CHAPTER 4

PSYCHOTHERAPY AND DISRUPTED ATTACHMENT IN THE AFTERMATH OF APARTHEID SOUTH AFRICA

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INTRODUCTION

While there are a few trained psychoanalysts in the country who practise in pockets of privileged socio-economic communities, a purist pursuit of psychoanalysis is beyond the reach of most South Africans. This chapter is based on four clinical cases chosen because they are representative of the ways in which psychoanalytic concepts and ideas are applied in child psychotherapy undertaken in state hospitals and community clinics in the South African context. Because of the restrictions in terms of resources, trained staff, and the disadvantage of patients with limited funds and time available, the work by its very nature is short term, disrupted and often incomplete. Nevertheless, it is argued that an understanding of the implications of disrupted attachment and the use of psychoanalytic ideas and concepts can help patients to be thoughtful and reflective in

relation to their own affects, traumas, motivations and behaviours. Additionally, it is apparent that psychotherapists also benefit from psychoanalytic thinking, concepts and techniques in understanding the powerful transferences and projections that result from working in traumatised communities, and which assist in limiting the ubiquitous burnout that so often occurs among colleagues who work in these conditions for any length of time. These four cases were chosen because they are representative of the difficulties faced in post-apartheid South Africa where apartheid still casts a long shadow over its citizens, who continue to struggle with disrupted family constellations, violence and trauma, competing cultural practices and diverse epistemologies of meaning. The use of psychoanalytically informed psychotherapy in assisting patients and therapists to deal with their painful legacies will be demonstrated. It is hoped that the value of psychoanalytically informed psychotherapy can be considered in other contexts faced with limited resources and short-term applications. These cases not only challenge notions of idealised psychoanalytic practice in the South African context, but also bring into focus contemporary global debates about theoretical purism versus theoretical plurality, as well as the general financial pressure to produce shorter-term interventions (Chessick, 2001; Green, 2005; Kernberg, 1993, 2007; Wallerstein, 2005a, b).

BACKGROUND

The consequences of South Africa's previous apartheid policies, specifically the Group Areas Act (No. 41 of 1950), the pass system and the migrant labour system, have been both long reaching and devastating for many South African families. These laws separated families from each other, disrupted parental partnerships and deprived children of secure relationships with their parents. Many children were sent to grandparents or aunts in the 'homelands', where they were often reared in poverty. Despite the advent of a new political dispensation in 1994, the pattern of parcelling children around between families continues today, albeit for different reasons. For many this pattern of rearing has become familiar and normative. Children are sent to live with families in different provinces and often face a change in language and subculture as well. For others, the fracture of family structure is exacerbated by the pandemic of HIV/AIDS, resulting in large groups of AIDS orphans being cared for by older siblings, overburdened and aging grandparents or remote extended family members. The

results have been tragic. Children have lost their childhoods, many have become parents prematurely and all have had their family characterised by disruption and loss. Many of the caregivers are reluctant parent figures, communicating their ambivalences, resentments and anger openly or unwittingly. Others are simply overwhelmed.

These disrupted family structures have impacted negatively on the quality of attachment in early childhood. Many of these children are developing severe insecure attachments or what is often termed 'reactive attachment disorders' (APA, 2000). They have difficulty forming lasting relationships, they struggle to establish trust in relationships and many go on to develop personality difficulties. As these individuals grow into adolescence and adulthood, many abort their education, have unwanted pregnancies, choose unsuitable partners and begin to repeat the same cycle of dispatching their children to other families. Some engage in high-risk sexual practices and find themselves HIV/AIDS positive. Others transmit HIV/AIDS to their children.

From a psychodynamic point of view, the lack of secure attachments has implications for the development of the self-structure, the internalisation of the parental objects, and the maturity of their defences. These building blocks of object relations are often eroded at the very outset of development, leaving individuals with very few ego resources to cope with extraordinary demands, stressors or traumas. Based on 28 years of clinical experience in a large state academic hospital and in several community clinics, I argue in this chapter that psychoanalytically informed psychotherapy is helpful in understanding the repetitive self-defeating cycles that are witnessed in the lives of so many from disrupted and dismantled family backgrounds. It is also helpful in assisting psychotherapists working in under-resourced settings with disadvantaged families to manage their countertransference responses of hopelessness and secondary traumatisation. The use of psychoanalytic ideas and concepts has been beneficial to patients who have been able to use these ideas to come to terms with their traumatic losses, and unacceptable feelings or attitudes toward their overwhelming duties and often unwelcome responsibilities. Drawing on case material, the chapter will illustrate the development of impaired attachment and the subsequent internalisation of neglectful or persecutory parental objects. The lack of ego strengths and the use of primitive defence mechanisms leading to maladaptive coping and impaired relationships will be traced.

THE 'RAINBOW NATION': AFTER 1994

After the promise of the first South African post-apartheid democratic election in 1994, expectations for change and immediate transformation of fortune for many disadvantaged South Africans were unrealistically, perhaps even dangerously, high. Expectations of access to health and welfare services, improved schooling and basic human rights resulted in a deluge of demand and the poorly planned and limited resources previously available to the privileged few were hopelessly overwhelmed. In addition, there are an estimated 8 million illegal immigrants or unofficial refugees from neighbouring states living in South Africa that add a further burden on state health services (Solomon, 2005). Subsequently, idealistic policy planning, leadership and management based on political patronage rather than skill or training, spiralling corruption and the failure to prioritise appropriately according to national and provincial budgets have resulted in a disillusioning failure of delivery of essential services in many parts of the country. The result has been a complete lack of confidence in the education system in South Africa, where the matriculation pass rate is at an all-time low, the number of public school matriculants has dropped and the number of school dropouts has increased since 2005 (Dugmore, 2011). In addition, South Africa has been ranked as having one of the highest murder and robbery rates globally (Altbeker, 2007). In effect, hundreds of South African families are deeply traumatised by the violent assault and death of loved ones (Kaminer & Eagle, 2010). In the health sector, unnecessary deaths occur due to the failure to repair and maintain basic hospital equipment, incompetent budgeting and dysfunctional administration (Bateman, 2011). Sadly, infant and child mortality rates have increased since 2007 (UNICEF, 2010). Added to these woes was the government's initial failure to provide timeous medication to contain the HIV/AIDS pandemic (Heywood, 2010), which resulted in the death of many adults and parents in the prime of their lives, leaving ruptured family structures and countless AIDS orphans to fend for themselves (Smith & Albertyn, 2011). While AIDS is now recognised as a chronic global disease and is being successfully treated in many Western countries, only 28% of HIV/AIDS-infected people in Africa, mostly in sub-Saharan Africa, are receiving antiretroviral drugs (Earls et al., 2008). It is noted that while there is one disease there are two distinct epidemics: one characterised by epidemiological characteristics and the other by access to treatment (Sepkowitz, 2006). As the incidence of HIV/AIDS has spread in South Africa, the incidence of death in adults and children caused by secondary infection, such as pneumococcal pneumonia as well as associated tuberculosis infection, has increased steadily (Gray & Zar, 2010). Finally, the exodus of professionally skilled colleagues as they emigrate out of fear, disillusionment or both has deprived the country of desperately needed resources.

In the face of limited resources, long waiting lists and overwhelming need in South Africa, the role of psychoanalytic psychotherapy, theory and ideas needs careful elucidation. Does psychoanalysis have anything to offer the South African context? If so, what kind of psychoanalytic paradigm would be appropriate to the South African context? Is there a uniform psychoanalytic paradigm? Is psychoanalysis not pre-paradigmatic? What would inform the choice of an appropriate psychoanalytic approach? And what would the clinical practice of such psychoanalytic thinking look like?

THEORETICAL CONSIDERATIONS

The issue of allegiance to a particular psychoanalytic theoretical orientation is of particular importance as psychoanalysis faces a global crisis of relevance and survival in the harsh economic environment of managed healthcare and a digital age of instant gratification and quick results (Fonagy interviewed by Jurist, 2010; Silver, 2003; Stepansky, 2009; Wallerstein, 2005a, b). The question of whether there should be adherence to a purist approach embodying a single psychoanalytic theoretical approach is relevant because this then impacts on the practice of such an approach and its debated suitability to the South African context. In addition, the question of whether psychoanalysis is pre-paradigmatic (Kuhn, 1996), a dominant narrative (Green, 2005), theoretically pluralist (Wallerstein, 2005a) or should enter the scientific mainstream (Kernberg, 2012a; Stepansky, 2009) has significant implications when considering the future of psychoanalytic practice, not only in under-resourced countries such as South Africa but also in the global economy of managed healthcare and the demand for short-term, evidence-based interventions. Psychotherapy in general may be considered pre-paradigmatic as the clashing epistemologies of humanism, cognitive behavioural therapy, psychoanalysis and the eco-systemic approach compete for legitimacy. Psychoanalysis itself may be considered pre-paradigmatic as it is without a dominant paradigm, being characterised by many competing schools of thought: drive theory, ego psychology, object relations theory, self-psychology, relational psychoanalysis, constructivist and intersubjective approaches.

By contrast, the argument for theoretical pluralism is evident in the influence of postmodernism on contemporary psychoanalysis. Postmodernism would regard notions of a unified paradigm as a relic of the dominant narrative of modernism. Intersubjective and relational psychoanalytic thinking as refracted through a postmodern lens embraces an epistemological pluralism (Altman, 1995; Aron, 1996; Benjamin, 1998; Davies, 1996; Hoffman, 1998; Mitchell, 1997; Renik, 1993, 1996; Stern, 1997). As knowledge is regarded to be contextual, it would be argued that psychoanalytic concepts and interventions can only be understood within the linguistic, theoretical and ideological frameworks in which they are embedded. Patients are challenged to construct their personal meanings based on their unique developmental experiences and the matrix of social, linguistic and cultural influences in which they live. The appeal of postmodernist influence on psychoanalytic thought has been that the dominant narratives of race, gender and sexual orientation, which have historically marginalised minority groups, have been challenged. The relevance of such an approach is obvious in the South African context. Hence, more appropriate psychoanalytic theories may be those that do not privilege internal experiences and fantasy life at the cost of external impingements that require acknowledgment or overt challenge by virtue of their unjustness.

A further consideration in the choice of theory and approach in the South African context regards the roots of psychoanalytic thinking. Walls (2004) has argued that because psychoanalysis is the cultural product of 19th century Western Enlightenment, its emphasis on liberal individualism has limited its applicability across races, classes and cultures. He argues that the contemporary shift away from the universalising of a Eurocentric perspective, brought about by the advent of globalisation, has called for the reorienting of traditional psychoanalytic assumptions about human nature towards those that are more appropriate to the recognition of a culturally pluralistic world. By this argument, relational psychoanalytic theories have the capacity to interrogate socially constructed dimensions of the analytic dyad, including race, class, gender, culture, ethnicity and sexual orientation, and hence offer pertinent theoretical and clinical possibilities lacking in traditional psychoanalysis (Altman, 1995). These possibilities offer the promise and hope for psychoanalytic psychotherapy to address some of the important political and cultural sources of psychological suffering. Within relational psychoanalysis, the unconscious as manifest in everyday life and in the transference and countertransference of psychoanalytic therapy is restructured to include social, political and cultural differences.

THEORETICAL LIMITATIONS AND CONTRADICTIONS

Notwithstanding the opportunities offered by relational psychoanalysis, the value of drive theory, ego psychology, object relations, attachment theory and self-psychology in contributing to meaningful psychoanalytic thinking and understanding cannot be discarded. In addition, although relational psychoanalysis has much to offer, it is not without its limitations and contradictions (Mills, 2005, 2012). While postmodern psychoanalysis argues for a plurality of views, it paradoxically privileges its own view over others. Concepts that are widely disputed within psychoanalysis currently include: concepts such as drive theory, and the death instinct in particular, being supplanted by object relations theory; the ego's replacement by the self to provide a global all-encompassing entity; the assertion that psychic life begins with factual reality based on infant observation; the relegation of castration anxiety below separation anxiety; the role of attachment theory that replaces infantile sexuality; the conceptions of memory based on neuroscientific findings rather than repression; and, finally, the use of self-disclosure where enactments versus therapeutic neutrality are debated (Green, 2005). Attempts at rapprochement range from appeals for tolerance of psychoanalytic pluralism (Wallerstein, 2005a, b) to ambitious attempts at comprehensive psychoanalytic integration (Fonagy, 2001; Fonagy & Target, 2007), often compromised by glaring epistemological and ontological contradictions. Interestingly, Green (2005) points to a paradoxical 'enigma' that despite the practice of psychoanalysis applying different techniques based on theoretical assumptions that are often incompatible, they each nevertheless obtain some positive results.

It is with this enigma and awareness of contradictions and paradoxes that one engages a psychoanalytic approach appropriate for state hospitals and community clinics in South Africa, offering shorter-term interventions and a capacity to accommodate the impingements of context. In my focus on four clinical cases in this chapter, I argue that the use of psychoanalytic ideas in developing countries must include theoretical flexibility and significant changes in methodological application. Psychoanalytically oriented psychotherapy, rather than idealised classical psychoanalysis, is by necessity a given. Psychotherapy is often disrupted and sessions are often missed due to difficulties with transport or financial limitations. Breaks occur without adequate preparation, which impacts significantly on transference phenomena and undermines the therapist's sense of efficacy and purpose. Due to time constraints, the focus of the therapy must selectively neglect certain psychodynamics, and the decisions about what to prioritise and

what to exclude are based on trial and error as much as on clinical experience. Where significant trauma has occurred, as is often the case, certain defences need to remain intact and ego strengths fortified. Other defences, which may be impeding psychic function, need to be interpreted and unconscious dynamics worked through.

