Layering Lenses: An exploration of integration in Counselling Psychology

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pp 184-216: **Section D. Publishable paper**: 'Maybe if I had heard my mother's tongue I might speak easier': a multi-layered exploration of internal processes in Psychodynamic therapy.

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

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Declaration

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SECTION A - PREFACE

INTRODUCTION TO THE PORTFOLIO

1.0 Part A: Overview

This doctoral portfolio is bound together through the theme of integration. Each piece demonstrates how different paradigms, approaches, and lenses can be layered together with the aim to create an integrated and meaningful understanding. It contains three pieces of work, a research project, a publishable paper and a case study. They were completed as part of my doctoral training in Counselling Psychology at City University, and reflect my developing identity as a counselling psychologist and a researcher, as well as an expression of my personal development.

The first part of the portfolio is the research project (Part B). It is an original piece of qualitative research exploring how Black and Ethnic Minority (BME) clients internally process psychodynamic therapy using an integrated, multi-layered methodology. Part C is a demonstration of my clinical practice. It is a case study describing a piece of clinical work using an integrative approach. Part D is the publishable piece based on the same multi-layered analysis as the research piece, but focusing on one participant's interviews in order to create a detailed case study. In this preface I will summarize each piece of work in order to further illustrate the theme of integration.

2.0 Part B: Research Project

My qualitative piece of research is entitled 'Maybe if I had heard my mother's tongue I might speak easier': A multi-layered exploration of internal processes of BME clients in psychodynamic therapy and is based on the research question 'How do Black and Ethnic Minority clients internally process psychodynamic therapy sessions? Three BME participants in psychodynamic led therapy were interviewed three times. The interviews were interpreted using a multi-level approach, including a phenomenological, discourse and psychodynamic readings. These three analytic lenses,

each with varying paradigms for understanding internal processes, were integrated to create a layered analysis of the interviews. Each layer creating a deeper understanding of their internal processes. They were bound together by the overarching epistemological stance of moderate constructionism, which postulates that 'reality' exists in some form but that it may not be concrete or accessible. In order fully integrate the approaches, I also proposed that knowledge is constructed through discourse, but is limited and founded in 'reality'.

An integrated multi-level analysis was needed in order to address the complexities of inner processes in psychodynamic therapy, which range from conscious thoughts and emotions to unconscious elements such as defences, attachment and mental models. Chamberlain, Cain, Sheridan and Dupuis (2011) argued that complex phenomena need complex methodologies, and by bringing together different readings within a multi-level approach the researcher can examine a phenomenon from varying perspectives. A pluralistic approach is not restricted by the assumptions and theoretical framework of a single approach, allows the researcher to use a range of analytical tools and emphasizes transparency at every level (Frost et al., 2010). In accordance with this, counselling psychology also holds a framework where concepts and interventions from different therapeutic approaches are brought together (Cooper & McLeod, 2007). Therefore, McLeod (2001) stated that a pluralistic approach is in-line with the values and traditions of counselling psychology.

The aim of this project was to explore whether there are shared and/or unique aspects about the way BME clients internally process this type of therapy. I also reflected on the benefits and weaknesses of using a multi-levelled analysis, challenges, transferability and limitations of the methodology and the results. I summarized the major themes and discussed the results in the context of relevant literature, implications for practice and suggestions for future research. In line with McLeod's (2001) emphasis on maintaining an intimate relationship between research and practice within counselling psychology, this piece aimed to enrich our understanding of the clinical work with BME clients.

3.0 Part C: Professional Practice

Counselling psychology embraces a pluralistic approach within the therapeutic work (Cooper & McLeod, 2007). This case study demonstrates my integrated, pluralistic approach of working with a client with depression and Borderline Personality Disorder. It includes an outline of the client's presenting problems, followed by a psychological formulation, description of the interventions used, and a critical analysis of the work.

This approach integrated Cognitive Behavioural Therapy and a psychodynamic approach through theoretical integration and technical pragmatism. This created an amalgamation of the core theoretical aspects from each approach that were bound together in an overarching structure, in which specific techniques and interventions were pragmatically used according to the needs of the individual in-line with their formulation and therapeutic goals. This integration addresses both the theory behind the approach and what the work with the client looks like.

In order to theoretically integrate these two models, I used Gold and Stricker's (2001) three tier model. It proposes that personality is divided into an unconscious mental processes tier, a conscious cognitions and affect tier, and a behaviour tier. From this model I conceptualise that psychodynamic theory explained the developmental aspects of a formulation, whereas CBT described current functioning according to behaviour and cognition. Psychodynamic theory provide the general and overarching interventions, whereas CBT provided the specific day-to-day interventions.

4.0 Part D: Publishable Paper

I will be submitting this paper to the Qualitative Research Journal (QRJ). I chose this journal because it focuses on articles with diverse, qualitative methodologies, in-line with the research presented in this portfolio, and is perceived as being at the forefront of modern qualitative approaches. It is also an international journal with a high impact factor, therefore this article could reach a wide audience. Due to the constraints of the submission guidelines, I focused on one participant from my research project in order to create an in-depth case study. The publishable piece used a multi-level qualitative

design to explore the internal processes of one BME participant in psychodynamic therapy with a White therapist. I chose to keep the multi-level analysis rather than limiting the analysis to a single reading, as I felt the three readings had been designed to build on the previous analysis and therefore were not stand alone readings. It also maintains the theme of integration. Furthermore, a case study is in line with the emphasis Counselling Psychology places on the individual human experience.

5.0 Reflective threads and personal experiences

The theme of integration is also relevant regarding my personal experience and general philosophy. A theme that I reflected on in the research project is how I am both British and American and grew up moving from country to country. Furthermore, I am from an American state called New Mexico, which has its own unique cultural blend including Mexican and Native American. As a child I felt that I had to choose one culture at a time, but as an adult I have been able to create a more stable, integrated sense of self.

As a child who moved frequently I learnt to pull together different skills and perspectives in order to move past obstacles. If I had gaps in my knowledge I would often approach the issues from a different perspective. I have since taken my varying experiences and cultural outlooks and built up a layered sense of self. I can now see that this layered and integrated sense of self is mirrored with my multi-layered methodological approach.

My clinical work also mirrors this integration and sense of layering. Within my training I was always drawn to both the CBT and psychodynamic approaches, but initially worked purely in one approach or the other. In my final year I have felt confident enough to assimilate these approaches through theoretical integration and pragmatic interventions based on empirical evidence, the formulation and therapeutic goals. This integrated approach can be seen in my case study.

Counselling psychology also follows a scientist-practitioner model (Corrie & Callahan, 2000). In agreement with this, my personal philosophy is pragmatic, accepting both

positivist and hermeneutic approaches based on the circumstances. Therefore, both the external reality and internal process are valid, resulting in an integrated theory. In my clinical work, this involves choosing specific interventions based on empirical evidence, the formulation and therapeutic goals.

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SECTION B – EMPIRICAL PIECE

The Research Component

'Maybe if I had heard my mother's tongue I might speak easier': A multi-layered exploration of the internal processes of Black and Minority Ethnic clients in psychodynamic therapy.

Genevieve M. Hughes

Supervised by Dr Jessica Jones Nielsen

Abstract

Black and Minority Ethnic (BME) communities are encouraged to engage with psychological services and psychodynamic approaches are recommended to meet their diverse needs. Although external aspects have been explored, there is a gap in the literature regarding internal processes of BME clients in this type of therapy. This thesis aimed to fill this gap by using a multi-level, pluralistic qualitative design to explore the internal processes of three BME participants in psychodynamic therapy; ultimately investigating shared and/or unique elements. Three semi-structured interviews were analysed using three analytic strategies: descriptive phenomenological, discursive and psychodynamic readings. The main themes from the phenomenological reading were the importance of the therapeutic relationship, 'strong persona' defences, the past and the present: personal and family history, 'aha' moments, fear and vulnerability, and differences to the therapist: not feeling fully understood. The common discursive themes were maintaining control, externalizing difficult aspects of therapy, fragmenting parts of themselves, and struggling to vocalise differences in ethnicity, leading to frustration and compartmentalization. The main findings of the psychodynamic reading were recreating the original culturally infused injury, cultural differences in the transference, feeling different/same, multiple identities and a further exploration of defences. The findings suggested that both the client's and the therapist's ethnicity, culture and race impacted the clients' internal processes in psychodynamic therapy. The practical implications are to enhance therapeutic work with BME clients by increasing the applicability and usefulness of psychodynamic therapy with this specific ethnic minority group. This thesis' emphasis on individual perspective, reflexivity, intersubjectivity and diversity are in-line with Counselling Psychology principles. Recommended future research could focus on BME participants in a specific and structured model of psychodynamic therapy and perhaps use data collection methods that go beyond semi-structured interviews.

CHAPTER 1 - Introduction

1.1 Overview

In this overview I will identify the key sections of this chapter and then summarize the findings that lead to the rationale and aims of the present study. This chapter entails an exploration into the literature on the Black and Minority Ethnic (BME) communities' relationship with mental health services in Britain, as well as race, ethnicity and culture in psychological therapies. It will also look at key themes and criticisms of modern psychodynamic therapy and process research, with an emphasis on internal processes. It will then discuss criticisms of research in psychodynamic therapy, BME women in psychodynamic therapy and race, ethnicity and culture in psychodynamic therapy. Finally, the aims and rationale for the thesis will be identified.

This chapter will also summarize the key psychodynamic theories regarding internal processes in therapy. This includes the structure of the psyche, defences, interpreting dreams, continuous construction developmental theory, attachment theory and object relations theory. Although the literature has been mixed, some psychodynamic theory propose that inner processes can be affected by race, ethnicity and culture. Javier and Yussef (1995) stated that introjections and identifications are enabled by our cultural and ethnic object world, which influences how we interact with the world around us. Thompson (2012) found that African Americans had unique internal conflicts concerning sense of self and trusting others. He also proposed that family dynamics, social class, appearance and colour all play a role in African American identity formation.

Williams, Turpin and Hardy (2006) found that BME groups were marginalized and excluded from psychological services on a number of levels in the United Kingdom. The Delivering Race Equality Action Plan (2010) and the Analysis of the Impact on Equality of Talking Therapies (2011) indorsed offering psychodynamically led approaches in order to meet the needs of the BME community. However, there are concerns regarding the culture of whiteness attached to psychodynamic therapy, which

may lead to BME clients compartmentalizing aspects concerning their race, ethnicity or culture (Dos Santos & Dallos, 2012). For example, Thompson, Bazile and Akbar (2004) found that African Americans clients reported that they edited themselves in order to feel understood by their therapist.

The emphasis that mental health initiatives are placing on offering psychodynamic therapies to BME clients and research regarding the impact race, ethnicity and culture have on internal processes warrant further consideration of BME internal processes in psychodynamic therapy. Therefore this study aims to explore BME clients' internal processes to investigate whether there is something shared and/or unique.

1.2 Personal Statement

As the sole researcher in this project I was involved in every aspect from inception to the final product. It was important that I was systematically self-critical at every stage in order to detect any of my own thoughts, ideas, and biases that may have arisen. In order to create a frame of reflexivity for this research I used the Yardly criteria, which highlights the qualities of good qualitative research practice (2000). This includes 'sensitivity to context', 'commitment and rigour', 'transparency and coherence' and 'impact and important' (p219). In order to achieve this I relied on the support from my supervisor, therapist, and faculty as a whole during this process. I also worked with my supervisor to create a Research with Minority Participants working group to think about and work through some of the complexities of working with BME participants.

With regard to my personal history with this topic, I have an ambivalent relationship with psychodynamic approach. On one hand I am drawn to it and feel that it resonates with me on a personal and professional level, and on the other I am mystified and somewhat scared of it. I feel that my curiosity and desire to learn more of the internal processes of the patient within this approach has stemmed from this sense of 'mystery'. Throughout my training I have actively sought out ways to increase my knowledge on psychodynamic theory in order to help me research this

question. This has involved joining a psychodynamic reading group, attending external and internal lectures on the topic, and personal reading on topics such as Lacanian theory.

As for my positioning on the topic, I have often personally felt outside of mainstream culture and slightly different or not quite understood by those around me. From this position I would try and think about how others who are outside of the White, middle class population - from which psychodynamic therapy arose from - may feel. I suppose it may have been a sense of imagined empathy around feeling like an outsider, and how that may translate during the therapy that emphasizes the internal and working relationally. This was a topic which I explored in therapy, particularly as I began to put words to these feelings. I felt that it was important to articulate this so that I could either bracket it or write about this in my reflective journal.

I have my own experiences with psychodynamic therapy from the perspective of both the client and the therapist, which could potentially lead to my own presuppositions and biases around the internal and external processes involved. I am not purely a researcher, my status as a research/practitioner is likely to have affected this piece of work as I am not approaching the subject with fresh eyes. During the subsequent chapters I will be exploring my own biases in more depth. The rationale for this is an attempt to increase the rigour of this research.

1.3 BME: A definition

The term Black and Minority Ethnic (BME) describes minority groups living in the United Kingdom based on ethnicity, shared language, culture and/or skin colour. According to the national census in 2001, 7.8% of the population of Britain consider themselves BME (Fernando, 2005). The main subgroups have been identified as Asian, Chinese, Afro-Caribbean and Black African.

It is a heterogeneous group based on self-inclusion or identification within the group. Generally speaking they fall outside of the majority population of 'White British', and

the term denotes an experience of prejudice because of this (Cantle, 2006). Fernando (2005) stated that the concepts of 'race' and 'culture' have been replaced by the term 'ethnicity' for the purpose of categorization based on the national census. However, he described how the term ethnicity is designed to encompass the two, as it reflects the history and language constructed within the identity.

1.3.1 BME: Relationship with psychological therapies in Britain

Over the past 50 years concerns have been raised over the inclusion of BME groups into psychotherapy services, as research demonstrates that they are not given adequate access to psychotherapy. In a literature review carried out by Williams, Turpin and Hardy (2006), they found that BME groups were 'generally marginalized and excluded from mainstream services on a number of different levels' within the United Kingdom (p. 324). This included a lack of referrals, professional misinterpretations of psychological distress, and inadequate attentions to spiritual, language, and cultural differences. The organization Mind (2013) reported that 40% of BME service users had to actively request psychological therapy as they were not offered the service from a health professional. Nadirshaw (1992) identified incorrect stereotypes about BME communities, such as above average psychological robustness, preferring physical treatment and to 'care for their own', which increase misunderstanding.

Various sources have found that the BME population is over represented in acute mental health services. The Afro-Caribbean community has a higher level of both compulsory and voluntary admission to mental health wards (Parkman, Davies, Leese, Phelan & Thornicroft, 1997), West Indians had a higher readmission rates to psychiatric hospitals (Glover, 1989) and Black patients were more likely to take anti-psychotic medication (86% of Black mental health patients compared to 60% non-Black patients; Lloyd & Moodley, 1992, p. 17). Turner, Ness and Imison (1992) found that 47% of people referred to a psychiatric unit by the police in the borough of Hackney were Afro-Caribbean, a figure they called 'excessive' (p. 26).

There has also been reports and research suggesting that including psychological therapies that goes beyond the standardized, short term CBT model, such as the

psychodynamic approach, may help to engage the BME community. The charity Mind in Croydon found that their numbers of BME service users was proportionate to the BME population in that area, and they credited a broad range of interventions, including psychodynamic therapy, that were not restrictive in the number of sessions offered which appealed to a wide range the population (Pacitti, Hughes, Statter, Alvarado-Rivero & Chaddha, 2011). The authors questioned the appropriateness of limited psychological services, such as that of short term CBT, for BME populations.

CBT is the most commonly IAPT funded therapy, but according to research carried out by Mind (2013) over a third of service users felt that IAPT did not fulfil the requirements of the BME community. The Delivering Race Equality Action Plan (2010) recommended a 'more balanced range of effective therapies, for instance psychotherapeutic and counselling treatments for BME communities' (p. 6). This is in line with the Analysis of the Impact on Equality of Talking Therapies (2011) report, which endorsed increasing the amount of non-CBT approaches, such as the psychodynamically led Brief Dynamic Interpersonal Psychotherapy and Interpersonal Psychotherapy, in order to ensure that the needs of the BME community are met.

There are concerns that BME clients often have a negative experience when they do engage in psychological services (Pacitti et al., 2011). A report by Mind (2013) found that an absence in diversity amongst staff and the experience of not having their cultural and religious needs addressed hindered ethnic minorities experience of mental health services run by the NHS. Mclean, Campbell and Cornish (2003) found that an African-Caribbean community in an English town felt that they were misunderstood by psychological services due to misinterpretation of their vernacular language, seemingly extroverted manner and mode of behaviour that was perceived as aggressive.

Bhui and Bhugra (2002) stated that because of mistrust of mental health services by the BME population, more time and focus will need to be placed onto the therapeutic relationship. In the United States, Watkins and Terrell (1988) found that when assigned a White counsellor, Black participants expected the counsellor to be less accepting and trustworthy and had lower expectations regarding outcome then when assigned a Black

counsellor. In this study they gave Black university students information about attending counselling with either a White or Black counsellor, and then asked them to complete questionnaires on mistrust and expectations. However, the research scenario was fabricated as it was carried out in a lab with university students rather than with those actively seeking counselling with a mental health context. Furthermore, ethnic minorities in Britain cannot be compared to those in the United States, but this study does highlight potential issues when therapeutic dyads are from minority and majority ethnic populations. Although this study is dated, further research has reported similar results (Nickerson, Helms & Terrell, 1994; Constantine, 2002).

1.4 Ethnicity, culture and psychological therapy

Burman, Gowrisunkur and Sangha (1998) stated that psychology has made assumptions on the universal generalizability of early human experiences, in which they exclude culture. They described how the field is disregarding cultural adaptability in parenting, such as multiple mother figures, which would impact the way we understand the formation of structures for relating to others, sometimes referred to as attachment. Atkinson, Thompson and Grant (1993) advised considering the 'locus of problem etiology' and acculturation when working with racial and ethnic minorities (p. 259). They stated that although certain problems may seem as though they stem from an internal source, they may originate from factors such as discrimination and oppression. They gave the example of a client's feelings of inadequacy stemming from years of negative feedback from teachers during his developmental years. They also advised reflecting on how much of the dominant cultures values, beliefs and customs the client has adopted, which they called acculturation, as it can impact the attitude they hold towards therapy.

Research on race differences in psychotherapy has suggested that race can also influence the process. Dos Santos and Dallos (2012) found that although 'visible racial differences' are an issue in therapy, patients felt they had to separate and ignore the 'racial' part of their identity in order to make sense of the therapeutic process (p. 62). It appeared that patients entered into therapy with the preconceived idea that it was not appropriate to talk about their racial or cultural self, which the authors found created a

'distant and cautious' therapeutic relationship (p.70). As Dos Santos and Dallos (2012) took a social constructionist approach in which the self is influenced by the relationships and cultural contexts that surround it, they described racial identity as a constantly changing integration of narratives based on socially acceptable discourses. Importantly, they emphasized that as psychotherapy often focuses on the self and identity, it is necessary to explore the relationships and cultural contexts that form the basis of this.

Jones and McEwen (2000) carried out Grounded Theory on interviews with ten undergraduate females of varying ethnicities in the United States in order to explore the multi-dimensions of identity. The key themes they found were the significance of difference, the numerous effects of race, and the importance of culture, family and personal background. However, Sue (2001) commented that psychology mostly focuses on individual identity, and neglects that race, ethnicity, and culture are powerful variables in influencing how people think, make decisions, behave, and define events' (p. 795). Sue (2001) presented a tripartite framework of personal identity, which includes a universal, group and individual level. The group level focused on individual differences and similarities in race, culture, ethnicity, religion, gender and socio-economic status.

1.5 Psychodynamic therapy

Psychodynamic therapy encompasses a wide range of theories and approaches, which are bound together by psychoanalytic roots. To clarify, psychoanalysis refers to the theories of Freud exclusively, whereas psychodynamic encompasses Freud and his followers' theories. In this thesis I will use the umbrella term of 'psychodynamic', unless the term 'psychoanalytic' has been specified. McWilliams (2004) argued that most types of 'therapeutic encounters' have been influenced by Freud's work, at least in some distant form (p.1).

Cabaniss, Cherry, Douglas and Schwartz (2011) identified the fundamental aim of this approach is to uncover how the unconscious is affecting the patient's thoughts, emotions and actions (conscious), then identifying whether it is best to expose or

support this from moment to moment and following through with this. The techniques in this approach, such as transference interpretations and free association, are designed to achieve this. The relationship between the therapist and the patient is seen as fundamental, both in terms of creating a safe and trusting environment, as well as fostering transference. Greenacre (1954) described transference as the emotional bond that develops between two people, namely the therapist and patient, which is potentially based on a matrix derived from the mother-child relationship (as cited in De Jonghe, Rijnierse & Janssen, 1994).

A major concern for psychodynamic therapy is how internal processes such as emotions, drives and needs motivate our behaviour. Unexpressed emotions and unconscious influences, both within the client's internal and external world, are explored. The therapeutic relationship is seen as the vehicle of analysis and change, and similarities and differences between the therapist and the client are material for transference/counter-transference (Bateman & Holmes, 1995).

1.5.1 Modern psychodynamic therapy in Britain

Throughout the past few decades there have been several authors calling for the end of psychoanalysis (Tallis, 1996; Crews, 1996). However, Cooper (1991) argued that the acceptance of theoretical pluralism in the 1980s brought about significant changes to psychoanalysis, which led to a resurgence in the field. Fonagy and Target (2000) stated that although there are still limitations that need to be rectified, the 'core psychoanalytic precepts are not only consistent with some of the most important advances of the last decade but may also be helpful in elaborating these new discoveries in the next century' (p. 407). The authors saw modern psychodynamic therapy as focusing on the core theoretical components whilst also considering the wider cultural context of the individual.

1.5.2 Key themes in psychodynamic theory

The id, ego and super ego are how Freud (1923) hypothetically constructed the structure of the mind (as cited in Marcus, 1999). The id, which is fully unconscious and present

from birth, is made up of instinctive behaviours governed by drives and emotions. The ego acts as the control centre, where thoughts and perceptions are located as well as defences and internalised object relations. The ego tries to balance the external and internal worlds for the individual. It also attempts to modulate the id through repression. The superego is the value system that has been internalised from the surrounding environment, and is therefore learnt rather than inherent (Ahles, 2011).

According to Drapeau, De Roten, Perry and Despland (2003), Freud believed that the purpose of defences was to deal with the tensions between the ego and the id, and originally listed repression, isolation, reaction formation, undoing, introjection, and projection. Freud, along with the object relation analysts, also included sublimation, displacement, projective identification, and identification with the aggressor. Cramer (2000) distinguished defences from coping mechanisms due to their unconscious and unintentional nature. Walkerdine, Lucey and Melody (2001) commented that defences allow us to avoid the painful content of our unconscious. In modern clinical psychology defences within therapy are often related to attachment style. For example, Dozier and Kobak (1992) found that those with insecure attachment styles were more likely to alter information about their relationship with their care givers.

According to Freud (1992) by interpreting our dreams we are able to explore the id, as she postulates that our 'dream thoughts' are the same as our 'id content' (p.16). This is because sleep is meant to disinhibit certain aspects of the ego, thus allowing previously repressed materials, often unconscious wishes, to be expressed. Freud (1953, as cited in Pesant & Zadra, 2004) distinguished between manifest and latent content, where what happened in actual dream is different from the unconscious meaning behind it. In psychodynamic therapy, the emotional content of the dream is explored, followed by the therapist offering an interpretation based on their understanding of the client. Pesant and Zadra (2004) stated that although varying psychodynamic approaches, such as ego psychology or object relations theory, have varying approaches and understanding of dream analysis, free association is 'at the heart' (p. 492).

Within psychodynamic theory, a great emphasis is placed on the role of childhood and early relationships. Zeanah, Anders, Seifer and Stern (1989) stated that the continuous construction developmental theory has surpassed the fixation regression model, in terms of understanding how childhood experience affect experiences later in life. According to the fixation regression model, traumas that occur during the libidinal stages of childhood (oral, anal and phallic) lead to a regression to that stage in later life which causes psychopathology. Therefore the aim of psychodynamic therapy was to discover the infantile trauma so that it would be explored and worked through. However, according to Zeanah, Anders, Seifer, and Stern (1989), the continuous construction model, as the name suggests, does not look for a specific incident in childhood but instead looks to examine the continual interactions of the person with their environment and how this affected their sense of self and relationship patterns. Attachment theory is an example of a continuous construction model.

According to Bowlby (1977) 'attachment theory is a way of conceptualizing the propensity of human beings to make strong affectional bonds to particular others' (p. 201). It proposes that a child will develop an attachment to their caregiver in order to foster a sense of security. The type of attachment formed will depend on how much the infant can rely on the caregiver for their sense of safety (Ainsworth, 1979). There have been four types of attachment identified, which are secure, avoidant, resistant, and disorganised (Benoit & Parker, 1994). Accordingly, infants will internalise exchanges with their care giver in order to generate a mental representation of how future relationships will function (Main & Cassidy, 1988). Simpson (1990) described how those with secure attachments generally see themselves a 'good natured' and others as 'well intentioned', whereas those with a resistant attachment style view themselves as 'misunderstood' and others as 'unreliable' and avoidant attachment styles believe they are 'aloof' and others are too quick to commit (p.971). Shorey and Snyder (2006) stated that the disorganised attachment category was created those who did not fit into the other three categories and is characterised by 'chaotic and conflicted behaviours' (p.2). According to Ainsworth (1969) another theory that attempts to understand a child's relationship with their mother is object relations.

Fonagy and Target (2000) stated that psychodynamic theory emphasises the role that mental representations play in the development of the self and how we interact with our surrounding environment, which is based on Object Relations Theory. This theory postulates that relationships – primarily the mother-child relationship – are the basis for the formation of mental representations of how relationships work, thus affecting future interactions with others. However, Greenberg (1983) commented that this theory is complicated by the ambiguity of its usage based on the different views of various authors. This included Klein, Fairbairn, Kernberg and Winnicott.

Winnicott was a paediatrician who focused his work on observing the mother-infant relationship. In his paper 'The theory of the parent-infant relationship' he wrote about the importance of the mother physically 'holding' the infant, both in terms of biological needed and 'the establishment of the infant's first object relationship' (1960, p.592). Previously, he had written about how a good enough mother 'starts off with an almost complete adaptation to her infant's needs, and as time proceeds she adapts less and less completely, gradually, according to the infant's growing ability to deal with her failure' (1953, p. 95). This theory postulates that a mother, or primary care giver, should started off as devoted to her young infant, but as the child develops she should allow the child to experience failure and frustration.

1.5.3 Psychodynamic therapy: Criticisms

Historical accounts of the development of psychoanalysis have emphasized the effect of the increasingly anti-Semitic atmosphere of Austria –especially considering Freud's position as a 'non-religious Jew' – in creating an approach that reflects the culturally and historically oppressive conditions in which it was developed (Burman, Gowrisunkur, & Sangha, 1998). This may have been further compounded by his desire to demonstrate that psychoanalysis was a 'science' by creating a culture free approach. However it appeared that by excluding cultural and political issues, the approach was actually reflecting the trends of the time. For example, in Billig's (1997) commentary on Freud's work with 'Dora', he argues that the lack of discussion on cultural and political matters was based on a conspiracy between the therapist and patient caused by

oppressive society they lived in. However, cultural and political exclusion within psychodynamic history go beyond the historical context.

A major criticism of psychoanalysis is that its founders only wanted to treat people similar to them, who were also White and affluent (Thompson, 1989). This is connected to the central European beginnings of psychoanalysis and its growth over the last century due to middle class demand (Bateman & Holmes, 1995). According to Schacter and Butts (1968, as cited in Leary, 1995, p.130), this led to an oversight of the subjects of race and class. Thompson (2012) also described how people of different races are underrepresented within this approach.

Javier and Herron (2002) describe the 'culture of whiteness' attached to psychoanalysis. More than purely skin colour, this is a social construction where the economic status and educational level dictate social and political norms. They noted that the positive outcome gained from exploring differences within the therapy room (Raphling, 1997 as cited in Javier & Herron) arose within a 'shared cultural base', which is not always present (p.159). Leary (1995) claims that although this approach began to incorporate issues concerning race, 'incomplete conceptualizations and overgeneralizations' still persisted (p.128). However, Leary also felt that psychoanalytic treatment was going through a period of change, which was occurring alongside an active drive to increase access to longer term psychotherapy, such as psychodynamic, for those who could not normally afford it.

