

Psychodynamic therapy with low-income women:

The “talking cure” as a desirable and alternative intervention

By

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STATEMENT

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

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ABSTRACT

This study reviews the literature regarding psychodynamic therapy with low-income women. Low-income women are at psychological risk for developing emotional distress as a result of their deprived living circumstances. They have, however, received little attention from psychological research and practice. This literature review explores what psychological interventions are available for low-income women. It is found that psychodynamic therapy is largely unavailable to low-income women for a variety of reasons, which range from classism, sexism and ignorance to the cogent feminist and cross cultural critiques. It is argued that psychodynamic therapy should be more available to low-income women as it provides a sophisticated understanding of how oppressive social ideologies are internalized in the unconscious, thus facilitating, through therapy, a process of deconstruction and political subversion. Suggestions are also offered as to how to make psychodynamic therapy more accessible to low-income women.

ABSTRAK

Hierdie studie bied 'n oorsig van die beskikbare literatuur aangaande psigodinamiese terapie vir laer inkomste vrouens. Die groep is tot 'n meerdere mate blootgestel aan die ontwikkeling van emosionele stress trauma weens hul ontnemende lewensomstandighede. Laer inkomste vrouens het tot hede min aandag geniet met betrekking tot psigologiese navorsing en praktyk. Hierdie literatuur oorsig fokus op gepaste psigologiese ingryping wat beskikbaar is vir die spesifieke groep. Die toeganklikheid van psigodinamiese terapie beskikbaar, vir laer inkomste vrouens, kan toegeskryf word aan 'n verskeidenheid faktore: die strek van klassisme, seksisme en onkunde tot oortuigende feministiese en kruis kulturele beoordeling en debat. Hierdie verhandeling stel voor dat psigodinamiese terapie meer beskikbaar moet wees tot laer inkomste vrouens, want dit stel 'n gesofistikeerde begrip, ten doel van hoe onderdrukkende sosiale ideologie geïnternaliseer word in die onderbewussyn en die teenwerking daarvan. Die geskrif beredeneer hoe terapie kan fasiliteer in die proses van de-konstruksie en politieke subversie. Dit word ook voorgestel hoe om psigodinamiese terapie toeganklik te maak vir laer inkomste vrouens.

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Table of Contents

1. Introduction	1
1.1 Low-income women and psychological risk	1
1.2 Low-income women and psychological intervention	3
2. The case against psychodynamic therapy with low-income women	8
2.1 Traditional argument	8
2.2 Effectiveness and cost-effectiveness argument	12
2.2.1 Effectiveness	12
2.2.2 Cost-effectiveness	15
2.3 Theoretical argument	18
2.3.1 Feminist critique	18
2.3.2 Cross-cultural psychology critique	20
3. The case for psychodynamic therapy with low-income women	22
3.1 A social constructionist resolution to the dilemma of the individual versus the social.	22
3.2 Contemporary psychodynamic therapy with low-income women	23
3.3 Political psychodynamic therapy	24
4. Theorizing psychodynamic therapy with low-income women	29
5. Towards accessible psychodynamic therapy for low-income women	31
5.1 Group format	31
5.2 A short-term approach	32
5.3 A modified approach to psychodynamic therapy with low-income women	33
5.4 A psychodynamic approach to formulation and consultancy	37
6. Conclusion	39
7. References	42

1. INTRODUCTION

1.1 Low-income women and psychological risk.

As we enter the 21st Century 70% of the 1.3 billion people living in poverty are women (Brundtland, 1999). Since the 1970's economic conditions have actually deteriorated for many women, despite the impact of feminism, and increases in technology and wealth (Belle, 1985). In 1967 a black, single mother was 7 ½ times more likely to be poor than was a white man supporting a family; 10 years later this woman was 10 ½ times more likely to be poor (Belle, 1985). Although women have infiltrated the paid work force in greater numbers, women continue to earn on average 30-40% less than men for comparable work (Brundtland, 1999). In the U.S the wages of women aged between 30 and 64 years are less than half those of men (Brooks and Buckner, 1996). This phenomenon of deteriorating economic and material conditions for women has been described as the "feminization of poverty" (Padgett, 1996). Female-headed single parent families constitute 50 % of all families living in poverty in the United States (Gladow & Ray, 1986). This feminization of poverty is reflected in the drastic increase, since the 1970's, of homeless women in first-world countries (Johnson & Lee, 1994). There has also been an increase of ethnic minority women who fall into a low-income category (Rivers, 1995). Reid (1993) points out that 35% of all Black women and 30% of all Hispanic women in the US are poor, compared to only 12% of White women. However, this 12% of white women represents two thirds of all poor women in the US (Reid, 1993).

Salomon (1996) reviewing data from one of the United States' most comprehensive studies of poor, female-headed families, found that these low-income women had desperately low economic resources, constant residential instability, minimal support networks and frighteningly high rates of violent victimization. Low-income women also experience the stressors of lowered social status, minimal health care, inadequate nutrition (Rivers, 1995), job tedium, (Padgett, 1996), job discrimination (van Mens-Verhulst, 1998), and high exposure to crime (Belle, 1997). These stressors are chronic and severe (Rivers, 1995). Poor women are generally more likely to have had significant childhood losses such as parental death, to have been abused sexually and physically as children (Banyard, 1999) to have conflictual marriages, maternal depression, and to be single parents (Belle, 1997). It is very difficult for women to break free of poverty as classism, sexism, and racism serve to maintain women at the bottom of income, educational and occupational levels (Rivers, 1995; Warwick, 1999).

Salomon (1996, p. 486) notes that “not surprisingly, these women were severely distressed, as reflected in elevated rates of depression, post traumatic stress disorder, substance abuse, acute and chronic medical problems”. This association between economic deprivation and psychological distress has long been recognized (Belle, 1985; Bernard, 1965; Davis & Proctor, 1989; De la Rey & Eagle, 1997; Gibson, Swartz & Sandenbergh, 2001; Lerner, 1972; Padgett, 1996; Schnitzer, 1996). In fact, the severity and incidence of emotional distress is highest among the poorest in the population (Bernard, 1965; Lerner, 1972; Rowden, Michel, Dillehay & Martin, 1970; World Health Organization, 2001 a). It is of particular significance that women represent the poorest of the poor (Belle, 1985; De la Rey & Eagle, 1997; Johnson & Buszewicz, 1996; Rivers, 1995; Schnitzer, 1996).

Besides socio-economic status, gender also has an effect on mental health. For example depression and anxiety are far more common in women than in men (Padgett, 1996). Depressive disorders account for almost 30% of psychological disorders in women compared to 12,6% among men (World Health Organization, 2001 a). Almost 20% of women attending primary health care in developing countries experience anxiety and/or depressive disorders (World Health Organization, 2001 a). These symptoms are frequently not recognized and remain untreated (World Health Organization, 2001 a). The association between poverty and emotional distress is particularly strong among women who care for young children (Belle, 1985). In a sample of women living in Central London, the rate of affective disorders was 5 % among middle class women, 25 % among working class women and a startling 42 % among working class women with at least one young child of preschool age (Belle, 1985). The addition of race further increases this association between gender, poverty and emotional distress, with black women having even higher rates of mental illness than white women (Green, 1996; Mohamed & Smith, 1997).

The internalization of the experience of poverty with concomitant classism, sexism and racism is likely to have a significant impact on low-income women's personalities. Low-income women appear to experience an objective sense of personal powerlessness, which is felt subjectively as low self-esteem (Trotman, 1984), inadequacy, shame (Russell, 1996), humiliation (Gibson et al., 2001) and guilt (Kuppersmith, 1987; van

Mens-Verhulst, 1998). Russell (1996, p.65) speaks poignantly of how “it seems inevitable that a child growing up in poverty will conclude - sometimes with thought and sometimes without - that her social and economic circumstances have something to do with who she is and what she really deserves”.

It would, thus, appear that the increasing rate of poverty amongst women has serious and long term consequences for their overall psychological health status (Thomas, 1994). The World Health Organization states that the interaction of gender and poverty constitutes the greatest limiting factor to human development (Brundtland, 1999). This low-income status could even be considered to be intrinsically abusive (Russell, 1996). Poverty is a multidimensional phenomenon that refers to far more than simply a lack of money (Gibson et al., 2001). Poverty has, for example, medical, nutritional, economic and political implications (Gibson et al., 2001). In this paper it is argued that we need to gain a more sophisticated understanding of how poverty affects people psychologically in order to intervene more effectively through psychotherapy. In particular, the question of how a psychodynamic approach can be relevant to the experience of women living with poverty is explored.

1.2 Low-income women and psychological intervention

Considering how vulnerable low-income women are to experiencing emotional distress as the result of deprived living circumstances, the availability and nature of accessible psychological intervention is very important. This topic of suitable psychological intervention is of further pertinence, because low-income women constitute a large and growing group at psychological risk (Brundtland, 1999; Reid, 1993). Despite their dire need, low-income women have received relatively little attention in psychological research or clinical practice, even within feminist psychotherapy (Belle, 1985; Chalifoux, 1996; Kruger, 2000; Liebenberg, 2000; Reid, 1993).

Researching the topic of psychodynamic therapy and low-income women presents certain difficulties. The central complication pertains to the paucity of research regarding low-income women and psychotherapy (Chalifoux, 1996). Reid (1993), exploring a large United States electronic database, found that the combinations of the words “women” and “poverty” or “women” and “working class” or “women” and “low-income” provided little more than 0.5% of the total of abstracts containing the word “women”. She (1993,

p.133) contends that the silence on this particular topic reflects how poor women have been “shut up and shout out” of all psychological research due to classist and racist bias.

