Therapists' Constructs of Healthy Functioning as Aspirational Goal in Transformative Psychotherapy.

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ABSTRACT

This dissertation reviews the ways in which psychotherapists working in relatively long-term 'transformational' therapies construct the outcome goals of their interventions. It is generally accepted that a therapist's beliefs about what constitutes mental health will influence the client, and will therefore facilitate a certain outcome accordingly. A problem in a long-term, 'non-directive' therapy is that the eventual outcome is not always visible in the interim development of the client or in the business of individual sessions. Without a clearly defined 'plan' or 'goal' there is a real danger of the intervention having opposite results to what would have been desirable, or no noticeably beneficial results, both of which can be an abuse of the client's investment and trust in the process. The absence of clearly constructed goals makes it difficult to assess efficacy of a therapeutic method used to attain an improved state of mental health that will be lasting, i.e. a positive 'transformation'; it also problematises comparisons across orientations. The identification of explicit goals is of special importance in a developing 'third-world' community like South Africa, where western ('European') concepts of mental health are being offered as an alternative to so-called 'indigenous healing' and where different cultural communities may have different expectations, needs or demands of their members 'in health'. Individual-based therapeutic orientations included in the research were psychoanalysis and psychoanalytic therapies, including object-relational therapies with various emphases and self psychology, as well as transformative types of hypnosis, Gestalt therapy, client-centred therapy and transactional analysis. Twenty of the semi-structured interviews with 52 therapists working in one or more of these areas were selected for construct analysis. Through analysis of the constructs of mental health as aspirational goal that emerged in therapists' talking about their experience of the process and the consequences of therapy observed in their patients, it appeared that there are generalisable constructs across various orientations in the transformative therapies. It is hoped that these constructs may serve as a foundation for further research in the problem areas indicated, but also that therapists working in the field may use this research not only as a basis for self-evaluation, but for adding to the constructs from their own experience, to the further enrichment of the whole field of work.

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TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTION

O'Brien, Woody and Mercer (in Kaplan and Sadock 1995, p. 1885) emphasise the central importance of outcome in psychotherapy research because of the need to assess the effectiveness of treatments. They quote the APA Commission on Psychotherapies as follows: 'Psychotherapy is taken to mean the informed and *planned* application of techniques derived from established psychological principles, by persons qualified through training and experience to understand these principles and to apply these techniques with the intention of assisting individuals to *modify such personal characteristics as feelings, values, attitudes, and behaviors* which are *judged by the therapist to be maladaptive or maladjustive*' (p. 1887, italics mine).

According to these criteria, psychotherapy should not be attempted unless the therapist has a plan for the application of techniques and a goal for the outcome, i.e. the modification of personal characteristics. Establishing the effectiveness of a long-term (i.e., a minimum of two years' weekly contact), 'non-directive' psychotherapy is problematic, especially when there appears to be a lack of consensus among various practitioners and among different schools of psychotherapy about the outcome goals against which the relative success of each intervention can be measured (Wallerstein, 1968/1994).

Outcome goals in transformative psychotherapy are not only constantly changing with both personal insight into the ways the psyche functions and politico-cultural observations into the historical milieu from which metatheories arise (Stolorow & Atwood, 1979), but are often not defined at all (Bader, 1994; Eysenck, 1980; Toukmanian & Rennie, 1992). This despite Rogers' plea of almost six decades ago (Rogers, 1940) for more adequate formulation of the fundamental aspects of such therapy. The process of a long therapy can further be so compelling of itself, that goals are not always a focus either at the start or during the process for some therapists. Lakin (1988, p. 34) warns that some transformative/ psychoanalytic therapists "become so enamored of their discoveries as to lose sight of the real-life

consequences for the individual" which may lead to pathological consequences for the client or his/her environment. Without the specification of outcome goals in psychotherapy, it would be difficult to improve methods of intervention with sufficient confidence that practitioners from associated fields of work can find recommendations acceptable (Wolberg, 1988).

Attempts are constantly being made to improve the effectiveness of transformative psychotherapies by focussing on the elements that could lead to a positive outcome, or 'psychological growth' (Allison, 1994). However, it appears that psychotherapists working in various schools of transformative therapy are usually not purists in their methods, and often not in their theoretical beliefs (Jones & Pulos, 1993; Wallerstein, 1968/1994; Ehrenberg, 1992).

A further problem is that published research on outcomes of long-term psychotherapy has usually been done to prove or disprove effectiveness in this type of intervention – and often in comparison to directive therapies. The result is that "the consolidation of therapeutic goals", which requires a maturation period of up to five years after termination, is not usually studied, which leaves us with false results of this kind of therapy determined in "a period of upheaval and stress" when there is often a temporary reemergence of symptoms and other disturbances (Strupp, Fox & Lessler, 1969, pp. 48-49). Even when research is done inside the field of psychoanalysis with cognisance of the time factor, some researchers have validated such practices as determining goals *post hoc*, with the 'goal' adapted to the findings (Jones, 1968).

It is therefore not sufficient to ascertain the outcome goal constructs as proffered by the various schools of therapy through their mouthpieces, but necessary to establish the working constructs of various practitioners of transformative psychotherapy in the field. This was attempted here through a qualitative analysis of constructs of healthy functioning and of the proposed 'transformation' of the personality as outcome goal in long-term therapies through interviews with persons selected by others in the field as 'informed' and 'effective'. The specific focus was their report of their observations and understanding of these observations, in their *practice* of transformative psychotherapy.

This dissertation reviews the ways in which psychotherapists engaged in relatively long-term 'transformative' or 'reconstructive' therapy construct the goals of such therapy, in which the process focus is on a general improvement in the healthy functioning and comfortable 'being-in-the-world' of the client over time, rather than on the dissolution of specific symptoms.

It is hoped that by finding the essences of explicit outcome goals and by making the implicit and unconscious goals overt through an analysis of the constructs embedded in the narratives of such psychotherapists about the process of their work, a foundation can be laid for future further research into the effectiveness of transformative types of psychotherapy, including the applicability of such therapy to non-western communities such as the broader population in South Africa. It is further hoped that a clearer defining of such basic constructs will be of heuristic value in current research in such areas as integrative psychotherapy.

CHAPTER TWO

THEORETICAL CONTEXT

2.1 THE TERM 'TRANSFORMATIVE' PSYCHOTHERAPY

> In any analysis [---] increasing one's understanding, which is a goal of psychoanalysis, is only a means. The idea that it was an end is a mistaken notion that came from Freud's famous statement, 'Where there was id, there shall ego be', which means that we should know what is going on in us. But even that is only a step. The ultimate goal of psychoanalysis is restructuring of the personality. For what purpose? So that the person can live better with himself. (Bettelheim & Rosenfeld, 1993, p.1-2.)

It is the nature of qualitative research that the basic terms of reference used are negotiated with the participants (here, the therapists who were interviewed) until agreement is reached on acceptable terms and formulations (Guba, 1987). When this research was initiated, the term 'reconstructive' psychotherapy (Wolberg, 1988) was first used to indicate various psychotherapies that shared the following characteristics: Clients/patients[1] were seen on an individual basis by a single psychotherapist. The therapy was 'long-term' which usually implied a fixed contract for regular weekly sessions (at least one a week, but usually two or more a week) for a period (of usually a minimum) of two years or more. Contents of discussion during sessions were usually introduced by the client, and the therapist tended to minimise overt 'direction'. Exploration of the ways the client experienced his/her world and his/her connection to it was facilitated. Extra-sessional contact, except for contracted telephonic contact, was avoided. 'Homework' was generally not given. The setting was fixed and in a room designated for the purpose of therapy, under control of the therapist.[2]

The term 'reconstructive' was chosen also according to Bettelheim and Rosenfeld's (1993, p.1-2) definition of the "ultimate goal" of psychotherapy as the "*restructuring* of the personality [---] so that the person can live better with himself" (italics mine). After exploration of the term with interviewees, however, it was felt that the most

[1] For the sake of brevity I will in future refer to 'clients' exc ept when directly quoting a source.
[2] Ivey (1999, p. 5) summarises the analytic setting under the headings "The spatial, temporal, and financial constants of the setting", "Rules concerning the relationship between therapist and patient", and "Rules concerning the nature of the therapist's interventions".

neutral and generally acceptable term would be *transformative* (Jung, 1966). Some interviewees objected to 'reconstructive' as they understood it to mean 'creating a new and different Self'[3], or that it implied an acceptance of terms of psychic *structure*, like 'id' or 'superego'. Some interviewees further felt that terms like 'psychoanalytically-orientated' or 'psychodynamic' had been too broadly used over the years and may be too inclusive (e.g. of shorter-term or group interventions).

It was felt that the construct 'transformative' had useful implications for the identification of therapy goals in this type of therapy where goals are usually not overtly stated at the outset: the outcome of the intervention for the client would therefore be some form of permanent positive change in his/her way of being-in-the-world, rather than the reduction of specific symptoms or the acquisition of specific skills.

2.2 THE CONSTRUCT 'OUTCOME GOAL'

While written specifically from a Jungian analytic perspective, Murray Stein's (1984) chapter on the 'aims and goal' of analytic treatment summarises the vagaries, conflicts, confusion and disparity around the goals of psychotherapy[4]: "Much of the apparent confusion [---] may result in part from the absence [---] of an agreed-upon and precise distinction between short-term, issue-orientated psychotherapy and long-term, transformational analysis" (p. 33). He refers to Guggenbühl-Craig's (1977) distinction between 'well-being' as the goal of short-term psychotherapy and 'individuation' as the goal of analysis. The first goal is achieved by resolving "*conscious* issues, crises or problems" so that tensions are relaxed and a general state of well-being achieved; the second by "engaging intensively with material from the unconscious" resulting in an *increase* of intrapsychic tensions which are relieved only after resolution of the conflict that originated in the Self (Stein, 1984, p. 33, emphasis added). "As the ego

[3] According to interviewees' preferences and literature use generally, the convention will be followed to capitalise 'Self' when referring to such structural concepts as 'the core of the personality' (or, for that matter, the subject of the study of Self psychology.) When 'self' is understood to refer to the person/whole of the self ('myself' as opposed to 'others', 'self-esteem'), it will not be capitalised. In quotations the original use of the author will be maintained.

[4] 'Long-term' generally appears to refer to two or more years of 'non-directive' therapy usually comprising two or more sessions per week

comes to terms with the unconscious, the result is not necessarily a pleasurable sense of well-being, but rather a more conscious sense of Self." (Stein, 1984, p. 33.)

Stein uses the term 'aims' for the more specific outcomes of short-term therapy or for process goals in a session in longer therapies, and 'goal' (singular) for the 'Self-related' outcome of the longer-term analytic intervention. The fine distinction in nuances of meaning appears to be supported referentially by denotations in popular dictionaries: 'aim' seems to imply a directional, specified intent, and 'goal' an eventual outcome of "ambition or effort" (Pocket Oxford Dictionary). For the purpose of this dissertation, I will adopt Stein's terminology, so as to avoid further confusion about the types of goals raised in interviews.

Stein also refers to Jung's warning (1966, p. 41) that the goal of analysis should not be too rigidly fixed by the therapist as "there is no universal recipe for living. Each of us carries his own [irrational] life-form within him" (Stein, 1984, p. 34). It thus appears that the aims (which are focused on helping an individual to function in his/her world, rationally, in such a manner that stress is reduced) and goals (of becoming his/her true Self, which may be 'irrational') could seem contradictory. It would be useful also to test whether this differentiation between aims and goals does indeed exist among the interviewees and whether or not it is felt to be contradictory.

Winnicott (1954-5) further implies that there may be a need to have different goals for different developmental deficits in different phases of a long-term therapy, for instance for persons who have or not yet achieved the characteristics of having reached the depressive position. Interviewees' responses to this view could also help in the formulation of a comprehensive construct of outcome goal(s).

Ivey (1999) uses the term 'the analytic task' to indicate aspects of the transformative psychotherapeutic goal from the psychoanalytic perspective. He defines the analytic task as "the attempt to facilitate a greater degree of psychological freedom in our patients through the insightful resolution of unconscious conflicts. [---] The aim is thus not to remove symptoms, but to conduct a painstaking exploration of why patients need their particular symptoms, and what catastrophe they fear might eventuate should they give them up" (p. 3). Ivey concludes that "our task as therapists

is to think the unthinkable and speak the unspeakable in the hope that this will assist our patients in thinking and conversing more freely". Further, since they cannot initially tell us what the unthinkable may be (i.e. they cannot know what is unconscious), "our main task as analytic therapists is therefore really nothing more or less than to provide a quality of relationship that will facilitate freedom of thought and speech" (p. 4). Accordingly, 'task', 'main task' refer to what the analyst must do/not do to facilitate the therapeutic 'goal' (as use by Stein above), of a liberation of the self, and 'aim(s)' refers similarly to the particular aims that govern the analyst's activities in a session. The concept of the therapist's 'task' is therefore also investigated in the analysis of interviews (Chapter Four).

2.3 THE 'UNCONSCIOUS'

Another possibly contentious issue in transformative psychotherapy raised by Stein (1984) is that of the unconscious, and the implications of this construct for determining outcome goals in terms of it. An exploration of unconscious matters in order to achieve the freedom to transform appears generally to be seen as essential to transformative therapies (Bettelheim & Rosenfeld, 1993; Ivey, 1999). The question arises whether practitioners of transformative therapies can agree about the construction of the term *the unconscious* - about that which becomes the focus of the work to produce the result of healthy functioning (the 'unthinkable' and 'unspeakable' according to Ivey, 1999).

Not all transformative therapists agree with the original (Freudian) structural terminology around the concept of the unconscious. Not everyone accepts the terms 'superego' or 'id' as constituting the target of interior conflict resolution that many hold essential to the 'aims' or 'task' of the therapy in order to achieve the goal of transformation (e.g., Knight, 1996).

While a detailed exploration into terminological similarities between schools of thought in this regard falls beyond the scope of this research, even on gross review we

can find evolutionary constructs that appear to suggest a relationship between apparently divergent conceptual paths: The 'critical parent' construct of, for instance Transactional Analysis, and the Kleinian 'fierce parental imago' construct recall strongly certain qualities contained in the original 'superego' construct, and there appear to be some inferred links (despite differences in intensity or value judgements associated with the terms) between Jungian and other 'spontaneous child' or 'recalcitrant child' concepts and those contained in the term 'id'. In this respect, the Object-Relations concept of 'introjects' or Gestalt terms like 'protagonist alter egos' may provide an explanatory link for this kind of terminological evolution, so that the unconscious can be re-constructed in terms of *relational experiences* (Knight, 1996).

Further, the apparent link between Jungian 'archetype' constructs, 'past life' or 'ancestor' ideas in some current transformative therapies (including those from non-western psychologies) and some modern foci on cultural influences on metatheories (e.g. Stolorow & Atwood, 1979), appears further to suggest the possibility of a common understanding of the unconscious, which could impact on our construction of outcome goals in various psychotherapies well into the future.

Another important issue in transformative therapy, which by definition purports to be 'long-term', allowing for unspecified lengths of analyses that could last for much of a person's life-span, is whether the unconscious can ever fully be explored and made conscious. And how would this impact on our constructs of mental health and our formulation of outcome goals? Is a goal of 'mental health' merely 'illusory'? (Shedler, Mayman & Manis, 1993.)

Stein says that for Jungians, while "certain contents, such as thoughts, feelings, fantasies and images, do pass over from the unconscious into ego-consciousness [,---] the unconscious per se continues to exist as a dynamic factor and source of new contents no matter how conscious an individual may become of such contents. Coming to terms with the unconscious [---] means establishing a more vital and aware relationship between two enduring components of the mind, the unconscious and ego-consciousness" (1984, pp. 35-36). This view appears to support a goal of 'liberation', in that such a relationship, if less conflicted or determined because of increased understanding, should increase the individual's choices in action and being.

Jung's concept of a dynamic and enduring unconscious with its impact on the way outcome goals are formulated, appears to resonate with ideas in other orientations: According to Kohut (from the Self psychological perspective, 1971), basic [unconscious] narcissistic needs, for instance, remain throughout life in various forms despite our gaining consciousness and being able to meet some of them and the continually renewed goal of therapy would thus have to include the continued exploration of the unconscious. In narrative psychotherapy as in various forms of hypnotherapy and Gestalt therapy, an attempt is also made to accept the 'dasein' (or inevitable existence) of the past which has become conscious, and simultaneously to create a different life-outcome which can be experienced parallel to what remains or becomes newly created in the unconscious (Orne, Dinges & Bloom, 1995; Wong, 1995; Altshuler, 1995). Similarly, object-relational concepts like 'introjects' (aspects of significant others which are assimilated to become part of the individual's experience of self, and thus part of what organises his/her conduct) imply an enduring unconscious dynamic despite growing consciousness of what had been unconscious: new relationships result in new introjects, which may again later become conscious (Bott Spillius, 1994).

While some existential-humanist therapists appear to deny the existence of the traditional form of an unconscious as a source of motivation for current actions (Altshuler, 1995), the very act of making analytic links between foreground and background memories of a client suggests that present and past can exist concurrently in a client's experience, even when one is not always in the focus of his/her awareness. This type of linking would have to be included in the formulation of a generalisable outcome goal from the interviews.

2.4 CONCEPTS OF PATHOLOGY AND HEALTH, AND THE GOAL(S) OF TRANSFORMATIVE THERAPY

2.4.1 THE TERM *THERAPY*

The term (psycho-)therapy (from Gr *therapeuó* = cure) contains the construct opposites of pathology (what needs to be cured) and an ideal of a person in health, or 'wholeness' (Old Eng *haêlt).* The goals of transformative therapy accordingly could include attempts to rectify, fix or heal that which was broken (fragmented), supply that which was missing (such as general organising experiences or specific symptom-related skills, like impulse-control), or coordinate that which was already present and undamaged to function more effectively as a whole/more holistically. Orlinsky and Howard (1986, p.447) define psychotherapy as "a solicited and intentional intervention by one type of person acting as a socially recognized 'therapist', to help, repair, or otherwise beneficially influence the psychological affairs and well-being of another type of person who is identified as a 'patient'".

What brings a person to therapy, according to some perspectives is "his personal immaturity. Basically, he wants to be a child and uses infantile techniques to attain a mixture of infantile and adult goals. His dilemma is that he as well as society finds his immaturity and his stratagems unacceptable; he deceives himself, and yet he is often outraged by his dimly perceived childishness" (Strupp, Fox & Lessler, 1969, pp. 2-3). The 'repair' or 'beneficial influence' of transformative therapy accordingly needs to be focused on correcting the causes of the maintenance of this 'immaturity' in such a way that the client is able to evolve and execute adaptive and socially acceptable 'stratagems' from a 'healthy' (or 'more mature') self state. Such a state can be reached only after an experiential level of self-knowledge has been obtained within the milieu of hope created in the therapy for the facility of better functioning in future. The issue of difference in observed presentation of the client at the start and termination of therapy, is also investigated in the interviews (e.g. prompts 2.3 and 2.4, Addendum A).

Another view of healing holds that defenses should be respected (rather than 'corrected') as part of an attempt to survive, i.e., to remain as healthy as possible within a disempowered state. Thus, in transformative therapy "patients attempt to proceed towards their own goals [--- which] are related to strengthening the basic structure of the self and it regulatory capabilities and to mounting an effort to resume interrupted and thwarted self development" (Brandchaft, 1988, pp. 91-92). The implied task required to achieve this outcome is therefore to create a setting wherein clients may feel less disempowered, less threatened. In the interviews this area was covered by questions such as "What do you do (in the room) to facilitate transformation (etc.)?" (prompt 2.2, Addendum A).

2.4.2 PROBLEMS IN DEFINING *PATHOLOGY* AND *HEALTH* IN TRANSFORMATIVE PSYCHOTHERAPIES

It is generally acknowledged in modern transformative psychotherapy that the therapist cannot be *tabula rasa* and that his/her beliefs about what constitutes psychological health will inevitably influence the process and outcome of the therapy (Atwood & Stolorow, 1984; Karasu, 1995). There can be no therapy (in the sense of a healing endeavour) without goals, whether overt or implicit. There have even been assessment tools created that delineate *general* views of pathological (vs. healthy) emotional behaviours, such as the Fundamental Repetitive and Maladaptive Emotion Structures (FRAMES) program (Dahl & Teller, 1993).

A differentiation exists with regard to the constructs of pathology and health that is similar to that between aims and goals as delineated earlier (p. 9). Pathology can be circumscribed in terms of specific symptoms or states of being, such as "excessive anxiety or crippling defensiveness" (the targets of shorter, directive interventions in some sessions), or it can be circumscribed in terms of Self states, such as disjunction between what is distortedly mirrored by ego-consciousness and the underlying Self (Stein, 1984, p.38).

Similarly, health can be described in terms of absence of specific pathological ways of functioning, such as freedom from excessive anxiety or from addictive defenses, or in terms of a general Self state – "a psychic state in which [the] patient begins to

experiment with his own nature – a state of fluidity, change, and growth, where nothing is eternally fixed and petrified" (Jung, 1966, p. 46, quoted in Stein, 1984, p. 38).

Apart from the question of whether agreement can be reached among transformational (western) psychotherapists about what constitutes mental health – whether it is indeed a 'fluidity' as described above – there also appears to be dispute about how to *measure* or ascertain whether someone is 'healthy enough' either not to need this kind of therapy, or to qualify a prior therapy as 'successful'/'effective'. In other words, to what concept of mental health is transformative psychotherapy pointed, and how can one measure *post hoc* that the client has reached this goal? Further, according to what indicators during the journey of the long therapy, can the therapist conclude that his/her intervention is on course to reach the outcome?