1.5.4 Criticisms of research in psychodynamic therapy

There has been a long history of criticism of psychoanalytic research from both the 'so called Freud bashers and the more serious psychoanalytic scholars' (Blatt, Corveleyn & Luyten, 2006, p.571). For example Eysenck (1994) called it a 'quackery' with no evidence for psychoanalytic theory (p.482) and Torrey (1992) declared it was on the 'same scientific plane as the theory regarding the Loch Ness Monster' (p.211 as cited in Blatt, Corveleyn & Luyten).

Fonagy and Target (2000) identified major barriers that are holding back psychodynamic research. This included fragmented theory, over reliance on induction over deduction, confusing terminology, a Reconstructionist position, an isolated stance from other fields, and the lack of coherence between clinical work and theory. More recently, Roth and Fonagy (2006) commented on how evaluation of psychodynamic treatment research has been hindered by a lack of research trained clinicians, ambiguous treatment aims, complications in monitoring long term treatment, and the lack of 'research tradition' (p.40).

In contrast, Shedler (2010) stated that a substantial amount of research supports psychodynamic therapy, and claimed that 'biases in dissemination of research findings' are the problem (p.98). According to Levy and Ablon (2009) 'psychodynamic psychotherapy has come a long way since its inception', and although empirical research in this field has been carried out, this approach belongs to the realm of hermeneutics rather than science (p.ix).

1.5.5 BME Women in psychodynamic therapy

Frosh (1994) commented how psychoanalysis has 'never fully coped with the way in which sexual difference come to play' (p.12). Thompson (2012) described how in psychoanalytic literature, women were viewed as 'castrated men' with less superego strength (p.337). The author described how women primarily seek out psychotherapy when there are problems with their relationships. Furthermore, Green (1997), who examined psychotherapy with African America women in US, highlighted that although African American women and White women have a shared history of gender oppression, African American women have different social realities, such as coping with discriminatory barriers and internalized racism. Thompson (2012) described how African American women place more emphasis on their identity as part of an extended family network than the dominant White culture. Therefore family support, relationships, social class, appearance and colour all play a role in their identity formation.

Burman, Gowrisunkur and Sangha (1998) commented on how women belonging to ethnic minorities are particularly unrepresented in psychotherapy literature. Furthermore they describe how the interaction between race and gender has been either omitted or oversimplified. According to Greene (1997), this may be particularly relevant as racial and gender oppression are interrelated and examining them individually may diminish our understanding. However, Frosh (1994) described how although the theory is caught up in 'patriarchal conceptions' it can also offer valuable tools to explore this (p.12)

1.6 Process Research in psychological therapy

Llewelyn and Hardy (2001) describe therapy process research as an investigation into both the content and mechanisms involved in psychological change with the therapeutic context, both within a session and across the treatment as a whole. This includes both external factors, such as observable behaviours, and internal factors, such as thought, emotions and reactions (Hill & Corbett, 1993). Garfield (1990) recognised a trend within the research of separating process from outcome, which is concerned with the effectiveness of the therapy.

The process of therapy can be shaped by pre-existing characteristics and events (Beutler & Hill, 1992). This may include demographic variables, expectations, attitude, and personality variables such as gender or racial identity. Hill and Corbett (1993) emphasized that how gender and race affect process and outcome is a significant issue. However, they argued that it is important to explore what race and gender mean to the individual rather than create a generalization. Thompson, Bazile and Akbar (2004) found that African Americans who had been in therapy reported that they 'edited' what they discussed in therapy due to concerns that the therapist would not be able to understand. This included racism, 'the stress of paying bills', and 'balancing work and family life' (p.24).

Llewelyn, Elliott, Shapiro, Hardy and Firth-Cozens (1988) carried out a process study in order to examine helpful and hindering aspects of short term (8 sessions) CBT and psychodynamic therapies using self-report measures. They found that both therapies

offered 'reassurance' and 'personal contact', but that CBT provided more 'problem solution' and psychodynamic therapy created more 'awareness'. In terms of negative aspects, 'unwanted thoughts', 'unwanted responsibility' and 'misdirection' where all more common in the psychodynamic therapy. Interestingly, the aspects of therapy found by this study did not correlate with better outcome measures. Blagys and Hilsenroth (2000) wrote a review of comparative psychotherapy processes and concluded that Cognitive Behavioural Therapy (CBT) and Psychodynamic therapy did function using different mechanism of change.

1.6.1 Criticisms of process research

Garfield (1990) wrote a review of problem issues in process research. The author was critical that these types of studies are not related to outcome measures and therefore questioned their usefulness. She described that methodologically they used sample sizes that were too small and were unable to be replicated, and linked this to the 'individualized nature' of the researchers who both lacked cross validation and a sense of integration with other process studies. Process researchers responded to criticisms by introducing qualitative research methods such as case study research, significant events, exploratory approaches, and other qualitative approaches such as grounded theory.

1.7 Process research in psychodynamic research

Loewald (1960) defined psychoanalytic process as 'significant interactions between analysis and therapist that ultimately lead to structural change in the patient's personality' (p.221). Much of the process research within psychodynamic approaches has focused on the therapeutic relationship (Hill & Corbett, 1993). Henry, Schacht and Strupp (1990) investigated the role of interpersonal processes in psychodynamic therapy using the structural analysis of social behaviour system, which aims to measure moment to moment interactions within the therapeutic dyad. They found a significant relationship between elements that were occurring interpersonally and the way the patient talked about themselves. For example, therapists that demonstrated 'hostile and controlling' behaviour where more likely to have patients that were 'self-blaming and critical' towards themselves (p.772).

Silberschatz, Fretter and Curtis (1986) researched how interpretation affected the process of short term psychodynamic therapy. They examined the transcripts of three sessions and concluded that the appropriateness of the interpretations affected the process more than the type. However, they also identified other important variables, such as therapist's skill, therapeutic relationship and facilitating a sense of hope. However, when researching internal processes, the focus is shifted slightly away from content, such as the number of interpretations made, and towards the mechanisms involved in this.

Psychological therapy has been broadly divided into two components, the internal processes and the external events (Seeman & Raskin, 1953). Internal processes are occurring within us at every moment, and psychotherapy is interested in the interaction and movement between these two components. Within research, we use certain concepts and methods to interpret and understand our internal processes using particular frames of reference (Seeman & Raskin, 1953). Rogers (1958) identified understanding emotions, constructing meaning, experiencing the therapeutic relationship, and changing thoughts as important internal processes within the humanistic framework.

Hill, Thompson, Cogar and Denman (1993) used qualitative methods to explore 'beneath the surface of long term therapy' by analysing both video/audio tapes of sessions along with a written evaluation. They found that clients often concealed negative thoughts, feeling and reactions, as well as parts of the therapeutic process, such as an increased self-understanding. The author identified a fear of being misunderstood, shame and insecurity as the main reasons for lack of disclosure. However, only 2 of the 26 participants fell outside of 'White' category – one was Black and the other Asian. Furthermore, the therapists involved used a variety of different approaches, including humanistic, CBT and psychodynamic. Therefore whether clients in different types of therapies have different 'beneath the surface' processes were undetermined. Also, with a focus on what purely what was hidden during therapy, we fail to understand the therapy process as a whole.

Much of the previous research on internal process has focused on the change process as regards to treatment outcomes (Copper, 1989; Hill, 1993) and are from the therapist's or researcher's perspective (Javier & Rendon, 1995). It appears necessary to examine this process from the perspective of the patient, as the aim of psychoanalysis is help the patent to better understand their own psychic life (Renik & Spillius, 2008).

1.7.1 Internal processes in psychodynamic therapy

Within psychoanalysis, Freud (as cited in Hilgard, 1962) proposed that there were two mechanisms that controlled our emotions, attention, motivation and consciousness which he called primary and secondary processes. Primary processes involve the unconscious and are made up of symbols, wish fulfilment and displacement. In contrast, secondary processes have a logic and realistic mode of functioning (Epstein, 1994). It is an aim of psychoanalytic therapy to make the unconscious or primary process, conscious so that it can be resolved using secondary process thinking. Therefore much of psychoanalysis takes place with the realm of internal processes.

Within the psychodynamic world, patients' internal processes are often examined through the eyes of the therapist based on 'reconstructed narratives', using their memory and perhaps session notes. Based on this, therapeutic change has been located within the realm of the interaction between the therapist and the patient, as the patients begins to understand how they are with others, which is known as implicit relational knowing. Stern et al. (1998) examined detailed process notes made by psychotherapists about their therapy sessions and concluded that the majority of therapeutic change is not conscious, but rather an increase in implicit knowledge of how to think, feel and behave within a relationship. They found that it was 'moments of meeting' within the therapeutic relationship that was the catalyst for this implicit change.

Bruschweiler-Stern et al. (2002) promote the use of videotaped sessions as a way to analyse the 'local level' of the interaction, which includes small, precise events beyond that of the larger 'here and now' interpretations (p.1052). From this they concluded four points regarding therapeutic change within psychodynamic therapy. Firstly, that change does occur from both obvious and subtle moments in therapy. Secondly, change

occurring from the subtle moments is based on change in implicit relational knowing, which is within the local level of the therapeutic relationship. Thirdly, the therapeutic relationship allows the dyad to articulate a way of being together, which can change can lead to change in implicit relational knowing. Lastly, recognising the fit or the coming together of the relationship facilitates the articulation of being together. Bruschwiler-Stern et al. (2002) primary used video recordings of child analysis to make these conclusions. Within psychodynamic literature, studies focusing on therapeutic change in adult therapy often use child and infant observations, as this is period in which humans change the most. It is also apt considering the emphasis the approach places on developmental factors.

1.7.2 Race and ethnicity's impact on internal processes in psychodynamic therapy

Javier and Herron (2002) emphasized that modern psychoanalysis has been widening its parameters in an attempt to conceptualise how culture impacts practice and theory. This included race, ethnicity, gender and class. Thompson (2012), a Black psychoanalyst working in the USA, suggested there are particular issues that will arise within psychoanalysis with African American patients. These include internal conflicts concerning their middle class identity, sense of self, and ability to trust others. Thompson also notes that within adult object relations, a sense of self and others does not exist within a racial neutral context, and that skin colour of the infant can affect the care taker's mirror functioning. This function is often taken up by the limited re-parenting role of the psychodynamic therapist.

Javier and Rendon (1995) commented on how formulations within the psychodynamic tradition have focused on the 'individual's internal structure' and disregard the role of ethnicity, especially the function of ethnic unconscious within transference, resistance and countertransference (p.514). However, Javier and Yussef (1995) state that primary introjections and identifications are actually facilitated by our cultural and ethnic object world, which then infuses and influences how we interact with the world around us, and ultimately our psychic reality. According to Javier and Rendon (1995), race, ethnicity, language and culture are therefore all integral to the development of the self, self-

definition, identity formation, superego formulation, and the process of internalization; leading ethnic identity and general identity to be 'governed by the same mechanisms' as listed above (p.515). Accordingly, ethnic unconscious refers to those unconscious processes which need to be understood according to the individual's ethnic and cultural background. For example, the patient's beliefs and expectations about the therapist may be governed by the ethnic unconscious.

This section aimed to demonstrate that the psychodynamic field is beginning to formulate how race, ethnicity and culture may impact internal processes such as sense of self, transference, object relation, internalization and super ego formulation. However, there are limitations to these theories. Firstly, they are based on African American clients rather than British minorities. Although this may point others in the direction for researchers to look, it cannot be directly applied to BME clients. Secondly, both process research and psychodynamic theory are often focused on the clinician's or the researcher's perspective rather than the voice of the BME client themselves. The section below will map out how this piece of research aims to begin to address this hole in the literature.

1.8 Aims & Rationale for the current research

A heterogeneous group, BME clients have been singled out in both research literature and practical health care initiatives. Although emphasis has been placed on the external aspects of BME clients and psychotherapy in Britain - increasing access overall, and recently to psychodynamic therapy – less attention has been given to their internal processes. Research and theories that do address internal processes often originate from the United States and are from the perspective of the clinician or researcher. This research aims to take a step further in the research by exploring whether there is something shared and/or unique about the way that BME clients internally process psychodynamic therapy based on their own accounts.

As much of psychoanalysis takes place with the realm of internal processes, it is important that we try to understand what is occurring during a patient's internal processing during therapy. It is possible that race and ethnicity can influence the

internal process of the participants' therapy. This appears particularly important for BME clients according to growing identification of the 'potentially biased nature' of psychological research to the growingly multicultural population due to the lack of integration of socio-demographic variables (Sue, 2004, p.762). The implications of this will help psychologists who work psychodynamically to better understand the internal processes of their BME clients, and whether certain considerations may need to be taken. The results of this study could be applied in a therapeutic setting and potentially contribute to counselling psychology practice. Therefore, this study aims to answer the question: How do BME clients internally process their psychodynamic therapy sessions?

CHAPTER 2 - Methodology

2.1 Research Design

This study was conducted using a qualitative methodology. Data was gathered from semi-structured interview with a homogenous sample of BME women. A multi-level approach was utilized to examine the data using a phenomenological, discourse and psychodynamic reading.

2.2 Rationale for a multi-level approach

Capturing the internal experience of therapy has proven challenging using traditional quantitative methods, but Hill, Thompson and Williams (1997) believe using qualitative approaches allows us to address this complex phenomenon. In accordance, Chamberlain, Cain, Sheridan and Dupuis (2011) stated that 'complex issues demand complex methodologies' and that using different lenses within qualitative methodology can create novel insight (p. 164). This is because a multi-layered approach is not limited by the assumptions and theoretical framework of one approach. However, the authors emphasized the importance of maintaining a relevant, critical and reflective approach even when working creatively.

Frost et al. (2011) stated that bringing together qualitative different readings within a multi-level approach allows the researcher to examine this phenomenon from varying angles and perspectives to form a triangulation or holistic picture. Multiple lenses provide different paradigms to view inner process through, and when one methodology reaches its limits another lens can continue on (Madill, 2008). For example, one lens may focus on the conscious internal process while another can tentatively explore unconscious motivation. A multi-layered approach also allows the researcher to use a range of different analytical tools, such as the participant's insight, discursive positioning, and power dynamic within the researcher-participant dyad.

The use of a single qualitative approach would have allowed me to explore inner processes using one paradigm. However, the research question did not specify a single

paradigm, such as experience or meaning making process, but instead referred to the exploration of the multi-faceted and directly inaccessible internal processes. A single approach would have raised questions regarding what the single paradigm was unable to explore due to its epistemological assumption, hermeneutic stance, and particular focus during data analysis. Furthermore, the interview data may not have been used to its full potential.

A multi-level analysis also holds many methodological advantages. For example, Frost (2011) proposed that when using multiple analyses the researcher makes fewer assumptions, which reduces bias. Frost et al. (2010) argued that a pluralistic method encourages the researcher to reflect on the impact that the researcher and the different methods had on the analytic process, which creates a 'heightened transparency' (p.443). Transparency in qualitative research requires the researcher to describe every facet of the process, including their assumptions and motivations (Snape & Spencer, 2003). Frost et al. (2010) emphasized the importance of transparency when aiming to make research clinically relevant. As this thesis aims to assist those who are clinically working with BME clients using a psychodynamic approach, heightened transparency is an important factor. Lastly, McLeod (2001) stated that a pluralistic methodology is in line with the principals and practices of counselling psychology. This is because counselling psychology also holds a framework from which concepts and interventions are used from different therapeutic approaches, based on the concept that there is not a single, correct therapeutic model (Cooper & McLeod, 2007).

Inner processes in psychodynamic therapy exist both within the realm of conscious and unconscious and all that lies between, especially regarding transference, defences, attachment, mental models and the nuances of the therapeutic relationship. A major aim of the approach is making unconscious process conscious, and this study aimed to capture this complex phenomenon. Therefore the methodology used needed to be able to carry out theory driven analysis that both went beyond the data through the hermeneutics of suspicion while still maintaining an open and explorative stance and keeping the participants' voice at the centre of the analysis. I believe using a multi-

layered analysis will create an in-depth exploration of inner processes from varying perspectives while making the most of the tools at the researcher's disposal.

2.3 Overview of the Approaches

The aim of using a multi-layered analysis was to create an in-depth, multi-dimensional understanding of the internal processes of individual BME participants in psychodynamic therapy. Each lens or layer built on the previous in order to create a deeper level of analysis. The descriptive phenomenological reading formed the first layer, from which internal processes are described from the viewpoint of those involved. This analysis stayed close to the voice of the participants and aimed to address what the conscious internal processes were, particularly focusing on thoughts and feelings. The discursive lens was the second layer and built on the phenomenological reading to delve deeper into the analysis. This involved identifying how the participants' used discursive tools and discursive positioning when speaking about their therapy, and what this could tell us about their inner processes. The last layer was the psychodynamic lens, which built on both the previous two readings to delve into the unconscious inner process based on their developmental background. This is the deepest point of the analysis as it uses psychodynamic interpretive strategies to attempt to tentatively understand inner processes by exploring how external or social aspects become internalised within the psyche and vice versa (Frosh & Baraitser, 2008).

2.3.1 Theoretical and Philosophical Influences

As a qualitative piece of research this methodology subscribes to a post positivist research paradigm, where the pursuit of reality remains but is understood to be opaque and perhaps unreachable. Within this, a pragmatic philosophical approach has allowed me to select the most appropriate method for the research question, in this case a multi-level analysis. In accordance with this, critical multiplism recommends examining a phenomenon from multiple lenses in order to make use of the individual strengths and weaknesses of each approach (Letourneau & Allen, 1999). Another significant theoretical influence is that of contextual constructionism, as it draws attention to how the researcher and subject of research are both conscious beings interpreting and acting

on the world around them within networks of cultural meaning' (Madill, Jordan, and Shirley, 2000).

2.3.1.1 Moderate Constructionism

This epistemological stance of this thesis is moderate constructionism, sometimes known as contextual constructionism. The constructionist stance accepts that knowledge and truth exist and that it can be accesses by various viewpoints. However, within constructionism there is the 'constructionist dilemma' based on how much the researcher accepts or rejects the idea of 'objective reality' (Hallett & Rogers, 1994, p. 193). As the prefix 'moderate' suggests, the moderate constructionist stance does not fully reject the concept of 'reality', nor does it accept that is it concrete and accessible. It holds a middle ground in which 'reality' exists in some form, but that it occurs as part of a 'dialogue, critique and consensus in different communities' (Järvensivu & Törnroos, 2010, p.101). Therefore it is not fixed and concrete but it can be studied.

My reason for holding this stance is that by using a multi-level approach I am aiming to gain knowledge on 'inner processes' from varying angles of analysis in order to construct new and usable knowledge. However I am not stating that 'inner process' is an objective reality, but something opaque and complex. Ultimately my rationale for this epistemology is an attempt to position my stance in order to best answer my research question. The nuances of the epistemology of my multi-level approach will be explored later in this chapter.

2.3.1.2 Hermeutics

By using a multi-layered design that considers both conscious and unconscious understandings of the data, opposing forms of hermeneutics are being considered. Ricoeur (1991) identified two distinct forms; hermeneutics of faith which stays with the meaning of the text, and hermeneutics of suspicion which goes beyond the text to search for the meanings behind the words. According to Josselson (2004), it is feasible to include both forms within multiple layers of interpretation, as long as there is a clear identification of when the shift occurs and the weight that is given to each. Within this multi-layered approach, the participants' words, meanings and experiences on a

conscious level needed to be identified before the unconscious content could be tentatively explored. Therefore the first level of analysis, the descriptive phenomenological, held a hermeneutics of faith and created the core of the analysis. Examination of the unconscious factors where then layered above in order to enhance our understanding of the participants' inner processes.

2.3.1.3 Idiography

This piece of research is idiographic in nature, as it is concerned individual and unique internal processes of each of the three participants. Therefore the methodology was designed to probe detailed interviews using multiple approaches in order to create an in-depth analysis. However, a secondary aim was to explore whether there was anything shared and or unique about their internal processes in order to potentially inform psychodynamic, therapeutic work with the BME community. In accordance with this, idiographic research does propose that a thorough investigation of a few participants can possibly create broad principals or a general knowledge of others. Hilliard (1993) stated that in order to understand generally what people do, we first need to explore what individuals do and then look for commonalities.

2.3.1.4 Epistemological Reflexivity

Although I am using a multi-level approach with three readings each with their own epistemological understanding of what knowledge is and how we can capture it, there needed to be an overall epistemological stance which organized and bound together the different readings in order to create a sense of cohesion. During the initial stages of this research I intended to take a postmodern stance under the umbrella term social constructivism. However further thought on how I understood – as well as planned to capture -the phenomena of 'internal processes' led me towards a moderate constructionist stance. This was further concretized when working with the varying epistemologies of the different types of analyses, as it allowed for a sense of continuity between the readings.

There needs to be some clarification between the epistemological stance of discourse analysis and the overarching stance of this piece of research. The epistemological

position of a discursive approach is social constructionism. This suggests that the researcher is not aiming to discover the 'truth' but rather to create a way to understand how various social facets, such as power, race and ethnicity, influence the participant meaning-making process (Willig, 2012). However, the overall stance is moderate constructionism, which aims to discover 'truth' and reality, which is a part of dialogue. To remedy the different aims of these two stances, I propose that knowledge is constructed through discourse, but is limited and founded in 'reality'.

2.3.2 Compare against Grounded theory

The initial methodology I proposed to research this question was Grounded Theory (Corbin & Strauss, 1990). Grounded Theory's primary intention is generating new theories, which are solely grounded within the data, rather than the data justifying the theory. The main reasons why I chose to use a multi-level analysis over grounded theory was the wealth of psychodynamic theory on internal processes and the importance of the intersubjectivity between the researcher and the participants. I will further explore these reasons in the section below.

When using Grounded Theory, Dey (2007) emphasized the importance of setting aside theoretical ideas and Wooley (2000) commented on the usefulness of this approach when there is relatively little known on the subject. Therefore this method is useful when the phenomena under investigation is an unknown quantity. However, internal processes are the main focus of the psychodynamic approach and there is a wealth of theory on the subject from a clinical perspective (Hill & Corbett, 1993; Cabaniss, Cherry, Douglas & Schwartz, 2011). I felt that by using a multi-layered approach I could include a reading where I stayed close to the data and bracketed my assumptions (phenomenological), and then also begin to deepen the picture by using a reading where this wealth of theory could be used to enhance the results (psychodynamic).

I was initially drawn to Grounded Theory as I could start the research with what I believed could be a 'clean slate', and only focus on the data rather than any of the more complex and exposing factors that would also be occurring. However, as a Counselling Psychology trainee I was aware of the significance of non-verbal communication and

the subtleties of discourse when two people are interacting. I was also mindful of the potential 'defended' nature of participants when speaking about their therapy and my own status as a non-minority. I felt that by using a multi-level approach I could use these intersubjective factors to enhance the analysis rather than discarding them.

2.4 Sensitivity, rigour, transparency, impact and importance

According to Whittemore, Chase and Mandle (2001), when adopting a pragmatic philosophical approach and applying multiple analyses it is important to ensure validity. This thesis used the validity criteria as set out by Yardly (2000), which are flexible principals designed to guide the researcher towards a higher quality of validity. The author's main principals are 'sensitivity to context', 'commitment and rigour', 'transparency and coherence' and 'impact and importance' (p. 219). In this section I will touch upon how each of these principles were achieved. I will also explore the guidelines I used to maintain trustworthiness during this process.

With regard to sensitivity to context, I have considered philosophy of my approach, the relevant literature, the socio-cultural background, the power dynamic and relationship between the researcher and participants. The multi-level design of this thesis encouraged a high level of commitment and rigour, as there were several layers of analysis, a lengthy engagement with the subject, a saturation of data through three extensive interviews with each participant, and an emphasis on reflexivity. Much importance was placed on the use of competent research skills during each of the three analyses. However, this was a challenge and will be further discussed at a later point.

In order to maintain a reflective stance and level of transparency, I kept a reflective journal throughout this process. Directly after each interview I took detailed notes on my impressions, emotions, reflections and any details that would not be picked up by the audio recording. I took the stance that transference and counter transference are present with the researcher-participant dyad even when attempting to conduct 'objective' research, and that my thoughts and feelings – as the researcher - could direct me towards something I may have otherwise missed (Walkerdine, Lucey & Melody, 2001). Frosh and Baraitser (2008) stated that reflexivity is important in order to

maintain a critical eye on the work being produced, and I attempted to use this journal as a tool to record my reflexivity during every aspect of this research project.

Impact and importance are significant elements of qualitative research. The objective of this thesis was to explore the inner processes of BME participants in order to aid those who are therapeutically working with this population using psychodynamic led approaches. Inner processes are the main focus of this approach (Cabaniss, Cherry, Douglas & Schwartz, 2011), therefore insight into this area has potential for clinical relevance. The socio-cultural background to this objective is an increased drive by governmental and third sector agencies to engage the BME population with psychological therapies (The Delivering Race Equality Action Plan, 2010; Mind, 2013) due to their history of being over represented in acute services (Lloyd & Moodley, 1992). Furthermore, it aimed to use a challenging multi-layered approach in order to gain novel insight from the perspective of the therapeutic clients themselves rather than the clinicians.

I also attempted to achieve the three main points of trustworthiness in qualitative research as identified by Williams and Marrow (2009), which are 'integrity of data', 'balancing reflexivity and subjectivity' and 'clear communication of findings' (p.577). At each of the three stages of analysis I attempted to both articulate and carry out the methodology in a clear and systematic way. I also put different methods in place to ensure that I focused solely on one reading before progressing to the next. Although the analysis was focused on how I approached the data, rather than a step-by-step guide, I tried to convey the aims and questions I was keeping in mind as I coded the data line-by-line. I believe that the procedures used could be replicated by a reader.

2.5 Procedures

I will now briefly outline the procedures used during the data collection stage. Three BME participants currently in psychodynamic led therapy were interviewed three times. The interviews lasted 40-60 minutes and were approximately four weeks apart. The first interview was semi-structured with a few key questions that were based on their experience in therapy (see APPENDIX F). The second interview aimed to create a

dialogue between myself and the participant, which was prompted using a theme from the previous interview. The final interview was based on the Free Association Narrative Interview from Hollway and Jefferson (2000), which also focused on their developmental background. Interviews were transcribed after each interview took place and I kept a reflective journal to note down non-verbal communication as well as emotions, thoughts and dreams. I will now further describe issues around sampling and recruitment, data collection and transcription, ethical considerations and the participants' wellbeing.

2.5.1 Sampling and recruitment

I recruited three BME participants. The reasons for this were both practical and conceptual. On a practical level I was aware that BME participants are underrepresented in health research (Iwamasa & Sorocco, 2002) and that barriers to recruiting ethnic minorities, such as the researcher's attitudes and engagement with local communities, have been found (Rugkasa & Cavin, 2011). I also knew that the analysis on a multilevel approach would be time consuming, especially under the constraints of carrying out a professional doctorate. On a conceptual level, the research question aimed to understand the 'internal processes' within therapy, which is a lofty feat and according to my epistemological stance cannot be directly accessed (Hollway & Jefferson, 2000). I believe that interviewing participants three times allowed me to collect a rich and in-depth amount of data as well as facilitated a stronger relationship between myself and the participants (Knox & Burkard, 2009). According to Boyce and Neale (2006) conducting in-depth interviews with a small number of participants allows the researcher to collect detailed information about a person's thoughts in order to explore a new issue in depth.

During the research process I made two changes to my sample group and one to my recruitment measures. Firstly, I allowed for participants who had a connection to the psychology world, and my three participants are part time psychology students. I understand that is was not ideal for answering my research question in a purist fashion, and may have influenced the data. However I believe there were benefits to this. Firstly, I believe they were much more comfortable reflecting on the therapeutic process and

were more robust regarding sitting with difficult emotions. Knight, Sperlinger and Maltby (2010) stated that the reflective practice involves in studying psychology aims to increase students' self-awareness. I also feel that they had the vocabulary to discuss both internal and external processes within the therapy, due to their studies. Furthermore, it could also be argued that participant who sought out therapy but are not connected to the psychology world may be considered a more vulnerable group.

