
**A PSYCHODYNAMIC UNDERSTANDING OF
TRAUMA
AND ADOLESCENCE**

A CASE STUDY EXPLORATION

BY JODIE L. MACKAY, B.A. HONS

**A dissertation submitted in partial fulfillment of the requirements
for the degree of Master of Arts in Clinical Psychology**

University of Cape Town

September, 2001

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ACKNOWLEDGEMENTS

I would like to thank the following people for their support:

Kerry Gibson, who supervised my thesis, rendering invaluable suggestions and encouragement, and to whom I owe my interest and enjoyment of psychodynamic theory.

Jenny Twiggs and Andrea Hay, who supervised the work with my adolescent client and gently facilitated my understanding of clinical practice.

Edward West, who upheld me in so many ways, for love and painstaking editorial assistance.

Horace Briel, for insightful comments and humour.

Ilse Ahrends, for patient assistance in the library.

Esther Price, for special friendship and encouragement.

My Mother, Yoshi and Niki, without whom none of this would have been possible.

Noleen Seris, for being with me every step of the way.

Finally, I owe a debt of gratitude to Leila and her family, for sharing their experience and offering me such fertile ground for learning.

ABSTRACT

This dissertation explores the unique ways in which trauma affects adolescents as opposed to children and/or adults. This is an area of research that has not received sufficient attention. The various approaches in defining the concept of trauma are outlined. Developmental challenges and difficulties regarding the period of adolescence are discussed. Emphasis is placed on particular vulnerabilities evoked during adolescence and the importance of looking at a case in its developmental and environmental context. The impact of the environment, which forms the backdrop to the study, is addressed with reference to the South African context. It is observed how trauma and underlying conflicts augment stress already present in adolescence and complicate successful resolution of developmental tasks, such as autonomy in late adolescence.

The research takes the form of a case study of an adolescent girl, who experienced a traumatic assault when she was already struggling with the demands of an unplanned pregnancy. The study illustrates the manifestations in late adolescence of the adverse effects of violence-induced trauma as well as the impact of secondary trauma on the family. The adolescent was seen in the context of exploratory family therapy, which was conducted weekly for 8 months. This offered an opportunity to gain insight into the ways she presented symptoms of trauma to other family members. In this respect a psychodynamic approach is shown as a useful way to explore the emotional features after trauma, such as loss, guilt and difficulties with trust, intimacy and safety. This approach highlights the subjective experience of unexpected violence-induced trauma that overwhelms the ego and produces a state of helplessness. Psychodynamic phenomena, such as regression, defenses and the inner world of the adolescent are discussed in relation to trauma and provides the context in which the meaning of trauma can be understood.

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CHAPTER 1: INTRODUCTION

One of the biggest problems facing South Africans today is the extent of past political violence as well as current levels of domestic and criminal violence (Hamber, 2000). In particular, children and adolescents are an important group of victims for whom there are as yet few services available (Smith & Holford, 1993). Smith and Holford state that for many children and adolescents, acute episodes of violence are experienced in the context of multiple traumatic events and adverse factors that have undermined their development from early on. As some researchers have argued, violence has become “normalised” in that it is a part of their daily lives. In this context the likelihood of being exposed to one or even several experiences of violence, is very high. According to Haggard (1974), if these stressful experiences become too intense and/or prolonged enough, trauma, which indicates a functional breakdown of the psychic system, will result.

Attempts to understand adolescence have acknowledged that it is generally a stressful time, but it has also become increasingly clear that there are additional external sources of trauma which adolescents are being subjected to in South Africa. According to Rosenthal (2000), attempts to account for psychological stress among adolescents have to include exposure to community violence, because many South African children and adolescents present with trauma as a direct consequence of violence. Examples of community violence include assault, threat of rape, and violence around gangsterism and the pavement drug-trade. Rosenthal (2000) postulates that because of developmental changes that occur in the adolescents’ psychology, they may suffer more serious emotional consequences as a result of exposure to community violence, compared to children or adults.