THE HEALING POWERS OF MUTILATION

The first case study to be presented is one that challenged my cherished beliefs about attachment, trauma, ethics and comfortable middle-class values. Nokuthula (isiXhosa female name meaning 'quiet person'), a nine-year-old AIDS orphan, came to the local community clinic with symptoms of enuresis, encopresis and stealing. Her mother had died when she was five years old and she had been parcelled round to various extended family members until she was finally placed with her grandmother, who was depressed, overburdened and resentful. Her father died shortly after her birth, apparently due to an 'unknown illness', a local euphemism for AIDS. Prior to her death, her mother had been very ill and unavailable to Nokuthula for lengthy periods. Nokuthula was emotionally deprived and appeared depressed, angry and miserable. On first meeting, she was wary and simply looked at the various toys without engaging in any meaningful or symbolic play. She made little eye contact but occasionally stared vigilantly at me. After several sessions she developed a pattern of playing with various small animals in the sandpit. The outcome was always the same in that the baby animals were left out of the enclosures to fend for themselves and the adults seemed to be self-involved and unaware. At times she played with the dolls and, similarly, the babies would be left out of the home at the end of an outing or ignored at the family meal. It was clear that Nokuthula was repeatedly playing out her sense of abandonment and that she had a deep sense of feeling overlooked, unseen and disregarded. I commented on her feelings of being invisible and overlooked and how sad this made her. She seemed surprised at my attention to her play and continued to play as though I did not exist. I interpreted that she ignored my existence in the playroom much as she felt ignored and overlooked by her maternal objects. This was usually rewarded with a cold glare and further dismissal, leaving me feeling that I was a nuisance and spoiled her game. Such 'looks that kill the capacity for thought' (Wheely, 1992) were effective in shutting down any reflective function I was hoping to achieve.

After a while her babies began to be scolded for being naughty and a nuisance. Her feelings of anger at her neglectful, abandoning objects were slow to emerge. While it was apparent that Nokuthula was insecurely attached, her disengaged style appeared to reflect her feeling of being discarded and unseen in the playroom. She evoked a feeling of remoteness in me and I suggested that she expected me to find her small, insignificant and a nuisance too, in the way she felt when her mother was ill and when her *gogo* (isiZulu term for 'granny' used by many South Africans) was tired. Over time, Nokuthula spoke of her sense that she was 'not a good girl' when her mother was ill and that her wishes for attention were naughty and she felt a nuisance. I also commented that now she felt she was not a good grandchild and that she felt ungrateful for her *gogo*'s efforts and had spoilt her life. She nodded in agreement and solemnly continued her game.

Over time, it was clear that she felt heard and seen in the therapy and that her grandmother, who was seeing her own therapist, was working through her anger and resentment at the loss of her daughter and the added burden of a young grandchild to rear in her old age. Nokuthula's stealing had stopped, she was no longer encopretic and she was making friends at school. Her enuresis, however, remained obstinate and she felt extremely ashamed about this. She felt humiliated and likened herself to a naughty, lazy baby that needed nappies and deserved a hiding.

After bringing Nokuthula to play therapy for 11 sessions (these were intermittent due to taxi strikes and transport costs), her grandmother announced that she would be taking Nokuthula to her late parents' home province, where she would undergo various traditional rituals that had been neglected by the family. One aspect included the removal of the last digit of the left small finger as a symbol of clan membership. This ritual, referred to as *ukungqumla ingqithi*, is practised by some Xhosa and Zulu people as a way of welcoming an individual into the membership of a particular ethnic clan (Hammond-Tooke, 1989; Ngubane, 1977; Swartz, 1998). I was highly ambivalent about this practice and felt it would be both traumatic and harmful to Nokuthula to undergo this form of mutilation. As her attachment was insecure and we were attempting to consolidate *gogo* as her primary attachment figure and her secure attachment base, it seemed unwise for this maternal figure to preside over a traumatic mutilating procedure. In addition, she was responding well to the play therapy. An object relations theoretical frame inclusive of attachment concepts was incorporated into this psychotherapy, as so many of the child cases seen in local clinics have severe attachment ruptures in their lives. Contextually, an increase in rates of

disorganised attachment among children from poor, disadvantaged communities in South Africa has been reported (Tomlinson et al., 2005). In agreement with Robbins (2007), relational psychoanalysis has more recently considered attachment theory to be the developmental basis for deeper psychological structures, with a more sophisticated approach to the implications for the development and functioning of the internal world.

Nokuthula was duly sent off to undergo her traditional clan membership ritual and have her fingertip removed without any form of anaesthetic. When she returned to the clinic some two months later, her grandmother announced proudly that Nokuthula had not wet her bed since her ritual. Nokuthula beamed and showed her raw, bulbous wound to the entire clinic with obvious pride. The wound was purple, ugly and disfiguring.

In her play therapy that day, Nokuthula played out the welcoming ceremony she remembered and made food for all the guests she invited to her ritual, including myself. She told me with great feeling that she now had a family. I remember thinking – but did not comment – that she had not met this family before and would not see them regularly or consistently so they could not become meaningful attachment figures. I felt anxious that this honeymoon feeling of elation would finally fade as she realised over time that her newly found attachment figures would not materialise into meaningful relationships. This concern of mine did not appear to perturb Nokuthula in the least. At the end of the session when Nokuthula got up to leave, I looked down at her sandpit scene and noted that for the first time all the baby animals were placed together with their families. After several more sessions Nokuthula ended therapy as her grandmother was satisfied that her final symptom of enuresis had finally resolved. At a six-month follow up Nokuthula remained dry and appeared confident and happy.

The outcome of this case was disconcerting for several reasons.

First, mutilation is usually considered painful and disfiguring and therefore associated with trauma. Fears that the traumatic, abusive and oppressive effects of this mutilation could lead to a worsening of her psychological symptoms and further regression, as some psychodynamic theorists would suggest (Garland, 1998; Herman, 1992), were not supported. Furthermore, Nokuthula's own family, who could be expected to protect her from such additional trauma, inflicted this mutilation upon her. Failure to protect Nokuthula from such trauma would challenge the notion of parental figures providing a secure attachment base as a prerequisite for establishing reflective function and thereby the capacity to

be aware of self and others as independent psychological and emotional beings. All these assumptions would be further coloured by the lens of a dominant Western, middle-class narrative where such rituals are considered primitive and uncivilised. In traditional African belief systems, misfortune – including bodily symptoms – is attributed to ecological imbalance, pollution (e.g. state of impurity due to menstruation, miscarriage, abortion or contact with death), impaired social relationships or bewitchment. In African ancestor worship the spirits of the deceased are believed to look after the interests of their descendants, but they can also send illness and misfortune if moved to wrath (Niehaus, 2005). The relationship of the ancestors to their living relatives is somewhat ambivalent, as both punitive and benevolent responses may manifest. Ancestral benevolence is assured through observance of ritual and sacrifice. The usual reasons for ancestral interference in the affairs of the living are failure to accord due respect to seniors or neglect of necessary rituals that should be performed at pivotal points in the life cycle – birth, initiation, marriage and death.

It could be argued that compliance with traditional ritual in the case of Nokuthula alleviated considerable anxiety and ambivalence in her grandmother and that this anxiety would have been communicated to Nokuthula both consciously and unconsciously. This could have occurred by a process of projective identification. As *gogo*'s sense of being unclean and disrespectful of her ancestors was projected onto Nokuthula, her granddaughter internalised this projection, manifesting with encopresis, enuresis and stealing, all considered unclean and disrespectful behaviours which were then punished and rejected through *gogo*'s experience of Nokuthula as disrespectful and ungrateful. Parental projective identification has a profound impact on a child, who is under great pressure to comply with the parent's need for her to act as repository for the parent's intolerable emotions and states of mind. The child therefore enacts the role she has been assigned. Children are vulnerable to this kind of pressure because they need to be loved by the parent, even if the price is the development of a distorted sense of self as a result of parental projections. The uncleanliness could no longer be located in Nokuthula when *gogo* dealt with her own anger and resentment in her therapy and acknowledged her contribution to her misfortune by accepting responsibility for not completing the required traditional rituals.

Notably, the work on Nokuthula's anger at the abandonment by her parental figures had not really developed in this therapy. I felt that Nokuthula had been severely traumatised and had suffered multiple compounded losses, as is often the case in child trauma where the loss of parents invariably results in a move to

a different home, a change of school and a new town. Familiar places, friends, support structures are all lost at once (Smith & Holford, 1993). In considering the impact of her multiple losses, the psychotherapy was focused on establishing ego resources and not undermining defences that retain coping resources in the face of real trauma (Kaminer & Eagle, 2010; Straker, 1994). Prematurely confronting Nokuthula's defences regarding her anger at her parents' abandonment through death would have undermined her trust and heightened her resistance to the therapy. Additionally, it was thought that because Nokuthula's attachment to her granny was insecure, the interpretation of her anger at her internal maternal object would have overwhelmed her coping resources. In accordance with Fairbairn's (1943) theory of repression of bad objects, it seemed psychologically essential to preserve the perception of the parent as benign and protective, as it would have been intolerable to consciously acknowledge internal bad object relationships. Fairbairn (1943) indicated that traumatic experiences with a parent are often felt to be particularly shameful, and because self and object representations are always linked, the child unconsciously believes herself to be involved in her parents' badness. As a result the external object, although in this case deceased, is protected and the badness is internalised by the child.

The idea was to establish a secure attachment relationship in the therapy through an experience of felt security. Once established, the therapeutic relationship becomes a developmental crucible within which to help the patient deconstruct attachment patterns of the past and construct new ones in the present. The concepts of parental attributions, including attachment patterns, and projective identifications derive from very different paradigmatic assumptions and indicate two different levels of psychic experience (Silverman & Lieberman, 1999). Parental attributions and their associated attachment behaviours are observable within clinical material and are understood to represent the more conscious manifestations of experience. Alternatively, projective identification incorporates an unconscious, fantasy-level process. The intention was to address both these processes in the therapy once Nokuthula had developed the ego resources to tolerate disavowed or dissociated thoughts and feelings associated with the premature death of her mother. This was not to be, due to the early removal of Nokuthula from her therapy by her grandmother. Despite this lack of resolution of repression of internal bad object relationships that would seem essential to her mourning process, Nokuthula had done rather well.

Finally, the issue of a dominant Western, middle-class narrative which gives ontological priority to individual needs over societal and cultural requirements

(Walls, 2004) requires discussion. A crucial distinction between the traditional African worldview of an individual and that of Western thought is that in the African view, it is the community that defines the person and not his/her individualistic qualities (Gumede, 1990; Menkiti, 1984; Mkhize, 2004; Taylor, 1994). As a result, the requirements of the community take precedence over individual need. Many African people within South Africa currently adopt a hybridised explanatory system that allows the incorporation of both Western and traditional beliefs (Eagle, 2005). The notion of a communal or collectivist self is ontologically diverse from that offered in psychoanalytic thinking (Altman, 2005), and with such fundamental differences in how identity is situated contextually within different cultural or religious belief systems psychoanalytically oriented psychotherapists require considerable adaptations to their thinking and practice. In clinical practice it is often the case that patients find psychoanalytically informed interpretations regarding ambivalent affects in relation to their parental figures disrespectful. As a result, such links need to be made with caution and great sensitivity. Finally, while in principle it is regarded as politically correct to respect the different practices of varying cultures or religious groups in the spirit of respecting a plurality of cultural views, it becomes less defendable when particular practices are destructive or oppressive of vulnerable groups, such as disempowered women or children. In addition, it is possible to regard a particular tradition within a culture as harmful without disrespecting the entire culture (Dhai & McQuoid-Mason, 2011; Macklin, 1999). It is also noted that culture is not static and that all cultures change over time (Gyekye, 1997). Where cultural or religious practices reinforce the subordinate position of woman in families, the position of cultural relativism becomes ethically indefensible (Bowman, 2003). Eagle (2005) has pointed out that the dilemma facing the therapist is to reconcile her psychoanalytic assumptions and clinical practice while empathically engaging the patient's frame of reference with regard to what a culturally embedded sense of cure or meaning is. In the case of minors, this becomes all the more complex, as they do not choose a particular cultural practice from any position of independent adult autonomy. The outcome of this case challenges many psychoanalytic theoretical assumptions about trauma, loss and healthy psychic function. Far from feeling discarded, abandoned and further traumatised by her mutilation, or oppressed and disempowered, Nokuthula felt incorporated, affirmed and identified with her family clan, which afforded her a sense of secure attachment and an integrated sense of self.

THE DEATH OF FATHER CHRISTMAS

There is a complex debate within the psychoanalytic literature regarding the process of mourning and the transformation of internal objects. Freud (1917/1957) took the view that the mourner suffers due to his or her internal attachment to the deceased and that the aim of mourning is to detach those feelings and attachments from the lost object. The ego, then freed from its former attachments, is available to attach to a new living person. Baker (2001) contests this view, suggesting that a continuing internal relationship with the lost object is found in many bereaved individuals. Recently Kernberg (2010) voiced similar concerns, questioning whether grief and mourning are indeed a time-limited experience completed with the process of identification with the lost object, as suggested by Freud (1917/1957). He also challenges whether mourning is completed with the reworking of the depressive position and the reinstatement of the good internal object, as mentioned by Klein (1940). As a result of a profound personal loss, Kernberg (2010) subsequently proposed a review of 'normal' mourning. He suggests that mourning may bring about a permanent alteration of psychological structures that affect various aspects of a bereaved individual. These structural consequences of mourning comprise the establishment of a persistent internalised object relationship with the lost object that affects both ego and superego functions. Furthermore, Kernberg (2010) suggests that the persistent internalised object relationship develops in parallel to the identification with the lost object, and the superego modification includes the internalisation of the value system of the lost object.

When working with extreme trauma and loss in children, the debate regarding mourning becomes more complex with the recognition that children still have an immature cognitive apparatus, are psychologically developing and their primary objects continue to play an active role in their lives (Sugarman, 2009). The child's cognitive immaturity influences how they present material and how the psychotherapist responds. In the case of pre-schoolers this task is all the more challenging. In keeping a psychoanalytic frame for thinking and mindfulness, the aim is that underlying painful feelings can be understood and given words and meaning.

