autonomy, in part they must recognise that there are others who are just like them - like subjects who are equal (Miehls, 1999).

As Benjamin (1995) discusses, the relational approach to psychoanalysis represents the possibility that the therapeutic processes involves two people and therefore two subjectivities, as opposed to the one-person based understanding of therapeutic processes. Within the relational psychoanalytic perspective, the concept of intersubjectivity has provided a relatively new perspective to, or rather an expansion of, the earlier theoretical understandings which took as their central theme that the subject's object relations with the other entailed a conceptualisation of the other as a fantasy object and who was psychically internalised by the subject. This original understanding of a relational psychoanalytic perspective was therefore based on a subject – object dyad whereas intersubjective theory suggests that, in fact, “where objects were subjects must be” (Benjamin, 1990, p. 34).

Each individual subjectivity has its own unique array of intrapsychic patterns (Benjamin, 2004). Each subjectivity, however, also inter-relates with other subjectivities in order to co-construct a new set of internal relations that exist between (that is, within the therapeutic context, between the client and the therapist) (Benjamin, 1995). Benjamin's approach calls for us to hold this tension between apparently opposing ideas or theories (intrapsychic and intersubjective theories), with the aim being to keep a “paradoxical tension in theory” (Benjamin, 1995, p. 6). Benjamin (1995) therefore takes the stance that although each theoretical approach represents its own unique perspective and understanding, this does not mean that each approach must necessitate exclusivity but

rather that both approaches must be held in “a transitional space in theory” (Benjamin, 1995, p. 6).

This transitional space in theory calls one to set aside the contradiction in order to enable one to “entertain more than one idea” (Benjamin, 1995, p. 6). From these sentiments, it may be evident that Benjamin's perspective suggests we need to hold and maintain the concepts of sameness and difference in order to understand a singular process. This holding of oppositions is complex and encompasses being able to hold contradiction and resist the urge to dismiss the tension. This theoretical structure, as proposed by Benjamin, suggests that each subject is thus able to assume, simultaneously, contrary positions in therapy. Significantly, it is this 'dual' role of opposites that relates to the processes of recognition and identification. In other words, this paradoxical stance allows each subject to be able to hold the other as a separate, unique and equivalent other subject (recognition) whilst simultaneously being able to relate to the other subject as a familiar and similar object (identification).

Benjamin's intersubjectivity theory “postulates that the other must be recognised as another subject in order for the self to fully experience his or her subjectivity in the other's presence” (Benjamin, 1990, p. 35). This reflects the concept of mutual recognition (Benjamin, 2004), which suggests that not only do we have the capacity (and need) to be able to recognise the other's subjectivity, but we also have the need to be recognised by the other as a subject.

The call to hold not only an intersubjective understanding, but also to maintain an intrapsychic perspective, suggests that subjects are not only able to recognise the unique differences of other subjects, but are also able to hold intrapsychically (through processes of identification) “the inner representation of an ideal, fantasy object which ultimately bridges any difference and perceives the other as an equivalent centre of being” (Benjamin, 1995, p. 7). The process of identification attempts to consume or devour the other into the self, which appears to preclude the capacity of the self to be able to recognise that the other is a separate, unique, independent and equal subject (the capacity

for mutual recognition) (Benjamin, 1995). Benjamin proposes that this ambiguity needs to be held both in practice and in theory, whereby the therapist must maintain both seemingly opposing positions.

2.2.1. Intersubjective space in a therapeutic context

Part of the complexity of an intersubjective stance within the therapeutic context is to shift the relation between client and therapist from subject and object to one of subject and subject (Benjamin, 2006). This shift entails changing the relation of one person *doing to* the other whilst the other is *done to*. Consequently, the complexity in shifting to an intersubjective therapeutic space is to hold the importance of the subject-object relation whilst holding the importance of having two individual, different, yet equal subjectivities who are nonetheless able to relate to each other and co-construct meaning within the therapeutic space as both 'like subjects, love objects' (Benjamin, 1995).

This shift, as Benjamin (2006) suggests, may be the ultimate goal of therapy: to assist the client in recognising the analyst as a subject – a separate, unique and different entity who is equal to the client, whilst still functioning as an object with whom one can identify. In order to help this process shift from subject-object relations to an intersubjective space is to provide the opportunity to allow the client to experience being perceived by the therapist as a subject (recognition) and thus being able to recognise their own subjectivity. However, part of this process would then also involve the client recognising, concurrently, that not only can and does the therapist view them as a subject, but that the client can view the therapist as a subject too. In other words, as Benjamin (2006) proposes, this would encompass mutual recognition. Benjamin (2006) proposes that in order to achieve the space of reciprocal or mutual recognition, the therapist needs to assume the *intersubjective position* or the *place of the third*, a place of more than observation.

2.2.2. Place of the Third

Benjamin proposes that the place of the third or thirdness, or the intersubjective position, refers to anything that could assist the therapist in helping to shift towards perceiving the client as subject and thereby help the client to view themselves as subject. This position of the third could be the profession or a theoretical perspective. Any element or approach that enables the therapist to create “another point of reference outside the dyad”, is the process of creating the space for the third – the space in which objects are shifted into, and experienced as, subjects (Benjamin, 1995, 2004).

The space of thirdness is the space in which subjectivity is acknowledged, co-experienced and co-constructed, whilst holding and experiencing the importance of having objects. Benjamin (2004) suggested that the “primordial third” can be thought of as an exchange of gestures that is regulated through “affective resonance and mutual accommodation” (Benjamin, 2005, p. 449). This exchange becomes a rhythmical dialogue which requires that both members of the dyad are active and adaptive (Benjamin, 2005).

Benjamin however warns not to reify the position of the third, but rather to maintain this space as a principle relationship (Benjamin, 2004). The message in helping this space to be created should not be to hold onto the position of the third but rather 'letting go into it'. This could be referred to as surrendering to the third (Benjamin, 2004).

2.2.3. Surrender

In this framework, surrender has “nothing to do with hoisting a white flag” (Ghent, 1990, p. 108), but rather it is intended to convey a sense of a “liberation of the self” as a means of “letting down of defensive barriers” (Ghent, 1990, p. 108). Surrender is meant to convey the process of being able to let go of the self, which enables one to consider another subject's point of reference and thus to be able to view the object as subject (Benjamin, 2000, 2004). The process of surrender involves being able to connect to

another's mind (identification) whilst also being able to acknowledge and experience this other as a separate and equal being.

Surrender is not submission (Benjamin, 2000, 2004; Ghent, 1990). Surrender does not represent any attempt to control or coerce, in fact quite the opposite. Submission is intended to maintain the relation between subject and object, between the one who is passive relative to the one who is active; the relation between doer and done-to. Surrender is about letting go to the other person – accepting that another reality can be equal yet different and accessible.

Ghent (1990) further proposed that we long for the opportunity to surrender, to be recognised for who we are, as subjects, to liberate our true selves. However, the expression of this longing may in fact present itself in the form of masochistic or submissive tendencies. Ghent argues that the therapist should “tread softly” (Ghent, 1990, p. 117) upon these submissive or masochistic needs, as they are ultimately the pathologized form of surrender in which the patient confuses the thing that is symbolised relative to the symbol itself. In other words, clients may present as submissive, however this is in fact a longing for the therapist to view them as their true selves, the need to be acknowledged, the need to be seen as a powerful and independent being. However the symbol intended to represent the 'true self' becomes the enactment of submissiveness where the therapist becomes the dominant member relative to the submissive client.

Surrendering consequently enables the therapist to create the position of the third in which meaning is co-constructed between two *subjects*. Benjamin suggests that being able to recognise the mutual influence of each member as subject enables both members to co-construct thirdness, a place of mutual recognition and identification (Benjamin, 2006).

2.2.4. Breakdown

Each subject must and does have their own unique attributes, yet can also experience the other as a familiar and similar object (Benjamin's 'like subject, love object'). Within the intersubjective space, there are no true and absolute binary relations between subject to object or active to passive or doer and done to. Rather, each member is doer and each is done to; each is subject and each can be both passive and active simultaneously. In other words, this intersubjective space enables both members to hold and perceive the other as separate beings with mental capacities. The relationship between object and subject, between doer and done to, between passive and active is a complementary relationship. However, the intersubjective space is a space of reciprocity, where differences are never asymmetrical.

The process of surrendering to the third, where there is a shift from object – subject to two subjectivities inter-relating and co-constructing meaning is understandably a complex and delicate process that can and **must** break down (Benjamin, 2004, 2006). The space in which intersubjectivity breaks down, where recognition of the other as subject collapses, where “thirdness always collapses into twoness” (Benjamin, 2004, p.29), is an essential part of therapeutic work.

Breakdown is when the dialectical exchange between recognition and negation collapses, when the tension between holding the other as both subject and object dissolves into holding the other as object only. As Benjamin suggests, “breakdown means unassimilable difference” (Benjamin, 2006, p. 44). Benjamin distinguishes between breakdown and negation. In order to recognise the other as subject, we are obliged to see ourselves as being different from the other (negating).

Breakdown represents the moment in which the other feels too different (too negating) to ourselves to be able to hold each other as subject. In other words, the point of breakdown is when the client feels that the therapist is too different to be able to view them as subject – when the “interpretation of our actions and intentions or even (her) very existence, is

too alien (too negating) to our own sense of self” (Benjamin, 2000, p. 44). In such moments of breakdown, the space feels like “one person is acting, the other reacting” and therefore neither member is able to participate in mutual recognition, and the co-construction of meaning is lost. Each member would thus feel as though they were “without agency, without the ability to stop or affect the other, I feel merely done to reactive and my subjectivity collapses along with the third” (Benjamin, 2005, p. 450).

This breakdown, however, is inevitable and expected and forms part of the fundamental basis for therapeutic work – the aim of the process being to learn how to manage breakdowns (Benjamin, 2000). Benjamin suggests that the reason for breakdowns may be due to the tension having to hold the other as both object as well as subject. This tension can be resolved when one person asserts their domination over the dyadic relationship and in effect displaces the opportunity and possibility for mutual recognition to occur. This then becomes a complementary relationship where reciprocity, and thus agency (both our own and the other), is disabled.

2.2.4.1. Key features of breakdown

Agency in the intersubjective space is experienced through the co-creation of this space and being able to recognise the other’s as well as our own subjectivity. Once we are able to recognise the other as subject we are in effect enabling them to experience themselves as subject. However, agency in the complementary relationship (in the breakdown of recognition; the breakdown of the third) is experienced as either submitting to the other's domination, which is imbued with a sense of coercion, or being the dominator and taking control. The complementary relationship does not enable either member to process, work through, hold, mediate or play with conflict (Benjamin, 1995). Agency morphs into a binary choice or reaction to assuming the role of the submissive, controlled and passive member of the dyad or the coercive, active, doer member. The position of thirdness, experienced in a complementary relationship, remains a position of mere observation. In this space, however, thirdness no longer embodies a sense of liberation, but rather a sense

of helplessness, a sense of being aware yet unable to take control or exert one's understanding (Benjamin, 1995).

Another key feature of the complementary relationship, according to Benjamin (1995) is that of symmetry. Symmetry functions, on the one hand, to enable both client and therapist to feel united, that by being so similar they are able to know the other. However, this symmetry disables the ability to truly recognise the other, as one sees the other as too similar to oneself that one is not able to view the other's unique characteristics, power or agency. It is this symmetry that makes the pair feel as though they are united, yet it also functions to disable any sense of mutual or reciprocal recognition that is required in order to help the other and oneself experience independence and subjectivity. Symmetry thus leaves each member with a choice of either submission or resistance.

Another feature of complementary relationships is that each member of the therapeutic dyad firmly holds the belief that it is only their perspective that is valid or, at best, that the other's perspective is essentially incompatible with one's own (Benjamin, 1995).

Furthermore, Benjamin (2004) suggests that within the context of complementary relationships, therapists experience self-blame. This self blame is a type of false responsibility and is really a form of helplessness. Although the therapist may attempt to reclaim their sense of agency, this cannot be achieved, as the therapist truly believes and feels that the other is in control. The only option that the therapist feels is available to them is to react or be rendered ineffective (Benjamin, 2004). Such feelings of helplessness may however be representative of compelling projective forces. The therapist may be consciously and intellectually aware of the back-and-forth nature of such processes, however the affective or more client-centered understanding of what is underlying these back-and-forth processes is actually dissociated.

2.2.5. Restoring the intersubjective space

Benjamin (2006) suggests that during these moments of breakdown and complementary relationships, surrendering to the third is needed. What this surrender entails is for the therapist to experience, hold and accept their feelings of helplessness or destruction. Part of this process of surrendering to the position of the third requires that the therapist acknowledge their own contribution to and co-creation of the process of breakdown, in order to accept the position of being responsible and thus reclaim his / her agency. The therapist is therefore required to accept and own their contribution and responsibility.