Shedler, Mayman and Manis (1993) have concluded that many formal scales according to which mental health is premised to be measured give false results and that the clinician's own judgements are far more accurate. But the clinician presumably bases his/her judgement of an individual's health against some normative understanding of mental health, whether seen as an absence of overt or 'unconscious' pathology, or as some ideal of a healthy state which allows for adequate growth and strengthening in most circumstances. It is the aim of this investigation to ascertain both whether a generalised outcome goal construct can be formulated based on the clinical judgement of transformative psychotherapists generally considered (e.g. by their peers) as effective in their fields of work, and what - if any – the signs are that they consider to be indicative of future positive outcome in a long therapy.

A determination of the goals and signs in this research would be a necessary prerequisite for further important work that begs to be done in related fields, for instance, to answer the question whether such 'western', and perhaps 'individualistic' (Guisinger & Blatt, 1994) psychological orientations are useful and valid in a broader context, such as in the broader South African population.

2.4.3 WHO DEFINES MENTAL HEALTH/OUTCOMES?

Before the paradigmatic shift in much of the western philosophical ideation after Einstein's introduction of the relativity principles at the start of the twentieth century, the trained scientist was regarded as the chief arbiter of health in any form (Zukav, 1979). From shaman or king the power was simply transferred to the scientist, specifically here, the analyst/therapist. Each in his/her time was thought to be representative not only of existing societal opinion and values but also of what it *should be*, according to some special/specialised knowledge.

The shift in twentieth century western psychology from constructs of an 'all-knowing' therapist and the 'faulted' patient, to a focus on the patient's own experience and judgement (Loewald, 1960), raises the question of who decides what is healthy and what is ill, and makes it essential to incorporate societal and individual outcome goals into our planned interventions. On the other hand, we must consider whether the client's judgement of a desired outcome in therapy can be trusted in those times when impaired judgement is pathognomic of his/her state of dis-ease? Or whether a 'diseased society' (as judged by internal and international critics) can be considered fairly able to prescribe the characteristics of a healthy mind?

Eriksen (1968, quoted in Strupp, Fox & Lessler, 1969, Preface) suggests that psychoanalysts, after listening to life histories for the greater part of a century, have concluded "an 'unofficial' image of the strengths inherent in the individual life cycle and in the sequence of generations" and that the loss of symptoms is but a result of an increase in the strength and resilience of the client's ability to focus on "pursuits which are somehow right, whether it is in love or in work, in home life, friendship, or citizenship". The implication is that initially the therapist, but later also the client, knows what is 'somehow right'. The concept of healthy outcomes as identified by the therapist is tested in the interviews by, for instance prompt 4.1 ("What observations in your practice would you identify as 'proof' that psychotherapy is useful and effective?", Addendum A).

De Moor (1980, p. 116) suggests that every client be approached in "a personalistic way" which will allow, within the "framework of a comprehensive restructuring of the

personality as a whole" for the setting of goals in different areas, like interpersonal relations, relation-to-self, work and living effectiveness and even symptom removal. This does not mean, however, that the client is co-creator of the outcome construct of health but rather just the co-determinant of which issues need to be dealt with in a certain period of therapy.

In this regard it seems that *pathology* is generally defined in terms of a client's own degree of (dis-)satisfaction with his/her (emotional) condition (for instance the degree of his/her 'neediness') – and this condition is highly dependent on the degree of his/her satisfaction with relationships, with 'selfobjects', 'significant others', 'aspects of the Self' (according to various developmental perspectives). It is part of the therapeutic task to help the client find the reason(s) for the perceived relational failures that breed his/her current emotional distress, so as to facilitate agency and autonomy. This might mean going beyond the client's definition of pathology (e.g. expressed in such terms as 'not hard-working enough') to a different one held by the therapist because of his/her understanding of the genesis and effects of defensive structures or because of his/her psychological orientation (e.g. the client's words reinterpreted as 'not enough in touch with the self's need to rest')

From the operationalisation of pathology and health as evidenced in tests and inventories generally used in psychology, it is obvious that some external value judgement is in place in the therapy situation, not just the patient's own formulation of his/her problems, as seen in scales such as Eysenck's Dimensions of Personality list or the Minnesota Multiphasic Personality Inventory (MMPI-2) (Aiken, 1994/1976).

Patients who are considered to have undergone transformation because of their therapies themselves echo and identify therapists' stated outcomes of, for instance autonomy in their evaluations of their therapies in terms like "an increased sense of mastery" not only of symptoms, but also in many areas of living, and "the achievement of conscious control over impulses, symptoms, and neurotic trends" (Strupp, Fox & Lessler, 1969, p. 14).

While some theorists may wish to see greater democracy in the setting of outcome goals, the defining of mental health and a greater participation in selecting and

controlling the process (e.g. Masson, 1989/1993), there appears to be sufficient evidence that clients, in 'health', generally agree with the outcomes set by therapists. And there is no doubt that, according to the present APA guidelines (O'Brien, Woody & Mercer, 1995), the decision about outcome is above all the responsibility of the therapist, which includes his/her cognisance of the needs, mores and demands of the client's society, whether they are considered fair or not.

2.4.4 DESCRIPTIONS OF MENTAL HEALTH AND PATHOLOGY

Since the beginning of our knowledge of theories about mental health, usually as an integrated state with physical health, ideals of health - and by implication therefore outcome goals - have been centred around concepts of wholeness, equilibrium, balance[5] (from constructs like 'temperament', and 'health'/['gesond'/'heling'] in the comprehensive new lexicon, *Woordeboek van die Afrikaanse Taal;* see also Bergler, 1956). These concepts are also found in the circumscription of goals of psychoanalysis/ transformative therapy.

Among tribal communities psychopathology is usually described in terms of a loss of soul: "He is unable to take part in his society, its rituals, and traditions. They are dead to him, he to them. His connection to family, totem, nation, is gone. Until he regains his soul he is not a true human. He is 'not there'. It is as if he had never been initiated, been given a name, come into real being. [---] Without his soul, *he has lost the sense of belonging and the sense of being in communion* with the powers and the gods. [---] Yet he is not sick with disease, nor is he out of his mind. He has simply lost his soul." (Hillman, in Moore, 1990, pp.17-18, italics mine.) Mental health is thus suggested to be a state of unity, with persons and nature around, as well as with the past and future 'history' of the culture.

Is there a consensus in the literature among transformational therapists about what constitutes mental health?

[5] While the holistic view has been recognisable since antiquity in eastern and tribal communities (Jung, 1958), it is beyond the scope of this dissertation about a prevailingly western, post-19th century form of psychological healing to review these.

For some theorists mental health is represented by the term 'maturity', in the sense of a mastering of childish/immature impulses, behaviours and defenses. Strupp, Fox and Lessler (1969, p. 4) define the therapist's task as facilitating growth from "the devious, self-defeating ('neurotic') tendencies" to a 'mature' state evident in "strength, tolerance of frustration, and the toughness that grows out of the realization that infantile wishes and goals cannot be fulfilled". They believe that such 'growth' occurs when the patient is led to confront his/her resistances/defenses and overcome them – the actual goal of therapy. They see symptoms as "a manifestation of a faulty approach to the solution of life's problems [;---] once the patient has achieved greater *maturity and autonomy* his symptoms will diminish or disappear" (italics mine). Such terms were tested in the interviews, so as to more finely construct the connotations of, for instance, 'maturity'.

In 1978 Kohut and Wolf defined the goal of therapy as "the rehabilitation of the defective and weakened structures of the self" (Wolf, 1988, p. 144), which harmonises with the understanding of 'therapy' and 'health' reflected at the start of this section (see 2.4.1). Those 'defective and weakened structures' appear to be what constitutes pathology, and suggest that there is some generalisable construct of a 'strong and healthy' Self. Such a Self would be 'without defect', a construct which carries the meanings of both 'not damaged' and 'properly grown/matured/cohesed'[6] because of the presence of all the necessary 'ingredients' for such growth. Stolorow and Lachman (1980) point out that, while a 'cohesed' and strong self structure is generally the desired outcome, even within Self psychology opinions are divided as to how the defective structures can be repaired (made whole): Kohut and his followers tend to focus in their work on the provision of what was lacking in a client's development, whereas Kernberg tends to focus on the removal of what was hampering, inhibiting or damaging (Wolf, 1984). Thus the therapeutic *task* could be different even if the goals are the same.

[6] There is a semantic difference between the adjectives 'cohesive' which implies ongoing function, and not necessarily pertaining just to the primary subject, and 'cohesed' which appears to indicate an end-result or end-state of a particular subject, for instance after therapy, congruent with this study of outcomes. This last term has been in use primarily in works of modern Self psychologists, and will be used here accordingly.

Winnicott (1960) adds to our understanding of a defective Self, the idea of an apparently cohesive Self, but one that is *false*. This then suggests a qualification of the 'healthy Self' construct of one that is true or authentic for a specific person, but also implies that health is dependent on equilibrium between the needs of the individual and the needs of his/her society.

Do these indications of construct opposites of pathology and health imply that there is some kind of generally applicable (perhaps Platonic) 'Ideal Self', one which could be achieved through 'optimal' development or after 'corrective' therapy? Stolorow and Atwood (1992, pp. 14-17) warn against the conclusion of an 'isolated mind' concept and hold that there is no such thing as a mature ego which is '"autonomous' and 'immune' from impacts of the environment" or "a self with an 'inherent design"'.

What appears to be generally acknowledged from different perspectives is that there are at least two main processes involved in the growth of the psyche, an inward exploration into the self, with resultant 'unification', and an outward exploration into the world of human and non-human others, with which the self then also becomes 'unified' (Munoz, Hollon, McGrath, Rehm, VandenBos, 1994). The second process is sometimes neglected in the focus of transformational therapies, except in how it impacts on the first, as is demonstrated by Guisinger and Blatt's (1994) summary of this century's (western) psychological '-isms':

Typical of psychologies that currently dominate Western thought are: romantic individualism - in which humans are posed to be inherently good unless corrupted by society; individuals would thus naturally develop into moral, healthy and mature persons through their desire for mastery (e.g., Hall, Dewey, Rogers, Piaget); egoistic individualism - in which people are seen as fundamentally selfish, egocentric and aggressive so that these qualities need to be suppressed by 'civilisation' (e.g., Freud); ideological individualism - in which social hierarchy (represented by social institutions) is deemed an obstacle between the individual and the truth (e.g., Kohlberg); and alienated individualism - in which the intellectual assumes responsibility for the repudiation of invalid, ephemeral social institutions, and thus inevitably is alienated from society (e.g., May, Perls, Laing). The individual is not seen as 'integral' to his/her social world; not enough attention is focussed on the

feeling of belonging to a group as giving purpose and direction in life. Instead, society is seen as either a corrupting influence or as a means of 'civilising' our 'asocial' nature (Guisinger & Blatt, 1994, referring to classification as per Hogan, 1975.)

While not a focus in this dissertation, the applicability of transformative psychotherapy in its present (individualistic) forms to the broader (non-western) South African community was also tested in the interviews (e.g. prompts 3.4 and 4.1.1, Addendum A) – although many participants preferred not to voice their views/expand on them in this area, which will hopefully be investigated more thoroughly in future research.

Developmental theories have been revised from various schools of psychology to emphasise relatedness in addition to individuality (e.g., Bowlby, Guntrip, Fairburn, Winnicott, Bowen, Miller). Such fields as object-relations, family systems and feminist psychology have grown popular. In non-western cultures the self versus non-self boundaries are not sharply drawn - therefore self can be defined in terms of combinations, like self-other, self-nature, self-social structure, self-God(s).
Thus the 'pathologies' defined in western psychology (alienation, narcissism, terrifying isolation, joyless consumption, violence, devaluation of women and minorities) are thought to be the result of individualistic values, and the 'cure' then lies in re-socialisation: Accordingly, the therapist's task appears also to become an intermediary relational object who can model 'safe' relational parameters and socially effective modes of communication, until s/he can be replaced by others in the client's social milieu.

2.4.5 CONSTRUCTS OF THE GOAL(S) OF TRANSFORMATIVE THERAPIES

It is noteworthy that even for the early unfragmented cultures the cure for a pathological state was not in the removal of symptoms, as the symptoms are interpreted as signs of a soul that is just beginning to show, "at first tortured and crying for help, comfort, and love, but which is the soul in the neurosis trying to make itself heard, trying to impress the stupid and stubborn mind - that important mule which insists on going its unchanging obstinate way. The right reaction to a symptom

may well be a welcoming rather than laments and demands for remedies, for the symptom is the first herald of an awakening psyche that will not tolerate any more abuse. Through the symptom the psyche demands attention. Attention means attending to, tending, a certain tender care of, as well as waiting, pausing, listening. It takes a span of time and a tension of patience." (Hillman in Moore, 1990, pp. 18-19.)

The previous paragraph, while reported from a Jungian perspective, seems to summarise much of contemporary description of aspects of many transformational therapies, specifically the shift in focus from 'symptom change/management' often found in shorter-term, directive therapies, to a 'listening perspective' (Hedges, 1991/1983) that allows for a exploration and greater understanding of the self in interaction with its world. Are these goal formulations traceable in the development of formal western transformational psychology since its beginnings at the end of the nineteenth century?

For Freud the process of analysis had as its primary goal the removal of unconscious barriers to health (the so-called amnesias of childhood) in order that the client might be liberated to *work* and to *love* effectively (Karasu, 1995). Later analysts added further constructs that inferred health: Colarusso (1993) and Winnicott (1968) emphasise the freedom to *play*. Kennedy (1993) focuses on the freedom to *relate*, Baltner (1983) on the ability to *perform* viably and competently, and Buchholz and Mishne (1983, summarising Self psychology views) on the ability to perform *age-appropriate life tasks*, as well as the capacities for *sublimation, pleasure, healthy object relations* and *healthy community relations*.

Fischer (1994) holds that our growing appreciation of the complexities of the psychoanalytic process has resulted in an ever-expanding list of outcomes, including those mentioned above, and, for instance, the creation of a more integrated life narrative, the promotion of self-analytical functioning, and 'transmuting internalisation'. Kelly (1996, p.55) describes a positive (healthy) outcome as one in which the client has gained "the propensity to engage in interpretive understanding" by becoming open to "unfamiliar understandings" of his/her self/person.

Are all of these part of what constitutes the necessary and inevitable goal of transformative psychotherapy? The question is further whether the qualities listed above are, in fact not the *goal* but generalised *signs* of health, or, for that matter, signs that a liberating transformation has occurred, for instance after psychotherapeutic intervention. These issues are one of the foci of the construct analysis in Chapter Four.

The term 'transformation' implies a change in Self state: Is that the goal of therapy or the result of other goals being achieved (such as the facilitation of the ability to trust, because of 'unconditional positive regard', Rogers, 1965)? In either case, how is a successful transformation conceptualised? If the main aim of a therapy is, for instance, to resolve intrapsychic conflicts (like the Oedipal conflict) as many still hold (Malan, 1979; Hoglend and Heyerdahl, 1994), the *goal* would surely be some transformation to a state of being as a *result* of such resolution.

Gendlin (1980) stresses the importance for the patient to find a place to be heard, and where what is not said can also be heard. This focus on the exploration of the unconscious and the un-said or un-heard resonates with Ivey's (1999) conceptualisation of the main therapeutic task as providing a space where the unthought and unthinkable can be expressed, so as to achieve the *goal of liberation* from inhibiting thoughts and events.

Guisinger and Blatt (1994) propose a 'dialectical model' to account for the development of interpersonal relatedness and self-definition. They point out that "it is apparent [---] that an increasingly differentiated, integrated, and mature sense of self is contingent on establishing satisfying interpersonal relationships; conversely, the development of pure relationships is contingent on the development of mature self-identity" (p.104, Abs.). The development of integrated self and self-in-community is thus interrelated from birth.

The implications for therapy are then that if the 'satisfying personal relationships' (also in the context of needs, e.g., for love, empathy, protection, being satisfied) are lacking, the mature sense of self will not develop, thus preventing further satisfying relationships and leading to the isolation that feeds further on lack, resulting in

feelings of insurmountable alienation. This brings in evolutionary terms an end to the social-genetic[7] influence of such persons through elements like increased stress, increased proneness to disease, lack of creativity and power. Thus the primary 're-parenting'[8] role of many modern therapists is a genetic and social necessity for any further 'growth' of self to take place (and thus also the necessity of a prerequisite of 'adequate ego strength' for less supportive analytic therapies: if there is only self, and that self is revealed as personally 'ugly' without compensatory union or acceptance, then annihilation/fragmentation is indeed a danger).

Lakin (1988, p. 54) poses the question: "How do people attain a degree of individual autonomy that also takes account of needs for community and mutual obligation?" He then identifies 'alienation' and 'spiritual malaise' as the definitive disturbances of the late twentieth century, and suggests that "goals of independence, emotional self-control, adaptability, and personal productivity may be weighed against goals of cooperativeness and commitment to the welfare of others, to the larger purposes of the community."

According to Guisinger and Blatt's model the constructs of *healing* and *health* would include the capacity for mutuality and intimacy, and generativity. "The sense of self-worth and pride that emerges during the pre-adolescent phases of the development of individuality now allows the individual to feel that he or she has something to offer and share with others [i.e., s/he is wanted/desired ---]. Generativity involves a concern for extending beyond one's own self-interest and dedicating oneself to goals, values and principles, the teaching of another generation, and mentoring." (Guisinger & Blatt, 1994, p.108.) They suggest that the predominant Western twentieth century 'ideal' of 'self-contained individualism' is incomplete and narrow, and that the goals of therapy should encompass both individualist and societal needs. This might prove to be an essential outcome that would make western psychotherapy acceptable to the broader South African community as well.[9]

[7] In the sense of positive contribution to the development of the greater society in terms of maturisation.

[8] Used here in the object-relational sense of being a 'good-enough' relational other or selfobject that can act, as a good-enough parent would have done, in welcoming and inviting the individual into his/her social milieu.

[9] In South African context there is a repeated cry in the media for the recognition of the tribal tradition of 'ubuntu' – translated loosely as 'humble respect for the other' – in the community: healing of the

Whether from personal or societal discomfort, the question is further how pathology comes into being, and becomes so fixed that it needs 'transformation' over a long period of time to resolve: the cause may well determine the 'cure'.

Rice (1992, p. 13) notes the importance of "enduring constructions" or "schemas"[10] in guiding healthy or disturbed functioning: For anyone some classes of experience have been inadequately processed; when these amount to a number of the classes important to our development, it leads to "maladaptive and unsatisfying experiences in various classes of situations", which result in an individual's discomfort with his/her present level of functioning and thus become part of what creates the (hidden?) goals of therapy, idiosyncratic to each individual.

Fonagy, Moran, Edgcumbe, Kennedy and Target (1993) use the term "mental representations" in a similar context as 'schemas' (above) and see the goals of therapy as the assimilation of primitive mental representations into "higher-order mental organizations": "Through enhancement of the integrity of mental organizations, elaboration of their connections with other systems, and the creation of new representations of both internal and external states, the representational system is restructured. This takes place in such a way that previously isolated, unintegrated, incompatible representations cease to be pathogens. [---] The representational model assumes that therapeutic action comprises *the harmonization of mental representations through interpretation, and through the patient's natural capacity to achieve increasingly sophisticated constructions concerning experience*" (p. 22, italics mine).

Kohut (1977) has a similar concept of how the 'restructuring' goal can be achieved: "The essential structural transformations produced by working through do not take place, however, in consequence of such supportive intellectual insights, but in consequence of the gradual internalizations that are brought about by the fact that the old experiences are repeatedly relived by the more mature psyche." (P. 30.) The goal

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community can only come through the practice of 'ubuntu' (per *South African multi-language dictionary and phrase book,* 1991)

of the restructuring of the Self by "increasing the cohension and wholeness of the self through transmuting internalization" had gained general acceptance in Self psychology by the end of the eighties (Wolf, 1988, p. 103). Accordingly, the experience of repeating early traumata in the present relationship without the traumatic outcomes, allows for the client to "continue to become stronger and therefore less reactive, that is, less disrupted" by current selfobject failures (Wolf, 1988, p. 104). Bacal (1985) emphasis the necessity of creating "confidence in the possibility of a 'good-enough' selfobject" to provide "an optimal experience [---] in which self defect or faulty self structure is repaired and *new self structure can be built*" (p. 216, italics mine).

Henry, Strupp and Schacht (1990) emphasise the importance of the "affiliative therapeutic relationship" in the healing process, and show how this has been a cohesing factor between various psychotherapeutic orientations. They propose that health can always be attributed to positive introjects, and pathological functioning to pathological introjects, and that these "introject states [---] become self-perpetuating through the dynamics of interpersonal complementarity" and are "subject to development and change across the lifespan". They hold that "individuals who are psychologically healthy, by definition, evidence introjects that are relatively friendly (self-accepting, self-nuturing, self-helping) most of the time. Emotionally disturbed persons, in contrast, tend to have hostile introjects that are recurrently self-critical, self-destructive, or self-neglectful." Outcome thus defined in terms of introjects, implies that the relative health of the therapist in the interaction with the client, within an enduring relationship, is the underlying goal of transformative therapy (pp. 768-769) – a theory that appears to validate the vast amount of work done in the area of therapist characteristics by researchers like Truax and Carkhuff decades earlier (e.g., 1967).

These issues are examined in the interviews through prompts 2.1 and 2.4.1 (Addendum A).

[10] It is noteworthy that this construction exists also in the cognitive-behavioural therapies when there is talk of a need for the 'restructuring' of the personality, as demonstrated in various works by Jeff Young.

If we accept a general trend in constructs of healthy outcome or goals of therapy to include the capacity for healthy interpersonal relationships and an openness to their dialogical re-construction of our Self, as is suggested by all the foregoing references, how do we then know that a therapy has been successful, or that our outcome goal of an adaptive and 'cohesed' Self has been achieved? For this we need to look at how the strong and healthy Self is constructed in terms of *signs* of healthy structure and functioning.

