Exploring 'Cultural Countertransference': A Qualitative Study of therapists' understanding of the interface between culture and countertransference.

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Declaration

I, Lilian Nyasha Chichevo (216071872), hereby declare that the Dissertation for Master of Social Science (Clinical Psychology) is my own work and that it has not previously been submitted for assessment or completion of any postgraduate qualification to another University or for another qualification.

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Thank you for wonderful people who walked with me and held me up every time I stumbled. The greatest gift is the people who are fellow travellers on this life journey:

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Abstract

There has been limited research on the relationship between culture and countertransference. Although extant literature indicates that culture-induced countertransference has a profound effect on therapeutic alliances with clients from culturally diverse population groups, this association between the two concepts remains relatively unexplored. In the South African multicultural context, there is no published research exploring the understanding that therapists have of the interface between these two concepts. The qualitative research design enabled the therapists to provide comprehensive descriptions of their culture-induced countertransference experiences. These culture-induced countertransference experiences were explored and analysed utilising Interpretative Phenomenological Analysis perspective. The therapists' experiences and perceptions were obtained through semi-structured interviews conducted with nine registered and practising therapists from KwaZulu-Natal. Four superordinate themes were obtained from the data, namely: (1) Awareness of Countertransference and Culture; (2) Cultural Aspects Inducing Countertransference; (3) Affective, Behavioural and Cognitive Reactions; and (4) Managing the Countertransference Experiences. The main findings indicated that therapists acknowledged an interface between culture and countertransference. Additionally, the therapists made a distinction between cultural countertransference and general counter-transference. Cultural countertransference was perceived to originate from the beliefs, assumptions, biases and unresolved conflicts within the therapist, triggered by various cultural aspects, including language, racial and ethnic diversity, cultural practices and age. The interplay of these triggers and origins resulted in the countertransference being manifested through affective, behavioural and cognitive reactions. Furthermore, the study revealed that there were slight differences in the management of cultural countertransference in comparison with general countertransference. The discussion of the findings drew on the Structural Theory of Countertransference and the Theory of Multicultural Counselling and Therapy in understanding the therapists' perceptions of cultural countertransference

Keywords: Culture, Countertransference, Cultural Countertransference, Interpretative Phenomenological Analysis

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Chapter 1: Introduction

1.1 Brief Background

Increasingly, literature has been advocating for therapists to become competent in providing treatment and interventions within a multicultural context. Literature indicates that globally and nationally, there has been a rise in help-seeking behaviour amongst individuals from diverse cultural backgrounds (Cadaret & Speight, 2018; Bryant et al., 2019; Mishne, 2002). However, even with acknowledging clients from diverse backgrounds, it appears that the training and the practice tend to either ignore or oversimplify the competency required to operate within a multicultural society (Foster, 1998; Bantjes et al., 2016). Studies have identified a lack of cultural competence in psychotherapy with ethnically diverse population groups, which has compromised the therapeutic outcomes (Foster, 1998; Pedersen, 2001; Sue & Sue, 2013; Tummala-Narra et al., 2018).

Central to the positive outcomes of psychotherapy is the therapeutic alliance, which refers to the working relationship between the therapist and the client (Gelso & Hayes, 2007). Countertransference is identified as a crucial aspect of the therapeutic alliance (Sperry, 2010; Gelso, 2014). This phenomenon can be generally defined as the unconscious reactions that a therapist experiences towards the client (Gelso, 2014; Stefano, 2017). These unconscious reactions can affect the therapeutic alliance, as the perception and the behaviour of the therapist towards the client may be thus influenced. Consequently, it can play an essential role in contributing positive and negative outcomes within psychotherapy. Various authors have posited that these reactions are ingrained in the therapist's values, beliefs and vulnerabilities (Stampley & Slaught, 2004; Gelso & Hayes, 2007). Furthermore, their cultural backgrounds can influence the values and beliefs of the therapist. Therefore, it can be argued that an insightful therapist would be aware of the culture and therefore becomes aware of possible countertransference reactions and manifestations influenced by culture.

There has been more interest in the countertransference phenomenon’s contribution to the therapeutic alliance over the last few decades (Holmes, 2014; Stefana, 2017). Additionally, there has been a shift in how countertransference is generally viewed. The shift involves moving from viewing countertransference as an obstacle or hindrance but also as a beneficial tool within the treatment process (Fauth, 2006; Gait & Halewood, 2019; Gelso, 2014; Gelso & Kline, 2021; Hayes et al., 2018; Stampley & Slaught, 2004). There have been increased investigations into the origins of countertransference. However, researchers admit

the difficulty of conducting empirical research for this concept primarily due to definitional inconsistency and measurement issues (Fauth, 2006; Gait & Halewood, 2019; Hayes et al., 2018; Hofsess & Tracey, 2010). As might be expected, the role of culture has been one of the areas under investigation (Foster, 1998; Hayes et al., 2018; Stampley & Slaght, 2004). However, research on cultural countertransference is still in its infancy.

1.2 Rationale

There is a lack of clarity on what definition of countertransference would be helpful to employ when investigating the therapist's cultural reactions. What needs to be explored is the *meaning* that the therapist places on culture and countertransference together. How is culture *managed* in relation to countertransference?

In the context of South Africa, a country with diverse population groups, this study attempts to explore therapists' understanding of cultural countertransference and the contributions, if any, that it can make to the therapeutic relationship and the outcome of psychotherapy.

When the statistics on South Africa's population groups are reviewed, one understands the need for this research study. These statistics highlight some cultural discrepancies that occur between the providers and users of mental health services, when the racial aspect of culture is considered. South Africa is a multilingual and multicultural country with a population consisting of five racial groups: Black African, Coloured, Indian/Asian, White and Other. Additionally, according to the Health Professionals Council of South Africa [HPCSA] (2017) there are 65.6% White, 14.7% Black African, 7.6% Unknown, 6.8% Indian and 5.4% Coloured registered psychologists for a population of 80.6% Black Africans, 8.8% Coloureds, 7.8% Whites and 2.5% Indians/Asians (Statistics South Africa [StatsSA], 2018). In this context, where the discrepancy is prominent, a lack of awareness regarding any unresolved cultural conflicts can hinder the therapeutic process with clients.

There has been no published or reviewed research conducted in South Africa exploring the meaning and understanding that registered therapists have about the phenomenon of cultural countertransference. However, in her study, Esprey (2017) noted limited research within South Africa that focused on race and its influence on the therapeutic alliance. Race, which is an aspect of culture, is perceived to have the ability to compromise the clinical process even at an unconscious level (Esprey, 2017). Hayes et al. (2018) state that more

research is required to understand the countertransference reactions influenced by the interaction of the therapist's and client's culture within the therapeutic process. This suggests that culture might play a role in the countertransference experienced by therapists towards their clients. Countertransference by definition is primarily unconscious, thus, the contribution of understanding cultural countertransference as distinct from other cultural competencies appears essential (Breivik et al., 2020; Foster, 1998; Gelso & Hayes, 2007). Due to the unconscious nature of the phenomenon, the study of countertransference has primarily been based on the therapists' self-reflection or the reflection of the therapeutic process. Therapists are able to offer self-reports of their experiences when these have reached their conscious awareness through these reflection processes. Thus, the study will explore the lived experiences of the therapists.

A focus on cultural countertransference will, hopefully, lead to a better understanding of:

- The unconscious responses of the therapist to the patient;
- The internal conflicts of the therapist regarding cultural elements in the therapeutic relationship; and
- The therapist's experiences during the therapeutic process regarding cultural countertransference.

The theoretical framework employed for this study encompassed two theories, namely the Structural Theory of Countertransference and the Theory of Multicultural Counselling and Therapy. The aspects of culture in relation to the therapeutic relationship and psychotherapy were explained by a theory grounded in multiculturalism.

1.3 Objectives

The objectives of this research study are to explore the concept of cultural countertransference, as well as to explore how therapists, based on their clinical interactions, understand and experience the relationship between culture and countertransference.
Hence, this study aims:
1. To explore how culture and countertransference are perceived to interact in the therapeutic relationship.

2. To determine the perceived effects of cultural countertransference on the therapeutic relationship.

3. To explore the experience and management of cultural countertransference in comparison to normal countertransference.

1.4 Research Questions

1. How do therapists, based on their clinical interactions, understand and experience the relationship between culture and countertransference?

2. What are the perceived effects of cultural countertransference on the therapeutic relationship?

3. How do therapists manage cultural countertransference in comparison to normal countertransference?

1.5 Methodology

This study used a qualitative research design, appropriate when exploring the meaning that participants ascribe to their experiences and how they make sense of these experiences (Rubin & Babbie, 2011; Creswell, 2014).

Interpretive Phenomenological Analysis was used in order to gain insights into the phenomenon of cultural countertransference. Data was collected through semi-structured interviews. The study population consisted of 9 registered therapists within the province of KwaZulu-Natal. The population sample included Black African, Indian, and White therapists.

1.6 Definitions of Core terms

Countertransference - is the therapist's internal or external reactions, shaped by the therapist's past or present experiences, emotional conflicts and vulnerabilities. These reactions occur within the therapeutic relationship (Gabbard et al., 2007; Gelso & Hayes, 2007).

Culture – "Culture refers to systems of knowledge, concepts, rules and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals and customs, as well as

moral and legal systems," including race, ethnicity, and sexual orientation (American Psychological Association [APA], 2003, 2013, p. 749).

Cultural countertransference – the reactions of the therapist towards the client that are influenced by their cultural identity and constructed by their subjective worldviews and past experiences (Gabbard et al., 2007).

1.7 Structure of the dissertation

Chapter 1: Introduction- this chapter introduces the rationale, objectives, research questions, definitions of core terms. Additionally, the structure of the remainder of the dissertation is also provided in this chapter.

Chapter 2: Literature Review- the second chapter reviews the literature relevant to this research. It focuses on the definitions and evolution of the phenomenon of countertransference, multicultural therapy and the possible interface between culture and countertransference.

Chapter 3: Theoretical Framework- this chapter explores the theories that have been utilised to understand this research. The Structural Theory of Countertransference and a Theory of Multicultural Counselling and Therapy will be discussed in this chapter.

Chapter 4: Methodology- in this fourth chapter, the research design, sampling methods and data collection methods are described. Interpretative Phenomenological Analysis was utilised for this research's analytical and interpretative stage, which will be discussed in this chapter.

Chapter 5: Findings and Discussion- this chapter presents the results and a discussion of the themes uncovered during the analysis stage. The findings will be presented with a detailed discussion in this chapter.

Chapter 6: Conclusion, Recommendations and Limitations- in this final chapter, the conclusions drawn from the preceding chapter will be presented. The recommendations and the limitations of this research study will be discussed in this chapter, concluding the dissertation.

1.8 Summary

This introductory chapter provided a brief background and the rationale of the research study. This research study explores the interface between culture and countertransference based on experiences and perceptions from therapists' interviews. It is noted that there has been limited research in South Africa in the areas of countertransference and culture. Additionally, there has been limited study in areas of culture, race and psychotherapist reactions.

The current chapter additionally includes the aims, objectives and structure of the dissertation. The following chapter will present the literature review for the study.

Chapter 2: Literature Review

This chapter reviews literature relevant to the research. It focuses on the definitions and evolution of the phenomenon of countertransference, multicultural therapy and the possible interface between culture and countertransference.

2.1 Introduction

> We have become aware of the 'countertransference,' which arises in him [therapist] as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognise this countertransference in himself and overcome it…(Freud, 1910, pp. 144-145).

The concept of countertransference was introduced and coined by Sigmund Freud in 1909 in response to a letter from a colleague, Carl G Jung, who had related distressing experiences that he was encountering during his interactions with a patient. In his response, Freud stated that challenging experiences were beneficial and contributed to an individual overcoming "countertransference" (Jung et al., 1973). At that point, this "countertransference" was a vague concept that Freud had used to express how he viewed Jung's experiences, viewing them as a "foe" within Jung that needed to be overcome. Freud, however, did not provide a concrete definition for this new concept. Despite this, Hayes et al. (2018) infer that it could be concluded from his utilisation of this abstract term that he [Freud] viewed it with negative connotations.

Thus began the historical origins of countertransference, termed the classical view. The classical view has regarded this phenomenon as an impediment, an obstacle in the therapeutic relationship that needs to be identified and vanquished- a clinician's internal conflict to be resolved (Gelso & Hayes, 2007; Stampley & Slaght, 2004; Stefana, 2015).

This intriguing concept of countertransference has had resonating influence in psychology, as observed in its utilisation with other theoretical frameworks, namely cognitive-behavioural therapy (Cartwright, 2017; Gordon et al., 2016; Hayes et al., 2015; Machado et al., 2014). It has also been fraught with much debate and some controversy over the last century. Thus to the therapist, this concept would be something to constantly contemplate, as to whether to view it as a friend or foe within the therapeutic space.

2.2 Evolution in the definitions of Countertransference

One of the primary challenges in empirical research of countertransference has been definitional consistency and measurement issues (Fauth, 2006; Gait & Halewood, 2019; Hayes & Gelso, 2001). Therefore it is essential to explore the evolution of this concept and establish a working definition for this research study (Gelso & Kline, 2021). Since the classical view, which concluded that this was a foe, other perspectives have emerged, including the totalistic, complementary, relational and moderate perspectives, which have attempted to develop a comprehensive definition of this concept. Each of these perspectives has expanded on those that have come previously, either reinforcing the notion that countertransference is negative or advocating the benefits that the concept contributes to the psychotherapeutic relationship. However, there are still areas of commonality in some aspects of these diverse perspectives.

2.2.1 The totalistic view

The totalistic view emerged in the 1950s. Its definition is the most inclusive, stating that countertransference is "the entirety of the analyst's emotional reactions to the patient within the treatment situation" (Bouchard et al., 1995, p. 719). In addition, this view diverted from the classical view regarding countertransference as negative and deemed it a positive and beneficial tool in the therapeutic alliance. From this point of view, countertransference has been viewed as "friend", a tool that informs the understanding of the client and the therapeutic relationship (Holmes & Perrin, 1997; Machado et al., 2014; Stefana, 2017). In her paper, Heimann (1950) was one of the first contributors to view countertransference as a beneficial tool instead of a hindrance in the therapeutic relationship. Heimann (1950) argued that countertransference reactions were a valuable therapeutic tool that the therapist was meant to use to uncover the client's unconscious processes. However, this view did not acknowledge the therapist's contribution in this interaction and viewed the therapist as responding solely to the projections of the client. Though, her observations formed the basis for more investigations into the phenomenon

However, as Gelso and Hayes (2007) argued, not all emotional, cognitive and/ or behavioural reactions should be viewed as countertransferential. Notably, this broad view could restrict the scientific value of the concept and invalidate the necessity for the term. For example, a therapist experiencing tiredness leading to compromised concentration in therapy due to inadequate rest would be deemed to be having a normal and healthy reaction and not countertransference (Gelso & Hayes, 2007).

2.2.2 The complementary view

The complementary view was introduced as a third conception. In this view, countertransference is inevitable, but is linked to positive and negative transference that attracts positive or negative countertransference respectively (Gelso & Hayes, 2007). The therapist and patient are believed to influence each other's reactions in a cycle that Gelso and Hayes (2007) state continues throughout therapy.

2.2.3 The relational view

The relational view is closely linked to the complementary view. However, it does not attempt to assume that the therapist will react to every aspect of interaction that occurs with the patient (Gelso & Hayes, 2007). Instead, it posits that the patient and therapist jointly construct the transference and countertransference that occurs within the confines of psychotherapy (Gelso & Hayes, 2007). Thus, the origins of the conflict are viewed as being in either the therapist or the client.

2.2.4 The moderate perspective

Currently, the moderate perspective affirms that countertransference is not solely a negative phenomenon to be overcome. It is also not simply a reaction that the patient "pulls" from the therapist through transference (Gelso & Hayes, 2007; Stampley & Slaght, 2004). This view evolved from the totalistic view and defined countertransference as:

> …therapists' idiosyncratic reactions (broadly defined as sensory, affective, cognitive and behavioural) to clients that are based primarily in therapists' own personal conflicts, biases or difficulties (e.g., cognitive biases, personal narratives or maladaptive interpersonal patterns) (Fauth, 2006, p. 17).

Defining the term has been fraught with ongoing controversy (Hayes, 1995), with definitions dependent on the term's usage in the specific contexts under investigation. Hayes (1995) states that these countertransference reactions can be embedded in the unresolved intrapsychic conflicts of the therapist or the transference of the patient. However, this does not address the ongoing influence of cultural identity, which this research attempts to address. Therefore, it has to be acknowledged that a therapist's countertransference might not always be a result of an internal conflict.

For the purposes of this study, a broad definition of countertransference will be adopted since it is unclear whether cultural countertransference is viewed as originating in the patient or therapist's conflicts, which is part of the study's exploration. Therefore, it is defined "as the therapist's internal or external reactions that are shaped by the therapist's past or

present experiences, emotional conflicts and vulnerabilities." (Gelso & Hayes, 2007, p. 25). These internal and external reactions can be influenced by both the therapist and client's cultural identities. Thus, this process occurs within the context of a therapeutic relationship. This adopted definition is influenced by the relational and moderate perspective of countertransference.

2.2.5 Other Conceptualisations of Countertransference

In addition to the above perspectives, numerous other authors have contributed to the understanding of countertransference, namely Heinrich Racker, Charles Gelso and Jeffery Hayes. These authors have made prominent and substantial contributions to the study of countertransference, with Hayes (1995) developing the Structural Theory of Countertransference that assists with the integration of findings in countertransference research. Their work has motivated studies regarding therapists' subjective experiences utilising the theory; however, these studies are still limited (Fauth, 2006; Gelso et al., 2002; Hayes et al., 1998, 2015). Similarly, Racker contributed extensively to the understanding of the phenomenon (Feldman, 2007). Below are some of the views about countertransference that they have posited.

Racker (1982) made a distinction between direct and indirect countertransference. Direct countertransference was in interaction with the patient, whereas indirect was to third parties (Geltner, 2013; Gorkin, 1987). He further divided direct countertransference into complementary identification and concordant identification (Racker, 1982).

In complementary identification, the therapist identifies with the patient's internalised objects (Bruscia, 1998). In this regard, the therapist can partially identify with the feelings of individuals who interact with the patient. However, this could also be the unwanted part of the patient which the therapist represents. Racker (1982) stated that this type of countertransference was unavoidable, even with experienced clinicians (Gorkin, 1987). Similarly, Gelso and Hayes (2007) state that this is the therapist embodying a complementary aspect of the patient's inner conflict.

According to Racker (1982), in concordant identification, the therapist identifies with the patient on a conscious, preconscious and/or unconscious level. The therapist recognises the patient's internal state as their own and their patient's reality feels as if it belongs to them. The therapist identifies aspects of his personality with similar aspects in the patient (Racker, 1982; Bruscia, 1998; Gelso & Hayes, 2007). This countertransference serves to increase the

therapist's empathy for the patient, which can be viewed as a beneficial aspect of countertransference (Racker, 1982).

Gelso and Hayes (2007) also differentiated between acute and chronic countertransference. Acute countertransference is experienced with particular clients and in specific situations. For example, a therapist might identify with the patient's anxiety and attempt to alleviate that particular anxiety; whilst in another patient, it could be an attempt to soothe aggression. Hence, these refer to specific situations with specific patients that induce acute countertransference.

Chronic countertransference is generally experienced throughout the therapeutic interaction and is not specific to the client or their behaviours (Gelso & Hayes, 2007). In chronic countertransference, the therapist might engage in a particular behaviour. For example, the therapist might take to 'over advising' all patients, regardless of presenting problems. Therefore, chronic countertransference may be viewed as a response or reaction guaranteed to occur with a specific therapist (Gelso & Hayes, 2007). At present, it is unclear how the above distinctions relate to cultural countertransference. This study will assist in clarifying whether there is a distinction between culture-induced countertransference and the other conceptualisations of countertransference identified in this section. Recognising the different domains or types of countertransference can assist therapists in developing their awareness and recognising when their own values, beliefs or needs are being activated within the therapeutic alliance (Kachele et al., 2013; Sue, 2016).