What literature is available is often outdated, with very little current research, such as Mill's (1996) “Shanti” project or Trevithick's (1998) “Womankind”. The literature is difficult to access because various terms are used to describe low-income women, for example working class, poor, disadvantaged, minority and so on. Such studies and accounts, which are reviewed, pose some difficulty in that they provide varied emphases and often do not often offer details of the therapy. The literature sampled consists of both theory and practice, which is problematic in that research findings are not easily or simply translated into clinical practice and vice versa (Edelson, 1994).

It would also appear that low-income clients are systematically discriminated against in terms of the psychotherapy made available to them (Davis & Proctor, 1989). Low-income women obtain minimal psychological assistance and what is provided is generally of poorer quality than that received by middle class patients (Davis & Proctor, 1989; Johnson & Buszewicz, 1996; Lerner, 1972; Liebenberg, 2000). Gender (Azocar, Miranda & Dwyer, 1996), class (Bernard, 1965; Gould, 1967) and race (Rivers, 1995) biases influence what types of psychological interventions are made available to low-income women and the quality thereof. In particular, low-income women have restricted access to the ‘talking’ therapies.

Women, in general, are less likely than men to be accepted into psychological treatment programmes (Davis & Proctor, 1989; Johnson & Buszewicz, 1996). When low-income women do manage to access therapy, they are likely to have inexperienced, poorly paid, often student-therapists (Davis & Proctor, 1989; Lilienfeld, 1969; Rowden et al., 1970). Low-income women are typically found to be less suitable for all types of psychotherapy, especially psychodynamic therapy (Davis & Proctor, 1989; Kruger, 2000; Mills, 1996; Nettle & Phillips, 1996). This form of therapy is typically reserved for middle-class clients (Lerner, 1972; Kruger, 2000). Liebenberg (2000) exploring the availability and accessibility of mental health care services for low-income women in a rural area in the Western Cape found that existing services tended to be custodial care for the mentally ill and mentally disabled. She notes that for low-income women with problems of living there is almost no care at all. Low-income women, despite their needs, be it for talking,

insight, social work or lifeskills are likely to receive directive therapy, inpatient treatment (Davis & Proctor, 1989) and medication (Gammell, & Stoppard, 1999).

Low-income women, in particular women of colour (Green, 1994), are more likely to be offered only pharmaceutical intervention than middle class women, even when they expressed a desire for an opportunity to talk with a therapist (Belle, 1985; Van Mens-Verhulst et al., 1999). Women are more likely to be prescribed addictive benzodiazepines, often incorrectly (Hellerstein, Flanssaas, Zweban-Howland & Samstag, 1994), and more frequently than men (Gadd, 1996; Padgett, 1996). Middle-class female patients tend to be both prescribed medication and referred for psychotherapy; the same referrals are not made for low-income patients (Kruger, 2000). This medicalization could be understood to be a method of silencing the patient's illness experience and narrative (Swartz, 1991), in order to maintain social power structures such as patriarchy and capitalism.

Mental health workers tend to misunderstand how low-income women's circumstances hamper their ability to access psychotherapy (Bumagin & Smith, 1985). The great effort and emotional risk taken by many poor women to arrive at the therapist's office is usually not appreciated. For example, poor women usually have to arrange childcare and transport in order to attend therapy (Mills, 1996). Few psychological services take this into account or accommodate these needs in any way. Emotionally, low-income women may be distrustful and hesitant of such services because of consistent abandonment in the past from social structures (Trevithick, 1998). This may be interpreted negatively by the therapist and may result in a lack of selection into therapeutic programs, because of what is perceived as a lack of motivation (Davis & Proctor, 1989). It is, therefore, evident that in many ways "the experiences of low-income women are too often ignored, pathologized" (Baker, 1996, p.14) by psychology and psychotherapy.

Despite this apparent reluctance of therapists and mental health services to provide psychodynamic therapy for low-income women, a small number of therapists and psychological services have made such help available. A review of this literature finds diverse populations of low-income women are described. These papers range from detailed accounts of the therapeutic intervention to more general descriptions of therapeutic work with low-income women and men. In particular, Trevithick (1998), Mills

(1996), and Bumagin and Smith (1985) provide useful accounts. Trevithick (1998) writes of her therapeutic project *Womankind* set up in the UK for women with a variety of mental health needs. Mills (1996) describes a feminist, intercultural, psychodynamic psychotherapy center, named *Shanti*, in the inner-city community of a Brixton housing estate. Bumagin and Smith (1985) reviewed the effectiveness of their psychodynamic therapy group with low-income mothers.

Selma Fraiberg and her colleagues Adelson and Shapiro (1987 a, b) provide beautifully written accounts of their psychodynamic work with low-income mother-infant dyads, in which the infants failed to thrive. Lerner (1972) offers perhaps one of the seminal descriptions of psychodynamic therapy with low-income patients in a deprived U.S. community. Kruger (2000) presents a paper regarding psychodynamic intervention with low-income farmworkers in the rural Western Cape. Landman (2001) and Swartz (1997) refer to the *Khayelitsha* mother-infant project, which is a community-based intervention programme, incorporating psychodynamic principles. Olarte and Masnik (1985) relate a long-term psychodynamic group therapy with low-income minority women in the U.S. Shulman (1985) writes also of her long-term psychodynamic group with elderly low-income women. Harper (1999) provides a short account of psychodynamic therapy on the streets of London with a homeless woman. Guthrie et al. (1999) performed a study to explore the cost-effectiveness of brief psychodynamic therapy in high utilizers of psychiatric services, who were typically low-income, minority women.

A number of other authors are briefly referred to in connection with their clinical work with low-income women. For example, Menikoff (1983) provides a description of a short-term psychodynamic group for low-income minority women. Mohamed and Smith (1997) refer to their brief psychotherapy project which aimed to make psychodynamic therapy more accessible and palatable to black women in the U.K. Green (1994), Koppersmith (1987), Sieber and Cairns (1991), Skodra (1992), Smith (1997), and Trotman (1984) write of their clinical experiences working psychodynamically with individual low-income and/or minority women.

These psychodynamic interventions appeared to fulfill an urgent need amongst low-income women for a talking therapy. Mills (1996; p.220) writes of how the women in her community desired "a safe, anonymous, user-friendly place where they could come and

talk comfortably about their distress and difficulties". Women, in fact, seek psychodynamic treatment twice as frequently as men (Bernstein & Lenhart, 1993), although they may not receive it more as often. Kruger (2000, p. 24) adds: "We never thought our farmworkers [would] value the simple experience of talking, of being listened to. We were even more surprised by their willingness and ability to explore their feelings and experiences by using symbols and metaphors". Landman (2001, p.7) quotes a community counsellor working in a deprived township: "No one listens to women. No one knows how they feel. Women don't share their problems, as there is no one to listen. But if you are available they open up and it all comes out". Reid (1993) maintains that there is much evidence that low-income women are aware of the issues and problems they face and that they do in fact have voices which are raised in concern, but that no one is listening.

Low-income women consequently appear to require psychotherapeutic intervention because of significant levels of emotional distress and many of these women seem to value a talking, insight-oriented intervention. This form of therapy is, however, seldom offered to low-income women and the reasons for this are discussed in the following section.

2. THE CASE AGAINST PSYCHODYNAMIC THERAPY WITH LOW-INCOME WOMEN

2.1 Traditional Argument

Historically, psychoanalytic therapy has been reserved for the middle and upper classes. For a variety of different reasons it has not been recommended or made available for low-income clients. According to Lerner (1972, p. 3):

From its inception, psychoanalytic therapy has been, in essence, a medicine for mandarins, designed and prescribed primarily for mildly to moderately disturbed middle and upper class individuals....Mildly or moderately disturbed middle and upper class people are good clients; severely disturbed and or lower class people are poor ones, rejected by and rejecting of professional therapy and therapist.

It has long been assumed that there are inherent factors in the personality of low-income individuals, which render them unsuitable for psychodynamic therapy. This assumption, lacking any scientific basis (Lilienfeld, 1969) has been promoted and reinforced in the literature through the process of stereotyping and classist and racist prejudice (Davis & Proctor, 1989; Lee, 1980; Lerner, 1972; Sidel, 1996). Belle (1997, pp.3-5) refers to the "profound misconceptions" and "systematic distortions" regarding the poor and hypothesizes their origin as resulting from the exotic, questionable, dangerous and decontextualised stereotypes of poverty and the poor portrayed by the media for political expedience.

Although much of the research into the inappropriateness of low-income patients for psychodynamic therapy stems from the late 1960's and 1970's, the lack of current psychodynamic work with this population suggests that this thinking may still hold sway. In particular, the concept of the "unsuitability" (Lilienfeld, 1969; Overall & Aronson, 1963; Rowden et al., 1970) of low-income clients arose from their assumed "inappropriate treatment needs, wants, or expectations" (Frank, Eisenthal & Lazare, 1978, p.61). Low-income patients have been accused of wanting immediate gratification, practical advice (Frank et al., 1967; MacLennan, 1968), "miraculous cures...pills and needles" (Overall & Aronson, 1963, p.422), sympathy, warmth and an active therapist (Azocar et al., 1996; Davis & Proctor, 1989), which are all anathema to the traditional abstinent psychoanalytic approach (Rowden et al., 1970). Research, however, has ascertained no social class differences in requests for psychodynamic insight (Frank et al., 1978), or in

expectations of therapy (Davis & Proctor, 1989; Lilienfeld, 1969). Azocar et al. (1996) found that low-income clients are as interested in talking to a mental health worker as middle-class clients.