2.5 SIGNS OF HEALTHY STRUCTURE AND FUNCTIONING

It is impossible in the space available to give a comprehensive account of the historical evolution of the construct(s) of health, but an attempt will be made to review the beliefs of a few key theorists in psychotherapy research. It is useful to keep in mind how much our theories and values are artefacts of our tempero-cultural connections (Stolorow & Atwood, 1979), when we review how some of the foremost theorists in the field of psychotherapy and counselling construct the idea of a psychologically healthy person. It would be interesting, heuristically, to see to what degree modern practitioners of transformative psychotherapy subscribe to traditional definitions of health, and whether the constructs around psychological health have undergone noticeable evolution, although such a focus is beyond the scope of this minor dissertation.

Rogers (1940) holds that the word 'therapy' implies client dissatisfaction with his/her present level of 'adjustment' and some 'fundamental need of help'. He then qualifies the type of help given, so that the following signs of successful therapy may be achieved: decrease of psychic tension after emotional catharsis (of present as well as past events), recognition and acceptance by the client of his/her spontaneous or 'real' self at an emotional level, ability of the client to take responsibility for his/her choices and to identify and challenge barriers to his/her independence, increased causal insight at emotional level of experience, survival of defeats and discouragements, and resultant continued growth towards independence.

Truax and Carkhuff (1967, p. 335) state the outcome of therapy for the client to be "a more authentic, genuine and congruent person", and that this outcome is represented by the qualities already existing in the therapist. They list the following eighteen[11] characteristics of what they judge to be the 'whole' (as in our definition of health) person[12]: (1 and 18) S/he is in tune with and acts on the basis of internal consistency on the basis of his/her integrity. S/he does not fear the destruction of his/her inner being and therefore does not flinch from new ventures or societal limitations, while understanding and respecting social systems. (2) S/he is committed to honesty and creativity as a way of life. (3, 11 and 12) S/he lives life with an intensity of affect, well-defined boundaries and deep insights, and can be "full with [her-/]himself *when alone*". (4) S/he is able to discriminate, select, and act on decisions reached. (5) S/he does everything "fully and well" and (6) "functions at a high energy level". (7 and 13) S/he can accept that "a full relationship, free of neurotic drainage, is only possible among whole people", accepts the consequences of "functioning a step ahead or above most of those with whom [s/]he comes in contact" and (8) that all relationships are dynamic, always either growing or deteriorating. (9) S/he has insight into how people respond contradictory to their intention, out of fear. (10) S/he does not cling to past draining associations. (14 and 15) S/he leads others to find fulfilment without playing societal games. (16 and 17) S/he avoids societal 'traps' that could render him/her impotent. (1967, pp. 198-219, italics theirs.)

Some specific signs of healthy functioning, up to 25 years post-treatment, reviewed by Truax and Carkhuff (1967) include increased grade-point averages compared to the general population, and a greater contribution to society (measured by scales).

Wallerstein (1968/1994) in his 40-year review of psychotherapy research circumscribes a list of 'psychological capacities' from which the following signs of health (and of a desired outcome of therapy), vs. those of pathology, may be inferred: *Hope* (vs. excessive optimism/pessimism); *Zest for life* (vs. overexcitement, drudgery or apathy); *Attribution of responsibility* (vs. overexternalizing or overinternalizing); *Flexibility* (vs. closed-mindedness, or confusion and self-doubt); *Persistence* (vs. 'driveness' or giving up); *Commitment to standards and values* (vs. moralism or

[11] Grouped here, because their lengthy list appears to have some tautology.
[12] Or, in fact as they intended, the 'ideal' therapist/ counsellor as a whole person.

absence of principles); *Commitment in relationships* (vs. compulsive overinvolvement or limited, tenuous commitment); *Reciprocity* (vs. exploitation of others or surrender of self); *Trust* (vs. extreme suspiciousness or gullibility); *Empathy* (vs. emotional absorption, emotional blunting or egocentricity); *Affect regulation* (vs. out-of-control affect storms or hypercontrol); *Impulse regulation* (vs. overindulgence or overinhibition); *Regulation of sexual experience* (vs. impulsive or driven expression, or inhibition); *Self-assertion* (vs. bullying or timidity); *Reliance on self and others* (vs. rarely able to rely on self or others, or to be relied upon); *Self-esteem* (vs. grandiosity or self-depreciation); *Self-coherence* (vs. inconsistency).

Scales such as Eysenck's Dimensions of Personality list under the 'neurotic' (or emotionally unstable) qualities such concepts as moody, anxious, rigid, sober, pessimistic or optimistic, reserved, quiet, restless, excitable, impulsive, active. Under the 'emotionally stable' qualities - i.e., the implied outcome goals of therapeutic intervention - concepts like passive or lively, sociable, thoughtful, peaceful, even-tempered, calm, outgoing, easygoing, carefree, responsive, are listed. (Aiken, 1994/1976, p. 251). Similarly, many constructs of pathology (with implied opposites of signs of health) are operationalised in the Minnesota Multiphasic Personality Inventory (MMPI-2) scale, e.g., hypochondriasis, depression, anxiety, fears, obsessiveness, anger, cynicism, familial discord, emotional alienation, amorality, authority problems, naivete, need for affection. (Aiken, 1994/1976, p. 302).

Clients themselves describe their positive outcomes in such constructs as "greater autonomy". A patient, for instance, accounts for rating her therapy as successful in terms of being able to experience (appropriately) "joy beyond words", being at peace with him/herself, able to relax and not be perfectionistic to compensate for internal feelings of failure, discovering creative abilities, becoming assertive but less concerned about approval from others and popularity, taking each day as it comes and deriving satisfaction from little things (Strupp, Fox, Lessler, 1969, p. 21) - a convincing testimony indeed!

A graph comparing presenting problems and changes noted at the end of therapy of at least 25 sessions per patient with a fairly large sample (131 returned surveys) measured 12 months after entering therapy at an outpatient clinic, reveals the

following data (Strupp, Fox, & Lessler, 1969, p. 65): The most common presenting problems (often multiple problems were listed) were generalised anxiety (about 50%), physical symptoms, loss of interest or feeling overwhelmed, depression or suicide attempts (about 30% each) and negative self-evaluation (about 20%). The most significant positive changes were in interpersonal difficulties (e.g. being able to love significant others, like family, without reservation, to be assertive and to experience and accept own feelings without guilt or shame, less aggression, less shy) and self-evaluation (less hostile, improved interpersonal relations, less self-critical, able to weather crises, feeling attractive and able to achieve) - both about 60%; loss of interest/overwhelmed (able to make decisions, less futility, enjoys some experiences) over 30%; and anxiety, poor judgement/reality testing (accepting difference between reality and ideal, less escapism, trusting decisions) and general (less depression, not feeling alone, understanding reactions and fears) - both about 20%. Interesting features are that little change occurred in physical symptoms (about 5%) whereas no patient had listed problems of poor judgement or reality testing initially despite the 20% improvement noted later. This could be an indicator of the effectiveness of therapy in overcoming defenses related to the fear of 'being wrong' or imperfect.

In terms of the goal of positive introjection mentioned in the previous section (see 2.4), signs of healthy functioning would include such behaviours as being self-accepting, self-nurturing and self-helping rather than self-critical, self-destructive or self-neglectful. Associated emotional and interpersonal behaviours would include signs of sadness, shame, or boredom, and 'maladaptive relationship patterns' which are the cause of symptoms (Henry, Strupp & Schacht, 1990). They propose a three-tier model (with foci on Other, Self, and Introject, p. 770) that demonstrates construct continua from pathology to health in various areas, like: freeing and forgetting – watching and managing; attacking and rejecting – nurturing and comforting; ignoring and neglecting – affirming and understanding; belittling and blaming – helping and protecting; sulking and appeasing – self-protecting and enhancing; walling off and avoiding – disclosing and expressing; asserting and separating – deferring and submitting; protesting and recoiling – approaching and enjoying; self-indicting and oppressing – self-protecting and enhancing; daydreaming and neglecting self – self-accepting and exploring; self-rejecting and destroying – self-nourishment and cherishing; spontaneous self – self-monitoring and restraining.

Wolf (1988, p. 114) summarises the signs of healing under two concepts, resulting from the cohesion and strengthening of the Self, "(1) a sense of being understood by the other and (2) a sense of one's own efficacy regarding the other". These suggest outcomes of (1) finding meaning and acceptance/connectedness and (2) empowerment (including autonomy) – a summary that seems applicable to many of the lists of signs of healing/health.

Prompts 2.3, 2.4, 2.4.1, 4.1 and 6.1.5 in the interviews allow for the exploration of signs of healthy functioning as constructed by the participants (Addendum A).

2.6 CURRENT TRENDS: MOTIVATION FOR THIS RESEARCH

"One of the central problems of a comparative psychoanalysis resides in the fact that from any one of the psychoanalytic perspectives the theories of any other framework are viewed as inevitably flawed" (Ornstein, 1995, p. 49). Can common ground be found among different orientations for the process of transformative/reconstructive psychotherapy?

In this regard learning theory has contributed to our understanding of processes involved in psychic change by isolating specific parameters that can hopefully be applied to conclusions reached through repeated observations of individuals in psychodynamic therapies (Rachman & Wilson, 1980; Carkhuff & Berenson, 1967).

A possible problem in defining clearly the process of transformative therapies may have been the tendency to focus on the templated process goals (e.g., identification and resolution of oedipal conflict) to assess 'effectiveness' rather than on outcome goals. Thus new techniques from other orientations which could perhaps have benefited the patients, were usually treated with suspicion (Bader, 1994). Further, therapy 'failures' were often attributed to such factors as patient non-compliance, resistance, or unsuitability, rather than to insufficiencies of the therapeutic method (Bader, 1994).

One result of such short-sightedness is the emergence of what appears to be replications of discarded methods and concepts in different orientations through the necessity of each genre evolving its own 'new' type to accommodate new findings of effectiveness (such as the evolution of Object-Relational and Self psychology in the analytic sphere). Can the older forms of various psychotherapies still be tolerated ethically, without any recourse to external checks of the method (Bader, 1994)?

Even from within the ranks of the analytic orientation there is a call for clarification of goals (i.e., a determination of long-term and short-term outcomes) across a posed continuum of analytic therapies ranging from psychoanalysis proper to supportive therapy, but also an expressed hope that a clear delineation of boundaries between the analytic therapies will lead to mutual enrichment (Allison, 1994).

Ehrenberg (1992, p. 195) says: "Because each of the existing schools of psychoanalytic thought comprises a range of perspectives, *affinities often exist across orientations that may not exist within them* with regard to conceptions of what the specific implications for technique of those interactive considerations might be. [That which is healing in the psychoanalytic interaction whether or not it evolves from psychoanalytic technique] may be the basis for the common observation that there is often a discrepancy between how analysts work and how they think they work." (Italics mine.)

Indications are that psychotherapists from such diverse areas as psychoanalytic, humanistic-existential, behavioristic and bioenergetic orientations converge methodologically in their actual practice of psychotherapy, which generally appears to be 'eclectic' rather than 'pure' according to each tradition's guidelines (Tremblay & Pepin, 1986). And since outcome should inform method and process goals, it follows that a formulation of a generalisable outcome goal – if such a phenomenon does/can exist – would be useful in future attempts to increase the effectiveness of transformative psychotherapy.

Karasu (in Kaplan & Sadock, 1995), with reference to the work of Schafer, Chessick, D. Stern, and especially Pine, identifies the integration of previously diverse theoretical orientations and their practical applications as a major trend in current

'psychoanalytic' therapy. Accordingly, outcome goals would be determined in different phases of therapy with different patients, based on their specific developmental needs or 'deficits', determined by assessment measures such as Pine's 'matrix' of the dyadic deficit, dyadic conflict, triadic deficit and triadic conflict (Karasu, 1995; Pine, 1990). In the interviews prompts 2.1 and 5.1 to 5.2.2 were used to investigate this area (Addendum A).

Some current focus in process research appears to suggest the possibility of unification in such apparently diverse orientations as non-analytic and analytic therapies: An example is Kahn's (1996) conclusion that the Client-centered and Intersubjective (Self psychological) approaches to therapy are 'one at their core', spanning an apparent metapsychological schism of more than 40 years.

Modern developments in Self psychology, by focussing on need-based process goals even in micro-moments of each session, also allow for integration of both theoretical understanding and method, so as to facilitate meeting umbrella outcome goals like 'cohesion'. An example of such need-based focus is Lichtenberg's motivational systems theory (Lichtenberg, Lachman & Fosshage, 1992).

We also find need-based goals aimed at general transformation of the personality rather than specifically at symptom removal or management, in theories and psychotherapies of generalist psychologists and motivational speakers in the latter half of the twentieth century, for example John Gray's concept of developmental needs explained in lay terms of 'ten love tanks' that need to be 'filled' (1999).

All of these developments lead us to the question of what is happening practically in transformative psychotherapy by the last decade of the twentieth century: Has there been a dynamic movement away from the analytic constructs already in existence early in the century, or even before, in non-western psychologies, or has the wheel of development merely gained centrifugal momentum to have come a full circle, while perhaps embracing a broader area? How have the various orientations or schools of thought which developed in the course of the century, influenced our ideals of mental health? And what, in fact, are our outcome goals now in the long-term transformative psychotherapies?

Are such outcome goals generalisable? If they are, do practitioners agree on how we can assess the effectiveness of our therapies by determining which signs of improved/healthier functioning *should* be present after therapist and client have invested a great amount of time, money, and energy in the intervention? Another question is whether different phases of a long transformative therapy require different outcome goals for the therapy ultimately to be on track towards an effective restructuring/transformation of the client's personality/Self/ego.

It is hoped that in answering the most basic questions raised here, some groundwork may be laid for later research into comparative or integrative psychotherapies, which at last have begun gaining visibility in the literature, conferences and practices in the last decade of the twentieth century. It is also hoped that findings from this research may facilitate further research around the question of whether such (western) psychological practices can be considered valid within the broader South African community, given the often prohibitive costs involved: If goal needs inform method, as has been suggested by so many of the authors mentioned in this chapter, it seems imperative for a thorough identification of such goals so that they can be tested against the needs and developmental ideals of different communities represented in our country and in our health system.

CHAPTER THREE
METHODOLOGY

3.1 ORIGINS OF THE RESEARCH

The pertinent data for this research were selected from data collected in 1996 for what was intended to be a much larger project in the field of Research Psychology (at UCT). In transferring the research to the field of Clinical Psychology, it was necessary to focus on a narrower area of research, a smaller sample and a different method of analysis than originally intended.

3.2 DATA COLLECTION

Data were collected through semi-structured interviews with selected psychotherapists. Interviews lasted between 1 and 1.5 hours. Hand-written notes were supplemented by taped recordings where hand-written notes were not clear enough and when interviewees permitted recording of interviews. Some taped recordings had to be discarded because of problems with audibility or clarity.

3.2.1 PARTICIPANTS

52 psychotherapists working in the field of long-term (i.e. periods of at least two years) individual psychotherapy with adults were selected. Participants generally defined the type of psychotherapy they did as broadly psychodynamic or psychoanalytically-orientated work and they tended to accept terms like 'reconstructive', 'transformative' or 'qualitative' when such terms were suggested by the interviewer, based on previous interviewees' usage.

A pilot sample group of five lecturers from the University of Cape Town psychology department were initially selected both for the data they could provide and to test and comment on the instrument. These first participants also were or had been in private practice which included long-term psychotherapies, and were involved with the post-graduate training of psychoanalytically-orientated psychotherapists.

For this qualitative research further participants were selected on the basis of their being considered rich sources of information by their colleagues (Guba, 1987) and according to the principle of maximum variation in their approaches or schools of thought (Glaser & Strauss, 1967). Selections were made by referral from initial and later participants (see questionnaire, Addendum A, last section), and by contacting psychotherapists listed by various applicable societies or schools, like the South African Association of Jungian Analysts (SAAJA), the Psychoanalytic Reading Groups (PRG), the Self Psychology Reading Groups (SPRG), the South African Society for Clinical Hypnosis (SASCH) and the South African Institute of Psychotherapy (SAIP).

In participants' descriptions of their work the following psychotherapeutic orientations were included: various kinds of eclecticism; various mixes of long-term methods; psychodynamic therapy; psychoanalytic therapy, psychoanalysis; psychoanalytic phenomenology; transactional analysis; Gestalt psychology; medical hypnoanalysis; Ericksonian hypnosis; ego-state hypnosis; object-relations (with sub-specifications like 'British Middle School' or 'Winnicottian'); Kleinian psychoanalysis; Jungian analysis; Self psychology (with various sub-specifications like 'Intersubjective school'); client-centred therapy; systems therapy; narrative therapy. While certain types of hypnosis may be considered to be more directive than most of the psychodynamic types of therapy included, persons who used hypnosis (as with Gestalt therapy mentioned by some) did so as an adjunct to a long-term psychodynamic therapy, for instance when during an external crisis time when ego-strengthening was required, or integrated with other forms of psychodynamic work. Practitioners also pointed out the similarities between traditional long-term psychoanalytic work and types of hypnosis in goals of transformation through a focus on the Self[13] and its optimal development, and methods aimed at cohesion of the damaged or fragmented Self.

From the 52 initial interviews, twenty were selected as a basis for qualitative analysis. Selection of these twenty sources of information was decided by such factors as the richness of information supplied by a participant (Guba, 1987), the originality of

[13] Claire Frederick has done much work on comparing Self psychology and both ego state and Ericksonian psychology, for instance in Frederick and McNeal (1999).

descriptions (i.e. that the descriptions of their work flowed from observations in practice and from their thinking about their work, rather than from merely quoting authors in the relevant schools of psychotherapy) (Guba, 1987), and as equal representation of the various orientations as possible within the limitations of the selection process.

Problems affecting this last criterion included that the majority of participants worked from an eclectic or mixed orientation, so that duplication was inevitable, the necessary small sample selected for this qualitative research from the wide variety of possible orientations represented, and the necessary de-selection of participants based on other criteria mentioned above. From an overview of the way the twenty participants constructed outcome goals, a further selection of seven relatively rich sources of data grouped according to similar orientations in therapy, was made for detailed construct analysis, supplemented where important by qualitative additions from the remaining thirteen.

3.2.2 DATA COLLECTION METHODS

Data were collected from semi-structured interviews lasting between 60 and 90 minutes. Detailed notes were taken during the interviews, and where necessary, amplified by transcriptions of taped recordings. In general, the areas investigated during the interviews initially, were (1) therapists' beliefs about what made their therapies effective, i.e. what they considered to be the essential process elements of effective long-term therapy; (2) their beliefs about what constituted relative health and pathology in their patients, i.e. the explicit and implicit outcome goals; (3) their beliefs about effective training of psychotherapists working in the transformative modes investigated in this research; and (4) their opinions regarding the applicability of their type of work to the broader South African community.

From these long sets of data, sections pertaining to (1) and (2) were selected for analysis in this dissertation. This allowed for the following research questions to be investigated: Is there a consensus about what constitutes relative mental health as an ultimate goal of transformative psychotherapies? How do therapists in their practices at the end of the twentieth century construct the outcome goals of their therapies? Do

therapists working from different theoretical orientations within the field of transformative psychotherapy have different goals, or are there similarities? Can a generalisable outcome goal construct be deduced as a basis for further comparative research across such therapies, or as a basis of further process research? Is there agreement about which signs therapists consider to be indicative of a positive outcome (i.e. of increased mental health)? What are these signs? Are there different goals for different phases of a long therapy, and what are they?

Interviews varied in the ways participants preferred to respond: Some spoke in general and fairly expansively about the process of psychotherapy from their observations in practice, and they tended to cover all the pertinent areas without many prompts from the interviewer, whereas some participants required some prompting to focus their thoughts and others preferred to answer the questions used for prompting as listed. The original questionnaires used as prompts are shown in Addendum A.

The following ethical conditions were contracted with the participants: (1) that their names, specific responses and, in some cases, the fact that they were participants were to be kept confidential, even from examiners; (2) that all case material used to illustrate concepts would be confidential and would be screened out of the transcripts and the analysis. To allow for this last condition, the interviewer would test imagery and other formulations of her understanding of participants' views at particular points, to ensure fair and truthful representation of their responses in co-constructed descriptions. Where retrospective analysis during summarising proved in one case that this had been inadequately done in important areas of response, the interview was de-selected from the data pool.

3.2.3 DATA PROCESSING AND INTERPRETATION

First, transcriptions of taped interviews were made randomly of five interviews where taped recordings had been allowed, and the transcripts compared to the notes taken during the interview. Since these notes were thus proved to be fair and representative of interviews, further transcripts were made only where pertinent data seemed insufficient or unclear, or where notes appeared ambiguous.

Point-form summaries were then made of the notes and amplified notes, where new points indicated merely that a new thought or area of focus had been reached, as indicated by content or by sonic cues (like long pauses with different inflections, or rhythms after the pause), or by the actual asking of a question or giving of a prompt by the interviewer.

The selection of twenty documents considered most useful for this research, according to the criteria on pages 33-34, was then made. At this point the summaries were typed out (shown in Addendum B), and on these summaries the analysis of data could be done.

The method of analysis selected is that of *construct analysis*, in which an attempt is made to determine the basic meaning of a communicated idea, with all its mentioned and unmentioned derivatives, through a study of its connotated and denotated fields of reference. Denotations are the lexicon (dictionary) indications of the common usage of a term and connotations the personal, subjective or selective additional meanings as intended by the users (both the signifier and the decoder) within the context of an area of discussion (Kempson, 1977).