Violence is a major public health problem, not only in South Africa but also in many other countries. Whatever the exact constellation of causes, there is general acceptance among mental health professionals that there has been a worldwide increase in public violence (Garbarino, 1999; Sugar, 1999). In this context trauma has been found to be particularly distressing in human-induced victimisations, as opposed to

traumatic events of “natural” origin (Eagle & Watts, 2000). The human desire to maintain a sense of invulnerability is increasingly at risk and people can no longer perceive themselves as safe and secure in their own environment. According to Herman (1992), traumatic events shatter the sense of connection between individual and community, creating a crisis of faith. She believes it is this breach of trust that gives trauma its intense emotional power. A growing awareness of this and the impact of violence has led to more interest among researchers and therapists in understanding the psychological effects of traumatic events in the lives of adolescents (Herman, 1992; Pynoos & Nader, 1993; Sugar, 1999; Van der Kolk, 1996).

It has been shown that violence creates trauma, and trauma disrupts lives, affects relationships and, in the case of adolescents, may compromise development. Honig, Grace, Lindy, Newman, and Titchener (1999) find the long-term effects of a traumatic event often take the shape of persistent character traits, which may have originated as coping responses to a trauma. There is the further importance of the conditions in community living in South Africa as a contributory factor in violence-related trauma. Intervention based on thorough knowledge of adolescents in their environment provides the opportunity to change a risky life course that has additionally been adversely affected by a traumatic event.

1.1 Aims and Rationale

Statistics suggest the extent of the danger of urban violence that confront teenagers on a regular basis, but do not tell us about the complexity of the experiences of those who face it and how this subsequently affects their lives and relationships. The purpose of this study is to evaluate the effects of a traumatic event on an adolescent’s development, system of relationships and internal world. The symptomology of trauma as experienced by the adolescent will be explored within the context of psychodynamic psychotherapy.

I have chosen a clinical case study to illustrate the struggle of an adolescent in response to violence-induced trauma, an area in which there are gaps in the existing research. During the course of a therapeutic relationship with my adolescent client, I was able to

develop a practical understanding of the developmental nature of the problem. In particular I was interested in exploring the way in which the age and developmental level of the child or adolescent interacts with the impact of the event and the specific trauma symptoms. Research has indicated that in addition to disorganising the apparatus of the psyche, trauma also compromises development in adolescence (Pynoos, Steinberg, & Goenjian, 1996) with more dramatic effects than in other age groups. By incorporating knowledge from the rapidly expanding field of developmental psychology, understanding of the developmental impact of traumatic stress can be enriched.

A case study such as this is useful when exploring an individual's subjective experience, as it provides depth by highlighting the complexity of the interaction of various factors related to the traumatic incident. The traumatic incident that forms the foundation of this study was a particularly violent one that brought the reality of certain issues in trauma work sharply into focus. According to Stake (1995), it is more useful to choose a case most likely to enhance our understanding than to pick one of the more typical case studies. In fact, he states that atypical cases can contribute to our understanding of other cases as it helps illustrate matters occasionally overlooked in more typical cases. Generally he argues that extremity in any form may help highlight and illustrate patterns in literature and therapy more clearly.

Sugar (1999, p. 173) states that in North America the "experience of community violence takes place within a larger context of risk for many children." He explains that the constellation of risk, for example: poverty, parental depression or substance abuse and lack of education or employment prospects, by itself creates enormous challenges for young people. This scenario is also observed in South Africa, where it is common for trauma to take place in an even greater context of risk (Smith & Holford, 1993). However in this case study the trauma was brought on by a single atypical incident, which, while not entirely representative of the context of risk, does allow the focus to be on the effects of extreme trauma on an otherwise seemingly fairly well-adjusted young woman in her late adolescence. This type of single-incident trauma should be differentiated from multiple traumatic events, which have a history of ongoing exposure

to traumatic and chronic stressors (Terr as cited in Yule, Perrin & Smith, 1999). In the context of a violent community however, even a single traumatic incident may complicate full developmental recovery, because of the ongoing exposure to a climate of violence. An awareness of the effects of environmental stressors that affect adolescents is critical to addressing the needs of traumatised adolescents and their families.