Part of the reason why this process (acknowledging the therapist's own contributions to breakdown) is so difficult and filled with tension is that the therapist fears that their own failures in the therapeutic process may resemble the actions of the original attachment figures in the client's past experiences (Benjamin, 2006). What Benjamin suggests separates the original attachment figure from the therapist is that the therapist is able to acknowledge and take ownership for their difficulty in being able to bear their feelings that may arise in relation to the client (Benjamin, 2006). It is this acknowledgement and ownership on the part of the therapist that will ultimately enable the client to be able to express their own feelings without fear of reprisal or rejection, and to be able to be connected with the therapist without the coercion or submission that may have been necessary with the original attachment figure (Benjamin, 2004).

By the therapist not sharing with the patient the felt experience of how the earliest fissures with attachment figures (Benjamin, 2009a) were recreated within the context of the therapeutic space, the patient is most likely to realise this and feel lost. Rather the therapist should share this with the patient and thereby invite "the abandoned, shamed and wounded part to become more vocal" (Benjamin, 2009a, p. 444). Not sharing these felt experiences of the original injury with the client would be a repetition of the devastating features of the original injury in which the adult attachment figure "denied the child's reality" (Benjamin, 2009a, p. 444). Significantly, as Benjamin (2009a) states, "what usually solidifies and makes intractable re-traumatization in the analytic dyad is

not the enactment itself” (p. 444), but rather it is the inability of the therapist to own and share their contributions and assumed role within the enactment.

The perspectives of the disability / Deafness literature as well as Benjamin’s intersubjectivity theory are in fact complementary. The literature on disability / Deafness provides insight into how a therapeutic process with a Deaf client can easily break down, which is when the therapist is unable to hold and explore the key elements of working with a Deaf client. Intersubjectivity theory therefore provides a rationale as to why the therapist may be unable to hold and explore the key elements (in working with a Deaf client), as well as providing a resolution that requires the therapist to surrender to the position of the third.

University of Cape Town

3. CHAPTER 3: METHODOLOGY

This methodology chapter begins by reviewing the aims of this study. Thereafter the rationale for using a hermeneutic paradigm and a psychoanalytic case study approach is discussed and the potential limitations thereof explored. The chapter then describes the case material and how it has been selected; provides background information on the case and discusses the approach to data analysis. Finally ethical issues pertaining to this research study are considered.

3.1.Aims of the research

This psychoanalytic case study aims to develop an understanding of the therapeutic failures which occurred in the early stages of therapy between myself as a training therapist and a Deaf client (Mary) and her family. The client's husband, Jon, initially formed part of this therapeutic process; however, he stopped attending the clinic after two sessions. The reasons he provided were based on a lack of available time on his part. The remainder (and thus majority) of the therapeutic process was therefore focused on Mary.

In order to achieve an understanding of the therapeutic failures in this case, a psychoanalytic case study methodology has been applied. The primary lens used in understanding this clinical case material is the theory of intersubjectivity as delineated by Jessica Benjamin. The constructs which have been applied in understanding this therapeutic process include breakdown, complementary relationship, surrender and the position of the third. In addition, the literature relating to therapeutic work with Deaf clients will be drawn on to contextualise this theoretical understanding, since the intersubjective process between therapist and Deaf client cannot adequately be understood without reference to the meaning of Deafness for both therapist and client.

3.2. Research Design

Clinical material is constructed by and through both the participant / client and researcher / clinician, which suggests that there can be no one singular truth, but rather multiple (whilst valid) truths that must be positioned within the stories and experiences of their authors (and co-authors) (Gibson, 2002). This highlights not only that the researcher has an interpretative function, but also points to the significance of considering context. Both the context of the client / participant as well as the context of the clinician / researcher must therefore be borne in mind. This constructs the client / participant and clinician / researcher as subjects with their own stories-within-contexts and alludes to a psychoanalytic perspective with an inclination towards an intersubjective understanding (Attwood & Stolorow, 1984). Attwood and Stolorow (1984) propose that an intersubjective understanding calls for a dialogue between the participant / client and researcher / therapist, which is influenced by their personal contexts. Consequently a psychoanalytic case study methodology was used in order to meet the aims of the research.

A psychoanalytic understanding of clinical material may be compatible with the interpretative approach as used in hermeneutics (Gibson, 2002). Attwood and Stolorow (1984) state, “(h)ermeneutics is the theory of interpretation” (Attwood & Stolorow, 1984, p. 2). A psychoanalytic understanding may be viewed as interpretative as it consistently attempts to understand the subjective meanings of individuals through their various modes of communication. In other words, psychoanalytic material is understood through interpretation and the construction of meaning achieved through such interpretation. These constructions, however, originate through the individuals (both therapist and client) involved in the psychotherapeutic process and are accessed through the process itself, by way of the therapist’s empathic understanding of the client’s context. There exists however a paradox in this approach, referred to as the hermeneutic circle. Within this hermeneutic circle the “parts give rise to the whole and the whole provides a context for evaluation of the parts” (Attwood & Stolorow, 1984, p. 5).

Such an interpretative approach involves an articulate and organised description of the client or participant's experience, with the aim being to "deepen understanding" (Gibson, 2002, p. 81). This hermeneutic process does not however produce facts or causes that underlie behaviours and situations, but rather aims to acknowledge the significance and meaning of interpretation from both the perspective of the participant / client as well as the researcher / clinician (Attwood & Stolorow, 1984).

Considering that the nature of the clinical material is that of an intersubjective dialogue, the psychoanalytic case study may be the most appropriate and meaningful research design for accessing and exploring such data in a valid and coherent manner. Attwood and Stolorow (1993) proposed three main components of a clinical case study approach. These included that clinical case studies are personalistic and phenomenological; historical; and lastly clinical and interpretative (Attwood & Stolorow, 1993). The personalistic and phenomenological components entail understanding the phenomenon from the individuals' (client / clinician or participant / researcher) "personal world" (Attwood & Stolorow, 1993, p.28) whilst the historical component pays heed to the historical or developmental context of the individual's story.

The clinical and interpretative perspective "advances the understanding of individuals not by the testing of delimited hypotheses arrived at on some independent basis, but through a process of interrogation and construction evolved from the empirical materials at hand" (Attwood & Stolorow, 1993, p.28). Once more, a case study approach necessitates the acknowledgement and consideration of context and interpretation as based on the construction of meaning(s) through the individuals' subjective experiences. These components of a clinical case study may then provide the tools for accessing clinical material that is both contextualised and intersubjective.

In order to account for the freedom of interpretation and produce authenticity in the results, such findings may best be evaluated in terms of hermeneutic criteria or presented using thick description (Attwood & Stolorow, 1984; Gibson, 2002). These concepts involve having a logical and coherent argument, overall comprehensiveness, as well as

consistency with established psychological knowledge (Attwood & Stolorow, 1984; Gibson, 2002).

The exercise of self reflection is “crucial to the researcher’s abilities to locate the meanings and assumptions they bring to the process of research” (Gibson, 2002, p.82). A self reflexive function enables the researcher / clinician to acknowledge the potential for unconscious emotional patterns (Hollway & Jefferson, 2000.). As Strupp (1981) proposes “each therapeutic dyad constitutes an experiment, albeit an experiment with built-in limitations” (p. 216). He suggests that we are “participants in and observers of immensely intricate human interactions” and consequently have the unique chance of being able to make “observations, discern connections (and) form hypotheses” (p. 216).

Gibson (2002) further discusses the importance of applying self-awareness in terms of understanding how the interpretations and any conclusions constructed through the psychotherapeutic process are necessarily framed through both the researcher / clinician and participant / client’s assumptions (Gibson, 2002). This would necessitate considering not only the individual contexts of the members of this therapeutic dyad, but also the social constructs of their communities which have undoubtedly influenced the meanings they bring into the therapeutic process (Gibson, 2002).

Even though the applicability of psychoanalytic case study methodology is valid and meaningful in exploring psychotherapeutic material, there have nonetheless been numerous criticisms against the use of case study methodology. These criticisms have included their lack of generalisability as well as a lack of objectivity (Hollway & Jefferson, 2000; Stake, 1994, Yin, 2003).

The case study is based on the constructs of subjective interpretation and the meanings generated by the participant / client as well as the researcher / therapist. Consequently, the case study does not necessarily have objectivity as its fundamental aim. Furthermore, there exists an insistence through the literature in support of case studies that, in order to maintain the rigor of case studies, it is the researcher’s duty to adopt a comprehensive,

systematic and self reflexive approach (Denzin & Lincoln, 1994; Kazdin, 1981; Kiesler, 1981; Strupp, 1981).

With regards to the lack of generalisability (Hollway & Jefferson, 2000; Stake, 1994, Yin, 2003) the strength of a case study lies within its capacity for being specific, as opposed to generalising to populations (Stake, 1994). Furthermore, Yin (2003) argues that a case study is in fact generalisable, however to a theoretical framework rather than to a population.

There is also the concern that although the advantage of a case study lies in its capacity to include context, at the same time there are difficulties in deciding how much or how little context to include (Gibson, 2002). This is referred to as the boundaries of a case. In attempting to maintain systematic rigor (Kiesler, 1981) in the current research, the manner in which the boundaries have been decided on in selecting case materials will be presented in as transparent a manner as possible.

As Messer (2007) suggests, criticisms against the psychoanalytic case study have also included “reliance on the therapist’s memory or brief notes; selection of the data by the therapist alone, the tendency to interpret case material in terms of reigning theoretical orthodoxy; lack of available context to allow the reader to accept or refute the therapists reading of the case and restriction of the data source to the therapist alone” (p. 55). These potential pitfalls in substantiating the validity of the data selection and analysis have been borne in mind throughout this study. In order to attempt to counteract these pitfalls, the suggestions of rigorous case study work have been applied in the form of thick description and self awareness or a self reflexive function. Furthermore, the therapeutic material included for analysis does not rely on the therapist’s memory but rather comes from video-recorded sessions as well as from notes taken during supervision sessions.

3.3. The clinical setting and background information

The therapeutic process with Mary, her husband, Jon, and Mary's child, Peter, took place at the University of Cape Town's Child Guidance Clinic (CGC) during my first year of training. The CGC is a university clinic which offers services of short to medium term length (maximum of 9 months duration). The services are mainly aimed at families and children, however may also include individual adult therapy. The fees for these psychotherapeutic services are in accordance with a sliding scale and are negotiated with the client at the intake interview.

The intervention with Mary took place over a period of seven months. Mary was my first intake client at the CGC. She was aged in her late 30's and her husband, Jon in his early 30's at the time of intervention. Mary had a Grade 12 education, and at the time of the therapeutic process worked in an administrative position. Mary lives with her husband, Jon, Mary's son Peter (from a previous relationship) and Mary and Jon's two-year daughter, Sally. Mary's son, Peter, was 8 years old. Mary is Deaf, however the specific details of whether she was born Deaf or whether she became progressively Deaf were reported inconsistently during the course of therapy and remained unclear. Mary's husband, Jon had a cochlear implant. The details pertaining to when Jon had the implant or the reasons why he had the implant were however not discussed or explored during the two sessions with Jon. Mary's son, Peter, was not Deaf.

They had entered the therapeutic process with the concern that their son was "misbehaving". This 'misbehaviour' included not listening, being forgetful and becoming 'lost in his own world'. Other concerns included that Peter was a sad child which was of particular and great concern to Mary. It was evident that they were both concerned about their son's apparent misbehaviour. They were unsure how best to manage Peter's 'misbehaviour' and were seeking parental advice as to how best to do this. Specifically, they indicated that they would appreciate feedback with regards to their parenting skills, that is, whether they were using appropriate strategies or not.

The aims and nature of the intervention changed during the course of therapy. Initially, the intervention included working with Mary and Jon as a couple, in order to assist with their concerns regarding Peter's behaviour. My formulation of the emotional and behavioural concerns was that Mary and Jon were experiencing a conflictual relationship. Specifically, struggled to communicate their needs to each other and find shared parenting solutions about how to raise Peter. The friction between them as a couple filtered into Peter's relationship with both Mary and Jon, thus giving rise to his own emotional struggles. Based on Mary and Jon's inability to reconcile their differences, neither parent was able to assist or focus effectively on Peter's emotional adjustment. The aim of the intervention was initially to access the emotional struggles which Mary and Jon shared as a couple in order to assist them in managing their son's feelings. My management plan was that by guiding Mary and Jon as a couple and helping them to find more effective communication mechanisms and to reconcile their differences, some of the tension that had developed within this family context would be resolved.