2.3 Uses and Benefits of Countertransference

Countertransference has been traditionally viewed as an impediment or obstacle. However, recently, it has also been viewed as a valuable source of information during the therapeutic process and formulation of the case (Gelso & Hayes, 2007; Holmes & Perrin, 1997). The phenomenon has been described a having numerous benefits that can lead to successful therapeutic outcomes.

In their book, Gelso and Hayes (2007) explore four benefits of countertransference in the therapeutic work, namely:

- Firstly, disturbances occur in the therapist, prompting the therapist to conduct self-reflection and seek resolution for these disturbances. This resolution enables the

therapy to continue productively. These disturbances can be emotional, behavioural or cause concentration and attention problems (Gelso & Hayes, 2007).

- Secondly, self-examination of inner conflicts can assist the therapist in understanding the client's issues.
- Thirdly, the patient can be understood in the here and now by the therapist's emotional experiences during their interaction (Gelso & Hayes, 2007).
- Lastly, it is suggested that the patient's unconscious can be invaded by the countertransference emitting from the therapist. This invasion or infiltration can be observed in exploring the patient's reactions, behaviours and actions. However, Gelso and Hayes (2007) have stated that this supposition needs to be investigated further in an attempt to explain its contribution to the therapeutic work.

Gelso and Hayes (2007) suggest that an external trigger is responsible for the countertransference. This trigger can be the client's behaviour, the interaction occurring between the therapist and client, and/or the therapeutic situation or frame (Gelso & Hayes, 2007). Additionally, the authors state that the interplay of origins and triggers can be viewed as the cause of countertransference. Whilst the trigger is external, the origins are viewed as internal processes and unresolved intra-psychic conflicts or vulnerabilities that can influence the origins (Gelso & Hayes 2007).

Hayes et al.,'s (1998) study determined that the origins of a therapist's countertransference included unresolved intrapsychic conflicts regarding family, needs, role as a therapist and cultural issues. The 'cultural issues' sub-category explicitly listed by Hayes et al. (1998) includes gender, race, sexual orientation, social class and religion. Similarly, Foster (1998)'s paper identified these aspects as influencing the therapist's countertransferential responses. However, at present it is still unclear how the above issues are understood in terms of cultural countertransference and their management. Thus, this study aims to contribute in determining the association between the different aspects of culture and countertransference.

2.4 Culture

Culture can be a very challenging concept to define. It appears to be an abstract concept that people have difficulty formulating a comprehensive response to. Nevertheless, to some extent, individuals are keenly aware of identifying themselves as part of particular cultures.

Definitions of this phenomenon range from viewing culture as the values and beliefs that certain groups hold, to specific cultures being identified by the geographical proximity of groups to each other. For this study, the definition used is the one offered by the Diagnostic and Statistical Manual of Mental Disorders.

> "Culture refers to systems of knowledge, concepts, rules and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals and customs, as well as moral and legal systems," including race, ethnicity, and sexual orientation (American Psychological Association [APA], 2003, 2013, p. 749).

All the aspects mentioned in the above definition affect the therapeutic relationship between the therapist and the client, as they both possess a culturally influenced identity. Furthermore, these identities are influenced by values, beliefs and experiences.

2.4.1 Cultural Competence

An insightful therapist would be aware of culture and therefore be aware of possible countertransference reactions and manifestations. Studies have identified a lack of cultural competence in psychotherapy with ethnically diverse population groups (Foster, 1998; Tummala-Narra et al., 2018). Sperry (2010) has identified cultural sensitivity as one of the core competencies that a therapist requires in order to be considered effective in their work. A therapist practising in South Africa must acknowledge the explicit fact that they are practising in a multicultural context

However, culturally informed psychotherapy remains limited, whilst the integration or adaptation of traditional therapies is often inadequate and, in some instances, ineffective (Foster, 1998; Jones et al., 2018; Sue & Sue, 2016; Tummala-Narra et al., 2018).

According to the American Psychological Association (2003),

> In an absolute sense, multiculturalism recognises the broad scope of dimensions of race, ethnicity, language, sexual orientation, gender, age, disability, class status, education, religious/spiritual orientation and other cultural dimensions. All of these are critical aspects of an individual's ethnic/racial and personal identity, and psychologists are encouraged to be cognizant of issues related to all of these dimensions of culture. In addition, each cultural dimension has unique issues and concerns (p. 380).

This definition highlights the comprehensiveness of multicultural aspects that psychologists need to consider when practising in such contexts. Similarly, Edwards (2015) asserts that

multicultural counselling involves acknowledgement of cultural diversity, and aspects of race, beliefs, practices, and ethnic differences. In her article focused on multicultural social work and national trauma in South Africa, Abdullah (2015) proposes principles that can be applied in multicultural practice that respects the multicultural aspects mentioned above. Furthermore, the article discusses the challenges that are observed in attempting to work without principles or guidelines that determine the expectations in service delivery and interventions in a multicultural context (Abdullah, 2015). However, these principles are specifically tailored for social workers; although, this highlights the need for such principles that provide a framework in psychotherapy.

Emphasising the importance of cultural competence in their study, Hansen et al. (2000) propose twelve multicultural competencies to be used in practice in order to enhance the benefits of psychotherapy. They also state that these are the basic competencies required to be competent in multicultural practice.

These twelve competencies are:

1. Recognition of how the therapist's own culture influences responses to identified groups during interactions (Hansen et al., 2000).
2. Understanding the changes that occur within the discipline over time in response to societal and political changes (Hansen et al., 2000).
3. Awareness of the history of discrimination, oppression, and segregation of identified groups in particular countries and the effects thereof (Hansen et al., 2000).
4. Awareness of how the socio-political climate affects the identified groups.
5. Recognition of a diagnosis that is specific to cultures (Hansen et al., 2000).
6. Understanding the norms surrounding the issues of illness and the behaviour in response to it (Hansen et al., 2000).
7. Competency in evidence-based assessments that are specific to a culture (Hansen et al., 2000).
8. Knowledge of the facets of the individual, personality formation, and interpersonal influences in the context of the upbringing, values, worldviews, etc. in identified groups (Hansen et al., 2000).
9. The ability to create conceptualisations or formulations specific to identified groups (Hansen et al., 2000).
10. The therapist's ability to reflect on their own multicultural competence and acknowledge if it negatively influences the therapeutic alliance (Hansen et al., 2000).

11. Competency in adapting assessment for use with the identified groups (Hansen et al., 2000).
12. The therapist needs to develop and provide accurate interventions for identified groups (Hansen et al., 2000).

These competencies highlight the importance of culture in the therapeutic alliance, as well as the various levels that require negotiation to provide accurate and appropriate interventions. The existence of these competencies also highlights and emphasises the challenges that culture also contributes to this therapeutic space, which need to be acknowledged and addressed appropriately.

The route to becoming culturally competent is a developmental process and these competencies offer guidelines for this journey (Sue & Sue, 2013). In a South Africa study conducted by Rensburg et al. (2012) among occupational therapy students they determined students felt ill-equipped to work within cultural specific situations after completing their programme. The results established that the current curriculum was insufficient to address the issues of cultural competency. Hence, this highlights the contribution guidelines could make to revision in curriculums to enhance cultural competency.

However, these competencies do not address the therapists' difficulties concerning their subjective experiences and countertransference reactions within the therapeutic space. The competencies suggested by Hansen et al. (2000) can assist in guiding the therapist in the development of self-awareness and cultural awareness, thereby increasing the therapist's awareness of culture-induced countertransference reactions.

Rosenfield (2020) points out there are numerous studies and literature that address this requirement for multicultural competency; however, there is a paucity of literature that investigates the internal processes of the therapist in this dyad. This oversight in addressing the internal experiences of the therapists increases the challenges that are experienced in attempting to become culturally competent therapists.

2.4.2 Problems in Multicultural Counselling and Therapy

Eagle (2004) observes the difficulty in attaining multicultural competency in South Africa for mental health professionals. She points out that therapists are unprepared to engage with the clients' cultural belief systems; thus leading to compromised service delivery. Furthermore, Matthews and Van Wyk (2018) determined there was limited literature that addressed cultural competency in health professionals. Their study conducted with medical students demonstrated the need for cultural competency attainment with all health professionals;

however, there are limited opportunities for professional development in that area. In contrast, there has been increased research on how mental health professionals can become culturally competent in high income countries. These studies identified multicultural competencies that can be used to highlight problematic areas in multicultural psychotherapy.

In their research, Tummala-Narra et al. (2018) determined four domains with sub-themes for multicultural competence. Additionally, Pedersen (2001) described twelve positive advantages of making culture central in the context of multicultural therapy. In addition, the previously addressed study by Hansen et al. (2000) refers. When analysed and consolidated, the following themes overlapped from all three studies:

1. The importance of a therapist being aware of their own cultural identification and the value and beliefs they encapsulate. This helps a therapist identify their own bias or prejudice towards different groups.
2. Understanding that behaviour needs to be interpreted in the context of culture.
3. The ability to adapt or create treatment plans that are culturally appropriate and specific to a patient in their cultural context.
4. A therapist's commitment to continuous professional development, as well as the realisation that psychological theories are evolving and changing, as are political and social environments.
5. An understanding of social oppression or social injustice issues. To understand how the environment has socially, politically and historically influenced the client's experiences.

Cultural competence is essential in a therapist's work with clients from different cultural origins or values (Hansen et al., 2000). However, although cultural competence had been considered in general, it is not clear how issues of cultural competence interface with managing countertransference factors in the treatment setting. In addition, cultural competency is viewed as a process that is ongoing and changing throughout the therapist's professional and personal life (Gallardo, et al., 2009; Sue & Sue, 2013).

Therefore, a therapist needs to be continuously engaged in processes that increase their cultural awareness of themselves and clients from culturally diverse populations. The guidelines proposed by Hansen et al., (2000) in the section above can highlight the areas, processes, and activities that the therapist can engage in to increase this awareness. This cultural awareness provides a reference point for understanding countertransference reactions that might be induced by culture.

2.5 Culture and countertransference

In some cases, the cultural background might not be examined as there is a general assumption that the client and therapist share similar backgrounds, especially in particular geographical locations (Stampley & Slaght, 2004). For example, in a study conducted by Stampley and Slaght (2004), when therapists experienced adverse reactions towards their clients, these reactions were concluded to be rooted in a mismatch between the therapist and client, with positive reactions equated to similarities (Stampley & Slaght, 2004). Additionally, Stampley and Slaght (2004) state that these assumptions of similarity probably stem from feelings of being related culturally.

Cultural countertransference can be defined as the internal and external reactions of the therapist towards the client that are influenced by their cultural affiliations, including but not limited to ethnicity, language and socio-economic group (Foster, 1998; Hayes et al., 1998; Stampley & Slaght, 2004). The term was coined by Foster (1998) in her study of the therapist's cultural countertransference influences on the therapeutic alliance. According to Foster (1998), culturally diverse populations received compromised mental healthcare services due to the clinicians' lack of cultural competency. In addition, there appears to be an association between a therapist's subjective cultural worldview or perspectives and adverse treatment outcomes with minority groups (Foster, 1998).

According to Foster (1998), the therapist's cultural countertransference could be triggered by family origin, society and background. Several factors can attribute to countertransference that has cultural origins. For example, racial or ethnic influences, religion or gender (Lane, 1986, as cited in Foster, 1998). Foster (1998) further stated that cultural countertransference was often denied and therefore went unacknowledged by therapists.

However, conflicts related to culture in the patient that are externalised may also elicit countertransference responses in the therapist. For example, the patient might be struggling with the failure of fulfilling particular cultural obligations that a therapist from a different culture might not perceive as being significant enough to warrant the patient's reaction.

The origins of this countertransference may perhaps lie in both or either therapist or patient. How do therapists understand it? Do they indeed observe the difficulties in themselves and patients when it comes to cultural countertransference? The therapist can unconsciously view the patient as an "outsider" due to their own identification with a particular group that might hold opposing values or beliefs (Robertiello & Schoenewolf, 1987).

On the other hand, such an attitude may also have its origins in the therapist's own cultural conflict. For example, a therapist's own failure to fulfil particular cultural obligations similar to those of the client. These considerations deserve further research. For the purpose of this study, and in keeping with the above discussion, this researcher expands on Gabbard et al.'s (2007) definition to define "cultural countertransference" as the reactions that the therapist has that are influenced by their cultural identity and constructed by their subjective worldviews and past experiences. In addition, these countertransference reactions can be induced by the patient's internal attitudes towards culture that are externalised in the therapeutic space.

Thus, there is a distinction between "ordinary" countertransference and cultural countertransference that can be identified by the origins and triggers of the countertransference (Hayes et al., 1998). "Ordinary" countertransference can be viewed as responses or reactions to personality features; relational dynamics particular to the therapeutic couple; and external factors such as anxiety and aggression (Hayes et al., 1998; Gelso & Hayes, 2007). On the other hand, cultural countertransference may be triggered by an array of behaviours or beliefs that are strongly associated with cultural identity, such as gender, ethnicity and language. Whilst, the latter aspects mentioned in ordinary countertransference can also have cultural influences, within cultural countertransference the cultural influence is more pervasive.

Regarding the interface of cultural dynamics and countertransference, Rosenberger and Hayes (2002) posited that insufficient focus had been directed towards these aspects. While little has been written about "cultural countertransference" per se as a concept, there is now a plethora of literature written about the therapist's reaction to culture in the psychological field. Comas-Diaz and Jacobsen (1991) postulated that there was an unconscious aspect of culture that affected the therapeutic process. With regard to racial aspects of culture, black patients induced more complex countertransference in comparison to white patients within white therapists (Jones, 1985, as cited in Comas-Diaz & Jacobsen, 1991).

"Ethno-cultural disorientation" was experienced by therapists who worked with patients from different ethno-cultural backgrounds and who also experienced barriers to empathy during the treatment process (Comas-Diaz & Jacobsen, 1991). Furthermore, when confronted with difficulties in dealing with culturally-induced reactions, therapists have sometimes responded by either over-emphasising or underestimating the importance of the cultural context (Comas-Diaz, 2012; Comas-Diaz & Jacobsen, 1991; Nagai, 2009).

Additionally, Rosenfield (2020) stated that cultural issues within the therapeutic space were often left unexplored. Addressing cultural dynamics within therapy can assist the therapist to become more aware of any countertransferential reactions that may be occurring. However, the first step is to investigate and explore these experiences.

2.6 Summary

This chapter explored the history and evolution of the concept of countertransference coined by Sigmund Freud. The chapter highlighted the primary views of the perspectives developed to explain the concept of countertransference, from the classical perspective that concluded that this phenomenon was an obstacle in therapy that needed to be vanquished to the moderate perspective. In these latter perspectives of countertransference, it is viewed as an essential tool that could increase positive outcomes in psychotherapy.

Regarding culture, studies have identified numerous aspects that contribute to the understanding of this concept. Some of the aspects included in this definition are race or ethnicity, religion and language. These aspects influence and affect the therapeutic alliance, as both the therapist and the client bring culturally related experiences into this psychotherapeutic relationship.

Research has established that cultural competency is also necessary and beneficial for attaining increased positive outcomes for the client. Therapists must be aware of their own culture-related conflicts if they are to provide optimum services to clients perceived as being culturally different from them. However, research has also indicated that there is minimal emphasis on the importance of cultural competency, therefore compromising the services rendered to the clients.

The therapist must be continually engaged in a process of cultural awareness and the management of any identified cultural conflicts. Similarly, the few research studies that have focused on the interface between culture and countertransference have supported this view. Thus, addressing the countertransference experienced in the therapeutic alliance is an ongoing process. It can only be undertaken when the therapist is aware of its origins and understands how it affects the process of psychotherapy.

As previously mentioned, there is no research in South Africa on how therapists understand the interface between culture and countertransference. This research may provide information on how therapists understand culture-induced countertransference experiences in

their therapeutic practice and how they manage these countertransference reactions. In a multicultural context such as South Africa, therapists require all the tools necessary to improve the treatment outcomes of the culturally diverse population they serve.

The subsequent chapter will explore the theoretical frameworks that underpin this study.

Chapter 3: Theoretical Framework

The Structural Theory of Countertransference and Theory of Multicultural Counselling and Therapy (MCT) were used in this study. The Structural Theory of Countertransference was applied to explain and understand the aspects of countertransference. The aspects of culture in relation to the therapeutic relationship and psychotherapy were explained utilising a theory grounded in multiculturalism.

3.1 The Structural Theory of Countertransference

Although the structural theory of countertransference was initially utilised to integrate the theoretical research findings of group psychotherapy, it is now additionally used to consolidate findings from individual psychotherapy (Hayes, 2004). There are minimal theories on countertransference available in the literature. Despite the interest that the concept has generated over the decades, there is a noticeable scarcity of research available (Hayes, 2004; Hayes et al., 2018; Kachele et al., 2013). Therefore, the Structural Theory was developed as the organising theory for all the research conducted on the concept and to assist in integrating the findings (Hayes, 2004).

This theory addresses the significant components of countertransference relevant to this study. It highlights the processes of the countertransferential reactions; offers explanations on the causes of these reactions; and concludes with the possible management of these processes. This theory has previously been applied to studies that investigate the subjective experiences of therapists within the therapeutic dyad (Hayes et., 2015).

The structural theory of countertransference organises countertransference into five fundamental components, namely the origins, triggers (conscious or unconscious), manifestations, effects and management of countertransference (Hayes et al., 1998).

3.1.1 The Five Concepts

The origins are perceived to be the unresolved conflicts from the past or conflicts that the therapist is presently experiencing, which might arise during therapy (Hayes et al., 1998; Fauth, 2006; Gelso & Hayes, 2007). An example could be a past trauma that is similar to the trauma the client is presenting with. Hayes et al. (1998) state that these conflicts can serve as helpful tools, or obstacles, for the therapeutic process. In some cases, the conclusion is that

the therapist is unaware of these conflicts or has not adequately managed them (Gelso & Hayes, 2007).

The triggers or precipitants occur during the interactional process in therapy and activate the therapist's unresolved conflicts or vulnerabilities (Gelso & Hayes, 2007). Hayes et al. (1998) state that triggers can be events during therapy, dialogue regarding the client's problems or the behaviour of the client (Hayes et al., 1998). One may also argue that if anticipated interaction does not occur in therapy, it can also be a trigger. The therapist's expectations of how the therapeutic process will unfold, if unmet might elicit countertransference.

Manifestations: According to Gelso and Hayes (2007), countertransference may manifest itself through affects, behaviours and/or cognitions. Although not always evidence of countertransference, these manifestations are indications that the therapist needs to conduct self-examination. These reactions may be attributed to the unresolved conflicts or vulnerabilities that have been triggered within the therapist. The affects can include anxiety, anger, and fear among other emotions. The behaviours can be observed, for example in avoidance and withdrawal. The cognitions may include distorted perceptions about the client or the content of client material.

The effects: Countertransference can sometimes affect the treatment process and outcomes negatively (Gelso & Hayes, 2007). Countertransference can either be acted out or go unrecognised. Unrecognised or unexamined countertransference can interfere with the creation of an effective working alliance. Sometimes, therapists may recognise reactions to the client within the therapeutic process. However, they may choose to ignore these and continue with the process. Gelso and Hayes (2007) claim that unmanaged countertransference will harm and cause hindrances in all aspects of the treatment process.

The management: Finally, regarding the management of countertransference, Gelso and Hayes (2007) propose five factors. These are the therapist's self-insight, self-integration, empathy (vicarious introspection), anxiety management and conceptualising skills. All these factors need to be attended to in order to make the countertransference experienced beneficial.