Secondly, I changed the recruitment criteria from those who were finished to those who were currently in therapy. This also had both practical and conceptual advantages. Primarily, the organisations that I was recruiting with advised me that access to those who were finished with therapy would not be possible. Secondly I felt that if difficult issues were raised during one of the research interviews, the participants would be held by their therapy sessions and could bring this emotion to their therapy. I felt this also linked in to the participants being connected to the psychology world. Studies have been carried out that have yielded rich data with both psychology students (Macran, Stiles & Smith, 1999) and regular therapy clients (Knox, Hess, Petersen & Hill, 1997) who were currently in long term psychodynamic therapy.

I offered a financial incentive of £25 to those who took part. Before this, I had really struggled to recruit participants for this piece of research. Although organisations were keen to put my poster up and to pass information on to their psychodynamic therapists, no one came forward for 6 months. After discussing possibilities with my research supervisor, we made the decision to offer payment for participation. Payment is common within psychology research with BME participants (Areán & Gallagher-Thompson, 1996; Yancey, Ortega, & Kumanyika, 2006). However, ultimately all three participants wanted the money to be donated to the organisation that there were recruited through. All three participants were recruited through the Black and Asian Therapists Network (BAATN), as my poster had been placed on their website. In the appendices I have included the demographic information of each participant, including the type and duration of their therapy, as well as a short paragraph detailing their background (APPENDIX A). The reader may wish to refer to this information as they read through the analysis.

2.5.2 Data Collection and Transcription

I interviewed three Black women who are currently in psychodynamically informed therapy three times each. The interview lasted from 40-60 minutes and were approximately 4 weeks apart. The time frames were created with practicality in mind. The interviews took place at the participants' convenience, with an agreed upon location and timing for each. This meant that the interviewee was an environment that they felt comfortable in, which possibly could have shifted the power dynamic in the researcher/participant dyad. I interviewed Annie, my first participant, in a private room of her local library. Pamela booked a room at her work, and I interviewed Karen in a room at the mental health organisation that she volunteers at. Each of the three interviews occurred in the same setting for each participant, which hopefully also allowed participants to feel more comfortable as the interviews progressed.

All of the interviews were what Frosh, Phoenix and Pattman (2003) called 'interviewee centred' (p.9). This meant that it was my role to facilitate the interview by following up on specific themes and encouraging them further reflect, expand upon or illustrate particular point. As participants may have interpreted the interviews questions differently than I had intended, I used only a few open ended questions to allow space for the participant's narrative to unfold without them trying to give the 'right' answer. As each participant was interviewed three times, the open ended questions of each interview were geared towards the three types of analysis that were to be carried out on the data.

The rationale behind this method is based on Hollway and Jefferson's (2000) approach, which assumes that there is no clear trajectory between knowing yourself and communicating that to others; therefore our outer world is not a pure reflection of our inner world. Hollway and Jefferson (2000) also believe that participants may not only be unaware of the reasons behind their experience, but may also unconsciously use discourse to protect themselves or to hide these reasons.

The first interview intended to pick up on the phenomenological experience. Initially I gathered some demographic details and further explored the type of therapy they were in, their motivation for going, and whether they had any previous experience of therapy. As Hollway and Jefferson (2000) feel that anxiety can cause the participant to become more 'defended', the first interview focused on the experience of psychodynamic therapy while building up a relationship between myself and the participants (p.26). I then asked the very general statement, 'could you describe your experience of psychodynamic therapy?' and had prompts about their first session, their therapist, and the therapeutic relationship (APPENDIX F).

The second round of interviews aimed to be more of conversation between myself and the participants, in order to facilitate variations and diversity in their discourse; to bring out different aspects of the research question. All three participants seemed more comfortable with talking and being prompted about their therapy, as well as the setting and being recorded. I started off by bringing up a theme from the first interview, and continued to explore and fill in the gaps from the first interview, as well as explore new material arising that was directly linked to internal processes, the main crux of the research question.

During the final round of interviews I believe that the three participants were comfortable with me and that we had a formed a relationship of some kind. This will be further explored during the analysis stage. I used a Free-Association Narrative Interview (FANI) style which is based on the biographical interpretive method and created by Hollway and Jefferson (2000). In order to foster the transparency of our interviews and perhaps to increase the potential of this final interview to produce 'rich' data, I explored any differences in race between myself and the participants (Frosh & Baraitser, 2008, p.360).

I transcribed each interview in the weeks between the interviews. The rationale for this was to be able to capture both verbal and nonverbal communications as well as have the context fresh in my mind. I also used it as an opportunity to probe more deeply on certain areas in the follow up interviews, and the second interview was started from a

prompt from the first interview. Based on the type of in-depth analysis that I would later carry out on the data, I decided to transcribe verbatim and include details such as sighs, pauses and repeated words. In order to maintain the participants' confidentiality I removed all identifying details such as names and specific places (street names, universities, etc.) and used pseudonyms for all three participants. All data, including the transcripts, were password protected.

I attempted to work methodically by carrying out each phase before starting the next. For example I completed all the interviews and transcription before I started the analysis. I then carried out the phenomenological reading of all 9 interviews, but focused on each participant's three interviews at one time, and work chronologically from the first interview through to the last. Once this reading was completed I took a small break before moving onto the discursive and analytical readings. I attempted to carry out all analyses as rigorously as possible according to guidelines of each respective analytic reading. This will be further discussed in the following chapters.

2.6 Ethical Considerations

The utmost care was placed on the consideration of ethics when carrying out this research. All research carried out was in line with the BPS Code of Human Research Ethics (2010). My research proposal and all the supporting documentation was passes by the City University, London research committee. However, the two main areas for consideration were working with BME participants and carrying out a psychodynamic reading of the data. In this section I will further explore the implications of these two concerns, as well as describe how I worked to manage these concerns in an ethical manner.

There are certain ethical implications when working with research groups based on race, ethnicity, or culture. According to Leary (1995), sensitivities on this subject are connected to social, political and historical aspects which have made them taboo and avoided. Leary also commented that race and ethnicity have not been adequately explored within the psychodynamic treatment process. Although this research aims to contribute towards the remedy of this, it is important to understand that conclusions

from cultural and ethnic studies can be exploited (Stanley, 1998). In order to be sensitive to the needs of my participants I worked closely with my research supervisor, Dr Jessica Jones Nielsen, who is also passionate about this subject area. We set up an Ethnic Minority Research group at the university which met to discuss these culturally sensitive research issues. I also read extensively on the matter and attempted to remain reflective, thoughtful and sensitive throughout the process of this study.

Confidentiality was an important aspect of this study. Research has shown that BME clients were more likely to emphasise the importance of anonymity and confidentiality then White British clients, which is believed to be tied into the stigma of mental health that can be held by BME communities (Pacitti, Hughes, Statter, Alvarado-Rivero, & Chaddha, 2011). I therefore meticulously carried out confidentiality measures to ensure the participants' anonymity. This included highly anonymising and encrypting the interview transcripts, using pseudonyms, altering demographic details and keeping the consent forms completely separate.

2.6.1 Participant wellbeing

In line with the BPS Code of Human Research Ethics (2010) I was very aware of the importance of being sensitive to any impact caused during this research process. This included possible psychological distress, transference/counter transference, and the inevitable power dynamic between researcher and participants. I felt that sensitivity and caution were necessary in order to maintain the participants' wellbeing.

Once participants had either called or emailed to say that they were willing to take part, I organised a pre-screening telephone interview. This both allowed me to check that they reached the recruitment criteria and their general wellbeing. Ultimately, I was looking to recruit psychologically robust participants who were comfortable with reflecting on their therapy process. I also wanted to make it clear before the interview took place that they were interviews regarding therapeutic process, not therapy sessions; no interpretations or interventions would take place during the interview. After reiterating how the interview process would occur, I asked them to inform me of any

factors that they felt may lead to potential risk, and all three of the participants felt comfortable scheduling the first interview face to face.

During the face to face interview but before participants agreed to take part, they were reminded of what the process would entail, and that their confidentiality would be protected. This took the form of an information sheet (APPENDIX C), which I went through with them and asked if they have any questions. I told the participants that their wellbeing was a high concern of mine and shared what actions had taken place in order to minimise any risks. This included telling them that my research proposal had been approved by the City University Ethics panel. As the interviews were based on processes of psychodynamic therapy, I was aware that sensitive topics may have arisen with a potential to cause psychological distress or harm. I was open with the participants about this and reminded them that they did not have to answer any questions that they were not comfortable sharing.

They then signed a consent form (APPENDIX D), and were informed that it would be kept separately from their data, and would only be recognisable through their corresponding participant number. I reminded them that all identifiable details in any data collected would be removed or changed, all recordings, transcripts and forms were stored securely and separately. Hard copy data have been locked in a filing cabinet and electronic files have been encrypted. The data will kept securely

After each of the three interviews, participant were debriefed and informed that they had a right to withdraw at any time during the research stage, and that any unprocessed data would be destroyed. They took the debrief form (APPENDIX E) with them as it contained their participant number, which was the only way their data can be identified at that stage. On an informal level I would also ask for feedback at the end of each interview, and then again at the beginning of the subsequent interview. Participants seemed thoughtful and reflective. All participants reported that they had informed their therapists that they were going to take part, and that the therapists had given their consent. During the debrief after each interview they were given information about where further counselling services were available. However, each participant was

already in therapy and therefore could bring any difficult thoughts and feelings brought up to their therapy.

I was aware that during the interviews there was a risk of possible psychological distress, difficult feelings concerning transference/counter transference, and a power dynamic between myself as the researcher and the participants. These concerns were at the forefront of my mind during the interviews in order to attempt to minimise this. I attempted to use the skills I have learnt as a trainee counselling psychologist to contain any distress felt, as well as to bracket my own countertransference during the interviews. There were times during the interview when participant became distressed. For example, one participant became tearful during our last interview when a talking about a difficult time in her life. I would always ask if they wanted to continue, take a break, or talk without the recorder on for a while. None of the participants asked to stop and they all reported that they felt comfortable with the questions asked. Importantly, I tried to keep the tone of my questions, comments, and emotional reactions very tentative and in line with what they were bringing to the interview. I wanted to convey the message that they were the ones with the knowledge, and I was simply a curious researcher. I hoped this would even out the power dynamic between us.

My participant were all part of the BME community, a group which, historically, has experienced prejudice because of their ethnicity. It tried to be sensitive yet transparent at every stage of the process. Firstly, I spent time considering the wording of my research poster, and sought out the advice of my research supervisor as well the contacts who were distributing the poster. When it was appropriate and in keeping with the tone and material of the interview, I discussed the differences in race between myself and the participants and asked how they felt about me carrying out this type of research.

Although this research carried the risk of potentially causing distress to my participants, I felt that the possible benefits it could bring to BME clients in psychodynamic therapy and to counselling psychology were significant enough to carry on with the research. I attempted to minimise distress through careful planning and regular analysis of the process and myself as the researcher.

2.7 Analytic Strategy

Each transcript from the three interviews with each participant were individually analysed using three different interpretive lenses. I continued to use my reflective diary throughout this stage. The first analysis was the phenomenological reading, which stayed with the meaning of the text and adhered to the hermeneutics of faith. I focused solely on this reading before progressing to the next. After a short period away from the analysis, I returned to the transcripts with a fresh mind in order to approach the data from a discursive mind set, which focuses on the effects of language. However, I did build on the analysis from the previous reading in order to create a deeper level of analysis. Once the discursive reading was complete, I again stepped away from the data. I returned for a final time in order to explore the unconscious motivations behind the participants' words through the psychodynamic reading. For this analysis I was building on the previous two readings in order to take the analysis to an even deeper level. It was during this reading that I changed to a hermeneutics of suspicion. Once the three readings were completed, I then started tentatively writing up my findings.

The rationale for using three separate readings was to layer each lens in order to create a progressively in-depth analysis. Discourse analysis and psychodynamic theory are often combined in order to carry out a psychosocial analysis (Parker, 1997; Young & Frosh, 2009). However, I wanted to use the discursive reading as a link between the phenomenological reading, which focused on conscious internal processes through hermeneutics of faith, and the psychodynamic reading, which focused on unconscious process through hermeneutics of suspicion. I felt that in order to fully explore internal processes, both conscious and unconscious aspects should be included. I also wanted to use the phenomenological reading, which stayed close to the voice of the participants, as the baseline of the analysis. Using a phenomenological reading and a psychosocial reading would not have created the sense of layering or unity between the different approaches. Ultimately, each analysis was answering a different aspect of the question, each with varying levels of depth and analysis, therefore each lens could stand alone and as part of the larger picture.

I have presented the findings using a multiple case study approach. This allowed the results to stay true to the research's ideographic nature, and focus on the in-depth analysis of the individual participants. According to Benbasat, Goldstein and Mead (1987), this approach allows complex phenomena to be intensively explored and examined in order to build up an understanding. Therefore, using a multiple case study approach worked in tangent with the pluralistic design, which used multiple layers to build up an understanding of the participants' inner processes.

For the descriptive phenomenological and the psychodynamic readings, this took the form of first exploring the themes from each participant individually, before moving on to an exploration of shared themes. This format was changed slightly for the discourse analysis reading, as this chapter acted as a bridge between the phenomenological and the psychodynamic readings. In this chapter the general discursive themes were the laid out first, and then they were broken down into a multiple case study format focusing on the individual participants. This was in order to facilitate the change of hermeneutics between chapter one and three, while still adhering to the principals of discourse analysis.

2.7.1 The descriptive phenomenological analysis reading

The first level of analysis was a descriptive phenomenological reading which focused on the participants' experience of therapy. Phenomenology is a qualitative method based on the work of Husserl. It allowed for the study of consciousness, therefore leading to insight into the experience of phenomena (Wertz, 2005). According to Groenewald (2004), the goal is to describe and understand the social and psychological phenomena from the viewpoint of those involved. There are a variety of ways that this method is interpreted, and for this reading descriptive phenomenology is used.

2.7.1.1 The approach

The aim of this reading is to engage directly with the data from the participants' interviews in an attempt to better understand the meaning and significance of their time

in therapy. Willig (2012) emphasised that this approach focuses on what is directly presented from the data, and therefore engages with the participant's account.

2.7.1.2 Choosing phenomenology

This phenomenological reading aimed to encapsulate the conscious meaning and significance the participants made of their therapy sessions in order to explore their experience. I feel that this is a substantial aspect of inner process, and it an important starting point for the multi-layered analysis. The raw data was very rich, and I felt that engaging directly in their account of the therapeutic process - their reported thoughts and emotions – took an important first step towards answering the question. As inner processes involved both conscious and unconscious factors, I believe it was important that the conscious factors were explored. Furthermore, a therapeutic aim of psychodynamic therapy is to make unconscious processes conscious. As my participants have been in therapy, their unconscious process will have become known to them on some level and the phenomenological reading could potentially pick up on this process. This reading will then provide the groundwork for both the discursive and psychodynamic readings, which will the aim to provide a deeper understanding of the internal process, including the unconscious factors.

2.7.1.3 Choosing descriptive phenomenology

There are two main phenomenological approaches, descriptive phenomenology and Interpretative Phenomenological Analysis (IPA). This section aims to express my rationale for choosing descriptive phenomenology over IPA. Firstly, the descriptive approach is in-line with the aim of the research question. By asking 'how do BME participants internally process their psychodynamic therapy?' this piece of research makes the assumption that there are internal processes which can be accessed from the data, but that they have not been fully addressed by previous research (Beck, 1992). I was aiming to identify the key features and structures of the inner processes in order to create the first layer of my analysis, which could be further built upon (Finlay, 2009). Descriptive phenomenology has been criticised for being too simplistic (Wertz, 2005), however Lopez and Willis (2004) argued that this is an advantage of this approach as it

can be used to as part of a larger picture. The objective of using a descriptive phenomenological reading was to allow for a cohesive, multi-layered approach in which all of the different lenses built on in order to create a more in-depth picture. I felt that the descriptive form of this analysis could achieve this.

2.7.1.4 Methodology

I carried out this analysis following the guidelines set out by Hycner (1985) based on the work of Giorgi (1975). In order to gain what Giorgi (2008) has called 'harmonious integration', I have followed these steps rigorously (p.2). The first step was to familiarise myself with the interview transcripts as a whole. I listened to the recordings and read through each interview transcript paying special attention to extra-discursive communication. As I carried out many roles in this research, including interviewer and transcriber, it was not the first time I had encountered the data. However, at this stage I attempted to read the transcript as if reading from a fresh, third party perspective.

The second was to break the text down into the building blocks of the narrative, called 'meaning units' (Giorgi, 2006). Nothing was omitted or removed from the transcript at this stage, in order to maintain the context of each unit. According to Hycener (1985) the next step was to create delineating units of general meaning in which the 'essence' of each meaning unit was extracted, while attempting to remain close to the original text (p. 282). I then considered the psychological implications of each general meaning unit according to 'internal processes in psychodynamic therapy', as asked by the research question. I attempted to use what Giorgi (2007) calls imaginative variation to test out different aspects of the phenomenon to see which were essential – the phenomenon collapses without it – and which were not. Once this was accomplished, the final step was to synthesise the meaning established from each building block into descriptive themes. Shared themes from each participant were then compared and contrasted in order to create an overall picture.

2.7.1.5 Methodological considerations

Giorgi (2008) argued that the research needs to maintain a 'disciplinary attitude' based on the context of the research (p.2). For this research, a psychological attitude has been adopted, in order to analyse the data in a thorough yet achievable manner. Although this meant the full potential or richness of my data was not used, it allowed the analysis to be focused.

This approach recognises the function of both the researcher and the participant in creation of this meaning, but also acknowledges the importance of the cultural environment both past and present (Langdridge, 2007). Therefore it was important that I 'bracketed' my beliefs and assumptions in order to maintain an 'open mind' (Willig, 2012, p.155). This included both personal and theoretical knowledge. Giorgi (2008) stressed the importance of employing a phenomenological reduction. This involved both the bracketing of personal knowledge, as well as holding the results of the analysis as a phenomenon – something that is emerging within the context – rather than objective fact. This limits the epistemological underpinning to that of an experienced event rather than the event itself. When adapting this method for psychological purposes it is important to acknowledge that although, as the researcher, I have used a phenomenological reduction, the participants will hold a 'natural attitude'.

This reading used a descriptive phenomenological approach, which according to Wojnar and Swanson (2007), differs from interpretative approach in the way it views both the generalizability of the results and the impact of the researcher. Although not empirically generalizable due to factors such as small participant numbers, Hycener (1985) argued that by 'investigating the experience of one unique individual we can learn much about the phenomenology of human beings in general' (p.295). Furthermore, more emphasis is placed on bracketing in the descriptive approach by using a reflective diary during the analysis, in which the researcher writes down their assumptions and observations in order to separate those from the data. As I am using a multi-layer approach, the reflective diary was already in place.

2.7.2 The discourse analysis reading

The second level of analysis was a discourse analysis reading which focused on how the participant's communicated about their time in therapy. Discourse analysis is the examination of language. It contains a collection of theories and methods that scrutinise speech in order to understand how the processes in which words are selected and the manner in which they are spoken influence the meaning of what is being said.

2.7.2.1 The approach

The aim of this reading is to engage with the participants' language in order to investigate how their responses are constructed, the consequences this created, the linguistic tools used and the way they discursively position themselves (Wetherell, Stiven & Potter, 1987). According to Parker (1997), this approach proposes that language is not a 'simple transparent medium' which allows us to communicate thoughts to others, but instead we become 'caught up in meanings, connotations and feelings they cannot control' (p.2). This reading is not an in-depth investigation into detailed nuances of their speech, but rather the identification of broad themes and trends, punctuated by examples from the interview transcripts.

2.7.2.3 Choosing Discourse Analysis

By using a multi-level analysis I am attempting to examine, explore and understand the 'inner processes of my participants from various angles or lenses. This discursive lens allowed me to hypothesise how the participants used language during the interviews to construct the meaning of their therapy sessions, as well as how they positioned themselves both on a conscious and unconscious level. Parker (1997) stated that 'language provides the settings for thoughts and emotions' as there is not clear trajectory between our internal thoughts and feelings and communicating those to others (p.2). Parker also discussed how people cannot create new discourses specifically for their 'internal mental states', but instead use discourses that are 'caught up in meanings, connotations and feelings they cannot control' (p.2). It is therefore necessary to examine and explore the participant's discourse for more clues regarding their internal thoughts and feelings, which are part of the internal process.

Furthermore, by using discourse analysis we can explore the research relationship by analysing the participant and researcher's communication and co-created discourses. This is due to the postulation that conversations do not occur 'in a vacuum', but rather in a contextually rich environment that are navigated through 'racialized relationships between researchers and participants' (Archer, 2002, p.112). Lin (2013) argued that everyday 'symbolic struggles', such as differences in race, are difficult to reflect on as we have come to take them for granted within privileged positions (p.3). The author suggests that by problematizing issues such as differences in race with discourses, which is achieved by letting go of underlying assumptions in order to critically evaluate the subject, novel understanding of how differences in race play out can be identified. Therefore, engagement during the discursive reading with differences between the researcher and the participants within this study may help to illuminate similar internal processes within the participant's therapeutic dyad.

In many ways I see this reading as a bridge between the phenomenological and psychodynamic readings. The phenomenological reading focused on capturing the inner processes that were conscious to the participants, whereas the psychodynamic hypothesises about the unconscious processes. This bridge therefore attempts to bring together the outer world – the only source of information that we have access to – and the inner world, which cannot be directly accessed. Therefore this discursive reading is an important part of a methodology which is attempting to access the 'inner processes of the participants.

2.7.2.4 Methodology

Firstly, it was important that I let go of the assumptions and understandings formulated during the phenomenological reading. I then began the discursive reading by rereading each of the interview transcripts with a focus on the language properties used throughout. Once a broad understanding of the themes present in the transcript had been noted, I coded the data line-by-line in order to once again break the transcript down to its building blocks. In-line with Potter and Wetherell (1987) I attempted to keep the coding directly linked back to the research question, which meant that the coding and

analysis were a cyclical rather than stepped process as I went back and forth between the data and the implications that it held for the research question. Furthermore, as recommended by Willig (2012), I saw this reading as a way of approaching the text rather than a set of step-by-step instructions. I approached the data with four main questions in mind and wrote analytic notes in the margin to capture them.

1) What meaning was constructed?
2) What discursive strategies were used?
3) What were the consequences (action orientation)?
4) How did they position themselves?

I was looking to identify the mood and the style of what is being communicated, as well as pauses, pacing, emphasis, inflection, and intonation. I examined linguistic evidence of patterns, function, and affect (Potter & Wetherell, 1987). I also aimed to understand what is being implied by the discourse and what is at the centre of the message being communicated. As advised by Willig (2012), I also included my own contributions, as the interviewer, in the analysis. The rationale behind this was that my comments were part of the discursive framework in which the participants built upon.

Once the building blocks were analysed, the final step was to bring them back together, along with the information garnered from analysis, in an attempt to create a more comprehensive understanding of the discourse used by the participants when discussing their therapy sessions.

2.7.2.5 Methodological considerations

Willig (2012) stated that there are various styles of discourse analysis which differ according to how much emphasis they place on the use and availability of discourse. Wetherell (1998) described how 'boundary lines' have been drawn between conversation analysis and Faucauldian analysis (p. 388). Conversation analysis focuses on the action orientation of discourse, whereas Faucauldian explores how people position themselves within the discourse. However, as demonstrated by the methodology outlined above, I have chosen not to adhere to this boundary as I included

both action orientation and discursive positioning in my analysis. Wetherall argued that this creates a 'synthetic approach' allowing the full tools of discourse analysis to be at my disposal. However, during the analysis I was aware that this reading is part of a multi-level analysis which is attempting to occupy the 'moebius strip' been the participants' inner and outer worlds (Young & Frosh, 2009) and that the discursive reading was essentially providing the groundwork for the subsequent psychodynamic reading. In agreement with Hollway (2011), I found the participants' positioning within discourse to be useful for psychodynamic reading, and therefore the Foucauldian idea of positioning featured more in the write up of the analysis.

2.7.3 The psychodynamic reading

A psychodynamic reading attempts to delve behind the consciousness of the participant's words in order to hypothesise the motives, emotions and drives that lie beneath the participant's consciousness. It therefore addresses both conscious (face value) and unconscious (unknown elements underneath) forces at work in the participant's words. For example, in this section I will use psychodynamic theory in an attempt to explore the possible motivation behind the way the participants discursively positioned themselves in the previous reading.

2.7.3.1 The approach

Kulish (2002) stated that psychodynamic epistemology suggests that there is a reality outside of our subjectivity that exists, although it may not be 'verbalisable or even knowable' (p. 495). This suggests that underlying psychic processes outside of our conscious awareness do exist, but that psychodynamic theory may not be able to fully reach it, understand it, or put it into words. He used the term 'critical realist' to describe this epistemology, and suggested that we can get to the core of human experience, even though it is beyond what a person observes in their everyday life. I also intend to adopt a critical realist epistemological stance for this reading.

By adopting a critical realist stance, researchers can also attempt to bring together discursive and psychodynamic methods in order to explore the possible unconscious

processes involved behind participants' discursive positioning. However, when interpreting data in this way there is a debate around the level at which we can 'know' the underlying psychic processes. For example, Hollway and Jefferson (2005) identified unconscious conflict and defences in their analysis, placing them more firmly in the 'realist' end of the epistemology and suggesting that underlying processes such as these can be 'known'. This approach is known as a Klienian reading. Whereas those who hold a Lacanian perspective, such as Savillle Young and Frosh (2010), suggest that the unconscious is a concept that cannot be identified or put into words, hence it is more 'critical' of the concept of 'knowing' what lies beyond our consciousness.

There appears to be a conflict within the literature between Lacanian and Kleinian schools of thought. Frosh, Pheonix and Pattman (2003) described this choice as 'awkward and complex' (p.42). I feel that it is not necessary to choose an alliance to either of these schools. Instead, I intend to hold both a 'critical' and a 'realist' position, in which I hold that unconscious psychic structures exist but I am tentative in my description as I feel my reading is a hypothesis of what the participants' inner processes may be.

A critical realist position is in line with the overall epistemology stance of this piece of research, which is moderate constructionism. This also postulates that inner processes do exist, but due to the 'moderate' nature of the epistemology, it does not hold firmly whether there is an 'objective reality' that is true or false. This is in line with the 'critical' aspect of critical realism.

2.7.3.3 Choosing Psychodynamic Reading

The reason I chose to carry out a psychodynamic reading of the data is that by further exploring the results from phenomenological and discursive readings using psychodynamic analysis I am attempting to bring together the outer experiences of therapy with the inner processes involved. As the psychodynamic epistemology suggests, there is no way to access inner processes directly, so I needed to use a series of tools to build up a picture of what they might be like. This included building a relationship, encouraging free association, analysing non-verbal communication, using

intersubjectivity and examining power dynamics. Without this stage in the analysis, I feel the research question would not be fully addressed. This reading is similar to a psychosocial approach. However, I felt that the phenomenological experience of the participants was an important aspect of the research question, and by creating separate readings for each analysis I could build on the one before to create a larger multi-angled result.

2.7.3.4 Methodology

As discussed above, I adopted the position in line with Hollway and Jefferson (2000) that my participants may have been defended and therefore may have used their discourse to protect the vulnerable parts of themselves or perhaps were unaware of what motivated them or why they experienced things as they did. I therefore used an interviewing style for the third interview that Hollway and Jefferson called the Free-Association Narrative Interview (FANI). This interview style adopted principals from the biographical interpretive method. This included:

- Using plenty of open-ended rather than closed questions
  Example: What does your therapeutic relationship mean to you?
- Attempting to elicit stories from my participants
  Example: Tell me something about your background?
- Avoiding 'why?' questions
- Using my participant's wording and phrasing
- Asking the participants to say whatever comes to their mind

I urged the participants to talk as openly as felt comfortable, and attempted to 'hold' them using my skills as a counselling psychologist during any periods of vulnerability. During periods of ego strength or emotional robustness, I tried to probe deeper through follow up questions regarding their motivation or own interpretations. I also paraphrased their responses as a way to foster a continued open stance. I did not interpret their response during the interviews.