When Jon stopped attending sessions (after two sessions), this therapeutic approach needed adjustment as I was only able to engage with Mary. My intervention goal therefore changed to address Mary's own emotional difficulties in her relationships with Jon and Peter. This approach included trying to elicit information regarding Mary's emotional states and needs and her perception of other people's emotional states and needs, including Jon and Peter's.

The interpreter's role during this early stage in therapy was to translate my words for Mary and then translate Mary's words for me. The interpreter's role was therefore to function as a conduit between Mary and I.

During these early stages of therapy, however, an impasse or breakdown started to build. I consistently felt stuck and struggled in finding an adequate means of communicating with Mary – particularly during sessions without an interpreter present. During these sessions (without an interpreter present) I felt intensely awkward and uncomfortable in Mary's presence. Furthermore, I felt incompetent (indeed, disabled) as a therapist in

being / feeling unable to access Mary's thoughts, feelings and struggles. Throughout most of these sessions with Mary, my own countertransference responses were filled with anger and frustration. Anger at feeling disempowered, that is unable to connect with Mary, and frustrated at feeling unable to access information about her personal history or emotional struggles.

3.4. Description of case material

The sessions selected for analysis took place from between the beginning of therapy (initial intake session) until and including the 8th session. Any additional sessions, beyond the 8th session were not included, as the focus of this analysis was on attempts to understand the difficulties of the early stages of the therapeutic interaction. The 8th session was the beginning of a shift in the therapeutic process, when the impasse began to resolve. Case material includes (1) transcripts for the four video-recorded sessions (sessions 2, 6, 7 and 8 out of the first 8 sessions); (2) therapy notes for all eight sessions with Mary and (3) supervision notes for all eight sessions. The analysis focuses mainly on transcripts of the four video-recorded sessions, but therapy and session notes are utilized to track the therapeutic process as a whole.

3.5. Approach to data analysis

The aim of this dissertation was to explore how therapeutic failures occurred and functioned within the therapeutic space between myself and my Deaf client, Mary. The transcripts, session notes and supervision notes were examined closely through several re-readings. Recurring patterns in the communications between myself and Mary (and sometimes Jon or Peter, when they were present) were identified, named and described. Thereafter, the literature on Deafness / disability as well as Benjamin's intersubjectivity theory, were employed in order to develop an understanding of why these therapeutic failures recurred, and what functioned they served.

Although the subjective nature of using psychoanalysis as part of the research process has potential for creating a space for bias towards the personal and idiosyncratic characteristics of the researcher / clinician, the importance of such subjectivity has been acknowledged as a vital and significant component of psychoanalytic investigations (Hollway & Jefferson, 2000). Consequently countertransference experiences may be regarded as essential tools within a psychoanalytic case study and therefore examination into the researcher / clinician's as well as subject / client's unconscious assumptions remains a core element of psychoanalytic research (Hollway & Jefferson, 2000). It is however recognised that such limitations need be acknowledged and considered (Gibson, 2002; Hollway & Jefferson, 2000).

3.6. Confidentiality and ethical aspects

Ethical approval for this study was granted by the Ethics Committee of the UCT Psychology Department. As per the procedural policy at the CGC, the clients are informed with regards to the following:

- 1) sessions may be video-taped
- 2) data collected from sessions may be used for research purposes
- 3) if information from the therapeutic process is used for research purposes, there shall be no names or other identifying information used

The clients are given the opportunity to state whether or not they feel comfortable with these policies. Before the intake session, the client is requested to read the documents which expound upon these policies and provide a signature if s/he gives consent. The above policies are then verbally discussed at the beginning of the intake session. All consent forms were signed by Mary and verbally agreed to by her during the initial intake session. A sign language interpreter, arranged by the client, attended this session and translated the content for the client as well as her response. Although Jon did not attend the initial intake session, I discussed these policies with him in his first session at the clinic. Even though both written and verbal consent had been obtained and identifying information has been largely disguised, there nonetheless remain ethical concerns that are

necessary to acknowledge with regard to the use of clinical case material for research purposes.

As Bridges (2007) discusses, although “most analysts agree that writing about clinical work is essential for the development of therapeutically valuable ideas and advancing clinical work, there is no consensus in the field about how an analyst-author ought to proceed when it comes to reporting patient data and process” (p. 24). Sperry, Hartshorne & Watts (2010) propose that there are basic proponents when considering ethics which include confidentiality, conflict of interests, informed consent, and clinician competence.

With regards to confidentiality and informed consent, the concern pertains to whether clients would in fact be open to divulging their personal information if they were to fully realise that such information may be published (Bridges, 2007; Wharton, 2005). Client’s rights have been highlighted as an essential component within the therapeutic process, however conflict arises when juxtaposing client’s rights against “pedagogical responsibilities” (Sperry, *et al.*, 2010, p. 136). In other words an ethical dilemma exists when the rights of clients are held against the professional responsibility of the dissemination of clinical knowledge.

Clients may not fully comprehend the ramifications of providing such consent, and may potentially be incapable of providing consent whilst in a therapeutic process (Bridges, 2007). Furthermore, if consent has been provided, the possibility that such a decision may have been influenced by “transference or other unconscious factors, including a wish to please” (Bridges, 2007, p. 26) or a desperate need to receive mental health services should be considered.

This may suggest that the implications of informed consent need be fully expounded upon; however this may result in the patient refusing to provide informed consent (Wharton, 2005). The question then remains as to whether the research should or should not be conducted and how this would then influence the therapeutic process and the client’s rights (Bridges, 2007; Sperry, *et al.*, 2010; Wharton, 2005).

With regards to clinician competence, Sperry, *et al.*, (2010) suggest that knowledge alone is not sufficient to manage these ethical concerns. Rather a comprehensive understanding and meaningful consideration is required on the part of the clinician who is then able to “estimate(e) the impact of both the request for permission and the probability to which the client may be harmed through disseminating such client information” (Sperry, *et al.*, 2010, p.137) .

As suggested in the literature, another option beyond informed consent would be to disguise the information or even construct a composite client (Bridges, 2007; Sperry, *et al.*, 2010; Wharton, 2005). There remain, however, concerns with the applicability of such choices as the client may nonetheless be able to identify themselves and, furthermore, the information provided in such research is required to be as accurate as possible (Bridges, 2007; Sperry, *et al.*, 2010; Wharton, 2005) Combining the information from multiple clients may potentially blur and obscure significant pieces of information (Bridges, 2007; Sperry, *et al.*, 2010; Wharton, 2005).

As Wharton (2005) suggests, certain aspects should be considered in an attempt to resolve such ethical conflicts. These include waiting to start the research process until therapy has been completed (as was the case in this particular research study). Although obtaining informed consent, disguising identifying information and creating composite clients have been used as potential, although flawed, solutions, “(t)here may be no satisfactory way to reconcile the needs of the profession while protecting patients” (Bridges, 2007, p.24). Considering these difficulties and ambiguities, the ethical implications with regards to Mary and her family’s rights have been consistently considered throughout this research process. Although these ethical concerns have been managed through informed consent and disguising information, I acknowledge their imperfection and the complexities and ethical nuances that are core elements in such processes.

4. CHAPTER 4: ANALYSIS

The motivation for this analysis stemmed from my intense and consistent feelings of being overwhelmed and stuck during the early stages of therapy with a Deaf client and members of her family. During this time, I felt frustrated in my narrow and inhibited understanding of the client. Furthermore, during these stages I felt that the client was neither able / willing to hear me nor was the client able to provide (what I considered at the time) valuable information pertaining to her personal history and emotional struggles. I constantly felt disempowered and struggled to find a common therapeutic space where we (the client and I) were able to feel at ease in the therapeutic process. These feelings and experiences thus motivated me to search for patterns in the interactions between my client and I in order to make sense of this breakdown.

This analysis identified three ways in which therapeutic failures occurred during the therapeutic process. These therapeutic failures represented my own actions within this therapeutic context that disinhibited my capacity to meet my clients' needs, to find appropriate methods of communication. These therapeutic failures embodied my anxieties relative to my client's disability. These three forms of therapeutic failure are 1) over-talking, 2) not asking therapeutically pertinent and relevant questions, and 3) putting words into the clients' mouths. Each of these forms of therapeutic failures will first be illustrated using examples from therapeutic sessions. Thereafter the Disability / Deafness literature and Benjamin's intersubjectivity theory will be used to understand and explore why these therapeutic failures occurred and how they functioned within the therapeutic process.

4.1. Forms of therapeutic failure

4.1.1. Over-talk

I have used this concept to describe my tendency to be verbose in speaking with my client. This entailed my inclination to speak too much when explaining a concept or idea, using more words than was necessary and repetition of words. These moments of over-talk often consisted of an initial statement or question followed by a lengthy paragraph that attempted to further explain or even justify the initial statement, without giving the client adequate time to respond. This failure in the therapeutic process occurred multiple times and in the majority of sessions.

Example 1

An example of over-talk was apparent in the first session with Mary and Jon. This was Mary's second session and Jon's first, as he was unable to attend the initial intake interview. (The initial interview session included Mary's mother, Mary and Mary's two children.)

Within two minutes of being in the room with Jon and Mary, and without the interpreter, who was late, I began by introducing Jon to the therapeutic process. In accordance with the general practice of the clinic, I was required to introduce Jon to the basic procedures¹; however, both the length and content of my speech were verbose. Although I speak for a number of minutes, the actual proportion of information I conveyed to Jon was relatively small:

Therapist: "okay so just to start off, I know Mary I did speak about one or two of the things but to let you know Jon that all the information discussed here is confidential so it stays within the clinic, (um) I am recording the sessions, its just that it helps me remember everything (pause) you know a lot of information gets spoken about and I can't remember everything, so also because this is a team work (pause) and I think today is just to, Jon as I said over the phone, is just to hear your thoughts your feelings about things just to get

¹ These included advising clients about confidentiality, that the clinic functions as a team and that we general record sessions

some more information about what's going on you know whatever information you would like to give to me (pause) so is there any place you would like to start (pause) Jon, is there any place you would like to start (pause) anything you have been thinking about?"

Here I speak lengthily, conveying many ideas rapidly, using more words than necessary.

Example 2

This example was taken from the same session with Jon and Mary (session 2). The particular moment occurred five minutes into the session whilst Jon and Mary began to present their differences in speaking about Peter and Peter's needs. From this example, one can clearly see how I asked a multitude of questions, without providing my clients with the opportunity to respond adequately. Furthermore, I have also included a multitude of different messages each time I speak, which may have been experienced as confusing and overwhelming for my clients, further inhibiting their ability to answer any questions appropriately.

Therapist: "so I see that there are different views on Peter's behaviour...is that Jon you see it more as being a discipline issue whereas I think Mary you see it as being that Peter needs more of an emotion, there are times he needs to play but Jon you feel that that actually this isn't the case. So you are basically looking at the same issues but from very different perspectives..."

Jon: "and the other thing I picked up was that when you speak to him he does the opposite..."

Therapist: "can I ask Mary, you and Jon, where do you think this behaviour comes from? I know Mary you were saying that Peter's behaviour has changed...where do you think this change in behaviour has come from? What are your thoughts on this and Jon what are your thoughts on why this is happening?"

My response to Jon and Mary demonstrated my tendency to bombard my clients with multiple statements, queries or questions, which they are, in effect, unable to answer.

Furthermore, I have provided them with my own interpretation as opposed to first hearing their responses, opinions and experiences.

Example 3

Another example comes from a later session with Mary, Peter and I (session 7). This example takes place at the beginning of the session.

Mary and Peter enter the room. Peter immediately starts exploring the room as it is filled with toys, a desk and chairs, a white board with pens; however, he consistently walks back to his mother in between exploring the room.

I enter the room and immediately begin:

Therapist: “I thought what we could do today was just spend some time with you and with Peter and we could do some paints...spend some time and see how you guys spend some time together...”

This is yet another example of how I have tended to repeat the same concept, multiple times, as well as being wordy in my suggestions for the session.

Example 4

Another example of my tendency to repeat occurs further along in this session with Mary and Peter (session 7). At this point, Peter and Mary have started painting and I am still busy preparing the yellow paint, which Peter requested. During this period, however, I try to engage in conversation about how Mary and Peter spend time together. Once I have finished mixing the paint and after trying to state my question to Mary using Oral (verbally spoken) English, I write my question down and speak it at the same time:

Therapist: “just you and him...just you and him?...”

Mary answers yes and we engage in further discussion of the activities they engage in with each other. Eventually, Mary leads onto her concern that Peter often comes home

with little (if no) homework or homework that has been half completed. In such cases, Peter would have to go to bed early. I respond by asking Peter:

Therapist: “what do you think about having to go to bed early (pause) what are your thoughts (pause) What’s it like to go to bed early (pause) Mary he’s saying its not nice to go to bed early (Mary continues to look at me, yet without response or comment...”