The therapist has to be willing to develop self-insight that will enable them to address conflicts that might arise during psychotherapy. Any anxiety that is experienced has to be confronted and managed. When a therapist is able to confront and manage any issues, challenges or conflicts that emerge, they can achieve self-integration.

This theory is the most comprehensive as it attempts to track and understand the process from the onset to the possible resolution or conclusion of the process. Additionally, the interview questions were guided by this theory as this framework was appropriate for obtaining data that would address the research questions.

3.2 A Theory of Multicultural Counselling and Therapy (MCT)

The Theory of Multicultural Counselling and Therapy developed in response to the limited models that addressed the treatment needs of diverse cultures (Sue et al., 1996). This theory will be utilized to examine the importance of cultural competence in therapy and how it influences countertransference experiences in the study. The theory attempts to address the needs of a multicultural and bilingual population and discourages the use of Eurocentric models in these contexts (Sue, 2001). MCT addresses some of the cultural competencies required by the practising therapist and provides guidance on attaining these competencies. Sue's (2001) definition of multicultural counselling and therapy was the basis of this theory.

> Multicultural counselling and therapy can be defined as both a helping role and process that uses modalities and defines goals consistent with the life experiences and cultural values of clients, recognises client identities to include individual, group and universal dimensions. Advocates the use of universal and culture-specific strategies and roles in the healing process and balances the importance of individualism and collectivism in the assessment, diagnosis and treatment of client and client systems. (Sue, 2001, as cited in Sue, 2001, p. 814).

Multicultural psychology and counselling emphasises the importance of the patient's cultural context during the treatment process (Smith & Trimble, 2016). The American Psychological Association published guidelines on multicultural education, training and research in an attempt to address the requirement of cultural competency in mental health practitioners.

According to Berry et al. (2011), the multiculturalism perspective addresses the maintenance of heritage, culture and identity. Furthermore, they add that this construct addresses the issue of relationships being sought amongst diverse groups in the larger society. Thus, Berry et al. (2011) assert that this is a positive strategy in acculturation and is viewed as a necessity amongst diverse cultures. However, Berry et al. (2011) also mention other views of multiculturalism and the preservation of diverse cultures in a society, without

engagement or involvement. Another view they mention regards multiculturalism as a transient state en route to assimilation (Berry et al., 2011).

There has been acknowledgement of the difficulty in developing cultural competence and debates on whether the multicultural training models offered are adequate (Tomlinson-Clarke, 2013). This has led to the development of numerous models and theories that have failed to address multicultural competence in a holistic manner (Sue, 2001). For this study, the Multicultural Counselling and Therapy (MCT) is proposed due to its inclusion of the counselling and therapeutic aspects.

Sue et al. (1996) propose the MCT grounded in six fundamental propositions, namely:

- The first proposition recognises counselling and psychotherapy models, both Western and non-Western, as representatives of diverse worldviews (Sue et al., 1996). Thus, neither is viewed as right or wrong;
- The second proposition understands that the identities of the client and therapist are rooted in multiple experiential levels and environments, with experiences determined at an individual, group and universal level (Sue et al., 1996);
- Thirdly, cultural identity is recognised as influencing the attitudes of the client and therapist in reference to the self and others (same group, different group and/or dominant group) (Sue et al., 1996);
- The fourth proposition acknowledges that no single modality is effective with all populations. Therefore, modalities and goals must be client-specific regarding the client's life experiences and cultural values (Sue et al., 1996);
- The fifth proposition of MCT theory advises the utilisation of multiple facilities for intervention and prevention that have been created by diverse cultural groups and societies (Sue et al., 1996); and
- The last proposition is the liberation of consciousness about relating to the self, group and organization, thus resulting in therapy that draws from the traditional healing methods of diverse cultures (Sue et al., 1996).

The MCT was explicitly created for utilisation in a multicultural context (Sue et al., 1996; MacCluskie, 2010). This theory also helps to understand how therapists think about therapy and practice in a multicultural context. Thus, the MCT is more appropriate for this study.

3.3 Summary

This chapter has illustrated how the Structural Theory of Countertransference addresses the origins, triggers, manifestations and management of countertransference. In addition, this theory provides an understanding of the participants' experiences and perceptions of their countertransference reactions. The second theory, the MCT, provides an understanding of the participants' therapeutic experiences within a multicultural context.

The chapter also illustrated how applying the Structural Theory of Countertransference and the MCT is appropriate for understanding the countertransference processes that participants are experiencing and how their cultural awareness or lack of it influences these processes. Thus, the participants' experiences and perceptions can be explored within these two frameworks.

The subsequent chapter provides the methodology that was utilised in this research study.

Chapter 4: Methodology

This research study attempted to qualitatively explore the perceptions of therapists on the interface between culture and countertransference from an Interpretative Phenomenological Analysis. This chapter elucidates the research methods used in this study, describing the research design, study population, sampling, data collection, data analysis and ethical considerations.

4.1 Introduction

According to Stampley and Slaght (2004), countertransference as a concept is difficult to document, thus a qualitative approach is deemed an appropriate methodology in its research. Challenges have been faced in attempts to measure the concept of countertransference, hence an empirical inquiry has been complex through the decades of research on countertransference (Hayes, 2004; Gait & Halewood, 2019). More importantly, countertransference and culture have not received much research attention and require exploration in order to understand the core issues and experiences thereof. Various authors have explored countertransference using the qualitative method (Holmes, 2014; Machado et al., 2014). This study also uses a qualitative analysis in order to gain insights into the phenomenon of cultural countertransference.

4.2 Research design

This study used a qualitative research design, which is appropriate when exploring the meaning that participants ascribe to their experiences and how they make sense of these experiences (Creswell, 2014; Rubin & Babbie, 2011). Creswell (1998) states that qualitative research is conducted when the research problem or issue requires an exploratory method and the researcher is seeking to achieve an in-depth understanding of the phenomenon under investigation. This research method produces detailed data that is rich in descriptions from the participants' perspectives, with the researcher serving as an interpreter (Howitt, 2016; Willig, 2013). Thus, qualitative research is appropriate to explore the therapists' understanding of the interface between culture and countertransference and draw meaningful conclusions on how they make sense of this phenomenon.

4.3 Interpretive Phenomenological Analysis

Interpretive Phenomenological Analysis (IPA) was utilised specifically for analysing and understanding how the participants perceive or make sense of their culture-induced countertransference experiences (Lester, 1999; Smith & Osborn, 2007). IPA assists in understanding the lived experience, empahsises subjectivity, and acknowledges multiple truths. The method involves in-depth examination of the participants' experiences. This is a useful method in understanding the participants' perceptions of culture and countertransference and the interface of the two concepts for this study (Smith et al., 2009). IPA explores participants' experiences while attempting to understand and communicate these experiences and perspectives (Larkin et al., 2006).

IPA seeks to understand the meaning of these experiences by reflecting on the accounts that are related by the participants (Willig, 2013). Therefore, the interpretations are a collaboration between the participant and the researcher (Smith & Osborn, 2007). The researcher attempts to understand and make sense of the participants' experiences through describing the experiences; developing an interpretive analysis; and providing "a critical and conceptual commentary upon the participants' personal sense-making activities" (Larkin et al., 2006, p. 104).

The value of IPA is in the effectiveness of the approach in accentuating perceptions from individual perspectives and challenging pre-established assumptions or norms (Lester, 1999). In the context of this study, IPA method attempts to understand how the therapists make sense of their cultural and countertransference experiences within the therapeutic space (Smith et al., 2009).

4.4 Research objectives and questions

4.4.1 Research objectives

The main objective of this research study is to explore the concept of cultural countertransference, focusing on how therapists, based on their clinical interactions, understand and experience the relationship between culture and countertransference. Hence, the researcher aims to achieve the following objectives:

1. To explore how culture and countertransference are perceived to interact in the therapeutic relationship;

2. To determine the perceived effects of cultural countertransference on the therapeutic relationship; and
3. To explore the experience and management of cultural countertransference in comparison to normal countertransference.

4.4.2 Research questions

1. How do therapists, based on their clinical interactions, understand and experience the relationship between culture and countertransference?
2. What are the perceived effects of cultural countertransference on the therapeutic relationship?
3. How do therapists manage cultural countertransference in comparison to normal countertransference?

4.5 Participants

Participants in the study were selected using purposive sampling. Purposive sampling is a non-probability sampling procedure, also referred to as selective sampling. The participants were recruited through referrals from colleagues, lecturers and the directory for psychologists located online that is accessible to the public. In this sampling method, individuals are selected based on their knowledge of the area that is being investigated. Due to the complex nature of culture in South Africa, three racial core groups have been selected for this study to offer diversity within the sample. The racial diversity consisted of 3 Black African, 3 White and 3 Indian registered psychologists. This study will attempt to explore the experience of countertransference across different cultures. Smith and Osborn (2007) suggest 4 to 10 interviewees as appropriate for a research sample using the Interpretive Phenomenological Analysis.

Table 1: Participant Information

No.	Pseudonyms	Counselling/Clinical Psychologist	Gender	Race	Location	Years of experience
1	Andrea	Clinical	Female	Black African	Public	7
2	Thandiwe	Counselling	Female	Black African	Private	10
3	Rachel	Clinical	Female	Indian	Private	4

4	Emma	Clinical	Female	White	Public	7
5	Claire	Clinical	Female	White	Private	20
6	William	Clinical	Male	Black African	Public	5
7	John	Clinical	Male	Indian	Private	43
8	Kershen	Clinical	Male	Indian	Private	21
9	Trevor	Counselling	Male	White	Private	12

4.6 Data collection

Data was collected through semi-structured interviews using an interview schedule (see Appendix 1). Additionally, the researcher is an instrument who is viewed as an active contributor to the interview process (Smith et al., 2009). The interviews were conducted in the English language, which is one of the official languages in South Africa.

At the start of each interview, the respondent was informed of the purpose of this research and the nature of the interview. The information sheet was provided (see Appendix 2), explaining the nature and purpose of the interview and that participation was voluntary. The participants were informed that they had the option of refusing to participate and would not be required to answer any questions they did not feel comfortable with. The participants were also informed that their responses were strictly confidential and would not be communicated to anyone else. The interview data will be anonymous, with no record of the participant's name. A numerical number and pseudonym was used to code each interview transcript. In addition, a consent form was provided to the participants for them to sign (see Appendix 2).

4.7 Reflexivity

> When the researcher and researched are of the same order, that is, both living, experiencing human beings, it is necessary for researchers to reflect on how that might impact the research scenario when gathering and analysing data. (Shaw, 2010, p. 233)

Reflexivity is viewed as a crucial process in experiential qualitative research in psychology (Shaw, 2010; Willig, 2013) because the researcher plays a role in the research process. The researcher is not a bystander but a participant in the interaction occurring. Consequently, the researcher has to consider and reflect on the role they play within the process and there must

be adequate self-awareness. I am a foreign Black African female student. In the context of the research topic, I sometimes felt that the participants were too uncomfortable to be candid about some of their perceptions of culture-induced countertransference. I wondered if, at times, my racial identity affected the responses of the participants. The topic was interesting as it highlighted the discrepancy in the mental health system. There is a dearth of studies on the internal processes of therapists within culturally charged dyads. I was curious about the experiences of the therapists in this multicultural context that has a political history which has made culture significant; particularly the racial aspect.

I also had my own preconceived ideas of the participants' responses, which might have influenced my probing direction. I had also experienced being a therapist in this multicultural context of South Africa and had retained my own biases from the experience. This could have also influenced how I engaged with the collected data, and I had to bring this to my awareness continually. Although I had my own experiences of culture and countertransference, I had to acknowledge that my participants were the experts of their own experiences, and that their experiences would be unlike mine. Shaw (2010) mentions that a failure to examine ourselves may result in our biases contaminating our research.

The topic was challenging and I was frustrated at my own limited experience in engaging with a concept that felt at times was beyond my capacity to comprehend. My knowledge and curiosity increased as I continued to engage with the subject of countertransference.

4.8 Data Analysis

Data analysis was conducted using Interpretive Phenomenological Analysis (IPA), which is appropriate for qualitative research, specifically for analysing and understanding how individuals perceive or make sense of life experiences (Lester, 1999; Smith & Osborn, 2007). The value of IPA is in highlighting individual perspectives whilst challenging the assumptions and norms that have already been embraced (Lester, 1999).

Smith and Osborn (2007) offer steps to use during this research stage of data analysis, namely:

1. The researcher read through the transcripts more than once in an attempt to understand the flow of narration by the participants and engage with the data (Smith & Osborn, 2007). In addition, this provided familiarisation with the cases and an

opportunity to identify the patterns in the narration of their experiences (Howitt, 2016). This also allowed the researcher to become familiar with her own reactions towards the material.

2. Secondly, anything significant or interesting was highlighted and noted in the initial level of analysis, making use of exploratory commenting. Exploratory commenting was conducted by the researcher using descriptive comments, linguistic comments and conceptual comments (Smith & Osborn, 2007).
3. The emergent themes were extracted from the exploratory comments. This identified the preliminary themes (Howitt, 2016). The researcher noted these themes down as phrases or titles. During this stage, the researcher was aware that the themes reflected her understanding of the participants' experiences. According to Smith and Osborn (2007), this understanding is attained through continued engagement with the data.
4. Superordinate themes were developed from the interconnections and patterns identified in each case (Smith & Osborn, 2007). All similar themes were grouped together and given an appropriate title. Sub-themes were also identified under the superordinate themes. This process was repeated for all nine transcripts.
5. Finally, the superordinate themes and sub-themes identified across all the cases were compared across the cases. The tables of themes were compared for connections. This involved the researcher re-labeling some of the themes and discarding some themes. A master table of themes was developed from the individual tables. The master table captured the most potent themes.

4.9 Assessing the Validity

The validity and reliability of a qualitative study is important. However, it has to be established using appropriate criteria (Smith et al., 2009). This study will make use of the four broad principles compiled by Yardley (2000). The four principles are:

1. **Sensitivity to context**: This principle requires a researcher to be sensitive to the research context. IPA establishes sensitivity to the context from the initial stages of the research, from access to the research sample to communication with the gatekeepers. There is also acknowledgement that data collection is an interactional process (Smith et al., 2009). Therefore, I attempted to interact with the participants respectfully during the process, acknowledging that they are the experts in their

experiences. In the results and discussion chapters, I also provided verbatim extracts from the interviews to ensure that the participants' voices substantiated the arguments. Additionally, the discussion chapter included reference to existing literature to assist in the orientation of the study and the findings.

2. The second broad principle includes **commitment and rigour** (Yardley, 2000). The researcher's attentiveness demonstrated commitment towards the participants and the data analysis (Smith et al., 2009). I was committed and invested by ensuring that the participants were comfortable and listening attentively during the interview process. Rigour is established when the thoroughness of the study is explored. This includes the appropriateness of the sample, the interview conducted and the analysis conducted. There was a match between the research question and the sample chosen to respond to it, indicating that rigour was achieved. I attempted to attain rich data by probing and noting cues from the participants and then conducting an in-depth analysis of the data.
3. The third broad principle is **transparency and coherence** (Smith et al., 2009). Transparency includes detailing the research study procedures; selecting research participants; constructing the interview schedule; and the analysis stage. Tables have been included to illustrate the details of the participants and the themes that were obtained from the analysis stage. Coherency is achieved when the data, the findings, and discussion flow logically together without any ambiguities. Initial drafts of the analysis and results were written before the final drafts submitted.
4. The final broad principle is **impact and importance** (Smith et al., 2009). In a multicultural context similar to South Africa, this research could be beneficial in highlighting the aspects of culture that induce countertransference, thereby influencing the therapeutic process.

4.10 Ethical Considerations

Smith et al. (2009) emphasise the importance of conducting ethical research that protects participants and avoids harm. Therefore, several procedures must be followed to ensure that the research study is conducted respectfully and safely, namely:

4.10.1 Informed Consent

The written consent of participants was obtained. The consent forms (see Appendix 2) indicated that the participants were aware of the nature of the research and the aims of the research. Participation was voluntary and the participants could withdraw at any stage. The confidentiality of the participants was assured, and all data would be made anonymous.

4.10.2 Ethics Review

Permission for the research to be conducted was obtained from the Social Science and Humanities REC of the University of KwaZulu-Natal (see Appendix 3).

4.10.3 Respect for participants

The raw data obtained will be stored in a secure location and disposed of after five years. The participants' names and identifying details were removed from the transcribed data to ensure that their confidentiality was maintained. All data was made anonymous through the use of numerical codes and pseudonyms.

4.11 Summary

This chapter described the research methodology used in conducting this study. A qualitative research design was employed, with the use of the Interpretative Phenomenological Analysis approach. The study sample consisted of therapists whose lived experiences were explored using IPA. The data collection methods and analysis were highlighted. The results obtained from this data analysis are described in the following chapter.

Chapter 5: Findings and Discussion

This chapter presents the superordinate themes and sub-themes that were obtained from the analysis of the transcripts. The superordinate themes are as follows: (i) awareness of countertransference and culture; (ii) cultural aspects inducing countertransference; (iii) affective, behavioural and cognitive reactions; and (iv) managing countertransference experiences. This chapter additionally presents a discussion of the superordinate themes and sub-themes mentioned above.

Table 2: Emergent Superordinate and sub-themes

Superordinate Theme	Sub-themes
Awareness of countertransference and culture.	a. The origins of countertransference - *"I always notice that [reactions], so any kind of emotional or behavioural response that I observe in myself."* b. Culture in the therapist and therapeutic space - *"You cannot escape that difference [cultural] be it obvious or it's just subtle."*
Cultural aspects inducing countertransference	a. Language - *"So, from the beginning the conversation had already identified that we are not the same in terms of the language that we are speaking."* b. Racial and Ethnic diversity- *"This is post-apartheid South Africa. It's been many years, but sometimes I think we are still afraid to talk about race."* c. Cultural Practices - *I imagine no matter how hard I try to be empathetic and communicate a sense of understanding, they would sense at some level that I don't can't get it, that I don't quite wrap my head around it."* d. Age - *"Interestingly, with women who were white and older, I would suddenly feel too young again."*
Affective, Behavioural and Cognitive Reactions	a. The feeling – *"I think I was overcome with a lot of guilt, because I realised that somewhere I am connected to this"* b. The enactments – *"I would be throwing words, so that I allow her to sort of finish them, but sometimes it's not what she wanted to say to me."* c. Cognitive activity – *"I would have to think and rethink about whatever response I am going to give to*

that person."

Managing the countertransference experiences – *"Being aware of what was unfolding was important, so reflecting on it was an important aspect."*

5.1 Theme 1: Awareness of countertransference and culture

In order to understand the participants' perceptions of the interface of countertransference and culture, the themes of their experiences of countertransference and culture as individual concepts are discussed in this section.

5.1.1 The origins of countertransference - *"I always notice that [reactions], so any kind of emotional or behavioural response that I observe in myself."*

Most participants defined countertransference as a process occurring within the therapist and sometimes manifesting itself within the therapeutic process. There was commonality in some of the participants' responses, with minimal variation on how they defined the concept or experienced it in their therapeutic practice. According to most of the participants, countertransference experiences included emotional and behavioural reactions that the therapist displayed in response to interactions with the client. These were not limited to external manifestations, but also alluded to internal processes that were occurring in the therapeutic space. **Trevor** describes his perspective of countertransference experiences as:

> "This includes the thoughts and feelings that a therapist might experience in relation to a particular client. You know it's sort of the therapist's half of the transference relationship. I suppose if I got my head around it, so you know whatever, yeah, personal thoughts and feelings a particular client elicits, yeah, within a therapist's self."

Trevor's countertransference experience also included "all kinds of enactments" that were behavioural towards the clients during the therapeutic process. He termed these as "one's psychological and whole entire response to a particular patient", indicating that he viewed all his emotional, cognitive and behavioural responses as countertransference. However, these were limited to "particular clients". This indicates that these countertransference reactions were not experienced with all clients, indicating that there seemed to be specific patients that induced these experiences in him. He additionally felt that the countertransference is created within the therapeutic relationship, as he states that "it's sort of the therapist's half of the

transference relationship". Hence, he views his client as a co-creator of his countertransference reactions.