The purpose of such analysis is to understand as fully as possible what participants think about any aspect of the process of psychotherapy, and how their thinking impacts on their practice of psychotherapy and on how they observe and interpret observations regarding the therapy's effect on the patient. This is a necessary first understanding that can lead to formulation of their ideas in terms that are relatively free from exclusive use (e.g., in a specific school of psychotherapy), so that the heuristic sharing of beliefs and observations between various practitioners may subsequently become possible. This might hopefully lead to greater sharing of insights, to avoidance of duplication of error findings, and thus to greater effectiveness across the spectrum of long-term 'transformative' or psychoanalytically-orientated psychotherapy.

3.2.3.1 Construct Analysis:

Garfield (1981, 1973, Chapter 1) has used the term 'construct' to denote different conceptualisations of structure and function across various schools of thought in psychology. So he discusses, for instance structural constructs (i.e., theories about the structure of the psyche or mind) or motivational constructs (e.g., Freud's drive theory), and summarises how various schools of psychology construct illness, cure and the process of therapy.

Garfield (1981, 1973) defines a *construct* as "a schematic label that captures some meaningful relation to other idea-units or constructs that the theorist is trying to express" (p.6). He explains that "When we ask someone 'What do you mean by that?' we are trying to clarify the *relational ties* he or she is putting together mentally so that we can understand the point being made" (p.7, italics mine).[14]

To analyse an idea or concept expressed or identified, is therefore to de-construct it to account for its origins and connotations but also to re-construct it by adding further implied relationships, as it were, with the inevitable future meanings that can be derived by its very existence: It is not enough to understand what something means, but also what that meaning communicates about the result of its presence in our thinking and actions, the intent of the constructor and the implications for the future associations to the construct. To give a rather simplistic and banal example: without the construct of the 'unconscious' would forensic science have considered a defence like 'I did not know what I was doing'? The consequences of a construct existing can thus reach further into the future and into other fields of meaning than may be conceived by someone who accepts or uses that construct or its referral agents.

This also implies that a determination of the widest connotations of a construct, in addition to its obvious denotations[15], is important for the creation of *meaning*.

[14] The connection to attempts to understand the client's world empathically in the therapies investigated, appears obvious. The similarity was also pointed out post-hoc by several participants who gave feedback that the interview itself had felt "like a therapy session".

[15] As described in previous section: 'Denotations' are the generally accepted or lexicon meaning of a word or phrase; 'connotations' are the additional personal nuances of meaning for a particular user.

'Meaning' is defined as "*the relational tie existing between two or more poles*, each of which focuses on a construct" (Garfield, 1981, 1973, p.7, emphasis in original). Meaning can thus exist as a tension between two opposite poles that can describe or define the same construct (e.g., 'good' and 'bad'), or it can exist as a construct somewhere in the middle between two or more other descriptive (complimentary or opposing) constructs, e.g., 'house' as in 'huge house'/ 'mansion' and 'tiny house'/ 'shack'. But it is also obvious in this last example that 'mansion' and 'shack' can be semantically analysed (or deconstructed) to have many more connotations than 'huge house' or 'tiny house': other constructs that are connected would include, for instance, wealth, squalor, status, position, stereotypes of characters (human and animal) and flora associated with each, decoration, fashion, habits, diet, company, and even whether the occupant is likely to know the word 'psychoanalysis' or not!

The speaker's mental picture of 'mansion', which is his/her *intended* meaning (whether used denotatively or ironically), would potentially contain all the conscious or unconscious connotations the word has for the speaker (Kempson, 1977). The problem, as the overwhelming presence of misunderstanding in our society suggests, is that the listener/ 'receiver'/'decoder' may have not only different cognitive connotations but also different affective connotations to the speaker/ 'sender'/'signifier' about that same construct (Kempson, 1977).

This appears to have happened also between schools of psychology: To some participants in this research, for instance, the construct 'reconstructive' (psychotherapy) was acceptable as they understood it to mean 'transformative' whereas to others it meant something like 'replacing' (e.g., the core of the personality), which was unacceptable. It is the aim of the construct analyst to make personal constructs in a field of interest overt and communicable to ensure accurate understanding for a wider audience.

This goal has thus informed the method: Participants were selected, for instance, on the basis of their being considered excellent informants by their peers; by incorporating participants also according to the principle of maximum variation, the widest possible nuances of a construct could be investigated. Using the instrument of a semi-structured interview further allowed for the finding of inherent constructs in

the natural narrative of a participant about a subject, but also for the clarification and 'stretching' of the construct to clarify its potential and developmental meanings acceptable to that participant (Guba, 1987). This last aim was enabled by the generic nature of the qualitative interviews, where apparently similar ideas expressed in different terms by a previous participant, could be tested at the end of the interview with a later participant.

3.2.3.2 Construct Synthesis:

Within the qualitative exploration of constructs as described by various participants, similarities or overlaps become discernible, which can then be combined or synthesised. This results in the further qualification and enrichment of a construct. During this process the construct becomes 'fleshed out' to contain as wide a group of connotations as possible, within the limits of coherence and the intentions of the participants.

It is important to remember that some synthesis has already occurred during the data collection, when previous participants' ideas or terms were tested in later interviews[16]. The broader contexts thus constructed could therefore be posited to be part of the connotations for particular participants. That process is continued in the synthesis of constructs in Chapter Four. Here, however, the 'testing' of a construct here is not a function of chronological serendipity, but rather a theoretical 'multi-logue' between participants from initially similar, and later different orientations, who were selected on equal basis of richness of information, and the researcher, who has enriched understanding gained from all 52 interviews reviewed for this research.

There are several advantages of construct synthesis: It is possible more finely to determine the meaning (with all possible connotations) of the signifier, which allows for wider application in the discourses of that and other speakers with similar orientations or beliefs; the richness of the material that becomes available to readers/ receivers allows for their own continued exploration of the constructs and of their own beliefs; they can also add important further connotations and interpretations that

[16] As stated at the start of this chapter, such 'contamination' is desirable in qualitative as opposed to quantitative/positivist research (Lincoln & Guba, 1986).

further enriches the field; there is a sharing of terminology which allows for the enrichment of separate orientations and for the greater understanding of ideas across boundaries between them; making constructs explicit allows for further comparative and evaluative research, both of the constructs and by ideas based on them.

3.3 TRUSTWORTHINESS

According to Lincoln and Guba (1986) in naturalistic/ qualitative research the concept of 'rigour' in quantitative or 'laboratory' research needs to be replaced by one of 'trustworthiness' of the research, pertaining to context, method, analysis and conclusions. Accordingly, external and internal *validity* are demonstrated by *credibility* and *transferability* respectively, and *reliability* and *objectivity* by *dependability* and *confirmability* respectively. In this research credibility was obtained through the continual informal testing of the researcher's understanding of information given by re-wording and asking for the interviewee's evaluation of the interpretation offered; known terms used in the field of orientation represented by the interviewee's discourse, were also overtly clarified so that there could be dialogical agreement as to their meaning in each specific interview (Lincoln & Guba, 1986). Similarly, transferability was achieved through narrative development about the context which would allow for others to research similar constructs (Lincoln & Guba, 1986). The meticulous testing of interview notes against taped recordings satisfied the confirmability criterion and both the testing of understanding during the interviews and the supervision of conclusions drawn from raw data fulfilled the criterion of dependability (Lincoln & Guba, 1986).

CHAPTER FOUR
ANALYSIS OF DATA

4.1 RESULTS OF CONSTRUCT ANALYSES OF IMPLICIT AND EXPLICIT OUTCOME GOALS EXPRESSED IN KEY INDIVIDUAL INTERVIEWS

It was difficult to group the selected data sets into 'types' according to orientation, which would have made the identification and comparison of goal 'types' easier, because of the amount of overlap in the orientation groups represented by the participants according to their own description. However, an attempt had to be made at some form of grouping, not only to prevent this minor dissertation from becoming impossibly long and unmanageable, but also to avoid unnecessary repetition where the outcome goal already begins to appear comprehensively 'fleshed out'. The data sets were therefore grouped according to what was stated by the participants as their main (if any) orientation, or according to what appeared to be either most prevalent, or most divergent (according to the principles of richness of information and maximum variation discussed in Chapter Three). In any such selection from a large amount of data to a smaller sample for qualitative analysis, some valuable information given by the participants must necessarily be lost, for which I apologise. It is done not to demean any opinion, but to make this work possible.

The groupings appear to be roughly the following:

1. Broadly psychoanalytic/ psychoanalysis, with some object-relational understanding: A, M
2. Object-relational with specific reference to Klein: B, P, Z
3. Broadly Self-psychological, with inclusion of other orientations like general object-relations, or Jungian psychoanalysis: C, L, N, O
4. Predominantly Jungian, with object-relations, Self psychology and others: D, G, S, T
5. Ego-state and other forms of hypnosis with, psychoanalytic therapy, client-centred therapy, Gestalt therapy: K, R

6. Phenomenology, with psychoanalysis, Jung, Gestalt: E, F, H

7. Other, like family systems, transactional analysis, narrative therapy: J, W

NOTE: 1. The first data set chosen for analysis, 'A' was judged on gross inspection to be one of the richest sources of material in the sample. The analysis of 'A' here will therefore show more detail of how the reasoning associated with the technique of construct analysis develops. In subsequent analyses, similar ways of deconstructing the main elements will be followed without repeating the detailed explanations and motivation in respect of the method.
It is important to remember that the speakers' implicit *as well explicit goals are being traced. This results in initial (hypothetical) inferences that will be tested against the general contents by the end of the analysis.*
2. Supplementary data are given in square brackets with the source indicated by letter symbol at the start.
3. Double quotation marks were used to quote terms/phrases used by interviewees in the exploration of meaning, or from other referral sources, and single quotation marks for referring to terms/constructs already signified thus and appropriated into the discussin/analysis.

GROUP 1: BROADLY PSYCHOANALYTIC, WITH SOME OBJECT-RELATIONAL UNDERSTANDING

(Analysis of A, supplemented by some data from M, and two quotations from P in Group 2)

'A'

Pathological functioning is defined here as "the lack of freedom to pick up potentials of being". Healthy functioning can thus be constructed as the opposite, i.e. *the freedom to pick up potentials of being.* 'Potential' is denoted as "capable of coming into being or action; latent; capacity for use or development; usable resources"[17] and

[17] All denotations, as signifiers of common usage, but also pertinent to respondents' usage, are quoted from *The Pocket Oxford Dictionary of Current English, Eighth edition* (1992), except where otherwise indicated, as this condensed dictionary contains the most common denotations of current English usage

'being' as "existence; nature or essence (of a person, etc.)". 'Free'/ 'freedom' include denotations of "unrestricted, not confined or fixed; spontaneous; unforced; [having] liberty of action". The most pertinent denotation of the phrase thus appears to include the following signified meanings: (1) Human beings are capable of becoming what their nature or essence is/ should be, and thus: (2) They are not necessarily yet as their essence could allow them to be if they could develop optimally. (3) This development to their latent or essential Self is impaired by constrictions/ restrictions, (4) set by external forces (5) which prevents them using resources for optimal development. (6) This curtails their freedom of action, so that (7) they are fixed or bound to certain behaviours (which in general psychological denotation include: thoughts/ beliefs, speech, emotional and physiological responses, and physical actions).

In the text we find corresponding indications that validate the above denotations for this respondent as follows: (1) The goal is for the client to find "his/her own sense" or understanding of the world and his/her experience in it – "the totality of life situations". (2) "'Increased understanding", "increased/greater ability", "more free", "more visible", "increased trust", "decreased resistance", "remission", "increased awareness", "more adaptive", and "greater potential for adaptation" are indicators of the potential for development to a different (aspirational) level (which might be the 'essential Self' construct of #3 above), which the client has not yet reached. (3) and (4) The "stuckness" or impairment of this development has been constricted/restricted by actions of external forces/significant others[18], and appear as: inequality in relationships, where the client has not learnt to believe that his/her existence is as important as the significant other's (i.e. lacking a sense of "mitsein" – togetherness, equal standing, connectedness); a lack of "adaptive introjects"; a lack of understanding of the "meaning" or "sense" of his/her actions, which validate his/her actions so that they are no longer judged "insane" (= without thought/meaning); a lack of validation of such actions from "more informed players"; "broken trust"; critical "scrutiny" and the threat of being inclined to "destroy"/"annihilative consequences" (of intimacy) from the Other; lack of containment of the Other and self's emotions; absence or permeability of "boundaries".

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commonly available here. From the various uses denoted, only those pertinent to the obviously intended meaning are selected in each case.

(5) The following indicate that clients have been prevented from using resources for optimal development: Clients have been unable to "select appropriate action based on the counsel" of Others; they have lacked "flexibility of options of response"; *"caught up* in attending to traumatic associations to micro-events" and thus not free to use resources; unable to "factor" "unknown and frightening elements" that are yet invisible; unable to tolerate intimacy because of fears of abuse/destruction. (6) and (7) Curtailed freedom of action and bondage to certain behaviours are suggested by descriptions of a lack of awareness of the "presence of more than the here and now", the need for "greater freedom of choice" and again for "greater flexibility of options of response and creative acts", a lack of "ability to affect [---] causes of stress" and of "adaptive behaviours towards [Others]", and scarcity of "transformative moments".

By implication the goals of therapy expressed by this participant should therefore include *the removal of certain constrictions in the developmental history of the client, which will allow him/her to access resources in order to become, in action and being, true to his/her essential nature.* Questions also arise, like 'What are these resources? Are they internal or external? What are the constrictions? How do they arise? Is there a generalisable quality to the 'essential nature'?' Both the inferred goal and the questions can be tested against the contents of the interview by deciphering the connotations revealed by the interviewee about these matters.

If one accepts the premise that the type of therapy investigated here has compensatory or corrective purposes, it follows that the nature of the curative or transformative elements identified by the interviewee to be effective in the therapy process would be indicative of the resources that a particular client had been prevented from utilising at some previous stage of his/her life. The first clue to the nature of the resources appears very early in the interview, namely that healing depends on so-called "mit-sein" (equality) in the therapeutic *relationship*. This is supported later in the mention of "(adaptive) introjects" and the "benign interest" of the "Other". 'Resources' (previous paragraph) would thus appear to refer to *relationships* that empower the client to grow towards a freedom to *be*, as s/he had had the potential to be before

[18] 'Significant other/s' is often indicated in the literature by capitalised 'Other/s', which convention will be followed here.

certain constrictions arose. [M: What is specifically communicated by the therapist is "a kind of *faith*: the belief that the obstacles are part of a larger process and can be endured". This suggests the importance of finding meaning but also that the 'faith' in the client's ability to endure becomes a resource (e.g. for maintenance of hope) and also points to the client's own qualities (e.g. to 'endure') as a further resource.]

The relationships can be both external (as that with the therapist originally) or internal, through *introjection* which is psychologically denoted as the internalisation of a person's particular qualities pertaining to his/her response to, evaluation of and effect on the client.[19] Concretely put, introject may suggest a type of internal mirror, with similar truth or distortion that the external respondent to the client on which it is based, had shown. 'Constrictions' can thus refer to repeated distortions in the feedback given by important external figures in relationship with the client, regarding the client's essential nature. [M: These repeated distortions create a certain *memory* set in the client, who co-constructs the story of his/her personal 'past' accordingly. Because such constructions are a mental function, they can be changed: "If you can change the story, you can change the outcome".][20]

The interviewee gives clues also to some qualities of a client's *essence/ essential nature* by describing the results of a successful transformative therapy. In the generalisations based on the interviewee's practical experience of several clients over time, it is also implied that these potential qualities are considered general to all persons. The outcome *behaviours* (as denoted above) can thus be considered representative in the interviewee's opinion, of basic potential or qualities present initially in all persons.

The following are revealed in the interview: (1) Freedom from behaviours ("symptoms") over which the client has little or no control. This includes negative, self-destructive or debilitating thoughts and feelings as in depressive, manic or

[19] Introjection is defined by Rycroft (1968/1972) as "The process in which the functions of an external object [i.e. usually a person, 'selfobject'] are taken over by its mental representation, by which the relationship with an object 'out there' is replaced by one with an imagined object 'inside'. The resulting mental structure is variously called an *introject*, an *introjected object*, or an *internal object*. Introjection is preceded by internalization, may or may not be accompanied by the phantasy of incorporation, and may be succeeded by secondary identification."

anxiety states. Examples given in the interview include less "stuckness" in physical gestures and movement; more adaptive behaviours towards authority figures; increased ability to affect the causes of stress, including loss and threatened loss; better affect regulation; greater flexibility of all options of response and creative acts. [M: "a freer range of actions, e.g. in taking risks".] The infant thus has the potential to be creative and effective in the world and to regulate his/her own needs and emotions. (2) Ability to reestablish or create appropriate boundaries. This implies a sense of self as a separate entity from others, and would also show in, for instance, awareness of physical and social boundaries between self and others. This leads to the ability to be intimate in relationships without feeling overwhelmed by or being overwhelming to others, with awareness of "nested layers" in the interaction. (3) A sense of continuity of self, which is seen in the client's ability to construct a meaningful and cohesive self-narrative, including "archetypes, personal history and many characters". (4) "Ability to make sense of complex life texts", both of the client's own life and of his/her interaction with others. This is described in terms of finding *meaning* in the life narrative.

The outcome goals of therapy therefore appear here to include (1) freedom from earlier constrictions which had impaired the ability to *be* according to the essential nature of a person; (2) ability to access relationships that are a continual resource for further optimal development and functioning; (3) efficacy in the world, which implies power over own behaviour and decisions, and an ability to negotiate appropriate power over the external reality.

Two further points made here are especially noteworthy in the light of literature reviewed in this paper.

The first refers to the issue of the unconscious and to "insight" as a possible goal of transformative (here specifically psychoanalytic) therapy: The denotation of *insight* is given as the "capacity of understanding hidden truths" (Pocket Oxford). In the field of psychoanalysis this construct is further specifically denoted as "the capacity to understand one's motives, to be aware of one's own psychodynamics, to appreciate the

[20] This view appears to me to be similar to that expressed in Groups 5 and 7, specifically relating to ego state hypnosis and to Gestalt therapy.

meaning of symbolic behaviour" (Rycroft, 1968/1972). Rycroft makes a distinction between "*intellectual insight* [as] the capacity to formulate correctly one's own psychopathology and dynamics, and *emotional insight* [as] the capacity to feel and apprehend fully the significance of 'unconscious' and symbolic manifestations. Intellectual insight is usually classified as an obsessional defence since it enables the subject to understand and control aspects of himself from which he remains alienated. Emotional insight, on the other hand, is evidence of freedom from alienation and of 'being in touch with the unconscious'. It is possible to have insight in sense **1** and to lack it in sense **2**, i.e. to be sane and yet clueless. Although insight refers in the first instance to self-awareness and self-knowledge, it is also used to refer to the capacity to understand others. [---] The aim of psychoanalytic treatment is sometimes defined in terms of the acquisition of insight, though Freud himself never used this formulation, preferring the idea that its aim is to make conscious the unconscious. Both definitions imply that consciousness has an integrating function." (Rycroft, 1968/1972).

It appears that this interviewee is referring to such an *integrating function* when s/he states that "insight is the result, not the goal of therapy". Earlier s/he stated that the work is aimed at helping the client/"patient" to "make meaning of what does not appear to make sense, through an increased ability to analyse the elements during the story-telling process, so that the patient can find his/her *own* sense". This construction suggests that the acquisition of some measure of intellectual and emotional insight – not as a defense but as a conveyer of the meaningfulness of the client's actions within the context of forces that have ever influenced him/her – is somehow prerequisite to the gaining of a sense of greater relatedness and integration.

For this interviewee there seem to be two elements involved in the 'insight' thus gained: The first seems to be connected to the power of languaging in that it is in the *telling* of the story of the client's life that s/he begins to find meaning and relationships between events. This "telling" also has a dialectic quality though, as on the one hand, the client relates and re-relates his/her memory and selections (for instance of "micro-events"), it is "through increased ability to analyse the elements" that meaning is created and integration develops. This analytic ability comes in part from the therapist (one of the "more informed players" for instance in the transference

relationship) who helps the client to find relationships between events (including feelings) and provides some of the words with which to language the increased aware/conscious experience. [M: A further function of languaging is suggested, in that "the talking [about his/her memories] helps the client to play a more active role in the client's life story": "It's not a question of getting to the truth, but about the way you look at yourself in the world"; it is the changing of this perspective that creates change.] I will include a comment from Group 2, which overlaps with the object-relational representation included in group 1, and which appears to expand the construction of perception here appropriately: [P: There is the suggestion that the maladaptive way the client looks at himself in the world, has been through the creation of "a fantasy character s/he would like to be". In the validation of the real self, i.e. in changing the attributes of the character/s in the story, the ending can also change. This occurs in part because both the client and Others, including the therapist, become more *real*, less distorted by projections, so that the relationships become more real and sustaining.]

The second element in the construct of 'insight' is the creation of a positive/therapeutic relationship within which "the transformative power of language and gesture" can be experienced – the gaining of "more adaptive introjects through the therapeutic interaction". [P (Group 2) adds the following explanatory connotation: "Having had an experience of being loved satisfactorily by a maternal transference object".]

The final point is the implied distinction in this interview between the therapeutic *task* and the *goal* . The task is to provide a therapeutic relationship with all the qualities mentioned, like being available as a positive/adaptive introject, being trustworthy, helping the client find meaning and connectedness, helping the client to contain emotions and survive traumata like "the loss of the Other", invite intimacy. The goal is to allow for "transformation"/"transcendence" to a being/"player" whose life "story" has begun to make sense/have meaning.