Garland (1998) describes the response to trauma as comprising two stages. First, the nature of the trauma re-evokes infantile persecutory anxieties as the trauma can be experienced as a loss of both internal and external good objects. This leaves the individual with an internal world peopled by only bad objects.

The second stage involves the mind responding to trauma by trying to make sense of it in terms of earlier experiences, thus linking affects, transference phenomena and defences with a difficult relationship in the past. In the case of a small child, trauma need not necessarily re-evoke earlier persecutory anxieties as these anxieties may be developmentally current and ongoing. However, trauma can also confirm and perpetuate developmental anxieties, leaving the child with a distorted sense of intrinsic badness.

Some years ago on the morning of Christmas Eve, I received an emergency referral while at the Child and Family Unit. The child concerned was four-year-old Dora, whose mother had been brutally murdered by robbers on the weekend. Robbers had entered the home and, when disturbed by the parents, they bludgeoned the mother to death and severely injured the father, who subsequently survived. The father, Dora and her younger brother of nine months, who was being breast fed by his mother at the time, were locked in a cupboard for approximately five hours while the robbers ransacked the house. During this time Dora had witnessed the murder of her mother and the assault on her father. Her father later reported that while locked in the cupboard he was unable to comfort his nine-month-old infant son, who screamed throughout this period. He was also bleeding profusely from his head wound and could not see clearly as his eye had been damaged. In an effort to contain Dora, he had told her to open her Christmas presents that had been stored in the cupboard. As the father was still in hospital recovering from his injuries, a close family friend had brought Dora to the clinic. Dora was reported to be tearful, bewildered, struggling to sleep and having bad dreams. On meeting, Dora was an attractive child who appeared sombre and somewhat stilted.

In the playroom I explained that I knew some very bad things had happened to her and her family and that I was someone who spoke to children about their feelings and worries. Dora did not respond and instead wandered around the room looking at the toys. She finally sat at a small table and proceeded to draw a simple house. The first house that she drew had a door, some windows and a large roof. I asked her to tell me about her drawings. Dora said, 'The baddies came, they climbed in through the roof and they hurt the mommy and daddy.' I commented that some 'baddies' had climbed into her house and hurt her mommy and daddy too. She nodded. I said that she must have been very frightened when that happened. She nodded and said that Father Christmas was dead and that her daddy had been crying in the cupboard. I added that all the nice things about Christmas had been spoiled and that it felt like Father Christmas

was dead, too. I also said that it was so bad even her daddy had been crying. I commented that she must have been feeling sad and sore and very scared. She agreed and said that she was scared that the 'baddies' would come back and hurt her daddy again. I commented that she was afraid that Father Christmas had been killed and that the baddies would kill her daddy too. She nodded again. I commented that she had not mentioned her mommy and that perhaps she felt too frightened to talk about her mother. She ignored me and continued to draw. She drew a second house that was attached to the first but which had no windows or doors. I suggested that perhaps if her house did not have windows and doors, she might have been safe from the 'baddies' and they would not have been able to hurt her mommy and daddy. She nodded in agreement and proceeded to draw a third house. I asked her to tell me about the third house. She said this house was 'far away' and that she would have to go and 'live there now'. I said that she felt all alone now and that she felt she was far away from the people she loved. She nodded dolefully and stared at her drawing. I was left with the feeling that something vital had died that day and indeed carried that feeling for many Christmas's after.

As is often the case in child trauma, Dora's losses were compounded by subsequent moves to various caretakers within the extended family while her father recovered and struggled to cope as a single parent. These changes included the loss of her home, her nursery school and all the familiar places and people she knew.

In addition, the family lived far from the clinic and the father could only manage to bring her for weekly play therapy for a six-month period. I was very aware of 'making a little go a long way', as is often the case with state hospital patients (Pollet, 2010). When faced with a limited time frame in which to work, it is best to negotiate a realistic commitment from the parent that he/she is able to meet rather than allow a drawn-out pattern of missed appointments and failed commitments unrealistically accepted under pressure. In this way, the psychotherapist can avoid adding themselves to the list of 'abandoning adults' (Hunter-Smallbone, 2009).

During this time Dora asked for the toys she had at her previous home, specifically her teddy 'Edward' and her pram. As the therapy progressed, Dora played out the 'baddies' robbing houses, mommy figures getting sick and dying and daddy figures who were busy, sad and depressed. She never mentioned her sibling. She often wished to set fire to the crooks who had hurt her mommy. She became withdrawn at nursery school and complained that she had no best friend. Dora said that she wished her mommy would come back and that no one would

steal cars. She also described a very realistic recurring dream: 'In my dream I am in bed sleeping but the others are watching TV and the crooks came through my bedroom window and they kill my whole family with a knife. And they tell me to stand still while they kill my family. Then they go away.' The dilemma in interpreting this dream is that although it is typical of the sort of nightmare reported by children who have experienced extreme trauma, it is not only a re-experiencing of the trauma as a feature of Post-traumatic Stress Disorder but also an expression of her internal world. Trauma is usually not repeated or enacted literally; there is an internal response to that traumatic event. It is accepted practice to respect the child's defences in the case of trauma to facilitate coping resources and recovery. Support for the patient's ego, which has been overwhelmed by the trauma, may facilitate the opportunity for later analysis of conscious and unconscious fantasies connected with the traumatic experience (Blum, 2003). However, it is noted that Dora 'stood by passively' as her family were murdered in her dream and that she had very ambivalent feelings about this passivity. This could be attributed to her terror and to being immobilised by her anxiety, or it could be interpreted as evidence of her ambivalent attachment to her bad internal maternal object that had abandoned her and displaced her with a sibling. In the case of mourning, it is common practice to deal with ambivalent feelings by elucidating the nature of the hostility to the lost object.

On termination, Dora had settled in her new nursery school and had made a best friend. Her nightmares had stopped and her sleep difficulties had ended. She remained afraid that robbers would harm her father and she often thought of her mother and wished she would 'come home again'.

The father remarried some two years later to a close family friend who the children knew well and the family made sporadic contact with the clinic as various family issues arose. Soon after the marriage, Dora's stepmother fell pregnant and I received a most surprising call from Dora herself, now seven years old, who navigated the cumbersome labyrinth of the hospital switchboard and requested an 'appointment'. Her stepmother was a sensitive and insightful woman who had been attending her own psychotherapy in an effort to manage her newly reconstituted family as she also had two children from a previous marriage. She reported that Dora had recently become oppositional and difficult to manage. Dora then announced her wish to see me.

I had not seen Dora since her initial bout of play therapy. She had grown into a tall, striking, latency-age child. We returned to her old playroom where Dora proved to be quite verbal and played creatively. She said that she loved her

stepmother very much but that she loved her daddy best. She said that it was hard to share with all her new siblings and she hoped her stepmother would have a little boy, as there were too many girls in the family. She then began to paint. She painted her 'family', which comprised herself, her father and a very large and obviously pregnant mommy. I asked her to tell me about her painting and she became annoyed and began to paint over it. I commented that it seemed she wished that she was the only child in the family and that her stepmother's new baby would spoil that wish. I added that she must have some very mixed, sad and cross feelings. I suggested that she might be worrying that she would lose her stepmother when she had her new baby just as she had lost her own mommy after her baby brother was born. Also that it might feel as though she had to share her mommy with her brother and that this must have made her feel sore and angry and that when her mommy was murdered she must have felt very bad. Dora stopped painting over her initial picture. She said that she still thought of her dead mommy but did not miss her as much and then, surprisingly, said that she had missed me. She also said that she still worried robbers would hurt her daddy and new mommy. Hence, Dora appeared to associate her stepmother's pregnancy with the traumatic loss of her mother and this pregnancy had re-evoked her feelings of sibling rivalry and ambivalence at her maternal object for being displaced. It also evoked her fears of the associated trauma and hence her renewed anxieties about her parents' security.

While there are many aspects that could be discussed with regard to this case, I wish to focus on only a few. First, it is interesting to note that Dora referred to the death of her mother as the death of Father Christmas, indicating a very simple but powerful understanding that her mother's death would be a profound, pervasive and permanent loss of something very precious. This is despite the fact that at the age of four years, Dora's cognitive understanding that death is finite had not yet fully developed. Instead, children at this age tend to have a very concrete understanding of the death of a parent as having gone to be with God or to be in heaven, much as one goes to the shops or visits granny. The eventual comprehension of permanent loss tends to be experiential as the child realises day after day that the deceased parent does not return. Parents are often distressed that their pre-schoolers, having been told of a grandparent's death, start enquiring when they will return after a few days or weeks. Dora was not only aware that a terrible loss had occurred, but she was also unable to name the devastating fact that her mother had been murdered. Children, in particular, avoid internal phenomena such as affect when it is too frightening or too painful to bear (Sugarman, 2009).

Naming such fears and helping the child express them is essential. Most very young children are capable of insight in so far as they are able to reflect on their own minds and understand their behaviours, affects and fantasies. Small children do have limited affect tolerance and in the case of trauma are able to distinguish reality from fantasy.

The second point I wish to raise is the role of repression. In a contemporary psychoanalytic model (Fonagy, 2001; Fonagy & Target, 2007; Wallin, 2007), repression is thought of as the intentional keeping out of consciousness of the meaning of a memory rather than the memory itself (Knox, 2003). By this argument, uncovering repression during psychotherapy is therefore not the recovery of a previously unavailable memory but rather a change in the understanding and processing of feeling in relation to the repressed material. It was evident to me that Dora was avoiding the feeling associated with the murder of her mother in her own limited but effective little way, but she was perfectly conscious of the fact that her mother had been murdered.

The third point is that even during a very simple interaction with a small child of limited verbal ability, the communication of her intolerable, unspeakable and unthinkable feelings was very powerfully projected onto me, leaving me with a profound feeling of death, loss and mourning. The task of the psychotherapist in these circumstances is to receive and listen to such feelings and hopefully process and make sense of them for the child (Lanyado, 2009). These processes are quite clearly evident in the trauma work with a very small child and effective even when working in a short-term model.

The fourth point is that while it is clear that her stepmother's pregnancy re-evoked unresolved feelings of ambivalence with regard to Dora's displacement and her mother's untimely death, the very fact that she continued to remember, think of and carry her maternal object is evidence of an internal representation of the deceased parent signifying adaptive bereavement (Baker, 2001; Silverman & Worden, 1992). A Kleinian view would conceive of mourning as a process of reparation in which the destructive fantasies unleashed by the loss are contained and a positive internal relationship with the lost object is re-established. It can be argued that Dora's unconscious wish for reparation with the internal maternal object is evident in her constant concerns regarding the safety and security of her surviving parent and her new stepmother. Indeed, she returned to therapy, as she needed help to name and process her anxiety and ambivalence with regard to her pending displacement and associated feelings of destructiveness and badness. Nevertheless, it is difficult to assess the extent to which Dora's fear of additional

or further trauma to her external objects was based on reality and to what extent it was a function of her wish for reparation.

THE JOYS OF REVENGE

The theme of revenge, despite its prominence in mythology, literature, history and politics, is surprisingly neglected in the field of psychoanalysis (Beattie, 2005; Rosen, 2007). Despite this, revenge is very popular, as evidenced recently in the public address by the United States president, Barack Obama, when announcing the death of Osama Bin Laden. He said, 'We can say to those families who have lost loved ones to al-Qaeda's terror, justice has been done' (Obama, 2011). Thousands of Americans were televised around the world celebrating this death while simultaneously thanking their God and asking for blessings. This is despite the fact that 76% of American citizens identify themselves with Christianity (Kosman & Keysar, 2009), a religion with basic tenets that embrace forgiveness and oppose murder. Enactments of revenge are accompanied by regressive use of defences such as denial and splitting. By focusing on the righteousness and justified nature of the claim and entitlement to retribution, the avenger may render his or her sadism egosyntonic (Rosen, 2007).

In general, the wish for revenge serves a number of psychic functions. Of particular significance is the understanding of revenge as a defence against feelings of shame, loss, guilt, powerlessness and mourning. Where revenge is a prime motivator for psychic survival in the face of devastating loss or betrayal, it may serve a positive function for the avenger. This paradoxical state of affairs raises a disturbing feeling of disquiet, as described in the following case.

Fikile was nine years old when she accompanied her brother to the clinic together with her mother. Her brother had been attending the clinic for some time and her mother was attending parent counselling as part of his intervention. Her mother mentioned in passing that Fikile was a very good child despite the terrible thing that had happened to her. It transpired that Fikile and a friend had been part of a lift scheme, where a taxi driver would fetch them from home and take them to school. Her mother paid monthly for this service. Some months previously, the taxi driver had dropped off all his passengers and insisted on taking Fikile to his house, where he raped her before returning her home. Fikile immediately told her mother of the rape when she returned from work. Her mother had Fikile examined and found that her daughter had indeed been raped.

She was enraged by the betrayal of the taxi driver with whom she had entrusted her child. However, she did not report the matter to the authorities and instead mobilised her adult sons and nephews, who lay in wait for the taxi driver one morning and, with Fikile present, proceeded to beat him senseless until her mother was satisfied that 'justice had been done'.

Fikile was subsequently referred to me for trauma counselling. Fikile recounted her story authentically and was animated and engaged. She was able to reflect on her feelings and had no features of post-traumatic stress at all. She said that she felt better as the taxi driver 'got what he deserved' and that her family had 'taught him a lesson'. She felt that he would never try to hurt her or any other little girl ever again. Fikile was doing well at school, was integrating with her friends, slept well, did not have any nightmares and did not worry about being unsafe. Her play was creative and although she recounted the rape experience as very painful and scary, she felt that she had survived the trauma and put it behind her as the perpetrator had been punished. She also felt supported and affirmed.