Brown (2006) emphasised that psychoanalysis proposes that a large amount of our self is unconscious and not directly stated with words. In line with this, Bollas (1987) concluded that 'utterance of self through the manner of being, rather than through the representation of mind' (p. 33, as cited in Brown, 2006). Therefore, as part of the psychodynamic reading I used reflectivity and interpretation of other data besides the participant's words. This included my impressions, emotions, how I responded, non-verbal communication and the emotional and power dynamics between myself as researcher and the participants. I noted this down in a reflective journal after each interview, as well as after each listening of the recordings and analytic stages leading up to this point. The aim of this was to include the role of unconscious intersubjectivity from the interviews into the analysis. This was particularly relevant considering I hypothesised that my participants were coming from a defended stance.

2.7.3.5 Methodological considerations

The analytic strategy of this piece of work dictated that the ethics behind the psychodynamic interpretation needed the most ethical consideration. During the descriptive phenomenological analysis I aimed to bracket my own assumptions and thoughts, and focused only on the participant's responses. Within the discourse analysis framework, I was more concerned with dissembling data to understand its building blocks. It is not until the psychodynamic reading that data is expanded upon using psychodynamic concepts such as defences, attachment and externalisation. It is in this expansion of the data that extra care and attention needed to be placed.

Psychodynamic readings have been criticised for the 'power' the researcher holds over the interpretation and how the researcher can come across as an 'expert' who knows the participants better than they know themselves (Billig, 2011). Hollway (2008) also describes the 'danger of wild analysis', in which psychodynamic concepts, such as transference and psychic defences, are used without careful consideration (p.389). Furthermore, Frosh and Baraitser (2008) describe the 'loose and sometimes pious' way that psychodynamic theory has been conceptualised within research (p.346). To counteract these ethical issues, Willig (2012) stressed the importance of keeping the research question at the forefront of the investigation, maintaining the participant's

voice throughout, and being receptive to different interpretations and perspectives. There is also a great need for reflexivity and every stage of the research. Frosh and Baraitser (2008) suggest that reflexivity should be a way to keep interpretations more 'tentative' and less certain, and to keep abreast of what I, as the researcher, brought to the process (p.346).

There are also concerns about the complications of moving psychodynamic thought from the therapy room into the research environment (Clarke, 2002). This could be a difficult entanglement for this research question, which is trying to evoke the therapy room from within the research environment. I made sure to clarify to the participants that no psychoanalysis would take place during the interview; those who took part in the research were participants and not patients. I did not make any interpretations during the interview. I explained to participants that my role as a researcher was separate and distinct from their relationship to their therapists. The aim of this was to diminish the possibility of becoming a third element within the participant and their therapist's analytic dyad, thus affecting their therapy in an unhelpful way (Spezzano, 1998).

It is important to acknowledge that the results of this analysis are speculative in nature, especially considering the small amount of information I gathered about the participants' childhoods and experiences during their developmental stages. Also, any links and association that I made are under the assumption that they were unconscious processes that the participants did not consciously choose to communicate.

2.7.4 How I carried out the final analysis

The previous two reading have provided me with how the participants experienced their own inner processes (phenomenological reading) and how these processes were expressed through their discourse (discursive reading). This final reading is looking to hypothesize about why they process their therapy sessions as they do. Therefore, I felt I was able to move directly to the theoretical interpretation of the interview data at the start of this reading by using the themes and phenomena that arose during my first two readings. The aim therefore was to create a deeper understanding of the analysis already carried out, as well as return to the interview data to pick up on any important themes

that were not picked up during the first two analyses due to the parameters of the separate methodological approaches. Therefore I start with what was said in the interviews about their therapy, and then move beyond their words to look at their biographical information and my own emotional response.

2.8 Personal Reflexivity

This approach does expose aspects of myself, such as the whiteness of my skin, which can be challenging. One of the key elements and reasons for using the BME client group is that they are viewed as being in the minority, and may have experienced negativity or a sense of not belonging because of this. Sue (2004) suggested that although having White skin may not denote a particular racial group; it will affect a person's experiences. They also suggest that it is difficult for White people to discuss their 'whiteness'. This is something that I can resonate with, but now that I am beginning to understand the implication of the 'invisibility of whiteness' (Sue, p.762). It is important to acknowledge that I, as the researcher, have White skin and therefore I am part of the majority. This could have impacted the participants' descriptions, language and consequently their unconscious motivation during the interviews. For example, Comas-Diaz and Jacobsen (1991) commented that ethnic minorities may filter what they say in order to not reinforce stereotypes or may conceal differences to avoid confrontation.

Another way I could have influenced the participant's actions and discourse was through the ambiguity of my own background. I understand that I project a somewhat unclear sense of culture and ethnicity; I feel both British and American and grew up moving from country to country. I believe that by spending my childhood trying to blend into the dominant culture of each place has influenced my sense of identity and how I interact with others. I felt it was important to reflect on how my ambiguous background and White skin may have affected both the interview and interpretation stages in the reflective journal I kept. I also worked with my supervisor to reflect in my own ethnicity and the intricacies of working with minority populations ethically and sensitively.

During much of this research I was in psychodynamic therapy myself, which I found to be a useful tool to work through my own emotions during the interview process. However, I could see that during the sessions I was using certain discourses and social protocols as ways of defending the fragile aspects of myself and that I unconsciously tried to hide the motivation and meaning of certain emotions and behaviours. It is for these reasons that I resonated with Hollway and Jefferson's (2000) view that the research participants may be also unconsciously protecting themselves from difficult thoughts and feelings. Therefore my own defended stance during therapy did shape the way that I viewed the participants and consequently how they viewed me.

I feel that matters of difference in culture and ethnicity did come up during my sessions with my White British therapist. I have a large, close-knit New Mexican family who are catholic, which has affected my values and expectations, and I felt that he struggled to conceptualise that in regards to my identity. Furthermore, I feel that he disregarded other parental figures during my developmental years, especially the role that my older brothers played in raising me. I did find this frustrating and I did shy away from speaking about these matters further. I suppose there is a part of me that wondered if my participants might also experience something similar to this. However, I am aware that due to my physical appearance and compartmentalisation of my different identities, these parts of myself are hidden. My Black, Afro-Caribbean participants' experiences are likely to be different due to issues with marginalisation, discrimination and racism.

CHAPTER 3 – The Analysis

3.0 Overview of the analysis

In this section I will provide an overview of the analytic approach carried out in this chapter. I will first briefly describe each of the individual readings that make up the layers of this multi-layered approach, while also illustrating how the individual lenses will build upon each other to create a progressively deeper analysis. The first level of analysis was the descriptive phenomenology reading. This created a narrative account of the participant's knowledge and experience of their time in therapy, which have been divided into themes. This approach, based on Husserl's work, proposes that subjective information is important as the participants are influenced by what they believe to be real (Lopez & Willis, 2004).

The second layer of analysis used a discursive lens. This reading is a deeper analysis because it proposes the participants' description of their thoughts, emotions and experience are not a direct reflection of their inner processes, but that language and thought are intermingled (Willig, 2012). By examining how meaning was constructed through discursive tools and identifying how this positioned the participants, as well as the overall consequences of their discourse, the analysis can potentially reach a more in-depth exploration of the participants' inner processes.

The third layer was the psychodynamic reading. As stated by Willig (2012), this approach holds the assumption that 'people are motivated by emotional dynamics which have their origin in childhood' (p.214). The final level of analysis used what the participants said (phenomenological reading) and how they said it (discursive reading) in order to further explore internal processes by drawing on psychodynamic theories. Each reading built on the previous analysis in order to create a progressively deeper exploration of the participants' inner processes during their therapy.

3.1 Phenomenological Reading

A phenomenological lens provided a way to explore the participants' experience and conscious inner processes in therapy. This analysis stays close to the original meaning of the interviews and could make use of the insight the participants had gained. It provided the 'what' of the research question – what happened during their therapy and what can that tell us about their inner processes. Therefore it was the first level of analysis and provided the groundwork from which the other two lenses could build on. In this section I have presented the themes that emerged from each participants' based on the synthesized descriptions of building blocks of the participants' interviews regarding their inner processes.

3.1.1 Descriptive themes from Annie's interviews

The therapeutic relationship: Feeling understood

Annie had a Black male therapist, and reported that by having a Black therapist she felt more understood. She appeared to really emphasise the importance of this relationship, but also the need for it to build slowly. She described how she sought out a Black therapist because she did not want to be a 'guinea pig' who needed to 'explain' herself:

> My initial feeling of not wanting to explain myself would have been more like colloquially – if I was saying something, not wanting to be a stereotype, to slip into that.

She felt that her therapist 'gets it' so she does not have to 'hide' parts of herself. She gave the example of when she was really angry in a session, her therapist can tell the difference between the different types of 'cussing', which are different types of verbal communication of 'internal or external anger'. She described how she wanted to 'test' herself by being 'vulnerable' with a Black male who would be 'revealing things to me'.

Vulnerability: Uncomfortable with the closeness

She described therapy as 'getting undressed and dressed again in front of someone you don't know', and that she often feels 'naked' and 'vulnerable' during a session.

However, she said she thought her therapist wanted more vulnerability from her. She felt that vulnerability took time to develop and she needed to explore 'trust with a Black male'. Part of this vulnerability appeared to come from her feeling that every comment she made 'exposed' her and that she could not 'run away' from feelings. She had to 'sit there and be bare', to 'swallow it' – even when it 'irritated' her and 'got up her nose' that she could not 'hide'. At times this sense of vulnerability seemed to overwhelm her as she said at times she 'lied in a session' because she did not want answer. She described being concerned how she would be 'viewed' and that it was too far out of her 'comfort zone'.

Defences: Be strong and rescue others

Annie acknowledged her defence mechanism of attempting to maintain a façade, a performance where she repeated 'everything's great!' She was also aware that she would find herself talking 'around' the subject or using 'humour' to deflect from her feelings of vulnerability. Sometimes this took the form of getting 'crazy' in a session to make her therapist laugh. There were also examples where she would focus on circumstances outside of the session, particularly rescuing others, rather than what was happening inside the therapy room. This seemed particularly relevant at the beginning of her therapy, as she described feeling that there was not 'any of me' within the session. She described how this external focus led to her feeling 'detached', but with time she felt she could create an 'inward lens'. However, she found that as her defences came down she would have to face difficult emotions such as shame, embarrassment, and anger.

The past and present: Family dynamics

Annie spoke of an increased understanding of how her past affects her in the present, particularly regarding her family's dynamics and her role within her family. She also learnt how her relationship with her mother has formed over the years and how that affects her in the present ('things are going to pop up'*). She has also gained an understanding of how her current behaviour is affected by her childhood experiences. So knowledge from her past helps her to understand herself now. For example, she gained insight how her past rejection were impacting her current relationships:

I realised that I pushing people away before they had a chance to reject me.

She and her therapist were also able to understand the roots of certain patterns of behaviour that she was presenting, such as the role of 'rescuer' ('I present as a rescuer really strong. I rescue, rescue, rescue').

Annie described how she now understands that her story is 'always there in the background' and how she can see how her past, as well as 'generations of stories' affect her in the 'here and now'. For example, she described how she can see the effect her struggles with her parents' divorce affected her ('I have struggled with my dad, and the fact that my parents got divorced'), particularly how her relationship with her father affected her relationship with men. There was also a forgiveness and healing that came with this understanding for both herself and her parents as she readdressed her memories ('it would have been hard with three young children. I can understand'). She described how painful it was to talk about the family issues as she had 'to strip off loads of things'.

Pain: Addressing the hurt

The main source of pain, according to Annie, is having to look at things differently and understanding how her role or her 'unhelpful thinking' affected the situation.

> I thought I was right to have a particular way of being, but actually it's not, and, actually it's not healthy having that way of thinking. So then there's a pain that comes because I was thinking that things were okay and they're not.

She commented on how she could never predict when the pain would come during a session, if at all. She said that she now targets pain in a controlled way, as she is no longer fearful of it as she knows it can 'lead to change'. However, there are still sessions which can lead to a 'painful collision' in her chest, that will mean she has to physically retreat after a session as the pain will stay with her and continues to make her

feel 'raw'. She said she has learnt that when she feels 'sensitive' during a session, this is a warning that pain is to come.

'Aha!' moment: Taking on her mother's role

Annie stated that she had an 'oh my god, he's right!' moment when she could finally connect with her therapist's view that she had taken on a similar role to her mother. Her mother was the centre point of the family and of the community, always inviting others over and taking on their challenges. Annie initially rejected the idea, as she stated that she thought she did not want to be like her, but struggled as she felt that she could not 'argue her case' and that there was no way to 'win'. She described how she tried to squeeze herself around what the therapist was suggesting to her:

> I really tried to go around the corner and under the wall and… he would… move the wall, move the gate. So I had to just kind of sit there and be bare.

However, she felt that she could not get away from this comparison, and after two years of trying to run from it, she finally had her 'aha!' moment of realization. However, this was a recent development in her therapy, and Annie appeared to still be processing what that meant for her. She described how she has since been working towards intertwining her story with her mother's.

Summary of Annie's descriptive phenomenological analysis

Annie chose a Black therapist because she did not want to explain herself, feel like a guinea pig or have to hide parts of herself; she felt that having a Black therapist helped her to feel understood. However, letting her male therapist get emotionally close to her made her feel metaphorically naked and vulnerable. Her defences against difficult feelings were creating a strong persona or facade and focusing on other's needs before her own. She found it emotionally painful to be vulnerable with her therapist, let go of her strong persona defences, and think about how her relationships of the past may be impacting her in the present.

Annie could see that generations of family dynamics were impacting her in the present, particularly her role as a rescuer, and how her struggle with her parents' divorce was a part of her fear of rejection. She initially rejected any similarities between her role and her mother's role at the centre of the family. However, after two years of trying to escape this comparison, she finally had an 'aha!' moment where she could see how she had taken on certain aspects of her mother's role.

3.1.2 Descriptive themes from Pamela's interviews

The therapeutic relationship: Maternal

The maternal aspect of the therapeutic relationship was an intrinsic theme throughout the interviews with Pamela, but there was some uncertainty around her level of awareness that she was looking for a maternal figure. She reported that she was left cold at the thought of a male therapist, and actively sought out a woman ('I knew that I wanted a woman'). Her therapist is White, and she stated that she did not think about 'race issues' when picking a therapist. She claimed she was more focused on relationship itself, which she placed a lot of emphasis on.

She can see difference between them, such as ethnicity, backgrounds, and generation, which she feels may impact her therapist's ability to understand the intricacies of her life. She gave the example of how she was unsure whether her therapist could understand that her childhood punishment of being beaten by her parents was 'normal' for her Caribbean culture. However, she stated that this does not stop them from talking about these things. Ultimately, she described their relationship as 'strong, engaging and patient' and strong enough that she can bring racial issues into the room if necessary.

Longing for intervention and a space to be heard

She can see how her therapist represented the women she has known in her life. However, she made it clear that the therapeutic relationship is different to the one she had with her mother, but hypothesized that she was 'probably longing' for this type of relationship and interventions from her mother.

I had a very different relationship to her then I did my mother, and maybe there is a part of me that was longing for that – I don't know – that intervention or that interpretation as a child that I didn't receive.

Through therapy she has also come to recognise that as a child she felt unheard, which is why feeling listened to is significant for her now. So when she is able to articulate her emotions and have those emotions acknowledged, this feels very significant for her. She reported that she may not necessarily make her 'feel better in the moment' but this has allowed her to gain a better understanding of what to do with her feelings, such as sadness and loss, as well as becoming more 'comfortable' with her 'story'.

Defences: Hiding what is not brave or strong

She described how she, at times, tries to 'hide' something from emerging during a session, but has learnt that she cannot hide as her therapist knows when that she is 'defending'. She feels that her 'brave face' and need to display a 'strong persona' have made it 'hard work' for her therapist and they use a 'puppet metaphor' to communicate her use of defences to 'pretend everything's perfect'. However, with time Pamela has been able to show vulnerability in a session, as she has realised that 'vulnerability leads to strength and better coping' rather than a 'weakness'. She has also been able to change her perception of vulnerability as 'the worst possible feeling' to seeing how it can make you a 'different person'.

She claimed that in first year of therapy she was only willing to talk about 'surface level' things, but that as time has progressed she has learnt to see herself as a 'tier system'. It was difficult for her to 'strip the layers away' and she feels that it was 'time and willingness' that allowed her to do it, although she feels she still can be 'resistant about going deep'. She reported that this can cause her to leave the session with a 'heavy head', as the deeper the session the more likely she is to carry it physically. Although there can be a 'buzz' from going deep when things progress and feel integrated, it can also be painful with a 'nerve' is unexpectedly hit.

Past and present: Accepting flaws

By connecting her past to her present she was able to make links between present feelings and past emotions, as well as integrate new insight about her past into her and her family's 'story'. The insight was often based on cultural clashes with her parents as a second generation immigrant and a longing for more of their time. She felt that re-analysing the past had shown her that her 'good childhood' may have been on a surface level. She revealed that for the first year of therapy she did not want to acknowledge any 'flaws' in her mother or that she had anything but a 'good childhood'. She stated that she was 'glad' that she could not be 'angry' at her mother based on this re-evaluation during her sessions.

> I'm actually quite glad that my mum is not here because I would be quite angry with her about certain things that have been raised.

She stated that she is now 'acknowledging my own flaws' and accepting a version of her past that goes deeper than the surface level as 'good'.

Fear and uncertainty: Deeper levels

She described it as 'scary' for someone to have 'insight into your world' and to be able to make links to you past. She said that not knowing what would emerge when she explored 'deeper levels' scared her, but that she previously did not want to acknowledge this.

> I don't think I've always known that I was scared to go there. I think that in terms of my, my makeup – so to speak – I almost, probably didn't want to acknowledge that I was scared and, um, wasn't aware of it until I started therapy

She also acknowledged that there was a 'theme of uncertainty' that run throughout her sessions, which felt as though she was going through 'a tunnel without knowing where you are going'. She reported that it was through therapy that she has been able to connect with her fear and uncertainty, and has slowly allowed her therapist to see more of her 'deeper levels'.

'Aha!' moment: Bringing feelings to the surface

Pamela described how her moments of realisation can occur weeks after she initially rejected the idea. She disclosed that there can be a conflict and surprise when her therapist touches on something she's not ready for, which makes her feel 'flat, exhausted and numb' and can 'fill the room'. She compared this feeling to 'hitting a nerve'. She feels that her therapist is 'tapping on something that is not quite there yet' and that her immediate response is to think, 'no!'

> …there have been moments when I have left and thought, 'What's all that about?' You know, 'No!' in terms of whatever she had said. But then a few weeks down the line there is a connection.

She admitted that she does not always realise that what she is bringing to the session is linked to something deeper until later, but that a 'good connection' with her therapist means that these connections can be brought to her attention sooner. Although she feels this is 'painful' she also described it as 'relief' that these feelings have been brought to the surface.

Summary of Pamela's descriptive phenomenological analysis

Pamela had a strong maternal relationship with her therapist, but she felt the differences between their ethnicities and backgrounds may have impacted how much her therapist could understand the nuances of her life. Nonetheless, she wondered whether her therapist was able to give her the 'interventions', 'interpretations' and space to feel heard that she had longed for as a child. However, she has learnt that she is fearful of what she might find when exploring the deeper levels of her internal processes. She and her therapist use a 'puppet metaphor' to describe how she tried to hide emotions that do not fit in with her 'brave face' and 'strong persona', and that she is 'resistant about going deep'. She described how her therapist can tap on something that she is not ready yet so she will reject it. The connection often comes at a later date, and by making links between her past and present she is going beyond the surface level of her childhood so that she can accept her own flaws and those of her mother.

3.1.3 Descriptive themes from Karen's interviews

Therapeutic relationship: Conflict over comfortable or neutral

Karen stated that she started therapy for the specific reason of needing a 'neutral person' to talk to regarding important issues in her life. However, she described how starting therapy was very difficult for her, as she felt 'painfully shy' and doubted whether she would be able to make it through the front door of her therapist's room. In fact, she had several fantasies of 'running away' because her anxiety levels were so high. She described a conflict between wanting a 'stranger' and struggling to feel comfortable enough to share with this stranger. She revealed that at this point she was aware that fear may have been negatively affecting her life, but felt 'stuck' and 'surprised' by her emotions. She described her motivation to start therapy as something external based on life events rather than internal processes.

Differences to the therapist: Pushing them away

Karen's therapist was a 'White, middle class' woman, and she confessed that she had wondered what it might be like to have a Black therapist. She questioned whether she would not have had to 'explain' herself, or whether her 'mother's tongue' would have influenced the relationship or would have allowed her to communicate rather than regress to her childhood mutism. However, she very clearly stated that she did not want to change anything about her therapy and felt that questions regarding differences to her therapist were a 'distraction' from the 'work' she wants to achieve in therapy. So she pushed these questions away.

> I've been very clear about what I want to do in therapy, and, umm…you know this is something that I need to do. It could get, um, I could get distracted by all sorts of other things. I don't particularly want to do that.

When cultural misunderstandings did occur, she stated that she did not bring up the misunderstanding or the way it made her feel with her therapist. She gave an example of when her therapist had asked her why Karen's mother had wanted to immigrate to

Britain. She was left feeling surprised that her therapist did not really understand how immigration from the Caribbean worked during the 1940s.

> ….not that she should know my particular history, but just how, you know, Windrush, the Windrush era and how that came to be. You know, the way that maybe my auntie and my mum, you know, my auntie moved here first. She rented a room in somebody else's house, you know…leaving two children behind was just…there wasn't anything in particular about my mum. That's just what happened.

It also led her to wonder whether her therapist could understand that it was normal to leave children behind when emigrating, as her older siblings had been left behind when her mother emigrated. However, she did not speak to her therapist about these feelings or misunderstandings.

Defences: Not able to say what she needed to say

At the beginning of the therapy, Karen regressed to her childhood state of selective mutism. She expressed how she was 'shocked' when she stopped talking and was 'unaware' of what had 'triggered' this in her. She was faced with her 'previous ways of coping' as a child, as well as the 'childhood pain that was locked away' all this time. She has since gained the insight that she had not been able to say what she had needed to say, just like when she was a child.

> What slowly happened was that I became quieter and quieter until the point when we had one session where I didn't speak at all. And I think it was because I wasn't able to say what I needed to say, and when I was little I didn't talk at all.

It appeared that she struggled to connect with her vulnerable child self. She wanted to maintain her belief that she was unaffected by her challenging childhood, as she was a strong, adult woman with responsibilities and a family to look after. Through therapy,

she and her therapist worked on other ways to communicate her pain and vulnerability without words so that she could regain her voice in therapy.

Working through the regression: Seeing her isolation

They worked through Karen's regression using a sand tray. Although she was unable to talk, she was willing 'to engage with that sand tray' in a way that she could not with her therapist. She portrayed her 'ease' at working with the objects, which allowed them to understand the way she related to others, by 'building this picture' of the people in her life. She commented that it was the sand tray that showed her the isolation within her life. It also demonstrated to her therapist that Karen was not concerned with the therapeutic relationship.

> …and then it became clear that actually there weren't very many people, there were few people who were close to me.

Building a bridge: Letting someone in

Karen explained that she and her therapist used the metaphor of 'building a bridge' in order to help her to appreciate that they needed to 'build something together' to communicate. This allowed her to understand the need to have a therapeutic relationship in the first place, something that she was struggling with.

> I don't think I had an understanding of what the therapeutic relationship had to do with me and her.

When Karen looked back at this time she described it as 'bizarre' to think that she could not understand the need to have a relationship. She described having her interpersonal issues demonstrated through the therapeutic relationship as 'excruciating', especially as it demonstrated to her that she was probably was not allowing others to relate to her. Although it took a long time for her to understand the need for a therapeutic relationship, after five years of therapy she appears to cherish this relationship and really seemed to want to convey its importance during the interviews.

The past and present: Acknowledging childhood difficulties

Karen depicted how she realised that past experiences were a part of her present, and began to explore her past for the first time. She described this as a 'stark experience' as she found it difficult to acknowledge her childhood difficulties. However the picture of her past slowly began to emerge, and she described it as pieces of a 'jig-saw' that she pieced together. This led to a 'very slow progression towards sadness' as she began to connect to the emotions that she had felt as a child, such as mistrust and avoidance. As the story unfolded she began to gain a sense of who she was and how she was living when she was a child. She acknowledged that she could see that these were memories that she did not want, and she could see why she would have wanted to forget them.

> Yeah, you know you start to link areas of your life with other areas that you begin to remember, you know, some things you don't particularly want to remember, so things, but actually I guess if you've experienced it, it will be somewhere within you.

Part of creating this 'jig-saw' of her past in therapy was also understanding how her mother had immigrated to Britain and what it was like for her. During the interviews it appeared important that she was able to set the scene of her mother's journey from the Caribbean, as well as keep track of her sisters and aunties.

'Aha!' moments: Accessing fear of abandonment and her avoidant attachment

There appeared to be two major 'aha' moments for Karen. They were when she connected to her fear of abandonment and to her 'avoidant attachment'. She originally thought there were no issues regarding breaks in the therapy, but that a theme of 'fear and abandonment' did begin to emerge through her dreams. She began to understand that she did have feelings about breaks, and that she did not want to put herself in a position where she could be abandoned as an adult as she had been as a child when her mother left. She emphasized the importance of understanding how her fear of abandonment affected the therapy, which was also mirrored when she accepted that she had an 'avoidant attachment'. In a similar way, she also rejected the concept that she

had an 'avoidant attachment' at first ('I'm not avoidant!'). However, she can now say that this is 'obvious' as she can recognise her 'avoidant life patterns', especially in regards to forming a therapeutic relationship.

Summary of Karen's descriptive phenomenological analysis

Initially Karen felt conflicted between her desire to have a 'neutral' 'stranger' as a therapist and the discomfort and anxiety that this would bring. She regressed to her childhood state of selective mutism, as she felt that she was not able to say what she needed to during the sessions. They worked through this with a sand tray, which showed Karen the isolation in her life and her therapist that Karen was not concerned with the therapeutic relationship. They used the metaphor of 'building a bridge' in order to construct their therapeutic relationship and allow her therapist to form intimacy with her. She realised that her past was a part of her present and began to piece together her past and connect to her childhood emotions, particularly sadness. She also recognised the protective function her disconnection from her memories was playing. The two main 'aha' moments for Karen, her fear of abandonment and her 'avoidant attachment', which emerged based on the therapeutic relationship. Ultimately, she did begin to wonder if a Black therapist may have led to less misunderstanding and need to explain herself, or may have influenced her regression to her childhood mutism by strengthening the transference. However, she felt that these were 'distractions' and pushed them away rather than speaking to the therapist about them.

3.1.4 Descriptive phenomenological reading discussion

There were five main themes that emerged from the phenomenological reading that were shared by all three participants (TABLE 3.1). They were: importance of the therapeutic relationship, strong persona defences, the past and the present: personal and family history, 'aha' moments, and fear and vulnerability. The theme of differences to the therapist: Not feeling fully understood emerged for the two participants who had White therapists. In this discussion I will summarise the themes that were shared by the participants, followed by an overall summary of the phenomenological reading.

Table 3.1: Individual and shared themes from the descriptive phenomenological reading

Annie	Pamela	Karen	Shared
The therapeutic relationship: Feeling understood	The therapeutic relationship: maternal	Therapeutic relationship: Conflict over comfortable or neutral	The Therapeutic relationship
	Longing for intervention and a space to be heard	Differences to the therapist: Pushing them away	Differences to the therapist
Defenses: Be strong and rescue others	Defenses: Hiding what is not brave or strong	Defenses: Not able to say what she needed to say	Defenses: Strong persona
The past and present: Family dynamics	Past and present: Accepting flaws	The past and present: Acknowledging childhood difficulties	The past and present
Pain: Addressing the hurt	Fear and uncertainty: Deeper levels	Building a bridge: Letting someone in	Vulnerability
Vulnerability: Uncomfortable with the closeness		Working through the regression: Seeing her isolation	
'Aha!' moment: Taking on her mother's role	'Aha!' moment: Bringing feelings to the surface	'Aha' moments: Accessing fear of abandonment and her avoidant attachment	'Aha! Moments'

Importance of the therapeutic relationship

The therapeutic relationship was a key theme in each of three participant's interviews, as they really emphasized its importance above other factors and demonstrated a sensitivity to interpersonal processes. There was a shared need for the relationship to be built slowly over time. All three participants also appeared eager to praise their therapists' therapeutic skills. The overall essence of this theme appeared to be replicating elements of a parental relationship, which the participants sought out according to their own needs and background. There was also a dissonance within each participant between a warm and nurturing relationship and fear and anxiety in forming a close relationship and being vulnerable with their therapist. This theme is particularly

relevant as they were in psychodynamic therapy, which uses the relationship as a point of intervention from which interpersonal conflicts can arise.