GROUP 2: OBJECT-RELATIONAL, WITH SPECIFIC REFERENCE TO KLEIN

(Analysis of B, supplemented by some data from P and Z)

'B'

This interviewee refers mainly to long-term transformative therapy with clients presenting with "Borderline"[21] pathology. In Kleinian understanding as explained by the interviewee, this implies that very early, often pre-verbal, traumatic issues are the foci of the therapeutic intervention. A further implication is that the transformation or restructuring of the personality needs to include the cohesion/integration of a previously "fragmented" structure. According to Rycroft (1968/1972, p. 75) in classical theory "the human psyche starts as an unintegrated, unorganized Id and becomes integrated as a result of Ego-development. According to Object[22] theory the infant begins life in a state of primary [unitary] integration" that can develop dynamically to continued integration of experience or to fragmentation depending on how the individual's Objects relate to him/her.

It is not clear here which of these positions is supported by B, but what is indicated, is a movement towards increasing *structure* of/in the client's daily life as signifier of relative health, for instance in the structuring of "goals" and "in their practical lives", "the process of going about one's daily life", "the embedding of a meaningful relationship with the world", "integration of fragments".

The participant says that pathology is maintained initially because the (Borderline) client has a "vested interest in keeping things separate and apart" or "fragmented". [Z: The client experiences "triumph" or "the evacuation of his/her feelings when refusing to 'see"' what is being reflected by the therapist.] This interest is based in self-protection and appears to be the result of early interpersonal contacts which were

[21] As defined by DSM-IV

[22] In Object-relational theory, such as described by Fairburn (1952) 'Objects' refer usually to persons or parts of persons, or symbols of either, to which the subject relates through, for instance desire or action. Objects are most often significant persons (or parts of significant persons) who have a powerful influence on the subject.

somehow experienced as traumatic. [Z: The "truth" – which needs to be faced – "is painful".]

A clue to the reason for the need to maintain fragmentation can be found in that, through therapy the possibility is created that "all these personages can exist in the same room". This implies that parts or aspects ("personages") of the self cannot initially be tolerated together *within* the self or the conscious self/ego. They are denied "living space" because of some form of "terror" or "dread" associated with them. The cause of this terror/dread is in part derived from threats perceived in external interpersonal relations: The construction of the damaged self thus includes that the Other/Object is experienced as dangerous: it can reject (cause "not belonging") or "swallow [one] up", for instance. Similarly (in Kleinian denotation) the self or internal aspects of the self can be experienced as dangerous and thus not be allowed "living space" close to more vulnerable, consciously acceptable parts/"personages".

Part of the therapeutic task according to this interviewee's construction of health and pathology, is thus to create "living space" within the therapist initially, and later, through "feeding back", within the client, for all the aspects/Objects of the self. This means replacing "unnamed dread" firstly with descriptive language, which facilitates examination, "reality" testing and the creation of meaningful and endurable relationships between parts/"personages", and thereafter with coherent "Meaning". [Z: "The goal is to make *everything* visible, in the patient's self and in reality, those things which support *and* contradict beliefs".]

The goal of therapy according to this participant (B) is located in the concept that the client needs to gain "strength and courage to move forward to a higher level of development", away from the security of "narcissistic protection". The process is engaged through "the creation of meaning", which facilitates "the primary goal" of "integration". Signs of transformation are "a sense of groundedness or reality" and "value of the self".

Already there are some obvious similarities with constructs used by participant A. The outcome needs to be "a higher level of development" and the 'stuckness' here is

the fear of leaving a certain defensive structure, namely pathological (or by implication through the concept of necessary development) "immature" narcissism. Pathology is further described as a "chronic entrapment", which implies that liberation from such entrapment is, again, a goal of the therapy. The term "flexibility (of being in the world)" resonates with the concept of increased *adaptiveness* used by A.

The hurdles to optimal development that caused the adoption of the "narcissistic protection" are not specifically defined. However, from phrases like "trauma or neglect" one can safely infer, within common Kleinian denotation, that the constrictions were again of interpersonal origin: The "damage" is construed as the result of interpersonal injury (which includes the constructs of 'neglect' and 'intrusion'), resulting in a *devaluation* of the self, and seemingly of the "human spirit". This leads to misconceptions/ misunderstandings of how the world and self are constituted and the therapeutic task for the client includes learning "how to relate to the world as meaningful, rather than merely reactively or automatively". This phrase emphasises not only the importance of creating meaning, but also that meaning, in this sense, infers empowerment or *agency* in the client's relationship to the world – to be able to act, rather than just react. This ability is included in the desired outcome construct of health.

The therapist's task in the creation of meaning includes for this interviewee: the "languaging" of "preverbal" experiences; the modelling of valuing of self and "the human spirit" (presumably thus also the valuing of the Other as, for instance, trustworthy); presenting alternatives to bondage to social norms and valuations of experience in order to make "authentic" judgements; modelling of a continual search for meaning as a way of life; validation of the client's experiences of, for instance, the "terror of not belonging"; cohesion of "things" like qualities – which is seen as an actual cohesion within the therapist of his/her experience of the client (e.g. through 'projective identification'[23]) rather than just modelling; integration of aspects of the

[23] This Kleinian construct cannot be fully elucidated in the space allowed but can perhaps be most easily understood in concrete terms such as suggested by this participant: The therapist comes to "feel" the usually intolerable feelings, like "rage" or "terror" *on behalf of* the patient, who "projects" them into the therapist. There is some dispute about how this occurs: some readers of Klein have inferred that it supposedly occurs 'magically' that a client 'puts feelings into one', whereas others believe that micro-attunement to actual signals from the patient, or even to his/her electromagnetic field can account for the experience even though Klein herself had not had access to these terms that are related to late

client in the mind/memory of the therapist who then "gradually feeds back this understanding" or cohesed/coherent picture to the client.

This participant further specifically emphasises a concept of "steadiness" in the way a client needs to learn to deal with the world and the self, in health. This can be seen in "increased ability to structure their practical lives", and infers a self-regulatory function that is somehow learned in the therapeutic relationship (for instance through 'introjection'). The idea of 'steadiness' is obviously important in the typical Borderline pathology where everything is in a state of flux from one extreme to the other, but it is also a generally useful quality to add, in certain cases (e.g. where there is no danger of a kind of compulsive 'steadiness' as defense) to a general construct of health.

[Z: Two further outcome components are suggested. First, the internalisation of the therapist's communication of the utmost importance of the goal of the client's growth, through, for instance, abiding by aspects of the frame: The therapist communicates that s/he takes "the process and the patient seriously": "There is nothing I would do in my life that I take more seriously". Second, the internalisation of a relationship to the self that is "safe, unconfused, and reliable".]

GROUP 3: BROADLY SELF-PSYCHOLOGICAL, WITH SOME OBJECT-RELATIONAL AND JUNGIAN UNDERSTANDING

(Analysis of C, supplemented by data from L, N and O)

'C'

The outcome of therapy is described as the self becoming "stronger" (which construct appears to include the concept of "cohered"), and the process as "through the relationship with the therapist". The participant further qualifies "stronger" as agency/empowerment, with result that the world is no longer "so threatening".

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twentieth century psychological technology (as per discussions in Cape Town-based Self psychology orientation and reading groups, 1999).

Pathology is therefore seen as a state of disempowerment, a lack of equal standing with Others in the world and an inability to trust the world not to be destructive to the client. Pathology is constructed as caused by "misattunements" presenting as "hurt and rejection" by Others to whom the client has become emotionally attached. The interviewee constructs these misattunements as invalidatory of the client's experiences; they can be felt to have implied criticisms of the client's basic self-state as experienced by him/her, hence "rejection". When the client's judgement and experience have not been adequately validated, s/he becomes "insecure" about his/her own qualities ("I will make a mess of things") which impairs freedom of expression and association.

The interviewee suggests accordingly that the therapeutic relationship must provide a positive valuation of the client, attunement and validation, as well as language (to help the client learn "*how* to talk"); the therapist must also instil "trust" and model how to "repair [the relationship] if things go wrong" (indeed, prove that it "*can* be fixed/repaired/restored"). [L: The therapist proves s/he is able to "be with" the client, which is a basis for risking to encounter aspects of the Self.] All of this leads to the aspirational goals of cohesion and liberation.

The interviewee emphasises the function of "languaging around experience" in the process: "Naming" has the functions both of identification (e.g. of feelings, needs), which brings a coherent picture/knowledge of self, and of "communication", which creates "connectedness" and breaks the isolation of the previously un-welcomed self. In terms previously defined, the client thus gains both intellectual (i.e. in terms of knowledge, not as a defense) insight (through the languaging) and emotional insight (through the therapeutic relationship). It appears thus that 'insight' is incorporated in the outcome construct of health.

Here too (as with B), the quality of "stability" or "steadiness" (being able "to ride the storm", "to steady the storm-thrashed ship") is emphasised as a sign of relatively healthy functioning – and of the therapy having been effective. The quoted phrase infers the following connotations attached to the construct of 'steadiness': There is a sense of purpose/goal/being able to choose and follow compass direction; there is sufficient internal "strength" and cohesion that the psyche can stay "afloat" (or "on top

of things") despite chaotic experiences/milieus; there is the ability to self-correct/ maintain or restore equilibrium/regulate self; there is agency, efficacy and skill.

This leads to a state of being able to "behave and live more easily", i.e. less uneasily, less dis-eased.[24] This is a result of the client having learnt to "attend more successfully to his/her own needs". The interviewee specifically constructs the 'healing of the Self" as "cohesing", seen as the primary factor in being able to "live more easily".

An important goal for the therapeutic relationship is to make the development of other intimate relationships possible. This occurs when the therapist can *hear* and understand correctly what the client needs to communicate. Not only does being understood make the client feel "more sane", but it also generates trust in the Other's ability and willingness to hear/understand: thus "a bridge to others has been built".

The therapeutic relationship appears to have a further mediating role for this interviewee: In the experience of this relationship some process appears to occur by which existing "internal objects [are experienced as] less bad". The client is then "able to be alone in the presence of someone else", but also to have more stable, nurturing and *real* relationships with others.[25]

While the goal/s of the therapy appear the same throughout (increasing cohesion), this interviewee relates phases in the therapy to developmental phases, such as the grandiosity associated with a two-year old. The task of validation remains the same, though, irrespective of developmental phase.

[L: In this perspective there is also an inference of a potentially healthy Self at birth, who would be able to develop healthily, if this process had not been interfered with/ "arrested" by some force somewhere during early development. Part of the therapist's task is to "put the patient in a position where s/he can carry on with the natural

[24] Reminiscent of Bettelheim and Rosenfeld's description of the outcome goal of therapy, that the client "can live better with himself", quoted at the start of Chapter 2.
[25] While not explicitly stated here, object-relational denotations include the presumption that a decrease in projection and in denial of aspects of the Self would allow for a more real relationship (Cashdan, 1988).

development of the Self that had been arrested at some stage, i.e. to be able to carry on *from that point*". This appears to suggest that pathology is something added to the basically potentially healthy Self, which remains essentially uncorrupted and can resume its optimal development when contaminant effects are removed. The two main causes of the 'arrest' resulting in pathological functioning, are "*neglect* and *abasement/intrusion* into the patient's structure". While 'neglect' suggests a failure to replenish resources sufficiently, the second cause of 'abasement' and 'intrusion' support the image of some contamination of the Self by external agents. The construct of a diseased/damaged Self thus includes ideas of neglected potential or absence of growth factors, and an actual destruction of the 'structure' or 'wholeness' of the Self.]

[N: The contamination of the Self is experienced by the client as a corruption of the Self, i.e. that s/he *is* "toxic" and to such an extent that s/he can "infect" and "destroy" the therapist and "other positive relationships". This means that no nurturing interpersonal contact can be allowed that would re-supply the depleted resources. This suggests that, in the therapist's achievement in managing to "get close" and "survive"/not be "infected", there is communication to the client that his/her conclusions about him/herself may be false, leading to a new mental 'reconstruction'[26] of who and what Self is.]

[N further constructs the outcome goal in terms of a "return" to an uncorrupted state, so that one again becomes "able to fulfil one's creative potential". In health, and as a result of positive outcome in therapy, the Self would develop so that the person would be "able to contain his/her self and to do the functions of the self one is supposed to do as an adult, i.e., to integrate affect, to soothe oneself, to regulate tension, to be creative, to have some kind of goal" or purpose.]

The construct of 'health' in this group thus appears to include the following: health is a factor of appropriate nurturing and appropriate boundary formation, creating a strong yet adaptive structure from within which the client is able to interact with the

[26] As indicated in other places in this chapter, there is a cognitive and neurological restructuring when memory patterns are altered because beliefs about the self or 'schemas' have changed.

world in a manner which continues to support the self-structure in such a way that its dynamic evolution toward its optimal potentials are maintained.

GROUP 4: JUNGIAN, WITH SOME OBJECT-RELATIONS, SELF PSYCHOLOGY AND OTHERS

(Analysis of T, supplemented by some data from G, S and D)

'T'

The client's Self is constructed as having "essentially a good, creative force" or potentially healthy basic Self which can be either "contaminated" or "radiated" (in the positive sense of giving life force) by inner aspects (Inner Healer or Inner Destroyer alter-egos[27])[28], or by external forces (like therapeutic and non-therapeutic relationships). It is important that there is an interplay of inner and outer forces, so that, for instance, the inner alter-egos can be "triggered" by the external relationships ("what's in the room"). [D suggests that negative inner forces need to – and can be – "transformed" and "softened" when balanced with positive forces, such as new introjects, e.g. "the enraged self becomes less angry". The finding of a balance or mid-way point between polar opposites is an important concept in Jungian constructs around health (Moore, 1990).]

The causes of pathology are described by the interviewee in relational terms such as, for instance, having an "unresponsive mother", or through manipulative Others – who have *not* cared enough, been empathic, listened/heard, encouraged openness and directness, valued the client enough: These qualities are inferred from the interviewee's description of a "good relationship" (with the therapist) as encouraging "stuff like freedom to communicate, empathy, openness, directness, caring". Instead, the Others have encouraged dichotomous thinking ("shoulds, oughts"), devaluation

[27] An 'alter-ego'/'alter' is denoted in Jungian psychology as coexisting/supplementary types/facets of the self/personality. The concept of 'an alter' as a distinct and separate personality in Multiple Personality Disorder, is a later development. The hypnosis concept of an 'ego state' has similar qualities to the Jungian alter-ego concept (Watkins & Watkins, 1997).

and ignoring of the self and its needs ("denial of emotional needs"), and obedience and subservience to others ("being trampled on by others").

Signs of pathological functioning include for this interviewee: "recurrent illnesses"; "destructive" and "self-destructive acts"; inability to "start or maintain" positive relationships; "depression" and other disorders; "psychosis"; "denial of [own] emotional needs"; numbing and avoidance; "entitlement"[29]; lack of agency/responsibility for actions or degree of happiness; "romanticised" expectations; lack of clarity about and ability to deal with forces affecting the self; lack of boundaries; lack of energy; unhappiness; inability to deal with internal and external pressures.

Their opposites are given as signs of healthy functioning and that a therapy has been effective.

[S: The therapist's task/"healing functions" include the "empowering" of the client though the following: "listening", which creates a welcoming space for the client, "allows space for the client's voice to get interaction", i.e. to have power, and "the validation of experience" through the client "hearing the repetition of the narrative"; explicit validation of experience; "underlining"/bringing "attention to neglected issues"; "directing" by "linking contents to other sources"; "creating a steady frame" which through its consistency, "creates coherence".]

Outcome goals, or the signs that a therapy is "nearing completion or termination", are described in terms of "managing OK in life", which can be seen in the ability to cope with "work, love, own feelings, etc." and the finding of "meaning and purpose in life". The use of the term "purpose" here in addition to "meaning" appears to be in correspondence with the denotation of 'design' or 'intentionality', which again infers agency – the power to choose, decide and take responsibility (for one's life, happiness, success, but also in some manner for others, such as one's community). [S verbalises

[28] Both the Healer and the Destroyer can 'contaminate' or 'radiate' depending on circumstances Moore, 1990).
[29] Used as in DSM terminology, e.g. "I am entitled to be saved by/helped by someone else, or to have special treatment, initiated by others."

the goals as "connection to healing of the social sphere, a concept of the spiritual/ meaningful, and connectedness of self to others and to a deeper source of life".]

This interviewee (T) adds an interesting differentiation to general outcome, in the form of an aspirational outcome specifically "for psychologically-minded people". Accordingly they should achieve, in health, an "ability to delve deeper into themselves", i.e. develop an analytic attitude. They should also be able to transcend self into the awareness and consideration of "a spiritual dimension", which creates further "meaning" or an understanding of the relatedness of events and matter in the universe, and of "a force greater than the self", a set of "patterns" which incorporates also the self: This appears to be similar to what S has constructed as a *general* outcome goal (see previous paragraph). But this force is "not necessarily benevolent" and there is a suggestion that part of the outcome needs to be an acceptance of the non-centrality of the "I" in the vast "patterns" of the universe.

A special comment is made regarding *insight*, as "not sufficient". A type of mourning process is proposed and the client needs to gain "awareness that s/he needs to live with the damage". This seems to imply that being in health requires simultaneously to transcend aspects of the self and its history that cannot be 'fixed'/'repaired'/'restored' (terms used by other interviewees). In general terms, the construct of 'healing' does thus not equate 'cure', but rather 'transformation' with an incorporation of the 'wound'/'scar'. In terms of the previous paragraph it further seems likely that part of what needs to be mourned is the absence of a consistently benevolent and personally-orientated force, so that the client can give up his/her belief that "I will be saved" and make more consciously responsible choices.

[D and G: However, insight is important as well because, according to D, "people come to understand in a deeper way the role that they themselves play in their own unhappiness", so that they can move towards agency and responsibility. There appears to be a suggestion of empowerment in the idea that an individual has the power to cause some of his/her own happiness or lack thereof. However, other participants have suggested that it is the removal of the attribution of negative causality to the self alone, that allows for healing.]

[G: Languaging around experience is not only part of the healing process but also an outcome in itself: In the client's "learning to communicate intellectual and emotional issues, and specifically to communicate the *internal* world", s/he beings the process of "re-claiming of experience of self and the world", resulting in a sense of "cohesion" and integration, "a core sense of 'what is me'". Also, through being able to communicate, there can be "an increase of emotional intra-connectedness" and of "relational skills", resulting in continued provision of nurturing external resources. D relates the "strong sense of 'I'" to the client becoming able, as the therapist is able and can feed back through words and gesture, to "hold deeper things about the client's self in *memory*, leading to a more substantial sense of self *underneath* the circumstantialities and superficialities that are reported, or that occupy the client's daily consciousness".]

GROUP 5: TRANSFORMATIVE TYPES OF HYPNOSIS, WITH PSYCHOANALYTIC, CLIENT-CENTRED AND GESTALT THERAPY

(Analysis of R, supplemented by data from K)

'R'

The Self is construed as having various "ego states" which are denoted as "organized system[s] of behavior and experience whose elements are bound together by some common principle, and which [are] separated from other such states by a boundary that is more or less permeable" (Watkins & Watkins, 1997, p. 25). In practical terms this means that, while the human personality is usually experienced as a unity, it is actually separated into different entities/characters[30] representing ages or relationships in someone's life, for instance. They function as additions to or expansions of a person's "core self" and there is normally a particular state which is generally "executive", becoming identifiable as "the self in the here and now" (Watkins & Watkins, 1979, p. 25-27). In severe pathology distinct states occur as "multiple personalities", but in health they are generally dormant until "cathected"[31] by

[30] Apparently comparable to Jungian 'personae' as a more or less conscious experience of Self (Moore, 1990).
[31] Invested with energy by a specific association – per Rycroft (1968/1972).

incidents evoking specific emotional memories. Ego states can be positive or negative influences in a person's life (for instance when created during a time of very successful or joyous functioning, or when associated with traumatic consequences).

Pathology is described by this interviewee to be a result of traumatic occurrence(s) that create strong negative beliefs/"dysfunctional/fantasy premises" about the self in relation to the world which "control the [client's] thoughts, feelings and actions in all aspects of his/her life"[32]. Trauma creates a trance state in which the "impact of emotionally laden memory printing is strong". [K: This happens either because of the "high number of repetitions involved in an experience", for instance in hearing a disempowering comment about the self, or "through immense emotion involved" in a specific experience or type of experience.] In this condition the "strong or healthy ego states are dampened – have little voice", and cannot mediate either the emotional impact of the occurrence or the resulting beliefs.

Signs of pathological functioning include for this interviewee: illogical/dysfunctional thinking/reasoning; "self-defeating cognitions"; repression of aspects of the self, such as anger; depression; lack of trust in self and the world; lack of nurturing of the self; lack of spontaneity; fragmentation; lack of acknowledgement of others and inability to cooperate with them.

Goals/aims of the therapy process are expressed in terms of constructs similar to psychoanalytic or object-relational theories, such as: the internalisation of "loving figures"/"loving parent functions"/"good-enough parent" (positive introjects); the "bridging" of defenses against association of unconscious experiences and "catharsis"; "cognitive restructuring" of dysfunctional ways of thinking; the restoration of "trust" and "hope" that had been destroyed by trauma; greater "cohesion" through being "in touch with [more] aspects of the self"; "access to the internal world"/unconscious, which leads to insight – specifically emotional insight (as defined earlier) because of the experiential nature of trance work.

[32] I inferred that the meaning here is similar to 'schemas' used by other participants.

According to this interviewee signs of healthy functioning include specifically, "increased awareness of [own] needs and desires" and a greater "definition of [self-] identity"; "increased assertiveness"; feeling "valued and worth the therapist's [and Others'] attention and concern"; "greater spontaneity"; increased "trust in self" and in others; decreased depression, tension and anxiety; the client feels "relieved" of the burdens previously borne alone; the client demonstrates "new insights and new perspectives on self and others".