A recurring argument regarding the unsuitability of low-income women as candidates for psychodynamic therapy refers to the tendency these patients have of dropping out of treatment before their therapist would desire (Acosta, Yamamoto, Evans & Wilcox, 1982; Lilienfeld, 1969; MacLennan, 1968; Overall & Aronson, 1963; Trotman, 1984; Yamamoto & Goin, 1965). This phenomenon is assumed to reflect low-income patients' characterological unsuitability for treatment because of their unreliability, irresponsibility, disorganization, and apathy (Lilienfeld, 1969; MacLennan, 1968; Overall & Aronson, 1963; Rowden et al., 1970; Schnitzer, 1996).

Belle (1985) suggests, however, that this tendency to end treatment prematurely, reflects the disappointing experience of psychodynamic therapy that low-income women often endure. Low-income women, too frequently, experience their therapist as judgmental and blaming (Davis & Proctor, 1989; Parnell & Vanderkloot, 1997; Rivers, 1995). This perception of being blamed arises from the tendency many therapists have, when working with low-income clients, to limit their attention to intrapsychic dynamics and to ignore the stark social issues (Belle, 1985). Low-income women, on the other hand, often (justifiably) consider their stressful social circumstances to be largely the cause of their emotional distress (Belle, 1985).

The difficulties low-income women have in actually arriving at therapy sessions, because of high levels of environmental stress, and specifically because of child care and transport expenses, are often ignored. (Belle, 1985; Davis & Proctor, 1989; Kuppersmith, 1987; Lerner, 1972; Schnitzer, 1996; Trevithick, 1998). The low-income woman is more typically viewed as unwilling to engage in help. The psychodynamic perspective, which suggests that by missing appointments the patient may seek to unconsciously communicate her own experience of unreliable figures by making the mental health worker feel rejected, despairing, or angry, is seldom recognized when working with the poor (Weeramanthri, 1997).

The innate personality characteristics which low-income patients are assumed to have, making them unsuitable for psychodynamic treatment, include low levels of verbalization and insight and permanent developmental deficits (Davis & Proctor, 1989; MacLennan, 1968). Low-income clients are also perceived to have little faith that talking can help, as favouring action rather than insight, as externalizing their problems, and as being generally distrustful of others (Rowden et al., 1970; Shen & Murray, 1981)

Many of the above personality trait assertions, such as being non-verbal are blatant and unjustified stereotypes. However, the apathy, mistrust and hostility the therapist may indeed encounter, when working with this client base, can also be seen as possibly serving a protective function, considering the stressful and deprived lives many of these clients have led. Such ignorance, stereotyping and discrimination leads Parnell and Vanderkloot (1997, p. 361) to conclude that: "the existing body of knowledge for working with the poor is a caricature when compared to the realities of poor women and their families".

Mills (1996) comments that low-income women are often aware that they are considered unsophisticated, and that this lack of sophistication precludes them from talking treatments. Belle (1985, p. 144) quotes one low-income female client observing that she'd "run into mental health workers who....equate being poor with being stupid". This implicit prejudice and discrimination from mental health workers causes the minimal therapeutic services available to low-income women to be viewed by them with distrust and ambivalence. Schnitzer (1996) points out that from the client's perspective therapy appointments may not ultimately be viewed as worth keeping, due to the discrimination they encounter.

Various authors suggest that the reluctance of psychodynamic mental health workers to work with the poor is more as a result of therapist classist discrimination than with practical or theoretical reasons (Bernard, 1965; Davis & Proctor, 1989; Gould, 1967; Leeder, 1996; Lerner, 1972; Wyche, 1996). Much research supports the significant preference psychodynamic therapists have for middle-class patients (Bernard, 1965; Frank et al., 1978; Gould, 1967; Lerner, 1972; Lilienfeld, 1969; Rowden et al., 1970; Shen & Murray, 1981). Wyche (1996) contends that the preferred patient for psychotherapy meets the description of "YAVIS": young, attractive, verbal, intelligent and

successful – specifically middle or upper class. Non-YAVIS clients seem to evoke negative reactions from mental health workers.

Negative attitudes appear particularly in experienced, highly educated mental health workers - most likely to be psychodynamic therapists - than among paraprofessionals (Davis & Proctor, 1989; Rowden et al., 1970). There are numerous reasons for this, such as the stereotyped portrayal of difficult low-income clients, the general devalued status of work with low-status groups and individuals, resulting in lower pay and less peer recognition, the elitist nature of classical psychoanalysis, and negative prior experience in training with low-income clients. Psychodynamically, prejudice such as racism, classism and sexism is understood to employ one of the psyche's most primitive unconscious defence mechanisms of splitting and projection (Mohamed & Smith, 1997).

For example, the mechanism of racism can be conceived as a social phenomenon of mass splitting and projection by white society, in which the black community receives the unconsciously split-off aspects of the white psyche (Mohamed & Smith, 1997). Working dynamically with groups of people who hold this projected, split off "other" of the idealized, empowered male, white, middle class, is uncomfortable if not intolerable. The therapist will have to brave unbearable feelings of shame, loss and guilt when recognizing these parts as his or her own, admit his or her personal investment in this projective defence mechanism and finally take back these disowned parts. Poor women, in particular, hold negative projections for the middle-class. Baker (1996) describes low-income women as "the other" whose experience and tradition is too alien to comprehend. It should, however, be the psychodynamic therapist's task to give a voice to the experiences of working class and poor women (Baker, 1996).

Despite the deeply prejudiced handling of low-income women in psychological services, and the deep suspicion these women feel towards what is traditionally a white, male, middle-class institution, many low-income women continue to use the available services more frequently than their male counterparts (Bernstein & Lenhart, 1993; Rivers, 1995) and when asked, express their desire for a talking intervention (Kruger, 2000; Nettle & Phillips, 1996; Van Mens-Verhulst et al., 1999).

2.2 Effectiveness and cost-effectiveness arguments

As has been discussed above, psychodynamic therapy has frequently been regarded by mental health professionals as unsuitable for low-income clients. This unsuitability stems partly from the assumption that psychodynamic therapy is not very effective in treating emotionally distressed low-income clients (Lerner, 1972). The term “effectiveness” is used here because it refers to the effects of interventions in the actual settings in which the intervention will be finally offered (World Health Organization, 2001 b). In other words, we are looking at psychodynamic therapy with low-income women in their actual environments, facing all the difficulties that are described when working with this population. This term is used as opposed to “efficacy” which describes the examination of an intervention’s effect under controlled, experimental circumstances (World Health Organization, 2001 b). Psychodynamic therapy is also generally perceived as time-consuming and expensive, making it an inappropriate option for work with low-income groups (Guthrie et al., 1999; Pollack, 1996).

2.2.1 Effectiveness

Critics of the psychodynamic approach argue that research has yet to document convincingly its effectiveness for any group of clients, least of all for the poor (Lerner, 1972). Various authors propose that psychodynamic therapy is significantly less effective with low-income clients than with high-income clients (Acosta et al., 1982; Davis & Proctor, 1989). In fact, low-income clients are seen as incapable of benefiting from psychotherapy because of their poor verbal skills, their reluctance to engage in the process (Rowden et al, 1970) and their expectations of attending only a few sessions (Yamamoto & Goin, 1965). Davis and Proctor (1989, p. 287) suggest more reasonably that the problems low-income clients face in accessing therapy, the manner in which their problems are perceived and interpreted, their chances of remaining in therapy, and the motivation of their therapists are “in and of themselves a basis for concluding that [therapy] is not very effective at meeting the needs of low-income clients”.

Researching the effectiveness (or lack of effectiveness) of a therapeutic intervention is complicated. Firstly, the concept of effectiveness is problematic as different studies use the term to refer to different goals or aims, preventing easy comparison in research. Further the measure of effectiveness depends on the goals and aims of the therapy

type, which are not necessarily comparable. For example, feminist therapy will value independent actions on the part of the female client and note this as a sign of therapeutic success, while a more conservative therapy may rate this independent behaviour as problematic and a persistent symptom of maladjustment.

Lerner (1972, p. 12) contends that “no really satisfactory method of assessing the results of psychotherapy - or for that matter, of any other form of treatment or intervention with individuals or with groups - has yet been devised. Thus, the effectiveness or lack of effectiveness of psychotherapy with any population remains an open question”. Guthrie et al. (1999) and Sigal et al. (1999) point out that as yet there are no definitive criteria for suitability for psychotherapy and predictive outcome.

Pollack (1996) suggests that there is certain empirical evidence of psychodynamic therapy's effectiveness and that this information is possibly disregarded due to prejudice against psychodynamic therapy. Pollack (1996) describes, for example, the NIMH study of depression, in which psychodynamic therapy was compared with cognitive behavioural therapy and anti-depressant medication. It was found that the biological treatment was no more effective, in general, than either of the two psychotherapies. The psychodynamic therapy was found to be the superior intervention. In a long term follow-up of patients with recurrent depression treated biologically and/or with psychodynamic therapy, it was discovered that the therapy served to prolong the time between depressive episodes in patients who were not receiving medication (Frank et al., 1990, cited in Pollack, 1996). In a comprehensive review article Robinson, Berman and Neimeyer (1990, cited in Pollack, 1996) found that when exploring all controlled research outcome studies on the psychotherapy of depression, using excellent statistical techniques, the therapy proved to be as effective as pharmacotherapy. Guthrie et al. (1999) found similar positive results when studying the cost-effectiveness of brief psychodynamic-interpersonal therapy in high utilizers of psychiatric services who tended to be low-income, minority women. These authors report that six months after the therapy trial, the participants who had received psychodynamic therapy demonstrated a greater improvement in psychological distress and social functioning than did the control group, which received only psychiatric consultations.

In relating the effectiveness of the therapeutic interventions sampled in this literature review, one faces the problems that not all of the papers discussed their intervention's effectiveness, each paper described different goals and results and few of the studies provided empirical evidence. Nevertheless, it seems that many of these authors considered their intervention to have been in some way helpful to their clients.