'Strong persona' defences

The participants openly discussed the defences they used to protect themselves from difficult thoughts and emotions during sessions, as they felt they were a type of weakness. Their defences normally centred on keeping their 'strong' persona or mask in place, maintaining a sense that everything was fine. They described how they would rather not say anything that demonstrated struggle and connect to their negative emotions. They also appeared to extend this strength to those around them in their families and communities, often focusing on others problems during the session rather than their own. All three participants noted that changes could be made once they connected with difficult emotions that they were defending against, but that it was very challenging to do this.

Past and present: Personal and family history

The participants expressed the importance of understanding how their past was affecting their present, as well as a sense of readdressing the past to create an understanding of how their personal history fit into the larger family history. Within this, relationships and cultural family dynamics were explored. For example, in each of the participant's narratives their relationship to their mother appeared to hold particular importance. Furthermore, a major focus of this process appeared to be understanding how their parents' attitude towards their immigration to Britain impacted the family, such as the long hours they worked and the separation from family members back in the Caribbean. There was a sense of expressing the emotions connected with their past, whether it was anger, sadness, or joy within a safe space.

'Aha!' moments

All three participants described 'aha!' moments of realisation when something was brought to their awareness that had previously been affecting their inner processes on a preconscious level. These moments were often when the therapist made transference interpretations – when the therapist made a comment about the participant based on the

way the participants made them feel - which the participants reported they initially rejected. They appeared to often be based on cultural roles within family relationships. This theme is tied up with the previously described themes, as the participants would have to let go of their 'strong' personas and become vulnerable in order for these 'aha!' moments to occur.

Fear and vulnerability

There was a shared sense of fear and anxiety around the participants feeling vulnerable within the therapy room, which manifested itself in different ways. This appeared to stem from a sense of not being able to hide their feelings, and of intimately being known by their therapist who could demonstrated insight into their lives. It appeared to be a difficult and uncomfortable position for the participants to be in, one which they fought against at times through their strong persona defences. The participants appeared to convey a sense that by being vulnerable with their therapist it could lead to the therapist causing emotional harm through abandonment.

Differences to the therapist: Not feeling fully understood

The theme of differences to the therapist was present for the two participants who had White female therapists. There was a shared sense of not being fully being understood and feeling as though they had to explain themselves at times during their sessions. They described this as directly connected to their therapist belonging to a different race and culture, as misunderstanding often revolved around family history, dynamics and values. However, this theme did not emerge naturally, I specifically asked the participants if they felt that felt fully understood by their White therapists. They were also keen to demonstrate that they did not let this affect the therapeutic work and that their therapists were warm and kind. However, this misunderstanding appeared have a lingering effect on the relationship as it led to thoughts about whether a Black therapist might make a difference. The participant who did have a Black therapist, explicitly reported wanted a therapist who was the same race, so she did not have to explain herself, be a 'guinea pig' and could feel that her different types of anger were not misinterpreted.

Summary

This reading demonstrated that there were shared elements of participants' conscious internal processes, which were influence by their culture and race. Firstly, they placed a lot of emphasis on the therapeutic relationship, which appeared to be replicating elements of their own parental relationship. There was also a shared conflicting feelings between the sense of a warm and trusting relationship and a fear of being vulnerable and exposed. Therefore their defences appeared to be designed to maintain their 'strong' persona, as they struggled to demonstrate weakness. Secondly, they worked towards readdressing not only their individual past and sense of history, but also of their family history which included the migration to Britain. In the processes of understanding family dynamics they would reject certain concepts that their therapists introduced through transference based interpretations, only to later experience a 'aha' moment in which they understood. However, they would have to let go of their strong personas to become vulnerable in order to achieve this, which they were at times fearful, anxious and uncomfortable doing. Lastly, for the two participants with White therapist, there were moments of feeling culturally misunderstood, judged based on another culture's values and as they though they needed to explain themselves.

3.1.5 Reflection on phenomenological reading

Once I had decided to carry out a phenomenological reading first, I then had to choose the type of phenomenological analysis I would carry out. I felt torn between interpretive and descriptive types of analysis and I did go back and forth between the two at first. However, it was once I looked at the methodology as a whole, and each individual reading as a part of something bigger, that I decided that descriptive would work better in conjunction with the other two readings. I felt that the phenomenological and discursive reading should make up part of the groundwork for the psychodynamic reading – and if I had already analysed the data in the first reading then the readings might begin to clash with each other. Furthermore, I did not want the discursive and psychodynamic to work together, whilst having the phenomenological analysis just clumped on top for no particular reason. I felt that using the descriptive analysis would work in harmony with the other two reading to create a sense of continuity between the

three readings. I also felt that the data I collected was very rich, as the participants were in therapy themselves and a certain level of analysis seemed to have already been carried out before they came to be interviewed.

One issue that arose during the analysis stage was my desire to start to make connections and formulations from the data. Obviously, as a trainee psychologist this is what we are trained to do, and it was more challenging than I expected to stop myself. In order to manage this I relied heavily on my reflective journal, as I started to make notes for when I was carrying out the later analyses. I also tried to work very closely to the data itself at this stage, by keeping the participant's original wording and emotional tone. This also worked in line with the method of bracketing my personal beliefs and theoretical knowledge, which was an important aspect of out the analysis.

I also feel it is worth reflecting on the processes of the phenomenological interviews. I had initially planned to be strictly regimented in not deviating from the planned questions and prompts. However, I found that the nature of the interviews did vary according to relationship that I had with each participant, and I feel that this is in-line with a semi-structured interview. However, there were points during this process when I had to readjust my expectations. Furthermore, due to constraints with timing and recruitment, I was also carrying out different types of interviews at different stages. This meant that I had to switch mind-sets between interviews with participants who were are varying stages, which was challenging. In order to manage this I created a sheet of prompts for each of the three interviews, reminding me of the tone, aim, and style of interaction of each interview.

3.2 Discursive Reading

According to discourse analysis, the experience that I attempted to encapsulate using a phenomenological reading has been constructed using language, which has its own social influences and power on meaning making. This reading postulates that the conversations between the researcher and the participants have been co-created within a meaningful context, where wider issues such as gender and ethnicity can be observed. In this chapter, I used a discursive lens to try and answer the 'how' of my research question – how did my participants use language to talk about their therapy and what can that tell us about their inner processes?

In this summary I will encapsulate the four main discursive themes from across the three participants. They are maintaining control; externalizing difficult aspects of therapy; fragmenting parts of themselves; and struggling to vocalise differences in ethnicity, leading to frustration and compartmentalization. Within these themes I will retain the multiple case study format by focusing on how these themes individually play out for the participants.

3.2.1 Maintaining control

These three BME women appeared to be used to being in control of their environments outside of therapy, and the desire to keep this control remained during their sessions. It also seemed important that they demonstrated this control during the interviews, which could be seen through their discursive positioning as in charge of both the external and internal processes of therapy. For example, Annie described how she was the one that told herself if 'some things didn't actually fit', almost as if she was self-sufficient and did not necessarily need a therapist there.

> I will question myself…openly in a therapy session because I have a therapist that is going to respond in a way that I know – that I can go underneath, so I think that the process of psychodynamic counselling really does make me…question myself and think differently about me.

Similarly, Pamela positioned herself as the main driving force within her therapy, and her therapist as 'following' her lead.

> But if anything her interpretations are more likely her reflecting back what I have been saying in the session' and 'she will follow me basically.'

Karen appeared to lose the most control when entering into the therapy room due to her overwhelming anxiety at starting therapy and her regression to her childhood selective mutism. Through her discourse she may have attempted counteract this loss of overt control by positioning herself as in control of her emotions and the information she shared. She used few emotional words when discussing her therapy, and only spoke of one incident when she showed emotion during a session.

> It wasn't the first time, but I think it was the first time that I had really allowed myself to do…to cry.

She clearly identified that this incident was different to other times when she felt emotion, because she 'allowed' herself to feel the emotion, suggesting that overall she does not allow the emotion to come through and that she is in control of this. Similarly, the extract below demonstrates how controlled the flow of information by keeping the decision she had made about staying in therapy from her therapist.

> I just got quieter and quieter, and so, I think she had always felt that I would stop quite…(*louder)* so I hadn't said to her that I would come for a year and that would be it, that, that bit of information was with me. So she would often, it always felt like, 'are you going to come back next week?'

She did not, therefore, wrestle for control of the session, like Annie and Pamela appeared to, but instead would only share what she wanted to – she controlled her input or how much of herself she reveals. She even described a time when she would leave a session rather than talk about something that she did not want to 'deal with'.

KAREN   Not that long ago, actually, we had a session that ended and I left before the time was up.

INTERVIEWER   Oh okay, so sort of sometimes…

KAREN   Yeah, something comes up and I think I just don't want to…deal with it, so I leave.

The participants seemed to find it frightening to be out of full control, as if this was a negative thing to hand the control over to another. Remaining in control of the session appeared to help them to control the level of pain and vulnerability they felt. If something challenging or difficult was addressed during a session, they appeared to want it to come from within rather than the therapist. This can be seen in the extract below from Annie:

> It's not somebody coming to tell me that I'm wrong. They questioned me and I'm telling my own self that actually…some things didn't actually fit'

They appeared to find not being in the driving seat 'scary' and seemed to try to place themselves back in control quickly. For example, when Pamela spoke about defences she quickly turned the topic around to identifying her own defences, rather than her therapist.

PAMELA   I'm just very defensive.

INTERVIEWER   Okay, and have you spoken a little bit about the way you defend yourself?

PAMELA   We have spoken about – that's just it, if anything I'm beginning to recognize my own defence mechanisms, and by highlighting it, by not going there because obviously she knows that I'm defending, it makes me, um…it's likely to sit on my mind even after our session.

This desire to be in control may have affected the power dynamic of the therapeutic relationship, as there appeared to be little space for the therapist within their discursive positioning. For example, Annie often used the words 'somebody' and 'they' in the place of her therapist, which was at odds at other times in the interview when she spoke of her therapist personally.

> It's not somebody coming to tell me that I'm wrong. They questioned me and I'm telling my own self that actually…some things didn't actually fit, and that's quite hard.'

This may be connected to the difficulty she described ('that's quite hard') as she could be counteracting the vulnerability she feels during the session by attempting to take control of her sessions.

This power dynamic was also played out during the interviews, as with each participant there was a struggle over who took charge of the conversation and who was in the more submissive role. This took the form of struggling to make myself heard and at times, interrupting each other, identifying if they were willing to share certain pieces of information ('I'll share this with you'). In the extract below you can see how Annie seamlessly moved from one topic to another without any prompting from me:

> It helps me…be a better person. I have a lot more patience with myself. You know, I could have a session which was alright, and the next would be painful, and then the next session would be alright! *(Laughing)*

Pamela would let me know that she was tracking my body language by the example she gave ('they played with their ear a couple times' when I was playing with my ear) as well as using my name, which seemed to put her in the position of reflecting on my actions, rather than the researcher reflecting on the participant. She seemed uncomfortable to be the participant in the traditional researcher/participant dyad, and this appeared to also be the case with the client/therapist dyad. If I use myself as a

bench mark, I can image that a similar power struggle also played out with their therapists.

3.2.2 Externalizing difficult aspects of the therapy

Both Karen and Annie's language suggested that they externalized difficult parts of the therapeutic process, such as overwhelming emotions or internal conflict. This discourse also played into their defended stance, as there is a sense of separating these difficult feelings to externalize them in order to protect themselves. Although Annie liked to position herself as in control within the therapy room, there was a subtle undercurrent present that suggested that she saw her therapy has a strong external force that pulled her along, which she needed to battle with. The words that she used often have a strong physicality to them, such as 'collision', 'retreat' and 'thrown' which are used periodically throughout her speech.

For Karen, although she often positioned herself as disconnected from her emotions, she would commonly discuss how her therapist must have been feeling. At times she would even stop half way through a sentence in which she was talking about herself to address how her therapist must have felt.

> Its talk therapy, you know, if you can't explain your stuff – I suppose it makes it quite difficult for the therapist to understand you.

Perhaps this is the only way that she can connect with her feelings, through the vehicle of her therapist. Perhaps they also felt safer located within her therapist.

She also positioned the struggle to communicate in therapy within her therapist, rather than within herself, and placed her therapist in the role of the one to try and change Karen's inability to speak.

So she tried to work in a number of ways and it wasn't until she decided that I might like to work with the sand tray, um, and so she decided to ask me to use objects for myself.

The repeated use of 'she' places the decisions and the work within the therapist; it feels as though Karen does not see herself as visible in the process at this time, almost as if things are done to her.

This externalization was often connected to painful aspects of therapy, which may have made them feel safer, as these women preferred to be in control of their sessions and were uncomfortable with feelings of vulnerability. This could be particularly seen in Annie, who appeared to be externalising the therapy in order to push it away, yet it physically came bouncing back in a menacing way. For example she uses expressions such as 'they throw things back to you', 'he reflects it back to me' and 'they just whack it back'. These terms are often used when Annie was discussing the 'pain' of therapy. Furthermore, her language suggests that she is forced to respond, through the use of 'I had to' 'it makes you' and 'you need to'.

3.2.3 Fragmenting parts of themselves

Through their language, the participants appeared to often split themselves into distinct fragmented pieces. This could be particularly seen in their language around emotions, which created a sense of estrangement, as well as how they seemed to make sense of their individual identities as Black women and second generation immigrants.

A sense of separating emotions from their everyday functioning could be seen in varying levels of explicitness. Pamela would preface talk about emotions by openly verbalising a partition between herself and the emotion. It was almost as if her whole self could not feel the emotion, only a part of her was allowed or able to. The consequence of this appeared to be that she wanted her emotional part to be cut off and distinct from the rest of her.

> So it's – there is something kind of, umm, there is a part of me if I split myself in two, there is a part of me that is very angry with her, and part that is 'well maybe there is something going on that was more important', putting her needs before my own. You know, and that's just therapy, you know, trying to work out that balance.

She used the word 'balance', as if the split has created two parts of herself that are distinct and do not interact. It appeared significant to her that therapy is about balancing her divided parts rather than any integration.

Karen was less explicit about separating herself from her emotions, but this sense of disconnection came from the words she used to describe her feelings. She used the terms 'shocked', 'bizarre', and 'strange' over and over again. It is almost as if she could not understand why or how things were happening, or particularly connect with how she was feeling. This also fed into a larger sense that Karen used to separate herself from those around her, as she positioned herself as disconnected and unattached to her therapist, her therapy, other people in her life and ultimately to herself – all before therapy, of course. She described how she felt her therapist's questions about their relationship were 'random' and how she did not understand how a therapeutic relationship worked.

> I don't think I had an understanding of what the therapeutic relationship had to do with me and her, actually, bizarrely! (*Laughs*) But it's true, I didn't understand…

By saying 'actually' after her confession she is acknowledging that it opposes the 'norm' of what people might expect and then again has to convince the listener that it is actually true – regardless of how unbelievable it may sound ('But it's true'). She also uses the term 'bizarrely' again, almost as if she is removing herself from this confession in the way the she had previously removed herself from the therapeutic relationship. She also laughs after this, perhaps positioning herself within the 'norm' by demonstrating the 'bizarreness' of her previous disconnected positioning.

It also appeared that the participants' sense of self - their race, ethnicity and nationality – was divided according to their different identities. Unlike participants or clients that belong to the British Majority, these Black women had two cultures and a second generation immigrant status to make sense of. An example of this could be seen clearly in the way Pamela used her discourse position herself as trying to balance her two cultures, British and Caribbean, yet not particularly belonging to either.

So it's interesting sort of having two cultures, and sort of having to balance that.

By using the word 'have' she was suggesting that this was something that was out of her control, something that she needed to do. The use of the word 'balance' also suggests that this is something unstable that may teeter back and forth from in an unstable manner. Therefore suggesting that this is an ongoing process rather something set in stone.

In addition, there was a sense of positioning themselves as separate to the British Majority, their therapists, and me as a researcher with White skin. Annie's use of 'we' and 'others' seemed to create a distinction. For example, she stated: 'We say Bajan, but others say Barbadian' and 'when I'm cussing, cussing or cursing, as some people say'. The 'others' or 'some people' is where the separation from the British majority appeared to lie. It seems to suggest that she sees herself as different from the majority and that this separation is significant, possibly with regards to feeling different and her identity. She reported that she chose a Black therapist as she wanted to feel 'understood'. Perhaps this may stem from a desire to have this difference acknowledged and validated.

In contrast, she did seem to feel that she did need to explain herself to me during the interviews which seemed to create a distinction between us. Although the separation from the British majority was a generic separation, she appeared to be giving the 'English' version for my benefit. She also appeared to reaffirm this separation on a personal level. When speaking about our respective backgrounds, I commented that we

both went to school in London and her response appeared to communicate that this similarity was only on the surface level.

> Because it seems like when you're at school it's a level playing field, but actually it's not. It just isn't. It just isn't. It just seems that way.

Although Annie is discursively separating us, she seemed to be suggesting that it is society that separates us, even though there is an illusion of 'a level playing field'. Perhaps my inability to understand this illusion of unity when in fact she feels separate may be a demonstration of why she wanted to have a Black therapist. Her discourse seemed to be suggesting that society gives an advantage to the majority, but disguises this through an illusion of a level playing field. Therefore her feelings of being different are not acknowledged by others, so she may feel the need to demonstrate that she is not part of the British majority. By choosing a Black therapist she may wish to be able to acknowledge these differences, and at the same time feel understood.

3.2.4 Struggling to vocalise differences in ethnicity, leading to frustration and compartmentalization

Analysis of Pamela and Karen's discourse about the differences in ethnicity between them and their therapists appeared to highlight three main problematic issues. These were a struggle to communicate the nature of these differences, followed by a sense of frustration, and ultimately an impression that they were pushing these differences away or compartmentalizing them.

Firstly, Pamela and Karen seemed to struggle to cohesively communicate what differences in race, culture and ethnicity between them and their therapist meant to them, beyond that of the initial identification of a difference. This commonly led to a sense of ambiguity over these differences. One way that this was observed within their language was how they discursively located themselves and their therapists within a racial identity. For example, Pamela was the only participant who positioned herself as 'Black British' even though all three participants came from the Caribbean and were

born in Britain. In the extract below it appeared that she put being born in Britain to be an important part of her background.

INTERVIEWER: So why don't you tell me….

PAMELA: Okay, well. So I was born in the UK and I have an older brother.

This suggests that she aligned herself with the British part of herself for the purposes of the interview. In contrast, she positioned her therapist as 'not Black', placing her in the category of the 'other' which is different to her. It seems that she is emphasising this difference - 'not Black' – rather than her therapist's particularly ethnic identity. In fact, as the interview continued she appeared to need to think about what term to actually call her therapist, often pausing before using terms such as 'Caucasian'. This perhaps suggested she was unsure of how to name the difference between them. This was further demonstrated through her use of a variety of terms to denote this difference. These included 'race', 'colour', 'nationality', 'skin colour' and 'Black'. This led to a sense of ambiguity about nature of this difference.

Karen clearly positioned herself as 'Afro-Caribbean' and her therapist as 'White, middle class'. However, she located her childhood in the children's home as 'White' with a sense of remembering and longing for her Afro-Caribbean heritage and mother. Because of this contrast she ultimately appeared to position herself in the middle - being comfortable with both worlds - but not particularly belonging to either.

> You know, growing up in a children's home it's very White – it was very White. You know, but… I, I could remember a time when I was old enough to – so there are some things that…like, I don't know, there are some things that are very curious, like umm…when I was [a child] and… I found it really comforting, it was really nice to hear people speak Patwa…

So although Karen was initially clear cut about the differences in race between her and her therapist, she later begins to unpick these differences whilst aligning herself with both White and Black ethnicities.

When further exploring this struggle to communicate what these differences meant to the participants, a feeling of frustration can be felt. It is almost as if it would be easier if they were not mentioned, and a sense of indecision about the importance of this difference. For example, when I started to ask Pamela whether she thought her therapist could understand the intricacies of her life as a Black British women, she cut me off before I could name the intricacies and said:

> I am not entirely sure whether she can. She's White, and we have very, very different backgrounds, and you know, *(outward breath of air)* I am not entirely sure how important that is.

She was keen to demonstrate the difference between their backgrounds by using the term 'very' twice, but then appeared to exhale in frustration while expanding on this. She seemed to be suggesting that although there are differences between her and her therapist, she did not feel they were important.

What seemed to immerge from this frustration was a sense that they wanted to compartmentalize thoughts about differences for fear that they would create 'distractions' from the therapeutic work. There were small instances during the interviews when the participants acknowledged this slightly, but this was often met with an overall sense of pushing these thoughts away. This might have been connected to a sense of fear of being different, or perhaps this bringing about negative consequences. This can be seen in the quote below from Pamela.

> I mean my partner is White, as well. I mean, I know there could be a part of me that doesn't really want to acknowledge that, you know, I am… different, if that makes sense. That has probably come out wrong.

99

For a brief moment she described 'a part' of herself that she struggled to locate as different to others, especially as she positioned her world as quite White, including her partner and her therapist. However, you could feel the tentativeness in her voice, and the way she paused before using the term 'different', almost as if she was searching for the correct term to use. She also appeared to be worried about not being fully understood, which is demonstrated through her quick comment 'that has probably come out wrong'. This may have felt like a taboo subject for her to be discussing. For the most part, Pamela was keen to communicate that these differences and the way she felt about them did not affect her therapy.

Karen openly articulated that she had wondered about having a Black therapist, and from her discourse this wondering appeared to be something set in stone and very apparent.

So of course I do wonder whether it would be different.

However, this certainty was also mirrored in her language around how these thoughts were a 'distraction' from her therapy and therefore it would be best if she did not engage in them.

Of course they would, of course they would distract me!

She really stressed the 'of course' aspect of this sentence, almost as if there was no doubt. She did not want there to be any discussion or exploration of this, almost as if speaking about this distraction would be a distraction in itself. She appeared to be communicating that in order for her therapy to be successful she would need to put these thoughts away.

3.2.5 Discursive reading discussion

This chapter explored the four main discursive themes that emerged across the three participants. The themes were maintaining control; externalizing difficult aspects of

therapy; fragmenting parts of themselves; and struggling to vocalise differences in ethnicity, leading to frustration and compartmentalization. This chapter acted as a link between the descriptive phenomenological and the psychodynamic readings, and therefore deviated from the multiple case study format in order to facilitate this. However, a focus of the individual nature of these four themes for each of the three participants was maintained. This format was also more conducive to examining the wider context of the discourse the participants used, as well as power dynamics and issues of difference.

By using the power dynamics which occurred within the research relationship as a benchmark, this reading proposed that the participants attempted to maintain control of their sessions in order to lessen their vulnerability. This was also connected to the theme of externalizing the difficult aspects of therapy, such as vulnerability and difficult emotions. Examining how the participants positioned themselves in relationship to others through their discourse created insight into how these BME women appeared to have a somewhat fragmented sense of self as second generation immigrants and Black women. Furthermore, in this chapter differences in race have become problematized in order to examine how the BME participants with therapists of a different race make sense of these differences within their therapy. The result of this was the shared theme of struggling to vocalise difference in ethnicity, leading to frustration and compartmentalization.

3.2.6 Reflection on the Discursive Reading

I found the discursive reading to be the most challenging analysis to carry out methodologically. One reason for this is that I knew the least about it. As discussed previously I wanted each reading to be able to stand alone, yet also work as part of a larger, holistic analysis, and I struggled to find this balance. I attempted to manage this by taking part in a student lead study group on discourse analysis, which worked with a faculty member who specialised in qualitative methodology. I found this group to be

very helpful as I was able to better understand some of the intricacies of this approach, especially the relationship between the discursive and psychodynamic readings.

Although I kept four main questions in mind during the analysis, as I briefly touched upon in the Methodological Considerations section, I found that the Foucauldian concept of hypothesizing how the participants were positioning themselves was the most useful for exploring inner processes. Therefore, this question (how did they position themselves?) featured more during the write up then some of the others questions I held in mind. I did find it difficult to not include all of the analysis, or aspects that arose that I found interesting, in the final write up. Especially as I analysed over nine hours of interview transcripts. I managed this by always keeping the research question as the focus of write up. I also felt it was necessary that I was satisfied that a significant amount of the ground work for the psychoanalytic reading had been laid before I could move on to the next reading.

When analysing my discursive input in the interviews it became apparent that different power dynamics were at play. I was sensitive to the balance of power coming into the interviews, as I was aware that 'alleged racial effects can be compounded or diminished by differential power relations between interviewer and interviewee' (Sin, 2007, p. 480). However, the three participants were strong, assertive females, and at times I struggled to make an impact on the interview. This was particularly relevant with Annie. I was happy to let Annie take the lead for the most part, but I did not want to only hide behind her and not meet with her during the interviews. This appeared to lead to a power struggle between our different social constructs; myself as the researcher and Annie as the strong, Black female. In parallel with this, I was at times positioned as different or the 'other' within the dyad. This was a slightly uncomfortable position during the interviews, but I would rather that this distinction occurred rather than ignored. It seemed like Annie had an important message regarding the insincerity of perceived equalities between those of the majority race, ethnicity and culture and those in the minority. It certainly made me re-evaluate power dynamics and equality.

3.3 Psychodynamic Reading

During this psychodynamic reading, the unconscious processes behind the themes that arose during the phenomenological reading and how the participants discursively positioned themselves are hypothesized. The intersubjective dynamics between myself and the participants are also considered. Simply stated, this reading attempts to combine what the participants said and how they said it, with their potential motivation for speaking about their therapy in this way. It also attempts to use all the tools at the researcher's disposal, therefore includes their emotional responses and an analysis of interview process.

3.3.1 A psychodynamic reading of Annie's interviews

The first stage of this reading will be to outline the important themes from analysis already carried out. I will then tentatively attempt to flesh out these themes by making connections with Annie's development history, as well as explore her motivation for locating herself as she did through her discourse. This will involve exploring the recreation of the original injury through her choice of a Black male therapist, positioning therapy as an external force to protect herself from vulnerably, her role as a rescuer, positioning herself as in charge as a form of armouring, and separating herself to make sense of her inter-related psychic realities. It is important that I emphasize that this is a hypothesis based on the information that Annie gave during the three interviews.

Annie reported that she specifically chose a Black, male therapist as she wanted to challenge herself by putting herself in a position where she would have to be 'vulnerable' with a Black, male. Part of this vulnerability was having this Black, male reveal aspects of herself to her. She described how this was a painful process in which she felt 'exposed' – as if she was getting 'undressed' in front of a stranger. However, when her therapist did reveal things to Annie she described how she would at first reject them, but in time this would lead to 'oh my god' moments of realisation. It appeared that she did find it difficult to be in the vulnerable position in therapy, and her defence from this may have been through positioning herself as in control in her discourse.

However, this appeared to be a conscious positioning, which conflicted with a more subtle discourse in which she located the process of therapy as something external to her. Once she placed her therapy as an external object through her discourse, she then used physical, fighting words, such as 'collision', 'retreat' and 'thrown', to suggest that she was battling her therapy, which perhaps is where some of the pain she described can be located. However, not only did she separate herself from the process of therapy by externalizing it, through therapy she also began to separate herself from those around her.

Recreating the original injury

From a psychodynamic point of view, it may be helpful to explore Annie's motivation for choosing a Black, male therapist. It may be possible that this is connected to the absence of her father in her life. In her account, she made it very clear that she was raised in a 'single parent household' after her father returned to the Caribbean when Annie was a baby. She also made it clear that she had no relationship with him until she was an adult. In the words of Bishop and Lane (2000), perhaps by specifically choosing a Black male she was setting out to 'recreate in himself in the same injury originally inflicted by the parent in an attempt to gain mastery over the traumatic experience' (p. 106). So by having a therapist that could potentially be in the image of her father, she was recreating the scenario in which she could be abandoned by the father figure as a possible way to gain some control over the scenario. Annie plainly stated that her relationship with her father had negatively affected her subsequent romantic relationships. However, by recreating the potential for paternal abandonment with in the safety of the therapeutic environment, perhaps instead of recreating the original injury she was allowing for a healing experience which ends differently.