This extract demonstrates my tendency to verbally bombard the client, asking a barrage of questions, without providing any real opportunity for a response.

Example 5

Another example of over-talk appears in the session with Mary, a new interpreter² and I (session 8). This session begins by everyone walking in and taking their seats.

Mary (signs to interpreter): “thank you for paying for the interpreter... Yes no I think (pause) that...She forgot to say in the email...”

Therapist: “And I think it’s a very important part of understanding each other because I think what I also wanted to say today was that I have been thinking a lot about our time together and our different sessions together and and actually I..I think I have been walking on eggs shells a lot and there’s a lot of things I don’t know (pause) I don’t know what your life must have been like, I don’t know what its like to be deaf and I think I have been (pause) instead of just asking questions I have been walking around them (pause) and (pause) I think I have and I am not quite sure how have you felt in these sessions or what you have noticed but um I am sorry about that actually because I don’t think we have actually (pause) you know (pause) communicated or were able to communicate and I think that’s why we decided that an interpreter is vital so that we can better understand and that I can better understand you and I think I have asked maybe some strange questions that seemed a bit odd but I

² Unlike the interpreter who previously attended the session with Peter, this current interpreter had never worked with Mary previously, or myself

think that really its really to try and understand you and your life and your family's life so...I was hoping that today we could almost start again in a sense”

As can be seen, I have used many words to describe a basic message. This message was meant to convey that in past sessions, I may have appeared strange and asked odd questions. By speaking less, I could have provided the client with more time and space to explore and express her own experiences.

4.1.2. Not asking pertinent questions

This form of therapeutic failure entails not asking questions that are relevant, appropriate and important in relation to the therapeutic process. Specific to the disability literature, these lost opportunities may include not asking questions related to issues of communication, to theory of mind or to differences and similarities of the client and therapist within the therapeutic context. This type of breakdown also occurred during all four sessions that have been included in this analysis. Throughout the sessions, I did not enquire as to Mary's history of being Deaf and how her family may have dealt with Mary being Deaf. For example, I never explored with Mary whether she was born deaf or whether her hearing loss was gradual. Similarly, I never explored with either Mary or with Jon how their mothers and fathers responded when they found out they had hearing problems. These questions would have been critical to understanding both Mary and Jon's lived experience and how this might have impacted on their own parenting of Peter.

Example 1

An unmistakable opportunity became apparent at the beginning of the first session with both Jon and Mary (session 2), whilst waiting for the interpreter. Here, I could have inquired as to Jon's and Mary's thoughts, feelings, attitudes, understandings or even previous experiences of having used, or needing to use, an interpreter. Pertinent questions may have included asking Mary and Jon what this experience of using an interpreter may represent or mean for them, whether they have had to use an interpreter in other situations and what these experiences may have been like.

Furthermore, I could have used this opportunity to engage with Mary and Jon about Jon's absence during the first session. I could have explored how Jon may have felt about not being present at this intake session, and asked Mary how she may have felt about Jon not being present during the first intake session. Additionally, I did not ask Jon why he decided to come to the clinic for the current session. Evidently, there were a multitude of very pertinent and relevant questions that could have begun this session, whilst waiting for the interpreter, which were not explored. Instead, I swiftly progressed into starting the session as follows:

Therapist: "whenever (*interpreter's name*) arrives, we'll just..."

Looking at Mary as if trying to gesture without hands but rather through facial expression that we will wait for the interpreter before we begin the session"

Jon: "continue"

Jon's phone rings, he answers and has a short discussion. When he is finished, I continue:

Therapist: "okay so just to start off, I know Mary I did speak about one or two of the things but to let you know Jon that all the information discussed here is confidential so it stays within the clinic, (um) I am recording the sessions, its just that it helps me remember everything (pause) you know a lot of information gets spoken about and I can't remember everything, so also because this is a team work (pause) and I think today is just to, Jon as I said over the phone, is just to hear your thoughts your feelings about things just to get some more information about what's going on you know whatever information you would like to give to me (pause) so is there any place you would like to start (pause) Jon, is there any place you would like to start (pause) anything you have been thinking about?"

Example 2

This next example further demonstrates a missed opportunity to explore pertinent and relevant aspects directly related to working with a Deaf client. This example also comes

from the above session with Jon and Mary (session 2), at the first point when Jon begins translating for Mary (as we are waiting for the interpreter to arrive). This moment represented an opportunity to explore the concept of communication and could have included what my clients' previous experiences have been of going to service providers and how they communicated with each other and with service providers in these situations.

Instead of engaging both Mary and Jon in exploring these aspects of their experiences, I ignore this situation (i.e. Jon translating our conversation for Mary) and allow Jon and Mary to continue their discussion (which ultimately excluded me). This moment occurred after I had introduced Jon into how the clinic operated and asked if he preferred to start with anything in particular or had any questions:

Jon: "maybe just to carry on, my questions might just pop up
(pause) I actually don't have questions"

Therapist: "okay so maybe also thinking, I wonder what's going to happen, what they gonna ask me...?"

Jon: "yes"

Therapist: "well it's also because (um) why have you decided to come to the clinic? In the last session, it was discussed that Peter was hav... (pause) that there were one or two things about Peter that you were a bit concerned about that he was not remembering things that he was forgetful that his mind wonders. I think its just to maybe just to asking questions about Peter and what life is like at home (pause) we'll be asking questions about yourselves and your family I mean obviously, whatever you feel comfortable in telling us is fine so it really is just a very informal chat for me to understand as much about yourselves as is possible (pause) okay?"

Jon: "okay"

Therapist: "there are no strict questions it's just about what you..."

Jon: "I have certain questions"

At this point Mary signs to Jon, however I am unsure of what she is saying or asking. Jon signs back without translating.

Mary (looking at me with a smile on her face): “(he) has different (pause) he doesn’t believe same”

Jon: “different aspect”

Therapist: “okay well I would like to see”

Jon: “okay, behaviour wise (pause whilst signing) behaviour wise I am very strict because of the area that I live in

Therapist: “okay”

Example 3

Another clear example of not asking appropriate questions or exploring the clients’ meaning sufficiently follows in the same session as above (session 2). After Jon and I had been discussing his childhood and consequently his approach towards discipline, Mary interjects that she would prefer to wait for the interpreter as she is not following what we (Jon and I) are saying:

Jon: “okay, next question?”

Therapist: “so if you would like to tell me a bit more of what your childhood was like?”

Mary gestures to Jon as though she does not understand, Jon responds by gesturing back for her to wait for a moment...

Jon and I engage in conversation about his parents and his childhood, however he is not signing for Mary.

Although I am well aware of this tension, I am at a loss as to how to draw her in. Eventually, Mary interrupts, with hand gestures and asks that we rather wait for the interpreter. She explains using verbal / spoken English and seemingly exasperated hand gestures that she cannot follow, as there are too many words.

After she says this, it almost seems as if she is embarrassed as she wipes her hands on her trousers in an uncomfortable and somewhat shy and embarrassed manner. Even her posture

at this point seems that of a young schoolchild. We now wait for the interpreter. There is silence, and then:

Therapist: “it’s frustrating...”

Jon: “yes, she finds it frustrating...” (he says this with compassion and a sense of endearment).

Therapist: I ask looking at Mary: “do you feel disconnected?”

Immediately Jon answers: “yes!”

And then signs as much to Mary.

At this point the interpreter arrives.

Once again, this moment provided a clear and direct opportunity to engage with both Mary and Jon about issues related to Deafness and disability and what both of their experiences have been. Furthermore, this would have been a perfect opportunity to engage with Mary about communication issues and any differences that she and Jon experience (both past and current) regarding communication abilities. Clearly, this may also have provided an opportunity to explore issues regarding theory of mind, as I could have put forward questions related to how either Jon or Mary understand what is going on in the other person’s mind. Instead, as demonstrated above, I do not ask any of these questions, but rather make a statement regarding what I assume to Mary’s emotional state.

Example 4

This example took place during the session with Mary and me alone (session 6), without the interpreter. Jon was supposed to be in this session, however, according to Mary, Jon was not able to attend as he had misplaced his keys and could not leave his house. Realising that Jon would not be present to translate, I attempted to use a computer to write my questions / comments down, to which Mary would be able to respond.

The beginning of this session presented an opportunity to explore Mary’s feelings about sitting alone with me (without an interpreter) or to explore any previous examples of

when she had to communicate with people who did not know how to speak sign language, and what her thoughts / feelings were about this.

Instead, this session begins with Mary attempting to explain why Jon was not able to make the session, which is followed by mostly a struggle in understanding each other and, most likely, much therapeutic information becoming lost in our exchange. We are trying to communicate by Mary speaking whilst I am typing on the computer, however ultimately nothing is truly discussed. Although I do eventually ask her if she is comfortable in communicating through the computer, I do not engage with her about what it is like for her to always have to speak with me by using a third person or, in this case, an object. Similarly, during this period, I did not ask Mary what it was like to communicate with others who do not speak sign language and how people who do not speak sign language have responded to her and how she has responded to them. In addition, I do not ask how she feels about Jon not being there.

Example 5

Another example similarly comes from the same session (session 6) with Mary and myself alone (without an interpreter) and occurred at the end of the session, just as we were about to run out of time. This session was difficult in trying to understand each other without an interpreter. Although, I attempted to use a computer to write down my questions, after a few minutes this felt more like a barrier than a helpful aid. I then began to write down most of my questions, to which Mary replied orally. At the end of this session, I sensed that we had a relatively good session as, at the time, it felt as though I had gained more information about Mary's history. At the point when we both realised that we had no more time left, Mary commented that I had worked / written quite a bit. I replied that we had achieved much during the session. Mary then says:

Mary: "its fine with you but with Jon there (pause) feel emotion
(points to other side of room and shakes her head...)"

Although Mary says more, I am unable to make out her words. I assume and interpret that she means to say that it is difficult to for her to speak with Jon present in the session

Therapist: “it makes it difficult as all the emotion comes out...”

Mary: “I must show him how I feel...”

Therapist: “so you feel that when Jon is here, you need to think of him and say things for him and it makes it difficult to balance me and him (pause) (Mary nods) (pause) okay”

After this we briefly discuss the time and date for our next session, Mary suggesting that she email me to confirm to which I agree. We then say goodbye to each other.

This example demonstrates that I clearly missed an opportunity to ask Mary why she feels uncomfortable with Jon being in the room, even though she seemed determined to have him attend sessions.

Example 6

This example takes place in the session with Mary, the second interpreter and I (session 8), at the start of the session. An interpreter had been pre-arranged and payment was subsidised by the clinic. This moment entails Mary thanking me / the clinic for paying for the interpreter, as well as my explanation and apology for conducting myself in previous sessions with such awkwardness. Mary starts:

Mary (signs to interpreter): “thank you for paying for the interpreter... Yes no I think (pause) that...She forgot to say in the email...”

Therapist: “And I think it’s a very important part of understanding each other because I think what I also wanted to say today was that I have been thinking a lot about our time together and our different sessions together and and and actually I...I think I have been walking on eggs shells a lot and there’s a lot of things I don’t know (pause) I don’t know what your life must have been like, I don’t know what its like to be deaf and I think I have been (pause) instead of just asking questions I have been walking around them (pause) and (pause) I think I have and I am not quite sure how have you felt in these sessions or what you have noticed but um I am sorry about that actually because I don’t think we have actually (pause) you know (pause) communicated or were

able to communicate and I think that's why we decided that an interpreter is vital so that we can better understand and that I can better understand you and I think I have asked maybe some strange questions that seemed a bit odd but I think that really its really to try and understand you and your life and your family's life so....I was hoping that today we could almost start again in a sense"

Interpreter's cell phone rings

Mary tries to sign to me what the interpreter had signed to her when she was looking for her phone to answer (pause) I eventually understand that Mary is telling me that the interpreter signed to her that we (Mary and I) must look at each other. We share a laugh when we understand each other

Therapist: "it's been strange as I have been looking at you and you have been looking at her"

Mary acknowledges that it has been strange with a smile and nod

Therapist: "it is an odd situation"

We both wait for the interpreter to finish....

Therapist: "maybe this is a good opportunity to chat, because I know '*interpreter's name*', thank you very much for coming in today (pause) but also gives a chance to chat because normally..."

'Interpreter 2' interrupts me by saying that Mary needs to look at me also. She turns her chair to sit next to mine so that we are both facing Mary who is sitting now out of circle and facing both of us.

'Interpreter 2': "important that she must see your face"

As with the other examples, I do not use this opportunity at the beginning of the session to engage with Mary about how she has felt during previous sessions in not having an interpreter; what her thoughts may have been regarding how we have been communicating; how she feels about using interpreters in general; or her experiences of having to communicate with people who are hearing as well as with people that do not know / use sign language.