To succumb to revenge enactments is to resort to primitive defences such as denial, splitting and projective identification (Rosen, 2007). While it is clear that the child's mother in this case undertook the revenge enactment, the 'benefits' were that Fikile felt supported and vindicated by her family's actions. This did indeed help her defend against feelings of helplessness and shame that often serve to compound trauma. As the regressive defensive behaviours were located in her mother, one could speculate as to whether such sadistic gratification in the maternal object would be harmful to Fikile as a role model. It must be noted that her mother did not present a pattern of regressive or sadistic behaviours, so that outside of this enactment of revenge, the mother was an ordinary, law-abiding citizen whose actions were 'justified' by her belief that the criminal justice system would not be effective in prosecuting the perpetrator and bringing him to justice. This opinion would be supported by the very poor conviction rate of child sex offenders in South Africa (Conradie, 2003).

Notwithstanding a certain empathy for the mother's position, it remains obvious that if private citizens were to take the law into their own hands and undermine the basic principles of a just, democratic and civilised society, it would be a very dangerous development. It is likely that revenge in this instance was an attempt to restore a narcissistic injury within the mother. While revenge may serve to restore a narcissistic wound, it is nevertheless considered a primitive attempt at righting a wrong or undoing a hurt, by whatever means (Kohut, 1977). In the case of the mother, her psychic functioning reveals defensive

splitting which may have been part of general paranoid-schizoid functioning in Kleinian terms or the result of regressive functioning (Herman, 1992) as a consequence of her own trauma in dealing with the rape of her child. While rage and vengeful acts may appear primitive, Poland (2006) argues that lust for revenge need not reflect a primitive way of relating. Vindictiveness need not imply an incapacity for empathy but rather a lack of sympathy for another. It is possible to retain a capacity for empathy or attuned sensitivity despite vengeful feelings. It is also possible that Fikile's mother was an empathic and sensitively attuned maternal object, given Poland's (2006) argument.

However, given that the feelings of revenge were enacted, certain moral concerns arise. The ethics and morality of her revenge enactment suggest a pre-conventional stage of moral development embracing an obedience–punishment orientation (Kohlberg, 1977), which would be developmentally consonant with Fikile's formulation of moral dilemmas. Thus, the punitive consequences for the perpetrator resulting from her mother's act of revenge would have resonated with her developmental understanding of moral justice. Poland (2006) argues that adaptation and revenge are of the same family and considers them conceptual cousins. While it is difficult to speculate on the internal world of the mother, this revenge enactment was indeed adaptive for Fikile, albeit that the act offends many sensibilities.

TAINTED BY AN INTERNAL BROTHEL

The following case is an example of the difficulties of working in a psychoanalytically informed manner with children who are mismanaged by the social services that are purported to be their guardians. After the 1994 elections and the demise of the apartheid government, social services were dismally under-resourced and under-prepared to cope with the demand for integrated child services for all South African children. The situation worsened with the HIV/AIDS pandemic and the government's initial failure to make antiretroviral treatment available to patients. As a result of HIV/AIDS denialism (Chigwedere et al., 2008), a legacy of orphaned children was left at the mercy of inadequate social services. Subsequently, some of the most vulnerable children, already with unprocessed trauma, were subjected to further trauma from repeated separations and failed foster placements within the social service system. As a consequence, these children have less opportunity to develop an internal world populated by more

benign figures to help support them against intrusive and persecutory experiences in either internal or external worlds.

The difficulties in offering a consistent therapeutic alliance and creating basic trust to assist the child in establishing a sense of containment over their inner turmoil and chaos become apparent in the next case. Apart from the external barriers to receiving assistance, these children offer considerable internal resistance as they are often mistrusting, angry and destructive, making efforts at therapeutic engagement difficult.

Benita was four years old when I first met her. It was late on a Friday afternoon when her mother walked into the waiting room of the clinic and announced that she had come to give her daughter up to 'the welfare' as she was 'possessed by the devil'. I indicated that the clinic was not a welfare organisation and did not have any statutory powers or placement facilities and that her request was somewhat unusual and required some explanation. Following a lengthy interview with the biological mother, during which time Benita played with the doll's house in the corner, her mother explained that Benita had been 'caught having sex' with a temporary lodger in her apartment and that she was now soiled and contaminated. As Benita was considered complicitous in this act of obvious sexual abuse, her mother regarded Benita as 'possessed by the devil' and would no longer have her in her home. Her mother promptly left Benita in the clinic and did not bother to wait for the arrival of social services. After social services had fetched Benita, it was noted that she had turned the doll's house into a very explicit brothel. Benita was subsequently placed in a children's home and brought to play therapy weekly. Her social worker reported that her father was unknown and her mother was a well-known prostitute who lived in a single-room apartment; she partitioned off a section of this room with a curtain when she serviced clients. Benita was fully aware of her activities and, as it later transpired, would often peek through the curtain and observe her mother's sexual activities. Benita played out her internal badness repeatedly with various expressions of a highly idealised mother in her psychotherapy. She felt that if she had not been so bad and naughty her mother might have loved and kept her. Bonita was placed in over seven different foster placements. Each time she would alarm and provoke her foster parents by sexually interfering with their children and, having ruptured her foster placement, she would be returned to the children's home. Despite considerable efforts to prevent her from repeated foster placement breakdowns and repeated rejections, Benita would be placed with yet another unsuspecting family. Throughout this time, her biological mother would emerge for two or three annual visits and

promise to fetch Benita and take her home. This never materialised and Benita would make excuses for her mother's failure to keep her word. This tragic attempt to protect the external mother from criticism is an example of Fairbairn's (1943) moral defence against bad objects, where the child's denial or repression of any memories of a frustrating object serve to retain the hope of future fulfilment.

Finally, when placed with the eighth foster family, who had no children in the home, Benita was 12 years old. This foster placement lasted for two years and was the longest she had ever stayed in a family. Unfortunately, at this time Benita became ill with an acute kidney infection and when she was admitted to hospital it was discovered that her second kidney was defunct and had to be removed. Social services decided to contact her biological mother and inform her of this decision. Her mother arrived at the hospital and with great dramatic flair promised to support Benita through her surgery and then take her home. Benita rejected her foster mother immediately and refused to see her. After the surgery, she returned to the children's home where she stayed until she completed school and found a job. Her mother never came to fetch her.

It appeared that Benita ruptured every one of her foster placements in an attempt to retain an attachment to a needed parent by viewing her rejection as deserved and thereby keeping the rejecting parent 'good'. Benita solved the fundamental problem of staying attached to a frustrating and alluring (exciting) internal object (Fairbairn, 1944) that promises but frustrates delivery of care and nurturance by internalising the bad object and confirming her badness by engaging in behaviours that resulted in repeated rejections from her foster families. Another consideration might be that through Benita repressing her painful affects of rejection, she was able to identify with the betrayer and aggressor and thereby repeat such experiences of rejection (Fraiberg et al., 1975). Lanyado (2009) notes that there are two extreme defence mechanisms which help the individual survive, namely dissociation and identification with the aggressor. The danger is that these survival mechanisms can continue long past their usefulness and become part of a defensive structure that avoids unpleasant and painful realities.

Benita attended play therapy throughout her childhood but this was peppered with breaks as some of her foster families could not bring her to therapy and there were two periods in her adolescence when she terminated the therapy herself. This occurred once at the age of 14 years when she returned to the children's home after her surgery and again when she was 16. Children in foster care or placement in children's homes are often abandoned by a living parent who repeatedly reconnects and re-abandons the child (Hunter-Smallbone, 2009). The grief process at

the loss of such a parent remains both complex and incomplete and is characterised by anger, guilt, self-blame, fear and helplessness. The relationship with the abandoning parent is likely to have been ambivalent and characterised by insecure attachment, leaving the child feeling unlovable and intrinsically bad. It is also important to distinguish the task of psychotherapy from the maternal role, which is to establish a secure attachment. The therapeutic relationship, apart from providing a secure working alliance, also evokes transference feelings, which contribute to the revival of insecure attachment. Psychotherapy is not an alternative form of parenting. The psychotherapist's focus on unconscious material and defences against painful feelings evokes anxiety and ambivalence toward the therapy. Benita terminated psychotherapy herself shortly after her surgery and her mother's final betrayal, as she could not bear to think that her mother would never take her home and that the reunion fantasy would never be. My own fury at her mother for her destructive and dishonest promises while visiting Benita in the hospital had led me to interpret Benita's disappointment and rage at her mother's final betrayal too soon in the process. I revived an insecure attachment and the associated ambivalent affects in the therapy and Benita, overwhelmed by these feelings, fired her psychotherapist for several months.

When Benita returned to psychotherapy aged 16 years, she was tense, drawn and traumatised, which was unusual as she tended to be quite easy-going, vocal and upbeat. It transpired that she had spent the weekend with her mother and had asked her mother why she had given her up to a children's home. Her mother had explained that Benita was a very evil child and that she was unable to cope with her. She told Benita that she (Benita) had locked a small child in a disused stove when she was approximately six years old and that as a result the child had died. Benita was horrified and had come to 'see her file' because she did not recall the event and was sure that I would have remembered this and noted it in her file, as I 'knew everything about her'. Benita continued to experience herself as bad due to the internalised badness of her frustrating object, which she attempted to retain as a pristine object. However, in this instance, although she doubted her own memory and experience, Benita returned to the therapy to validate her confusion and did not entirely accept her mother's destructive projections.

Benita terminated her psychotherapy after leaving the children's home. Over the next few years I received an annual call from Benita informing me of her life circumstances and her whereabouts, but she refused to come in and see me. She would always phone and, without identifying herself, assume that I knew who she was. Fortunately I always did recognise her voice. She had an extremely high

turnover of jobs and relationships. Finally, in her early twenties, Benita called and requested an appointment. Again, she simply assumed that I would still be at the clinic.

Benita walked into my office and resumed her psychotherapy as though there had been no break. She recounted how she had been very promiscuous and that she had now finally settled down. She had married a very stable young man from a 'nice' family and despite loving him very much, she was currently having an affair with a very exciting but irresponsible young man. She knew this was unwise but she could not help herself and anyway, her husband was rather 'boring'. She felt that as I 'knew everything about her' I would be the best person to help her. I suggested that she was re-enacting an internal sense of badness and that she would repeat an experience of rejection with this affair. I also commented on her sense of emptiness and tendency to get bored in relationships and that she was something of an 'intensity junkie', which helped defend against the emotional void. Benita was very taken with the notion of being an 'intensity junkie' and felt that this resonated with her internal experience and her tendency to seek out novelty at the cost of long-term mature relationships. Benita phoned again almost a year later to report that she had left her husband and become pregnant by her then unsuitable lover, who had predictably become 'boring'. She had returned to her husband and was hoping that he would accept the child as his. She wanted me to know that she really was an intensity junkie and that she hoped she would not repeat her own experiences of abandonment and reconnection with her unborn child.

Benita had certainly repeated a pattern of promiscuity in alignment with her mother's rejection of her as a bad object soiled by sex. She also repeated a pattern of rejection and reconnection that was the experience of her childhood. She was able to reflect on her own internal state of emptiness and self-destructiveness, albeit for fleeting moments. Despite not returning to psychotherapy, she continued to use the internalised therapist as her emotional memory and reflective compass at difficult times in her life.

CONCLUDING REMARKS

The four cases presented describe the value of psychoanalytic concepts and ideas in psychoanalytic psychotherapy in the South African context, despite restrictions of time and resources. Each case challenged psychoanalytic

theoretical epistemologies, concepts, practices, cultural belief systems or issues of ethical relativism. It is also clear that the practice of psychoanalytically oriented psychotherapy in the context of disadvantage and limited resources cannot be characterised by rigid theoretical loyalties and that technique, practice and certain conceptualisations often come from epistemologically diverse theories. This is evident in the chapter, with the application of concepts from attachment theory and drive theory, each of which holds contrasting epistemologies of primary motivation. Despite these theoretical contradictions, the 'enigma' of positive effects nevertheless occurred in each case (Green, 2005). Rather than fearing the theoretical differences within the psychoanalytic paradigm, the insights offered by these diverse theories and applications should be embraced and integrated as they ultimately contribute to effective and meaningful psychotherapy outcomes. Technical pluralism need not imply theoretical confusion, as the tension between clinical practice and theoretical purism within the field of psychoanalysis is well recognised.

Finally, a psychoanalytic approach that privileges context and accommodates a diversity of cultural beliefs and practices is necessary for social relevance in the South African context. It is here that the most difficult ontological, epistemological, methodological and moral issues often arise. The very conceptualisation of the self differs within psychoanalytic thinking as a rather egocentric concept when compared to the African concept of self, which is considered communal or collectivist. Working with issues such as agency and boundaries often directly challenges deeply held cultural beliefs and practices. Issues of personal responsibility and the role of defences against painful separation and autonomy assume a different hue in this context. Certain interpretations can therefore be experienced as persecutory and/or alienating. Decisions have to be made to consider neglecting certain themes and defences within psychotherapy, and accepting that such practice of psychodynamic psychotherapy is 'incomplete' when compared to the idealistic practice of classical psychoanalysis. Perhaps we should consider the notion that, rather than being superior to local hybrid applications, Western applications of psychoanalysis may be inappropriate to the South African context (Swartz, 2007). The very notion of 'criticising' parental figures, albeit through the interpretation of internalised fantasy of negative parental objects or actual failed attunements, strikes at the very heart of the required cultural respect for elders and ancestral figures. As most black South Africans adhere to a mix of traditional beliefs, Christian religion and modern healthcare practices, an acceptance of these contradictions to the psychoanalytic frame is essential for the psychotherapist.

Ethical dilemmas are raised when adopting a position of cultural relativism. Cultural practices that include mutilation, subservient roles of women, racism between different ethnic and language groups, prejudice against individuals of homosexual orientation, and punitive practices in child rearing that condone child abuse are difficult to bear in the very personal psychotherapeutic context. Sensitivity and tolerance are not always possible and, in some cases, not desirable or morally defensible. These issues are brought into stark relief when minor children infected with HIV are taken off antiretroviral therapy and treated by traditional healers instead, with certain death as the outcome. While an acceptance of cultural relativism is often encouraged in clinical practice, the bleed into ethical relativism is often difficult to gauge and at times painful to witness. Ironically, while the practice of parcelling out infants to multiple caretakers is often referred to by contemporary parents as part of their 'culture', it is in fact a consequence of the Group Areas Act under apartheid legislation, where mothers working as domestic helpers in 'white' areas were not permitted to keep their infants with them and were forced to send these infants to relatives in the 'homelands'. This practice has become both familiar and normative for many contemporary parents, who unknowingly regard it as a 'cultural' practice worth defending despite its roots in apartheid ideology.