I based the case study on my own understanding of therapy I conducted with an adolescent girl who had experienced the stress of an unwanted pregnancy and had subsequently been violently assaulted. It is her response to the assault that is the primary focus in this study. Therapy continued for a period of 8 months, and as trauma therapy is usually of a briefer duration (Kaplan & Sadock, 1998; Pynoos & Nader, 1993) this was a rare opportunity to observe some of the effects of trauma exposure in great detail. In addition, dealing with the after-effects of trauma often falls to the people who care for the adolescent, who may themselves also be traumatised by their exposure to the emotional and/or physical results of the incident. In my intervention, family therapy was undertaken for the entire period, offering the opportunity to observe how the entire family was vicariously affected. According to J. Cohen (1998) helping parents resolve their own emotional distress related to the trauma (to which they have had either direct or vicarious exposure) can help them be more perceptive of and responsive to the adolescent's emotional needs.

This study also attempts to address some of the limitations in the existing studies on trauma and adolescence. An overview of the literature presents many problem areas; for example, although there has been progress in documenting the phenomenology of adult and childhood trauma, there has been relatively less in the understanding of adolescent trauma. Within developmental psychopathology, adolescents have received much less attention than children (Kazdin, 1993). Early, middle and late adolescence are not differentiated in studies and yet this differentiation is important because late adolescence appears to be the most vulnerable age in terms of exposure to crime and violence (Rosenthal, 2000). In sum, violence-related trauma in adolescence certainly deserves more attention.

There are many other problems in the literature of this study that remain significant for further research in the area of trauma and adolescence. Some examples are the following: many studies do not differentiate adolescents from younger children (Boney-McCoy & Finkelhor, 1995); in literature on trauma and adolescence, several studies combine domestic, community and sexual violence into a single exposure to violence index (Berton & Stabb, 1996; Singer, Anglin, Song & Lunghofer, 1995) (as cited in Rosenthal, 2000); most examine only a single type of psychological symptom, such as depression (Fitzpatrick, 1993; Schab-Stone, 1995) (as cited in Rosenthal, 2000). This can be problematic as adolescents may present with symptoms not included in the diagnostic criteria, which would then get overlooked during intervention. It appears that the link between violence-related trauma and how it affects adolescents in particular has not been adequately addressed in the literature.

One of the reasons for paucity of research is that adolescence has been viewed as a transitional phase between childhood and adulthood rather than as a period of interest in its own right (Kazdin, 1993). As a transitional period, emotional and behavioural problems are also considered to be stage and age specific and hence likely to pass with time. Kazdin states that the primary focus of trauma research has been on adulthood, when development is seen as relatively stable; or childhood, when the roots of adult adjustment have been planted. These beliefs need to be re-examined in view of the prevalence of violence-related trauma in late adolescence.

There are many theoretical approaches within discipline of psychology, but some devote even less attention to adolescence than others. Psychodynamic theory has, for example, made instructive roads into early childhood, but has not been as focused on adolescence (Adelson & Doehrman, 1980). Adelson and Doehrman state when the focus of research has been on adolescence, there has been more emphasis on instincts and attachments than on emotions intensely felt during this period. They refer (p. 99) to an oft-quoted statement made by Anna Freud almost two decades ago in which she termed the study of adolescence in psychoanalytic theory a "stepchild". Since that time the extent of neglect

is no longer quite so considerable; there has been a modest, but steady increase in the number of papers devoted to adolescence.

This study will attempt to address some of these issues by focusing on the way trauma affects a young woman in late adolescence. It draws on psychodynamic literature to make sense of the experience and some unique features of the case itself. In this manner the usefulness of a psychodynamically informed perspective in the understanding of how trauma affects adolescents in the South African context, is revealed.

The structure of the dissertation is as follows: **Chapter 2** looks at the prevalence of violence in South Africa and the epidemiology of posttraumatic stress reactions. It provides a theoretical discussion on the explanatory models of trauma, which include psychiatric, cognitive-behavioural, psychodynamic and developmental perspectives. The emphasis is on the psychodynamic perspective. Thereafter adolescence is defined, taking a look at the specific challenges that they face in the South African context. An attempt is then made to understand the ways in which trauma specifically affects adolescence. ✓
Chapter 3 reviews the qualitative case study methodology with reference to a psychodynamic approach. Relevant information regarding the structure of the case is set out. **Chapter 4** provides a case analysis that illustrates certain theoretical concepts from the literature review. Relevant background information, a description of the family, personal relationships and the intervention is discussed to familiarise the reader with the information necessary for an understanding of the case. A discussion of the case material follows wherein I share my thoughts on the way trauma was experienced using didactic themes. Finally, **Chapter 5** offers a conclusion that draws together the key areas covered in this work.