I feel that it is important at this stage to interject some cultural perspective. Chamberlain (1999) described how the Afro-Caribbean family in Britain has an extended family focus, rather than on than the nuclear family of European tradition. Annie spoke of being close with her aunties, her brothers, and with her community as a whole. However, she described how her father returned home to the Caribbean, remarried and had two daughters, and that he has remained within the family unit since. It is possible

that this felt like a rejection of her personally, and not a rejection of this type of family. Chamberlain (2003) also emphasized the role that grandparents play in Caribbean families, but Annie did not have contact with her grandfathers. She had no male figures within her life, and she directly referenced this regarding her choice of a male therapist. There did appear to be pain associated with her father's absence.

Annie shared that through her therapy she had gained insight into how her past rejection from her father had led her to push others away before they could reject her. However, Annie had to stay in therapy due to her course and ultimately could not run away. Also, according to the description below, she felt that she could not 'argue' her way out of the situation.

> I had to swallow it. I had to – I couldn't…argue. I couldn't argue my case. That was, so that was the challenging aspect. The most challenging aspect of the therapy was that I *(inhale of breath)* I couldn't argue my case – arguing wouldn't win.

Although having a Black male therapist possible may have allowed Annie's hurt around her father and the repetition of hurt in other relationships, to heal and change, it appeared that recreating the potential for paternal abandonment was difficult for Annie to process. Just by placing herself back in that environment meant that she was placing herself in a vulnerable position, one which I hypothesize she had previously defended herself against.

Vulnerability

Discursively, Annie positioned her therapy has something external to her which she physically pushed and fought against. It is possible that Annie was using externalization to deal with the anxiety and stress that came with putting herself in a vulnerable position again. According to Sandler (1996) this defence allows us to place 'unwanted or unacceptable aspects of the unconscious self' outward (p.90). By thinking about it in this way it is possible to tentatively hypothesise that Annie's inner experience during therapy may mirror this. Annie grew up in a 'notorious estate' without a father and with

a mother who was busy because she was a single parent, and I image that there were times when Annie could have been vulnerable. However, she may have coped by taking on the 'masculine energy', which may have also helped to fill the void of an absent father. Perhaps the battle that Annie constructs discursively is a representation of her unconscious need to protect her more vulnerable self, and the battle that ensues because of this. She described how therapy 'makes you go to the core' and she described how 'exposing' this was – perhaps at her core as a young girl who is vulnerable and hurt, but there is a well-practiced 'masculine energy' that fights to protect it.

The rescuer

It felt as though Annie rescued me at the beginning of this research. She was the first person to contact me after a long wait for participants and I remember feeling elated after I spoke to her on the phone. I also left the first interview feeling inspired by what she had said. King and Ferguson (2006) stated that rescuer persona within Black women is an internalization of the 'community ethos' in which the woman of the family has to safeguard the existence of the culture by taking care of all of the members of the community (p.115). As Annie and I were both part of the psychology community, it appeared she felt the need to rescue me by volunteering to take part in my research. However, she appeared to be able to function in both roles, both the participant and the researcher. I was left with the feeling that I was invisible in the processes. At times I felt that I was disrupting her or butting in if I asked her a question. This feeling appeared to be in parallel to her discursively placing herself in control of the therapy sessions, as she also left little space for her therapist.

Armouring

By discursively positioning herself as in charge of her therapy sessions she may have been defending herself, once again, from being vulnerable. According to Greene (1997), ethnic minorities that face daily institutionalised racism and discriminatory obstacles need to develop further defence mechanisms above those of normal development. Annie may have been using armouring, where an individual takes the responsibility of looking after themselves and the situation around them in order to protect themselves (Faulkner,

1983). It is important to acknowledge the function that armouring could have played in Annie's life, and how emotionally strong she has been. However, it appeared that allowing herself to be vulnerable with her therapist has been a focal point of the sessions, and to be open and allow her therapist to care for her appeared to have been part of this.

Interrelated psychological realities

Annie discursively placed herself as in the process of separating out her different identities, and separating herself from the world around her. As an Afro-Caribbean woman with immigrant parents who spent a period of time growing up in White, middle class areas, and is now in a field that Annie felt was dominated by White women ('all my tutors are like White females'), she appeared to have a complex set of intertwining identities. It is possible that part of her inner process during therapy was getting to grips with her multiple identities and psychological realities, and separating herself from others may allow her to do this. This can be demonstrated in extract below.

> I think I have to separate myself out of it, as well. I don't have to fit anything. I can be anything. I don't have to pick sides. I used to think of myself that I had to pick sides. Who cares about that? I care about myself more than being…a woman, or a Black person, or thinking about them together.

By 'picking sides' it seemed that Annie was alluding to the us/them dichotomy of identity from which significance and meaning are attached to colour and race (Dalal, 1997). There is a sense that she is acknowledging the oppression she has faced as a Black woman, without letting this label her or making her 'pick sides'. It is possible that through therapy she was beginning to identify others' projections and assumptions about her a Black female, rather than internalizing them as part of her identity.

There was a sense of a struggle between her identities as English and Afro-Caribbean, which appeared to play itself out during her therapy. It is possible that growing up in England had led to the internalization of the dominant White society within her superego. An illustration of this was when Annie and I were waiting to enter the

interview room, an elderly Black woman was speaking loudly on her phone as employees tried to tell her that this was a no phone area. Annie laughed and stated that this women reminded her of her mum, 'so Afro-Caribbean' and unaware of what was happening around her. Annie had previously spoken of how she initially did not want to be anything like her larger than life, centre of the community mother, but that through therapy she had an 'aha!' moment when she realised she was just that.

For Annie, this separation from others may possibly be seen as a later life separation-individuation, in which she has intrapsychically regressed in order to then reorganize her object relations, the way she sees herself and others, in order to reformulate her sense of self. Akhtar and Kramer (1998) stated that children of immigrants may not have the integrated sense of social expectations and cultural values that are needed to create the positive ego formation needed in order to create an enduring individuation-separation that occurs during adolescence. Annie reported that the cultural world of her home life and community was different to that of her 'White' school life. Furthermore, her family did not have the Western tradition of moving away from the family home to attend university, which is when individuation-separation is seen to occur (Gnaulati & Heine, 2001). Within the safe environment of the therapeutic relationship which included a cultural context created by Annie and her therapist, she may have had the cultural stability to needed to create a more positive ego formulation and identity.

3.3.1.1 Summary of Annie's psychodynamic reading

By choosing a Black, male therapist Annie may have been unconsciously recreating the potential for the father figure to abandon her again, thus placing herself in a 'vulnerable' and emotionally 'raw' position. Due to the 'painful' situation that this created, there may have been a potential for Annie to push her therapist away before he could reject her, but a combination of Annie having to stay due to course requirements and the insight she gained around her unconscious reasons for this behaviour seemed to have allowed her to continue with her sessions. She also felt that she was not able to verbally distract, or in her words 'argue', with her therapist and may have had to begin to process the emotions and feelings about her father's abandonment. Her motivation for positioning her therapy as something external to her, which she battles against, may

have been her desire to externalize how her masculine self or rescuer has to fight to protect her vulnerable and hurt self at her core.

Annie's need to protect herself from vulnerability appeared to be a focal point for her therapy. By taking control of the interview and positioning herself as in control of her therapy sessions she may have been defending against this through armouring. This defence may have been necessary when growing up in a society with institutionalize racism and discriminatory barriers. Through therapy Annie had become aware of her 'rescuer' persona, and it felt like she had also rescued me by volunteering to participant. This rescuer trait in Black women has been described as their internalisation of the community spirit. However, on an interpersonal level this felt as though she took control of process, leaving little space for me, which ran parallel to the discursive theme of positioning herself in control of the sessions.

As an Afro-Caribbean woman with immigrant parents who grew up in a dominantly White society, Annie did appear to have a complex set of intertwining identities and psychic realities. For example, it is possible that she has internalized British values within her superego which may have been at odds with her parents. Through therapy she appears to be recognizing others' projections and assumptions about her as Black female, rather than internalizing them. There is a sense that she is acknowledging the oppression she has faced, without making her 'pick sides'. In order to achieve this she may have gone through a later life separation-individualization in order to makes sense of her various identities and realities, leading towards a more integrated reformulation of herself.

3.3.2 A psychodynamic reading of Pamela's interviews

I will start my analysis with a brief summary of the significant themes which have emerged from the phenomenological and discursive analyses of Pamela's three interviews. Next, I will use the biographical information she provided during the three interviews, particularly in the third interview, to hypothesize her unconscious motivation for speaking the way she did about her therapy, paying particular focus on her internal processes.

Pamela emphasized the importance of the maternal relationship she shared with her therapist. She positioned herself as heavily defended, and through therapy she has a clearer understanding of how her 'brave face', 'strong persona' and 'puppet' defences were – to a certain extent still are – stopping her from connecting were her emotions. She also spoke of the importance of feeling 'heard' in her therapy, but struggled when she felt her therapist 'jumped' on something 'innocent' she had said. This appeared connected to her feelings of fear around her therapist having insight into her world and picking up on something that Pamela was consciously aware of yet. She also appeared to partition herself according to her different identities, such as British/Caribbean and adult/child. She identified herself as 'Black British' and her therapist as 'not Black', suggesting that she placed her therapist as 'different' to her. However, she also discussed how she struggled to see herself as different to others.

Longing for intervention

From a psychoanalytic perspective, it may be important to explore why Pamela believed she was searching for a 'maternal figure' in her therapist. Although she used the term 'maternal', suggesting mother, from her interviews she implied that her therapist held a slightly different role for her than her mother had.

> Umm, well when I think about maternal and, you know, I had a very different relationship to her then I did my mother, and maybe there is a part of me that was longing for that – I don't know – that intervention or that interpretation as a child that I didn't receive.

It appears that Pamela felt that her therapist may provide her with the input ('intervention or that interpretation') that she was longing for from her mother. When exploring her background, Pamela stated that both of her parent's worked full time and that from a young age she spent a lot of time in different clubs and after school activities. It may have been possible that as a child Pamela craved the attention of her mother who may have been too busy for her. This was hinted at by Pamela during the interviews.

Mum was always working and there was something on your mind and there was no one to share it with.

She reported that her parents immigrated to Britain as teenagers and gave the sense that they worked very hard to provide Pamela with the life of a British child, dancing lessons and extra tutorials. However, Pamela appeared to be left craving for their attention, particularly her mother who she appeared to idolise.

The matriarchal role and taking charge of her therapy sessions

According to Gregory (2006), Afro-Caribbean families are commonly 'matrifocal' in that the mother is the head of the house hold and often assume the role of decision making (p.351). Pamela stated that when her mother passed away, she went into a 'maternal drive' in which she took on this matriarchal role.

When mum had passed, um, it was almost like – I mean he [her brother] is older than me – but it's almost like I went into this maternal drive to make sure that everything would be according to how mum would have wanted it.

This could be seen as Pamela modifying her self-image by internalizing this identity within the superego. She therefore appeared to place herself in charge of her family, even though – as she stated – she has an older brother. Perhaps this could have also been mirrored in her therapy, where placed herself in charge of and in control of the therapy so that could preserve the status quo and remain defended as a way of self-preservation.

I believe her desire to be in control also played out in the researcher/participant dyad. From our initial phone contact she was in charge of the details of our meetings, as she arranged for a room to be booked at her office. From my perspective I was grateful and relieved, but when I went to her pristine office I felt intimidated. However, when I spoke to her I sensed the juxtaposition between the up-scale and cold environment around us and her personal desire to connect. In a way, it also felt like this was

internalized within our interaction; she wanted to connect and share but she also seemed to want to keep a metaphorical barrier between us and remain somewhat defended. I feel that although Pamela did want to be in control of both the interview and her therapy, that perhaps there was a softer side to her that was looking to connect but perhaps did not know quite how to achieve this. This may run parallel to her therapy sessions, where perhaps she is longing to emotionally connect. However, a control mode as facilitated by the internalization of her mother's matriarchal role, perhaps with the aim of self-preservation within an unfamiliar dynamic, is at odds with this.

Recognising anger

It is possible that by acknowledging that she did not have the 'perfect' childhood that she presented when she started therapy as part of her 'everything is fine' and 'puppet' defences, has allowed her – to some degree – to acknowledge that childhood part of herself that is angry at her mother. Her struggle to vocalise this anger may have influenced by her family's cultural value of respecting parental figures. She described how she was aware of how her childhood friends were able to vocalise their anger to their parents, but she was not allowed to 'talk back'. She appeared to still be in the process of recognising this anger in therapy, as at times she names the emotions in a hypothetical form which may have still been defended against.

> I'm actually quite glad that my mum is not here because I would be quite angry with her about certain things that have been raised.

Childhood anger at a mother that is not fully available to them due to work duties has been documented in psychoanalytic case studies (Altman, 2002; Lester, 1993). Lester (1993) commented that this experience is 'internalised by the individual and are activated in similar relationship contexts throughout life' (p.169). An example of this could be when Pamela spoke of discussing a situation with her therapist in which she felt she was not getting the attention she needed from her supervisor.

Cultural element of feeling unheard

Pamela shared that she had gained insight from therapy about her desire to feel heard, and how the therapeutic space allowed for this.

> I think when I vocalise my emotions it may not impact me straight away but I feel that there has been a voice that was heard, and that will definitely go back to my story where growing up there were stories that went unheard…

As she may be hinting at in the extract above, this may be connected with her mother being busy when Pamela was a child and feeling that perhaps her mother was too preoccupied to hear what Pamela had to say. There may also have been a cultural element which contributed to her sense of being unheard. She described how she felt that she did not have a 'voice' as a child due to her parents' cultural belief that children were seen and not heard.

> You don't have a voice, basically…and if you do have a voice they do shut – I tested my mum and dad as I was getting older, I kept getting it as a child because I used to push the boundaries.

She appeared to grow up in an environment where her mother's busy schedule and the cultural context contributed to her feeling like she was not allowed 'a voice'. I wonder if feeling unheard perhaps meant that she also may have felt misunderstood at times by her parents.

Feeling different to her parents

Pamela positioned herself as 'Black British', but described how her parents were more aligned with the Caribbean island where they had grown up. Their identity and culture had not been as integrated with British culture as hers. She reported that while her parents idolised their home in the Caribbean, she looked forward to returning 'home' to Britain and her 'creature comforts' whenever she visited.

Even though it was a holiday, I was looking forward to coming back to my own creature comforts, you know? My own space and little things like TV, you know?

Like Annie, Pamela also appeared to have various cultural identities and sense of self. However, it appeared that there was a hierarchy of her identities, with British being the one with the most emotional connection, a sense of feeling like her home. However, this was at odds with her parents, possibly creating a sense of feeling different or not quite in sync with her parents.

Language also appeared to separate Pamela from her parents. They spoke the native language of their Caribbean home, but did not teach their children as they felt they should speak English. She described how it was like a comfort to them, and it they spoke about feelings and emotional subjects in this language. Pamela described how it felt like she 'didn't really know what was going on' and how it felt 'awful' to be 'kept in the dark'.

I mean they were able to speak English but it was there way of, connect, you know? And obviously saying certain things that we weren't allowed to hear.

Could it be possible that with a childhood experience of longing for intervention from your parents, feeling unheard, emotionally separated through language and culturally dissimilar, it might feel strange and unnerving for another to have insight into your world – as Pamela reported her therapist demonstrates? Perhaps this is connected to her fear of her therapist uncovering something that she is not consciously aware of? Or feeling that people can 'jump' on something that she says 'innocently'? This may have led to her to feel out of control and therefore increased her desire to hold the matriarchal role.

Feeling different from her parents may have led her to repress her Afro-Caribbean culture in favour of the dominant British culture further, as she may have been wishing to combat feelings of cultural isolation. In this light, feeling different to her British

therapist may have reminded her of previous feelings of cultural isolation, which may have been particularly difficult in regards to the maternal feelings she reported towards her therapist. This could have led to the frustration she demonstrated when thinking about differences, as she may wish to repress these difficult thoughts and feelings.

3.3.2.1 Summary of Pamela's psychodynamic reading

This reading started by exploring Pamela's motivation for the importance she placed on the maternal aspect of her therapeutic relationship. Pamela's mother may have not have been fully available to her, and she described how perhaps she was longing for the type of input that her therapist now gives her. It is possible that after her mother's passing, she internalized her mother's cultural matrifocal role within her super ego which impact her discursive position as in charge of her therapy. I also hypothesized that Pamela may have felt misunderstood by her immigrant parents due to feeling culturally different and excluded from their mother tongue. Perhaps this contributed to her fear and uncertainty when her therapist demonstrated insight into her life. Furthermore, she may have felt emotionally isolated and a different culture to her parents, which may have influences her current struggles when think about the differences between her and her therapist and to connect to someone emotionally.

Part of her internal process may be acknowledging her childhood feelings of anger that have been hidden behind defences, which may have been an internalization of her family's cultural expectations that child should be respectful and quiet. However, there then appeared to be a conflict between the previous submerged anger towards her mother that was emerging during therapy and the image of a perfect childhood that she projected when she first started therapy. I postulated that perhaps by beginning to let go of her defensives splitting during therapy she is creating an integrated picture of her mother and her childhood.

3.3.3 A psychodynamic reading of Karen's interviews

This analysis will start with a synopsis of the salient themes from the phenomenological and discursive analyses of Karen's interviews. I will then delve deeper into these themes by attempting to examine the unconscious motivation behind these themes

through her background information and an inspection of the unconscious intersubjectivity of the interview process.

I shall start with a brief summary of what has been established so far during this research regarding Karen's inner process of her therapy. She stated that when she started therapy she wanted someone 'neutral' and struggled to both form a therapeutic relationship as well as understand the reason for needing a relationship. She also returned to her childhood state of selective mutism. She described herself as having very few emotions, and those that did break through she was unable to comprehend. In line with this, Karen positioned herself through her discourse as disconnected, often placing herself as an outsider who did not understand her own past and her first few years in therapy. She also often located emotions, motivation, and the therapeutic work with the therapist rather than with herself. She communicated that it was normal for her to wonder about having a Black therapist, that this would distract her from reason for attending therapy – to be able to continue to foster children.

Her therapist used the metaphor of a bridge and a series of other mediums to communicate, and Karen was able to regain her speech as well as connect with the therapeutic relationship. From this she was able to gain insight, but still found herself rejecting the more difficult aspects of her past, such as her 'avoidant attachment' style and her continued fear of abandonment. Karen described how therapy allowed her to create a 'jig saw' of her past and how this connected to her present. However, the result of this was Karen positioning herself as damaged and in need of therapy.

Avoidant attachment

Karen's avoidant attachment style may be an important element of how Karen internally processed her therapy. According to Levy and Blatt (1999) the term attachment signifies the theory that as infants we create 'mental representations' of ourselves and others that are founded on our interactions with primary caregivers (p.546). We carry these mental representations with us into adulthood, and they continue to affect how we see ourselves and others and how we relate to those around us. For Karen, it appeared

116

that the loss of her love object, her mother, at a young age and her subsequent coping mechanisms have impacted the way she understood the therapeutic relationship.

Karen's mother had immigrated to Britain from the Caribbean, leaving children behind with her sister. Due to large scale immigration from the Caribbean to Britain after World War II, the impact of separation, loss and the fight to survive for Afro-Caribbean immigrants and their children has been well established (Smith, Lalonde & Johnson, 2004; Arnold, 2006). However, Karen's story is slightly different. She was born in Britain and was put into a foster home at a young age when her mother became 'unwell'. She and her sisters would go back and forth between foster homes and her mother's care, until she permanently entered a children's home. This back and forth between the care system and her mother, with a final perceived abandonment age nine would have an individual impact on her attachment style. For Karen, whose mother was emotionally and physically unavailable to her, she had to grow up very quickly and learn to look after herself and her sisters. This may have created a mental representation within her mind of others as unavailable to her, and that she did not need others to look after her – she took care of herself physically and emotionally.

Her avoidant attachment may have been part of the reason why she did not understand why she needed to have a relationship with her therapist when her therapy started, and why she felt it was odd that her therapist would ask her about it. Her history of continually entering in and out of foster homes and then going to a children's home where there was little consistency in the care she was given may have really emphasized to young Karen that she should not become attached to people – to form a relationship. It may also have played a part in her desire to have a 'neutral' person to talk to – her reason for seeking out therapy – as perhaps she initially saw her therapist filling the role that her many foster parents may have filled.

Therapist in the White foster carer role

During the interviewing process I hypothesized that I represented a 'foster parent' role for Karen, in the sense I was a benign, neutral figure that would carry out some function

and then be on my way. For example, Karen made it clear that the interviews would not have an impact on her therapy, and seemed confused that I was asking the question.

INTERVIEWER	Hmm, how have you found talking about therapy and the things that…I hope it hasn't made you
KAREN	Here?
INTERVIEWER	Yeah, with me. I hope it hasn't made your bridge seem different or…
KAREN	*(Loud laughing)* No, no!

This type of relationship appeared to mirror the initial therapeutic relationship, suggesting that she may have also seen her therapist as a type of foster parent. As she described her childhood as 'very White' and there would not have been many other Black people in her life, as a child Karen may have created separate mental representations of Black people and White people. For her, White faces may represent her childhood in the children's home. An example of how separate mental representation may still be present, is how she reported that she has been told that she speaks in a more formal tone and in higher pitched voice when speaking to White people compared to Black people.

Having a transference representation of her therapist as a type of White foster carer may have had an influence on Karen's return to mutism when she first entered therapy. Gelso and Mohr (2002) stated that when a therapist belongs to a different cultural group, the therapist can come to symbolize past traumas associated with members of that group. For Karen's therapist she may have symbolized the abandonment of Karen's mother when she was placed within the children's home. Therefore, Karen may have regressed to a childhood state of mutism in her sessions as she was facing the childhood traumas that she had previously been repressing.

Disconnection and attachment style

From the discursive analysis, I hypothesized that Karen positioned herself as disconnected from her emotions. This may also be connected to her attachment style.

According to Bowlby (1973) those with an avoidant attachment struggle to display both positive and negative emotions (as cited in Mikulincer and Florian, 1998). Perhaps Karen disconnection from her emotions acted as a defensive armour against stressful events. In Karen's case, her reason for attending therapy (the fostering assessment) and the process of connecting with her past as well as her therapist may have been very stressful for her. Seeing the process of therapy, as well as her former self before she was able to start connecting to her past, as 'bizarre' and 'strange' may have allowed her to continue with a process that was 'excruciating' for her. It may have also been safer for her to externalize her past in this manner, and keep it confined to the paper fostering reports that she had received, rather than locate in within herself.

Karen stated that her therapist, who she placed as having a 'secure attachment', could not fully understand her, as those with secure attachments could not understand what it would be like to have a mother who was not available to you. However, she stated that her therapist could connect with the emotions of Karen's childhood.

> I don't, I think it's probably hard for anybody to understand what it must be like to have a mother that's not available to you and to live in those sorts of situations that are less than ideal for children. What she does understand – and you know she can get the concept- but what she does understand is…how, what the feelings might have been for me at those times.

Therefore, Karen was struggling to connect to her emotions but she saw that her therapist could. This may be associated with Karen's discursive positioning of placing emotions onto her therapist, rather than holding them herself. So she can connect with the emotion through her therapist, but she leaves it with her at the end of the session. Perhaps it was also safer for her therapist to hold them, to contain them and make them safer for her.

Holding environment

From Karen's descriptions, it is unlikely that as a young infant she received much interaction with her mother. Karen described how there was little age gap between she

and hers sisters, and that her mother was trying to work as well as spend time in and out of hospital. It is possible to hypothesize that she was not able to interact with her mother in a way that would allow her mother to 'mirror' young Karen's emotions through her own facial expressions. According to Winnecot (1967, as cited in Murray, 1989) when a mother mirror's the infant's emotions through with their own face, they are creating a sense of emotional attunement which contributes to the emotional developmental needs of the child. Gerhardt (2004) stated that a when a caregiver cannot attune with a child's emotional needs, a child may learn they 'shouldn't really have feelings since his parents didn't seem to notice them or be interested in them' (p. 24). Therefore, as an infant Karen may have learnt not to bother with emotions, especially as without the help of a caregiver to decipher them or to contain them and demonstrate that they are tolerable, they may have overwhelmed her. However, Karen's therapist may have been able to create a holding environment in which she could begin the process of connecting with the emotions Karen may have felt as a child. Karen, therefore, may be at the stage where she can see and recognise the emotions that her therapist is feeling for her, but not quite be able to express them to a stranger in an interview.

Differences to the therapist

As Karen's therapist was a White British woman, her facial expressions, gestures, language and accent would have been different to Karen's mother's, which could have impacted the transference. She did appeared to have a longing for her therapist to be more like her mother.

> Maybe if they talked, or maybe if we could talk in a way that…you know a Black therapist would have an understanding of and I don't have to explain some of those…I don't know, things that…maybe if she, maybe if I heard my mother's tongue I might speak easier.

Karen became mute in her sessions, much like she had been mute when she was in the children's home when she was missing her mother. It seems that Karen was suggesting that she needed something familiar and comforting in her sessions in order to talk about the trauma of her childhood. Through the therapeutic relationship Karen was able to get

her voice back, and Karen wanted convey that her therapist had been warm and kind throughout. This seemed to lead to an interesting opposition between Karen wondering about having a Black therapist versus her fear that this train of thought might negatively impact her therapy. I wonder if this could be another mental representation that Karen holds in mind which she learnt during her childhood. She described how the children's home she grew up in was 'very White'. She also said that when she first entered the children's home she kept asking for her mother, but she never came. I wonder how as a child she coped with this. I wonder whether she had to push these feelings down as they may have stopped her from being able to survive living in the harsh environment, as Karen described it, of the children's home. I wonder if this is now being mirrored in the way that Karen is pushing away thoughts about a Black therapist.

During the phenomenological reading, Karen's example of a minor rift that occurred from a misunderstanding due to cultural differences was explored. Leary (2000) described how misunderstandings based on racial stereotypes act as 'micro-traumas' within the relationship which can lead to narcissistic vulnerability – a weakening of client's self-esteem and self-image (p641). For Karen, this misunderstanding seemed to suggest that her therapist was negatively judging her mother, family and culture, which were important aspects of the 'jig-saw' that she was piecing together. It may have also threatened her ethnic unconscious, how she internally understood her own heritage and culture. However, she appeared to be repressing any negative feelings towards her therapist because ultimately she felt that they had a warm and caring therapeutic relationship. Comas-Diaz, Frederick and Jacobsen (1991) described how clients with therapists who are a different ethnicity, race or culture may struggle with feelings of ambivalence. They feel both a growing attachment and feelings of negativity towards their therapist.

3.3.3.1 Summary of Karen's psychodynamic reading

In summary, this chapter focused on how Karen's avoidant attachment and her potential mental representations as others as unavailable to her affected her unconscious processes in therapy. I hypothesized this may have motivated her inability to understand the need for a relationship with her therapist. Through investigation of the unconscious

dynamic between myself and Karen, I hypothesized that she may have seen me in a 'White foster parent' type relationship. From a shared experience of confusion when bringing in the 'here and now' between the interviews and when she first started therapy, I hypothesized that our unconscious dynamic may mirror the way she perceived and related to her therapist at first as well. However, by representing the White foster carers of Karen's past, this may have triggered the feelings of abandonment that she felt when she entered the children's home, leading to a return to her previous way of coping – mutism.

During her therapy a lot of difficult childhood memories were coming to the forefront, and perhaps by positioning herself as disconnected from the painful emotions may have allowed Karen to continue with the therapeutic process. In line with this, she reported that although her therapist was unlikely to be able to understand Karen's past she was able to connect with the emotions that Karen's past self may have felt. Perhaps Karen's own protective function of disconnecting from her emotions, but seeing her therapist connect with these very emotions created the unconscious discursive positioning as her therapist as the one that held the emotions. I connected this to a hypothesis that Karen did not develop in a holding environment in which she received emotional attunement, and that her therapist is now providing a holding environment in which she can begin to recognise her own emotions within her therapist.

Karen did appear to be longing for a cultural transference from within her own identity group; a longing for a maternal figure and childhood familiarity in order to talk about the trauma from this period. I wondered whether she was pushing the thoughts about racial differences away during her therapy like she may have pushed away thoughts about her mother's abandonment as a child. Although Karen developed a warm and caring therapeutic relationship with her therapist, at times there were cultural misunderstandings which may have acted as small traumas that affected her self-esteem and ethnic unconscious. Her attachment to her therapist combined with these misunderstanding may have led Karen to struggle with feelings of ambivalence.