The inherent contradictions in applying psychoanalytic thinking in a context with disparate worldviews, belief systems and understandings of trauma and psychic suffering inevitably lead to psychoanalytic pluralism in practice that is both ontologically and epistemologically diverse. For theoretical purists, this is an unpalatable compromise; for theoretical pluralists, this enriches debate. When practising psychoanalytically oriented psychotherapy in a developing country such as South Africa, it is often assumed that the compromises and adaptations made by psychotherapists are unique to the South African context. It is worth noting that with globalisation, the preference for behaviouristic interventions by managed healthcare, the contemporary expectation for instant results and the exorbitant cost of long-term psychoanalysis have placed the practice of classical analysis in jeopardy even in developed, first world countries (Fonagy, 2006; Jurist, 2010; Kernberg, 2012a, b; Silver, 2003; Stepansky, 2009; Wallerstein, 2005a, 2012). It may be that the future of the practice and training of psychoanalysis depends on its adaptation to a contemporary, digital-age, 21st century society for its survival. The pressure to adapt and seek effective psychoanalytic interventions that are flexible, socially relevant and short term is not only a South African dilemma but a global one as well.

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CHAPTER 5

TRAUMATIC STRESS, INTERNAL AND EXTERNAL: What do psychodynamic perspectives have to contribute?

Gill Eagle

Working in the traumatic stress field for the past 25 years in South Africa as therapist, trainer, clinical supervisor, consultant and researcher – with populations as diverse as rape and torture survivors; political detainees; accident, crime and domestic violence victims; combat veterans; refugees and the traumatically bereaved – I have found it of great value to draw upon aspects of psychodynamic thinking and practice, as will be elaborated in this chapter. During these 25 years the landscape of trauma and trauma intervention has changed markedly. My earliest exposure to trauma intervention was through involvement in the feminist-influenced, rape crisis organisations that grew up around the country in the 1970s. The counselling offered by these organisations was located within a crisis counselling model influenced by insights from feminism about understanding the causes and effects of sexual violence. Later, in the 1980s, like many other

progressive professionals in the country, I became involved in an anti-apartheid group, the Organisation for Appropriate Social Services in South Africa (OASSSA), which aimed to address mental health issues relating to oppression and political repression, including trauma-related issues. Two central projects of OASSSA were, firstly, to offer counselling services to ex-detainees, many of whom had been tortured or abused during their time in detention, and secondly, to run crisis counselling workshops for community groups. The latter often entailed conducting some trauma intervention for the trainees themselves, many of whom had been damaged in a variety of ways within the political system. During this time few of us explicitly understood our work within the framework of traumatic stress, a diagnostic and conceptual category that really only gained purchase in South Africa in the early 1990s, although it is now widely employed by a range of practitioners and theorists across the country. Pioneers of trauma work in South Africa tended to become involved in such work in large part out of a political commitment to victims and survivors, given that traumatised populations often represent groups that have been oppressed in some way. In contemporary South Africa there is a much broader spectrum of people involved in trauma work dealing with a wide range of victims, much of this work being undertaken in workplace employee assistance programmes. The field of traumatic stress studies has grown exponentially internationally over the last two decades and local practitioners have been exposed to a number of different conceptual models for treating and understanding traumatic stress. While there has been training in technique-focused approaches such as Traumatic Incident Reduction (TIR) and Eye Movement Desensitisation and Reprocessing (EMDR) (Kaminer & Eagle, 2010), there has perhaps been less emphasis on the contributions that psychodynamic theory can make to such work, except within specifically psychoanalytic forums. This chapter will elaborate and discuss some of these contributions for a wider audience.

CONTEXTUALISING TRAUMATIC STRESS CONDITIONS IN SOUTH AFRICA

Thinking and writing about traumatic stress in post-apartheid South Africa is a rather daunting task, in large measure because it is difficult to do justice to the range and complexity of issues that might be encompassed under this topic. It seemed to me that it would be important to begin by sketching out some of the

historical and contemporary contexts in order to understand the kinds of traumatic events and experiences that trauma interventionists in South Africa have found/find they were/are required to deal with.

A history of violation

As the introduction to the book discusses, South Africa has been characterised by a violent and oppressive past that saw colonial exploitation extended into the more modern apartheid state in which the vast majority of the population were denied basic human rights on the basis of a complex system of racial categorisation and capitalist relations. In order to maintain this unjust political dispensation, the state employed considerable repressive force of both an ideological and physical/structural nature. The history of conflict between those fighting either to maintain or to overthrow the apartheid state has left its mark in the form of remembered violations such as the detention, torture and assassination of actual and suspected political activists; participation in the military conflicts on the border of the country; and violent confrontations between rival political party members, and between activists and those suspected of collaborating with the government of the time. Many of the gross human rights violations perpetrated prior to 1994 were exposed during the hearings of the national Truth and Reconciliation Commission (TRC, 1998) that took place in the years soon after the African National Congress was elected into power during the first truly democratic elections the country had seen. It was evident during the TRC hearings that the violence committed during the apartheid period had left many traumatised at both individual and collective levels and it was often almost unbearable to come to know and engage with the cruelty and suffering that was laid bare during the hearings. While there has been considerable criticism of the TRC process from a range of different quarters (see for example, Jolly, 2010; Posel, 2006; Van der Walt et al., 2003), it was evident that the spirit within which it was undertaken, under the leadership of Archbishop Desmond Tutu, was designed to bring about some sort of political, spiritual and psychological healing through a process of catharsis, confession, bearing witness and, in many instances, the anticipation of forgiveness and reconciliation (Gobodo-Madikizela, 2008). Individual stories told during the public hearings were intentionally chosen so as to represent collective forms of traumatisation and there was a hope that the unearthing of material that had been denied and repressed at a political level would bring about both relief on the part of victims and their families and remorse on the part of the perpetrators and those who had supported them. Although not overtly couched

in these terms, it could be argued that in addition to serving an overtly political function in relation to justice and retribution, the TRC process was designed to facilitate what broadly might be understood psychodynamically as exploration of that which had been repressed (in many different senses), emotional catharsis, working through, reparation and mourning. Rather than burying the past, it needed to remain active in people's minds if they were to move forward into a new dispensation in a reconciliatory spirit sensitive to past damage and committed to the non-repetition of abuses of power. A powerful strand then in trauma work in South Africa is the ongoing need to hold in mind a past that brutalised many and continues to stimulate resentment, bitterness, guilt and defensiveness despite the TRC hearings, although the TRC may well have served to help many to metabolise some of this traumatic past to a greater or lesser extent.

In addition to the gross human rights violations highlighted by the TRC, it has been observed that apartheid had more pervasive and insidious effects. These included racial segregation, discriminatory laws and practices, forced removals of people, migratory labour, lack of access to schooling and basic services, and the devaluation and humiliation of individuals based on skin colour and racial differentiation (Kometsi, 2008). The Apartheid Archive Project,[1] launched in 2009, aims to document what has been termed the more quotidian or everyday impact of the apartheid system. Based on personal testimonies, the project has begun to explore some of the psychological features of people's lives, related to experiences of racism in particular. For example, researchers have focused on the role of domestic workers and the suffering entailed in separating from their young children in order to maintain employment, on the violations entailed in being ostracised and excluded from public spaces, and on the confusion, shame and anger evoked in witnessing parents demeaned and treated with disrespect and contempt. Beneficiaries and perpetrators of racism have also evinced feelings of alienation, shame and guilt. These historical relations and associated memories also continue to infuse current-day interactions (and perhaps more particularly those of a traumatic nature).

In engaging in trauma-related work in post-apartheid South Africa, it is incumbent upon interventionists to hold this history in mind and to recognise not only the direct intergenerational transmission of traumatic material but also the manner in which violence, suffering and misfortune in the present may carry residues of this collective past. Similar to the manner in which psychodynamic theorists argue for the appreciation of developmental history in understanding the significance of contemporary traumatic events for the individual (Garland,

1998a), so too, in some respects, does the socio-political history of the country colour the interpretation of traumatic events in the present in important ways.

Contemporary social problems contributing to traumatisation

Having pointed to the violence of apartheid both at the level of state repression and everyday practices, and having proposed that the present is still very much influenced by this past, it is also important to outline some of the other more contemporary features of South African society that render large numbers of people vulnerable to traumatic kinds of stresses. Without going into detail about all of these features, it should be noted that statistics demonstrate that motor vehicle accident rates are very high, many of these involving serious injury and loss of life; violence against women and female children is extraordinarily pervasive, with partner abuse widespread and reported rape figures among the highest in the world; and gang violence and homicide among young adult men is also of significant proportions (Kaminer & Eagle, 2010). In the recently conducted South African Stress and Health (SASH) study, researchers found that nearly 75% of interviewees reported having experienced at least one traumatic event in their lifetime (Williams et al., 2007: 850). The study included both direct exposure and exposure related to personal loss and witnessing traumatic events. Both nationally and internationally, life in South Africa has become associated with vulnerability to crime and it has become rare to encounter individuals who have not been either directly or indirectly exposed to some form of crime in their work or home environment, or indeed to multiple such events. In the SASH study it appeared to be the norm rather than the exception for those surveyed to report exposure to more than one traumatic event, with close to 10% of the sample reporting exposure to six or more traumatic events (Williams et al., 2007: 849). As summarised in Altbeker's 2007 review of violent crime, 'South Africa ranks at the very top of the world's league tables for violent crime' (quoted in Kaminer & Eagle, 2010: 13). In the 2007 National Crime Victims Survey, some 22.3% of respondents interviewed (more than one in five individuals) reported direct exposure to crime in the preceding 12 months (Pharoah, 2008: 7). If one considers that the families, acquaintances and work colleagues of this somewhat over 20% of the population may well have also been affected by the survey victim's exposure to a crime, it is apparent that a large proportion of South Africans are likely to carry some awareness of vulnerability to crime and associated affects. South African Police Service statistics for 2009/2010[2] reflect the following patterns per 100 000 of the population: 34.1 murders, 35.3 attempted murders, 416.2 serious

assaults, 138.5 sexual offences, and 129.4 robberies, reflecting disturbingly high levels of interpersonally driven attacks, in addition to burglaries, muggings and thefts. It is also commonly accepted that many crimes go unreported, particularly those of a sexual nature. It cannot be disputed that crime is a serious social problem and it is evident that concerns about vulnerability to crime are pervasive among the South African population, creating a sense of background stress to everyday living. One of the ways in which this manifests is in 'Fear of Crime', 'the emotional response to potential victimization' (Adams & Serpe, 2000: 607), levels of which increased steadily from 1998 to 2008 (Pharoah, 2008). Fear of crime often translates into behavioural and interpersonal constriction (such as fear of travelling outside of one's immediate neighbourhood and fear of strangers). In this respect high levels of crime, and particularly of violent interpersonal crime, have multiple effects beyond those of severely traumatising direct victims. It is also evident that rather than subsiding over time with the introduction of the new political dispensation, crime levels and perceptions of vulnerability to crime have increased, suggesting that many citizens feel uncontained by the present government in this respect, and this contributes to disillusionment, anger, anxiety and fear. The SASH study also confirmed that with exposure to increased numbers of events, there was evidence of increased psychological distress or mental health difficulty as measured by a global distress scale, with 'those with the most traumas (six or more)...5 times more likely to be highly distressed than those with no trauma' (Williams et al., 2007: 853).

A further significant stressor in post-apartheid South Africa is the AIDS epidemic, discussed at some length elsewhere in the book. There has been considerable debate about the links between HIV contraction risk, AIDS and vulnerability to traumatic stress (Nightingale et al., 2010), given that the life threat implied by exposure to the virus is often not immediate and that terminal illness may be staved off by antiretroviral treatment. However, it has been demonstrated in a variety of studies that the diagnosis of life-threatening or terminal illnesses may well lead to traumatic stress-related conditions (Kaminer & Eagle, 2010). AIDS-related deaths are also clearly implicated in traumatic bereavements, often compounded by the stigma and consequent secrecy still attached to the condition. In a study into the mental health of 60 AIDS-orphaned children in Cape Town, it was found that 73% scored above the cut-off point for Post-traumatic Stress Disorder (PTSD) (Barbarin et al., 2001: 22). The researchers speculate that the traumatic stress-related responses may have stemmed not only from the loss related to final death, but also from the horror of witnessing the ongoing deterioration and disability of parents prior to this. Given the prevalence of AIDS in South Africa, it is evident that large numbers of individuals and families have been, and will continue to be, exposed to the ravages of the illnesses associated with compromised immune functioning, and to premature AIDS-related bereavements, often of a multiple nature within extended families. Again, what is evident is a rupture to the social fabric that creates a sense of widespread contamination and the possibility of loss.

A final aspect of South African society that warrants mention in relation to traumatic stress is the influx of many thousands of economic and political migrants, asylum seekers and refugees from other African countries. Among these refugees, a significant proportion has been subject to torture, abuse, imprisonment, genocide, rape, sexual and other assaults, and the destruction of homes and family, implying vulnerability to classic traumatic stress symptoms and conditions. Their trauma-related suffering is further compounded by their displacement and need to expend resources in adjusting to an unfamiliar environment (Grootenhuis, 2007). Beyond these adjustment difficulties, there is also widespread exposure to xenophobia, abuse and exploitation in this current environment, some of which is cynically perpetrated by precisely those entrusted with the welfare of refugees within South African state systems. The possibility of xenophobic violence, which came to a head with the disturbing attacks and murders of 2008, continues to threaten the social fabric and points to ongoing scapegoating and intergroup conflict. Allegations of 'foreigner's' involvement in the commission of crime are often used to justify discrimination, but many attacks on refugees appear to be driven by envy, projection, displacement of aggression, and sadistic exploitation of those who are most vulnerable. The maltreatment of refugees by significant proportions of the population suggests a disquieting underbelly of resentment and intolerance that belies the assertion of values of *ubuntu* and the upholding of human rights and dignity.