4.1.3. Putting words into the client's mouth

This form of therapeutic failure refers to moments when I provided answers on my clients' behalf. This usually occurred when I asked my clients a question and proceeded to provide the answers for them instead of allowing them to answer for themselves. This also included that I stated my own assumptions of how they could be feeling or what they may have been thinking, rather than exploring this more openly. Furthermore, this failure included that I presumed to know what my clients thought and felt and pre-empted their responses before I could confirm my own interpretations. Ultimately I did not allow my clients the opportunity to express themselves freely.

Example 1

This example comes from the session with Mary and Jon together whilst waiting for the interpreter (session 2). I had asked Jon if he had any particular questions he would like to start with. He replied:

Jon: "maybe just to carry on, my questions might just pop up (pause) I actually don't have questions?"

Therapist: "okay so maybe also thinking, I wonder what's going to happen, what they gona ask me...?"

Jon: "yes"

Therapist: "well it's also because (um) why have you decided to come to the clinic? In the last session it was discussed that Peter was hav (pause) that there were one or two things about Peter that you were a bit concerned about that he was not remembering things that he was forgetful that his mind wonders. I think its just to maybe just to asking questions about Peter and what life is like at home (pause) we'll be asking questions about yourselves and your family I mean obviously, whatever you feel comfortable in telling us is fine so it really is just a very informal chat for me to understand as much about yourselves as is possible (pause) okay?"

Jon: "okay"

This example clearly demonstrates that I answered for Jon in stating what I assumed he was thinking, and did not acknowledge his clear response that he in fact did not have any questions or a place at which he would like to start. I even answer the question of why Jon came to the clinic at this point.

Example 2

Further examples of ‘putting words in the client’s mouth’ could be found in one of the sessions with Mary and myself alone (session 6). This particular moment occurred at the end of the session, after I had collected information regarding my client’s personal and family history. As noted above, initially in this session I began using a computer so that I could type out my words for Mary, but I soon abandoned this idea. Once Mary and I had realised what the time was (we had perhaps one or two minutes left), we both enjoyed a shared laugh, marveling at how distracted (in terms of time) we had become in going through Mary’s history.

Mary – laughing / smiling

Therapist: “yes, but we got a lot of information...it was great...it was good...it was good...how are you about today’s session?...as you seem (gesturing) you seem happier (Mary smiles and laughs in an coquettish kind of manner)...!”

This example demonstrates that I put forward my own interpretations of how the session was for me, not for Mary. I had felt that this session was productive and ‘good’, however I never actually asked my client what it was like for her, instead I made the suggestion that it was a good session. Only after I had stated that it was a good session do I ask my client what it was like for her and then proceed to intimate that it must have been a good session for her as she seemed happier.

Example 3

This example (which was also used above to illustrate another form of therapeutic failure) comes from the session with the second interpreter and Mary (session 8), at the

point when the interpreter receives and takes a cell phone call. Mary tries to communicate something to me through verbally spoken English. I assume I understand that she is commenting on the interpreter speaking on the phone whilst we are in a session. I smile and then respond with:

Therapist: “it’s been strange as I have been looking at you and you have been looking at her”

Mary acknowledges that it has been strange with a smile and nod

Therapist: “it is an odd situation”

From this short interaction, I presumed to know how Mary was feeling about this situation. These sentiments are in fact my own feelings of ‘strangeness and oddness’ and not Mary’s. Furthermore, I had not actually understood what Mary was trying to communicate to me whilst the interpreter was on the phone. Instead of presuming to know and understand, I should have asked Mary to explain again as I did not understand.

Example 4

This instance comes from a session with Mary and myself alone (session 6) and occurred towards the beginning of the session. Mary was explaining that she had “training” at work and although I cannot understand everything, I presume that she is referring to having to take time off or ask for permission to leave early so that she could come to the session.

Mary: “training...until 5...every Monday...had to ask for time...come through...make it on time...”

Therapist: “oh shame! And you still came...oh gosh, so it was a rush”

I gesture with my arms that I am running trying to demonstrate that I understand that she is telling me it was a rush to get from training to the clinic on time.

This example demonstrates that I was not able to comprehend all of Mary words and therefore may have missed out on information she was telling me. Consequently, I may have misunderstood what she was trying to say. Nonetheless, I still presume that what

Mary is speaking about warrants me to respond with “shame”, which assumed that she struggled with getting to the clinic and was looking for empathy. Mary never mentioned that this was a struggle and may have been trying to communicate something else. Once more I presumed to know what she was speaking about and instead projected my own emotional responses onto Mary.

4.2. Theoretical understanding of breakdown

The discussion which follows uses the lenses of both disability / Deafness literature and Benjamin’s intersubjectivity theory to understand how these therapeutic failures occurred and why they functioned in the therapeutic process. The discussion begins with an exploration regarding the therapist’s assumptions and anxieties, how these manifested within the therapeutic space and why they functioned as they did. The function and purpose of the therapeutic failures are then discussed in terms of the tenets proposed by the disability / Deafness literature in working with a Deaf client as well as Benjamin’s perspective of breakdown.

4.2.1. Nature of therapist’s assumptions and anxieties

As the disability / Deafness literature suggests, disability may be constructed as less than, incapable, unable and pathological (Crisp, 2002; French, 1996; Harris, 1995; Marks, 2002*a*, 2002*b*; Oliver, 1995; Zola, 1982*b*). Although it seemed as though my perspective of Mary was one of acceptance of her disability, I did not in fact engage with Mary’s Deafness at all during the initial stages of the therapeutic process. The underlying reason for my avoidance of engaging with Mary as a Deaf woman was based on my attempt to manage (to avoid, deny or pacify) my anxieties. My assumptions, upon which my anxieties were based, were rooted in common social constructions of Deafness / disability (Crisp, 2002; Marks, 2002*a*, 2002*b*), in that I unwittingly believed that being Deaf meant being vulnerable, ‘unable’ and fragile. These assumptions resulted in anxiety which

encompassed feelings of shame, guilt and discomfort. I felt anxious as, based on these mistaken yet unwitting assumptions and fantasies, I imagined Deafness as a shameful experience.

My anxieties included that I feared that by openly acknowledging Mary's Deafness, I would somehow damage, grossly offend, fatally wound, or break Mary and thereby share in these detrimental experiences myself. My assumptions were such that I imagined that being Deaf or disabled was tantamount to being unable-to, incapable-of-making-decisions, exceedingly vulnerable and fragile; that one was not able to function as a responsible and mindful adult fully capable of protecting oneself.

One of my most dominant anxieties pertaining to the initial experience of being with Mary was one of shame: I feared I would shame Mary, and inevitably myself, by highlighting her Deafness / disability, which would damage, break, grossly offend and fatally wound her. As the literature suggests, disability, when perceived of in terms of physical impairment, defines the experience of disability in terms of loss: loss of humanity, loss of independence, loss of agency (Finkelstein, 1996; French, 1996; Harris, 1995). I had unwittingly constructed Mary in terms of the physical impairment of Deafness and not in terms of Mary being part of a cultural group (i.e. in terms of deafness rather than Deafness). Instead of perceiving Mary as belonging to and having a particular cultural identity, I constructed her in terms of her physical loss and the lack of expected or 'normal' functioning. Consequently, I assumed that being Deaf meant being unable-to and being less-than-human, and having an experience of loss: the loss of Mary's humanity, the loss of her dignity and the loss of her independence. Such loss and inability as well as the lack of humanity were, in my fantasy, shaming.

My anxieties resulted in not only feelings of shame surrounding Mary's Deafness, but eventually morphed into feelings of being forced into a particular position relative to Mary. There were many instances where I felt obliged to function as Mary's savior, to help fix and eliminate her concerns. Once more, these sentiments were based on my assumptions that Mary was in fact in need of fixing. Understood from the perspective of

the disability and Deafness literature, many able-bodied individuals incorrectly assume that disabled individuals need and want to be saved and fixed (Crisp, 2002; Harris, 1995; Marks, 2002a; 2002b). Consequently, I assumed being Deaf meant needing to be fixed.

This mistaken fantasy was based, once more, on the construction of Mary in terms of physical loss and pathology: in that Deafness / disability was the equivalent of something pathological (Crisp, 2002) and therefore in need of a cure. Following this assumption, I imagined that I needed to assume or take on the full responsibility of looking after Mary. This was based on my fantasy or assumption that Mary ultimately was unable-to, and in need and want of 'fixing' / curing her (physical) ailments. These assumptions presented me with an experience of believing that 'fixing' Mary was fully positioned as my sole responsibility and that this was expected within the therapeutic process.

I felt trapped into such a position as ultimately (based on my assumptions) Mary was unable-to, incapable-of-making-decisions and excessively fragile and was therefore unable to help herself. My response to this feeling of having to take on being Mary's savior filled me with intense anger. In many session notes, I describe my feelings of rage towards Mary, rage that I interpreted was in response to feeling helpless in the face of such immense responsibility – i.e. having to 'cure' and 'fix' Mary. Once more, these assumptions and emotional responses were based on my unwitting construction of Mary as being less than, dependent, unable-to and exceedingly fragile.

Although my constructions and responses to Mary were largely based on my own assumptions and anxieties, at times these sentiments were reflected back to me and ostensibly confirmed Mary as being dependent and 'unable'. For example, in the early stages of setting up appointment times, Mary requested that I contact her husband's work on his behalf so that he would be able to attend sessions. Another similar example included Mary requesting that I contact her father in order to request that he (Mary's father) provides transportation for Peter, so that he may attend sessions.

However, the literature suggests that this identity may have been integrated (although inappropriately) as forming part of Mary's identity (French, 1996; Leigh, Corbett, Gutman & Morere, 1996; Oliver, 1995). The literature proposes that if one is consistently being constructed as being less than (by one's social environment), it may prove inevitable that this may become part of how one engages with the world. This experience of being constructed as passive and dependent, and then internalizing these perceptions as part of one's identity, may well have formed part of the painful emotional experiences that motivated Mary in coming to therapy.

However, these apparent confirmations of Mary's dependence only fuelled my sense of anger at Mary as being positioned as her savior, yet feeling helpless and unable to fulfil this role. My countertransference responses therefore included persistent feelings of being overwhelmed, angry and intensely anxious.

The three forms of therapeutic failures that occurred as a result of my anxieties and assumptions may be understood within the context of the three particular components that the literature on working with Deaf clients proposes need be attended to during the therapeutic process. These include holding differences and similarities; exploring and understandings issues of communication; as well as theory of mind.

4.2.2. Failure to hold differences and similarities

Understood through the lens of the disability and Deafness literature, these therapeutic failures resulted in the therapeutic relationship not being able to hold both differences and similarities. The literature suggests that Deaf clients are clients first and foremost (Oliver, 1995). This suggests that clients (both disabled and non-disabled) cannot be accurately defined simply by their physical attributes, which implies that the emotional components motivating clients (both disabled and non-disabled) to come to therapy may often originate from similar sources (Williams & Abeles, 2004). These sentiments relate to holding the similarities in doing therapeutic work with Deaf and hearing clients. In other words, the emotional struggles of Deaf clients may be (generally speaking)

comparable to those of hearing clients and most certainly go beyond their physical attributes. These similarities therefore are vitally important and significant when working with Deaf clients, as when working with any client.

The differences however are equally as significant. This is based on the client's experiences of being Deaf. This may have included being exposed to social constructions of deafness as 'damage' which may have been internalised by the Deaf individual, resulting in significant consequences in terms of the Deaf individual's psychological development. Understanding these experiences as a Deaf individual are therefore of vital significance within a therapeutic context – however they need to be held simultaneously with the similarities.

The three forms of therapeutic failure functioned to ignore or sideline such differences (i.e. the client's experiences of being Deaf and any possible emotional conflict). By over-talking I attempted to, unconsciously, replace both Mary's and Jon's emotional difficulties with my own words and avoided creating space to hear their experiences. Similarly, by not asking pertinent questions (such as about what her previous experiences have been regarding interpreters; or experiences of the health care industry or the service industry in general; what it must be like to sit with me, a hearing therapist who was not able to speak Sign Language; how they communicated with their family and what their emotional experiences of this have been; and what their understandings of being Deaf are and what their experiences have been that have impacted them the most) I was able to completely dismiss any of Mary or Jon's potential differences from me as pertaining to Deafness. Lastly, by putting words into both Mary and Jon's mouths, in essence I was replacing their emotional struggles with my own, assuming that their feelings were the same as mine (or what I imagined would have been mine in their situation).