Lerner (1972), for example, reported good results (without defining what these results refer to) in a brief time period, working individually. On average, the good results in her study were achieved in less than 9 months and required less than 30 hours of face-to-face contact between client and therapist. Lerner (1972, p.177) argues that:

The results of this research serve to undercut both rationalizations for second class service and the assumption of immutable inferiority which usually underlies them by demonstrating that the poor can and do profit from psychotherapy when they have the benefit of therapists who can deal with them on a respectful and egalitarian democratic basis.

Bumagin & Smith (1985) and Shulman (1985) providing long term psychodynamic group therapy and Mills (1996) offering short term individual sessions report similar results of increased self-help behaviour with their low-income participants. These authors suggest that the psychodynamic therapy appeared to modify assumptions of worthlessness, thus improving self-esteem. Mills (1996) reports an 86 % increase in self-esteem on follow-up after her intervention. Improved self-esteem, in turn, contributed to an increase in self-enhancing behaviour. For example, Bumagin and Smith (1985) describe how two clients out of a therapy group of 16 deprived mothers returned to school, six returned to work, and three moved to what were perceived as "better" neighbourhoods. Mills (1996) noted that one third of women in her sample had better work situations following psychodynamic therapy. Harper (1999) working psychodynamically with homeless women found that psychotherapy appeared to encourage self-helping behaviour such as investigating possible income support, and disclosing trauma experiences.

Research also suggests that interpersonal relationships seem to improve following psychodynamic therapy. For example, Bumagin & Smith (1985) found that women left abusive relationships and Harper (1999) reports that during his therapy women organized court interdicts against abusive partners. In the majority of the studies

reviewed, which provided information on the results of the therapy, social functioning in the patients was commonly noted as improving (Guthrie et al, 1999; Menikoff, 1983; Shulman, 1985). Bumagin & Smith (1985) and Mills (1996) cite increased parenting skills and superior behavioural and impulse control following psychodynamic therapy. Bumagin & Smith (1985) and Menikoff (1983) discovered that insight was gained by those patients able to link current issues with their past and that this insight increased their receptivity to future interventions.

Mills (1996) reports that depression and anxiety symptoms were greatly reduced during and after the psychodynamic intervention. Lerner (1972), Shulman (1985) and Menikoff (1983) also report a decrease in psychiatric symptom quantity and severity.

Two interventions working psychodynamically with mother-infant dyads found that the aim of promoting the infants' health was realized. Swartz (1997) reports that in the Khayelitsha mother-infant project the aim was that by intervening with mothers who are depressed or living in deprived circumstances, poor cognitive and emotional outcomes in the infant would be prevented. He suggests that this form of intervention may even play a role in preventing protein-energy malnutrition in the infant. Fraiberg, Shapiro and Adelson (1987 a,b) treating mothers whose infants had failed to thrive report that the infants picked up weight and began interacting more socially with their environment, indicating the success of their psychodynamic approach.

It would seem, therefore, that while no claims are made regarding the irrefutable effectiveness of psychodynamic therapy, many of the authors reviewed claim that the therapy had benefits for their clients. The questions remain, however, as to whether or not psychodynamic therapy is effective and how effective it is on its own and in comparison with other therapies. Much more research needs to be undertaken in order to provide answers to these questions. This literature review suggests that part of the thinking about psychodynamic therapy's ineffectiveness is misplaced and that such a form of therapy appears to offer certain benefits to low-income clients.

2.2.2 Cost-effectiveness

Guthrie et al. (1999) caution that few studies involving psychotherapeutic treatments have been specifically designed to explore detailed economic analyses and cost

reporting in studies has been inconsistent. Despite the lack of clear research regarding costs of therapy, there is a general trend away from psychodynamic therapy to solution-focused, time-limited approaches (Schwartz, 1997). This trend appears to reflect a growing assumption that psychodynamic therapy is an expensive, lengthy indulgence for the "worried well" (Pollack, 1996, p. 124). Cost is a particularly significant issue when considering therapeutic options for low-income clients, because these interventions will usually have to be subsidized by the state or by non-governmental organizations, as low-income clients are not able to afford private interventions.

While psychodynamic therapy does involve costs, it also appears to provide significant financial savings when compared to other interventions and the costs of emotional distress (Lerner, 1972; Sands, 1996; Smith, 1997). Psychodynamic therapy is, in fact, far cheaper than the inpatient treatment and medical consultation (Pollack, 1996; Sands, 1996) low-income women tend to receive when in psychological distress. Pollack (1996) reveals that fully 70% to 80% of the cost of all psychological and psychiatric care is for inpatient treatment alone. The substitution of a wide range of outpatient services leads to a 25% to 75% savings in total mental health care costs (Pollack, 1996). Guthrie et al. (1999) found that participants in their study who received psychodynamic therapy showed significant reductions in the cost of health care utilization in the six months following the intervention compared with the control group. The extra cost of psychotherapy was recouped within six months through reductions in health care use (Guthrie et al., 1999). Olarte and Masnik (1985), working with low-income minority women, argue that despite the unlimited time frame of their long-term psychodynamic therapy group, this form of treatment may burden the mental health system far less than traditional methods because group members decreased their inappropriate use of emergency rooms and other medical services. Shulman (1985) writes about her long-term outpatient psychodynamic group with elderly, low-income women. The aim of this group was to keep low-income elderly people out of hospitals and nursing homes for as long as possible. It was thought that many of the somatic complaints that these women suffered, which brought them regularly to the emergency room, were psychological in part. On the whole, Shulman (1985) reports that there was a reduction in the frequency of visits to medical personnel. Sands (1996) argues that mental health care can reduce medical overutilization by up to 75%. This cost saving is particularly relevant when working with low-income women as they tend to access medical services for

psychological complaints more frequently than higher income women and men of all income levels (Rivers, 1995).

More generally, Pollack (1996) argues that when accusing psychodynamic therapy of being too costly, there is confusion between time and money. He accedes that while psychodynamic therapy takes a substantial period of time to have effects and it is not without expense, when compared to an annual cost of \$16 billion in the U.S., attributed to depression in the work place, psychodynamic therapy appears far from expensive. Further, while psychodynamic treatment is generally assumed to be lengthy, the median length of treatment in the U.S. is between 6 and 10 sessions, with 75% to 90% of patients terminating by the 25th session (Sands, 1996).

Psychodynamic therapy also reduces costs to society caused by social pathologies such as violence, child abuse, and crime (Pollack, 1996; Sands, 1996). Smith (1997, p. 71) suggests that "while long term psychotherapy may seem expensive and slow, it is nothing to compare to what we now pay for prisons, foster care, state hospitals and all the other institutions that we too often use so we don't have to deal with poor people as people". A cost analysis of psychotherapy compared with the cost of other social services does not appear exorbitant. It is perhaps enough to note that a large proportion of supposedly difficult or even untreatable clients improve significantly in what looks like a quite reasonable amount of time and for a not too expensive cost (Lerner, 1972).

While the above arguments offer potentially biased or misguided criticisms of psychodynamic therapy's usefulness with low-income women, the following feminist and cross-cultural critiques of psychodynamic therapy provide compelling, if overgeneralised reasons for restricting the use of psychodynamic therapy with poor people.

2.3 Theoretical Arguments

Kruger (2000) asserts that the reluctance of mental health workers to offer psychodynamic therapy to low-income women can, in part, be traced back to the powerful effect that feminism and cross-cultural psychology has had on mental health. Feminism and cross-cultural psychology have argued against the psychodynamic treatment of women and poor people respectively. These two critiques, while having particular emphases, share common ideological and theoretical frameworks (Mulvey, 1988). Psychoanalysis is criticized by both disciplines for promoting a view of the self as private, autonomous and existing outside of history and culture (Maracek & Kravetz, 1998). This decontextualised view of the self causes the individual to be held responsible for psychological distress, which is the result of oppressive social forces (Mulvey, 1988). Psychoanalysis is held to be bourgeois (Banton et al., 1985), conformist, reactionary (McLellan, 1999) and misogynistic (Frosh, 1987). It follows that psychodynamic therapy is rejected as a form of institutionalized oppression (McLellan, 1999), which operates at the apolitical level of the individual. A social constructionist perspective questions this notion of the social and individual as opposites (Kruger, 2000) and provides a method of politicizing psychoanalysis.

2.3.1 The feminist critique

The terms feminism and feminist have many varied meanings and there is no single worldwide feminist movement or particular school of feminist thought (Reardon, 1990). Feminism as a social movement and as a manner of viewing the world manifests many cultural and political forms (Reardon, 1990). The doctrine of feminism generally, however, advocates that the rights of women and men be equal (McKay, 1995). This is not to suggest that women are the same as men and should always be treated the same, but rather that no one should suffer discrimination on the basis of gender (Reardon, 1990). Reardon (1990) proposes another almost universal agreement among feminists: women throughout the world suffer gender-based discrimination.

A feminist analysis refers to a system that observes the world, gathering and interpreting information through the eyes of women as subjects, thus separating itself from a patriarchal worldview (McKay, 1995). This feminist perspective suggests that patriarchal conceptual frameworks and the behaviour that emerges from these frameworks sanctions, maintains and perpetuates domination and oppression that may manifest as

sexism, racism and classism (Warren & Cady, 1994). Feminists generally believe that the gender systems of domination and subordination are not fixed, but are constructed through socialization and perpetuated through unjust political and economic structures (Tickner, 1995).