PSYCHODYNAMIC CONTRIBUTIONS TO UNDERSTANDING HISTORICAL, COLLECTIVE AND PERVASIVE TRAUMATISATION

It is apparent, then, that people living in South Africa are vulnerable to traumatisation of a variety of kinds, leading to the suggestion that the society as a whole is a damaged and 'traumatised' one, whatever this implies at a psychic and a social level. While there are problems with the direct and sometimes oversimplistic

extrapolation of psychodynamic constructs from the clinical consulting room to social formations, there are ways in which psychodynamic thinking is helpful in attempting to understand some of the likely consequences of the kinds of contextual difficulties outlined thus far. In the first instance, psychodynamic theory allows us to entertain notions of unconscious and preconscious forces at play in psychic functioning. This awareness assists us to appreciate the way in which the interpretation of present events is inevitably shaped by personal and social history. Danieli (1985), Laub (1998) and others have written about how experiences of Holocaust survivors come to be unconsciously represented in the lives of their offspring and even in successive generations, manifesting in dreams, enactments and traumatic repetitions. This intergenerational transmission of traumatic life experiences cannot be explained purely in terms of exposure to the recounting of events or caretaking by 'damaged' parents, but involves the internalisation or even introjection of such content at more primitive, unconscious levels, in part through complicated object relating during early childhood or infancy. There has been considerable speculation that similar unconscious transmission of painful, abject, fearful, paranoid and aggressive states of mind may have taken place across generations in South Africa, although it has proved difficult to research such relations. Perhaps because the atrocities committed by the apartheid state are more recent and exist in living memory for many more people, it is important to entertain the possibility of conscious, preconscious *and* unconscious associations to life under apartheid. The awareness that the past may manifest in the present in unexpected, indirect and unconscious ways may help clinicians to appreciate the affective intensity and traumatic associations that particular events carry for individuals. I would maintain that an awareness of the possible aliveness of this history in the present is potentially invaluable in the knowledge and skills repertoire of post-apartheid trauma practitioners.

Alongside the awareness that current events may be infused with past meanings of particular kinds related to the socio-political history of South Africa, it is also worth bearing in mind the strong pull towards repression and forgetting that psychodynamic theorists have observed as characteristic of responses to traumatic stimuli. Freud and Breuer's early work on hysteria and conversion disorders was predicated on the notion that events experienced as too traumatic to be consciously symbolised became repressed and manifested indirectly in symptom formation. Laub and Auerhahn have written more recently on the relationship between exposure to massive psychic trauma and 'knowing and not knowing', maintaining that it 'is the nature of trauma to elude

our knowledge because of both defence and deficit' (1993: 289). They argue that because knowing trauma can be 'a momentous, threatening, cognitive and affective task', it may be defended against by being rendered unconscious, and that, at the level of deficit, 'trauma also overwhelms and defeats our capacity to organize it' (1993: 289). Trauma-related memories may thus be more or less accessible to consciousness and communication depending upon the nature and severity of the experience, the capacity of the ego to bind anxiety, and the proximity of the individual to the event. Remembering and integrating traumatic contents is dependent upon the capacity to mobilise an 'observing ego' and upon interpersonal (such as in the form of a therapist) and cultural supports. The TRC was designed to produce a context in which those giving testimony were to some extent witnesses to their own histories and were offered both psychological and institutional support, even if this was not always borne out in practice. However, it has been observed that some 10 years on, there has been considerable contestation over the remembering and forgetting of apartheid, with a strong cultural pull towards 'moving on' and 'letting bygones be bygones'. Thus there are ideological forces abetting a form of social repression of this past. Young adult South Africans may well find themselves conflicted in wishing to establish an identity independent of struggle and oppression, yet simultaneously seeking to honour the sacrifices of their parents or, alternatively, to distance themselves from their parents' past collusion with the state. In this respect there is still considerable turmoil at a social and perhaps intrapsychic level as South Africans attempt to integrate the past without becoming overwhelmed or paralysed by this knowledge (Gobodo-Madikizela, 2008).

In addition to helping interventionists to think about the importance of the past in the present, psychodynamic theory also offers some useful ways of thinking about the likely impact of living in a contemporary environment characterised by high levels of crime, loss, risk and danger. In Freud's (1920/1948) seminal paper on many of the mechanisms at play in traumatic stress conditions and responses, 'Beyond the pleasure principle', he makes reference to the fact that trauma, by definition, involves a breach of the psychic boundary or protective shield of the self. In the normal course of events the ego is designed to protect the individual against potential sources of distress.

> In order to deal with aversive stimuli, the psyche, and more particularly the ego, becomes attuned to anxiety provoking cues in the environment, so as to anticipate, and therefore prepare for, exposure to such anxiety. With this

> signal anxiety the psyche protects itself from becoming overwhelmed by anxiety/displeasure by optimizing psychical resources available to deal with stress prior to the encounter. (Eagle & Watts, 2002: 9)

The sudden, overwhelming and transgressive nature of traumatic events is such as to preclude the binding of anxiety, and the individual is left psychologically compromised in various ways, many of these now detailed in the symptom patterns described under the diagnostic categories of Acute Stress Disorder and PTSD (APA, 2000). One of the consequences of direct exposure to trauma is that the distinction between signal and automatic anxiety is lost (Garland, 1998b), rendering trauma survivors vulnerable to constant and powerful anxiety, particularly in situations that bear any resemblance to the traumatic event. In South Africa, with its pervasive risks of traumatisation, it may well be the case that the population in general struggles to realistically appraise threat levels in the environment and that, even if at less intense levels than manifested in direct victims, there is increased anxiety-proneness related to difficulties in appropriately attending to signal anxiety. This may manifest in hyper-vigilance, suspicion in interpersonal interactions, avoidance of certain places and people, and increased irritability and propensity for aggression. When it is apparent that the world may not be a benign, meaningful and predictable place, assumptions argued to be constructive to mental health (Janoff-Bulman cited in Kaminer & Eagle, 2010), it may prove difficult to devote psychic energy to creativity and to constructive loving and working. Awareness of risk may produce both heightened anxiety and a kind of psychic constriction. Kirschner draws upon the work of a range of psychodynamic theorists (including Ferenczi, Klein, Winnicott and Lacan) in proposing that 'every society recognizes the parents' (or surrogates') duty to provide a reliable second skin around the child, a transitional zone in Winnicottian terms, within which the child can safely assimilate the rules of the socius…', and that complementing this is 'an equally vital requirement for a kind of third layer of protection and sustenance of the community's symbolic, linguistic structure, which encompasses systems of meaning, belief and value as they structure basic human interactions' (Kirschner, 1994: 241). Kirschner thus proposes that psychic development is in part dependent upon the maintenance of this third membrane (associated in his writing with Lacan's notion of the symbolic order), which provides a broader kind of containment in which optimal caretaking, object relating and interpersonal interaction can take place. The prevalence of trauma exposure in South Africa, and particularly of exposure

to multiple traumatic events and to events of an apparently gratuitously violent nature, means that it may be difficult for people to feel that this third layer is sufficiently robust or indeed exists at all. At such times South Africans may feel that they are living in a somewhat crazy or chaotic world in which it is difficult to assess what is rational in their own thinking. One manifestation of this absence of a sense of a sound third layer of protection or order appears to be a kind of general low-level lawlessness or tolerance of transgression (such as excessive drinking or speeding while driving) that further contributes to a sense of living in a somewhat precarious society. Kirschner (1994) suggests that the role of the analyst lies in upholding the basic human right of 'access to a symbolic order' that entails not only protection and restoration of 'good objects' at the individual and social levels (both the good maternal object and the good maternal environment), but also resistance to attacks on those aspects of society that promote social cohesion. In this respect it is important that trauma interventionists in South Africa work to actively promote both individual and collective healing, as to some extent each is predicated upon the other. While it was perhaps somewhat easier for mental health workers to assume a complementary political commitment in their work in the anti-apartheid period, it is evident that many contemporary trauma practitioners still demonstrate a strong commitment to the politics of upholding human rights. Thus, for example, post-apartheid trauma interventionists have assisted victim groups to establish self-help groups and to generate self-help projects; have conducted psychosocial interventions with ex-combatants; have documented the torture reported by refugees from particular African countries; and have lobbied the government and business to take victim rights more seriously, among a range of other interventions. I believe that this kind of work is undertaken to contribute to the psychological integrity and sanity of service providers as much as it is to benefit victims. In order to continue to provide containment at a therapeutic level, it is important to have some sense of contributing to a socially cohesive environment.

Having examined some of the contextual features of South African society that have contributed to historical and collective trauma, and also those that account for the high prevalence of direct and indirect exposure to traumatic stressors, the discussion now moves to examine more directly clinical elements of trauma practice in the country. With the background painted, it is now possible to begin to focus on the foreground, in this instance on more individual aspects of trauma impact and treatment as understood psychodynamically.

CLINICAL AND INDIVIDUALLY ORIENTED CONSIDERATIONS IN TRAUMA WORK IN SOUTH AFRICA

This section of the chapter includes discussion of both trauma impact and presentation, and psychotherapy for trauma-related conditions, including some discussion of countertransference and therapist engagement in trauma work. Reading the more recent international literature on traumatic stress as represented in the widely cited *Journal of Traumatic Stress* and the material generated by the International Society of Traumatic Stress Studies and its European and Australasian counterparts, it is evident that psychodynamic approaches to traumatic stress have become somewhat marginalised. In part because of the shift to evidence-based practice and the emphasis on clinical guidelines in offering treatment for mental health conditions, including traumatic stress-related conditions, there has been a shift away from psychodynamically informed approaches in favour of cognitive behavioural therapy (CBT) and protocol- and technique-based approaches. In a recent overview article comparing clinical practice guidelines for the treatment of PTSD and related conditions across North America, Europe and Australia, it is evident that there is consensus that trauma-focused CBT (TFCBT) and EMDR are the psychological treatments of choice (Forbes et al., 2010). While psychodynamic psychotherapy is mentioned in two sets of guidelines, it is given a lower category rating as a desirable treatment for traumatic stress. In addition to difficulties in verifying psychodynamic interventions within the 'best practice' research guidelines of randomised control trials, it is also commonly believed that psychodynamic approaches are necessarily long term and therefore unsuitable for the short- or medium-term therapy interventions generally associated with traumatic stress conditions. The relegation of psychodynamic approaches to the periphery is somewhat surprising given that the majority of the early literature conceptualising traumatic stress impact was written by psychodynamic theorists such as Janet, Freud, Kahn, Lifton and Horowitz. This appears to reflect the orientation towards cost-effective and scientifically proven interventions, as influenced by medical models of practice. Within South Africa, although there are many practitioners who use TFCBT and EMDR in the trauma field, it is evident that psychodynamic ways of thinking and working still enjoy considerable support. The nature of traumatic stress presentations in South Africa, and the fact that many interventions are offered by non-professional counsellors, has meant that therapists have drawn upon a variety of models and approaches, some of them infused with psychodynamic constructs. While

trauma-focused psychodynamic psychotherapy may not be practised with the same rigour or purity of approach as described by Tavistock Trauma Clinic practitioners (Garland, 1998a), it is nevertheless evident that psychodynamic theory occupies a central place in the work of many clinicians and community practitioners (Kaminer & Eagle, 2010). Some of the reasons for this are elaborated in the ensuing discussion.

PSYCHODYNAMIC CONTRIBUTIONS TO FORMULATING THE PSYCHOLOGICAL IMPACT OF TRAUMATIC STRESSORS

It is evident that 'trauma' has been understood relatively broadly within psychodynamic writing. Historically, the term has been used both to refer to developmental shocks and deficits (as in witnessing the primal scene, or experiencing a profound lack of mirroring), as well as to frame what would more commonly be understood by trauma practitioners as constituting a traumatic life stressor, for example exposure to stimuli of a sudden, life-threatening and/or injurious kind. For the purposes of this chapter, psychodynamic theory pertaining only to the latter kind of understanding is discussed. There are at least three theoretical traditions within psychoanalysis that have contributed significantly to the understanding of the impact of trauma of this kind, these being classical, ego-psychological and object relations perspectives, although it should be acknowledged that self and relational theorists have also made more recent useful inputs. As has been noted, Freud (1920/1948) made a seminal contribution to the theorisation of traumatic stress (although he did not explicitly use this terminology), arguing that exposure to catastrophic life events tended to produce some regression in psychic functioning, evidenced in the employment of more primitive defences, cognitive deficits (such as difficulties in symbolisation and articulation), and a propensity to dissociate. In addition, he argued that trauma was often implicated in repetition compulsion of various kinds, such as recurrent nightmares and trauma-related enactments. These ideas continue to remain useful to trauma practitioners and help to explain the sometimes rather dependant presentation of traumatised patients in psychotherapy. It has been widely observed that somatisation is a very common response to trauma among the South African population as a whole, and it is possible to understand this kind of presentation as representing signification of distress in a way that serves to protect the individual from the conscious knowing of the event which threatens to overwhelm psychic structures, in the kind of way suggested

by Freud. In addition, recent neuroscience research confirms that one element of trauma impact is some compromise to verbal expression and symbolisation (Van der Kolk, 2006). When clinicians understand that somatisation may represent a strong defence suggesting the enormity of the underlying distress associated with consciously entertaining traumatic images, this can offer guidance as to how quickly they can work to uncover and process trauma-related memories, as well as to how supportive they may need to be in this kind of work. For example, a woman presented at a township outpatient clinic complaining of chest pains for which no medical cause could be determined. In exploring the onset of her symptoms and her recent life history, she revealed that her husband had been shot in front of her a month previously. In the course of a relatively brief therapy it was possible to draw links between her psychic and physical heart pain and to tie her somatic experience back to the horror and tension she felt at the time of his murder. Working through the psychological impact of the trauma led to an abatement of the chest pains.