For **Thandiwe**, her countertransference was a response to the projection that she absorbed from her clients. She describes it as follows:

> "Countertransference should be, according to my understanding...should be a client's projection, obviously whether conscious or unconscious, either uncomfortable issues about each other's culture or rather not even each other's culture or rather, but my culture being the therapist. And countertransference would be me obviously responding to that, which I am absorbing from my client with regards to our cultural differences or cultural similarities."

Initially, it appears that Thandiwe had confused the two concepts of transference and countertransference before stating that her countertransference was a response to the client's "projection". This perspective appeared similar to Trevor's view, as he stated that the client "elicits" this countertransference reaction, thus indicating that they both felt that the client influenced their countertransference reactions. In Thandiwe's words, she is "absorbing" the client's "projection".

John similarly stated that it was "a patient projecting their...ahh, early perceptions onto you as a therapist", and the therapist reacting to those projections. **Kershen's** point further illustrated this when he stated that he experienced it as "my emotional reaction to the subject's contribution. If that person talks about something and it creates an effect in me", he added that it was a re-direction of his feelings towards a client. This indicated that the participants partially viewed their countertransference reactions as being "pulled" from them by their clients.

Another participant understood countertransference from a totalistic perspective, where every reaction that the therapist engaged in was deemed countertransference. **Claire** described the experience:

> "So, I always notice that [reactions], so any kind of emotional or behavioural response that I observe in myself. So actually, everything is countertransference in that perspective."

This indicated that whatever response she experienced during her therapeutic process was attributed to countertransference, and she further revealed that she used this diagnostically to understand the client. All the attitudes and feelings towards her client were important, hence she "observed" her countertransference throughout the session. This statement reveals that Claire felt that she constantly has to be aware of her reactions in therapy. She stated that her

countertransference assisted her in experiencing her client's affect and any disconnections during the therapy. She indicated later that she reacts to these affects and disconnections that she "observes" in the client. Similarly, she takes the same view as other participants that clients are co-creator of the therapist's countertransference experiences.

However, one participant could not articulate a definition of the term although she described internal processes occurring within the therapist during interactions with the client in therapy. She additionally stated that this process required identification, awareness and resolution to avoid impeding the therapeutic process. Despite this, she described experiences that she felt were countertransference reactions that manifested during therapy. Another participant was unable to differentiate between transference and countertransference. He stated that countertransference was not a process that he utilised in his therapeutic work as he did not practice from a psychodynamic perspective. Furthermore, he indicated that he viewed countertransference as a process beneficial to therapists that practised from a psychodynamic orientation. However, as the interview progressed the experiences he related indicated that he was aware of reactions that could be viewed as countertransference. This suggested that he did utilise the process countertransference despite his earlier assertion that it was only applicable to a particular modality.

In addition, the participants also explored what they believed were the origins of their countertransference reactions. Some of the participants felt that this countertransference originated from their own beliefs, conflicts or vulnerabilities. However, other participants stated that the patient caused their countertransference reactions, either elicited by the client or projected by the client. For example, Trevor felt that the origins of his countertransference were his own "deep-rooted beliefs" which influenced the therapeutic alliance:

> "I suppose the origin is, you know, exists in cultural differences, these deep-rooted beliefs that we have about how the world works and when we encounter something that feels very difficult to relate to on a personal level. You got to put in a bit of extra work to get your mind around it. And to try understand and experience it from the other person's perspective."

He views the cultural differences brought into the therapeutic space as a challenging experience, where he has to make an effort to understand these differences and the client's experiences. Trevor states, "you got to put in a bit of extra work to get your mind around it". Moreover, he acknowledges that the differences take him out of his comfort zone into the unknown. Another participant, **William**, stated that the therapist's "own biases, views and

opinions" came into the therapeutic frame or the therapeutic relationship and affected how the therapist related to the client.

Claire felt that the origins of her countertransference were based on how her own internalised culture responded to her client. She regarded the origins as "group programming and norms and patterns and also traumas" that she had internalised from previous generations. These factors influenced her countertransference reactions when interacting with what she perceived as culturally different clients. She viewed these reactions as being already "programmed" within her. This indicated that she felt that her experiences with particular clients were inevitable as she had already internalised a way of responding to those different from her own culture. Additionally, this can suggest that she has a "programmed" way of responding to her clients solely based on her perception of cultural similarities or differences. Such responses may lead to bias within the therapeutic space if she marginalises the other culture in comparison to her own or perceives the other culture to be threatening.

Most participants mainly experienced their countertransference as emotional or behavioural reactions occurring during the therapeutic process and originating from their own beliefs, conflicts or vulnerabilities. This was substantiated by Gelso and Hayes' (2007) argument that countertransference was part of unresolved conflict or vulnerabilities within the therapist. However, some of the participants viewed their countertransference experience as a response to the conflicts or vulnerabilities within their patients. This gives the impression that these participants perceive themselves as having little control over their countertransference reactions as the clients "pull" these reactions from them. Additionally, they view the clients as co-creators of their countertransference experiences.

5.1.2 Culture in the therapist and therapeutic space – *"You cannot escape that difference [cultural] be it obvious or it's just subtle."*

The participants asserted that "culture" was in the therapeutic space whether it was acknowledged or not. They explored their understanding of culture and how they experienced it in professional practice. The participants viewed as group identity that included, but was not limited to, individuals sharing similar norms, religion, values, language, ethnic background, racial background, age and gender. Some of the participants felt that their identity was linked to their culture. **Trevor's** response summed up the general perception that the participants had about culture:

> "Culture refers to you know a group's way of being in the world. That might set them aside as different or distinct from other particular groups and it seems to be something that is woven into the fabric of somebody's personal identity. You know, our cultural identity is not sort of a... I don't understand it as being a kind of overlay over an individual sense and vice versa. You know, it's part of the very fabric of our identity, so those beliefs, practices, norms etcetera that make up our particular society and that we are raised and then become a part of our you know, internalise within us."

For Trevor, there was no separation between people and culture, as he stated that the individual's identity was woven together by culture. There was no "individual identity without culture" in his perspective. He experienced his culture and identity as being intertwined. Trevor felt that his identity was created by how he chose to make sense of his culture's beliefs, norms and practices. He indicated that simply knowing about the group norms and practices was experiencing culture at a "superficial level". For him, culture had to be "lived". Culture, for Trevor is more than knowing about the nuances, it is embodying them and immersing himself in the experiences that shape his identity. This view echoed that of another participant, Thandiwe, who viewed these aspects of culture as looking "at culture in a traditional sense". She contrasted this with what she termed "the individualistic culture", which she defined as the lifestyle that an individual chose. Her view of culture was how she chose to live her life, and she felt that norms, traditions and common ways of living were restrictive. Interestingly, as she explores her cultural countertransference reactions later in the interview, she reverts to describing the aspects of her clients that induce countertransference, utilising the "traditional" perspectives that she seems to reject in her definition. Thandiwe appears to experience a conflict between the two cultures she identifies. Her chosen lifestyle embraces the individualistic culture; however, in therapy she uses what she has internalised which appears to be the traditional. This might speak of a transition stage that she is experiencing as she attempts to break away from "traditional" culture. There seems to be incongruence between her ideas about culture and her internalised experiences of it.

Another participant, **William**, alluded to the notion that various aspects of culture represented a "cultural journey" in which the therapist was engaged. It was evident from this expression that William did not experience culture as stagnant. He appeared to experience culture as a transitional process. The prominent example that he used was religion and how he understands his own religious biases as interfering with interactions within the therapeutic dyad. It seems that William's "cultural journey" is a process of becoming increasingly self-

aware of how his cultural biases, beliefs and values might manifest themselves during therapy. Whilst William acknowledged that his culture influenced the therapeutic space, he felt that his "cultural journey" aided in increasing awareness.

Other participants questioned "culture" and how it had moulded them and their interactions within a social and work environment. **Andrea** questioned what she termed her "taught" culture and how it affected her perspective on things. She explored her position on how she felt about subscribing to specific values and beliefs without questioning them:

> "There are so many things that we are taught to understand and believe and take in as our values. And moral values especially, in the name of them being culture. So I will say as a word itself it's being abused, in a way because there are so many things that we feel we have to do without really questioning why and how. What's the benefit of acknowledging or adapting a particular value or belief, simply because we have learnt through upbringing or through our social structural community that it is part of our culture?"

Interestingly, Andrea did not directly respond to her perspective of culture. Instead, she continued to question herself and seemingly the researcher about accepting this system and living by the imposed rules. She appeared hesitant to explicitly define the concept, as though somehow avoiding the constriction of the words. Despite acknowledging that culture was a social construct created by the social systems she lived within, she stated that it was still challenging to be objective in some instances. This indicated that there are areas of her culture that she might not accept. She acknowledged the difficulty in separating or detaching from practices or beliefs that had been recognised and accepted throughout her developmental stages into adulthood. Andrea further commented that these perceptions were brought into the therapeutic space. In exploring the term, she seemed to engage her own position in "culture":

> "But me viewing it as a social construct doesn't necessarily mean that it is easier for me to detach from certain things that I grew up to know to be true, to know to be the common practice, maybe among myself, the family, and my surroundings. It doesn't necessarily mean that I think it will be easier for me to sort of be objective, if I can use that word, when it comes to these things, because you can't objectively sort of separate from it, if it's something that you have been taught to recognise for a long time a lot to actually get to the point of actually questioning whether, is this culture or part of something that I need to identify with as an individual and if so, then how does it play a part in how I

> view things? Be it in a personal space, or be it in my working environment and in my interaction with other people."

It appeared that Andrea had concerns about the self that has developed through the influence of the culture that she subscribes to and how it affects her interactions. She also acknowledges that despite "knowing" her culture, there is still the challenge of objectivity. She realises and is also aware that she cannot separate herself from this culture or what she will perceive as "normal" or acceptable within the therapeutic process. This was similar to Trevor's experience of culture as being so deeply ingrained in the fabric of identity that separation was difficult. However, Trevor appears to “own” his cultural identity in contrast Andrea seems conflicted by this cultural identity that influences some of her actions in therapy. This also speaks of her inability to separate from the values, beliefs and norms that have been internalised and are known "to be true". Therefore, this indicates a struggle with any cultural practices or experiences that are different within the therapeutic space, as these deviate from the internalised standard of the therapist.

Most participants agreed that identified cultural aspects "influenced your makeup of how you viewed things". Regardless of whether it was group cultural identity or individual cultural identity, the responses indicated that the therapeutic relationship was affected by cultural influences. The therapist's cultural background was brought into the therapeutic space, and his/her reactions were related to the lens that they used to view the client. When describing her feelings with clients from different cultures, Andrea stated that from the initial contact, the way in which culture permeates the therapeutic space was noticeable:

> "It is always different from the initial conversation that you start having with that client or patient in front of you. It it's... from its beginning it starts as...ah... what's the word. You cannot escape that difference [cultural] be it obvious or it's just subtle."

She relates how she can feel the difference between herself and the client. She speaks of an inability to "escape" the differences, which echoes her doubts about her ability to be objective or separate herself from what she knows "to be true" during interactions. Her need to “escape” indicates that her preference is to avoid these cultural differences that induce discomfort and possibly threaten her performance in the therapeutic space. For Andrea, from the point of the initial contact, she has already "identified that we are not the same". This appears to set the tone for how the therapeutic process proceeds. She has labelled her client as an outsider that she might not be able to connect with due to the differences, which has

already created a barrier between them. Another participant, **Rachel**, examined the intricacies of the therapeutic process with a client of different cultural background:

> "In terms of differences, look it's... if I am sitting with a similar culture, there would be a lot of things that you would say or innuendos that I would be able to pick up, or it would be easier, not to say that you can't learn it, but it would be easier to relate to. If it's someone from a different culture, you would have to take the time to learn and reflect or explore. What does that mean to you? Every word that we use can have so much of depth that can so easily be missed."

In the above excerpt, Rachel acknowledges the difficulties in interactions with a client from a different culture. For her, more effort is required to understand and connect with these clients, indicating that the therapeutic process with these clients more complicated in comparison to clients of similar cultural backgrounds. When she is “sitting with a similar culture” it is comfortable and familiar. She worries about the nuances that make up the fabric of different cultures that she could potentially overlook in the interaction with her clients. She equates similar cultures with a connection that can enable one to "hear" what the client might not be communicating explicitly. Thus, the cultural differences appear to create a barrier within the therapeutic space and a sense of disconnect.

Most participants identified experiences where cultural aspects of the therapeutic dyad had induced countertransference within them, thereby acknowledging an interface between culture and countertransference, with the origins of the cultural countertransference identified as residing in the beliefs, biases, assumptions and unresolved conflicts within the therapist. This indicates that the participants acknowledge culture-induced countertransference occurring within the therapeutic process.

5.1.3 Discussion of awareness of countertransference and culture

The definition offered by Gelso and Hayes (2007) states that countertransference originates in the unresolved conflicts or vulnerabilities that a therapist might experience. These conflicts might be from the past or could be conflicts that the therapist is currently experiencing. Some of the participants identified unresolved conflicts, beliefs and biases as part of the countertransference process, substantiating literature findings. However, some participants appeared to attribute countertransference reactions as being elicited by the patient, contrary to

Gelso and Hayes's (2007) argument that countertransference was part of unresolved conflict or vulnerabilities within themselves. From these participants' perspectives, it appears that they viewed themselves as only responding to what was elicited by the client or projected from the client.

Therefore, this indicates that the participants held two perspectives on the origins of countertransference.

One of the therapists mentioned that it could be viewed as "a redirection of feelings towards the client", which was in line with Gelso and Hayes (1998)'s mention of displacements and distortions of the past brought into the present relationship. The totalistic perspective of countertransference was also obtained from the data analysis. However, this was not a view held by most of the participants as they did not attribute every reaction within the therapeutic process as countertransference. Hayes and Gelso (2001) stated that the assumption that all reactions, attitudes and feelings were countertransference invalidated the reason for the term. They further stated that not all reactions should be labelled as countertransference.

Stampley and Slaght (2004) argued that a comprehensive definition of countertransference needed to include the therapist's cultural aspects. Only two of the participants included some aspects of culture in their definition of countertransference. The cultural aspects they proposed included:

> "…culturally held assumptions, stereotypes, norms, beliefs, and values; attitudes related to race, ethnicity, and gender; world views including one's political, religious and moral views; and the influences of family of origin beliefs and intergenerational messages…" (Stampley & Slaght, 2004, p. 336).

The participants in this study primarily identified with negative countertransference. It appeared that for them, the countertransference experienced was more of an obstacle and a hindrance in the treatment process. This echoes aspects of the classical view, which states that countertransference required identification and resolution (Gelso & Hayes, 2007).

The aspects of the participants' perceptions of what *culture* represents are similar to the comprehensive definition offered by the DSM, stated in the literature review. Similarly, the participants mentioned culture being inclusive of language, religion, life-cycle stages, cultural practices, customs, ethnicity and race.

One of the participants, Claire, spoke of messages transmitted from one generation to another as she stated that she understood culture from a transpersonal perspective. The DSM posits that rules, practices and customs are transmitted through the generations. This echoes

that of social constructionist perspective which states that culture "locates meaning in an understanding of how ideas and attitudes are developed over time within a social or community context" (Dickerson & Zimmerman, 1996, p. 80).

Galbin (2014) states that culture can be viewed as the social construction of realities, and the individual's role is sustained through these realities. It appears that some of the participants viewed their roles as already pre-determined, which speaks of the complexity and interdependency of the individual and their community (Galbin, 2014). Consequently, this indicated that they brought their cultural assumptions and preconceived ideas into the therapeutic space.

The therapists' perspectives on culture identity additionally echoed one of the assumptions of the Multicultural Counseling and Therapy (MCT) theory, which was used as a framework for this study. Sue et al. (1996) posit that cultural identity is recognised as influencing the attitudes of the client and therapist in reference to the self and others. In this study, the therapists recognised that their cultural identity played a role in the way that they reacted to their clients.

These sub-themes indicated that although the participants had similar aspects making up their perceptions of countertransference and culture, they still maintained unique insights influenced by their own subjective and objective experiences. According to Stampley and Slaught (2004), therapists' perspectives are influenced by these subjective and objective cultural experiences, although self-awareness of this influence is limited within the therapeutic space. Additionally, the participants' experiences indicated that cultural aspects influenced countertransference reactions. The participants stated that the countertransference reactions were rooted in beliefs, conflicts, biases and cultural assumptions.

5.2 Theme 2: Cultural aspects inducing countertransference

Participants identified different cultural aspects that induced countertransference reactions within the therapeutic space as they interacted with their clients. In addition, they identified the triggers that induced the countertransference reactions. Four prominent sub-themes were identified, namely:

5.2.1 Language – *"So from the beginning the conversation had already identified that we are not the same in terms of the language that we are speaking."*

Some of the participants shared their experiences of misunderstanding or not connecting with the client when language was a barrier in the therapeutic space. Participants emphasised that the therapeutic process was about listening and hearing the client. Consequently, the inability to "hear" the client caused a rupture within the therapeutic alliance and introduced questions of competency for some of the participants. In some instances, the language barriers highlighted cultural differences. As Andrea stated, she realised that the client and herself were “not the same”:

> “So you find either, the client will be apologising for the fact that they may not be able to articulate themselves better in IsiZulu, therefore have to rely on English. However, doing so will also rob them, or me of understanding their presenting problem better. So from the beginning the conversation had already identified that we are not the same in terms of the language that we are speaking.”

She spoke about the language barrier and that utilising a secondary language "robbed" both her and the client of understanding each other. This indicates that she recognises that the client and herself have been deprived of an essential component of the therapeutic process. In a sense, she has missed a part of the client's story, which further makes her realise that the language causes this disconnect.

When she states that she and the client "are not the same" regarding language, she indicates that she does not identify with the client. During this point, Andrea appears to question the aspect of "sameness". It appears that this identification she makes of "not the same" also highlights the preconceived notions she holds of how she will experience a session with language barriers. She continued to explain that the language difficulty could not be “escaped”- it became part of the process and had to be dealt with somehow. This was the second experience in which Andrea mentioned the idea of "escape", which might indicate feelings of discomfort and being unsafe in situations or interactions with clients of different cultural backgrounds.

When the clients struggled with expressing “deep” emotions or emotional trauma, some of the participants felt that the sessions and narrations were superficial and blocked empathy. These experiences created barriers within the sessions and feelings of failure were induced within the therapist. They also experienced feelings of incompetence when faced with challenges that denied the progression of therapy. Rachel illustrated this when she tried to work with a young client from a different cultural background with a history of trauma.

She narrated the difficulty the client experienced in articulating his feelings in English and that the session felt superficial:

> "But it was very difficult, very... you are quite restricted in that space and I felt terrible. I was not doing him justice, I wasn't getting him completely. Ahhh and I was trying to follow his body language when he was breaking down. I was trying to give him the best that I could. But I really regret that if only I could get him in actual terms of language."

For Rachel, the challenge in language and not being able to "get" her client appeared to induce feelings of incompetence and possible failure as she related that she "was not doing him justice" and "I was trying to give him the best that I could". This indicates that she is questioning her abilities. She also speaks about feeling regret that she "blames" on the language barriers experienced in the therapeutic process. She additionally related another experience of communicating with another client and her inability to understand. This identified a pattern that Rachel equated her lack of understanding with failure or incompetence. She also recalls that "at one point I thought, she is going to think how dumb are you? Are you not understanding me? It's literally just the words that she was using." This emphasises the association she makes between incompetence and the language barrier.

Thandiwe also explored the countertransference she experienced concerning language difficulties during therapy:

> "So that has been necessarily the transference or the countertransference, but, I just feel sorry for my patients to an extent that you feel that you shouldn't be asking too many questions, because it ends up hindering you going as far as you possibly want to go because you are also considerate of the fact that this is stressful as much as they are here to destress."