Many feminist activists and therapists have argued that psychodynamic therapy is unsuitable for women as it is inherently sexist towards women (McLellan, 1999; Mulvey 1988). McLellan (1999, p. 327) charges psychodynamic therapy with being “a male-serving institution in a male-dominated society [and] that every brand of traditional psychotherapy has been created by privileged white males”. Psychodynamic therapy is seen as pathologising of women via the developmental theory, which is found to be biologically deterministic and paternalistic (Prozan, 1998). Skodra (1992), for example, points out that within psychoanalytic therapy, most of what is defined as female is conceptualized as deviant or psychopathological. Further, psychodynamic therapy is criticized for failing to employ a political consciousness aimed at improving the societal conditions for women. Rather it privileges intrapsychic experience, which may trivialize oppression such as child abuse or racism into an intrapsychic wound suffered by fathers and whites respectively (Brown, 1990). McLellan (1999) suggests that through this intrapsychic focus the female patient is taught to collude in her own continued social subordination, and society’s negative attitude towards women is reinforced. As a result of this individual, apolitical focus, and the lack of attention to problematic social conditions, psychoanalysis is dismissed as reactionary, and in collusion with dominant power structures, which directly and indirectly, serve to oppress women. McLellan (1999, p. 325) explains this point, noting that “a therapy which fails to address power issues in people’s lives works, automatically, to reinforce oppression”.

Sturdivant (1980, cited in Skodra, 1992, p. 88) suggests that “the questions addressed by psychotherapy have been answered by men, out of the male value system, with little regard for whether these answers were valid for women as well. The implicit assumption was that these were universal answers, applicable to all people”. In this way, psychodynamic therapies are accused of refusing to acknowledge the different experiences of men and women and every individual is viewed, naively, as being responsible for her own destiny.

Despite feminism's success at putting women on many social, political and research agendas, the movement has been guilty of similar class and race biases towards low-income women shared by other more traditional disciplines (Baker, 1996; Mulvey, 1998; Reid, 1993; Skodra, 1992). Feminism has tended to assume that gender is the primary locus of oppression, and thus frequently ignores the significance of race, culture or socio-economic class (Leeder, 1996). The feminist movement has been criticized by feminists for being an essentially middle-class, white movement (Brown, 1990; Green, 1994). Brown (1990, p. 4) suggests that even within feminism, the lives of women of colour and poor women appear "too far from sight to be included". This failure on the part of feminism to more comprehensively attend to the most oppressed individuals in society underscores how greatly low-income women have been marginalized within psychological research and psychotherapy. The feminist movement has, however, taken cognizance of the criticism and is working towards addressing the paucity in research and the provision of informed clinical intervention, as demonstrated by burgeoning research on the topic of class in feminism (e.g., Baker, 1996; Chalifoux, 1996; Leeder, 1996; Russell, 1996; Wyche, 1996).

2.3.2 The cross-cultural psychology critique

Cross-cultural psychology refers to a movement within psychology, which emerged in the sixties in response to traditional oppressive institutions and practices (Mulvey, 1998). The movement questioned the relevance of historical psychotherapeutic methods for the poor and disempowered (Mulvey, 1998). For example, low-income clients may not value the benefits of psychodynamic therapy, such as insight, and may instead desire more tangible help when their energy is absorbed by the daily struggle of putting food on the table (Kruger, 2000). Cross-cultural psychology contends that psychodynamic therapy is intrinsically representative of Western, middle-class, individualistic values, which are held as the universal standard of mental health and psychological adjustment (Sieber & Cairns, 1991). Psychoanalysis is understood to have been created, on the whole, by middle-class white practitioners working with middle-class white patients (Mohamed & Smith, 1997). People not from these groupings are pathologized, merely due to their difference from these Western, Eurocentric values. Psychodynamic therapy is seen to encourage adjustment to these stereotypical norms, which does not necessarily imply healthy change (Mulvey, 1998). Psychoanalysis has typically concentrated on assumed universal similarities and has tended to ignore cultural differences and the implications

thereof (Mohamed & Smith, 1997). The traditional doctor-patient relationship of psychoanalysis is criticized for replicating the dependency of disempowered groups (Mulvey, 1998).

Psychoanalysis' focus on the individual is held by cross-cultural psychology to be naïve at best and reactionary at worst. The intrapsychic focus of traditional therapy tends to blame the victim, because it effectively ignores the stark social oppression of poverty (Mulvey, 1998). Such an individualistic focus is understood to carry an implicit assumption that poverty is linked to the individual and not to the society (Sieber & Cairns, 1991). It follows that the individual is then held responsible for her poor socio-economic circumstances and that poverty is, therefore, some sort of curable psychological disorder. Finally, cross-cultural psychology argues that individual solutions are ineffective when working with low-income or marginalized individuals because the social inequalities, which cause the emotional distress, are not addressed (Mulvey, 1998).

The social focus of cross-cultural psychology is potentially problematic, in part, because of the assumptions regarding what low-income communities need most. Swartz (1991) points out that the premise that every psychiatric patient wishes for or would be helped by social or political activism is not empirically tested, and is possibly patronizing.

Both the feminist and cross-cultural psychology movements, nonetheless, provide powerful critiques of psychodynamic therapy with socially oppressed groups. These movements, while having specific focuses, recognize that inequality is built into our social systems and that these systems impact on psychological and personal reality (Mulvey, 1988). This influence of structured inequality and social conditions is viewed as predictable and systematic according to the various social constructions of gender, class, race, and age. Most significantly, however, certain strands of feminism and cross-cultural psychology emphasize that psychological distress is essentially caused by oppressive societal structures and that therapeutic intervention needs to occur at the social level through mass social action (Mulvey, 1998). These disciplines, consequently, contend that psychoanalysis' focus on the individual is reactionary, conformist, and oppressive.

3. THE CASE FOR PSYCHODYNAMIC THERAPY WITH LOW-INCOME WOMEN

3.1 A social constructionist resolution to the dilemma of the individual versus the social

If the feminist and cross-cultural critiques are so cogent, then how does one justify the practice of feminist psychodynamic therapy and contemporary psychodynamic therapy with low-income women? Kruger (2000) explains that the feminist and cross-cultural critiques observe a rather rigid differentiation between two orientations in the mental health field. On the one hand, there is the psychotherapy orientation, which privileges dynamic, internal, psychological factors, and individual change. This orientation is seen in opposition to the social action orientation, which stresses external forces, the need for social changes, and can be construed as antitherapeutic (Strean, 1996). It is argued, however, that this dichotomizing of the individual and the social is epistemologically flawed when viewed through a social constructionist lens.

The feminist and cross-cultural critiques consider psychoanalytic theory to posit a decontextualised view of the self. Historically, this criticism is correct, since psychoanalysis has traditionally accepted as unproblematic, the existence of an individuated, and ahistorical self. Contemporary psychoanalytic theory and psychodynamic practice, however, incorporate a more advanced perspective lent from social constructionism (Mitchell, 1988), feminism (Maracek & Kravitz, 1998; Prozan, 1992) and Marxism (Banton, Clifford, Frosh, Lousada, & Rosenthal, 1985).

Consequently, contemporary psychodynamic therapy, such as relational psychoanalysis, and feminist psychodynamic therapy can become a political and social therapy despite, or even through, its individual focus by incorporating a relational understanding, based on social constructionism. Such psychodynamic therapies provide sophisticated principles of psychoanalysis with a more modern approach that is suited towards therapeutic work with low-income women.

In order to explore how a social constructionist perspective can benefit psychodynamic theory and resolve the dilemma posed by feminism and cross-cultural psychology, a brief discussion of social constructionism is undertaken. Social constructionism understands the self, people's experience, social and psychological phenomena as

constructed through discourses of language, producing multiple, and contradictory 'realities' or narratives (Seu, 1998). Rather than consider our minds to be something possessed by individuals, social constructionism argues that our minds both create and are simultaneously created by our thinking (Launer, 1996). Most significantly, social constructionism reveals that the self is not an isolated, autonomous being, but rather is constructed 'in relationship'. This perspective promotes the relationship to a central position in philosophy previously occupied by the concept of the individual self (Becvar & Becvar, 1996). Decontextualised individuals or problems do not, therefore, exist, as all individuals are inevitably located historically, socially and culturally.

The dichotomy between a therapeutic focus on the individual and the antitherapeutic social action orientation is consequently shown as artificial (Banton et al., 1985) and unnecessary through a social constructionist lens: the individual both constructs and is constructed by society and culture, through the discourses of language. Contemporary psychodynamic therapy understands how the individual's subjectivity is intertwined with dominant ideological constructions (Frosh, 1987; Banton et al., 1985). Accordingly, this understanding suggests that psychological work with the individual impacts on the political level of the social, just as political intervention at this social level will affect the individual psyche.

The following two forms of psychodynamic therapy, relational psychoanalysis and feminist psychodynamic therapy, offer linked methods of working psychodynamically, while recognizing and incorporating an understanding of the self in relation to societal and cultural processes.

3.2 Contemporary psychodynamic therapy with low-income women

Contemporary psychodynamic therapy has developed greatly since Freud's time (Mitchell, 1988). Of particular significance is the vast impact feminism and social constructionist theory has had on psychoanalytic thought and practice, revealing misogyny, universalism, and oppression within the discipline (Frosh, 1987; Prozan, 1992), and problematizing constructs of self, choice, personal control, and freedom (Maracek & Kravetz, 1998).