Extending on Freud's formulation of an ego that becomes compromised and cannot retain the protective shield against external stimuli, ego-psychologists such as Horowitz (1992) argue that the intrusive force of traumatic experience is such as to destabilise meaning systems and to interfere with the normal integration of experience and laying down of memory traces. Combining insights from cognitive information processing theory and ego-psychology, Horowitz suggests that the manner in which trauma manifests in psychic functioning is in the vacillation between intrusion and avoidance of aversive contents. While the task of the ego is to assimilate and accommodate the new information, this requires engagement with unbearable contents that remained undigested, in the form of sensory associations and fragmented bits of memory that evoke massive anxiety. In consequence, there is a tendency to both behavioural and cognitive avoidance of trauma-related material. In his book *Stress Response Syndromes*, Horowitz (1992) thus anticipated and provided some theoretical rationale for the kind of symptom picture that is understood psychiatrically to be associated with traumatic stress (most notably the cluster B and C sets of symptoms – intrusive and avoidance/numbing respectively) (APA, 2000). I have also found it helpful to hold this model in mind in undertaking trauma work in South Africa, appreciating that the survivor is in some respects trapped in a cycle of avoidance and intrusion that precludes them from doing precisely that which is required in order for traumatic memories to be integrated into narrative or long-term memory. In contexts of multiple or poly-traumatisation and/or where external containment is lacking (as

is frequently the case in South Africa), this kind of psychological vacillation may well be exaggerated or prolonged and again may require careful assessment on the part of the therapist. Part of the therapist's task then is to gauge what 'optimal dosing' (Horowitz, 1992: 125) in respect of engaging with trauma-associated contents might entail for a particular patient, dealing with a particular traumatic event, and in a particular context at a particular time.

From an object relations (as well as a more classical) perspective, it is understood that traumatic events will hold or take on specific meanings based on the way in which current events map back onto earlier developmental difficulties (for example, castration anxieties) and, perhaps even more importantly for such theorists, based on the manner in which parental or caretaker introjects or objects have taken up residence in the psyche. Garland argues that 'there is a way in which a current trauma can link up powerfully with events from the past, through long established internal object relationships' (1998b: 108). This perspective is poignantly illustrated in her discussion of a rape case in which she describes how the introjection of a contemptuous, intellectual and mocking father-part and a 'vulnerable, despised, contaminated female aspect of herself' (Garland, 1998b: 115) appear to be implicated in the experience and processing of the sexual assault. While it may not always be possible to unearth these types of connections in the kinds of brief-term trauma interventions commonly offered in South Africa, it is useful to entertain the notion that traumatic events will hold highly personalised meanings for individuals as well as carry commonly understood associations. It is interesting that in the comprehensive TFCBT' model proposed by Ehlers and Clark (2000), considerable weight is placed upon the attributions that individuals have made in relation to both the circumstances of their traumatisation and the likely consequences this will hold for them in the future. This suggests that they also attach considerable significance to the meaning-making aspect of the trauma response, and that their exploration goes beyond assessing the kinds of trauma-related cognitions that would traditionally be the target of cognitive restructuring. Writing from a self-psychology perspective, and integrating aspects of schema theory, McCann and Pearlman (1990) also propose that an essential element of traumatisation is the rupturing of core schemas, specifically those pertaining to safety, trust, independence, power, self-esteem, intimacy and frame of reference. Although object relations theorists would probably maintain that more individualised depth work is necessary to the uncovering of the manner in which object-relational constellations articulate with traumatic experiences in the present, it is perhaps useful to view these kinds

of approaches to grasping the meaning-related aspects of trauma impact as occurring along a continuum, and to remain alert to the possibility of achieving such insight-oriented connections even in more short-term trauma therapy.

A second strand in object relations theorisation of trauma concerns the association of traumatic experiences with the absence of, or abandonment by, 'good object' (usually maternal object) introjects. The fact that one has been allowed to suffer so terribly suggests the failure and/or impotence of good objects to protect one and this may lead to the sense that such objects have been destroyed or cannot be trusted.

> Trauma disrupts the link between self and empathic other, a link first established by the expectation of mutual responsiveness in the mother-child bond and 'objectified' in the maternal introject. Indeed we...proposed that the essential experience of trauma was the unraveling of the relationship between self and nurturing other, the very fabric of psychic life. (Laub & Auerhahn, 1993: 287)

In a rather poignant case example, a young woman who had been assaulted and raped in a house robbery described how when her brother arrived, having accompanied her through her medical examination, he took her home and placed her in a hot bath, washing her body and her hair as if she were a child. Her recollection of this very maternal form of care was such as to restore a good and containing object introject, and appeared to have aided remarkably in her recovery.

Paralleling Laub and Auerhahn's (1993) understanding, but drawing more explicitly on Bion's understanding of the importance of the containing function of the mother, Garland (1998a) concurs that a further dimension of traumatisation is the experience that the maternal object has failed one. She argues that this inevitably leads to problems in the area of symbolisation, resonating with the ideas of Freud and Horowitz about the negative impact of trauma on cognitive capacities, although understanding that the compromise to thinking stems not so much from regression and ego dysfunction as from the felt absence of a containing other.

> Both the external and internal containers are lost: the world itself has become unpredictable and dangerous, and the dangers are such that one's good internal objects are powerless to prevent the worst from happening. The capacity to symbolize, to use aspects of the actual world to represent internal objects and object relationships for purposes of thinking and understanding, depends upon the proper functioning of an internal container. In a trauma that container is lost; in treatment an attempt is made to restore its function. (Garland, 1998b: 108–109)

This construction of the essence of traumatisation is also helpful to formulating traumatic stress responses in South Africa. In the first place, it is important to acknowledge the possibility, discussed elsewhere in this text, that for many traumatised individuals there may not have been the possibility for adequate attachment and early experiences of maternal/caretaker containment, given deprivation and a variety of stresses on maternal capacity and relating. In such cases, resources to deal with victimisation may be lacking from the outset and one may see a kind of resignation or passivity in the face of traumatisation (or intense anxiety and potential for disintegration). However, even for those who have benefited from good early containment, the experiences consequent upon attack may produce this sense of abandonment by one's good object/s. Many South African trauma victims describe bystander apathy and post-trauma isolation and rejection as a significant aspect of their trauma experience. Not only have they been the target of attack by the direct perpetrators, but those who might have intervened to prevent or assist them have often proved afraid or apathetic, or in some instances overtly exploitative or hostile. I am not sure if this kind of secondary violation is more prevalent in South Africa than in other contexts, but it is certainly not infrequent and may reflect something about a blunting to violence, and a lack of the kind of social cohesion that might allow for collective resistance to violence. There are also instances in which others do intervene in helpful and protective ways (as in the example described above) and in these cases it is less likely that good object introjects become completely unavailable to the psyche. However, in addition to bystander responses, the responses of those entrusted with law enforcement in the country are also implicated in the degree to which victims feel supported or let down by social containers. Again, it is not infrequent for victims to describe secondary victimisation at the hands of police personnel, or to detail incompetence, carelessness or a lack of concern from the criminal justice system. For example, a woman who had been involved in a motor vehicle accident and had been trapped for over an hour described her initial relief at being rescued from the vehicle, but her deep hurt at what she perceived as the deliberately sadistic treatment by a nurse in the emergency room who had put more pressure on her leg as she cried out that it was painful. This failure of an anticipated 'good object'

had stayed with her more vividly in many respects than the actual accident. It is helpful in such instances to recognise that experiences like these may represent not only real but also symbolic failure in the mind of the victim, and to appreciate that the restoration of good object introjects may require considerable effort.

A further area that deserves brief mention in thinking psychodynamically about traumatised populations is that of what has been termed Complex PTSD (Herman, 1992). Although the category has not entered formally into diagnostic classification systems, the notion of Complex PTSD enjoys considerable conceptual and clinical support in trauma studies. Essentially, what is argued is that adaptation to a pathological and dangerous environment over an extended period of time requires the employment of particular defences and coping strategies that may become almost characterological over time. Thus one sees increased dissociation, somatisation, substance abuse, depression and pathological relationship enactment in victims of prolonged, multiple and inescapable abuse. It is apparent that an enormous body of psychoanalytic literature could be usefully drawn upon to appreciate the kinds of psychic structure and relational patterns that such survivors might manifest. Shottenbauer et al. (2008) have argued that psychodynamic approaches to treatment have a particularly meaningful role to play in the treatment of Complex PTSD, in part because other approaches have proved less successful in treating this kind of population. Given the number of people reporting poly- or multiple-event exposure in the country, it is also becoming increasingly common for more of those presenting for treatment at clinics and treatment centres to manifest complex trauma-like symptom patterns, suggesting that psychodynamic approaches might have increasing value in this context.

A final aspect of trauma impact that warrants discussion in terms of psychodynamic contributions to trauma intervention in South Africa is the common development of exaggerated intergroup prejudice, racism and xenophobia in many victims. Although these kinds of attitudinal shifts are common in survivors, this dimension of traumatic stress response has received minimal attention in the international trauma literature. Trauma counsellors and therapists in South Africa have reported that overt and intense prejudice against groups of people associated with the perpetration of violence is the norm rather than the exception (Fletcher, 2008, and Sibisi, 2008, both cited in Kaminer & Eagle, 2010). Such attitudes tend to carry behavioural consequences such as suspicion, avoidance and fearfulness, or the overt expression of aggression towards group members. In Benn's (2007) study into this phenomenon, he proposes that a Kleinian lens is useful in trying to make psychological sense of what are often egodystonic responses for individuals. Based on interviews with victims of violent attack he suggests that the regression associated with traumatisation brings about an increased propensity to operate from paranoid-schizoid states or positioning, leading to increased employment of projection, splitting and projective identification. Within psychoanalysis, racism (and prejudice in general) has been understood by some writers to stem from the need to project disowned or devalued parts of the self into others, as well as the need to protect good object introjects from 'bad objects' by employing processes of splitting and denigration directed at those who are seen as in some way different to oneself (Benn, 2007). It is then not difficult to appreciate how deliberate human-inflicted trauma may bring about a kind of marriage between these two pathological ways of functioning in the victim, leading to the development or exacerbation of particular kinds of social prejudice. Of course, it is important to acknowledge that these kinds of attitudes also often have their origin within historical patterns of relating within a social environment, and that, in this instance, intrapsychically generated conflicts may find expression in pre-existing South African social discourses (such as those holding foreigners responsible for crime or attributing particularly aggressive tendencies to Zulu men).

Recognising that some aspects of impact deserve greater elaboration than is possible within the scope of this chapter, it is important to move on to discuss some of the ways in which psychodynamic thinking has merit in informing trauma interventions and psychotherapy in South Africa.

TRAUMATIC STRESS INTERVENTION AND PSYCHODYNAMIC CONTRIBUTIONS

As discussed earlier, psychodynamic approaches to working with traumatic stress seem to have lost favour internationally, in part because of a lack of empirical evidence and perceptions that such approaches are necessarily long term. However, Shottenbauer et al. (2008) make a case for the value of psychodynamic treatment of PTSD, suggesting that such approaches may be better suited to working with more complex forms of trauma and perhaps with the not insignificant proportion of people who drop out of the protocol-based treatments assessed in randomised control trials. They argue that psychodynamic approaches may produce more lasting psychological shifts beyond symptom reduction, such as improved reflexive functioning and capacity to tolerate future anxiety. They

also discuss two short-term models for working with PTSD. The first, elaborated by Horowitz (1997) and Krupnik (2002), entails a 12-session treatment model that includes three stages: establishing a working alliance and narration of the story; working through; and focusing on trauma-related loss and therapy termination (see Shottenbauer et al., 2008), as well as support and psycho-education.

The second rather similar model proposed by Lindy (1993) also involves three stages. The first stage focuses on developing a working alliance strong enough to allow the patient to shed his or her defences against confronting the feelings and memories associated with the traumatic event. The second stage is characterised by interventions aimed at understanding and working through the defences, feelings and memories associated with a specific traumatic event. This leads to the third stage, during which the patient restructures the memory of the event through a mourning-like process in which the trauma is endowed with a specific place and meaning in the life history of the individual, making for continuity and age-appropriate adaptive functioning (cited in Shottenbauer et al., 2008).

The authors present some evidence in support of the effectiveness of brief-term psychodynamic approaches but suggest the need to develop clearly defined manualised approaches to treatment that can be more easily researched. In addition, they make a strong case for the usefulness of specific aspects of psychodynamic practice in complex trauma work, including the need to work with attachment difficulties and to improve reflective functioning and mentalisation. Also writing about technical considerations in psychotherapy with traumatised patients, Nayar (2008) asserts the importance, firstly, of creating a safe holding environment (understood in Winnicottian terms) in order to create a context for the tolerance of trauma-related affects and memories. Secondly, he asserts the need for the therapist to be flexible in being used by the patient as 'transference object, developmental object and self object' (2008: 51). In Shottenbauer et al. (2008) and Nayar's (2008) papers there is an assumption that psychodynamically oriented trauma work necessarily involves the uncovering and narration of traumatic memories (what in CBT approaches might be understood as involving an element of 'exposure' to such material), and it is apparent that considerable initial work is undertaken to ensure that there is a context in which this can take place. However, it is worth cautioning that there is some room to debate whether in fact it is always therapeutic to work to uncover or recover repressed traumatic material. Writing primarily about those affected by the Holocaust, Rosenblum (2009) makes the argument that in some patients the magnitude of the horror associated with remembering, coupled with patient fragility, may mean that the encouragement

of full telling could produce the risk of psychosis or breakdown. She goes so far as to suggest that in some instances repression, denial and splitting may need to be left unchallenged. McCann and Pearlman (1990) also suggest in their treatment model that in some instances the initial goal of therapy may be to strengthen compromised self-capacities, before any kind of trauma processing is initiated, and note that this may take a considerable period of time. It is interesting that from a different perspective Straker and the Sanctuaries Counselling Team (1987), in writing about the treatment of South African political activists in the context of ongoing risk and compromised safety in the real world, also suggest that the narration of traumatic experience needs to be undertaken with circumspection, focusing more strongly on reflective, less personalised aspects of the trauma experience rather than primarily on somatic and affective contents. While it is generally accepted that trauma cannot be fully processed without retrieval of memory contents into the present, it is important to assess the capacity of the individual to engage in such a process, both from the perspective of internal resources and from the perspective of external safety and freedom from potential harm.