3.3.4 Psychodynamic reading discussion

Although the psychodynamic reading was an individual exploration of the possible internal processes acting as motivation behind their discursive positioning and themes from the phenomenological reading, there were themes that emerged across the three participants' readings. These were recreating the original injury, defences and vulnerability, multiple identities, cultural and racial differences in the transference and feeling different/same (TABLE 3.3). During this discussion I will explore how each of the themes manifested themselves across the three participants' psychodynamic reading, and then finally summarise the main points from this reading.

Table 2.3: Individual and shared themes from the psychodynamic reading

Annie	Pamela	Karen	Shared
Recreating the original injury	Longing for intervention	Therapist in the White foster carer role	Recreating the original injury
Vulnerability	The matriarchal role and taking charge of her therapy sessions	Disconnection and attachment style	Defences and vulnerability
The rescuer	Recognizing anger	Holding environment	
Armouring		Avoidant attachment	
Interrelated psychological realities	Feeling different to her parents		Multiple identities
		Differences to the therapist	Feeling different/same
	Cultural element of feeling unheard		Cultural and racial differences in the transference

Recreating the original injury

All three participants were daughters of immigrants from the Caribbean, which did appear to affect their parental relationships. This was then reflected with their therapeutic relationships on a conscious and unconscious level according to their individual circumstances. There was a shared desire to have mastery over each of their culturally infused developmental traumas, which could be summarised by a sense of

parental yearning. The participants' parents had immigrated into a difficult and discriminatory environment and had to work very hard to survive; working long hours, several jobs or perhaps have their children in the care system because there was no longer a family network to rely on. This appeared to leave their children (the participant's child selves) longing for their attention. Cultural influences included a matrifocal family system, the internalization of the community ethos in order to survive, and children being seen and not heard. Each of the participant's families had varying success as immigrants in Britain, which did impact the severity of the developmental trauma.

Defences and vulnerability

The participant's presented themselves as strong women who looked after themselves and those around them, which appeared to be an internalization of the collective values of their Caribbean culture. However, this meant that they struggled to connect to emotions that may have been classed as 'weak' by those that need to be strong in order to survive a difficult and discriminatory environment. They appeared to have a number of defences within their therapy in order to protect themselves from these difficult emotions. They included armouring in order to look after both themselves and the therapist, internalizing the matriarchal role and taking control of the session, and externalizing their emotions onto the therapist. When the participants did connect to these emotions they were often left feeling vulnerable, which was an unpleasant and uncomfortable position for them to be in. As minority women that are likely to have had to fight harder to get where they are than the average British person, feeling vulnerable appeared to be connected to negative connotations of weakness. However, through therapy they have been able to reframe vulnerability as not a weakness as a strength.

Multiple identities

All three participants seemed to have multiple identities connected to gender, culture, race and ethnicity, which they seemed to need to identify and separate during their therapy sessions before they could become integrated. For each participant these multiple identities appeared to have varying levels of importance, according to their individual relationships and history with each identity. However, as Black females it is

possible that society had already made certain projections onto them, before they even say a word, and this may have an impact on the way they see themselves. There may also be conflict between cultures that make integration difficult. For example, Afro-Caribbean culture is community based with a strong matriarch role. However, Britain is seen as an individualistic society, which is reflected within the focus on the individual with psychodynamic therapy. These women are likely working through issues regarding their role within their families and communities, but in the wider context of an individualized, western society.

Cultural and racial differences in the transference

This reading suggested that culture and race does affect the transference, but not necessarily in a damaging way. A particularly import factor was language. If the therapists had spoken the participant's mother tongue it could have fostered a deeper positive or negative transference. For Karen, it may have been a positive transference as she would have had the maternal familiarity she was craving. For Pamela, perhaps it would have fostered the negative transference regarding her feelings of isolation. However, the effect of the therapists not speaking their native language was a sense of distance in the therapeutic relationship, which needed to be actively worked towards closing. For example, Karen's therapist had to work with physical objects (sand tray) and metaphors (building a bridge) to close this distance.

Another important factor seemed to be differing cultural values between the therapist and the participants. When cultural values were not shared, or at least understood, it appeared to make the participants more defensive, almost as if their ethnic unconscious was being questioned. These misunderstanding could be viewed as micro traumas, which once again hindered the transference and sense of feeling understood. These differences did not appear to make the therapy ineffective, but did need to be handled with care and sensitivity.

Feeling different/same

Being children of immigrants seemed to have created a sense of feeling both different to their parents and to those around them, perhaps creating a split, disconnection or need to

reject similarities as a consequence. This difference may have taken the form of internalizing the dominant culture within their superego, positioning themselves as British after feeling disconnected from their native culture, or pushing away and repressing thoughts about difference. This appeared to also play out within their therapeutic relationship, according to their relationship to feelings included or different. I suppose much like they did when they were children, the participants appeared to crave familiarity within the therapeutic relationship, but it was through difference, including gender, culture and race, where trauma or pain often appeared to be located.

Summary

This reading suggested that the unconscious internal processes of BME women in psychodynamic therapy are culturally infused and can be impacted by the meaning and experiences they place on gender, ethnicity and race. Although this will depend on the individual's developmental traumas, family dynamics and experience as a minority within British society, this reading has picked up on some general themes across the three participants. They shared a sense of recreating culturally influenced developmental traumas through the therapeutic relationship, which could be characterized as yearning for their parents. Within their sessions, they seemed to demonstrate that they were strong women by attempting to take control, which simulated the cultural matriarchal role they held outside of the sessions. However, they struggled to connect to their vulnerable selves, possibly due to the discriminatory environment they live in.

Also during their sessions, they appeared to need to identify and separate their multiple identities according to gender, culture, race and ethnicity, before they could begin to integrate them in order to create a sense of wholeness. Furthermore, the therapeutic transference did appear to be affected by the race and culture of the therapist, especially regarding language and culture, but not necessarily in a damaging way. As second generation immigrants they may have felt different to both their parents and their peers, perhaps creating a split, disconnection or need to reject similarities to their parents as a consequence. Although the participants seemed to crave familiarity within the

therapeutic relationship, it was within differences in gender, culture and race, that the trauma or pain seemed to be found.

3.3.5 Reflection on psychodynamic reading

An aspect of this reading that I found challenging was the level of tentativeness when writing up the results. The degree to which the unconscious can be captured and described is greatly debated, and in congruence with my epistemology I wanted to convey that I took the stance that the unconscious did exist but that it was not necessarily directly accessible or stable. I wanted to convey this stance in the tone of my language, but it was difficult. As a trainee psychologist working with clients I often use concrete language during a formulation, with the understanding that this is a hypothesis that is likely to change. I believe that this has impacted the way that I analysed the interviews. Therefore I decided to not be too fearful of making hypotheses, as long as I clearly stated that this is what I was doing; using psychodynamic theory to help postulate a deeper level of analysis based in the information I held at that time.

In conjunction with this, I was also fearful of what Hollway (2008) described as the 'danger of wild analysis' in which psychodynamic concepts are used without careful consideration (p389). As a student of the psychodynamic approach, my knowledge is very much at the fledging level, and I felt that this did have an impact on the level of sophistication I held when exploring the participants' unconscious motivation. In order to manage this I worked with a member of staff who was very knowledgeable about psychodynamic theory to fine tune my analysis.

By the time I carried out the third interviews, which were a version of the FANI, I felt more comfortable with the person centred, open ended style of interviews. However, I did struggle to keep the interviews focused during the final interview. I feel that there are both positive and negative aspects to this. Firstly, as I was attempting to explore their unconscious in a relational way, deviations and side topics could be considered as part of the data that needed to be analysed; perhaps as part of a larger intersubjectivity between myself and the participants. I was also able to learn more about the participants' lives and backgrounds, which helped during the psychodynamic analysis.

The negative aspect was that perhaps it allowed the participants to hide behind changed topics and loose interpretations of the interview questions. Ultimately, I felt that the benefits of this open style of interviewing outweighed the negative aspects. However, during the interviews I tried to keep a holistic sense of where the interview was heading whilst gently steering the participants back to their therapy.

During both the interview and the analysis stage I became aware of how thoughts about my own therapy were coming to mind. I found that I was comparing my experience to my participants, and in some ways I found that I was jealous of their positive experience. I believe that this was not a malicious jealously, just a sense that my participants had an affirmative experience of therapy which they wanted to share, and thus possibly a motivating factor in their reason for volunteering to take part. I felt it was important that I name this feeling, and wrote about it in my reflective journal in order contain the feeling and minimize any impact it had on the analysis I carried out. I believe that I have been able to practice this skill during my training, and that I was more equipped to manage this feeling then I would have been when I first proposed this research question in my first year.

CHAPTER 4 - Discussion

4.1 Introduction

This study aims to address the question of how Black and Ethnic Minority clients internally process their psychodynamic therapy sessions. There has been a drive in the literature on engaging the BME community in psychological therapies (Fernando, 2005), with a particular focus on the reasons for their lack of engagement (Bhui & Bhugra, 2002) and changing policies accordingly (Clark, 2011). This has meant that the focus has been placed on the external factors rather than the voice of the BME client or internal factors, such as their experience, thoughts or feelings while in therapy. If more members of the BME community are encouraged to engage in therapy, then all factors of their experience should be addressed.

There have been calls for services to offer BME clients a wider choice of therapies, with a special recommendation to include psychodynamic type approaches (Fernando, 2010). However, psychodynamic therapy has been criticised for being too focused on the White, middle class (Bateman & Holmes, 1995). Research has also suggested that ethnicity and race can influence internal processes in therapy, which is particularly relevant for a psychodynamic therapy as it focuses on the client's internal world (Thompson, 2012). Therefore, this study's research question seeks to explore whether BME clients in psychodynamic therapy have shared internal processes that may differ from clients belonging to another community.

In this chapter I will reflect on the process of using a multi-layered analysis to answer the above stated research question. This will involve an exploration of the challenges, transferability and limitations of the methodology and findings from this thesis. Furthermore, I will attempt to create a holistic understanding of the BME participants' inner processes during their psychodynamic therapy by layering the findings from the three readings within one summary. I will also discuss the results in the context of relevant literature, implications for practice, suggestions for future research and relevance to counselling psychology.

4.2 The Research

Due to the complex nature of capturing internal processes, a qualitative approach was used to gain in-depth and rich data. Two Afro-Caribbean women and one Black British woman were interviewed three times each, with approximately 4 weeks between the interviews. The interviews were analysed using a multi-layered pluralistic approach, including a descriptive phenomenological, discourse and psychodynamic readings.

4.2.1 Reflections on the methodology

Using a multi-layered analysis has created a novel way of attempting to access the internal processes of the participants. It acknowledges the complexities of our internal world, and attempts to capture varying aspects through the use of different analytical lenses. According to Madill (2008), where one methodology falls short, another can fill the gap in the analysis. For example, the descriptive phenomenological reading stayed with the voice of the participants' interviews, whereas the psychodynamic reading added the layers of unconscious motivation and intersubjectivity between the participant and the researcher.

The aim of using three different qualitative approaches was to create a 'theoretical and methodological triangulation' (Frost & Nolas, 2011, p. 116). There were concurrent themes throughout the three analyses, which were explored from different angles according to the interpretive lenses. However, by using three different paradigms there was a possibility for epistemological dissonance, which could create a lack of cohesiveness throughout the thesis as a whole. To combat this, the epistemological position of each analysis was carefully considered under the umbrella stance of moderate constructionism, in an attempt to create unity across readings. Each of the analyses were firmly rooted within the transcripts of the interviews and the research question.

A weakness of this methodology was that I was unable to carry out a pilot study due to difficulties recruiting BME participants in psychodynamic therapy. This meant that the method could not be tested or tweaked, and there was a concern that this methodology

may not be able to capture internal processes. However, after completing the interview process I did not identify any changes that I would have made to this stage of the research.

Using a multi-layered and pluralistic approach has taught me a considerable amount regarding my understanding of qualitative research as whole, rather than as individual and incompatible paradigms. This understanding can be summed up by the quote below from Frost and Nolas (2011, p.116):

> Our actions, feelings, and thoughts intersect with issues of power, identity, meaning-making practices and interpretation, and practical, material challenges, all at the same time.

This understanding has closed the gap between the way I approach my clinical work and the way I have approached this piece of research, as I hold a pluralistic and integrated stance in my clinical work. I will further explore my personal reflections on the process in the segment below.

4.2.2 Personal Reflections on the process

There were several challenges and obstacles in the process of researching and writing this thesis, particularly the theoretical and practical issues that arise from using three different readings. Instead of intimately gaining knowledge of one type of analysis, I had to get to grips with three different readings. For each type of reading several decisions had to be made regarding the type of analysis I carried out and the individual epistemological stance taken. Phenomenological, discursive and psychodynamic approaches are complex forms of analyses, and I felt an immense pressure to honour the approach's integrity without becoming too overwhelmed with the details and theoretical arguments.

There were also several factors that I felt were very enjoyable and in-line with my personal philosophy and clinical practice. By using a pluralistic method I could hold a holistic stance while simultaneously immersing myself in the details of the participant's

internal world. I could also build layers of understanding by using a range of tools, such as discursive positioning and unconscious motivation, yet at the same time valuing the content of the interviews and the participants own insight.

Working with BME participants brought both challenges and a great richness. Firstly, I had difficulties recruiting BME participants. Although this is documented within the research literature (Iwamasa & Sorocco, 2002; Rugkasa & Cavin, 2011), I was still surprised how long it took (8 months) and how many organizations were distributing my poster (10) before the participants contacted me. Secondly, it has been uncomfortable at times for me to consider and reflect on how my ethnicity and culture may have impacted this research. Sue (2004) found that people with white skin did find it difficult to talk about their 'whiteness' (p.762). However, it was important to acknowledge that ethno cultural differences between myself and the participants could have affected what the participants were willing to discuss during the interviews. For example, the participants may have minimalized cultural differences (Comas-Diaz & Jacobsen, 1991). However, overall I greatly enjoyed interviewing the participants and building a relationship with them over the three interviews. I felt that they were important voices within a population of ethnic minority women who often are not heard. I often left the interviews feelings empowered and that my research question was worth investigating.

4.3 Layering the lenses: Major themes from across the readings

In this section I will attempt to layer the findings from the three readings in order to create a more in-depth analysis of the participants' inner processes in their therapy. This is a strength of using a multi-layered approach, as this layering enables an extensive insight into the experiences, relationships and processes of the three participants, as well as an understanding of how these phenomena are interconnected (Chamberlain, 2011). I will start by summarising the main aims of each of reading and the shared themes that emerged. I will then include an overall summary of the three readings as a whole. The first level of the multi-layered analysis was the descriptive phenomenological reading. It aimed to engage directly with participant's own voice in order describe the meaning and significance they made of their therapy sessions. It was used to capture their conscious

internal processes, what the participants were aware they were thinking and feeling. The five main themes were: importance of the therapeutic relationship, strong persona defences, the past and the present: personal and family history, 'aha' moments, and fear and vulnerability. The theme of 'differences to the therapist: not feeling fully understood' emerged for the two participants who had White therapists.

The second layer was the discursive reading, which aimed to explore how the participants used language to construct meaning within their sessions and how they consciously and unconsciously positioned themselves through their discourse. This reading acted as a bridge between the conscious internal processes explored through the phenomenological reading and the unconscious processes investigated during the psychodynamic reading. The shared themes were positioning themselves as in control of the sessions, externalizing difficult processes, separating or dividing themselves, and differences to the therapist. The final layer was the psychodynamic reading, which attempted to build upon the previous two readings by exploring the unconscious inner processes behind the themes and discursive positions that emerged from the previous readings through the use of psychodynamic theory, intersubjective dynamics and emotional responses. The main findings were categorised as recreating the original culturally infused injury, cultural differences in the transference, feeling different/same, multiple identities and a further exploration of defences.

Figure 4.1: Layering the lenses: How the three readings built upon each other
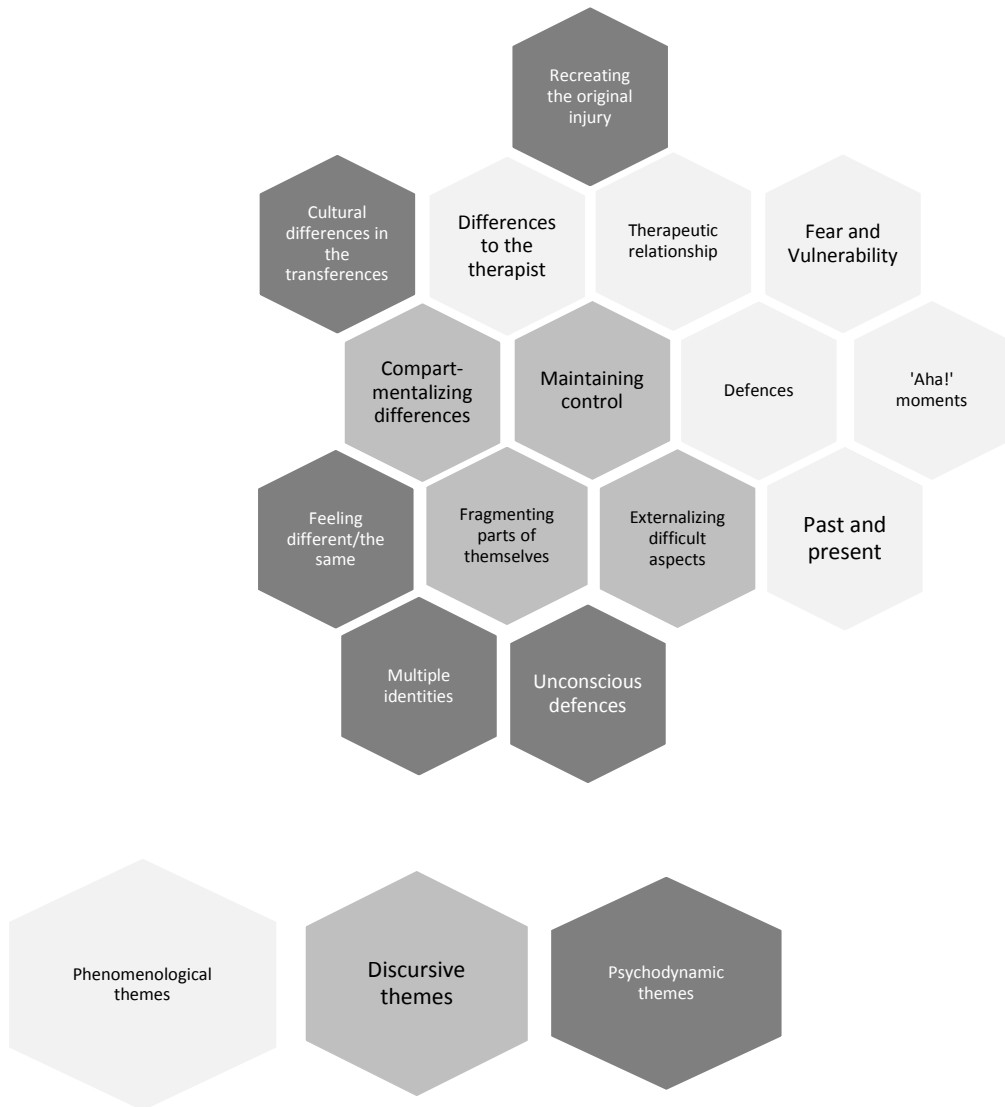
Layering lens: Overall summary

One of the key themes from the phenomenological reading was the importance the participants placed on the therapeutic relationship, which appeared to be replicating elements of their individual parental relationships. This theme was further explored during the psychodynamic reading, where it was suggested that participants may have been symbolically replicating their culturally infused developmental traumas. As children of immigrants who had to work long hours within a difficult environment, there was a shared sense of yearning for their parents' attention. However, they described how during their first year of therapy they did not want to let go of their strong personas, in order to demonstrate this yearning or that their childhood had not been perfect; they wanted to remain defended. They felt fearful of being vulnerable and saw it as a weakness. Their defences appeared to be both conscious and unconscious, and the discursive reading demonstrated how they positioned themselves through their discourse as in control of their therapy sessions, and externalized difficult thoughts, emotions and internal experiences as forms of unconscious defences.

Another shared theme from the phenomenological reading was understanding how the present was affecting the present. This theme centred on understanding complex family histories and their individual roles, as well as interpersonal dynamics. A significant part of their history was understanding their family's move from the Caribbean to Britain and the subsequent consequences this had on the family. However, in order for the participants to gain this understanding of their past, they appeared to need to let go of their defences, and to become vulnerable to difficult thoughts and painful emotions. Once they were able to achieve this within a safe environment they described having 'aha' moments where they were able to understand concepts that they had previously rejected.

For the two participants with White therapists, the theme 'differences to the therapist' did emerge from the phenomenological reading. They described at times feeling not quite fully understood, as though they had to explain themselves, and that their therapist might be unfairly judging their family's cultural values. Through the psychodynamic

reading it was proposed that differences in culture and race did affect the transference, particularly with regard to language and cultural values. For example, if the therapist had spoken the participants' mother tongue it could have either gave a sense of the parental craving the participant's appeared to be searching for within their therapeutic relationships or further crystalized their sense of feeling excluded by their parents. When cultural values were not shared or understood by the therapist, the participants seemed more defended. These misunderstanding can be seen as micro traumas within the relationship which damage their ethnic unconscious and possibly hindered the transference. Cultural and racial differences from the therapist did not appear to render the therapy ineffective, but appeared to need to be addresses with care and sensitivity.

The discursive reading suggested that they found it frustrating to think about differences, and would often struggle to communicate what these differences meant to them or what they felt like. There was a sense that they were pushing these thoughts away, compartmentalising them as separate to the therapeutic processes so they would not damage their therapeutic work. When exploring this in the psychodynamic reading, it appeared that as second generation immigrants they may have felt different and split off from both their parents and their peers. However, in order to function within the family, the school system and society they may have needed to ignore or push away these differences. Within their therapy, they may have been craving familiarity, but it was through difference, including gender, culture and race, where the vulnerability and pain appeared to be located. It was from this vulnerability that a greater understanding of how the past affects the future and 'aha' moments.

Part of the importance of the theme of understanding how their past affects their present, especially with regard to their role within their family, is that as Black, Afro-Caribbean women who were raised in Britain they have several different identities, which in turn create varying psychological realities. Within the discursive reading the participants appeared to externally separated themselves from others – the British majority, their therapist, myself as the researcher – as well as internally separate their different identities. They appeared to need to identify and separate their different

external identities and internal psychological realities during their therapy sessions in order to later create a more integrated sense of self.

The thesis aimed to explore whether there were distinctive, shared elements of the internal processes of BME clients in psychodynamic therapy. The analysis showed that the client's and therapist's ethnicity, culture and race did appear to impact internal processes, such as the symbolism of the therapeutic relationship, defences used, level of vulnerability, identity, transference, and compartmentalizing feelings of difference. For example, the participants appeared to be symbolically replicating their culturally infused developmental traumas within the therapeutic relationship along with a sense of parental yearning and familiarity. They also struggled with vulnerability within the session, and used various defences to maintain their strong persona, which appeared to be an internalization of the matriarchal role within Afro-Caribbean culture. As Black women who were children of immigrants, they appeared to have multiple identities and psychological realities, which may have caused a sense of a divide in their overall sense of self and a need to separate the different identities to then be able to integrate them. The analysis also suggested that culture and race affected the transference, particularly with regard to the therapist not speaking their mother tongue or having contrasting cultural values. However, the participants appeared to compartmentalise thoughts about differences in race in order to stop them from distracting from the therapeutic process. Although they did appear to crave familiarity within the therapeutic relationship, it was through cultural, racial and gender differences that the vulnerability and pain were found. Overall, it appeared that a sensitivity to differences and creating an environment which the client feels understood and safe enough to bring differences is an important aspect of facilitating change in BME clients in psychodynamic therapy.

4.4 Theoretical Implications

This section will examine how the results from this thesis sit within existing research, theory and clinical case studies. The themes explored will be the participants' strong persona defences as they struggled to demonstrate weakness, 'aha' moments of insight, not feeling fully understood by their therapist, cultural misunderstandings,

compartmentalizing thoughts about racial differences and cultural differences in the transference.

The phenomenological reading found that the participants' defences centred on retaining a mask or a strong persona where everything is fine regardless of the challenges they faced. Within the literature, this need to maintain strong persona within Black women has been identified. Wallace (1990), an American author writing about African American culture, proposed that young, black girls internalise an inflated sense of strength from family values and cultural identities. Harris-Lacewell (2001) described how the importance of strength for Black women originated as a counter response to a 'racist and patriarchal society', which then led to a 'superhuman' persona (p.2). Although literature on the impact of the strong, black woman has mostly come from the African American perspective, British studies have demonstrated the negative effect that this 'strong woman' persona has on psychological health.

Edge and Rogers (2005) carried out in-depth interviews with British Black Caribbean women and found that they saw depression as a sign of weakness, which threatened their identity as 'strong Black women' (p.15). The participants prioritised problem solving and proactivity over expression of emotion. West (1995) recommended that when working with Black women, therapists should create a space where vulnerability and fear can be demonstrated, as these emotions may seem unacceptable elsewhere. This ties in with another theme from this reading, where the participants were fearful of demonstrating vulnerability within their sessions.

The theme of an 'aha' moment of insight during a moment of vulnerability, often following a period of disagreement with the therapist with common throughout the three participants' interviews. Cooper (1989) described how working through a patient's unconscious fears and wishes, which arise through the transference within the safe environment of the therapeutic relationship, can lead to an 'aha' moment. In line with the psychodynamic theory, Johansson (2010) empirically demonstrated the key role that increased insight due to transference interpretations played in therapeutic change. Bhugra (1998) stated that therapist working with clients who are of a different ethnicity

should be aware of cultural differences in order to effectively work with transference and bring about a 'aha' moment.

Another theme that emerged during the phenomenological reading for the two participants with White therapists was a sense of not feeling fully understood by their therapist and at times feeling that they needed to explain themselves. This was also found by Chang and Berk (2009), who examined the phenomenological experience of minority clients in 16 cross-racial therapy dyads with White therapists. They reported that clients were likely to have a higher level of dissatisfaction when the therapist demonstrated an absence of group specific knowledge, leading to a sense of feeling misunderstood. In this study, the participant who particularly chose a Black therapist reported that she did so because she wanted to feel understood, and a part of this was using cultural vernacular and forms of emotional expression. Mclean, Campbell and Cornish (2003) found that African-Caribbean populations felt that their use of vernacular language and 'loud' mode of interacting with others was misunderstood by white mental health workers.

The participants with White therapists reported small moments of feelings culturally misunderstood, judged based on another culture's values and as though they needed to explain themselves. Within the literature, Sue et al. (2007) described these small misunderstandings and feelings of judgment as 'racial micro aggressions'. They are subtle and contemporary forms of discrimination towards minorities that are often automatic and unconscious and can be with verbal or non-verbal. They may include insensitivity to racial heritage, such as Karen's therapist questioning her mother's choice to emigrate, or an invalidation of cultural difference, such as Pamela defending her culture's method of punishing children. Owen, Tao and Rodolfa (2010) carried out research with female therapy clients in the United States of America, and found that perceived micro-aggressions were negatively correlated to the therapeutic relationship.

The two participants with White therapists appeared to be trying to compartmentalise their thoughts and feelings about differences in order not cause a 'distraction' from the therapeutic work. This sense of compartmentalising has been seen in other research.

Chang and Berk (2009) found that for those who reported a positive therapeutic relationship within a cross-cultural therapy dyad, 80% were likely use the strategy of 'conceptualizing one's problems as untouched by race or minimising the racialized aspect of one's being within the context of the therapy relationship' (p. 533). This appeared to be a common strategy for racial minorities with White therapists who wished to maintain a positive therapeutic relationship. The authors reported that it appeared as though by downplaying the significance of race they were trying to resolve potential internal conflict, while maintaining an idealised therapeutic relationship.