Relational psychoanalysis provides a current attempt at accommodating the Ego psychology conflict-based psychoanalytic theories and the developmentally-based theories of Klein, The British School and Kohut (Mitchell, 1988). The tension between these two theoretical positions is relevant in that it reflects the dilemma between an individual and a social perspective. The intrapsychic model reduces social life to internal, unavoidable and uncontrollable drives and ignores the influence of familial and social forces. The developmental model reduces formative experience to early familial relationships and ignores the effect on the individual from present adult relations. These two theoretical orientations are typically viewed as mutually exclusive and competing. Mitchell (1988), however, understands these two orientations to be integral parts of a holistic understanding of all psychodynamic processes. Relational psychoanalysis includes a third element of interpersonal relations, which resolves, to some extent, this tension between the individual, intrapsychic processes and the developmental, external processes.

The following section explores contemporary forms of psychodynamic therapy in order to provide further justification for working at the individual, dynamic level with low-income women.

3.3 Political psychodynamic therapy

Contemporary psychodynamic therapy recognizes the need for political reflexivity, or what Frosh (1987, p. 83) terms a “social” psychoanalysis. Criticisms of psychoanalysis as bourgeois, reactionary (Banton et al., 1985), misogynistic, oppressive, and conformist are undeniable (Frosh, 1987). Yet, Banton et al. (1985) and Frosh (1987) maintain that it is possible to use or invert bourgeois psychology for progressive, socialist and feminist ends, because while direct political action is necessary, it is not the only level at which political action can take place.

Contemporary psychodynamic therapy is politically relevant, because it addresses the internalized social structures, embedded in the individual’s unconscious, that contribute to psychological distress and the maintenance of the social status quo (Russell, 1996). In particular, psychodynamic therapy targets two interacting levels through which the self is constructed: the unconscious, internal, and individual level, and the internal, social, and ideological level (Banton et al., 1985). Firstly, psychoanalytic theory reveals that

people are subject to the unconscious direction of their behaviour, thoughts, and feelings (Malan, 1997). Individuals are not, thus, regarded as autonomous, individuated, or possessing freedom of choice. Psychodynamic feminist therapists have pointed out how this analysis of unconscious processes allows for a more sophisticated and potent conception of the psychological effects of social ideologies (Prozan, 1992; Frosh, 1987). In particular, psychoanalysis reveals “the tenacity of the gendered dynamics of unconscious processes....open[ing] up the possibilities for contemporary feminist theorists and psychotherapists to make use of psychoanalysis for women”(Heenan, 1998, p. 96).

Secondly, a social psychodynamic approach recognizes that people are subject to influential social structures. These economic, political, and ideological forces are more powerful and extensive than the individual and operate systematically on behaviour and consciousness (Banton et al., 1985). In this way, psychodynamic therapy is aligned with feminism in attempting to expose the insidious ideologies of patriarchy, in particular, so that they may be challenged (Sayers, 1992). These two sets of forces interact: the unconscious is constructed according to dominant discourses prescribed by society, while the social order is maintained by internalized, dominant power relations such as patriarchy and capitalism (Prozan, 1992). The individual then reproduces this internalized ideology in various microsocial encounters (Banton et al., 1985). To the extent that these links and the forces that underlie them are being uncovered and resisted, a politically subversive change is taking place (Banton et al., 1985).

Contemporary feminist therapy, following this line of thought, understands that the principle of empowerment is facilitated through this multileveled analysis of the client's internal and external realities (Skodra, 1992). This recognition of the dual gaze of the psychodynamic therapist is stressed by various writers working with low-income women (e.g., Bumagin & Smith, 1985; Casement, 1985; Ernst, 1997; Frosh, 1987; Green, 1994; Banton et al., 1985; Prozan, 1992; Trevithick, 1998; Trotman, 1984). Eichenbaum and Orbach (1987, p. 50) argue that a feminist psychoanalytic perspective addresses “the full meaning of an individual woman's experience, [and] reflects an understanding of the ways in which the material world created individual personality...symptomatology, [and] defence structures”.

Trevithick (1998) writing about her project, "Womankind", notes that the therapists began with a purely feminist approach. They hoped that by giving women a "good experience" and by being committed and supportive to women suffering from psychological problems, life would improve for these women. However, the author found that this failed to address the wide range of needs the women were experiencing and that a combined psychoanalytic, and feminist approach was required. Trevithick (1998, p.125) comments that:

Our quest began by returning to feminist writing on women's mental health and psychotherapy and also psychoanalytic theory because it was here that we found feminists addressing issues of concern to us about the importance of early childhood experiences in relation to women's emotional development and ongoing experiences of oppression and injustice.

Bumagin and Smith (1985) sum up the dual gaze of the psychodynamic therapist working with low-income women, by explaining that if the therapist responds to what she hears by only focusing on the psychological dilemmas, she will alienate the members and offend them. If the therapist only comprehends the social injustice, she will inevitably collude with the group members' helplessness and dependent positions. Therapists have to discover means of acknowledging both realities and the continuous interaction between them (Casement, 1985). Russell (1996) refers to the need for a middle ground, where the individual experience of internalized classism is recognized, while still attending to the political nature of class.

This process of analyzing both levels of internal and external, or individual and social occurs in therapy through the analysis of the transference. Considering that the psychodynamic therapist is inevitably middle-class (Rothblum, 1996), the transference between the therapist and the low-income client, will most likely be shaped by the class, and possibly gender and race dynamics within the therapy relationship. In this transference ideologies of classism, racism and sexism may be enacted and then deconstructed (Ernst, 1997; Green, 1994; Trotman, 1984), freeing up new and more flexible constructions of the self. Ernst (1997, p. 34) notes that:

From a feminist perspective we must look at what happens between a client and psychotherapist, acknowledging the ways in which gender and other socio-cultural dimensions are rooted in the unconscious. This can only be fully

understood by linking the developments of the concept of transference and countertransference and clinical developments within psychoanalytic thought and practice.

A therapist should, therefore, not have to be forced to choose between a focus on the individual or a focus on the social and political (Kruger, 2000). An analysis that ignores the person's idiosyncratic internalization of these forces is at best incomplete (Kruger, 2000), and at worst racist and classist since it is black and low-income people who tend to be thought of more in terms of external stressors (Swartz, 1991). Focusing on eradicating all social problems in the future is very optimistic, but ignores current individual distress. Lerner's (1972, p. 7) classic analogy of treating victims in a malarial swamp points to the flaws in the other extreme position:

Treating those already afflicted is a humane, even a heroic endeavour, but a rather futile one unless there is a simultaneous effort to drain the swamps to prevent new infections. In addition to psychotherapy, programs of primary prevention aimed at changing the social conditions, which produce the need for psychotherapy, must also be initiated.

Kruger (2000) thus emphasizes the importance of acknowledging the interaction between the person and the situation, the individual and society, and the self and the world. A psychotherapeutic analysis that fails to recognize the interaction of multiple, overlapping, and contradictory elements of a woman's oppression, can not sensitively or relevantly treat her distress in therapy (Green, 1994). The therapist must avoid the temptation to simplify a patient's dilemma to a series of dichotomized "either-ors" (Green, 1994). After all, class is usually only one of many issues that clients bring to therapy (Russell, 1996). An individual clinical response to low-income women's distress is what is relevant (Johnson & Buszewicz, 1996).

Politics cannot, however, be reduced to therapy despite how helpful or enabling the encounter between patient and therapist may be, because therapy remains a microsocial event, which on its own, cannot determine the structural conditions of society (Frosh, 1987). In the right form, however, therapy provides an important element in facilitating progress, because it not only alleviates individual distress, which is likely to

make someone more, rather than less, able to be politically effective, but also because it reveals the forces, which have produced that distress in the first place (Frosh, 1987).

4. THEORIZING PSYCHODYNAMIC THERAPY WITH LOW-INCOME WOMEN

This section briefly explores how the destructive, internalized experiences of classism, sexism, racism and deprivation may be worked through in psychodynamic therapy. It appears that the Winnicottian idea of a “goodenough” therapeutic environment appeals to various writers working with low-income patients (e.g., Applegate, 1996; Chesier, 1996; Sayers, 1992; Trevithick, 1998). These goodenough conditions can take the form of material conditions such as offered by the society or the term can refer to the emotional environment provided by parents for their children.

Many authors point to the usefulness of psychodynamic therapy to understand how the social effects of poverty for low-income women, such as early losses, deprivation (Bumagin & Smith, 1985; Harper, 1999; Menikoff, 1983; Mills, 1996; Russell, 1996; Shulman, 1985; Trevithick, 1998), sexism, racism (Olarte & Masnik, 1985), and classism (Lerner, 1972; Menikoff, 1983; Trevithick, 1998) have been internalized into the psyche (Russell, 1996). Swartz (1997, p. 16) notes that the Khayelitsha Mother-Infant project “takes seriously the important insights about attachment and loss which the psychoanalytic tradition has given us, but it uses these insights, not in the rarified context generally considered the sole domain of psychoanalysis, but in the context of an informal settlement in Africa. As early as the 1970’s, Lerner (1972) suggested that the social factors that impinge upon low-income women’s mental health need to be addressed, but psychodynamic therapy’s priority is the internalization process, which undermines the individual’s ability to act effectively upon the social.

Low-income individuals, especially those who will present themselves for therapeutic intervention have typically experienced earlier or current holding environments which have “dropped” them, damaging their ability for basic trust and making them vulnerable to “unbearable agonies” of a sense of falling forever, fragmenting, depersonalization and disorientation (Applegate, 1996). Individuals who have been neglected and uncared for as children may find these memories being revived when living in an environment of urban decay and neglect, where their needs are being persistently disregarded by the authorities (Trevithick, 1998).

Individuals whose minds and emotions are focused on surviving materially and psychically under immense physical and psychic threat are in no position to take action upon their oppressive social conditions (Lerner, 1972). Trevithick (1998, p.128) proposes: "what is needed is an injection of resources from outside in the form of care and other nurturing experiences, in order to remedy this sense of depletion so that psychic energy can gather strength and become self generating". The successful resolution of these earlier failure situations cannot be achieved unless favourable or good enough conditions are created (Trevithick, 1998). Therapy which moderates this environmental failure, by providing a corrective experience, can be healing (Applegate, 1996). The psychodynamic therapist's focus is on the creation of an emotionally goodenough experience, although when working with low-income groups this may mean attending to the provision of a materially goodenough experience as well.