The participant appears to incorporate a 'meta-goal' of increased degree of effectiveness both in reaching these objective and in economising on the time (and money) taken to reach them, by focusing on the ways that hypnosis speeds up the depth processes typical of transformative therapies: rapport is more easily established, the inner world more easily accessed, reexperiencing of events more easily attained, and – through the increased trust that facilitates trance work – positive introjection more speedily facilitated. A further gain mentioned is that positive or nurturing ego states can be reactivated to facilitate the other goals being met: This appears to resonate with the Jungian concept of a 'good, creative force' inherent in the self (as discussed in the previous section).

[K: The therapist's task includes "giving *permission*" (e.g. to be, to have traits, to change). Hypnotic trance is believed to facilitate the client's use of the permissive space because "in trance the client feels s/he has permission to talk about what otherwise 'may' not be mentioned" - possibly an artefact of the lay impression that people generally do things in hypnosis that they would not normally do, or that they are "in the power" of the hypnotist. Another function is to "demonstrate acceptance" of all aspects of the client, which allows for integration or cohesion: "Through the therapist's acceptance of bad parts of the self, the client can also come into touch with them"; these parts are accessed because "the therapist actively invites out the issues the client will avoid (through the use of various therapeutic techniques)".]

GROUP 6: PHENOMENOLOGY, WITH PSYCHOANALYSIS, JUNGIAN AND GESTALT THERAPY

(Analysis of F, supplemented by data from E and H)

'F'

In the phenomenological view the client is uncorrupted at the core, until his/her development is interfered with by "toxic" others. [E: In health, "if we are fed and kept physically safe and left to our own development, we would be our Self": According to E pathology results from pressure from external sources (other people) *not* to be ourselves.]

Pathology is accordingly constructed as "self-deception", and health as "authenticity", "the capacity to make sense of troublesome [experiences]", a "grasping towards freedom" presenting as "more agency, more control over self and the world, more coherence". [H: "health implies *balance*".]

Pathology is construed to occur because the client "has usually suffered *invalidation* from parental figures". [E: Pathology is the result of "a conditioned response pattern: the client is conditioned to see the self in a specific light and to react from that perspective".[33]] In ignoring, questioning or overriding the client's experience, such "parental figures" create, because of their relatively greater power in the relationship, feelings of confusion and powerlessness: The interviewee explains that the client becomes a "victim" of experiences that have confusing/relative/no meaning and are thus unpredictable and uncontrollable. [H: This happens for instance "through the adult's suppression of childhood fantasies, which results in the splitting off of these fantasies".] 'Symptoms" (presenting in patterns of "behaviours, feelings and [other] symptoms like dreams") often indicate attempts to regain some "control" but they have themselves usually become meaningless to the client and can seem to "overpower" him/her. [H: '"Pathology' can be inside 'normality"' and it is identified by the client who "senses that things are 'not OK': there are hidden pools of difficulty

[33] Through semantic inversion this would suggest also that "de-conditioning", resulting in "freedom of response choices" is part of the therapist's task.

underling the ego-syntonic sense of self", leading to the formation of symptoms like anxiety.]

In the client's "disempowered" state, s/he feels "ineffective" and "useless", unable to "contain" his/her "parts that are disparate", which creates tension and anxiety that maintain the need for symptoms. Because of feeling ineffective and useless, the client becomes both isolated (feeling alien because of not being able to be understood) and unable to take creative initiative to relieve the distress (lacking "agency").

The therapist's task/"function" is constructed here primarily as that of "empowering a 'victim"'. S/he is called to "witness", "understand", and "validate" the "*core* of [the client's] experience", creating meaning, and obviating the need for "self-deception". S/he needs to be "trustworthy" so that the client can learn to "trust appropriately". In focusing on the "totality of being", where "the past is present in memory and also in the imaginative world" the therapist allows for the "unification of 'islands of consciousness"'. [H: "Through languaging/communication things 'lost' through defenses against 'poison in the milk', can become alive, with the result that all the inner life can be spoken about".] The cohering function thus constructed results in the experience of an authentic and empowered, by implication 'whole' self.

[H: One of the therapeutic tasks is "to create a developmental 'vacuum' in the therapy, so as to entice the client to leave the 'womb' and use his/her own resourcefulness". This suggests that the client needs to move beyond dependency on the therapist or on previously comforting devices, in health. "Bad experiences" – also in the therapy, provided they are not malignant – "take one to a place where there is room for growth".[34]]

The therapist's function as transference object is important because the client's "inner world is reflected in the way [s/he] experiences the outer world" or external relationship. Accordingly, the experience in the relationship should lead to insight (denoted as the "capacity for understanding hidden truths"), which connects to the

[34] This appears to me to resonate with the early Kohutian concept of 'optimal frustration'.

goal of finding meaning. [E, quoting Van den Berg: "Other people are one's route to consciousness".]

Conversely, it also appears that the inner world reflects the outer, given that the transference is an "illusion" yet can cause the client to feel "contained and held and cared for", even when the therapist's understanding of the client's "now" is flawed. This allows for the client's "feeling or experiencing or sensing cure" (in the relationship), which for this participant is a precursor rather than a result of insight.

The participant raises some further important theoretical issues that could foreseeably impact on a generalisable understanding of outcome goals.

The first is that "playfulness is critical in healing [because] it challenges the false belief in the apparent concreteness of beliefs held". This construction implies that part of the aspirational goal of the therapy is to engender a playful attitude which allows for greater flexibility, less dichotomy in the way the world is viewed but also that the participant's view of health includes a flexibility and an openness to change and to views held by others. This is reflected also in the interviewee's final statement of goals, namely that the client "is able to 'be' and 'let be' without undue anxiety" and "can allow things to unfold".

The second issue is the attribution of aspects of transference-formation to the therapist, who co-creates the experience and influences the outcomes through his/her views "about people in general, about the patient" and about what constitutes health for that "patient"/client. An awareness of such co-responsibility in the transference is important for the validation of the client's experience, for instance of misunderstanding by the therapist (or others).[35]

A third issue is the avoidance of the term 'the unconscious' as a structural entity. Rather than seen as separated and 'repressed' the past is seen by the interviewee as "present in memory and also in an imaginative world": the past is still to be "dealt

[35] It is also important in the light of other psychological theories, where an acceptance of concepts like 'intersubjectivity' (for instance in Stolorow and Atwood, 1992) are necessary paths to achieve desired outcomes.

with", as in other psychoanalytic conventions, but its 'location' appears to be different than for instance in classical psychoanalysis.

GROUP 7: OTHER THERAPIES, LIKE SYSTEMS THEORY, TRANSACTIONAL ANALYSIS, NARRATIVE THERAPY, GESTALT THERAPY, WITH PSYCHODYNAMIC UNDERSTANDING

(Analysis of W, supplemented by data from J)

'W'

The goal here is stated as a "reconstruction of the Gestalt of the self". The term 'Gestalt'[36] literally means "form" or "shape" (how something presents) and in psychology denotes specifically a holistic view of the self, that "the whole determines the parts" and is more than "the sum of the parts" (Perls, Hefferline & Goodman, 1951/1977, p.19).

The "reconstruction of the Gestalt of the self" for this interviewee implies firstly the idea of *cohesion*, which is preceded by retrieval of memory about the self, which creates self-knowledge, validation of experience, the creation of meaningful relationships and the assumption of agency: "Split off parts that had been disowned, are owned, connected and utilised". Secondly, there is an inference of boundary formation[37] so that the client "can be/become able to contain him/herself" and "feel contained". This occurs as a result of validation and "mirroring" [J: also of the "shitty parts"] by the therapist: The client "needs to know his/her needs and strengths to achieve this". Thirdly, there is an inference in the construct of 'reconstruction' of a decrease in symptoms like tension and anxiety with an increase of positive self-evaluation and hope, so that the client "feels healed".

[36] In keeping with references used for this paper, I will use the convention of capitalising this German noun in English text.
[37] The 'boundary' concept is also included in the 'cohesion' construct by some participants (as shown earlier): Concretely put, like a 'skin' boundaries can 'hold together' the aspects of the Self.

The participant identifies a further initial goal in the therapy as leading the client from a "pre-contemplative" to a "contemplative" way of being in world, a precursor to becoming *aware* of self and others.

Pathology appears to be constructed by the interviewee in terms of various needs that have been ignored or negated by Others, so that symptoms develop as compensatory measure for unmet needs and associative conclusions made in childhood, like "I am not good enough", "I am a victim", or "the world is cruel". These often unconscious conclusions lead to repetitive "patterns" of behaviour or to "symptoms", neither of which are adequately successful in getting needs met or in achieving strength and cohesion to meet life's challenges effectively. The interviewee explains that because needs and other parts of the Self have not been validated, they are "split off"/"taken away"/ "hidden away", leaving the Self fragmented, with energy directed to the maintenance of symptoms rather than to more adaptive functioning.

The therapist's task according to this interviewee is therefore primarily to act as a "Nurturing Parent" (as opposed to 'Critical', 'Negligent' or 'Abusing' Parent roles, for instance) who respects the whole of the client and validates the previously rejected parts so that the "Gestalt of the self" can present as integrated, coherent again. The therapist provides "structure" in the therapeutic "frame" which "provides safety" for exploration of self and world and helps to "decrease chaos" – but which can be understood also to *model* how to structure self and world. According to the interviewee the therapist further functions as proof of a "benign Other/world" by being caring and trustworthy. S/he "digests" feelings for the client so that they can be tolerated and assimilated (which resonates strongly with object-relations theory in respect of the therapist being a 'receptacle' for projected and disavowed aspects of the Self)[38]. S/he also "models" appropriate self-evaluation, "healthy" behaviours, and "encourages the social liberation" of the client so that his/her needs can be met more adequately in the world.

This last, socialising function indicates a further aspect of the outcome goal, namely to enable the client to find and use resources outside of the therapy relationship. The

[38] As per Fairburn, 1952.

interviewee construct the healing process thus: through validation the client is given "permission to be who they are", which "restores" his/her power and also his/her ability to protect the self from further abuse, so that s/he is on equal footing with Others (also those from whom nurturance will be required).

The interviewee states that "regression" techniques (like reenactments or hypnosis) are sometimes initiated by the therapist to evoke reexperiencing of earlier traumata, but only once the client is able to feel safe and "held" enough (after "some months of therapy"). Such regression allows not only for the identification and verbalisation of "decisions", actions and needs, but also for the identification and activation of "possible helpers, also in self states[39] or fantasy, who can make the situation better/meet the needs, so as to change the decision about the self or world" which causes the symptoms or behaviour patterns.[40]

The inclusion (above) by this interviewee of "fantasy characters" as healing/protective/nurturing figures appears to be an important addition to the transformative therapies' arsenal as their use can speed up the positive neurological changes associated with the lengthy process of "working through" traumatic memories in psychoanalysis (as denoted by Perls, Hefferline & Goodman, 1951/1977). The interviewee further suggests that such inclusion also creates an experience of playful and creative engagement in the world, which was listed by some participants as essential aspirational goals in therapy.

Signs of healing here include agency and assertiveness, and greater awareness and control over actions and decisions; coherence and integration of different aspects of the Self, including those previously denied or repressed; new ways of speaking to the self and managing the self's needs and new, more realistic decisions about self and world; a sense of continuity of self in that the client has become "more conscious of his/her whole history"; personality traits and disorders remit when the client evolves more effective and direct ways of having his/her needs met.

[39] The connotation appears to include ego states accessed in hypnosis.
[40] These 'decisions' appear to have semantically similar connotations to 'schemas' discussed previously.

4.2 CONSTRUCT SYNTHESIS

A number of constructs that appear frequently among the participants have emerged in the analysis. While some synthesis has already followed naturally in the analysis within groups, the following are further expanded or qualified also between the groups. In attempting to present a coherent description of the expanded construct in each case, I will omit a repetition of sources at each phrase. What follows here remains a synthesis of participants' views, including denotations common to the field discussed or represented by them, and their own special connotations: They are not *per se* the views of the author. It is necessary in qualitative research to allow the participants to speak with conviction, through the instrument of the researcher's language. Some of the examples mentioned are derived from case material in the full texts which has been screened out of the published summaries, as per agreement with the participants to ensure patient confidentiality.

4.2.1 THE CORE SELF

The core Self is constructed firstly as dynamic, and thus able to change. This change can be in the direction of health or in the direction of pathology. Participants appear to differ in their concept about the core Self in infancy on a continuum from a psychologically fully self-equipped structure which will develop optimally provided it is fed and not allowed to be injured (e.g. in Group 6:E), through, one which is in a state of unitary integration, and able to develop towards either continued integration or fragmentation as influenced by the actions of caregivers/selfobjects (e.g. in Groups 2, 3), one which is free to pick up "potentials of being" if resources are supplied and negative interference minimised (e.g. in Group 1:A), to one which begins in health but can be corrupted also by preexisting[41] "inner aspects" unless these forces are brought into equilibrium - by benign external forces (e.g. in Group 4:T), and one which is not a unity at birth but one which has multiple separate "entities" added to it to form (e.g.

[41] Such aspects could be embedded from a type of cultural inheritance, as with 'archetypes', or could be caused by genetic/neurological qualities, for instance (Garfield, 1981/1973).

chronologically) into various functioning "states" relative to experiences[42] in the world (e.g. Group 5).

The classical view denoted by Rycroft (1968/1972, p. 75) as an unorganised Id moving through Ego-formation towards increasing structure and integration appears not to be supported in any of these data.

4.2.2 CAUSES OF PATHOLOGY

The causes of pathology must, of course, be constructed in terms of the views the participant holds about the core Self, as in the summaries above. Hence there should be a continuum from the position that the potential for and thrust towards pathological development is already embedded at the start of self-formation, to the position that pathological development is solely the result of extra-psychic forces, here specifically denoted as caused by 'Objects' or significant others (who have the stronger end of the power-dynamic) in a person's life. For most of the participants across the various orientations they represent, the causes of pathology appear to be constructed in terms of an internalisation/'introjection'/assimilation of modelling of negative conclusions about the self and its qualities, potentials and abilities, as well as about the world/ milieu with which the self is in interaction, by such significant others (like parental and other authority figures).

The conclusions about how the self and its world are evaluated, are communicated firstly pre-verbally (specifically mentioned by some participants), and later also verbally. Pre-verbal communication occurs through body language (in touch, for instance, which can soothe or hurt, be too short, or intrusively extended) but also through the frequent absence or presence of the Other, the quality of the presence (whether associated with loud, strident noises, or with sour milk, for instance), and the denial or provision of care (such as warm clothing)[43].

[42] According to examples given by some participants, these experiences are not just interpersonal ones but include, for instance, times when the person felt highly effective, or ineffective in activities s/he engaged in (like riding a bike).
[43] Many of these ideas appear to be derived from Klein's work (as described by for instance Bott Spillius, 1994).

The kinds of conclusions which are assimilated by the dis-eased individual include: "I am un-touchable/un-bearable/toxic", "I have no power to protect myself against hurt", "I deserve pain", "The world is cruel", "I can survive only if I accommodate to the Other's needs/ become stronger/larger than the Other", "My judgement/memory is inaccurate and untrustworthy" and many more of the same.

4.2.3 CONSTRUCTS OF PATHOLOGY AND PATHOLOGICAL FUNCTIONING

There appears to be general agreement that pathology is constructed to present as (1) a lack of freedom (e.g. of choices of actions); (2) a lack of power (e.g. to create better options/more freedom of choice) and agency, and a resultant denial/surrendering of responsibility; (3) negative evaluation of the self and of the relative safety/ benevolence of the world; (4) fearfulness (e.g. of own destructiveness or of annihilation by Others) which results in rigid patterns of defensive behaviour/ symptoms, and an inability to form or sustain nurturing relationships; (5) a 'stuckness' in the pathological/unhappy condition of the self and the absence of realistic (as opposed to fantasised) hope of change; (6) a lack of creative energy/strength for more adaptive functioning (in, for instance, problem-solving); immense effort in living/surviving; (7) a lack of awareness and acceptance of aspects of the self resulting in fragmentation or a lack of self-definition, and a narrowing of experiential possibilities (e.g. of a wide range of emotions); (8) an inability or defensive refusal to engage in investigative and associative internal and external dialogue (e.g. through a lack of words/language with which to describe/give meaning to pre-verbal experience); (9) an absence of meaning or purpose generally, and of meaningful relationships between internal and external events and characters, accompanied by feelings of isolation and rejection; (10) a lack of realness/ authenticity; self-deception, or presenting as a "false self"; (11) an inability to have/create/maintain/respect boundaries, including those of impulse control, and a lack of adaptive (as opposed to defensively compulsive) structure in daily life; a lack of definition of and respect for the Other.

4.2.4 THE THERAPEUTIC 'TASK'

The creation of what can generally be a termed 'a facilitative environment' within which the healing or resumed positive development of the Self can occur, appears to be a key concept in participants' descriptions of the therapist's task. Such an environment is constructed as an interpersonal one, where other persons, like the therapist, can influence the client's perception of his/her self and the world (of people, 'supernatural' influences, societies, and even causalities associated with matter).

The environment itself (e.g. through aspects of the 'frame') and the therapist's actions are geared towards allowing the client to feel welcomed, important enough to warrant full attention of both parties, effective (in that s/he can be heard, for instance), safe (also from internal/psychic 'threats'), a meaningful entity in a meaningful world, 'OK' or 'good-enough', and not alone/'connected' (i.e. in the relationship with the therapist, which also paves the way for intimacy with Others and a reconnection to external resources of all kinds). Most participants identify the internalisation/'introjection' of the therapist/therapeutic symbol as a chief function of the therapeutic environment. In some views the therapeutic environment also mediates, through 'facilitated introspection', between preexisting internal forces (for instance 'archetypal' forces) to create more balance and greater freedom of choice and agency.

The events that are facilitated by this environment include: accessing and reclaiming of repressed /'lost' memory of personal history; validation of experiences through such memories, the finding of 'meaning'/'reason' for them to be probable/possible/ actual (with the help of therapeutic question, comment or interpretation); the linking and integration of such experience into the Self; the empowerment of self through acceptance, insight and integration, so that pathological patterns of behaviour (including internal dialogue about the value of the self, for instance) can be reviewed/ changed/cancelled, and so that the client becomes free to choose 'how' and 'who' to be, i.e., to find his/her 'own sense'/'authentic self'.

4.2.5 CONSTRUCTS OF ASPIRATIONAL/ OUTCOME GOALS IN THE TRANSFORMATIVE PSYCHOTHERAPIES

Although the goals will be presented initially as if they were separate constructs of health, it has become obvious in the previous sections that there is an inter-relatedness between aspects of health. The relationship between various 'goals' will be indicated where connotations of constructs overlap.

4.2.5.1 Freedom

This construct indicates that the Self has been liberated from constrictions, like fears, defenses, fixed patterns of behaviour over which the individual has little or no choice or control, physical and interpersonal situations in which the individual has little or no power or choice. In the liberated state, the individual is aware of options and of resources, feels free to use them, and has the energy and initiative to do so.

4.2.5.2 Strength

This construct incorporates the concept of 'empowerment', which occurs through the such events as: the acquisition of knowledge and causal insight; the survival of confrontation with fearful fantasies, and the naming (and thus relativation) of 'nameless dreads'; the acquisition of verbal and non-verbal language with which to transact one's needs and desires in life; the validation of the self in the repetition, reexperience and meaningful interpretation of memory; the attribution of power and efficacy to the self in the therapeutic reaction via the validating responses of the therapist; the gaining of a strong auxiliary ego in the person, first of the therapist-ally, and later in other nurturing relationships; the space that allows being less vigilant against attack so that energy can be used more creatively, for instance to format 'real' problem-solution; the internalisation of the symbolic strength implicit in the 'frame' and the strength and structure represented by or experienced in the therapist in relationship (to for instance the 'destructive' parts of the client's Self); 'introjection' of 'strong' and resilient aspects of the therapist; the availability, through having gained access, of own strengths and resources (for instance, in 'ego states', 'alter-egos',

'archetypes', 'imagoes', 'internal objects'); the mustering of resources through integration/cohesion of aspects of the Self.

4.2.5.3 Cohesion

This construct contains the connotations of 'boundedness' and 'structure', and is thus in part formed by the internalising of structures and boundaries encountered and negotiated in the therapy, and thereafter practised outside of it as well. Also incorporated is the seemingly paradoxical concept of liberation from unhealthy or maladaptive boundaries (e.g. between people, or between feelings and thoughts connected to specific events) which were created/constructed as defenses: The 'restructuring of the personality' or 'transformation' thus implies for the participants both the removal of inappropriate 'boundaries' (i.e., ones leading to various kinds of pathological functioning, like isolation, 'splitting') and the construction or strengthening of appropriate ones, *within which* cohesion is facilitated.[44]

The other important connotations in the construct of cohesion are 'togetherness' (being 'cohesed'/'glued' to form a unity) and 'coherence', i.e. the formation of meaning and relationships between parts/aspects of the Self to create a meaningful entity/'Gestalt'. 'Togetherness' implies that there can be *communication and agreement* between parts so that the individual can act as a unity (and not be easily prone 'fragmenting' when confronted with stress, for instance), and also a *balancing* of dichotomous forces (e.g. strivings) in the person. Both connotations further also suggest the assumption of responsibility for the actions (including feelings) of the individual: if things are connected and are meaningful/make sense, they are less likely to be designated 'Not me'. This further implies that an individual will be unlikely to see him/herself as a 'victim' of uncontrollable forces (like Others), and that the 'unity' and 'structure' in the Self help to create 'Strength'.

The participants generally attribute the formation of both qualities to the encountering of previously hidden/'lost'/'repressed'/'forgotten' memories of events and of aspects of

[44] In this regard, the therapist is often metaphorically compared by the broad groups of participants to a 'container' of parts or feelings of the client – which are 'fed back' once they have been 'digested'/'de-toxified'.

the Self ('making conscious the unconscious'), and the creation of meaningful relationships between them (e.g. through interpretation/explanation associated with transferential encounters). This activity is often described by participants as 'gaining insight'.