She described compromising the therapeutic process to avoid causing distress to her client. It seemed that she was also attempting to avoid the discomfort she was experiencing with the struggles. However, this reaction or consideration that she gives the client affects the process and her ability to "hear" the client's entire story and explore the presenting problems.

Understanding the client is foundational within the therapeutic process. However, language is one of the most significant barriers and it induced discomfort and even questions of competency for some of the participants. In addition, it caused difficulty in creating the "connection" required to establish a strong working alliance between the two parties.

5.2.2 Cultural Practices – *"I imagine no matter how hard I try to be empathetic and communicate a sense of understanding, they would sense at some level that I don't or can't get it, that I don't quite wrap my head around it."*

Some of the participants related experiences where they had challenges establishing solid therapeutic alliances with clients after encountering cultural practices they could not understand. Participants related their experiences of attempting to make sense of "foreign" concepts and the inability to comprehend their clients' experiences fully. For example, two of the participants related experiences with clients in polygamous relationships. They explored the difficulty of comprehending this particular cultural practice. Trevor explains this difficulty and discomfort in navigating his way through "foreign" cultural practices:

> "Which [polygamy] is something that I find very foreign to me and it's something that I can't get my head around in a way that kind of makes sense from my frame of reference. That often leaves me in quite a difficult position, you know I think I can sort of get my head around where the person's coming from at a base level for me it just kind of seems, you know, so evidently problematic and the other kind of marital problems or problems to do with trust, you know, fidelity that could be manifesting. Ummm, yeah I kinda struggle with that and it does almost feel like there is a... I suppose there is a kind, there is a kind of taboo around talking about some of these things. You know, culture can be a bit of a loaded issue and I suppose in some of those moments I become incredibly conscious of the cultural difference."

Trevor acknowledges being in the "difficult position" of not understanding a cultural practice that he views as "foreign". At this point, he relates that he becomes "incredibly conscious of the cultural difference", indicating the high levels of discomfort experienced during the interaction with the patient. He is unable to ask the client for clarification of their experiences as he feels that discussing culture or asking the client for clarification is a "taboo". Therefore, a discussion of cultural differences is off-limits in the therapeutic process. In this case, the dis-avowed has become enacted through his discomfort. However, even as he continues the therapeutic process, he is keenly aware of how his own cultural practices are contrary to those of the client. As a result, Trevor has silenced himself and the client, and the gap between them increases. He controls the interaction by avoiding the client material that challenges the therapeutic process.

He realises that there is an expectation he has placed on himself to understand and he fails to achieve this. This is illustrated in his following statement:

> "I imagine no matter how hard I try to be empathetic and communicate a sense of understanding, they would sense at some level that I don't can't get it, that I don't quite wrap my head around it. Ummm, though I am willing to you know, accept it and talk about it."

As a therapist, Trevor feels that there are specific requirements that he has to fulfil, "to be empathetic and communicate a sense of understanding". His assumption that his clients know that he cannot connect with their cultural experiences induces further discomfort. He feels that he has failed at fulfilling a crucial part of his role as a therapist.

Another participant, **Emma**, mentioned the difficulty in expressing empathy for a client whose culture she could not relate to. Her feelings echoed Trevor's feelings as she also experienced failure to understand her client's experience. She tried to explain her encounters with different cultural practices as follows:

> "You know, if that's quite a foreign concept for you from where... how you have grown up. And you actually need to first gain some knowledge around it before you can even, truly have empathy...umm... so for me in a therapeutic space I often feel that I need to first, sometimes... with any person I can't assume that the culturally experiences are ever the same, even if they come from the same culture."

Emma appears to equate empathy with understanding. She states that "you actually need to first gain some knowledge around it before you can even, truly have empathy". Knowledge is foundational to understanding and Emma is seeking knowledge in order to understand her clients and she believes only them can she experience "true empathy". Thus, gaining knowledge of the client's culture becomes an important exercise. There is also a fear of assuming that she knows what the client is experiencing. Emma's responses as the interview progresses indicate a pattern of fear in "misunderstanding" her clients. She counters this fear by checking, clarifying and attempting to increase her cultural awareness. She appears to use cultural awareness as a safeguard from misunderstanding or making assumptions about her clients. She has to constantly attempt to understand her clients' perspectives, to put herself "in their shoes". However, even with these checks that she implements for herself, some cultural practices still seem to remain a foreign concept to her as she states "I think that it is very experiential". She feels even with the knowledge of a culture she can still be faced with a client that "might have experienced their culture in a different way". Therefore, she concludes that one can never truly understand. It seems there will always be that barrier for Emma.

Another participant, William, also related the challenges in understanding cultural practices of his clients, and how this compromised his ability to listen and engage in the treatment process. He stated that:

> "So it was just a completely foreign concept to me that made it difficult me to be able to listen firstly and be able to explore options that they had and I don't think they came back for a follow-up session. So I think that would be one example where there was complete breakdown in the therapeutic relationship for reasons that were more cultural than therapeutic if you think the two can be separated."

For **William,** the cultural experiences presented by the clients compromised his ability to perform his role as a therapist. He was unable to comprehend this cultural practice, which affected how he interacted with his clients. This cultural practice involved the termination of relationships through "talaq" and the reinstatement of the relationship afterwards. There seems to be a sense of disappointment for the participant as he acknowledges that the client material solely caused the barrier in the process. His difficulties in listening might have been exacerbated by attempts to understand the cultural experience and connect with his client. He seemed to equate understanding the cultural experience with establishing a working alliance. However, this seemed to have caused a rupture in the therapeutic alliance that was not repaired. The therapeutic process in this regard was terminated prematurely. The participant stated that in hindsight, it is beneficial to explore the experience with the client and make sense of the cultural experience from their perspective.

The participants experienced difficulty in connecting with the clients' cultural experiences and struggled to find a reference point to understand these experiences. It appeared that when faced with different cultural practices, the participants experienced feelings of incompetency; an inability to be empathetic; and struggles to maintain the therapeutic relationship.

5.2.3 Racial and Ethnic Diversity – *"This is post-apartheid South Africa. It's been many years, but sometimes I think we are still afraid to talk about race."*

Racial and ethnic diversity were aspects that some of the participants identified as inducing countertransference reactions. The participants related experiencing feelings of anxiety, discomfort and power struggles with clients from different racial and ethnic groups. For example, Claire relates her experience with teenage clients from a different racial group:

> "So I work with teenagers once a week, which is terrible *(laughs)* I find them so difficult and the most difficult countertransference I have is often black males. Black African teenage males, and I don't know if its and now I don't know if it has something to do with... an intercultural dynamic that they are expressing, but it just happens... It's not African males, it's more, it's the oppositional ones. That don't have a cultural programme of respect for me, whereas the white adolescents even if they are oppositional too there is something in them that says I have to be polite to this older woman. *(Laughs)* whereas you don't get that from the African boys and they are so oppositional and there is such a power struggle, but I also understand that it is not necessarily cultural, but also historical."

Claire appeared to be uncomfortable as she related these experiences. Her discomfort was clearly indicated in the way in which she laughed and shifted in her seat as she spoke. She mentions a particular racial group inducing countertransference during treatment processes, and it appears that she experiences guilt at having these feelings. Her demeanour was different in comparison to her discussing the language and age aspects of cultural countertransference. She appeared to feel guilt at the "power struggle" because somehow she feels responsible for this power struggle. This can be observed by how she speaks about victim-perpetrator dynamics concerning interactions with black Africans. She stated that she reacts to the "hostility" that she feels emitting from her clients and knows that it originates from the socio-political background of the country. She additionally appears to feel resentment at being viewed as the perpetrator. She seems to be searching for balance between the two emotions of guilt and resentment and she brings this struggle into the therapeutic space.

Another participant, **Rachel**, relates her countertransference reactions that appear to have origins in the apartheid past of the country. She also appears uncomfortable as she explores her experience:

> "This is post-apartheid South Africa. It's been many years, but sometimes I think we are still afraid to talk about race. If I am sitting with a middle aged white man in front of me, naturally if I am aware of myself. My accent will probably change, my demeanour, I'd probably shift into becoming a bit more submissive or compliant and where does that come from? As opposed to a teenage Indian person or black person."

Rachel appears to describe a power dynamic that she struggles with post-apartheid. The therapeutic dyad leads her to enact the personal conflicts that she experiences concerning race. In this case, she feels powerless and her cultural countertransference takes the form of behavioural enactment: a “change in accent, demeanour and a shift into becoming more submissive or compliant”. She stated that her countertransference reactions make her become "defensive", and she experiences feelings of "inadequacy". In an attempt to counteract these reactions, she puts "boundaries in place or ensuring that I am heard or giving off my credentials". This speaks of an attempt at self-protection in the face of vulnerability.

Thandiwe shares an experience in which she felt belittled and defensive while conducting therapy with a client from a different ethnic group:

> “I wasn’t comfortable, as a matter of fact, we never completed the therapeutic process, because she never pitched for her third and her fourth session and I just let her go. I didn’t even follow up on her as I would normally do with my other patients. I did, you know, the normal two calls. And after the two calls, I wrote on the file, patient *[inaudible*] missing, so that’s it. Whereas with the other patients, I would normally call and if I don’t get them after the two times, I would send an sms or something. So clearly those are issues that were culture related.”

She distinguished between the client's tribe and her own when she asserted that her tribe had their "own egos", indicating that she might have felt “attacked” by the client. There was a sense of relief when the client did not continue the therapeutic process. It seemed as if Thandiwe had “escaped” from addressing the struggles that she was experiencing in the therapeutic relationship. She relates how she was unable to follow-up on the client, indicating that she was unwilling to face the challenges in this particular therapeutic alliance. Thandiwe uses avoidance as her strategy for coping with the negative countertransferential reactions that she experiences in this interaction.

The participants appeared to be uncomfortable and ashamed as they related experiences that were directly related to race. They related feelings of discomfort, anxiety, inadequacy and defensiveness in their therapeutic encounters with the racially and ethnically diverse population. It seems that their feelings echoed Rachel’s words: “sometimes I think we are still afraid to talk about race”.

5.2.4 Age - *“Interestingly, with women who were white and older, I would suddenly feel too young again.”*

Age was one of the other aspects that the participants identified as creating a countertransference reaction within them. Interestingly, these reactions induced by age were linked to clients from their own racial groups. This theme was obtained amongst the female participants and not the male participants of the study. One participant explored countertransference feelings concerning males similar in age to her father, or any of the elderly males within her family system. She related the feelings as follows:

> "And make comments of you being a child, or displaying the kind of emotionally vulnerability around you. Automatically I would feel feelings of discomfort, not really discomfort in a sense that in my mind or I sort of shift from the role that I am supposed to play as a therapist to someone who is younger and this is my elder."

The idea of being compared to a "daughter" or a "child" induced feelings of incompetence for Andrea. She felt that she had to work harder to establish her competency within the therapeutic relationship and to avoid being undermined by the client's perceptions of her. She spoke of shifting from her role as a therapist to "someone who is younger" and viewing the client as "an elder". This indicates that the countertransference that she experienced led to her role being compromised within the therapeutic dyad. Andrea continued to express that these experiences resulted in a disconnect in the therapeutic alliance. She describes the barrier that had already been erected in the therapeutic process:

> "I am asking myself that was it because of the first comment or even if they didn't say anything, but if I look at this person and see that they are fifty plus year old and that they are a man. For example I had a person who had challenges with their libido, which was why they were there and it took them 3 or 4 sessions to actually bring the matter up. And it became apparent that they couldn't discuss that with me being a woman and being young and all those things. So, it creates a certain barrier, how do you then address that without really crossing that boundary that has already been created by the both of you in terms of how you relate to one another."

Interestingly, it appears that Andrea may still have experienced the discomfort even if the clients had not verbalised their concern about her age. She is aware of the age issue and appears to revert to how she would relate to the client from a cultural perspective if it were her father or older male family member. During the interview, she took the time to reflect on the process and explore the sequence of events that occurred in these experiences. She noted that there was difficulty in following the procedure of therapy and instead found that she had

“to normalise and reassure that this is a safe space and to address the issue of age or the difference of how they look at you”. However, she notes that in these experiences, there is difficulty in normalising, and the discomfort remains and becomes part of the process.

Similarly, Claire could not find adequate words to describe the feelings that she experienced during the interaction with older adults in therapy. She stated that "it doesn't feel right", and she felt that it was “going against the natural hierarchy” of how things should be. The “natural hierarchy” might represent a fear of failure and the need for approval and acceptance from the parental or authoritative figures and “going against” it might be met with disapproval and compromise acceptance. In this case, her professional obligations challenge her culturally internalised ways of relating. The conflict within Claire could be between who she needs to be as a professional and the needs she has as a “child”.

She expressed that these countertransference reactions were specific to older adults within her own culture, a similar observation made by Andrea. She stated:

> **“**You just feel it in yourself, like it goes against some sort of natural hierarchy of them being an elder in some way, but like I’m saying somehow that felt neutralised by being outside the culture for those we weren’t the same culture. So here I am going to age related culture. Ahhh, so that natural hierarchy I feel is culturally programmed and maybe in all cultures. That sort of hierarchy of age.”

Claire emphasised that she did not experience countertransference when the older adults were from a different culture. She pondered on this realisation for a while as she sat back and tried to make sense of her own experience. Finally, she explained that it felt like the male adults of her own racial group "activated" her "father issues". With regard to the women, she described an experience of feeling “too young”:

> “Interestingly, women who were white and older, I would suddenly feel too young again. And that was a countertransference were they felt like I am coming here at 60, telling this 30 year old or however old I was at the time. All of that and it’s against the hierarchy somehow, like an older woman coming to a younger women, you know what I mean.”

At one point, Claire described how she assumed the clients were feeling when they looked at her. She appeared to be projecting her own internal processes onto the client in this regard. She viewed this interaction as going against the "natural hierarchy" and assumed that the client must feel the same way, even if it was not explicitly stated. This echoed Andrea's feelings and experiences. Similar to Andrea, these experiences appear to induce doubt,

discomfort and feelings of incompetency. Claire seems to feel that her competence depends on her age notably when interacting with clients from her own racial group. This is emphasised when she ponders about her current age "I am older, like I am 45 so I don't feel it as strongly. Its feels fine". She feels that she is older now, therefore is competent enough to deal with individuals from an older age bracket. This can also indicate an internalised cultural aspect that views older people as accomplished.

The participants identified language, racial and ethnic diversity, cultural practices and age as the primary cultural aspects that triggered their countertransference. Indications are that the participants were aware of the culture-induced countertransference occurring within the therapeutic process. Some of the participants were able to use the countertransference and realised that the cultural aspects were creating barriers within the therapeutic alliance. Additionally, this created awareness of what client attributes or therapy content triggers their cultural countertransference.

5.2.5 Discussion of cultural aspects inducing countertransference

> "...that the clinician's own culturally based life values, academically based theoretical beliefs, emotionally charged prejudices about ethnic groups, and biases about their own ethnic self-identity, impact their clinical practice." (Foster, 1999, p. 256).

The participants' responses could be understood through the Structural Theory of Countertransference proposed by Gelso and Hayes (2007). They proposed that the triggers or precipitants of the therapist's countertransference occurred during the interactional process of therapy and these triggers activate the therapist's unresolved conflicts or vulnerabilities (Gelso & Hayes, 2007). Participants explored the aspects of culture that elicited countertransference reactions from them. There are three types of triggers identified in the literature, namely client attributes, therapy content and therapy process (Gelso & Hayes, 2001). Cultural countertransference for a therapist can be viewed as being influenced by client attributes and therapy content.

In keeping with the literature, the therapists' countertransference reactions were reported to be triggered by particular aspects of culture that are part of the clients' attributes and the therapy content. The client attributes identified included language, racial and ethnic diversity and age. Therapy content was identified in the sub-theme of cultural practices.

Language is considered to play an essential part in countertransference. However, it is often unacknowledged and classified as language or dialect differences (Nagai, 2009). Gould (2007) also suggests an association between language and culture or ethnicity, and that both contribute to countertransference. Van den Berg (2016) adds that culture cannot be separated from language. Verbal interaction is viewed as an essential aspect of therapy and without this aspect, the possibility of success is diminished. Most participants appeared to hold similar views in this regard. They related the negative countertransference experienced during sessions due to language barriers and the differences in ethnic groups. Van den Berg (2016) referred to these challenges as linguo-cultural barriers.

A participant identified that the client was "not the same" and Gould (2007) argues that someone labelled differently may trigger prejudice and bias from the therapist. The participants stated that as soon as the client spoke, the internal assessment is completed and the therapist has more or less realised that there will be a disconnect. The language has already caused a chasm that prevents the establishment of a working alliance. Gould (2007) adds that labelling a client "different" creates assumptions that can lead to a simplistic view of the client's attributes.

Some of the participants felt that when English was the common language but not the mother tongue of either the therapist or the client, essential information was lost in translation. The "deep" emotions were left unexpressed and unexplored, sometimes due to the language challenges. Bilingual clients might not be able to express themselves with clarity when speaking of emotional experiences. “English is where I defend myself, Spanish is where I feel” (Carrillo, 2001, p. 39). The findings indicated that when language was a barrier the work conducted in therapy felt superficial and there was no connection in the dyad. The “real” issues were left unexplored as the therapist and client tried to get through the surface issues. Ultimately, this could lead to the clients terminating therapy prematurely due to a lack of progress.

This aspect of language highlighted the challenges in working within the multi-linguistic South African population, which comprises eleven official languages (Matthews & Van Wyk, 2018; Van den Berg, 2016). The multiculturalism and diversity in South Africa have a profound effect on therapy.

In addition to language, race and ethnicity can affect the unconscious feelings of therapists, inducing countertransference reactions (Comas-Diaz & Jacobsen, 1991). Jones (as cited in Comas-Diaz & Jacobsen, 1991) reflected on how black patients induced complicated countertransference compared to white patients due to the differences in social images. The

social images depicted black individuals in negative narratives in comparison to their white counterparts. A few of the participants explored their experiences of countertransference induced by racial differences. However, most of the participant experiences were with clients from similar racial groups but different cultural practices and languages. Sue and Sue (2016) discovered that countertransference was often ignored within similar racial groups with different ethnicities. Therefore, the therapist must be aware of their own subjectivity influencing the therapeutic process regarding race or ethnicity (Foster, 1998).

According to Knight (2013), countertransference can be induced by race or "color". She illustrates this through the narration of her experiences with a black client and the countertransference connected to this interaction. Knight (2013) states that racial dynamics are a part of the experienced countertransference and that her own history shaped this countertransference. She terms this 'racialised' countertransference. The MCT theory indicates that a therapist must be aware of the effect that their cultural attributes and experiences has within the therapeutic dyad (Sue et al., 1996). Failure to acknowledge the differences can result in therapeutic rupture due to prejudices and assumptions (Sue & Sue, 2016). Similarly, Burt et al., (2016) asserts that overlooking or ignoring race or culture within the therapeutic space can have a damaging effect on the process.

Additionally, the stereotypes and cultural assumptions that therapists hold about particular cultural groups are also acknowledged as a source of countertransference (Foster, 1998; Stampley & Slaght, 2004; Sue & Sue, 2016). Stereotypes could generate from superior or inferior perspectives. For example, some therapists might subscribe unconsciously to the view that minority cultures do not possess sufficient insight to work through the therapeutic process (Foster, 1998, Sue & Sue, 2016). However, it should be noted that within the South African context, though Black Africans and Indians the numerical majority, the mental health system is predominantly established utilising Eurocentric or Western models; thus the results of "minority cultures" within these studies may be cautiously inferred onto the majority.