These therapeutic failures could be understood in terms of Kemp and Mallinckrodt's (1996) errors of omission and commission. These failures allowed me to avoid asking relevant and vital questions, which included asking Mary what it is like to be in a therapeutic process with a hearing therapist (an error of omission). A perfect example of

this was during the first session with Jon and Mary, whilst waiting for the interpreter. I could have asked how Mary felt about having to wait for someone to translate for her and if this (using an interpreter) was how she communicated in other contexts as well. These forms of therapeutic failures also allowed me to avoid hearing about Mary's experiences of being Deaf, which I had assumed entailed massive psychological damage. Errors of commission were demonstrated through the therapeutic failure of putting words into my clients' mouths. In all the examples of this, I presume to understand and know the experiences of my client, without having explored this with them at all. My statements and interpretations are in effect my own understanding / interpretation of what have been significant experiences for them, based almost purely on my own fantasies and projections about Deafness.

Furthermore, the therapeutic failures functioned to focus my attention on areas that were not necessarily important to Mary's needs and / or experiences. Through both over-talk as well as putting words in my clients' mouths, I inadvertently focused on my own anxious experiences of Mary's Deafness instead of exploring what may have been significant and pertinent for Mary. For instance, in Example 3 of putting words into my clients' mouths, I suggest to Mary that our journey together (Mary's and mine) has been a strange and odd experience. This is however focusing on my own experiences of feeling strange within the therapeutic relationship. I did not ask Mary what this experience has been like for her.

In the examples of over-talk, once more my focus is on my own voice and my anxieties which leaves little if no space to focus on what may be significant for Mary and Jon. In Example 1 for over-talk, I leave little room for Jon to truly state any of his thoughts or feelings but rather fill the space with what is important for me to discuss, thus constituting an error of commission.

Miller (1992, cited in Kemp & Mallinckrodt, 1996) proposed that these errors of omission and commission position the therapeutic dyad as therapist=rescuer and client=vulnerable and sick. This relates directly to intersubjectivity theory's notion of the

breakdown of the third, where the therapeutic dyad becomes a complementary relationship of doer and done to (Benjamin, 1995). Ultimately, the client remains the socially constructed vulnerable and sick client who is less than, disempowered and dependent. The therapist however remains the powerful and active expert, the rescuer.

By over-talking, not asking pertinent questions and putting words into Mary and Jon's mouths, I was ultimately unable to acknowledge their differences from me. Instead, I related to both of them as objects, and thus assumed certain similarities with myself. I was therefore not able to see Mary for who she was beyond her disability; and simultaneously was unable to acknowledge what her lived experiences were of being a Deaf individual. These biases resulted in me not being able to see Mary as a subject and I was therefore able to maintain her as object only.

Mary as object represents my biased construction of Mary as less than, unable to, vulnerable and fragile. This could be seen as in relation to myself as the constructed doer, the active participant, the subject. Relative to Mary's inactive, passive, and unable-to-make-decisions object, I was the subject who was actively going to make decisions and 'fix' her. Thus these three therapeutic failures functioned to maintain a complementary relationship (i.e. a place where differences and similarities cannot co-exist).

4.2.3. Communication ruptures

As the literature on working with Deaf clients in therapy proposes, discussing and engaging with issues of communication is a pertinent and essential component of therapy (Harvey, 1986; Leigh, Corbett, Gutman & Morere, 1996; Marks, 2002*b*). However, I never engaged with Mary as to her lived experiences of communicating with others or even how she felt communicating with me. Instead, the three forms of therapeutic failure functioned to deny or dismiss any issues of communication and therefore Mary's Deafness.

I did not ask Mary what it feels like to have an interpreter present when discussing emotional experiences, I did not share my own confusion about how best to address her communication needs, and I did not explore her historical experiences of communicating with both hearing and Deaf people in her environment. By over-talking, not asking probing questions and putting words into my clients' mouths, I was able to ignore or dismiss any communication difficulties, even though engagement with such issues would have provided invaluable insight into Mary's experience and ultimately her emotional struggles. By engaging with issues pertaining to communication, one is inevitably engaging with the Deaf client's culture and consequently with their socialisation processes (Leigh, Corbett, Gutman & Morere, 1996; Loera, 1994). Insight into these areas ultimately provides access to their integrated identities and meanings.

More specifically, engaging with issues of communication can provide insight into the client's experiences of how their families and / or other relevant figures responded to them (Meadow, 1980; Schirmer, 2001 cited in Williams & Abeles, 2004). By not engaging with any communication concerns, I was unable to gain access to Mary's lived experiences, and to any problems or obstacles (psychological or otherwise) that she may have had in expressing her needs in therapy – all of which functioned as significant hindrances in trying to help Mary identify and resolve any emotional struggles. These three therapeutic failures therefore functioned to inhibit a more client-centered therapeutic process.

4.2.4. Theory of mind

Understanding theory of mind entails engaging with and exploring the client's sense and understanding of their own mental capacities (i.e. their intentions, desires and beliefs) (Hindley, 2005; Meristo et al., 2007). Having a theory of mind also includes being aware of not only one's own mental states or mental capacities (i.e. intentions, desires and beliefs) but also that other people have mental states. Furthermore, having a theory of mind means being aware that other people's mental states may well differ from one's own. Theory of mind is therefore knowing what one's own intentions, desires and beliefs

may be, acknowledging that other people similarly have intentions, desires and beliefs and being aware that other people's intentions, desires and beliefs may differ from one's own.

The three forms of therapeutic failure described above functioned to inhibit my access into knowing and exploring what either Mary's or Jon's beliefs, desires and intentions were, whether in terms of their experiences as Deaf individuals or their experiences as people. My over-talk, putting words in my clients' mouths and not asking pertinent questions disabled me from exploring, with Mary, what she imagines other people's desires, intentions and beliefs may be, how these may be different from hers and how she may feel about such differences or similarities. In other words, the three therapeutic failures disabled me from engaging with and exploring Mary's understanding of her intentions, desires and beliefs as I assumed that Mary, as a Deaf woman, did not have the capacity for theory of mind.

My over-talk functioned to avoid any focus on Mary and Jon's intentions, desires and beliefs, by rather focusing on my own. Not asking pertinent questions prevented me from actually accessing Mary's intentions, desires and beliefs and lastly, by putting words into Mary and Jon's mouths, I once more replaced any of their intentions, desires and beliefs with my own. By not acknowledging and exploring Mary's intentions, beliefs and desires, I was able to prevent myself from experiencing and exploring Mary as a Deaf client, thereby avoiding my own anxieties and feelings of shame and discomfort.

Understanding and accessing a Deaf client's theory of mind (i.e. their understanding of their own and others' intentions, desires and beliefs) is therefore a vital component of therapeutic work. However, in order to acknowledge that this was a pertinent component of Mary's therapeutic process, I would have needed to acknowledge and engage with Mary as a Deaf person which (once more) would have meant acknowledging and resolving my own anxieties.

Understood through an intersubjective lens, ignoring or not fully engaging with Mary's intentions, desires and beliefs also maintains Mary as an object, as I did not have to engage with accessing or acknowledging her differences (recognition). Instead I was able to construct Mary as similar to myself and ignore any differences (identification). These processes were achieved through the three therapeutic failures and enabled me to maintain (or allow) our therapeutic relationship to become and remain one of subject-object (that is, a complementary relationship).

4.2.5. Breakdown

An intersubjective perspective may suggest that the function of these three types of therapeutic failures may have been to force the therapeutic relationship into breakdown so that Mary and I (Jon withdrew from the therapeutic process after attending two sessions) would be able to co-construct our therapeutic relationship and shift the process from a complementary relationship into one of mutual recognition, a skill which the client would then be able to apply to relationships outside of the therapeutic process (Benjamin, 2006). The three forms of therapeutic failure thus functioned as three mechanisms of breakdown.

Intersubjectivity calls for being able to hold a transitional space in theory – a space that is intended to accommodate holding the tension of ambiguity (Benjamin, 1995). This ambiguity comprises being able to hold the seemingly contradictory positions of the processes of identification as well as recognition; in other words, having to hold both that which unifies and makes similar the therapist and client (identification) as well as having to hold that which makes both members unique individuals (recognition).

The function of these three therapeutic failures may have been to force the therapeutic process to address the tension in having to hold and maintain a relationship of mutual recognition whilst holding and maintaining the process of identification. As Benjamin proposed, breakdown denotes the moment when the client perceives the therapist as being too different to see them (the client) as subject; when the differences between

therapist and client become “unassimilable” (Benjamin, 2006, p.44). These three therapeutic failures therefore facilitated the process of breakdown by disabling my capacity to see past Mary’s differences (in other words her Deafness) and therefore functioned to construct and maintain a relationship of object-subject (that is, a complementary relationship).

My over-talk functioned to focus almost exclusively on my voice rather than my client’s experiences, both in terms of actual time as well as perspective. With so many of my own words being inserted into the therapeutic sessions, there was literally no space or time for my clients to adequately express their views and understandings, to truly be ‘heard’. Furthermore, the assumption in using so many of my own words was that my clients automatically agreed with my sentiments, as there was no space for either Jon or Mary to disagree or be different from myself or even each other. The effect was that I gained very little, if any, information as to what their underlying emotional experiences were and thus was unable to develop a more client-centered understanding.

By not asking pertinent questions I further avoided having to engage with either Mary or Jon’s lived experiences, thus preventing myself from perceiving them as subjects. As taken from Example 1 for over-talk, waiting for the interpreter seemed a clear and appropriate opportunity to explore the clients’ perspectives on using interpreters, communication concerns, or even issues about theory of mind (for example, were they aware of each other’s beliefs, intentions and desires?). Using this opportunity to speak about such pertinent issues may have enabled me, as therapist, to begin to see and accept Jon and particularly Mary’s differences, so that I could begin to experience them as subjects.

Putting words into my clients’ mouths similarly functioned to distract and inhibit my capacity to engage with either Jon or Mary’s experiences of being Deaf, as well as other significant aspects of their lived experiences and, once again, to be able to experience them as subjects. In Example 2 for putting words in my clients’ mouths, although Mary did not mention how she was feeling, I suggested that she was feeling frustrated. This

feeling of frustration was in fact my own emotion that I was inserting for Mary, instead of providing the containing space for her to express her own emotional responses and experiences without fear of inhibition or control from myself.

These three forms of therapeutic failure were, furthermore, an attempt to manage my anxieties regarding Mary's Deafness. For example, over-talk seemed to function to fill the therapeutic space with my voice, whereby I was able to avoid engaging with either Jon or Mary's lived experience of being Deaf, and consequently avoided (or attempted to avoid) my own anxieties and feelings of shame and discomfort. By avoiding asking pertinent questions regarding either Mary or Jon's life, I was able to avoid engaging with questions and answers that were directly related to my anxiety and feelings of shame regarding disability and Deafness. Lastly, assuming that I knew the clients' thoughts and feelings similarly functioned to displace both Mary and Jon's experiences with my own. Instead of providing Mary and Jon with the space to voice their opinions and experiences, I was inadvertently focused on my anxieties about being Deaf.

The key features of breakdown can be used to understand how my anxieties functioned within this therapeutic process. The key features include that agency is experienced as coercion; the position of the third is in fact a position of only observation (that is, one is aware yet unable to take control or exert understanding) and that only one perspective can be held and maintained (that is, a single perspective renders all others incompatible). Lastly, although there is a sense of therapist self-blame, this is in fact a sense of helplessness and lack of agency where a client centered perspective becomes dissociated. My anxieties were maintained through these key features and functioned in accordance with the nature of a complementary relationship. As I was unable to engage with Mary's experiences of Deafness and therefore acknowledge and engage with her as a subject, I was unable to hold Mary as both subject and object, thus maintaining the complementary relationship.

My anxieties did not only relate to my feelings of shame surrounding Mary's Deafness, but (as understood in accordance with the key features of breakdown) were related to

feelings of helplessness and coercion. Although I (and most likely Mary herself) was aware that something was amiss in our therapeutic relationship, I was unable to change the patterns of therapeutic failure described above, hence my persistent feelings of with being overwhelmed and anxious. I attempted to perceive Mary as having agency, by assuming that Mary had the capacity to understand the emotional states of others, thereby being able to engage and resolve the emotional struggles of her son. This was in fact a form of coercion, as I was not able to engage with Mary as subject, only object, thus 'forcing' Mary to disengage with herself as subject. My attempts to perceive Mary as having agency followed my own needs of trying to dispel the sense of responsibility I felt in 'fixing' Mary's emotional struggles.

I could not therefore engage with Mary in a client-centered approach and was not able to truly acknowledge or accept her differences (that is, Deafness). Although I was aware that something was amiss, I felt unable to take control or clarify my understanding. Furthermore, as I was only able to engage with Mary as object, and was not able to accept or explore what her subjective perspective (or experience) was, the complementary relationship as well as my anxieties were thus further maintained. Lastly, throughout many sessions, I felt a burdensome sense of responsibility to perform my role as savior, in relation to Mary's role of being 'dependent' and 'excessively vulnerable'. This sense of responsibility or self-blame, within the context of breakdown, actually functioned as a sense of helplessness and lack of agency.