Cohesion is also made possible through the assumption of new concepts identified in words/language used by the therapist and becoming part of the client's self-description and self-identification (for instance in the naming of ambivalent feelings occurring together in one individual). Through language the 'impossible' has become 'possible' and thus more likely to occur. (The suggestion can be made, for instance, that the client can be 'angry' without being rejected/destroying others, or other parts of the Self, in the *way* the therapist 'risks' naming and talking about the feeling without flinching.)[45]

Cohesion can also function as a 'model' of how a person can function harmoniously and assertively in the external world. If the inner and outer worlds reflect each other (according to participant F), the experience of growing cohesion of the self can be expected to create the possibility of finding, for instance balance, mediation, and relationships in the external world (impacting on functioning in relation to society, family, work, culture, 'god'/universe). The individual thus gains agency and intentionality/ purpose, and also appropriate responsibility in the world.

4.2.5.4 Steadiness

'Steadiness' is constructed as a result of cohesion, strength and purpose, and contains a self-regulatory function. It has connotations of stability, reliability, directionality/ intention and planned structure; according to participant H, "health implies *balance*". Through steadiness, the individual can conserve and restore strength and resources so that life challenges do not deplete them. It further allows for the formation of stable relationships (with people but also with, for instance a career), which do not sap the energy but rather become resources in themselves. It is also a quality which in society

[45] This appears to be a general understanding of the construct: As one participant not included in the sample, said, "Naming calls things into being".

is likely to promote leadership opportunities, and other positive experiences which serve to promote continued positive self-esteem.

4.2.5.5 Commitment to growth

This is constructed in different terms like the "freedom [to continue] to pick up potentials of being" (A), "taking the self and the [growth] process seriously" (Z), to again "become able to fulfil one's creative potential" (N), "connection to healing of the social sphere" (S), "ability to delve deeper into themselves" (T), "a place where there is room for growth" (H), a "contemplative way of being in the world" (W). It is connected to agency and strength and implies that the client will continue to grow towards autonomy/authenticity/agency, and not revert to 'immature' ways of being in the world, or to the 'stuckness' that often preceded the therapy. This construct means that the therapist enables the client to become his/her own therapeutic force, rather than to be dependent on the therapy for ever: according to several participants the client must have 'internalised' the asking of questions, the seeking of the unknown, the making of connections, the naming and meeting of needs, to continue to grow optimally – to fulfil the continuous growth potentials of the core Self, according to some views.

4.2.5.6 Ability to communicate

This ability is assimilated through role-modelling and rehearsal in the relatively long term of the transformative therapies. On the one hand, the therapist teaches concepts and vocabulary, especially about the inner world, pre-verbal or non-verbal experiences to the client so that the client has enhanced ability to communicate who s/he is but also what his/her needs are. On the other, the client's own language, for instance in the selection of metaphors or the descriptions of experiences, is validated, so that the client can feel understood and 'sane' (able to communicate sense). This, as we have seen in the analysis, results in feelings of equality, efficacy, agency and acceptance, and creates hope for future needs to be met. Learning the correct (i.e. explicit and understandable) names for experiences (like feelings) dissolves disjunction between feeling and thinking, resulting in increased authenticity and increased cohesion.

The client also learns to notice and identify non-verbal signs that are focused on in the therapy, and can transfer the understanding of such communication to his/her social sphere, so that s/he becomes more adept at interpreting social situations appropriately – a prerequisite for social acceptance which further strengthens self-esteem and allows for more accurate social judgement and decision-making. In many of the transformative therapies, according to participants, the client is invited/given permission to speak spontaneously/'from the heart' and thus practises being authentic; then also the client is often invited to do most of the talking, which allows him/her to 'find his/her own voice', to hear his/her own ideas, not to be afraid of speaking/voicing and to have some power in the direction and focus of the sessions. In the silences (as specifically emphasised by one participant), internal dialogue and the surfacing of repressed/forgotten contents (including projections) are allowed to be experienced, as well as other important psychic experiences such as 'being with' someone without 'doing'.

4.2.5.7 Ability to play

Several participants consider the ability to engage in the world in a playful, exploratory manner, to explore creative possibilities through fantasy, an essential outcome of the therapy. This facility is learnt within the permissive space, safe from 'annihilative' repercussions, in the therapeutic relationship. When the authentic Self is invited out to play/get acquainted with the world/Others/self, and s/he neither destroys nor is destroyed by the (often tentative) revelations of the 'shitty parts'/'evil'/'poison', a space[46] is created where the question 'What if…?' can facilitate the changing of previously held convictions ('conclusions'/'schemas') about the self and the world. Apart from the physiological benefits gained by a less rigid mapping of the world, with resultant fewer disappointments and frustrations (as pointed out by several participants in groups 5 and 7), the capacity to engage in a playful attitude with the self and world opens up vast opportunities and resources for the continued growth and strengthening of the Self, also in relationships. There is also the possibility in play that if something can be imagined (e.g. 'a better outcome to the life narrative'), it can

[46] In Winnicottian terms used by some participants, a 'transitional space'

become real, which creates hope: "Playfulness challenges the concreteness of beliefs held" (F).

4.2.5.8 Agency

This construct has the connotations of empowerment, effectiveness, responsibility, choice, intention and self-definition. Participants suggest that by empowerment in the therapeutic relationship the individual finds that s/he can have effect on the world. While this allows him/her to create favourable conditions for meeting needs, it also negates the 'victim' role and allows the individual to assume co-responsibility for the way s/he deals with the vicissitudes of life. Further, according to at least one participant (D), the client has to assume some responsibility also for his/her past unhappiness, and by doing so, s/he becomes an 'agent' of the desired future through the purposive control of choice. By assuming agency, the individual gains "the ability to meet appropriate life cycle tasks and life tasks" (D). This construct thus appears to incorporate the idea that someone 'in health' is not just entitled to happiness, but is committed to responsibility (which could include an appropriate sense of 'duty', for instance towards one's minor children[47]).

Agency also implies that an individual can make decisions about the direction of his/her future development, even in the face of social opposition (D, quoting Paul Adams, "helping our patients to have the courage of their perversions"). This suggests that 'agency' can help to determine who or what the core Self is/needs to be, also from a moral or ethical decision-base.

4.2.6 SIGNS OF HEALTHY FUNCTIONING/ EFFECTIVE TRANSFORMATION THROUGH THERAPY

The lists of signs of healthy functioning suggested by participants are fairly exhaustive and often inclusive of what are also given as 'outcomes' – a natural result of being encouraged to speak broadly about the processes of therapy as observed in

[47] As per example in one interview where the phenomenon of child battery was discussed.

practice. The data will be presented here (Table 1) in list groups *not* suggested by the participants (who were speaking 'off the cuff' in the interviews), in an attempt to make the volume of data manageable. The many signs listed by participants or suggested by their discourses are grouped under broad construct-types, and the repetition of similar parts of larger constructs was avoided, even though such overlap would be accurate. These 'construct-types' have developed naturally through reading over the data from end to end, and are not presented as 'scientific' or conclusive entities; there are also some obvious and expected overlaps between these constructs, because of the prioritising of completeness and organisation in presenting participants' views in this section.

The reason for inclusion of this category in the interviews and in data selected for analysis in this research, is to allow for qualification and elucidation of other constructs used by the participants in their descriptions of process and outcomes of health, and also so that the researcher could gain a fuller (and sometimes more concrete) understanding of their construct intentions.

The lists are further included under the section dealing with 'Construct Synthesis' (rather than 'Analysis') because they represent a compilation of views across various orientations, and can also serve as a check on how representatively the synthesis of other constructs was done in 2.4.5.

The 'construct-types' that emerged are signs of healthier functioning in the clients' feelings/emotions; their ways of thinking; their self-descriptions that suggest greater cohesion, substance, self-esteem and power; their relationships generally; their accessing of resources and provisioning for their self; their increased sense of freedom and options in the world; greater assertiveness and effectiveness in daily living; their sense of meaning and purpose in life; greater ability to communicate is all ways and all spheres; more effective management of life tasks; presenting as generally healthier and more accessible people; hope and faith in the self and the future.

These signs support the constructs of aspirational/outcome goals discussed in the previous section.

Table 1: LISTS OF SIGNS OF HEALTHY FUNCTIONING SUGGESTED BY THE SAMPLE OF TWENTY PARTICIPANTS:

Feeling:

Adequate affect regulation and feelings of stability/stable/balance: A, P, C, O, N, D, H
Decreased distress/Increased contentment, happiness: L, O, T
Decrease of depression: A, O, T, G, D, R, K
Decrease of anxiety/tension: A, O, T, G, D, R, K
Decrease of neurotic guilt: P, T
Feeling contained: C, N, H, W
Less mania/pseudomania: L
Increased consciousness of feeling: T, R

Thinking:

Cognitive restructuring (e.g. of trauma-linked memory)/de-conditioning: R, E
Decrease in dichotomous thinking: B
Decrease in catastrophic thinking: C
Greater flexibility in thinking: O, J
More aware of own patterns: W
Able to re-decide about self and the world: W

Substance:

Decreased feeling of emptiness: P
Absence of psychosis: L, T
Awareness of body: L
Feels more real: K
Decreased 'splitting' and 'projection': H
Feels more 'whole'/'healed': H, W
Feels 'strong': E
Less 'chaos' in client's life: W

Relationships:

Tolerance/maintenance of intimacy (able to attach): A, Z, C, L, N, G, K
Appropriate trust of self and others: A, C, G, D, R, K, F, J
Less needy, increased acceptance of own separateness: A, P, C
More adaptive behaviours towards others, like authority figures at work: A, T, D, R, F
Feeling connected to others (less alone)/part of society: C, G, R, E, J
Greater range and complexity of relationships: M
Increased interest in the other: D, R
Appropriate dependence: A, D
Can start and maintain a relationship: T
Avoidance of destructive relationships: D

Tasks:

Increased ability to feel the way through a situation: P
Increased structure to practical life: B
Tolerance of frustration: P
Can do more things in the world: C
Not so easily overwhelmed: C
Appropriate defenses: L, G, J
Increased energy: T
Accomplish life cycle tasks: D
Managing grieving and loss: J

Choices:

Ability to make choices that bear satisfactory consequences: A, M, L, K
Increased freedom of choice: P, K, W, J
Freer range of actions (e.g. taking risks): M, K
Greater spontaneity: R
Freedom/permission to 'be': H, W

Power:

Increased assertiveness/ability to represent own interests: P, O, R, W
Appropriate responsibility/not a victim: M, T, G, D, F, E
Being effective in living: Z, F
Ability to set limits for self and others: T
Less bound to others' judgements: B, F, E
Feeling more power in the world: P, K, F, E
Confidence in own efficacy: C
Less addiction: L, D
Able to move out into the world: O
Able to take initiative: F
Feeling more power over self/own reactions: W
Autonomy: E

Provision:

Able to attend more successfully to own needs: C, D, R, W
Identification of resources/'helpers' (also within self): J
Decreased acting out: P, L
Increased creativity: L, N, S, J
Improved functioning in work: D
Belief in self-growth: H
Realistic expectations of self and others: M
Can enjoy pleasure: L
Increased interest in need to grow/ transform: D

Meaning:

Increased understanding of people, events and connectedness between them: A, B, C, S, F, J
Understanding defenses and using them more appropriately: B, F
Increased understanding and definition of self: A, S, W, J
Skilled at making the unconscious conscious: B, W, J
Feeling 'sane'/understandable/'normal': A, C, O, D
Finding sense/patterns in the universe: T
Creating a new, empowering discourse: S

Communication:

Increased ability to identify and express needs: P, R, W
Increased ability to communicate inner world/feelings: P, F, W
Able to talk and connect: C, K
Skill in communicating: C, K

Positive outcome in life:

Hope (e.g. for better outcomes of endeavours in life): M, B, O
Reaching out to life (including feelings): B
Sense of purpose: O, N, T

View of self:

Feeling valued/valuable, increased self-esteem: C, K, W
Likes self: C
Can cope: L
Increased sense of validity of own experience: O
Self-acceptance: N, G, W
Can be alone: C
Increased self-respect: O
Stronger sense of self-identity: N, G, D
Feeling whole: T

Actions/Presentation:

Freer gestures: A, M
Decrease or change in symptoms: M, W
Decreased personality disturbances: O, D, W
Decrease in destructive & self-destructive acts: T
Able to play: F
Different reactions to previous situations: W
Increased flexibility: P, N
Appropriate inhibition: L
Healthier: T
'Nicer people': K
Decreased problems in their lives: W

CHAPTER FIVE
DISCUSSION AND CONCLUSION

In the dialogues with experienced and informed psychotherapists during the data collection phase of this research, as well as in the intimate contact with their ideas during transcription, summarising and analysis, the author has been enriched, by the acquisition of language and insight in the broad field of the transformative psychotherapies but also by an internalisation of therapeutic concepts and qualities thus encountered. It is hoped some of this enrichment will also be available from the sample of work reviewed here, to other therapists and trainee therapists.

The aims of the thesis were to find out what the outcome goals of therapists working in the long-term, transformative types of psychotherapies were, to gain a proper and full understanding of these goals and their connotations and implications, and to see if goals held by different therapists, and across different orientations, held sufficient similarities for a generalisable outcome goal construct to be identified. Such a construct could then hopefully serve as a basis for future research within and across different kinds of psychotherapy, as well as for further expansion or qualification of the construct through other therapists' judgement of its applicability according to their own views and experience.

The literature reviewed for this paper generated a vast field of possibilities associated with desired outcomes of psychotherapy in general and in the transformative psychotherapies specifically. It also revealed the many problems in communication or research across orientations. Therapeutic methods and descriptions of process differ between orientations; very often dissimilar terminology is used for apparently similar concepts, or similar terminology is understood to imply different ideas. In the construct synthesis of the previous chapter, it is hoped that a format can be found for a way to organise the overwhelming volume of information already available in this area of research, by which also further research findings can be integrated.

The research around outcome goals has also produced heuristic insight into other constructs, like views of pathology and health, the structure of the personality, the origins of pathology, the way transformative therapy supposedly works to promote health and 'transform' the client. These are all constructs that are important for further research into the future of such psychotherapy, its possible incorporation in a 'national health' system, its applicability to the broader community in South Africa and other countries.

Before we can adjust our psychology to represent and provide for the psychosocial experience of, for instance the 'black' population here, identified as long neglected in 'mainstream' South African psychology by Seedat (1998)[48], it is essential to pinpoint basic constructs in such a 'mainstream' psychology. We are fortunate that very early in the history of psychotherapy/analysis in this country, Vera Bührmann, one of the founders of the Jungian analytic movement here, also attained the status and expertise of an indigenous healer (Bührmann, 1984): Hence, foundations already exist for dialoguing between 'western' and 'African' psychological systems, perhaps in a return to the holistic ideas expressed by Jung early in the century (e.g., Jung, 1958).

Not only is the gap between Europe and Africa bridgeable in certain schools of psychological thought, but also the gap between west and east, as is noticeable in the proliferation of eastern ways of accessing the 'unconscious' and of 'strengthening' the psyche, such as 'holotropic breathwork' or 'holographic repatterning' (Jean Campbell, personal communication, 1998[49]). A refining of current basic concepts in western psychology is necessary groundwork for any future comparative research and the evolution of valid therapeutic methods that can stand testing against external norms (rather than internal ones that may be biased towards supporting existing models).

[48] Seedat concludes from his analysis of psychology publications from 1948 to 1988 that representation and foci in South African psychology are those of the 'English', 'white', 'eurocentric' and predominantly male communities, to the neglect and exclusion of most other groups. However, Durrheim and Mokeki (1997) suggest there has been some progress towards greater equality in race-related considerations represented in the journals from the late 1980s onwards – which makes the type of foundational work presented in this research even more urgent.

[49] Jean Campbell is a holistic healer in Grahamstown in the Eastern Cape; in Holographic Repatterning the body's electromagnetic field is used to access unconscious beliefs and healing decisions through a series of questions given positive or negative (i.e. 'yes' or 'no') field movements.

So many questions have necessitated this research into outcome goals as a fragment of the vast field of the psychotherapy process, and many more have arisen in the course of this research: Unfortunately, very few can even be touched upon within the confines of this minor dissertation. This research was not intended as an exhaustive investigation of therapy process but rather a review of current understandings and beliefs about aspects of the transformative interventions used extensively in this country and elsewhere. While it is a loss that it was not possible to focus on the full set of interviews and the many issues important to the continued development of psychotherapy in South Africa that were raised by participants, the information excluded will also be easier to access and organise for future research by this author on the basis of the work presented here.

This research also has other limitations: Despite attempts at fairness in interviews, selections and analysis of data, the researcher was aware of some biases, which may have skewed the presentation of the final product: Some interviews flowed more easily than others and there was a ready rapport between the author and the interviewee, so that these interviews tended to yield more information than others that were characterised by less free interaction and dialogue. This was especially noticeable in some of the interviews with relatively pure 'analysts' (as per their own descriptions) where taped recordings yielded long, reflective silences[50], compared to others who were more discursive: The author tended to select texts that were relatively 'full' of information, personal opinions and examples from the therapist's practice, which meant that some potentially valuable and perhaps contradictory constructs may not have been included in the analysis. Then also, because the interviews were so long (up to 27 pages in length for a full transcription), the creation of summaries that reflected the main themes of each interview resulted in the loss of some rich and often poetic descriptions which may have further qualified and enriched the constructs investigated.

[50] I did at the time ascribe this to the 'habit' of traditional analytic silence on the part of the interviewee, but later wondered what my own unconscious contributions may have been, for instance that I was less comfortable with an initial silence and may have given a following prompt or question irrespective of whether the interviewee had had sufficient time to formulate his/her authentic and probably very rich response. A main issue for me was also some urgency because of the limited time available in interviews followed by the interviewee's normal professional activities, so that my preoccupation with 'getting to the important stuff' on my list may have preempted responses.

Other limitations included: As a time-saving device in interviews the author would affirm when asked and when applicable, an understanding of basic concepts of an orientation represented by an interviewee (such as 'projection'), rather than to include the interviewee's own explanation of such terms, which may have shed further light on constructs of pathology and health. Tiredness may have been a factor: Sometimes up to four interviews would take place in one day in different outlying parts of the Cape Peninsula, which may have resulted in less or more activity in the interview on the part of the author, and accordingly affected the richness of concepts that were generated; of course, in some cases the interviewee may also have been affected negatively or positively by factors like tiredness, or the ready memory of much case material, for instance when the interview was given after a full day's case work. In a study like this the subjective element is a strong influence: In a few cases the author judged the interviews to have yielded 'book knowledge' from one or more orientations rather than a revelation of the interviewee's personal constructions about aspects of the psychotherapy process investigated, and these data sets were de-selected, perhaps unfairly; and in general, the decision about the criterion of 'richness of information', for instance, was done on subjective response to gross appraisal of a set of data compared to others representing similar orientations.

A limitation of the analysis of summary notes - even though they contain the interviewee's own words - rather than full text, is the danger of misrepresentation of the signifier's true intentions. Ideally, the interviewees should have been given the chance to view the summaries and listen to the taped recordings of their interviews, and comment on these, prior to analysis of the data, but time and finance constraints prevented such further checking[51]. It is hoped that where interviewees recognise the summaries as originating from their interviews, they will not be disappointed by the way information was interpreted.

[51] Out of the 52 persons interviewed, one would have preferred to see the full transcript to ensure correctness, but this interview was not included in the analytic sample on other criteria. Four others would have liked to have transcripts, but reported it was so because they had felt it valuable to be given a space to talk about their ideas, and they wanted them for personal record or research. Several participants asked to be told when the results would be accessible, because of their interest in the research – the participants will be notified as per this request.

Another limitation was the absence of therapists representing 'black'[52]/'African' and other ethnic groups in the data pool or sample. The author would like to point out that both she and some of the participants tried for some months to secure interviews with transformative therapists from all ethnic groups, but were unsuccessful in getting responses. However, in the light of the need to define current constructs in 'western' psychology before its applicability to other communities may be assessed, this limitation appears tolerable.

For the rest, there was a fairly equal distribution of gender, and age groups (with the early twenties naturally underrepresented as newly-trained therapists did not yet have much experience of 'long-term' work); participants had also been trained in a wide range of universities and institutes (including in the UK) and in different decades of psychological development in this country; therapists from psychiatric backgrounds formed about one third of the data pool, with others having had various kinds of psychological training; Afrikaans-speaking therapists formed about one fifth of the data pool and the sample used for analysis – but only one worked from a 'psychoanalytic' orientation.

There were many benefits in this research, some of which were mentioned at the start of this chapter. Others pertain more directly to the goal of the research: The analysis and synthesis of pertinent concepts in this paper have resulted in a better understanding of how mental health and the process of healing are constructed by the interviewees and, because of the agreement with many ideas reviewed in the literature, probably by many other therapists working in the transformative psychotherapies.

The main similarities in the understanding of these constructs, appear to be the following:

(1) There is a general belief in something that can be called a 'core Self' or 'basic personality', that is an integration of many aspects of a person which develop from

[52] As per classification of Seedat, 1998.

potentials present at birth/conception. The core Self is dynamic and can change in the direction of more or less adaptive general modes/patterns of functioning.

(2) These modes of functioning are the result of basic beliefs about the self and the world ('conclusions'/'schemas'/'decisions') that are relatively firm and fixed because of strong memory imprinting due to the heavily-laden affect associated with traumatic events, or due to repetition in actual experience or in mental review of experience.