This theme illustrates that the participants acknowledged that there were cultural aspects that triggered their countertransference. Cultural countertransference was triggered either by the client's attributes or the therapy content. Moreover, participants identified the common triggers for their cultural countertransference as language, racial and ethnic diversity, cultural practices and age. This was in keeping with literature that stated that triggers were external stimuli (Gelso & Hayes, 2007).

5.3 Theme 3: Affective, Behavioural and Cognitive Reactions

The participants explored how their countertransference manifested during the therapeutic process. They identified cognitive, affective and behavioural reactions that occurred within the therapeutic dyad. These manifestations occurred with clients they perceived as culturally different and culturally similar.

5.3.1 The feeling – *"I think I was overcome with a lot of guilt, because I realised that somewhere I am connected to this."*

Some of the participants described and explored the affective reactions in the therapeutic process. The experiences included anxiety, frustration, guilt and incompetence. Most of these reactions occurred when the participants could not understand or connect with the cultural experiences of the clients.

For example, Emma recalls an experience that induced much guilt towards a client whose ancestors had been victims of genocide perpetuated by her "people". Although she was generations apart from the incident, Emma felt responsible for the client's feelings. Her countenance shifted as she relates the experience in a distant, haunted voice:

> "And he told me that, his...there was a genocide in Namibia where Germans killed a lot of indigenous people especially from the Herero tribe and a lot of them fled into Botswana for safety. And when he was telling me how that changed their culture, you know, having to move to a different country. I think I was overcome with a lot of guilt, because I realised that somewhere I am connected to this, because I am German and I am from Namibia, even though my ancestors were not involved in the genocide themselves."

For Emma, being faced with a "victim" of the crimes perpetrated by her "people" induced feelings of shame and guilt. She seemed to take ownership of what had happened to the client's "people" and its effect on his current presentation. She also realised that there was no separation from the culture of origin and their crimes had become her crimes. Her vulnerabilities tied to the history of her people and that client's ancestors induced affective countertransference reactions. She states that "he was still carrying a lot of pain and some experiences that his ancestors had", her tone of voice as she relates this seems to indicate that somehow she feels that she has to atone for this pain. These feelings can lead to compromised objectivity in the therapeutic process as she internally moves from therapist to perpetrator. Her work which includes being a container for the client as he processes his feelings could easily become one of attempting to eradicate his pain while seeking her own atonement.

Another participant, Kershen, describes recognising the emotions that he was experiencing towards his client and its effect on the therapeutic alliance. He could not manage his emotional reaction and the client became aware of his feelings towards her in the session. He describes the experience:

> "My non-verbal behaviour was one of concern and disgust at the same time. In terms of her subscribing to a practice that works against her. And the effect it had on her was that she closed off. Her body posture changed, she looked down, and away. The rest of the session was on her not maintaining any eye contact at all, even though prior to that part of the conversation, she did have intermittent eye contact with me. I think what actually happened there was that I was coming across as this dominating authoritative male in the session, which was a double whammy, because on the one hand ummm..., I was rejecting of her cultural alliance or her cultural obligations, cultural expectations and the second is that I was re-enacting this role of an authoritative male."

He appears to have judged the client's cultural choices and unconditional positive regard and acceptance have been compromised. Kershen also realised that the therapeutic alliance had ruptured and the client felt judged. He could track the countertransference reactions that he was experiencing and how the client was reacting to them. This experience indicated that Kershen was aware of the countertransference. However, he was unable to manage his reactions. Additionally, he appeared to be frustrated even as he attempted to understand the cultural reasoning for her decisions. However, he expressed difficulty maintaining complete objectivity and acceptance.

When faced with the language barriers in therapy, Thandiwe described the resultant experience: "therapy can also be uncomfortable because you feel frustrated the whole time. The therapeutic talks, they don't become as smooth". The inability to navigate the barriers that are presented induces negative affective countertransference reactions. She experienced a shift in her emotions as the session proceeds:

> "I just feel sorry for my patients to an extent that you feel that you shouldn't be asking too many questions, because it ends up hindering you going as far as you possibly want to go because you are also considerate of the fact that this is stressful as much as they are here to destress."

Her feelings of frustration eventually turn into feelings of guilt as she realised that neither herself nor the client are to blame for the barriers they are experiencing. However, the new

feelings seem to induce sympathy towards the client and discomfort with the therapeutic process. She avoids asking the questions that would assist her in "hearing" the client's story and convinces herself that this is to avoid distressing the client. However, this appears to be self-protection for herself against the challenges presented in the therapeutic process.

Rachel narrated her countertransference reactions with regard to gender, where she identified the dominant male as a threatening figure:

> "I think it's the dominant male or the... and I am saying the dominant because I will feel that maybe they want something specific or that they think I know a certain thing and I might be struggling with my own feelings where I go, can I give it to them. I am feeling a bit inadequate, whatever and I might come up feeling a bit defensive."

For Rachel, the questions of competency arise within herself. She also indicated that she feels physically unsafe when she states, "I mean being a female and slight built." Her defensiveness relates to two threats: physical safety and her role as a therapist.

Participants described the experiences that illustrated the affective countertransference reactions they attributed to cultural differences within the therapeutic dyad. Some of the participants stated that they were aware of the reactions during the therapeutic process, whilst others only became aware of these states outside of the therapeutic space.

5.3.2 The enactments – *"I would be throwing words, so that I allow her to sort of finish them, but sometimes it's not what she wanted to say to me."*

Some participants related experiences where their countertransference reactions manifested in behavioural enactments. The participants described countertransference reactions that included over-involvement and avoidance.

Andrea related experiences in which she displayed over-involving behaviours:

> "In our process, I would feel sometimes that I want to help her complete her sentences, because … she was trying to tell me something and I would be throwing words, so that I allow her to sort of finish them, but sometimes it's not what she wanted to say to me, because I feel that ... I would feel her frustration in a sense and I would assist her to be more comfortable, by assisting her to complete her sentences. But, the fact is that I didn't know what she wanted to say or what she wanted to communicate to me."

She seemed to find it challenging to sit in discomfort or keep asking the client to repeat or explain more. Therefore, she attempted to assist the client in relating their experiences. This appeared to be an attempt by Andrea to alleviate her own discomfort as she watched the clients struggle to make her understand their own experiences. Inevitably, this caused further difficulties as she felt that the clients could not tell their own stories because in a sense, she had silenced them. In addition, her discomfort and uncertainty led her to make assumptions about her clients' experiences, thereby compromising objective listening.

Additionally, Andrea related another experience of over-involvement in which she recognised her behavior: "you sort of go an extra, an extra mile. When the process doesn't really necessitate that, because you feel that, there is a gap that you are trying to sort of fill." She also seemed to feel that she has a responsibility to do more for the culturally different client, having to go "the extra mile", as she experiences something missing in the therapeutic process. It seems that the "gap" she is trying to "fill" is something in herself that might be inducing feelings of guilt at the client's struggles in the therapeutic space. Furthermore, there is an element of over-compensating behaviour designed to sooth the client's frustrations and in turn alleviate the therapist's own turmoil caused by the interaction. Similar to the above scenario, this is another attempt by Andrea to alleviate her discomfort.

Thandiwe states that there are times when the therapist's role is compromised during the process. She describes the experience:

> "I think for me personally it becomes a... not necessarily an added challenge, but the mere fact that you identify with someone means that there may be things that you take for granted within the process, so you must be more aware and pay more attention. And sometimes I feel, or have felt that over time it sort of robs me somehow of being present, and being in the process throughout..."

In this case, her perception of cultural similarities with the client led her to make assumptions about her client's knowledge, thus challenging her listening abilities. She stated that she felt she was robbed of "being" present. Moreover, she realised that she is not present in her role as a therapist. She continued that at some point, there was a sense that she was taking the challenges faced by the patient for granted and unconsciously assuming that the issues were not as difficult as the client was making them out to be. It seemed that for Thandiwe, the clients lost their individuality in cases where she felt: "I am familiar with this or this is something that I relate to, to the extent that as an individual I am able to deal with them in the following ways". This led her to formulate and implement a treatment plan without "hearing"

the client's story. Thus, she is "robbing" herself and the client of the full benefit of an objective treatment process. This was contrary to another participant, Emma, who felt that there was "culture within culture", and a therapist could not take it for granted that similar cultures equated to similar cultural experiences.

Some participants enacted their behavioural countertransference through avoidance, avoiding particular clients and avoiding talking about particular topics within the therapeutic process, primarily when the topics dealt with culture. Trevor stated that he experienced discomfort in such moments and felt that talking about culture was "taboo". Trevor wanted to understand the cultural experiences of his clients. However, it seemed that it was easier to avoid the issues than to conduct the exploration. It appeared that he also feared his clients' reactions when confronted with the admission that he was unable to completely "get" them.

Similarly, **John** displayed a pattern of avoidance with clients that he could not form a connection. He stated that he referred the client to another treating professional, and in the future, he would utilise the same solution: "if someone comes through to me who is Italian, I don't think I am going to be able to work with this patient. I will refer the patient off to somebody else." It appears that it is easier for John to avoid than to attempt to navigate these challenges.

Thandiwe also related that when she knew that countertransference would be inevitable with a particular client, she would not engage in a therapeutic relationship with that client, whom she referred to another professional immediately. This pattern of behaviour with the participants indicated a fear of incompetence regarding dealing with the issues presented in therapy.

Furthermore, Thandiwe spoke of another experience that induced affective countertransference reactions that were enacted behaviourally. She said that she had felt belittled and uncomfortable with a client from a different ethnic group. She described her behavioural response thus:

> "I didn't even follow up on her as I would normally do with my other patients. I did, you know, the normal two calls. And after the two calls, I wrote on the file, patient *[inaudible]* missing, so that's it. Whereas with the other patients, I would normally call and if I don't get them after the two times, I would send a sms or something. So clearly those are issues that were culture related."

The interaction left her frustrated and experiencing hostility towards the client. The feelings that she experienced manifested in overt countertransference behaviour. In this case, she disregarded the procedure that she has created to contact clients for follow-up sessions.

Instead, she actively avoided any further contact with the client. This indicates her avoidance of dealing with the countertransference she experienced in her interaction with this client.

5.3.3 Cognitive activity – *"I would have to think and re-think about whatever response I am going to give to that person."*

The third countertransference manifestation that some participants identified were cognitive reactions. These included distorted perceptions of the client or the client's behavior; defensive and reactive cognitive activity; and distorted perceptions of interaction with the client material.

One of the participants, John, felt that a therapist's "thinking" concerning the therapeutic process must also shift to accommodate specific interactions. He related the experience of an interaction in which he had to engage in a different way of "thinking" in order to understand the client's narrative. His initial assumptions about the client's behaviour and thought processes were invalidated as the session progressed. He stated that he realised:

> "I had to wrap my head around the way this person thinks and in accepting, first I have to acknowledge that this is not a local Indian, this is an Indian from India."

John described that a shift that had to occur mentally in order to proceed in the session and attempt to connect with the client. Firstly, he had to acknowledge that this client perceived things differently from his expectations, and that his response also needed to be different. He stated that his client's perception "was like a very rational perspective and less emotive, a lot of logical way of looking at things", and his mental activity had to accommodate her perspective in order to form a connection with her. He had to acknowledge and understand her way of "thinking" and experiencing her world.

Additionally, John highlighted the challenges of regulating cognitive and emotional reactions when faced with distinct cultural differences. He described an experience in which cognitive distortion appeared to occur:

> "And I was seeing that as being aggressive. And I was experiencing that as aggression. And I just felt that I see this disconnect over there, because it is like, somebody is like not listening to me, this person is being like...yeah, well, basically you know, you are coming see me for assistance. I could understand that maybe, you know, this is how culturally this person expresses himself, right. So he is not actually being angry towards you, but culturally that is how they speak."

In this case, John mis-perceived the client's affective reactions as being directed towards him. Interestingly, John was aware that the client was expressing himself in a culturally appropriate manner. However, he could not connect with the client. When the client did not attend follow-up sessions, John was both unsurprised and relieved. This indicated the degree of discomfort and frustration he had experienced within this therapeutic alliance. He further concluded that he would refer any clients of a similar background.

Another participant, **Trevor**, struggled to engage with the material that the client presented with in therapy. He struggled to understand her cultural experiences and the mental effort appeared to be frustrating, "I don't can't get it, that I don't quite have my head around it." Trevor realised that his perceptions of his client's cultural experiences affected his empathy. He felt that cognitively, he had to connect with his client's material as this leads to an increased understanding of his client's experiences. For Trevor, the only way to overcome challenges with cultural differences is to understand them firstly at a cognitive level.

Andrea illustrated the reactive mental activities that she experienced with her clients. She related the challenges when the client was culturally different, and the experiences appeared foreign. She described her reaction thus: "I would have to think and rethink about whatever response I am going to give to that person". The continuous analysis of her interaction with the client led to engagement in an internal conflict about her role:

> "I would feel feelings of discomfort, not really discomfort in a sense that in my mind or I sort of shift from the role that I am supposed to play as a therapist to someone who is younger and this is my elder."

Andrea's distorted perceptions about the client interaction and the client's attributes raised questions about her competency and induced self-doubt. This also indicated that her mental processes influenced the affective state. She described a cycle that she experienced:

> "I would go through of questioning whether you would be able to adequately assist your client. However, you would find that, as well as questioning your level of expertise … or also your ability to sort of overcome that obstacle that happens through culture or different concepts that you relate to that experience."

As Andrea describes the "think and rethink", it seems to indicate that she is also reflecting on her thoughts, unable to offer a "natural" or automatic response to the client. She appears to be conducting an inventory on what might be acceptable in response to this particular client who is different from herself. In addition to self-doubt, she seems to be exercising caution as she interacts with the client.

These experiences described by the participants highlight the importance of cognitive processing within the therapeutic space. The participants are aware of the distorted perceptions of client and client material; their reactive or defensive mental activities; and distorted perceptions of the client. Therefore, the countertransference manifested through cognitive reactions has the potential to become overt countertransference behaviour.

5.3.4 Discussion on Affective, Behavioural and Cognitive Reactions

According to the Structural Theory of Countertransference, manifestations of countertransference can be through affects, behaviours and/or cognitions (Gelso & Hayes, 2007). Although these internal and external manifestations are interdependent, thoughts and feelings are viewed as preceding behavioural reactions. The participants reported affective, behavioural and cognitive reactions during interactions with the clients they perceived as culturally similar to or culturally different from themselves. Stampley and Slaght (2004) argued that all therapists possessed prejudices about clients that they perceived as different from themselves and this was exposed in the cultural countertransference experienced.

Additionally, Sue and Sue (2016) indicated that cultural similarities between clients could lead to countertransference due to over-identification, which could lead to reduced objectivity. The findings indicated that in regards to cultural similarities there was a tendency for the therapist to assume they already "knew" the client material and therefore listening and objectivity were compromised.

The study conducted by McClure and Hodge (1987) concluded that therapists associated positive emotions with clients that they perceived as being similar to themselves. However, they also determined that negative emotions and experiences were associated with clients perceived as being different. In this study, there were three sub-themes under the broad theme, namely "affective, behavioural and cognitive reactions". The three sub-themes were affective reactions, behavioural reactions and cognitive reactions.

Some participants expressed that feelings of anxiety manifested in the therapeutic space at the realisation that they could not understand the client's experiences. Gelso and Hayes (2001) explain that anxiety is an expected response when a therapist is faced with a challenging situation in therapy. Gelso and Hayes (2001) posited that affective manifestations were a response to threatening situations perceived by the therapist. Anxiety was the affective state identified in countertransference manifestations and contributed to the rupture of the alliance (Gelso & Hayes, 2001).

Similarly, Fuertes et al. (2015) concluded that countertransference in multicultural therapy could be observed when a rupture occurred when the therapist withdraws from the client emotionally and psychological. This withdrawal was caused by feelings of anxiety and discomfort. The manifestations of these feelings could indicate that the client has "touched" unresolved feelings or vulnerabilities in the therapist (Gelso & Hayes, 2001).

One of the participants spoke of feelings of guilt during her therapy sessions with a patient from a culture group that had been in conflict with her own. Similarly, another participant spoke of conflictual feelings when in therapy with clients from a racial group that viewed her as a “perpetrator or oppressor” due to the socio-political situation in the country. In his paper, Srour (2015) concluded that therapists were likely to experience feelings of anger and guilt and negative countertransference when interacting with clients from groups that are in conflict with their own. Srour (2015) further states that the transference-countertransference dynamics are harmful and an obstacle in therapy.

Numerous studies have concluded that the absence of a good therapeutic alliance negatively affects the outcome of therapy as it affects the establishment of an emotional bond or connection (Gelso & Hayes, 2001). A participant explained that he considered the absence of a connection with a client detrimental to the therapeutic process. He felt that all therapists initially seek connection with the client and vice-versa. The inability to establish this connection may trigger conflictual and unresolved issues within the therapist (Gelso & Hayes, 2001). Additionally, a compromised working alliance may increase countertransference reactions for the therapist.

In some instances, therapists might encounter difficulty in being objective and reflecting on the client's experiences within the therapeutic space (Gelso & Hayes, 2001). Some participants mentioned this difficulty, particularly regarding client experiences that they perceived as being foreign to themselves. Gould (2007) described this as the inability of the therapist to hold the client in mind and maintain the connection required to continue therapy. This seemed to be particularly noticeable when the participants explored experiences around different cultural practices or expressions. Another participant related moments when he could not “wrap” his head around what the client was attempting to explain.

Some of the participants related experiences of countertransference that manifested in behavioural reactions. Some participants’ behavioural reactions indicated avoidance of the clients and the therapeutic situations. The MCT theory suggests that an inability to connect with the client’s worldviews leads to the therapist utilising behavioural enactments that compromise the treatment process and possibly alienates the clients (Sue et al., 1996).

Studies have indicated that avoidance and withdrawal were some of the behaviours that therapists exhibited in the face of negative countertransference (Gelso & Hayes, 2007). This was observed in the experiences of some of the participants in which they avoided engaging is some aspects of the client material that induced discomfort. There were also instances they would avoid seeing clients that had particular cultural attributes. These behaviours were linked to the therapist's feelings of anxiety or discomfort. Gelso and Hayes (2007) stated that the behavioural enactments were a response to the affective and cognitive countertransference that the therapist was experiencing. These behavioural manifestations of countertransference led to poorer outcomes of the treatment process.

According to the MCT theory, the manifestation of negative behavioural, affective and cognitive reactions is linked to the therapist's lack of culture awareness and an inability to acknowledge that the client's identity affects their presentation in therapy (Sue et al., 1996). The participants' attitudes towards their own culture and that of the client manifests in affective and behavioural reactions (Sue et al., 1996; Sue, 2001). Additionally, the feelings of anxiety and incompetence can be associated with unverified assumptions, bias and prejudices about dissimilar cultures (Sue & Sue, 2016).

This theme illustrated that the participants experienced manifestations of their cultural countertransference through affective, behavioural and cognitive reactions. The manifestations occurred interdependently and affective and cognitive reactions became behavioural enactments. These findings were substantiated by literature (Gelso & Hayes, 2007; Sue et al., 1996; Sue & Sue, 2016).

5.4 Theme 4: Managing the Countertransference Experiences

"Being aware of what was unfolding was important, so reflecting on it was an important aspect."

The participants explored the various ways in which they managed culture-induced countertransference within the therapeutic process. Some participants admitted to failure in managing the countertransference in a manner that was beneficial to the therapeutic alliance. However, some participants stated that they had not utilised these methods and it was in hindsight that they realised the benefits of managing culture-induced countertransference appropriately.

The most prominent method of managing countertransference for the participants was cultural awareness. A few participants emphasised the importance of cultural awareness through learning and exposure to diverse cultural worldviews. In addition, the participants

indicated that the process involved "curiosity" on the part of the therapist- to be curious about the client's culture and how the interaction between cultures within the therapeutic space. Claire speaks about this thus:

> "One of the things that I try to do, is that maybe I notice something that they are saying and I notice myself jumping to a conclusion, oh ok, let's use the example of polygamy. So somebody tells me they are polygamous. Then I jump into my head to my concept, my understanding of polygamy. And then instead ... you are not trying to ... instead of jumping to a conclusion, trying to be curious. I would say that the thing that helps me the most with countertransference is curiosity. Being curious about that person's experience."