The psychodynamic reading explored the significance of language and cultural values within the transference between the cross-cultural therapy dyads. Kuriloff (2001), an active psychoanalyst, wrote of a similar experience in his case study of his work with an immigrant patient with difference ethnic and cultural origins than himself. He described the process of as the 'bumping up of one culture against another', which created a culturally infused discordant experience based of their individually feelings of uniqueness (p.674). As children of immigrants it is likely that this sense of collision between the two cultures may have been diluted, but at times there appeared to be similar sense of discord between their culture and their therapist's. Furthermore, Clauss (1998) used a case study with a second generation immigrant patient to demonstrate the presence of language related transference, where certain aspects of the transference were symbolised only by patient's mother tongue. The author described how the patent spoke unemotionally and intellectually in English, but in their mother tongue they could express deep emotion and sense of loss. In line with this, it is possible that if the participant's heard their mother tongue during therapy they may be able to connect with their emotions and loss on a deeper level.

Overall, the findings of this thesis were in-line with previous research, theory and case studies. A wide range of resources were used during this section due to the holistic framework and multi-layered analysis used in this research. As highlighted during the Introduction section, research in the past has focused on small aspects of internal processes of BME clients within psychodynamic therapy, and most commonly from the perspective of the clinician rather than the voice of the client. It is the holistic

understanding of internal processes from the perspective of the BME client that makes these finding unique.

4.5 Strengths, weaknesses, transferability and limitations

This section will explore the strengths, weaknesses, transferability and limitations of the findings of this thesis. Firstly, I will identify the strengths. This is a novel piece of work that attempted to understand the complexity of the BME experience in psychodynamic therapy from the voice of the client themselves. I was able to recruit BME participants who had engaged in psychodynamic therapy, and I have approached the research in a culturally sensitive way. Both of which were challenging. I also used a creative methodology that yielded a deep level of analysis, which created a holistic picture of how BME clients internally processes their psychodynamic therapy.

A limitation was the participants' varying therapeutic experiences. The participants had been in therapy for varying lengths of time, had entered into therapy for distinct reasons, and were at different stages of therapeutic change. These differences did appear to have an impact on their internal processing, which made it challenging to capture common or dissimilar overall therapeutic processes within their psychodynamic therapy. This was made more challenging by the difference in race pairings within the therapeutic dyads (two participants had White female therapists, and one participant had a Black male) as more focus was placed on the two participants who were of a different race to their therapists.

Although the recruitment poster advertised for BME participants, only Black women over 40 years old from Caribbean backgrounds volunteered, which meant that the findings did not represent the diversity of the BME population as a whole. This may have been influenced by practical matters, such as language barriers, or concerns the BME population have over potential to be marginalised and a lack of trust over the ethics of research (Rugkåsa & Canvin, 2011). As I was also recruiting participants in therapy, there may have also been concerns around confidentiality and the stigma around perceived mental health problems (Kurtz & Street, 2006). Furthermore, all three participants reported a positive psychodynamic therapy experience; the findings

represent the experiences of those who felt they benefitted from psychodynamic therapy and were particularly motivated to share their experiences. Those who may have had more negative experiences may not have been as motivated to share their experiences, or may have dropped out of this type of therapy all together.

There are both strengths and weakness in having a multi-layered analysis. As internal processes are not directly accessible by either the researcher or the participant, a creative methodology was necessary. However, the constraints of this piece of work as part of a doctorate did place limitations on time and resources. Mingers (2001) argued that the results are 'richer and more reliable' when methods are combined, as using a single paradigm ignores anything that does not fit within that perspective (p240). As internal processes within therapy are a complex and multi-dimensional phenomena, a range of methods are more likely to capture this richness. The different paradigms of each of the three readings focused on different aspects of the internal process. However, Mingers (2001) also identified conflicting paradigms, changing the mind-set of the researcher, and practical barriers as potential difficulties when using a multi-layered analysis. This was further explored on a personal level during the Personal Reflections on the Process segment.

In a similar vein, using three participants allowed for a deeper exploration of each of the participant's understanding of their time in therapy, especially as they were each interviewed three times. By the third interview a wealth of information had been collected, and an alliance had formed and the participants appeared less defended. As this thesis aims to be an exploratory, inductive and analytic piece, it can be argued that a small number of participants is the way to achieve this (Crouch, 2006). Sandewski (1995) argued that small samples can create valuable generalisations.

4.6 Implications for practice

A major audience for this thesis is those who work therapeutically with BME clients, and its aim is to enhance their understanding of the client's internal process, with the potential to increase the applicability and usefulness of psychodynamic therapy with this group. Greenberg (1986) described process in therapy as different points along an

outcome continuum, in which identifying and understanding the patterns of process can led to a better understanding of the mechanisms of change. Therefore by understanding the client's internal process, we are closer to understanding both what facilities and what hinders change. Greenberg (1986) also emphasised the role that process research has in bridging the gap between research and the clinical work, as practitioners can take guidance from research that can 'illuminate the practice of therapy by discovering patterns of performance that explain the process of change' (p.8).

For this particular research, non-BME therapists working with this group may benefit from understanding how not speaking their client's 'mother tongue' may affect transference and the type of therapeutic relationship formed. It may also be useful to think about how clients may also be compartmentalising themselves, or feel that differences in race may interfere with the therapy. This research demonstrates that when working with BME clients, particularly Black or Afro-Caribbean women, using a psychodynamic approach that certain factors may need to be taken into consideration. This may include the impact of a maintaining a 'strong persona' in therapy, the perception of vulnerability as weakness, increased defences due to developing in a discriminatory society, multiple identities, and difficulties around feeling different which need to be handled sensitively.

4.7 Suggestions for future research

There is great scope for further research regarding the BME population in psychodynamic therapy. I believe that it would enhance the field of BME research, especially considering there are several initiatives promoting the engagement of this population in psychological therapies, and that organisation such as MIND are recommending the use of psychodynamic led therapies. Furthermore, the field of psychodynamic research has previously focused on the therapist's perspective, and I feel that hearing the voice of the BME therapy clients would enrich the field. This piece of work can act as a broad foundation from which many unanswered questions arise. For example, future research could focus on BME participants in a particular type of psychodynamic approach, particularly Dynamic Interpersonal Therapy (DIT) as this has been recommended by MIND for use with BME

communities. This would also keep other factors such as length of therapy and motivation for entering into therapy more uniform. Another suggestion would be to use different methods of collecting data beyond that of semi-structured interviews. For example, analysing audio recording of sessions or perhaps triangulating the data by interviewing both the client and the therapist.

4.8 Relevance to Counselling Psychology

This thesis aimed to explore in depth the internal processes of three participants from varying perspectives, with the focus on the individual perspective. This aim combined with a heavy emphasis on reflexivity and intersubjectivity are very much in lines with the ethos of counselling psychology. Rafalin (2010) emphasised the 'respect for diversity, multiple perspectives and the individual's right to hold these' that counselling psychology maintains, which mirrors the stance this research takes (p.14). Also in-line with the counselling psychology tradition is the importance of clinical relevance, and BME clients in psychodynamic therapy is at the front line of clinical relevance.

According to Dryden and Reeves (2008) the growing presence of ethnic and cultural diversity within the client base of counselling psychology obliges the field to increase its awareness of how this diversity affects the clinical work. Counselling psychologists have a presence in many organisations, such as MIND and other voluntary sector organisations that are actively engaging BME communities in talking therapies. Therefore research based on BME groups that can influence the clinical work of counselling psychologists, such as this thesis, are important to the field. Psychodynamic therapy also holds a significant place within counselling psychology. Wolfe, Dryden and Strawbridge (2003) draw on the 'wealth of clinical and theoretical work' coming from psychodynamic counselling within the field to demonstrate its continued presence (p.122).

4.9 Conclusion

This thesis aimed to explore whether BME clients in psychodynamic had shared internal processes that differed from the majority White British population. As internal processes are not directly accessible, a qualitative, pluralistic approach was used in an

attempt to capture and triangulate different aspects of internal processes through different analytical lens. This yielded rich results, and common themes in-line with existing literature that arose were the need to maintain a strong persona during therapy, a defensive stance due to the perception of vulnerability as weakness, at times feeling culturally misunderstood by the therapist due to micro aggressions, compartmentalising thoughts about race, and transferences related to the participants' mother tongue. This lead to the conclusion that internal processes were influences by culture, race and ethnicity of both the client and the therapist.

There were theoretical and practical challenges in using a multi-layered analysis, but I felt that this method was in-line with my personal philosophy and clinical practice. The weaknesses were the absence of pilot study, the lack of transferability to the BME population as a whole, limitations to the generalizability of the findings due to small participant numbers, varying therapeutic experiences and only positive therapy experiences included. The proposed audience was those who work therapeutically with BME clients, as it aimed to increase the relevance and value of psychodynamic therapy with this client group. Recommended future research would focus on one particular type of psychodynamic therapy, perhaps Dynamic Interpersonal Therapy as it has been recommended for future use with BME communities.

4.10 Reflection on Discussion

By layering the lenses in this manner, the overarching theme of difference emerged. It can be seen in varying forms throughout, including overt differences in cultures between the participants and therapists, discreet discursive positioning that suggest otherness and a lack of their mother tongue affecting the transference. This difference permeated the therapeutic relationship, the interview process and could be viewed in the larger sociological context. It was challenging for me, as a researcher, to think about this difference and it appeared that it was also difficult for the participants at times. It would seem that the difference and the varying lenses that it affects within inner processing is something that may need to be considered within a therapy with BME clients. This could include the effect of difference on sense of self, relating to other, and within the wider context.

The aim of this thesis was to inform counselling psychologists about factors they may have to consider when working with BME clients, and in a sense I was able to achieve this on an individual level through my own learning during this process. For example, I learnt how small and unintentional micro aggressions can be, while simultaneously being quite harmful. I have learnt that all differences need to be handled sensitively and with minimal assumptions. This learning brought me back to my own personal therapy, and how I hid differences out of frustration over feeling misunderstood or perhaps I did not want to feel different anymore. I have also considered my own cultures and sense of multiple identities on a deeper level.

Furthermore, writing the section on the theoretical implications of this thesis brought up some uncomfortable thoughts about mistakes or assumptions I may have made during past interactions with Black and ethnic minorities, including the interviews I carried out with my participants. For example, I thought deeply about whether I have misunderstood the participants' cultural vernacular and way of communicating, and perhaps misinterpreted it as something incorrect. However, I concluded that the participants probably did not feel comfortable enough with me to use vernacular, as demonstrated by Annie's discursive reading, which I would not necessarily have expected. Researching and writing this thesis did seem to crystalize what Annie said regarding how as a secondary school child in London, I thought I was on a level playing field to my Black friends, but that that was not necessarily true. This has meant that although writing this thesis has been fascinating and has brought me great joy, it has also been tinged with sadness and deep thought on a personal and professional level.

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APPENDICES

Appendix A: Biographical details of participants

Appendix B: Recruitment poster

Appendix C: Information sheet

Appendix D: Consent form

Appendix E: Debriefs 1-3

Appendix F: Phenomenological interview schedule

Appendix G: Tables of extracts from discursive themes for each participant

Appendix A: Biographical details of participants

This information has been highly anonymised to protect the participant's confidentiality. Pseudonyms have also been used.

Participant 1
Name: 'Annie'
Age: 40s
Ethnicity: Afro-Caribbean
Type of therapy: Psychodynamically led therapy
Therapist: Black male
Duration: 4 years

Annie came from a working class, single parent family. Her parents are from the Caribbean, and her father moved back when she was a young child. She attended a 'middle class' secondary school and started work full time afterwards. She has completed a degree in psychology. She had to be in therapy for her course, and choose to have psychodynamic to 'challenge' herself.

Participant 2
Name: 'Pamela'
Age: 40s
Ethnicity: Black British
Type of therapy: Relational approach
Therapist: White female
Duration: 3 years

Pamela grew up in a middle class family with both her parents working full time. Her parents emigrated from the Caribbean and she was born in Britain. She had worked in a high stress job for many years before starting her masters in psychology. She was required to be in therapy as part of her course, but has continued and has no current plans to stop.

Participant 3

Name: 'Karen'

Age: 40s

Ethnicity: Afro-Caribbean

Type of therapy: psychodynamically informed

Therapist: White female

Duration: 5 years

Karen grew up moving between foster homes and living with her mother, who had emigrated from the Caribbean. She then moved to a children's home permanently. She initially attended therapy to help her with a difficult life decision, and has stayed ever since. She has completed a course in psychology.

Appendix B: Recruitment Poster

Appendix C: Information Sheet

CITY UNIVERSITY LONDON

Information Sheet

How do Black and Ethnic Minority (BME) clients internally process psychodynamic therapy sessions?

The aim of this research is to better understand how BME clients experience, understand, speak and think about psychodynamic therapy. It is part of my Doctorate in Counselling psychology and, ideally, should contribute knowledge to how therapists work with BME clients.

If you choose to take part, you will be interviewed a total of three times. Each interview will last around an hour, and there will be a four week interval between each one. Each of the three interviews will focus on a slightly different aspect of psychodynamic therapy, from your experience, the way you speak about therapy, and your thoughts and feelings about it. Our interviews will be recorded, and then I will transcribe and further study them.

As the topic of this research is the process of therapy, participating in this study may bring up emotional or psychological issues. If this occurs then measures have been put into place to deal with this and this will be discussed during the debrief at the end of each of the interviews.

Your participation is voluntary, and you may leave at any stage. You can also choose to have any unprocessed interview data destroyed during the interview process. Otherwise, the interviews will be kept anonymous and confidential, subject to any legal requirements. Only myself, the principal researcher, and my supervisor will have access to the interviews. The research material collected will be kept for five to seven years, and then destroyed.

Appendix D: Consent Form

CITY UNIVERSITY
LONDON

<u>Consent Form</u>

Name of Participant:

_____

Project Title: *How do Black and Ethnic Minority (BME) clients internally process psychodynamic therapy sessions?*

Name of Researcher: Genevieve Hughes

Name of Supervisor: Dr Jessica Jones Nielsen

1. I consent to participate in this project and that the details have been explained to me.

2. I authorise the researcher to use the procedures involved in this project.

3. I agree that interviews can be audio recorded for the purpose of analysis.

4. I acknowledge that:

    (a) The nature of the interviews and the possible effects have been explained to me to my satisfaction;

    (b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed interview material previously given;

    (c) The purpose of this project is research and not treatment.

    (d) I have been informed that the confidentiality of the information I provide will be safeguarded, subject to any legal requirements.

Signature:_____**Date:** _____
                          (Participant)

Signature: _____**Date:** _____
                          (Researcher)

Appendix E: Debriefs

CITY UNIVERSITY LONDON

Participant Number:

Debrief

Thank you for taking part in this research!

The goal of this research is better understand how BME clients experience, speak and think about psychodynamic therapy. This was the first stage, which focused on your experience of therapy. The following two interviews will take place within the following months. A time and place will be agreed between yourself and Genevieve Hughes, the researcher.

Contact Information

If you have questions now, please ask. If you have additional questions about this research or the following interviews at a later time you should contact Genevieve Hughes at ████████████████████████ or call ████████████ You may also contact her supervisor at City University, Dr Jessica Jones Nielsen at

████████████████████████

Confidentiality

All research material collected today will be kept anonymous and confidential, subject to any legal requirements. Only the principal researcher and her supervisor will have access to the interviews. Names and identifying details will be removed and the materials will be stored securely.

Your participation is voluntary and you may leave at any stage. You can also choose to have any unprocessed interview data destroyed during the interview process. Otherwise, research material collected will be kept from five to seven years, and then destroyed.

Counselling support

If you feel upset after this interview or that an aspect of the interview triggered distress, you may wish to speak to your therapist or another organisation. Please see the list of important details of services that can help with this.

***Please keep a copy of this form for your future reference. ***

Mental Health Services

The Samaritans (London Branch)
46 Marshall Street, London W1F 9BF
TELEPHONE: 020 7734 2800
WEBSITE: http://www.samaritans.org/ **E-MAIL**: jo@samaritans.org
SERVICES OFFERED: You can speak to them any time and off the record -You
don't have to be suicidal.
CATCHMENT: National **OPENING TIMES:** 24 hours

British Association of Counselling
BACP House, 35-37 Albert Street, Rugby, CV21 2SG.
TELEPHONE: 01788 550899 **FAX:** 0870 443 5161 **E-MAIL:** bacp@bacp.co.uk
WEBSITE: www.counselling.co.uk
SERVICES OFFERED: Information and advice about counselling. List of local
counsellors. **CATCHMENT:** National **OPENING TIMES:** M-F 8.45am-5pm
HELP/CRISIS LINE: 0870 443 5252

NAFSIYAT
Therapy Centre, 262 Holloway Road, London, N7 6NE.
TELEPHONE: 020 7686 8666 **FAX:** 020 7686 8667 **E-MAIL:** nafsiyat-
therapy@supanet.com **SERVICES OFFERED:** Psychotherapy and counselling for
ethnic minorities. Means-tested fees. **CATCHMENT:** Self referral or referral via
Healthcare professionals
OPENING TIMES: M-F 9.30-5.30 pm

Debrief
Thank you for taking part in this research!

The goal of this research is better understand how BME clients experience, speak and think about psychodynamic therapy. This was the second stage, which focused on how you speak about therapy. The final interview will take place in around 4 week's time. A time and place will be agreed between yourself and Genevieve Hughes, the researcher.

Contact Information

If you have questions now, please ask. If you have additional questions about this research or the final interview at a later time you should contact Genevieve Hughes at ████████████████████████████████ call ██████████████ . You may also contact her supervisor at City University, Dr Jessica Jones Nielsen at ████████████████████████████████

Confidentiality

All research material collected today will be kept anonymous and confidential, subject to any legal requirements. Only the principal researcher and her supervisor will have access to the interviews. Names and identifying details will be removed and the materials will be stored securely.

Your participation is voluntary and you may leave at any stage. You can also choose to have any unprocessed interview data destroyed during the interview process. Otherwise, research material collected will be kept from five to seven years, and then destroyed.

Counselling support

If you feel upset after this interview or that an aspect of the interview triggered distress, you may wish to speak to your therapist or another organisation. . Please see the list of important details of services that can help with this.

******Please keep a copy of this form for your future reference*****

Mental Health Services

The Samaritans (London Branch)
46 Marshall Street, London W1F 9BF
TELEPHONE: 020 7734 2800
WEBSITE: http://www.samaritans.org/ **E-MAIL**: jo@samaritans.org
SERVICES OFFERED: You can speak to them any time and off the record -You
don't have to be suicidal.
CATCHMENT: National **OPENING TIMES:** 24 hours

British Association of Counselling
BACP House, 35-37 Albert Street, Rugby, CV21 2SG.
TELEPHONE: 01788 550899 **FAX:** 0870 443 5161 **E-MAIL:** bacp@bacp.co.uk
WEBSITE: www.counselling.co.uk
SERVICES OFFERED: Information and advice about counselling. List of local
counsellors. **CATCHMENT:** National **OPENING TIMES:** M-F 8.45am-5pm
HELP/CRISIS LINE: 0870 443 5252

NAFSIYAT
Therapy Centre, 262 Holloway Road, London, N7 6NE.
TELEPHONE: 020 7686 8666 **FAX:** 020 7686 8667 **E-MAIL:** nafsiyat-
therapy@supanet.com **SERVICES OFFERED:** Psychotherapy and counselling for
ethnic minorities. Means-tested fees. **CATCHMENT:** Self referral or referral via
Healthcare professionals
OPENING TIMES: M-F 9.30-5.30 pm

Debrief

Thank you for taking part in this research!

The goal of this research is better understand how BME clients experience, speak and think about psychodynamic therapy. This was the third and final stage, which focused on how you think about therapy. Your participation in this project is now complete. Once again, thank you for taking part in each of the three stages of this research.

Contact Information

If you have questions now, please ask. If you have additional questions about this research you should contact Genevieve Hughes at ████████████████████████ or call ██████████. You may also contact her supervisor at City University, Dr Jessica Jones Nielsen at Jessica.Jones.Nielsen.1@city.ac.uk.

Confidentiality

All research material collected during this research project will be kept anonymous and confidential, subject to any legal requirements. Only the principal researcher and her supervisor will have access to the interviews. Names and identifying details will be removed and the materials will be stored securely. Research material collected will be kept from five to seven years, and then destroyed.

Counselling support

If you feel upset after this interview or that an aspect of the interview triggered distress, you may wish to speak to your therapist or another organisation. Please see the list of important details of services that can help with this.

Please keep a copy of this form for your future reference

Mental Health Services

The Samaritans (London Branch)
46 Marshall Street, London W1F 9BF
TELEPHONE: 020 7734 2800
WEBSITE: http://www.samaritans.org/ **E-MAIL**: jo@samaritans.org
SERVICES OFFERED: You can speak to them any time and off the record -You don't have to be suicidal.
CATCHMENT: National **OPENING TIMES:** 24 hours

British Association of Counselling
BACP House, 35-37 Albert Street, Rugby, CV21 2SG.
TELEPHONE: 01788 550899 **FAX:** 0870 443 5161 **E-MAIL:** bacp@bacp.co.uk
WEBSITE: www.counselling.co.uk
SERVICES OFFERED: Information and advice about counselling. List of local counsellors. **CATCHMENT:** National **OPENING TIMES:** M-F 8.45am-5pm
HELP/CRISIS LINE: 0870 443 5252

NAFSIYAT
Therapy Centre, 262 Holloway Road, London, N7 6NE.
TELEPHONE: 020 7686 8666 **FAX:** 020 7686 8667 **E-MAIL:** nafsiyat-therapy@supanet.com **SERVICES OFFERED:** Psychotherapy and counselling for ethnic minorities. Means-tested fees. **CATCHMENT:** Self referral or referral via Healthcare professionals
OPENING TIMES: M-F 9.30-5.30 pm

Appendix F: Phenomenological Interview Schedule

Interview 1 (phenomenological orientated):

Main question:
- Could you please describe for me your experience of psychodynamic therapy?

Further possible questions:
- What was that like?
- Do you remember your first session?
- Could you tell me about your therapist?
- What kind of relationship did you have?
- How did the therapy end?

Appendix G: Tables of extracts from discursive themes for each participant

Annie

Position	Interview/page/line	Key quotes/terms
IN CONTROL: In the driver's seat	Interview 1/1/50-51	'They question me and I am telling my own self that actually…some things don't actually fit'
Could edit what she says	Interview 2/5/137--139	'it would be really easy for me to edit what I say. It would be really easy to edit it because you kind of have a perception of what the therapist is looking for and what you are saying'
Stands up to therapist	Interview 3/14/393-394	'Yeah, I was saying, 'No, I don't think that. I'm not like my mum. I'm way different'
GOOD PARTICIPANT/CLIENT: Proud of how many hours in therapy she has completed	Interview 1/5/126-127	'so far I have done well over…60 hours'
Demonstrating learning	Interview 2/1/42	'but it was probably one of my peak learning moments'
Skills from therapy	Interview 3/4/105-107	'I'm trying to think where I was in terms of relationships at that point, because that would have had an impact on why I was thinking that way'
HER/OTHER SEPERATION: Separating herself from her therapist	Interview 1/10/276-278	'It's more about me, it's not really about… the therapist. It's how I see myself and also whether I have…processes'
From others	Interview 2/7/187-188	'I have to comfortable of my own being, regardless

Position	Interview/page/line	Key quotes/terms
English (others) from Bajan (we)	Interview 3/1/6	'we say Bajan, but others say Barbadian'
JOKER: Laughs when things are painful	Interview 1/1/34-35	'Because I thought I was alright! (*laughs*) I thought I was alright'
Smiling to let me know she's okay	Interview 3/2/48-49	'although he gets on my nerves – with my, um, children's dad (smiling)'
EXTERNAL FORCE: Physical language and a sense of duty.	Interview 1 2/33-34 7/177 12/323	'It pulled me out of my comfort zone' 'They throw things back to you' 'it's like having to explain to your therapist'
Physical, battle language	Interview 2 4/96 2/49 13/347	'Collision' 'retreat' 'They just whack it back'

Pamela

Position	Interview/page/line	Key quotes/terms
In charge: Assertive about what she is willing to do during a session	Interview 1/5/137-138	'When she touches on something that I am not willing to face'
Main force of the sessions	Interview 2/4/66-68	'but if anything her interpretations are more likely her reflecting back what I have been saying in the session. Which she may saying a different way. A more therapeutic way, you know.
	Interview 3/9/311	'and then there are other times, Genevieve'

Sense of control over interview by saying my name		
Defended: Not wanting to acknowledge negativity about the past	Interview 2/5/89-90	'especially in the first year – I probably didn't want to acknowledge any flaws or things that would come up, growing up as a child'
Needing to defend from overwhelming emotions	Interview 3/13/463-465	'I convinced myself that if I looked at it straight away then it would be too much or something. But I think that is very much about your emotions'
Sensitive about losing people: Not wanting to think about the emotion	Interview 2/10/201-203	'gosh, I'd be…I don't' even know what I would do, honestly, because they played a big part of my journey'
Divided: Splitting her emotion off	Interview 2/11/215-216 Interview 3/3/89-91	'there is a part of me if I split myself in two, there is a part of me that is very angry with her, and a part that is…' 'if I split myself in two there is a part of me that wishes that I had that, um, I was able to sort of continue having that wholesome kind of 'daddy's little girl' image within myself'
Balancing two separate cultures	Interview 3/1/23-24	'so it's interesting sort of having two cultures, and sort of having to balance that'
Black British: Positioning therapist as different race to her	Interview 1/2/55	'She's not black'
Difficult to think about difference	Interview 2/100/102	'She's white, and we have very, very different back grounds, and you know (outward breath of air) I am

	23/485-484	not entirely sure how important that is' 'I know there could be a part of me that doesn't really want to acknowledge that, you know, I am different'

Karen

Position	Interview/page/line	Key quotes/terms
Disconnected: Disconnected from her own emotions	Interview 1/24/598	'It was a shock, a huge shock that I had responded in this way.'
Surprised by her regression	Interview 1/14/332-333	'So that was obviously a surprise'
Unaware of what was happening and why	Interview 2/1/18	'I suppose I hadn't really, really understood that before'
In control: What she is willing to do	Interview 1/20/498	'I was willing to do that'
What she allows other to see of her	Interview 2/24/586	'what I allow people to see'
In control of her emotions	Interview 3/18/477-478	'the first time that I had really allowed myself to do…to cry'
Placing things onto the therapist:	Interview 1/13/317-318	'Its talk therapy, you know, if you can't explain your stuff – I suppose it makes it quite difficult for the therapist to understand you'

From the therapist's perspective rather than hers.		
Therapist struggling in the session	Interview 2/3/54-56	'Well I think for her she found it quite hard that I wasn't able to, um, that I wasn't able to think about my younger life'
Therapist wanting to support her	Interview 3/16/444	'she has really, really wanted to support me'
Not distracted by race issues:	Interview 3/11/314-315	'It could get, um, I could get distracted by all sorts of other things. I don't particularly want to do that (*small laugh*).'
Demonstrating commitment to therapy regardless of thoughts about race	Interview 3/14/387	'I don't want to change! I won't change. I know that. I won't change.'

SECTION D – PUBLISHABLE PAPER

'Maybe if I had heard my mother's tongue I might speak easier': A multi-layered

exploration of internal processes in psychodynamic therapy.

Word count:7,866

Abstract

Black and Minority Ethnic (BME) communities are being encouraged to engage with psychological services and psychodynamic approaches are being recommended to meet their needs. Although external aspects have been explored, there is a gap in the literature regarding internal processes from the client's perspective. This paper aims to begin to fill this gap by using a multi-layered, pluralistic qualitative design to explore the internal processes of one Black and Minority Ethnic (BME) participant in psychodynamic therapy with a White therapist. It combined three analytic strategies, including descriptive phenomenological, discursive and psychodynamic, in order to create a multi-dimensional picture. The analysis suggested that both the participant's and the therapist's ethnicity and culture impacted the participant's internal processes through feeling culturally misunderstood, compartmentalising thoughts about race, and transference related to the participants' mother tongue.

Key words: Multi-layered, pluralistic, inner processes, BME, psychodynamic, phenomenological, discursive, therapy

Introduction

There has been a drive in the literature on engaging the BME community in psychological therapies (Fernando, 2005), with a particular focus on the reasons for their lack of engagement (Bhui and Bhugra, 2002) and changing policies accordingly (Clark, 2011). There have also been calls for services to offer BME clients a wider choice of therapies, with a special recommendation to include psychodynamic type approaches (Fernando, 2010). However, much of the focus has been on the external factors of therapy rather than internal factors, such as their experience, thoughts or