This goodenough experience begins with the establishment of a safe space in which emotional work can be facilitated. A safe space refers to a consistent and predictable therapeutic environment (Smith, 1997), in which no attack is made upon the client (Bumagin & Smith, 1985), and in which the client feels "held" by the therapist or therapy group (Shulman, 1985). This holding process occurs through conscious attention to the structure and boundaries of the therapy (Shulman, 1985). The client is held in the attention of the therapist and or group members.

The provision of such a safe, holding environment facilitates the initiation of a number of therapeutic processes. Firstly, Harper (1999) understands this process as providing a "space" for the woman's personal story to unfold and to centre itself upon her experience of loss. For example, Fraiberg, Adelson and Shapiro (1987 a) found that working with young mothers whose infants had failed to thrive, meant more than simply teaching these young women how to feed their babies. What was needed was recognition of these women's internal world or personal story (Fraiberg, Adelson & Shapiro, 1987 a). These were stories infinitely connected to the infants' failure to thrive (Fraiberg, Adelson & Shapiro, 1987 a). A psychodynamic intervention assisted these deprived and distressed women by bringing to light, in a safe, therapeutic relationship, the repressed emotional experiences of childhood trauma and neglect and connecting them with the memories of these events (Fraiberg, Adelson & Shapiro, 1987 b). Once this process

occurred, these mothers were able to renegotiate their relationships with their infants without the abusive repetitions of their traumatic past.

Mills (1996, p. 222) states that “talking therapy” is clearly the modality of choice, when working with low-income women, as it can “attend to early losses, problematic early attachments, intimacy and the nature of close relationships”. In the therapeutic space, a dynamic conceptualization of behaviour can be suggested, thus rendering behaviour comprehensible, as ensuing from legitimate feelings, and available for discussion and choice (Bumagin & Smith, 1985). These existing self-images or internalized social stereotypes of the women, such as deeply held beliefs that they were worthless, helpless and incompetent could be challenged in Bumagin’s and Smith’s (1985) group therapy. It is the telling of the story, as understood by the client, which is healing because this process is inherently validating and empowering (Mills, 1996), as opposed to merely being assessed, diagnosed and medicated.

The safe therapeutic space allows low-income women to work through their stories of loss, by internalizing a new story of connection and relationship. The ability to express the feelings connected to these losses, in the presence of others and of the clinician, can be a corrective experience that may assist in grieving for other, past losses (Bumagin & Smith, 1985). Herman (1992) working with female trauma survivors speaks of the importance of the survivor’s story being told or allowing the unspeakable to become speakable. This voicing of pain and loss, within the therapeutic space, serves to reconnect the individual to others and reduces feelings of shame and stigmatization (Herman, 1992).

Psychodynamic therapy is also of use when working with low-income women as it addresses the extreme defences, such as massive denial, somatization, and projection that these women have mobilized in order to survive the trauma of chronic and severe deprivation (Shulman, 1985).

5. TOWARDS ACCESSIBLE PSYCHODYNAMIC THERAPY WITH LOW-INCOME WOMEN

Psychodynamic therapy, in its most traditional form of long term, individual therapy with a neutral, abstinent therapist, is thought to be inaccessible for most low-income women. In order to make psychodynamic therapy more accessible to low-income women many authors working with this population, advocate a group format for reasons which are discussed. This is not to preclude individual treatment, but rather to suggest that individual treatment may not be the first or necessary choice when working with low-income women. Clinicians working psychodynamically with low-income women note that long term therapy is not always suitable and that a shorter approach may be adequate and more appealing to low-income women. Whether the chosen psychodynamic approach is short or long term, and the format group or individual, most therapists in this area agree that the therapist needs to be more active than is usually encouraged in psychodynamic tradition. Psychodynamic mental health services, in order to be more geographically accessible, need to be available at a primary health level in the community. It is suggested too, that a psychodynamic approach can be useful when working at this primary health level, through formulation and consultation.

5.1 A group format

Therapeutic groups offer a powerful form of holding space (Shulman, 1985), in which a goodenough experience can be internalized. Group psychodynamic therapy is accordingly proposed as a modality of choice for low-income women (Bernadez, 1996; Garvin, 1985), especially for minority women (Olarie & Masnik, 1985; Rivers, 1995). Group psychotherapy is particularly useful in that it can relieve feelings of secrecy, isolation and stigmatization (Dinunno, 2000), which are experiences common to low-income women. The group can bear witness to the painful narratives of group members, giving these stories social, as well as personal, meaning (Herman, 1992).

Shulman (1985) suggests that the psychodynamic group can resolve experiences of intense and devastating loss also common to low-income women. This is because the group acts as a social system as well as a therapeutic milieu (Bumagin & Smith, 1985). Shulman (1985) theorizes that the group can recreate the family or even provide a

surrogate family. Group members can survive together through the experience of loss, as it happens in the group.

Psychodynamic groups offer a chance for socialization (Shulman, 1985), during which participants can experiment with friendship and connectedness (Bumagin & Smith, 1985). The group provides a sense of belonging (Herman, 1992), in which members may share life issues, sorrows, and their fears of future losses (Shulman, 1985). Yalom (1985) writes of the powerful sense of universality that may be achieved in groups, which serves to alleviate some of the loneliness of existence. In particular, a group therapeutic format is especially useful for mitigating the power differential between the middle-class therapist and the low-income participant (Rivers, 1995). Group psychotherapy provides a supportive environment conducive to verbal exploration of common environmental, interpersonal and intrapsychic experiences and the subsequent development of a psychodynamic understanding of maladaptive behaviour patterns (Olarie & Masnik, 1985). Group therapy also offers the significant benefit of being less expensive to provide than individual therapy (Davis & Proctor, 1989).

5.2 A short term approach

A short term psychodynamic therapy is recommended when working with low-income women (Bauer & Kobos, 1984). Short term psychodynamic therapy has been well established as comparable in effectiveness with longer term treatment (Sigal, Paris, Kardos, Zimmerman & Buonvino, 1999), in the treatment of mild to moderate psychological distress (Mills, 1996). This suggestion of short term work reflects the general trend in psychotherapy to make therapy as cost-effective as possible (Crits-Cristoph, Barber & Kurcias, 1991). Short term work may have the added advantages of being comparable with low-income women's expectations of therapy length and more appropriate considering the difficulties low-income women encounter when accessing therapy, such as transport and childcare costs (Mills, 1996).

This is not to propose a subtle form of discrimination advocating only limited psychotherapeutic resources for poor people (Bernard, 1965). Therapy will always need to be individualized to the particular patient, regardless of social grouping. A formula should not, therefore, be applied to low-income women. While severe pathology will not typically be remedied in brief psychotherapy (Pollack, 1996), brief and group

psychodynamic therapies can be useful for most people and have particular benefits for the poor, due to restricted mental health budgets, limited time available for attending and the urgent need for intervention.

5.3 A modified approach to psychodynamic therapy with low-income women

When working with this population, many authors comment on the need for a modified psychodynamic approach to attend to the severe social conditions and interconnected psychological difficulties (Belle, 1985; Bumagin & Smith, 1985; Rivers, 1996; Smith, 1997; Trevithick, 1998). Freud (1956, p. 402), for example, envisioned a time when “the task will then arise for us to adapt our technique to the new conditions [of poverty]...Possibly we may often have to combine aid for the mind with some material support”. His observation appears to be supported many of the following authors.

Therapy under circumstances of severe deprivation and crisis demands greater action and flexibility on the part of the therapist, than usually required in middle-class settings. Mohamed and Smith (1997) suggest that therapists must actively demystify the process of psychoanalytic therapies in order to make the therapy more empowering and emotionally and cognitively accessible. Trotman (1984) remarks that low-income patients may require more active intervention and assistance with problems ranging from housing to discrimination before the patient can attend to her intra-psychic conflicts. Smith (1997, p. 71)) admits that:

At various times during my years at the clinic, I have accompanied clients to the hospital for tests that frightened them, brought gifts to children, lent small amounts of money when people were out of food, dropped clients at agencies on my way somewhere, and advocated for them at housing hearings.

Bumagin and Smith (1985) suggest that the therapists must also provide extras to keep the therapeutic process going, such as extra time, home visits, phone calls and post cards. Mills (1996) explains how it had been necessary to adapt psychodynamic understanding and practice in her project. Thus, Shanti provides crèche facilities, does not require referral letters and clients can walk in off the street. Trevithick's (1998) project, *Womankind*, consciously attempted to discover methods of creating favourable conditions for their clients' emotional growth which included attending to external environmental factors such as financial pressure. This project, for example, paid to have

a telephone installed in a young mother's home, paid bills and negotiated for essential services not to be cut off. This was done, mindfully, to create a more therapeutic environment (Trevithick, 1998).

Both of the community projects *Womankind* (Trevithick, 1998) and *Shanti* (Mills, 1996) place special emphasis on providing resources in terms of women's issues, mental health advice and liaison with other services such as solicitors, places of shelter, housing pressure groups and parenting workshops. Rivers (1996, p. 195) writes: "the therapist at times may have to advocate for the client with social service agencies, government agencies and private-sector businesses". Warwick (1999, p. 42)) explains how she uses her power as a therapist to motivate for clients with their insurance companies, the courts or social service agencies, while "always being clear with clients what I am doing and how and why".