A further debate in psychodynamically oriented trauma work concerns the role of interpretation, both of unconscious conflicts and of transference material. In some psychoanalytic writing about trauma there has been an inference that individuals may in some way invite traumatic events so as to establish a mechanism for representing pathological intrapsychic constellations, lending to the possibility of over-interpretation and a kind of victim blaming. In a previous paper, 'When objects attack in reality' (Eagle & Watts, 2002), Dr Jacki Watts and I aimed to contest this framing of trauma exposure within some psychoanalytic writings, asserting that while it might be important to explore what meanings individuals attach to such events, it is not necessarily helpful to insist that trauma responses can *only* and exclusively be understood in light of personal history and pre-existing intrapsychic conflicts and vulnerability. In keeping with Laub and Auerhahn, I would continue to maintain that modes of interpretation designed to unravel 'the manner in which a concern with external reality can serve as a defence against unconscious conflict' (1993: 300) are generally not appropriate in trauma work and may in fact produce iatrogenic effects, as they have suggested. 'Such a hermeneutic approach is effective when applied to non-victims, but disastrous with victims who can neither use their trauma defensively nor playfully, and experience such analysis of their reality as a conceptualization of all reality as fantasy and, hence, entrapment in the symptomatic level of knowing' (Laub & Auerhahn, 1993: 300). Without dismissing the importance

of the personal interpretive lens that the survivor brings to bear on their experience, it is important to take account of the features of external reality, such as the characteristics of the actual event and social constructions of particular kinds of victimisation, that play an equally significant role in the trauma response. A delicate balance needs to be struck between the emphasis on the internal and the external and their interrelationship in trauma work. Similarly, although it is important to pay attention to transference dynamics in working with trauma survivors, it is often useful or even necessary to allow for the development of positive or even idealised transference responses since these tend to allow for the reintrojection or bolstering of good object introjects. This is part of what is entailed in establishing the strong working alliance referred to in the brief-term psychodynamic approaches above. It is also not generally advised to make transference interpretations in this kind of work as this is often likely to take the therapy in a different direction and may well be experienced as confusing rather than helpful by traumatised patients. However, this having been said, it is useful to bear in mind, as suggested by Herman (1992) and others (Wilson & Lindy, 1999), that in trauma work the therapist may not always automatically occupy the place of benign, validating, concerned or nurturing object in the mind of the patient, but may in fact be perceived in many guises, including that of violator or perpetrator, that of bystander, and that of powerful, undamaged object of envy. Such insights into the therapeutic process may be of use to the therapist without necessarily having to be shared within the therapy room, unless they represent insurmountable obstacles to therapy progress.

Among clinicians and counsellors working with traumatic stress in post-apartheid South Africa, there is little consensus about optimal therapeutic approaches and much of the research that has been conducted into local interventions has been case-study based (Edwards, 2005). It is evident that for most of those clinicians who have been trained within a general psychodynamic framework, their work with traumatised populations is broadly informed by this theoretical perspective. It is less evident that the kinds of short-term psychodynamic approaches described by Shottenbauer et al. (2008) are employed in a systematic way by South African practitioners, although they may well understand their interventions to include the establishment of a good working alliance, the processing of traumatic memories and the elaboration of the meanings attached to this, and some exploration of the perceived future consequences of having experienced the event/s. A model that is fairly widely employed by South African trauma therapists is the Wits Trauma Model, understood to represent

an integrative approach to working with traumatic stress, drawing upon both psychodynamic and cognitive behavioural principles (Eagle, 2000). The components of the model are: telling the story, normalising symptoms, working with self-blame or survivor guilt (restoring self-respect), enhancing mastery (including the accessing of social support), and facilitating meaning (Eagle, 2000). For the purposes of this chapter, those aspects of the model that are of most interest from a psychodynamic point of view will be elaborated.

In the first instance, as noted, almost all trauma work involves the retrieval, rehearsal and processing of the traumatic experience, usually through the victim/survivor's face-to-face narration of the experience, although writing, acting, drawing and other forms of artistic expression have also been used to access and symbolise traumatic material. In the case of the Wits Trauma Model, the element of telling and retelling is viewed as importantly undertaken in a relational context. Thus, unlike some TFCBT models in which exposure to the traumatic stimuli is viewed as significant in and of itself, in psychodynamically informed approaches it is the witnessing of the experience and the psychological accompaniment of the victim through the experience that is every bit as, if not more, significant. I cannot emphasise enough the degree to which this understanding of one's role and function as a trauma therapist is core to the process of healing. Undertaking this kind of witnessing and deep empathic engagement with traumatic experiences can be enormously emotionally taxing. I still hold in my mind the extended narrative of a patient who described the loss of his wife in a car hijacking from the point of receiving the telephone call to tell him that she had been shot, to sitting with her while paramedics tried unsuccessfully to revive her, to having to identify her body in the mortuary. Each part of the narrative was described in great personal detail, including, for example, his impulse to clean away the smudged mascara from under his dead wife's eyes.[3] There is something profoundly moving about this aspect of trauma work and I have sometimes experienced deep therapeutic engagement during retelling to be akin to a kind of maternal reverie. While this holding function of the mother is generally understood to be important in various ways in the course of normal child development (including in the development of a sense of a cohesive self), it may also be important to the process of beginning to gather oneself together as the (survivor) narrator of an enormously damaging or psychically taxing event in which one is a central actor. The narration in the presence of another who provides both a holding and a containing function allows the patient to regain a sense of 'ongoing being', including that of an identity continuous with their

pre-trauma self, as well as to begin to process unbearable fantasies, thoughts and affects. In respect of the latter, it may well be that the therapist has to be open to projective identifications that initially allow the victim to void themselves of the worst aspects of the experience by projecting them into the therapist or by stimulating fantasies in the therapist that represent a kind of identification with their traumatised being. Given the nature of trauma, this may well mean tolerating powerful feelings of helplessness, impotence, despair, fear, anxiety, terror, anger, aggression, guilt, humiliation, shame, disgust and horror. Although these form part of the emotional repertoire of all human beings, such affects are not easy to bear and manage, as written about ubiquitously in the psychoanalytic literature. The therapist needs to find an optimal balance in retaining good-enough ego boundaries so as neither to over-identify nor to emotionally distance from the patient (Wilson & Lindy, 1999), while at the same time remaining sufficiently open or permeable to the patient's conscious and unconscious communications so as to be felt to be willing to 'bear' the experience together with the patient. Rosenblum, referring to Laub's work, suggests that the analyst may play three kinds of interrelated roles in this respect, those of 'the authenticating witness, the sanctuary provider, and the experience-sharing companion' (2009: 1335), and quotes Laub as writing that the therapeutic listener 'shares the journey into the eye of the hurricane' (2009: 1335). Although therapists and counsellors employing the Wits Trauma Model may not always be trained to draw upon such deeper psychodynamic levels of understanding about what listening to the telling of the trauma might be about, it is important that they nevertheless understand their role to be a receptive and active one in the sense of psychologically accompanying the traumatised individual through their remembered experience. Going back to psychodynamic understandings of trauma impact, it is apparent that this aspect of intervention is designed to rebuild the sense of available and accessible good object introjects that are willing to help bear the experience retrospectively, even if they could not prevent it happening in the first instance. Since trauma involves considerable re-experiencing, representing the reliving of past experience in the present, being available to the patient at these times as a sharing, reparative or protective good object is not insignificant. In the role of 'authenticating witness' it is also apparent that the therapist assists with reality testing and potentially with the restoration of the third, symbolic register of meaning. From a more classical psychodynamic perspective it can also be argued that the detailed narration of the events, together with accompanying sensations, affects and fantasies, allows for some catharsis or expression of inhibited affects and anxieties, and also helps

to restore cognitive coherence through the sequential and careful recounting of what took place and associations to various elements of the event. Although I have chosen to focus on interventions with adult survivors, it is also worth noting that psychodynamically informed play therapy for traumatised children entails many of the same processes, including psychological accompaniment, assistance in symbolising the experience, opportunities for emotional catharsis and attention to fantasies associated with the trauma and its impact.

The second feature of the Wits Trauma Model that is heavily influenced by psychodynamic understandings is that of 'meaning making' (linked also in some instances to addressing self-blame and threats to self-respect). A real strength of psychodynamic approaches is their attention to the ideographic meanings that people attach to experience, the way in which this reflects their inner worlds and how these map onto the external environment (although, as discussed above, interpretation of these relationships needs to be undertaken with some circumspection). The psychodynamic formulation of trauma-related responses assumes the importance of exploring the particular meaning that each individual attaches to the traumatic event. Although this kind of exploration is generally associated with longer-term work, it is possible to achieve aspects of this even in short-term trauma interventions. By listening carefully to the manner in which patients talk about the traumatic event and its impact, including the kinds of words and language employed, evidence of strong affect, repetition of material, and apparent avoidance of key issues, among other aspects, it may be possible to tap into core meaning-related issues. In Ehlers and Clark's (2000) comprehensive TFCBT model, they talk about working with trauma 'hotspots', usually those aspects of the traumatic event discussed with most intensity in the session. It is possible that these hotspots represent those aspects of the event that carry most weight or currency for the individual in terms of the meaning the trauma has come to assume for them. Also, in the assessment phase of EMDR treatment, a key element is the identification of the core 'negative cognitions' associated with the event. Although these latter two approaches may approach the notion of meaning making at a more conscious level than that pursued in more psychodynamically oriented treatment, it is evident that an important part of trauma intervention is to uncover and identify the specific ways in which patients have made sense of their victimisation. In some cases, meanings may be more event driven (as in taking on board the idea that 'these people really intend to hurt or even kill me'), and in others more personally driven (as in 'my father has always doubted my competence and now I have confirmed this by losing his money in succumbing

to this armed robbery'). In addition, making sense of human-inflicted trauma often involves an attempt to understand the perpetrators' motives and the selection of oneself as victim. Psychodynamic theory allows us to appreciate that these kinds of interpretations may involve processes of projection and of identification and disidentification. For example, victims may struggle to resist the abjection inflicted upon them by attackers and may internalise feelings of self-disgust (as is common in rape survivors) or, alternatively, identify with the powerful aggressor position by indulging in violent revenge fantasies (as is more common in masculine-identified victims). It is also important to explore how cultural attributions for misfortune (Eagle, 2005) might shape personal meaning making. For example, more traditional African people may view falling victim to traumatic events as an indication that they have alienated their ancestors or have become the target of bewitchment (Eagle, 2005). Again, psychodynamic ways of thinking allow one to explore how there may be an articulation between personal history, prior personality functioning, the characteristics of the traumatic event, and the social and cultural frameworks within which these events may be commonly understood. Psychodynamic approaches allow interventionists to be sensitive to cultural difference, and to appreciate the many features of both the internal and external world that come to shape the patient's interpretation of the event. Wherever possible, even in short-term trauma work, it is useful to identify and point out the kinds of interpretive links that the trauma appears to have evoked, and to spend some time exploring how this impacts upon the ability to integrate and live with the implications of traumatisation.

Accompanying the client through the traumatic retelling and exploring the meaning-related associations to the event can be taxing to trauma therapists. Providing the sense of a safe, supportive, containing and holding environment during the course of therapy may be particularly difficult when therapists themselves are subject to the same kinds of risks and frustrations as their clients. As will be evident from the introduction to the chapter, therapists in South Africa are very likely to have been either directly or indirectly affected by traumatic events in their personal lives and may struggle with issues of over-identification and vicarious traumatisation. Although this is an element of trauma work that deserves deeper exploration, suffice it to say that an awareness of countertransference and its multiple vectors as well as its place in psychotherapy, may go some way towards helping psychodynamically oriented therapists to be open to exploring the difficulties posed in undertaking such work without shame. Psychodynamically influenced supervision may be invaluable in assisting to identify and usefully employ such countertransference-generated insights.

In conclusion, it is hoped that this discussion of how psychodynamic thinking may be important to understanding both collective and individual aspects of traumatic stress has allowed for a greater appreciation of the value of this kind of theorisation in working in the context of post-apartheid South Africa. As a final note, I emphasise that while the discussion of traumatic stress inevitably involves a focus on the disabling and damaging aspects of such experiences, there is also an increasing interest in the traumatic stress literature in the phenomenon of post-traumatic growth (Tedeschi & Calhoun, 2004). It has been suggested that it is only in transcending experiences of damage and loss that human beings can develop a true sense of resilience and hope. This way of thinking resonates with some notion of what is achieved in the resolution of the depressive position as understood by Klein. Coming to terms with trauma may indeed offer an archetypical opportunity to recognise the interrelationship between good and bad objects and the necessity for repair and restoration in response to psychic damage (even if in this case one experiences oneself as the one transgressed against rather than the transgressor). However, post-traumatic growth is not an automatic outcome of trauma events and should not be assumed to be a necessary goal of therapy or a sign of patient health. Trauma workers perhaps need to hold tenaciously to the good objects in their own internal worlds, and to cherish those aspects of the social that offer them a sense of cohesion and connection, if they are to sustain themselves in conducting such work in the multifaceted context of post-apartheid South Africa, and may find it helpful to be open to vicarious growth opportunities as well as the demands of such practice.

NOTES

1 See www.apartheidarchivesproject.co.za.
2 See http://www.issafrica.org/crimehub/uploads/3_crime_situation.pdf.
3 Some details have been altered to protect confidentiality.

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