This enactment was co-constructed and contributed to by both Mary as well as myself and followed the complementary roles of 'done-to' (taken on by Mary) and 'doer' or savior (taken on by me). This enactment may have been necessary in order to ultimately help Mary resolve past injuries. These injuries most likely included being perceived and experienced as less than, vulnerable, unable to, lacking in agency and without independence, which were replicated in this therapeutic enactment.

These three therapeutic failures may therefore have functioned to help facilitate the reconstruction of Mary's previous experiences with her family or significant others

within the therapeutic space, so that she would be provided an opportunity to resolve the emotional conflict stemming from these painful experiences.

The function of experiencing breakdown and the complementary relationship and shifting into surrendering to the third, is to allow the client's true self (Ghent, 1990) to come forward, giving the client the opportunity to be able to heal from past injuries (Benjamin, 2009a). However, in order to allow this shift, the therapeutic process needs to surrender to the position of the third and thus allow the complementary relationship to shift into one of mutual recognition (Benjamin, 2006).

As noted in Chapter 2, surrendering requires that the therapist experiences, holds and accepts their feelings of helplessness or destruction, acknowledges their contributions to and co-creation of breakdown, and accepts responsibility (Benjamin, 2009b). The therapist must then step out of their resistance (Benjamin, 2006), which ultimately helps the client to experience their own feelings without fear of rejection or abandonment.

In my experience with Mary, my point of beginning to surrender came in the guise of feeling as though I was 'giving up'. I felt exceedingly frustrated and exasperated with the therapeutic process and conceded that the only option was to give Mary what she had originally requested. What Mary had requested upon entering the therapeutic process was advice and guidance on helping her son (i.e. parenting guidance). This entailed accepting Mary and what she brought into the therapeutic process, providing her with the space to be whoever she needed to be, and thus validating her opinions and perspectives. This process required that I accept Mary for who she was, which included acknowledging and accepting that she is Deaf, but also that she has the agency to know and state her needs. After struggling with a desire to 'give up' the therapeutic process, instead of focusing on what I perceived to be the most important aspects of Mary's therapeutic process, I decided to comply with Mary's original request for parenting advice. I began by acknowledging that in fact I had felt awkward and unsettled in previous sessions and, secondly, by providing sessions in which we discussed various parenting concerns. The therapeutic space between Mary and I seemed to take on a different atmosphere after this

session as Mary began to share more information than was asked of her, and was more open regarding her emotional struggles. Furthermore, my own countertransference feelings of anger and frustration steadily dissipated and were replaced with a certain affection and respect for Mary and her lived experiences. Mary and I seemed more able to find a comfortable space with each other during this later stage of the therapeutic process.

4.3. Conclusion

The causes and functions of the three forms of therapeutic failure can therefore best be understood through a combination of the disability literature and intersubjective theory. Taken from the disability and Deafness literature, the experiences of a Deaf individual may entail very painful and difficult experiences based on the social constructions of society as well as the responses and reactions of family members. Indeed it appeared that Mary's experience of her family was that they were lacking in acceptance and engagement. Such experiences may represent emotional injuries, which Mary has not had space to acknowledge and work through. As recognised in the literature, and demonstrated through the therapeutic examples provided here, there is a high risk of these injuries being repeated in the therapeutic relationship. This repetition may occur through difficulties in holding both similarity and differences, through inattention to communication issues, and through difficulties in engaging with theory of mind, within the therapeutic relationship.

In the initial stages of therapy, my role was to be the dominator, active participant, and 'expert' who was able to 'fix Mary's problems, relative to Mary's passive, fragile, lacking in agency and unable-to-make-decisions role. Within the therapeutic context, as Benjamin suggests, the aim would be to help Mary experience herself as subject – as an independent and unique being, by shifting from a complementary relationship to one of mutual recognition. By re-enacting these past injuries within a safe and contained therapeutic context, Mary could be provided the therapeutic space within which to resolve some of the conflicts she had experienced. Benjamin proposes that by

surrendering to the third one is in effect enabling the client to shift from a complementary relationship into a relationship of mutual recognition. This calls for being able to share with the client, as therapist, one's experiences and take ownership of one's own contributions towards the construction of the breakdown in the therapeutic process. If the therapist is able to share their experiences and own their responsibility, the client is more fully enabled to express their own emotions without the fear of rejection, reprisal or abandonment. In other words, the therapist needs to play their part (Benjamin, 2009b) in order to allow the client's true self to come through; however, this can only be achieved if the therapist is able to consciously acknowledge their anxieties, share their experiences with the client, and take ownership of their contributions to breakdown.

University of Cape Town

5. CHAPTER 5: CONCLUSION

“A wise old owl sat on an oak; The more he saw the
less he spoke; The less he spoke the more he heard;
Why aren't we like that wise old bird”

Unknown

This final chapter summarises the most pertinent findings of this mini-dissertation. In so doing, this chapter integrates these findings in terms of the main components of the disability / Deafness literature as well as Benjamin's intersubjectivity theory. Furthermore, this conclusions chapter discusses the limitations of this mini-dissertation and also provides recommendations with regards to the content and findings of the analysis.

5.1. Summary of findings

This mini dissertation explored the psychotherapeutic impasse which occurred between myself, a training clinical psychologist and a Deaf client, Mary (as well as her husband, Jon). A case analysis revealed that during this course of therapeutic intervention, I committed three forms of therapeutic failure which instigated the impasse or breakdown in our therapeutic relationship. In order to understand and explore why and how these three forms of therapeutic failure occurred, disability / Deafness literature as well as Jessica Benjamin's intersubjectivity theory were utilized as lenses through which to view and understand that case material.

The psychoanalytic case study methodology entailed applying a hermeneutic perspective which drew attention to the subtle and nuanced meanings of understanding a contextual psychotherapeutic process (Attwood & Stolorow, 1984; Gibson, 2002). This formed an essential component of understanding how and why my client's context (specifically her Deafness) became a core component of how and why the three forms of therapeutic

failure operated. Using a psychoanalytic case study also allowed my countertransference experiences (which were largely underscored by my anxieties and assumptions as related to disability / Deafness) to be explored as part of understanding these three forms of therapeutic failure. The disability / Deafness literature enabled an understanding of *how* the therapeutic failures occurred within the therapeutic context whereas Benjamin's intersubjectivity theory provided an understanding of *why* the therapeutic failures functioned.

The disability literature considered in this dissertation is critical of a biomedical model of disability. Such a biomedical model assumes that disability is akin to loss, being incapacitated and 'unable-to' (Crisp, 2002; Marks, 2002a; 2002b; Marks, 1999). The implication then is that disabled individuals are excessively vulnerable, are unable to make decisions, are lacking in agency and are thus pathologised (Crisp, 2002; Harris, 1995). A biomedical model has been criticized for not only being reductionistic, but for being prejudicial, as it inappropriately assumes that particular features (that is excessive vulnerability and a lack of agency) of the disabled individual are inherent to the disability as well as the person (Crisp, 2002; Marks, 2002b). A social constructionist perspective of disability instead suggests that individuals with disability cannot be defined through their physical attributes, but rather through their lived experiences of social, psychological and political contexts.

Specifically in reference to literature regarding Deaf individuals, the underlying motivation for having such an understanding of Deafness is based upon the projected anxieties, fears and discomfort of the non-disabled community as related to perceptions about death, illness and difference (Harris, 1995). Such projections underscore the misconception that Deaf individuals need to be fixed, managed or rehabilitated to help them adjust to a hearing world (Harris, 1995; Harvey, 1987; Kemp & Mallinckrodt, 1996).

This understanding directly related to my own experience with my client. I was forced to confront my anxieties and assumptions pertaining to disability / Deafness in order to help

the therapeutic process to shift out of the impasse or breakdown. I felt anxious that somehow my interactions with my client would break or damage her, as based on my fantasy of her fragility and excessive vulnerability. Furthermore, I unwittingly imagined that based on her supposed lack of agency and inability to make decisions, the responsibility for ‘fixing’ or resolving all her struggles was solely my responsibility. The three forms of therapeutic failure identified in the analysis functioned to manage my anxieties by trying to displace, ignore and avoid them.

Through an intersubjective lens, my anxieties and assumptions about disability / Deafness, as managed through the three forms of therapeutic failure, gave way to the process of breakdown with the resultant complementary relationship (Benjamin, 1995; 1990). In other words, in order to manage my anxieties by implementing (unwittingly) the three forms of therapeutic failure, I was inadvertently creating the shift towards breakdown.

Intersubjectivity takes a relational perspective to psychoanalysis and implies that two people and therefore two subjectivities are involved in the therapeutic process (Benjamin, 1995). Each member of this therapeutic dyad therefore must hold being both object and subject to the other member being both object and subject. Benjamin therefore suggests that holding these apparently opposing positions simultaneously results in a tension that must inevitably cause breakdown. Breakdown in Benjamin’s intersubjectivity theory entails the point where the differences between client and therapist become “unassimilable” (Benjamin, 2006, p. 44). The process of breakdown results in a complementary relationship which represents the dyadic interaction between object-subject, doer-done to.

By trying to manage by anxieties pertaining to disability / Deafness, I was enabling the process of breakdown through the three forms of therapeutic failure that would inevitably result in a complementary relationship. Benjamin however proposes that breakdown and thus the complementary relationship, are inevitable, and that the experience of shifting such a complementary relationship into a relationship of mutual recognition is the

underlying aim of a therapeutic process. Mutual recognition becomes a skill which the client is then able to apply to relationships and contexts outside of the therapeutic dyad (Benjamin, 2004).

The process of breakdown occurred due to my inability to hold and explore the key elements in working therapeutically with a Deaf client. These elements include that the therapist must hold and explore the differences and similarities of Deaf clients, attend carefully to communication issues and be aware of disturbances in theory of mind (Kemp & Mallinckrodt, 1996; Oliver, 1995; Williams & Abeles, 2004). These elements are essential in exploring and understanding the lived experiences of Deaf clients in attempting to resolve and work through any emotional struggles they may be experiencing.

As I was unable to hold and explore these basic elements in working with a Deaf client, I was unable to engage in a client-centered therapeutic process. Thus the three forms of therapeutic failure functioned to beget breakdown by inhibiting my capacity to hold any differences and similarities, or to explore communication processes and issue of theory of mind.

The function or purpose of experiencing breakdown and the complementary relationship is such that we, as a therapeutic dyad, would be able to learn how to shift this complementary relationship into one of mutual recognition (Benjamin, 2006). A relationship of mutual recognition encompasses being able to hold the other as both object and subject simultaneously whilst being held, in return, as subject and object.

The process of shifting a complementary relationship into one of mutual recognition necessitates surrendering to the position of the third (Benjamin, 2006). This entails that the therapist must step out of their resistance and acknowledge their anxieties and contributions towards the co-construction of breakdown and the resultant complementary relationship (Benjamin, 2006; 1995). This process involved myself, as therapist, having

to acknowledge and explore my own anxieties and role in the process of breakdown as well as being able to share these experiences with my client.

In order to break the impasse and shift the process out of breakdown, I was obliged to acknowledge with my client the failures I had committed. This process began in session 8 which was approximately halfway through the total number of sessions with the client. By acknowledging not only my mistakes but my anxieties as well, I was able to free myself and the process from being inhibited and to access a more client-centered approach. Through this shift, I was then able to access more of my client's lived experiences during the therapeutic process and thus provide the potential for a more healing therapeutic experience for my client.

5.2.Limitations

A prominent limitation of this study lies in the application of intersubjectivity theory to a therapeutic process that involved more than one client. Benjamin's intersubjectivity perspective is based on a dyadic therapeutic context – however much of the case material used in this analysis has included the interactions / relationships between three members (myself, Mary and Jon, Peter or an interpreter). Although Jon (Mary's husband) exited the therapeutic process early, his presence and influence during the two sessions undoubtedly added a layer of meaning and context that has not been considered or explored in terms of either an intersubjective perspective or through the disability / Deafness literature. Although this may provide even further insight and understanding regarding the nature and course of this therapeutic process, the magnitude of such an exploration was beyond the scope for this mini-dissertation. However it must be acknowledged that such an omission may have blurred or misconstrued understanding the functioning of the three forms of therapeutic failure.