(3) These beliefs are caused by events leading to feelings of conjunction/'cohesion' or disjunction/'fragmentation' about the self, where the first is associated with the experience of power in the world, and the second with disempowerment/'victim' status. Events causing conjunction are 'validatory' and allow for 'authentic' self-expression and the freedom to engage with all aspects of the self and many experiences, while events causing disjunction are negating/rejecting of aspects of the self and result in such (unconscious) acts as 'repression', 'denial', and 'projection', so that a 'defensive' or a 'false' self system is created.

(4) The causal events are usually interpersonal in nature, specifically through the 'messages' received by the verbal and non-verbal interaction of significant/important other people in the individual's early and later milieu. The response-types of such persons can be 'internalised'/'introjected' to form part of an individual's psychic make-up, affecting future actions and decision-making.

(5) When primary interpersonal contact has been mainly invalidatory/rejecting/ endangering, an individual's optimal ('normal' – in some views) development is 'arrested' so that s/he is not free to develop more adaptive ways of living/'being-in-the-world'.

(6) The task of the therapist is to create, through the therapeutic relationship with all its agents, like the 'frame', sufficient validatory events (or possibilities for 'introjection' of 'a good object' – in some views) so that the individual's development towards adaptive living/'maturity' can continue. Agents of validation include: the creation of a 'safe space' and strong benevolent ally in the relationship for the investigation of previously overwhelming events and associated feelings; the creation of

meaning/sense of previously apparently meaningless events through language/communication; the creation of connections between events; the giving of different perspectives on events that had been interpreted in negative/dichotomous ways; the validation of the individual's self as valuable.

(7) The aspirational outcome is a Self who can access a wide range of internal and external resources, who is not overwhelmed by internal and external events, who is in contact with and can activate appropriately many aspects of itself, who can balance need and demand both internally and externally/socially, whose defenses are appropriate to situation or threat, who uses power appropriately and assumes appropriate responsibility for itself, others, and its situation, and who is free to use energy creatively (in problem-solving, active living, and in recreation). For most participants the many aspects of a 'healthy' and 'mature' Self, were denoted by the terms 'cohesed'/'cohered' or 'integrated', and 'strong'/'empowered'. In terms of structure this implies that the 'transformation' goal of the therapy meant that the client was to change from a state of relative fragmentation and disempowerment to one of coherence and power. Such a transformation would then allow all the many positive qualities associated with 'healthy' or 'mature' persons (listed as 'signs' of healthy functioning) to be generated from the individual him/herself, including the tendency for further development in the same direction.

The goals in the transformative therapies are specifically stated to be the transformation or 'restructuring' of the personality rather than the changing of symptoms or the external and internal acts (such as 'dysfunctional thoughts' in the cognitive therapies) of the individual, because the changes in symptoms and behaviour are presumed to follow inevitably on the creation of a stronger and more integrated 'structure'. In contrast, the more 'directive' therapies claim that by changing symptoms and behaviours, the personality is gradually restructured/transformed as the skills that bring empowerment over the inner and outer environment 'generalise' to all aspects of the self[53]. While a comparison between these different types of therapies is not part of the present research, it is hoped that the constructs developed here will facilitate further research in such areas as well: In this research some similar key

[53] Rachman and Wilson (1980)

concepts have already emerged, such as the client's experience of power and efficacy in relation to aspects of the self and the world, the client's experience of self as valuable, and the role played by beliefs/'schemas' about his/her self and the world, and his/her relationship to others/the world.

Do the constructs that evolved mean that therapists generally subscribe to a view of health as being ego-centred only? From the analysis it appears *not* to be so simplistic: Many of the participants pointedly listed as signs of health the integration of the individual into his/her community, and the ability and desire to take up responsibilities within the greater community. To paraphrase Winnicott's often quoted aphorism about the infant:– 'there is no such thing as a client'; it is always the client in relation to Other/s.

The focus on the outcome/s constructed above, is certainly not a way of saying that results like 'cohesion' and 'strengthening' of the Self are all that therapists aim for. Rather, the implication is that, by generating such strength and cohesion, the client will be able to meet all the many other aspirational goals, such as being able to work, play, love, experience pleasure, be competent in roles in the community, etc., mentioned in Chapter Two (p. 19).

Similarly, the findings do not negate the need for skills of, for instance interpretation, or role play, generated since the start of the century. In fact, during discussion of process, specifically with *non*-Freudian therapists (e.g. under prompts 2.1 and 2.2, Addendum A), questions like 'Do you think/find it is still essential to deal with ideas from Freudian theory, like the resolution of the Oedipal complex?' were asked. Answers varied but generally therapists seemed to feel that such issues were still pertinent, although perhaps in a more symbolic sense: Thus, for instance, the Oedipal conflict could be basically a power struggle for the safety from annihilation seemingly to be gained by possession of the primary Other – in such a scenario sex would be a means of possession or attachment modelled by the Other's partner, in addition to an instinctual arousal response (e.g. from case material in the interview with K).[54]

[54] See Blass and Simon (1994) for further explication of Freud's seduction theories.

Despite similarities in many of the outcome goal constructs, and the apparent agreement on the signs of healthy functioning, most participants selected a 'main' orientation for their method of work, but gained understanding of the client's problems from other orientations as well. This might imply that no one theory can as yet fully account for all variables in psychological development and functioning – even though some proponents appear to proclaim self-sufficiency rather vehemently in the literature.[55]

The author's feeling is that the cliché about there being many ways to skin a cat holds true also for psychotherapy process: Perhaps the reason that similar outcomes can be attained through vastly dissimilar methods (including those of more directive therapies not included in this research), is that we have not yet refined our methods of observation enough to spot the *real* agents of change – for instance at psycho-biological level. Some modern neurobiological and technological developments (for instance in micro-photography , MRIs or PET scans) are helping us to refine our theories at a more basic observational level than when the theories were generated.[56] There are already several explanations accepted by the World Health Organisation of what happens at neurological level to create the pathways that result in control by 'schemas'/'fixed beliefs', or what happens in the laying down and activation of traumatic or validatory memory traces in the brain (e.g., Cummings, 1994).

Findings such as that the high levels of cortisol generated during traumatic events (and during fantasising about such possible events in for instance emotional abuse situations or about actual past events whether or not directly related to the self) causes hippocampal cell damage which impacts on the way memory functions in many ways, including the apparent 'loss' of experiential memory and 'somatic flashbacks' associated with trauma (Pally, 1997a), suggest avenues of reasoning from a biological starting point, that could help determine more accurately elements of the process of therapeutic (as of pathologising) events. Such findings appear now to provide proof of aspects of psychological theories generated early in the twentieth century, such as

[55] Kohut (e.g. 1984) and Lichtenberg (e.g. 1992) appeared to me to be such apologists in papers I read recently

[56] A story comes to mind about four blind persons describing their construct of what 'elephant' meant from only their fixed observation points, respectively in front, behind, on the side, and underneath the object about which they were generating their theories.

those posited by Mahler, Winnicott and other developmental theorists: An example is Pally's (1997b) review of work by Schore and others who conclude that, for instance the capacity to self-regulate is dependent on the development during a neurologically sensitive period (age 6 months to one year) *as a result of the mother's modulation of the infant's intense states of arousal*, dopamine-releasing axon terminals grow from sites in the midbrain into sites deep in the pre-frontal cortex, and there cause the growth of synapses and glial cells which become the "key element of the maturing ability to self-regulate affect states" (p.591). A psychologically and therapeutically-important finding is that in order for this growth to occur, "the infant must engage in *mutually responsive*, face-to-face, gaze, vocalisation and smiling interaction with the caretaker" (p.590, italics mine). Such findings elicit exciting questions about the transformative psychotherapy process – the result of which transformation takes place at neurological level as well as in (or before?) positive evaluation of self state and general functioning in the world[57] – that, while falling beyond the scope of this dissertation, beg further investigation, for instance: Does this mean that similar conditions should exist in the therapy room during early phases of the transformative/reconstructive therapy? Such finding also suggest how for instance positive maternal (or Selfobject) qualities may be 'introjected' in neurological terms (or conversely, how 'destructive' Others may also be internalised).

From an overview of the descriptions used by interviewees as well as the similarities in constructs shown above (p.85 onwards) it appears that specifically object-relational concepts seems to have permeated most of the narratives. This holds for the sample as well as the broader data pool, and specifically for persons holding Self psychological views – despite Paul Ornstein's position that self psychology is *not* an object-relations theory (1991). And noone has discounted basic outcomes held from the start of the century, such as the ability to work, play, love, relate, (and others, as per p.19 above). Can concepts such as Freud's Oedipal conflict or Klein's introjects have become generally appropriated if they fail to add some essential understanding of value to the community that uses them?

[57] As communicated by interviewee R, based on reading in the field.

The questions raised in the current movement towards the possible establishment of an integrative psychotherapy are mentioned in section 2.6 above (p.28 onwards). While there is not much in the line of literature in this specific field as yet, therapists involved in the exploration of such possibilities are currently investigating the similarities across various orientations, both directive and non-directive, in existing literature from different orientations and in their own case work. The feeling is that a kind of 'optimal provision' for the client would include various therapeutic functions (or perhaps 'tasks' as used above?) at different times in a therapy and even in a session (different to eclectic mixes such as that of Pine, 1990). Accordingly, a client may need more 'holding' at one time, or more 'interpretation', or counselling, or the use of cognitive-behavioral skills, and so forth (Cathi Michelson, personal communication, 1999-2000[58]).

The Wallerstein report (1968/1994) has brought to our attention more than three decades ago that therapists did *not* work purely according to the methods they subscribed to, that different methods had relatively equal success in outcomes if the relationship between therapist and client were positive (i.e. good rapport was formed), and that even such variables as the number of years of experience or academic seniority in a field did not positively affect outcomes. Truax and Carkhuff (1967) just as long ago found that the person of the therapist and his/her ability to understand the client's situation and communication were the main curative factors in therapy. And a recent study shows that there is no real difference between Rogers' formulation of 'unconditional positive regard' in the 1940s and modern emphasis on empathy as validatory and thus main curative factor (Kahn, 1996). It seems that there may have been many decades of the generation of very complicated theories with apparently different lines of reasoning, which may one day be validated by the levelling and unifying blow of a very simple common concept hidden behind the tangential forces.

Certainly it appears from the analysis in this dissertation that a unifying element among the transformative types of psychotherapy may be the identification of constructs of 'strength' and 'cohesion' as outcomes, with their implications of

[58] Catherine Michelson in Cape Town, together with Gill Straker from the University of the Witwatersrand in Johannesburg and several other local psychotherapists have been involved with discussions around such issues for several years.

constructs like 'validation', 'empathy', 'insight', 'positive introject'[59] for a method/therapeutic task, as identified through practical observations by practitioners in the field. Even a strong Kleinian or Freudian or Jungian interpretation could be experienced as validatory in itself, as described by some participants: whether mythical or familial, any explanation which makes *sense* of an individual's apparently meaningless or even 'insane' feelings, thoughts and actions, can be an experience of validation of a kind. (Although some theorists would not agree that this kind of 'validation' is sufficient – see Miller, 1990/1997.)

The idea of an integrative psychotherapy does not sit comfortably with everyone. Widlocher (1980, p.229), for instance, believes that psychoanalytic psychotherapy is often "a less rigorous, simplified version of psychoanalysis". He and "many others" judge "'diluted' psychoanalysis" to be inefficient, and introduces the idea of a "*technical goal*" exclusive to psychoanalysis proper: This goal is "the specific psychoanalytic *process*" (italics mine). A re-visit *post hoc* to a data set of an interviewee[60] who describes his/her method as relatively 'pure' psychoanalysis reveals support for Widlocher's call for a distinction between the two types of psychoanalytic interventions. However, Gendlin (1980) points out that where the frequency of sessions in traditional psychoanalysis can't be maintained to provide a holding/ listening space, there is an "invisible" attrition rate in that clients "must find others between sessions, trying to find someone who will hear, take in, and grasp what the therapist can't seem to understand" (p.280).

Wallerstein's (1968/1994) findings that patients who received 'pure' psychoanalytic treatment showed less evidence of reconstructive change than those receiving client-centred or interpersonal group therapies, and Strupp, Fox and Lessler's (1969) conclusion that the amount of improvement noted in a patient correlated with the therapist's perceived warmth, respect and interest, may be indicators that the emphasis on *validation* (and its co-constructs such as 'hearing'/'empathy', or 'introjection' – of validatory 'selfobjects') identified by participants as a main therapeutic task[61] could be the key to a basic reconstructive/ transformative agent embedded in all successful

[59] As described by Henry, Strupp and Schacht (1990), for instance.
[60] Not included in the sample for this dissertation.
[61] Above, pp.85-87.

transformative therapies. In this sense it would mean that a generalisable outcome goal of transformative psychotherapies could perhaps be formulated in terms of validation, for instance: 'The goal is for the client to feel validated' or 'that his/her existence is valid'. This outcome construct (i.e. validation) with all its applicable nuances of meaning, may hopefully be useful for much further research in the many areas indicated earlier in this dissertation. It seems to be a promising construct also for the questions raised specifically around the issue of the 'broader South African' and similar 'unfragmented' communities, where validation appears to be a part of healing rituals in many traditions (whether of religious 'absolution' or making peace with 'ancestors' or obtaining standing in a community).

It is hoped that this research of a single basic construct-type, which has already generated many other potentially rich process constructs that call for further investigation, will facilitate some of the necessary future research in the complex field of psychotherapy.

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ADDENDUM A

QUESTIONNAIRES

NB: <u>Sections marked in {---} were used in interviews but not for this dissertation</u>

ORIGINAL INTERVIEW PROMPTS

A] Introduce definition of reconstructive psychotherapy?
B] Difference between patient 'management' and patient 'change'/ 'growth'
C] - Info about research
- Any questions before start?

** [...] only asked if time / need

1.1. How would you describe the type of (reconstructive?) therapy you mainly practise?
1.1.1. - Expand? - time etc.; times per week; ? 'Long term'?
- Adults / Children?
1.2. Do you feel affiliated to any specific school[s] in your orientation / approach to Therapy?
1.2.1. - Expand: which? how 'purely' applied? 'Eclectic' types?

2.1. How would you describe the PROCESS of therapy theoretically? (I.e., What causes positive change?)
2.2. How do you implement this process in practical terms? (What do you do to facilitate transformation / growth, etc.?)
[2.3. In your own thoughts or notes, are there any diagnostic concepts that you find yourself using at the start or during the course of therapy?]
[2.3.1.- Expand]
2.4. Are there any terms you feel most comfortable with in describing the patient's condition at the beginning and end phases of therapy - i.e., in what terms can you describe your patients' 'pathology' and 'cure' generally? (The move from A sx cluster to B sx cluster)
2.4.1. - Or e.g., What is meant by the 'healing' of the 'self'?

** Explain shift away from process to allow for unconscious digesting of discussion to inform later questions

{3.1. What training have you had in reconstructive psychotherapy?
3.2. How do you rate the training (sufficient? etc)
3.3. Knowledge and rating of current training in reconstructive psychotherapy - various sources?
3.4. Recommendations for future training of therapists?

[3.4.1. - Views on unregistered persons practising lay/holistic/ holotropic (etc) therapy at present?]
[3.4.2. - Should future registration account for them? How?]**}**

4.1. What observations in your practice would you identify as 'proof' that psychotherapy is useful and effective? (Outcomes)
4.1.1. - Do you feel that more patients should be helped by such therapy? How? (Within broader SA community)

5.1. Do you think patients generally go through specific phases in the process of therapy?
5.2. Are you aware of identifiable patterns of different therapeutic foci in the process of therapy with different patients?
5.2.1. - Do you use classifiably different approaches at different 'phases' of patient 'growth'?
5.2.2. - Expand

** Combine with Q 1 if appropriate
6.1. What are your views on the optimal number of sessions per week and length of therapy necessary for optimal reconstructive change in most patients you see?
6.1.1. - Are there instances in which you'd like to increase the frequency?
- Why?
Why can't you?
6.1.2. What is the effect on the healing process for such patients? (What is delayed?)

{[7.1. How knowledgeable do you think you are of modern developments in psychotherapy?]
[7.1.1. How do you keep up with developments?]
7.1.2. How accessible is information?
- Comments?**}**

8.1 Anything else to add?
8.2. Referrals to other psy.therapists for interviews?

AFRIKAANS VERSION

A] ? Gee definisie van herstrukturerende psigoterapie?
B] ? Verskil tussen simptoombeheer en algemene kliënte-groei / verandering

---

1.1. Hoe sou u die soort (herstr) terapie wat u gewoonlik bedryf beskryf?
1.1.1. - Brei uit - tyd. ens.
1.2. Voel u dat u eie benadering / oriëntering jeens psigoterapie by enige spesifieke 'skool/e' in die sielkunde aansluit?
1.2.1. - Brei uit - watter? hoe suiwer volg u die tradisies?

2.1. Hoe sou u teoreties die terapie PROSES omskrywe? (Wat veroorsaak verandering?)
2.2. Hoe implementeer u hierdie proses in die praktyk?
2.3. Is daar enige terme/woorde/diagnosis wat u in u eie gedagtes of aantekening sou gebruik aan die begin of gedurende die terapeutiese interaksie?
2.3.1. Brei uit
2.4. Watter terme sou u gebruik om oor die algemeen pasiënte/kliënte se psigiese toestand/ gemoedstand aan die begin en einde van 'n terapeutiese interaksie (oor tyd) te beskryf?
- Deur watter woorde sou u u kliënte se 'patologie' en 'herstel' algemeen beskryf? Beweging van grp A na grp B simptome)
2.4.1. Of bv. Wat beteken 'die heelmaak/gesondmaak van die Self'?

{3.1. Watter opleiding het u in die herstrukt. terapie gehad (form/informeel)?
3.2. Hoe waardevol was die opleiding vir u? (genoegsaam? ens.)
[3.3. Kennis en waardebepalng van huidige opleiding (versk. oorde)?]
3.4. Aanbevelinge oor toekomstige opleiding van terapeute?
[3.5. Menings oor ongeregistreerde persone wat leke/ holistiese/ holotropiese (ens.) psigoterapie beoefen?]
[3.5.1. Behoort hulle geregistreer te word? Hoe?]**}**

4.1. Watter waarnemings in u praktyk sou u identifiseer as 'bewys' dat die psigoterapie effektief of nodig is/was?
4.2. In die breër SA gemeenskap:- Voel u dat meer mense deur hierdie soort terapie behoort gehelp te kan word? Hoe?

5.1. Meen u dat kliënte alg. deur verskillende fases beweeg in die terapeutiese proses? Watter?
5.2. Kan u patrone van verskillende terapeutiese fokusse in die ter. proses met verskillende kliënte/pasiënte waarneem?
5.2.1. Gebruik u verskillende benaderings in versk. 'fases' van u kliënte se 'groeiproses'?
5.2.2. Brei uit

6.1 Wat beskou u as die optimum aantal sessiess per week en hoe lank duur die terapie vir die optimum herstrukturerende verandering in die meeste van u kliënte/pasiënte?
6.1.1. Sou u soms die aantal sessies wou vermeerder?

6.1.2. Hoekom?
6.1.3. Hoekom is dit dan nie moontlik nie?
6.1.4. Watter effek het dit op die groeiproses/ gesondword van sulke kliënte? (Wat word uitgestel?)

{[7.1. Hoeveel kennis dra u van moderne ontwikkelinge in die psigoterapie?]
[7.1.1. Hoe bly u op hoogte?]
[7.1.2. Hoe maklik kan u inligting verkry? (Bibl./ leesgroepe?)]
[7.1.3. Opmerkings?]**}**

8.1. Is daar enige iets anders wat u wil byvoeg?
8.2. Verwysings na ander informante vir onderhoude?

ADDENDUM B

PARTICIPANTS' LIST

&

SUMMARIES OF TRANSCRIPTS

AND INTERVIEW NOTES

PARTICIPANTS' CODED LIST

Interview Code	**Analysis Code**	Orientation/s	**Group**	**Pg**
AJ	**[A]**	Ψanal/OR	[1]	2
AH	**[B]**	Ψanal/Klein/OR	[2]	5
AP	**[C]**	Ψdynam/Self Ψ	[3]	11
AM	**[D]**	Ψanal-modern/some Jung	[4]	17
BM	**[E]**	Phenom/Gestalt	[6]	26
AS	**[F]**	Phenom/Ψanal	[6]	27
AO	**[G]**	Jung/OR	[4]	19
BZ	**[H]**	Ψanal/phenom	[6]	28
BY	**[J]**	Ψdynamic/family systems/narrative	[7]	30
AA	**[K]**	Ψdynamic: Jung/Freud/Gestalt/hypnoanalysis	[5]	23
AB	**[L]**	Ψanal/Self Ψ	[3]	12
AC	**[M]**	Ψanal: Brit OR-Winnicott/Klein/Self Ψ	[1]	3
AD	**[N]**	Self Ψ	[3]	14
AE	**[O]**	Jung/Self Ψ	[3]	15
AF	**[P]**	OR/Klein/ex-Winnicott	[2]	6
BW	**[R]**	Hypnoanalysis/Ego-State θ/Ψanal/CBT	[5]	24
BK	**[S]**	OR/Jung	[4]	20
BO	**[T]**	Jung (+CCT/family θ earlier)	[4]	21
BP	**[W]**	TA/Ψanal/ego state	[7]	31
CA	**[Z]**	Kleinian OR	[2]	8

Note:

1. ***Items in square brackets here represent the researcher's annotations and NOT the participants' words.***
2. ***For easier access, the summaries have been placed in group order.***

PLEASE NOTE THAT ADDENDUM CONTAINING ORIGINAL DATA (SUMMARY TRANSCRIPTS) IS OMITTED IN THIS COPY, BECAUSE OF CONFIDENTIALITY CONTRACT WITH PARTICIPANTS. MOTIVATION FOR VIEWING THIS MUST BE ADDRESSED TO AUTHOR IN WRITING FOR CONSIDERATION.