Claire repeatedly mentioned polygamy as one of the primary cultural practices that she had difficulty understanding through the interview process. However, she realised that one method she can implement to improve the therapeutic process is "curiosity". Therefore, she decided to learn from the clients about their experiences. In this regard, she respects the client and acknowledges that they are the expert of their cultural experiences. It appears that this reduced the anxiety and the pressure that she felt regarding her lack of understanding. Her experience also indicates that she has become aware that she "jumps to conclusions" and is thus taking a curious stance to mitigate this behaviour.

Similarly, **William** also felt that he can learn from his clients as they are experts in their experiences. He described his experience as follows:

> "I was fortunate to have worked with people from various cultures, so you then learn and you inquire. They try to teach you more about that cultural framework. But also for me the easiest source of learning is through the client about their cultural differences to yours and learning how they want to be treated in that regard. Because sometimes you may overcompensate when you are trying your utmost best to be culturally sensitive when the person is not necessarily interested in that."

William indicated that exposure to colleagues of diverse backgrounds allowed him to engage with different worldviews. This appears to have been a stepping-stone in engaging with his clients differently within the therapeutic process. He explored the cultural experiences "with" his client. It seems that this method also allows the clients to engage with their own experiences differently. This method helps him deal with the anxiety of "not knowing what to do" or misunderstanding his clients. This might even alleviate any feelings of incompetency

that he would experience in this situation. This is illustrated when he stated that the countertransference can assist him in recognising areas that need clarification. He felt that an honest dialogue with the client is beneficial:

> "This is where I would disagree with the view that countertransference is always negative, because I think that if you as a therapist can pick that up, and you are for instance having supervision about it, you can then use it in meaningful ways to point it out to the client that these are issues that you would require them to take a lead in teaching you about those aspects of their culture or religion. So that you can be more competent in dealing with those."

In this regard, he takes the stance that culture-induced countertransference can be beneficial within the therapeutic process. He also admits that this method assists him to overcome feelings of incompetency in dealing with cultural differences.

Rachel, like William, also felt that constant exposure to different cultures assisted in managing the countertransference in interactions with clients from diverse backgrounds.

> "I think it also depends on how much exposure you have had. I think personally, maybe I have been lucky in that when we are at campus or when we are at work, we are mixing. We are culturally, you know, as opposed to someone that is coming from a place where they are very much in one or just exposed to one culture, then they find it more difficult. So I think...ahhh personally I find myself lucky in that I have mixed a lot. I have a lot of friends from different cultures or even different genders and all the rest of it. So it's become easier, when I think about a few years back when I came, because of community... being from a certain community, I was more exposed to a specific culture. So compared to before, I think this definitely leaves me in a better space now. So the more exposure that we have, the more respectful that we become."

For Rachel, socialising and working with individuals from different cultural backgrounds prepared her to manage her experiences with clients. This exposure appeared to increase her cultural awareness and respect for clients from the diverse cultural background. She appears to be more comfortable and confident after exposure to different cultures.

Another method that some of the participants explored was the process of reflection. The reflection process begins with the therapist's acknowledgement that issues and challenges are arising in the therapeutic process for the therapist. This acknowledgement brings with it the realisation that the therapist's "own biases, vulnerabilities, etcetera get in the way of

therapy", and these had to be explored. John felt that self-reflection and reflection on the process assisted in managing the countertransference that he experienced.

> "I think similarly as a therapist one needs to also process what you are doing in therapy and that after reflection will certainly help do that. And some of that would help deal if there are countertransference whether it is from a cultural or dynamic perspective, then yeah to reflect on those countertransference. Because, I think if, and but then again it's about smoothening the connection and deepening the connection. Ummm..so that's what the reflection would be about."

He is aware of the difficulty of complete awareness of one's reactions and behaviour during the therapeutic process. Therefore, his "after reflection" assists in processing the experiences. Additionally, this reflection extends to nurturing the therapeutic alliance by "smoothening the connection and deepening the connection".

Similarly, Rachel views reflection on the process and the self as an integral part of managing the countertransference. She felt that "reflecting, knowing ourselves, reflecting on what's going on in the process, always respectfully, is something that could help." Rachel associates self-reflection with "knowing herself". This indicates the desire to increase self-awareness as a means of managing countertransference reactions. She emphasised self-reflection in addition to reflection on the process. This echoes the views that **Kreshen** describes regarding the processing of countertransference. He states:

> "Being aware of what was unfolding was important, so reflecting on it was an important aspect of ...sort of determining a way forward in terms of adjusting my preconceived notions or ideas on cultural expectations and ummm. I started to process it, a little bit differently."

He associated reflection on the process by adjusting his "preconceived notions or ideas on cultural experiences." This indicates that he realised that during the process, a therapist cannot fully process all his reactions and the clients' experiences. However, being aware of the process and reflecting on it contributes to managing the reactions and increases his level of self-awareness.

The third method that some of the participants mentioned dealt with avoidance. Some of the participants appeared to avoid clients and situations that induced cultural countertransference. When addressing the cultural aspect of race, some participants admitted that they had limited clients from diverse racial groups. The participants viewed this as a benefit of working in private practice. John explained that he could choose to refer some

clients in private practice and not take some on when he perceived that there could be cultural difficulties in the therapeutic alliance. Claire also related her experience in private practice:

> "So, I don't get a huge broad range of cultural clients now in private practice. I run groups at Lusamina and then I see like also again a broad range, but most of the Zulu or black Africans are referred to psychologists of black African... yeah. So I think that the doctors tend to keep everything more cultural consistent, whereas in the hospital you get who you get."

For Claire, this appeared to be a relief- the ability to choose and not have to face the difficulties. In addition, this aided in avoiding the challenges that inevitably came with working with a culturally different client.

Trevor's experiences indicated that cultural issues which induced negative countertransference were better left unaddressed. He related his thoughts and actions on management as follows:

> "You know I don't know if I manage it the right way, you know and kind of talking about it is raising a question for me around, that there are probably better ways of managing it. I am thinking and feeling not articulating some of what I am feeling, because of this sort of perceived taboo around addressing cultural things. So, it probably completely the wrong way to approach it, but... you know as a therapist one should articulate these things."

Although avoidance appears to be a "way out" of being entangled in uncomfortable discussions, Trevor seemed to be aware that the way in which he managed the experience was not beneficial. The "perceived taboo" that he has surrounding cultural issues creates a barrier between him and engaging in the client's content. It prevents him from fully being present as he is "thinking and feeling not articulating". The process of censoring his words can compromise the alliance as he attempts to be culturally sensitive. This also appears to be an attempt to avoid engaging with the countertransference that might require him to question the reasons for perceiving some cultural issues as taboo. He seems clearly aware that the therapeutic space should be able to function as a container for everything that the client and therapist brings into it, as indicated when he states, "you know as a therapist one should articulate these things". This also highlights that he is aware that his role is compromised by his avoidance. However, in hindsight, he questioned whether he has been making the right decision on how to manage these situations. It appears that he second-guesses his decision even during the treatment process.

In comparison, **Thandiwe** related that she decides to avoid situations that induce cultural countertransference. She states, "I don't even want to start a therapeutic process with someone that I may potentially get countertransference." She feels that she might not be equipped to handle the challenges in such a situation. Therefore, it is preferable not to engage. Thus, the participants appear to be managing the anxiety that comes with these experiences through avoidance.

These participants identified three methods that assisted them in managing their countertransference. The first method identified was conducting self-reflection in order to increase their self-awareness within the therapeutic process. Another method identified involved the participants attempting to increase their cultural awareness through research and exposure to diverse cultures. Additionally, the participants utilised avoidance to manage their countertransference. However, they indicated that this last method was not beneficial to the therapeutic alliance or process.

5.4.1 Discussion on the management of countertransference experiences

> "...clinicians need to systematically examine and recognise their *cultural* countertranferences when their emotional reactions (thoughts and feelings) formed from their cultural biases are projected onto culturally different clients, thereby influencing the counselling relationship..." (Stampley & Slaght, 2004, p. 336).

Literature has indicated that unrecognised and unmanaged countertransference can become an obstacle in therapy (Gelso & Hayes, 2001; King & O'Brien, 2011; Stampley & Slaght, 2004). The authors also discovered an association between good therapeutic outcomes and better management of countertransference reactions. The participants emphasised the importance of managing countertransference within the therapeutic space in order to increase positive outcomes. There was general agreement that unmanaged countertransference would result in negative outcomes in treatment. In the final theme analysed, participants explored the methods they utilised to manage their countertransference reactions.

The key to managing countertransference is the therapist's response (Gelso & Hayes, 2007). In whatever manner the therapist chooses to behave or not behave, this is their response to the countertransference. Thus, this determines the management of the countertransference. The study revealed three response methods that the participants used, namely developing cultural awareness, the process of reflection and avoidance. Gelso and

Hayes (2007) proposed five factors in countertransference management: the therapist's self-insight, self-integration, empathy, anxiety management and conceptualising skills. These factors can only be achieved by the therapist's choice of response to the countertransference.

According to Tomlinson-Clarke (2013), a cognitive and emotional knowledge of oneself is attainable through reflection, namely the reflection of the self and the therapeutic process. It is essential to have the ability to utilise any opportunities available for self-examination to enable professional and personal growth. Self-reflection can contribute to the therapist's self-awareness, which may potentially lead to self-integration. Studies posit that self-integration in a therapist decreases the negative countertransference experienced (Gelso & Hayes, 2001). The therapist's integrated self can influence the therapeutic process positively as the therapist is able to maintain and separate self from the other (Hayes et al., 2018).

Additionally, the MCT theory advocates for therapists to examine and reflect on their own experiences, beliefs and values that induce negative countertransference (Sue, 2016). This examination and reflection can assist in anticipating the influence of perceived differences in culture on the therapeutic bond (Sue, 2016).

Foster (1998) argued that several impasses were created by cultural countertransference during the treatment process, leading to poor treatment outcomes. King and O'Brien (2011) posited that the reflection process could assist in understanding impasses that occur in therapy and overcoming them. Similarly, Safran and Kraus (2014) argued that overcoming these impasses and alliance ruptures increased positive therapeutic outcomes. Therefore, a therapist is encouraged to conduct a reflection on the self and process when faced with countertransference that affects the therapeutic process (Gelso & Hayes, 2001). Additionally, there is a challenge for the therapist to acknowledge that every part of them affects the therapeutic process: personal history, knowledge and skills (Sue, 2016). Although the participants were aware of the benefits of reflection, only a few of them engaged in this process.

According to Sue et al.'s (1996) MCT, therapists should work in a manner that is respectful of the client and the client's cultural worldview. The therapist learns and utilises models that represent diverse worldviews and recognises the differences in the identities of themselves and the client in these worldviews (Sue et al., 1996). This indicates that the therapist must be aware of the differences between themselves and the client, thus not imposing their cultural assumptions on the process.

Egan (2009) emphasised the importance of awareness regarding therapy with clients from diverse cultural backgrounds. In working with clients from diverse cultural backgrounds, a therapist has to commit to gaining cultural competence. The participants agreed that having an understanding of differences in cultures was essential, similar to the findings by (Nagai, 2009). However, Foster (1998) indicated that most therapists were not working with complete awareness of themselves in cross-cultural therapy.

Achieving cultural awareness can aid in the management of negative countertransference reactions. Sue and Sue (2013) concluded that a therapist had to be aware of his own cultural affiliations, the worldview of diverse groups or individuals and possess the ability to apply culturally appropriate interventions. According to Sue et al. (1996), the identities of the client and therapist are rooted in multiple experiential levels and environments, with experiences determined at an individual, group and universal level. Thus, these experiences have a profound effect on the therapeutic process.

The therapist's cultural self-awareness recognises and acknowledges the differences present in his or her culture and that of the client (James & Hastings, 1993; Sue & Sue, 2013). Cultural awareness is attained through various methods, namely research, learning from clients, continuous professional development that can take the form of workshops, courses, and or peer consultation. In addition, as globalisation increases, it has become essential that therapists are aware of their unresolved conflicts, culture or otherwise to decrease the possibility of negative countertransference reactions to clients (Gelso & Hayes, 2001; Bodnar, 2004).

Some participants reported that becoming more competent and avoiding pitfalls in therapy could be fulfilled by learning from the clients. They felt that clients are the experts of their experiences and can highlight the contexts that these experiences occur. Thus, the therapist attains the knowledge required to minimise the countertransference reactions that contribute to misunderstandings, biases, assumptions and preconceived ideas within the therapeutic alliance. Interestingly, Tomlinson-Clarke (2013) highlights that general knowledge of a culture might be inadequate to understand the nuances of a particular culture that can provide an understanding of issues presented in therapy.

For some of the participants, continued exposure and constant contact with individuals from diverse cultural groups assisted them in interactions with their clients. Literature suggested that continuous cross-cultural interactions facilitated connections between therapist and their clients and additionally, cultural empathy increased (Tomlinson-

Clarke, 2013). Improving cultural awareness is a developmental process that assists therapists in improving their ability to manage countertransference reactions (Sue & Sue, 2013).

5.5 Summary

Four main themes and sub-themes were identified from the data analysis. This chapter presented the findings and presented a discussion of the themes that were obtained from the analysed results of the study.

The first theme identified was "**awareness of countertransference and culture**". In this theme, the participants explored their experiences of the two concepts from a theoretical perspective and practice. They related what they understood the concepts to mean from their individual perspectives. The second theme explored was "**cultural aspects inducing countertransference"**. The participants explored the cultural aspects that triggered the cultural countertransference that they experienced.

The third theme was "**affective, behavioural and cognitive reactions**". In this theme, the participants explored how they identified with client-induced countertransference reactions. They explored identification with clients perceived as culturally different and those perceived as culturally similar. The last theme was "**management of countertransference reactions**". In this theme, the participants discussed methods that they felt were effective or useful in addressing countertransference in therapy.

The conclusion, limitations and recommendations for this study are presented in the following chapter.

Chapter 6 – Conclusions, Recommendations and Limitations

The study qualitatively explored therapists' understanding of the interface between culture and countertransference. The primary objective of the study was to explore how this relationship was perceived to interact in the therapeutic relationship. The secondary objectives were to determine the perceived effects of cultural countertransference on the therapeutic relationship and how the countertransference was managed. Four themes were obtained from the analysed data: (1) Awareness of Countertransference and Culture, (2) Cultural Aspects Inducing Countertransference, (3) Affective, Behavioural, and Cognitive Reactions and (4) Managing the Countertransference Experiences.

6.1 Conclusions

The analysis of the participants' lived experiences indicated that they acknowledged that there was an interface between culture and countertransference. The cultural identities of the client and therapist were perceived to play a role in the therapist's reactions to the client. Perceived differences in culture primarily induced negative countertransference reactions within the therapists. The conclusion of not being "the same" created barriers and increased the likelihood of rupture in the therapeutic alliance. The therapists' attitudes were influenced in reference to self and others in interactions with culturally dissimilar clients.

During this exploration, the participants identified their cultural countertransference as originating from beliefs, assumptions, biases and unresolved conflicts within the therapist. Additionally, these origins were deemed to be internal processes. This was consistent with current literature and theory exploring countertransference origins (Gelso & Hayes, 2007).

Within the therapeutic process, participants identified aspects of culture that affected the therapeutic alliance. These aspects were either client attributes or cultural experiences of the client that the therapist was unable to comprehend, also referred to as therapy content. The identified aspects of culture were language, racial and ethnic diversity, cultural practices and age. In current literature, these aspects are identified as triggers and are associated with external stimuli (Gelso & Hayes, 2007). Thus, the origins (internal processes) interplay with the triggers (external stimuli) to induce the cultural countertransference reactions.

It appeared that language was the most prominent trigger for negative countertransference within the therapeutic dyad. However, this was expected considering that South Africa is a multilingual country with eleven official languages.

The therapists identified three main ways that the countertransference reactions manifested, namely in behavioural, affective and cognitive reactions. The primary behavioural enactment was avoidance- avoidance of clients of dissimilar cultures or avoiding engaging with the client's cultural experiences within therapy. The affective reactions identified were anxiety, frustration, guilt and feelings of incompetence. The therapists appeared to struggle primarily with their affective reactions in comparison to the other two manifestations. The therapists' cognitive reactions included distorted perceptions of the client; defensive and reactive cognitive activity; and distorted perceptions of interaction with the client material. The results indicated that the therapists' cultural countertransference manifestations were primarily negative, thus highlighting the negative effect of countertransference on the therapeutic process and alliance.

Regarding the management of cultural countertransference, the participants viewed cultural awareness as essential, thereby indicating that cultural competency played a part in the treatment of clients from diverse cultural backgrounds. The participants regarded the management of cultural countertransference and general countertransference similar in some aspects, although they drew a distinction between the two types of countertransference, particularly when reflecting on the therapeutic process. However, participants admitted to intermittently engaging in methods that would decrease cultural countertransference. Instead, they engaged in avoidance, avoiding interaction with clients from dissimilar cultural backgrounds or avoiding exploration of cultural experiences. The findings of this study were consistent with the proposed Theory of Structural Countertransference (Gelso & Hayes, 2007).

The study highlighted that some of the participants struggled with objectivity concerning some of their clients' cultural experiences, thus experiencing increased cultural countertransference. The challenges with objectivity were also linked to limited cultural competency in therapeutic practice. It further highlighted the reluctance of therapists to confront the cultural barriers that are present themselves in therapy. The therapists appeared to struggle with acknowledging and exploring the cultural differences that affected them negatively. This highlighted fears of appearing incompetent and experiencing ruptures in the therapeutic alliances. This was consistent with the MCT (Sue et al., 1996).

Additionally, this study reveals that therapists are reluctant to admit to a lack of cultural competency within the therapeutic process, leaving important unexplored issues. Culture-induced countertransference is stifled and disavowed as the therapists attempt to maintain the appearance of cultural competency. What could be used as a beneficial tool to

inform and address the disconnect in the therapeutic process becomes an obstacle that increases poorer treatment outcomes.

With regard to the research objectives, the following was concluded: The participants acknowledged an interface between culture and countertransference. Various cultural aspects were identified as inducing countertransference. The countertransference induced by cultural attributes of either the client or therapy content was primarily perceived as an obstacle within the therapeutic process.

6.2 Limitations

This study only included nine participants located in one area of South Africa. The sample in this study is not indicative of all the registered psychologists in KwaZulu-Natal or South Africa. This study attempted to include the core racial groups in South Africa. However, the sample was not varied enough as the country has diverse ethnic groups. Therefore, it is difficult to generalise these results. Additionally, these are the lived experiences of a few individuals as related from their own perspectives.

Another limitation was the discomfort that some of the participants appeared to experience at the recollection and exploration of some of their lived experiences. This limited the extent to which they revealed sensitive information. This was particularly noticeable in explorations that included the aspect of racial diversity; therefore it is possible participants might also have given socially acceptable and desirable responses

As the researcher is also an instrument in the study, bias may be experienced. The researcher and the participant are engaged in an interaction. However, the researcher attempted to remain objective in the conduction of the interviews. There were instances when the results were unexpected. However, clarity was attained through further probing. Moreover, the researcher's own conceptions may affect the interpretative activity (Smith & Osborn, 2004).

6.3 Recommendations

Numerous research studies have been conducted on multicultural counselling and the interaction within the therapeutic dyad (Benet-Martinez, 2011; Sue et al., 2014). Actions are also being implemented to facilitate the attainment of cultural competency amongst mental health professionals (Johnston, 2015; Sue & Sue, 2013). As cultural countertransference

reactions come into awareness through self-reflection, the use of regular supervision and peer debriefing is recommended. Groups or platforms for mental health professionals with specific focus on cultural awareness within the South Africa multicultural context should be created. Therapists can also benefit from addressing their own skills gaps through continuous professional development activities.