A further limitation follows the exclusion of exploring the impact and influence of sign language interpreters. The role and influence of the sign interpreter has a profound effect on not only the therapeutic process, but the manner in which meaning exchanged during

this process is interpreted by both the Deaf client as well as the therapist (Brunson & Lawrence, 2002). This results in the construction of a “triadic effect” relative to the traditional dyadic relationship between client and therapist (Brunson & Lawrence, 2002). Although this influence is important and significant, a limitation of this mini dissertation is that this influence has not been explored, due to the specific focus of this dissertation on the impasse or breakdown which occurred between the client and therapist. This occurred even prior to any direct influence of a sign interpreter. The breakdown however began to shift when the decision was made to use the services of a sign interpreter (part of beginning to engage more actively with issues of communication). This influence, although significant, was not the main focus of this dissertation. Consequently, the importance of understanding the role and influence of sign interpreters is acknowledged, although left unexplored in this mini-dissertation.

As discussed in Chapter 3, the limitations of using a psychoanalytic case study methodology have also been acknowledged. These have included that such a methodological approach lacks generalisability and objectivity in the traditional positivist sense. The literature suggests that such a methodological approach is based upon the subjective interpretations and meanings generated during the therapeutic process, and that it is the responsibility of the researcher to construct a rigorous and valid investigation. Furthermore, pertaining to the relative lack of generalisability, the function of many case studies is to take a more specific and focused approach that is in fact generalisable to a theoretical position rather than to the general population. Although I have attempted to bear in mind these methodological limitations and endeavored to manage them appropriately, the potential for bias is acknowledged. In addition, the theoretical lenses that were selected for this case analysis allow for a very particular reading of the case material; other theoretical frameworks may have elicited different readings of the material. However, the use of the disability / Deafness literature and of Benjamin’s intersubjectivity theory allowed me to make sense and meaning of what felt like a stuck, messy and frustrating stage in the therapeutic process with a Deaf client.

5.3.Recommendations

This analysis indicates that an exploration of the issues related to working with disabled clients would be a useful and pertinent component of training programs for health and mental health professionals. Additional research is also required to further explore and acknowledge the experiences of Deaf or disabled clients in service related contexts, in order gain a more client-orientated perspective. Such a perspective and understanding of a disabled client's lived experience may contribute towards deconstructing the misconceptions generated by a biomedical approach and may well contribute towards improving the human rights context of providing adequate and appropriate services for disabled communities.

University of Cape Town

6. REFERENCE LIST

- Altshuler, K.Z. (1963). Personality traits and depressive symptoms in the deaf. In J. Wortis (Eds.), *Recent advances in biological psychiatry* (pp 63 – 73). New York: Plenum.
- Aron, L. (2006). Analytic impasse and the third: Clinical implications of intersubjectivity theory. *International Journal of Psychoanalysis*, 87, 349 – 368.
- Attwood, G.E. & Stolorow, R.D. (1984). *Structures of subjectivity: Explorations in psychoanalytic phenomenology*. New Jersey: Lawrence Erlbaum Associates, Inc.
- Attwood, G.E. & Stolorow, R.D. (1993). *Faces in a cloud: Intersubjectivity in personality theory*. London: Jason Aronson.
- Benjamin, J. (1990). An outline of intersubjectivity: The development of Recognition. *Psychoanalytic Psychology*, 7 (Suppl.) 33 – 46.
- Benjamin, J. (1995). *Like subjects, love objects: Essays on recognition and sexual difference*. (pp. 1 – 25). New Haven: Yale University Press.
- Benjamin, J. (1995). *Like subjects, love objects: Essays on recognition and sexual difference*. (pp. 27 - 48). New Haven: Yale University Press.
- Benjamin, J. (2000). Intersubjective distinctions: Subjects and persons, recognitions and breakdowns: Commentary on paper by Gerhardt, Sweetnam, and Borton. *Psychoanalytic Dialogues*, 10 (1) 43 – 55.
- Benjamin, J. (2004). Beyond doer and done to: An intersubjective view of thirdness. *Psychoanalytic Quarterly*, 73, 5 – 46.
- Benjamin, J. (2005). Creating an intersubjective reality: Commentary on paper by Arnold Rothstein. *Psychoanalytic Dialogues*, 15 (3) 447 – 457.
- Benjamin, J. (2006). Crash: What we do when we cannot touch: Commentary on paper by Meira Likierman. *Psychoanalytic Dialogues*, 16 (4) 377 – 385.
- Benjamin, J. (2009a). Psychoanalytic controversies: A relational psychoanalysis perspective on the necessity of acknowledging failure in order to restore the facilitating and containing features of the intersubjective relationship (the shared third). *International Journal of Psychoanalysis*, 90, 441 – 450.

- Benjamin, J. (2009b). Psychoanalytic controversies: Response. *International Journal of Psychoanalysis*, 90, 457 – 462.
- Bridges, N.A. (2007). Clinical writing about patients: Negotiating the impact on patients and their treatment. *Psychoanalytic Social Work*, 14 (1) 23 – 41
- Brunson, J.G. & Lawrence, P.S. (2002). Impact of sign language interpreter and therapist moods on Deaf recipient mood. *Professional Psychology: Research and Practice*, 33 (6) 578 – 580.
- Crisp, R. (2002). A counselling framework for understanding individual experiences of socially constructed disability. *Disability Studies Quarterly*, 22 (3) 20 – 32.
- Crown, N.J. (2008). Slips of the tongue, sleights of the hand: observations on psychotherapy in Sign Language. *Psychoanalytic Psychology*, 25 (2) 356 – 362.
- Denzin, N.K. and Lincoln, Y.S. (1994). Introduction: Entering the field of qualitative research. In N.K. Denzin and Y.S. Lincoln (Eds.) *Handbook of qualitative research*. (pp.1 – 17). London: Sage.
- Freeman, S.T. & Conoley, C.W. (1986). Training, experience, and similarity as factors of influence in preferences of Deaf students for counselors. *Journal of Counseling Psychology*, 33 (2) 164 – 169.
- Freeman, S.T. (1989). Cultural and linguistic bias in mental health evaluations of Deaf people. *Rehabilitation Psychology*, 34 (1) 51 – 63.
- French, S. (1996). Disability, impairment or something in between? In J. Swain, V. Finkelstein, S. French & M. Oliver (Eds). *Disabling barriers – enabling environments*. (pp.17 – 26). London: Sage Publications.
- Fusick, L. (2008). Serving clients with hearing loss: Best practices in mental health counseling. *Journal of Counseling and Development*, 86 (1) 102 – 110.
- Ghent, E. (1990). Masochism, submission, surrender. *Contemporary Psychoanalysis*, 26, 169 – 211.
- Gibson, K. (2002). Politics and emotion in work with disadvantaged children: Case studies in consultation from a South African clinic. Unpublished doctoral dissertation, Department of Psychology, University of Cape Town.

- Glickman, N.S. (2009). Adapting best practices in CBT for Deaf and hearing persons with language and learning challenges. *Journal of Psychotherapy Integration*, 19 (4) 354 – 384.
- Halgin, R.P. & McEntee, D.J. (1986). Psychotherapy with hearing-impaired clients. *Professional Psychology: Research and Practice*, 17 (5) 466 – 472.
- Harvey, M.A. & Dym, B. (1987). An ecological view of Deafness. *Family Systems Medicine*, 5 (1) 52 – 64.
- Harvey, M.A. (1986). The magnifying mirror: family therapy for Deaf persons. *Family Systems Medicine*, 4 (4) 408 – 420.
- Hindley, P.A. (2005). Mental health problems in deaf children. *Current Paediatrics*, 15, 114 – 119.
- Hollway, W. & Jefferson, T. (2000). *Doing qualitative research differently: Free association, narrative and the interview method*. London: Sage.
- Hoyt, M.F., Siegelman, E.Y. and Schlesinger, H.S. (1981). Special issues regarding psychotherapy with the Deaf. *American Journal of Psychiatry*, 138, 807 – 810.
- Jampel, J.B. (2010). When hearing clients work with a deaf therapist. *Psychotherapy Theory, Research, Practice, Training*, 47 (2) 144 – 150.
- Kazdin, A.E. (1981). Drawing valid inferences from case studies. *Journal of Consulting and Clinical Psychology*, 49 (2) 183 – 192.
- Kemp, N.T. & Mallinckrodt, B. (1996). Impact of professional training on case conceptualization of clients with a disability. *Professional Psychological: Research and Practice*, 27 (4) 378 – 385.
- Kiesler, D.J. (1981). Empirical clinical psychology: Myth or reality? *Journal of Consulting and Clinical Psychology*, 49 (2) 212 – 215.
- Leigh, I.W., Corbette, C.A., Gutman, V. and Morere, D.A. (1996). Providing psychological services to Deaf individuals: a response to new perceptions of diversity. *Professional Psychology: Research and Practice*, 27 (4) 364 – 371.
- Loera, P.A. (1994). The use and application of cognitive-behavioral psychotherapy with deaf persons. In R.C. Newell and L.E. Marshak (Eds.), *Understanding deafness and the rehabilitation process* (pp 155 – 187). Boston: Allyn and Bacon.

- Marks, D. (1999a). *Disability: Controversial debates and psychosocial perspectives*. London: Routledge.
- Marks, D. (2002a). Introduction: Counselling, therapy and emancipatory praxis. *Disability Studies Quarterly*, 22 (3) 1 – 5.
- Marks, D. (2002b). Some concluding notes – Healing the split between psyche and social: Constructions and experiences of disability. *Disability Studies Quarterly*, 22 (3) 46 – 52.
- Meadow, K.P. (1980). *Deafness and child development*. London: Edward Arnold.
- Mendelsohn, M. and Rozek, F. (1983). Denying disability: the case of Deafness. *Family Systems Medicine*, 1 (2) 37 – 47.
- Meristo, M., Falkman, K.W., Hjelmquist, E., Tedoldi, M., Surian, L. and Siegal, M. (2007). Language access and theory of mind reasoning: evidence from deaf children in bilingual and oralist environments. *Developmental Psychology*, 43 (5) 1156 – 1169.
- Messer, S.B. (2007). Psychoanalytic case studies and the pragmatic case study method. *Pragmatic Case Studies in Psychotherapy*, 3(1) 55 – 58.
- Miehls, D. (1999). Couple therapy: An integration of object relations and intersubjective theory. *Smith College Studies in Social Work*, 69, 2, 335 – 355.
- Moeller, M. P., & Schick, B. (2006). Relations between maternal input and theory of mind understanding in deaf children. *Child Development*, 77 (3) 751 – 766.
- Mollon, P. (1989). Anxiety, supervision and a space for thinking: some narcissistic perils for clinical psychologists in learning psychotherapy. *British Journal of Medical Psychology*, 62, 113 – 122.
- Oliver, O. (1995). Counselling disabled people: counsellor's perspective. *Disability & Society*, 10 (3) 261 – 279.
- Peterson, C.C. & Siegal, M. (1999). Representing inner worlds: theory of mind in Autistic, Deaf, and normal hearing children. *Psychological Science*, 10 (2) 126 – 129.
- Raifman, L.J. & Vernon, M. (1996). Important implications for psychologists of the Americans with disability act: case in point, the patient who is Deaf. *Professional Psychology: Research and Practice*, 27 (4) 372 – 377.
- South African Statistics <http://www.statssa.gov.za/publications/P0301/P0301.pdf>, accessed 15 October 2010.

- Sperry, L., Hartshorne, T.S. and Watts, R.E. (2010). Ethical considerations and options in publishing clinical case material. *The Journal of Individual Psychology*, 66, 2, (135 – 143).
- Stake, R.E. (1994). Case studies. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 236 – 247). London: Sage.
- Strupp, H.H. (1981). Clinical research, practice, and the crisis of confidence. *Journal of Consulting and Clinical Psychology*, 49(2) 216 – 219.
- Van Deusen-Phillips, S.B., Goldin-Meadow, S. and Miller, P.J. (2001). Enacting stories, seeing worlds: similarities and differences in the cross-cultural narrative development of linguistically isolated Deaf children. *Human Development*, 44, 311 – 336.
- Wharton, B. (2005). Ethical issues in the publication of clinical material. *Journal of Analytical Psychology*, 50, 83–89.
- Williams, C.R. & Abeles, N. (2004). Issues and implications of Deaf culture in therapy. *Professional Psychology: Research and Practice*, 35 (6) 643 – 648.
- Woolfe, T., Want, S.C. and Siegal, M. (2002). Signposts to development: Theory of mind in deaf children. *Child Development*, 73 (3) 768 – 778.
- Yin, R. K. (2003). Introduction. Case study research: Design and methods, 3rd ed. In R.K. Yin (Ed.) *Applied Social Research Methods Series*, vol 5. Thousand Oaks: Sage Publications, Inc. (pp. 1 – 18)
- Zola, I.K. (1982a). Denial of emotional needs to people with handicaps. *Archives of Physical Medicine & Rehabilitation*, 63, 63 – 67.
- Zola, I.K. (1982b). Social and cultural disincentives to independent living. *Archives of Physical Medicine Rehabilitation*, 63, 394 – 397.