Flexibility and adaptation in terms of therapy space is considered necessary when working with these clients. Harper (1999, p. 95) notes that his unusual therapy, literally on the streets of London with a homeless woman, "illustrate[s] how unexpected clinical phenomena can emerge in an unlikely setting when a certain type of listening process is put into action". Smith (1997) engaged in psychodynamic therapy in cockroach-infested offices, in which both she and her patients would take turns to kill the cockroaches as they talked. She also made home visits in severely deprived neighbourhoods, and was once compelled to meet her client in a bar! Fraiberg, Adelson and Shapiro (1987 a, b) wrote about psychodynamic therapy in the kitchen of their clients' homes.

Bumagin and Smith (1985, p. 297) contest that "a positive therapeutic outcome can be achieved in spite of unorthodox group structural configurations and processes". Their psychotherapy group while being based on traditional psychotherapy norms, "challenged the norms of group selection, composition, setting, preparation, attendance, membership turnover, and leadership. Our content, however, frequently included intrapsychic material in considerable depth" (Bumagin & Smith, 1985, p. 280).

Freud (1956, p. 402) pointed out, however, that "whatever form this psychotherapy for the people may take, whatever the elements out of which it is compounded, its most

effective and most important ingredients will assuredly remain those borrowed from strict psycho-analysis". Thus, Harper (1999, p. 94) discussing his therapy notes that:

Whilst the methodology used was somewhat crude and by necessity improvisational [sic], it nonetheless adhered to certain analytic principles - a regular time, continuity of personnel, some attempts to keep a boundary, and a receptive, attentive listening stance. The work had a tactical, strategic and ethical dimension. In terms of the tactics used, there was a reaching out and engaging of the client so that her experience could be put into words. The strategic dimension refers to the deciphering (through interpretation) of that which was being repeated or had been transferred into the then present context.

Mills (1996, p. 225) extends this discussion cautioning that "concerned as she must be with inner reality, it is not the therapist's task to give practical help herself in these areas", but that as much as possible, the therapist should be able to direct the client to available resources. This sentiment is repeated by Bumagin and Smith (1985, p. 291), who comment that their patients "knew they needed us to commiserate, not advise". Despite Smith's (1997, p. 71) unusual therapeutic settings and flexible frame, she describes herself "as a rather traditional psychotherapist, a believer in the 50-minute hour, a diehard interpreter of transference, steadily struggling to uncover unconscious meaning and to put action into words".

Working with low-income women in a politically psychodynamic manner involves much self-awareness and self-reflection on the part of the therapist. The therapist must be able to recognize within herself internalized classism, racism and sexism (Belle, 1985), so that she does not mistake her own responses for objectivity and potentially abuse her power as a therapist (Ernst, 1997). For example, Green (1994) suggests that while there may be a necessary deviation from the therapeutic frame, in order to be of maximum assistance to the client, such departures must be scrutinized for patronizing behaviour, motivated by guilt on the part of the middle-class, typically white therapist. The therapist should ideally examine how the experiences of social and cultural differences are reflected in the therapeutic relationship (Green, 1994). It is then the responsibility of the therapist to bring these differences into the consulting room (Rivers, 1996), giving clients permission to talk about discrimination, be it sexism, racism or classism (Mohamed &

Smith, 1997). In this way, the therapist must be able to acknowledge the effects of the social upon the individual (Belle, 1985).

To make psychodynamic therapy even more appropriate and available to low-income women, the service should be offered at a primary care level (Corney & Strathdee, 1996), and in the community so that the service is easy to access (Nettle & Phillips, 1996). The therapy team should be multicultural, so that the client can be offered the choice of a therapist from a similar ethnic background (Belle, 1985; Mills, 1996).

Language is a crucial issue when working with low-income groups as they often include minority women who may not speak English. Therapists should therefore be multi-lingual (Swartz et al., 1997), or there should be available therapists who can speak the language of the local community (Rivers, 1996), or at the very least, a translator should be on hand (Corney & Strathdee, 1996). Many writers stress the importance of providing child-care while mothers are engaged in a therapy session (Corney & Strathdee, 1996; Mills, 1996; Nettle & Phillips, 1996). In fact, Belle (1985) suggests that mothers and their children should be seen together because so many low-income women have parenting difficulties. As it is so difficult for many low-income women to arrange transport and child care, home-based intervention should be obtainable for low-income women (Corney & Strathdee, 1996). Therapy should also be available at subsidized costs in order to make it more widely available, and less of a middle-class privilege (Banton et al., 1985; Lerner, 1972).

Services such as further education, health care, legal aid, parenting skills, places of refuge (Corney & Strathdee, 1996; Nettle & Phillips, 1996), for example, need to be co-ordinated so that the total person may be assisted at the same place (De la Rey & Eagle, 1997). Due to the diversity of concerns demonstrated by low-income women, other forms of psychological intervention, such as crisis counselling or cognitive behavioural therapy ought to be available as there can be no single model of an effective, comprehensive mental health service for women (Gadd, 1996).

5.4 A psychodynamic perspective to formulation and consultancy.

Besides the direct interaction with the patient, a psychodynamic perspective affords additional uses when working with deprived clients. For example, psychodynamic formulations are useful in the management of low-income clients regardless of whether

the treatment is psychodynamic. A psychodynamic approach can also be valuable when working at the primary health care level, engaging in consultation and support. Swartz (1997, p. 13) argues that “psychological support involves allowing the space for all those issues [of race, class, gender and language] to be held within the boundaries of a consultation relationship and allows them to be explored painfully, but safely”. Long (1999) provides a description of a psychodynamic consultancy-intervention with community counselors in a deprived area in the Western Cape. Such a psychodynamic perspective is useful in understanding the unconscious forces being played out within the therapeutic community or the patient’s community (Swartz, 1999).

6. CONCLUSION

Low-income women are at great risk for developing psychological difficulties due to the deprived circumstances they live in and the concomitant prejudice they endure. Yet, they are systematically discriminated against in terms of the quality of psychological intervention they receive, tending to have limited access to the 'sophisticated' psychodynamic therapies. There are three central arguments advocating that psychodynamic therapy is not suitable with low-income women: the traditional psychodynamic argument, the effectiveness and cost-effectiveness arguments, and the linked feminist and cross-cultural critiques. Traditionally, low-income people have been perceived as inherently unsuitable candidates for psychodynamic therapy because of certain assumed personality traits. Psychodynamic therapy has been considered to be of doubtful effectiveness and too expensive to be made widely available for low-income patients. Feminism and cross-cultural psychology have shown psychoanalytic theory to be individualistic, conformist, reactionary, bourgeois and misogynistic, thus making it highly inappropriate for work with such politically and socially oppressed women.

Each of these arguments or assumptions is, however, questionable and receives further scrutiny in this paper. This paper argues that the traditional belief is steeped in classism, sexism and racism. The effectiveness and cost-effectiveness arguments are undermined somewhat by research, which finds psychodynamic therapy to have some benefit and to be relatively cost-effective, when compared to the hidden costs of current forms of treatment and the social and economic costs of psychological distress. Feminism and cross-cultural psychology offer particularly relevant criticism. One of the central dilemmas posed by these critiques is that psychodynamic therapy privileges an individual focus as opposed to a social focus. This individual focus is understood to undermine political activity and to pathologize the individual. The addition, however, of a social constructionist perspective resolves this dilemma, by showing how the individual therapeutic focus is not, in fact, in opposition to the antitherapeutic social focus. This is because the individual is seen to be both constructed by and constructing of the social. Therapeutic intervention at the level of the individual will also impact on the social level, because they are interlinked, thus allowing psychodynamic therapy to exercise a political agenda.

Furthermore, contemporary psychodynamic therapy, such as relational psychoanalysis and feminist psychodynamic therapy recognizes the self as contextual and positioned in relation to society. Contemporary psychodynamic therapy also significantly offers a means of understanding how oppressive social ideologies have been internalized into low-income women's unconscious, shaping how they experience themselves and their world. This recognition facilitates a rejection of oppressive ideologies and allows an acceptance of more empowering beliefs. In this way, psychodynamic therapy becomes more politically active, which befits work with a politically and socially oppressed group.

This paper suggests that psychodynamic therapy is a desirable and useful psychotherapeutic intervention for low-income women. Furthermore this study argues that this intervention has been generally under-used, even though many low-income women would choose such a form of therapy. Accordingly, it is suggested that psychodynamic therapy, which is active, politically, and socially conscious, effective, and affordable does, in fact, have some benefit for low-income women. Psychodynamic therapy could be tailored to better suit low-income women by using a group and short term format, although individual and long term work should be offered, if desired or required. Recognition of the social circumstances of low-income women should be demonstrated by more action on the part of the therapist.

Far more research is required in order to more fully meet the psychological needs of low-income women. In particular, we need to have a more detailed understanding of what low-income women want in terms of psychological assistance. We also need to explore which of the various forms of psychotherapy such as psychodynamic therapy, cognitive-behavioural therapy and narrative therapy, for example, are most useful to low-income women. As low-income women do not present homogenous needs, we need to investigate the more specific requirements of low-income women, such as homelessness or parent-child difficulties.

This paper is limited in that, for the most part, only Western, first-world women are described. The majority of the poor live in third world countries, where the levels of poverty, violence, rape, battery, child sexual abuse, and political conflict are far greater than in first-world countries. In fact, the descriptions of poverty in the UK and US bear

little resemblance to the utter deprivation of the third world poor. This dire situation points to the need for further research in the area.

Poor women have for the most part been pathologized, silenced and ignored in the service of the social forces of capitalism, sexism and racism. This paper suggests that psychodynamic therapy is one way in which the stories of oppression, loss and survival can be voiced and heard, creating new and more healing narratives.

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