This study could have implications for how the educational curriculum and training in cultural competency might be conducted, particularly in countries similar to South Africa with a prominent multicultural population. These findings indicate that there is need for increase in diversity training from the initial stages of tertiary education for mental health professionals.

Whilst this study was able to identify some of the reactions by exploring the therapists' lived experiences, it did not investigate the association between cultural competency and the countertransference experienced by the therapist. Future research should be conducted to investigate this association. Furthermore, one of the aspects identified as inducing cultural countertransference was race. In-depth studies should be conducted on the interaction between race and countertransference as this appears to be prominent aspect; particularly when the history of South Africa is considered.

References

Abdullah, S. (2015). Multicultural social work and national trauma: Lessons from South Africa. *International Social Work, 58*(1), 43-54.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *The American Psychologist, 58*(5), 377-402.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Publications.

Bantjes, J., Kagee, A., & Young, C. (2016). Counselling psychology in South Africa. *Counselling psychology quarterly*, *29*(2), 171-183.

Benet-Martinez, V. (2011). Multiculturalism: Cultural, social, and personality processes. In K. Deaux & M. Snyder (Eds.), The oxford handbook of personality and social psychology. (623-648). Oxford University Press.

Berry, J. W., Poortinga, Y. H., Breugelmans, S. M., Chasiotis, A., & Sam, D. L. (2011). *Cross-Cultural Psychology: Research and Applications* (3rd ed.). Cambridge University Press.

Breivik, R., Wilberg, T., Evensen, J., Rossberg, J. I., Dahl, H. S. J., & Pedersen, G. (2020). Countertransference feelings and personality disorders: a psychometric evaluation of a brief version of the Feeling Word Cheklist (FWC-BV). MBC psychiatry, 20(1), 1-12.

Bryant, A., Cook, A., Egan, H., Wood, J., & Mantzios, M. (2019). Help-seeking behaviours for mental health in higher education. *Journal of further higher education*, 1-13.

Bodnar, S. (2004). Remember where you come from: Dissociative process in multicultural individuals. *Psychoanalytic Dialogues*, *14*(5), 581-603.

Bouchard, M.-A., Normandin, L., & E-Hélène Séguin, M. (1995). Countertransference as instrument and obstacle: A comprehensive and descriptive framework. *The Psychoanalytic Quarterly, 64*(4), 717-745.

Bruscia, K. (1998). *The dynamics of music therapy*. Barcelona Publishers.

Burt, I., Russell, V. E. D., & Brooks, M. (2016). The invisible client: Ramifications of neglecting the impact of race and culture in professional counseling. *Vistas Online 38*, 1-10.

Cadaret, M. C., & Speight, S. L. (2018). An exploratory study of attitudes toward psychological help seeking among african american men. *Journal of black psychology, 44*(4), 347-370.

Carrillo, E. (2001). Assessment and treatment of the Latino patient. *The Latino psychiatric patient: Assessment and treatment*, 37-53.

Cartwright, C. (2017). Countertransference. Researchgate. https://www.researchgate.net/publication/312372695

Comas-Diaz, L., & Jacobsen, F. M. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American journal of Orthopsychiatry, 61*(3), 392.

Comas-Díaz, L. (2012). *Multicultural care: A clinician's guide to cultural competence*. American Psychological Association.

Cloud, J. N. (2013). *Exploration of Cultural Differences and the Therapeutic Relationship: The Role of Art between Ethnically Diverse Therapists and Clients*. (Master's thesis, Loyola Marymount University, Carlifornia, USA). https://digitalcommons.lmu.edu/etd/31/

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Sage Publications, Inc.

Creswell, J. W. (2014). *Research design: qualitative, auantitative, and mixed methods approaches* (4th ed.). SAGE Publications.

Dickerson, V. C., & Zimmerman, J. L. (1996). Myths, misconceptions, and a word or two about politics. *Journal of Systemic Therapies*, *15*(1), 79-88.

Edwards, S. (2015). Promoting family reslience in South Africa: a community psychological, multicultural counseling approach. *Inkanyiso*, *7*(1), 38-43.

Esprey, Y. M. (2017). The problem of thinking in black and white: Race in the South African clinical dyad. *Psychoanalytic dialogues*, *27*(1), 20-35.

Fauth, J. (2006). Toward more (and better) countertransference research. *Psychotherapy: Theory, Research, Practice, Training*, *43*(1), 16.

Feldman, M. (2007). Racker's contribution to the understanding of countertransference revisited. *The Psychoanalytic Quarterly*, *76*(3), 779-793.

Foster, R. P. (1998). The Clinician's Cultural Countertransference: The Psychodynamics of Culturally Competent Practice. *Clinical Social Work Journal*, *26*(3), 253-270.

Freud, S. (1910). *The future prospects of psycho-analytic therapy*.

Fuertes, J. N., Brady-Amoon, P., Thind, N., & Chang, T. (2015). The therapy relationship in multicultural psychotherapy. *Psychother Bull*, *50*, 41-5.

Gabbard, G. O., Beck, J. S., & Holmes, J. (2007). *Oxford textbook of psychotherapy*: Oxford University Press.

Gait, S., & Halewood, A. (2019). Developing countertransference awareness as a therapist in training: The role of containing contexts. *Psychodynamic Practice*, *25*(3), 256-272.

Galbin, A. (2014). An introduction to social constructionism. *Social Research Reports*, *6*(26), 82-92.

Gallardo, M. E., Johnson, J., Parham, T. A., & Carter, J. A. (2009). Ethics and multiculturalism: Advancing cultural and clinical responsiveness. *Professional Psychology: Research and Practice, 40*(5), 425a.

Geltner, P. (2013). *Emotional communication: Countertransference analysis and the use of feeling in psychoanalytic technique*. Routledge.

Gelso, C. (2014). A tripartite model of the therapeutic relationship: Theory, research, and practice. *Psychotherapy research, 24*(2), 117-131.

Gelso, C. J., & Hayes, J. (2007). *Countertransference and the therapist's inner experience: Perils and possibilities*: Routledge.

Gelso, C. J., & Kline, K. V. (2021). Some directions for research and theory on countertransference. *Psychotherapy Research*, 1-6.

Gelso, C. J., Latts, M. G., Gomez, M. J., & Fassinger, R. E. (2002). Countertransfrence management and therapy outcome: An initial evaluation. Psychotherapy: Theory, Research, & Practice, 58, 861-867.

Gordon, R. M., Gazzillo, F., Blake, A., Bornstein, R. F., Etzi, J., Lingiardi, V., McWilliams, N., Rothery, C., & Tasso, A. F. (2016). The relationship between theoretical orientation and countertransference expectations: Implications for ethical dilemmas and risk management. *Clinical Psychology and psychotherapy 23*, 236-245.

Gorkin, M. (1987). *The uses of countertransference*: J. Aronson.

Gould, D. (2007). Culture and countertransference. *Psychotherapy in Australia*, *13*(2), 67.

Gouws, A. (2013). Multiculturalism in South Africa: Dislodging the binary between universal human rights and culture/tradition. *Politikon, 40*(1), 35-55.

Hansen, N. D., Pepitone-Arreola-Rockwell, F., & Greene, A. F. (2000). Multicultural competence: Criteria and case examples. *Professional Psychology: Research and Practice, 31*(6), 652.

Hayes, J. A. (1995). Countertransference in group psychotherapy: Waking a sleeping dog. *International journal of group psychotherapy, 45*(4), 521-535.

Hayes, J. A. (2004). The inner world of the psychotherapist: A program of research on countertransference. *Psychotherapy Research, 14*(1), 21-36.

Hayes, J. A., & Gelso, C. J. (2001). Clinical implications of research on countertransference: Science informing practice. *Journal of clinical psychology, 57*(8), 1041-1051.

Hayes, J. A., McCracken, J. E., McClanahan, M. K., Hill, C. E., Harp, J. S., & Carozzoni, P. (1998). Therapist perspectives on countertransference: Qualitative data in search of a theory. *Journal of Counseling Psychology, 45*(4), 468.

Hayes, J. A., Nelson, D. L. B., & Fauth, J. (2015). Countertransference in successful and unsuccesful cases of psychotherapy. *Psychotherapy 52*(1), 127-133.

Hayes, J. A., Gelso, C. J., Goldberg, S., & Kivlighan, D. M. (2018). Countertransference management and effective psychotherapy: Meta-analytic findings. *Psychotherapy*, *55*(4), 496.

Health Professions Council of South Africa. (2017). *National survey of all registered psychology practitioners.* https://www.psyssa.com/wp-content/uploads/2017/07/HPCSA_Psychology_Survey_Report_FIN_320Feb202017.pdf

Heimann, P. (1950). On counter-transference. *International journal of psycho-analysis, 31*, 81-84.

Holmes, J. (2014). Countertransference in qualitative research: A critical appraisal. *Qualitative Research, 14*(2), 166-183.

Holmes, J. (2014). Countertransference before Heimann: An historical exploration. *Journal of the American Psychoanalytic Association*, *62*(4), 603-629.Holmes, G., & Perrin, A.

(1997). Countertransference: What is it? What do we do with it?. *Psychodynamic Counselling*, *3*(3), 263-277.

Hofsess, C. D., & Tracey, T. J. G. (2010). Countertransference as a prototype: The development of a measure. *Journal of Counseling Psychology 57*(1), 52-67.

Holmes, G., & Perrin, A. (1997). Countertransference: what is it? what do we do with it? *Psychodynamic counselling 3*(3), 263-277.

Howitt, D. (2016). *Introduction to qualitative research methods in psychology* (3rd ed.). Pearson.

James, W. H., & Hastings, J. F. (1993). Cross-cultural counseling: A systematic approach to understanding the issues. *International journal for the advancement of counselling 16*, 319-332.

Johnston, E. (2015). South African clinical psychology's response to cultural diversity, globalisation and multiculturalism: a review. *South African journal of psychology 45*(3), 374-385.

Jones, E., Huey, S. J., & Rubenson, M. (2018). Cultural Competence in therapy with African Americans. In C. Frisby, & W. O'Donohue (Eds) *Cultural Competence in Applied Psychology*. Springer.

Jung, C. G., Adler, G., Jaffe, A., & Hull, R. (1973). *CG Jung Letters, Vol, 1.1906-1950*: Routledge.

Kächele, H., Erhardt, I., Seybert, C., & Buchholz, M. B. (2015). Countertransference as object of empirical research?. In *International Forum of Psychoanalysis* 24(2), 96-108.

King, R., & O'Brien, T. (2011). Transference and countertransference: Opportunities and risks as two technical constructs migrate beyond their psychoanalytic homeland. *Psychotherapy in Australia*, *17*(4), 12-17.

Knight, Z. G. (2013). Black client, white therapist: Working with race in psychoanalytic psychotherapy in South Africa. *The International Journal of Psychoanalysis 94*, 17-31.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3*, 102-120

Lester, S. (1999) *An introduction to phenomenological research.* Taunton. Stan Lester Developments. http://www.sld.demon.co.uk/resmethy.pdf

Machado, D. d. B., Coelho, F. M. d. C., Giacomelli, A. D., Donassolo, M. A. L., Abitante, M. S., Dall'Agnol, T., & Eizirik, C. L. (2014). Systematic review of studies about countertransference in adult psychotherapy. *Trends in psychiatry and psychotherapy, 36*(4), 173-185.

MacCluskie, K. (2011). *Acquiring counseling skills: Integrating theory, multiculturalism, and self-awareness*. Pearson Higher Education.

Mishne, J. M. (2002). *Multiculturalism and the therapeutic process*. Guilford Press.

Nagai, C. (2009). Ethno–Cultural and Linguistic Transference and Countertransference: From Asian Perspectives. *American journal of psychotherapy, 63*(1), 13-23.

Pedersen, P. B. (2001). Multiculturalism and the Paradigm Shift in Counselling: Controversies and Alternative Futures. *Canadian Journal of Counselling, 35*(1), 15-25.

Racker, H. (1982). *Transference and countertransference*: Karnac Books.

Robertiello, R., & Schoenewolf, G. (1987). *101 Common Therapeutic Blunders: Countertransference and Counterresistance in Psychotherapy*. New Jersey: Jason Aronson Inc.

Rosenberger, E. W., & Hayes, J. A. (2002). Origins, consequences, and management of countertransference: A case study. *Journal of counseling psychology, 49*(2), 221.

Rosenfield, L. (2020). Unraveling Cultural Countertransference: The Experience of Caucasian Therapists Working with Asian-American Adults. *Psychoanalytic Social Work, 27*(1), 61-82.

Rubin, A., & Babbie, E. (2011). *Research methods for social work* (7th ed.). Brooks/Cole Cengage Learning.

Safran, J. D., & Kraus, J. (2014). Alliance ruptures, impasses, and enactments: A relational perspective. *Psychotherapy theory research pratice training 51*(3), 381-387.

Shaw, R. (2010). Embedding reflexivity within experiential qualitative psychology. *Qualitative research in psychology, 7*(3), 233-243.

Smith, J. A., & Osborn, M. (2007). Interpretative Phenomenological Analysis In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 53-80). Sage Publications.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: theory, method and research.* Sage Publications.

Smith, T. B., & Trimble, J. E. (2016). *Foundations of Multicultural Psychology: Research to Inform Effective Practice*. American Psychological Association.

Sperry, L. (2011). *Core competencies in counseling and psychotherapy: Becoming a highly competent and effective therapist*. Routledge.

Srour, R. (2015). Transference and countertransference issues during times of violent political conflict: The Arab therapist–Jewish patient dyad. *Clinical Social Work Journal, 43*(4), 407-418.

Stampley, C., & Slaght, E. (2004). Cultural countertransference as a clinical obstacle. *Smith College Studies in Social Work, 74*(2), 333-347.

Statistics South Africa. (2018). Mid-year population estimates. https://www.statssa.gov.za/publications/P0302/P03022018.pdf

Stefana, A. (2015). The origins of the notion of countertransference. *The psychoanalytic review, 102*(4), 437-460.

Stefana, A. (2017). *History of Countertransference: From Freud to the British Object Relations School*: Routledge.

Sue, D. W. (2001). Toward a Theory of Multicultural Counseling and Therapy. In J. A. Banks & C.A.M. Banks (Eds.), *Handbook of research on multicultural education* . (pp. 813-827). Wiley.

Sue, D. W. (2001). Multidimensional Facets of Cultural Competence. *The Counseling Psychologist, 29*(6), 790–821.

Sue, D. W., Gallardo M. E., & Neville, H. A. (2014). *Case studies in multicultural counselling and therapy*. Wiley.

Sue, D. W., Ivery, A. E., & Pedersen, P. B. (1996). *A Theory of Multicultural Counselling and Therapy*. Brooks/Cole Publishing Company.

Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory & practice* (6th ed.).. Wiley.

Sue, D. W., & Sue, D. (2016). *Counseling the culturally diverse: Theory & practice* (7th ed.). Wiley.

Tomlinson-Clarke, S. (2013). Multicultural counseling competencies: Extending multicultural training paradigms toward globalization. *VISTAS 2013*.

Tummala-Narra, P., Claudius, M., Letendre, P. J., Sarbu, E., Teran, V., & Villalba, W. (2018). Psychoanalytic psychologists' conceptualizations of cultural competence in psychotherapy. *Psychoanalytic Psychology, 35*(1), 46.

Van de Berg, V. L. (2016). Still lost in translation: language barriers in South African health care remain. *South African Family Practice, 58*(6), 229-231.

Van Rensburg, E. J., Van der Merwe, T., & Nel, M. (2012). Cultural competence among occupational therapy students at the University of Free State, South Africa. *Acta Academia*, *44*(3), 119-155.

Willig, C. (2013). Introducing qualitative research in psychology (3rd ed.). McGraw-Hill Education.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, *15*, 215-228.

Appendix 1

Interview Schedule

1. What do you understand by the concept of countertransference?

2. How do you conceptualise culture?

3. How do you understand the concept of countertransference when it is in the context of cultural differences or similarities?

4. What are do you believe to be the origins of this cultural countertransference as you understand it?

5. From your perspective, what feelings do clients from different cultures induce in you that are distinct from feelings that are induced by clients of a similar cultural background?

6. What are the triggers of this cultural countertransference?

a. Are they conscious or unconscious triggers?

7. How is the cultural countertransference manifested?

8. What experiences of cultural countertransference have you had in therapy?

9. How do you manage these experiences?

10. How do you see these feelings affecting the patient, the treatment relationship and the therapeutic process?

11. Do you think that cultural countertransference is beneficial to the treatment process?

a. If yes, how?

b. If not, how is it an obstacle or hindrance?

Appendix 2

Informed Consent Form (English)

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL

For research with human participants

INFORMED CONSENT

Information Sheet and Consent to Participate in a Research Study

Date: _____

Dear Participant,

My name is Lilian Chichevo, from University of KwaZulu-Natal, Howard College, currently completing my Masters Degree in Clinical Psychology.

You are being invited to consider participating in a research study. The aim and purpose of this research is to explore therapists' understanding of the interface between culture and countertransference. The study is expected to enroll approximately 12 therapists. It will involve answering questions during a semi-structured interview. The duration of your participation if you choose to participate in the study is expected to be approximately 30 minutes.

If participation in the research potentially causes any risks or discomfort, the researcher will provide de-briefing, and if necessary, a referral to the UKZN Psychology Clinic will be made. We hope that the study will become a possible source of information for future researchers. All information obtained will remain confidential. The information from the interviews will be used for research papers only. Participants' identities will not be revealed and will remain anonymous in any papers resulting from this project.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number HSSREC/00001098/2020).

In the event of any problems, or concerns/questions you may make further contact with the researcher at 216071872@stu.ukzn.ac.za, or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus
Govan Mbeki Building

Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

CONSENT

- I have been informed about the study being conducted by Lilian Chichevo
- I understand the purpose and procedures of the study.
- I have been given an opportunity to ask questions about the study and have had answers to my satisfaction.
- I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without any consequences.
- I understand that all information obtained will be stored safely and securely.
- I understand that the interview will be audio recorded for transcription purposes.
- If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher.

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Witness **Date**

(Where applicable)

_____ _____

Signature of Translator **Date**

(Where applicable)

Appendix 3

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

05 March 2020

Miss Lilian Nyasha Chichevo (216071872)
School of Applied Human Sciences
Howard College Campus

Dear Miss Chichevo,

Protocol reference number: HSSREC/00001098/2020
Project title: Exploring Cultural Countertransference: A Qualitative Study of therapists understanding of the interface between culture and countertransference
Degree: Masters

Approval Notification – Expedited Application

This letter serves to notify you that your application received on 04 March 2020 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

This approval is valid until 05 March 2021.
To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

HSSREC is registered with the South African National Research Ethics Council (REC-040414-040).

Yours sincerely,

[redacted]

Professor Urmilla Bob
University Dean of Research

/ms

Humanities & Social Sciences Research Ethics Committee
UKZN Research Ethics Office Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Tel: +27 31 260 8350 / 4557 / 3587
Website: http://research.ukzn.ac.za/Research-Ethics/

UNIVERSITY OF
KWAZULU-NATAL
INYUVESI
YAKWAZULU-NATALI

05 March 2020

Miss Lilian Nyasha Chichevo (216071872)
School of Applied Human Sciences
Howard College Campus

Dear Miss Chichevo,

Protocol reference number: HSSREC/00001098/2020
Project title: Exploring Cultural Countertransference: A Qualitative Study of therapists understanding of the interface between culture and countertransference
Degree: Masters

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HSSREC is registered with the South African National Research Ethics Council (REC-040414-040).

Yours sincerely,

[redacted]

Professor Urmilla Bob
University Dean of Research

/ms

Appendix 4

Turnitin *Originality Report*

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Exploring 'Cultural Countertransference': A Q... *By Lilian Chichevo*

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