CHAPTER 2: THEORETICAL DISCUSSION

2.1.1. The prevalence of violence in South-Africa

South Africa has often been referred to as a country where there is a “culture of violence” which accepts violence as a legitimate means to resolve problems (Vogelman & Simpson as cited in Hamber, 2000). Violent crime in South Africa has multiple causal factors in addition to social inequality and deprivation caused by the past apartheid regime. These factors include: a patriarchal society; the historical development of a culture of violence seen by politicians as a legitimate means to achieve their goals; an ineffective justice system and the subsequent perception that there will be no serious consequences for criminal activity (Simpson as cited in Hamber, 2000). The complexity of the nature of violence and crime was acknowledged by the First Regional African Safe Communities Conference Resolution (2001, p.16), which states that “violence does not refer to a single phenomenon but to different and complex determinants requiring multiple strategies in order to understand and address them effectively.”

Statistics published in the Sunday Independent (2001, June, 10) show increased levels of crime from 1994 to the present. In South Africa there are about 23 800 murders a year. There has been a dramatic increase in rape, assault and violent robbery. Almost a third of victims of violent crime are aged between 16 and 25 years; it is reported that 60% of assault victims knew the perpetrators. The article refers to a survey by the Centre for Statistical Studies which states that the risk of becoming a victim of crime has increased over the past year by 17% in Cape Town, while it still remains 25% higher in Johannesburg than in any other city in South Africa. This implies that the experience of being violently victimised has become a normal feature of everyday life in South Africa.

According to Hamber (2000), having to cope with poverty is an indicator of greater exposure to community violence in South Africa. This is in line with increasing international evidence that poor people bear most of the brunt of violence in society. According to the Draft Resolution of the 9th International Conference on Safe Communities (2001), violence, whether inter-personal, domestic, institutional or political,

affects the unempowered sections of society disproportionately. Osofsky (1997) states that many adolescents who were exposed early in their lives to much violence, disorganised families, poor education and limited opportunities, become delinquent and later develop into criminals. Hamber (2000) continues this line of thought by stating that if ignored, certain victims of past violence are at risk of becoming the perpetrators of retributive violence or displaced social and domestic violence.

Historically, literature on violence-related trauma in South Africa has focused primarily on type 1 trauma, that is, trauma that results from an “unanticipated single event.” There is a distinction between this type of trauma and type 2 trauma, which results from long-standing exposure to an event, or multiple events (Terr as cited in Smith & Holford, 1993). In the South African context recognition that the term Post Traumatic Stress Disorder (PTSD) is a misnomer has been suggested because of the continuous traumatic stress often present (Smith & Holford, 1993). Various studies augment this line of thinking. Peltzer’s (1999) study on rural children and adolescents from age 6-16 years, found that 67% had directly or vicariously experienced a traumatic event and another 28% had suffered a bad experience. In a community study in Khayelitsha (a township area outside Cape Town) among children and adolescents, it was found that all subjects reported indirect exposure to violence (Ensink, Robertson, Zissis, & Leger, 1997). A recent school survey in the Western Cape (Seedat, Van Nood, Vythilingum, Stein, & Kammer, 2000) found that adolescents reported an average of three and a half childhood traumatic experiences and 12.1% of them met the clinical criteria for PTSD. A significant correlation between multiple traumas and PTSD symptoms was also found. Studies have also shown that it is not only the direct survivors of traumatic events who may suffer from PTSD or related symptoms, but that witnesses, observers and those close to victims may also be affected. Blumberg (2000) and Friedman (1999) conducted studies at the University of the Witwatersrand which showed that while the symptom profiles of those individuals were less severe than directly traumatised subjects, they were also adversely affected (as cited in Eagle & Watts, 2000). Eagle and Watts (2000) state that while it is difficult to assess, popular discourse would suggest that traumatisation of the South African population extends even beyond indirect exposure

through affiliation to trauma survivors. It is also apparent in people's responses to publicized events such as the past Truth and Reconciliation Hearings and media coverage of disturbing crimes.

The potential seriousness of traumas documented by these studies underscores the need to examine their effects during the critical developmental period of adolescence. According to the Sunday Independent (June, 2001, p. 9), young people are disproportionately likely to become victims of crime: "their lifestyle, and the fact that they are less risk averse than older people, place them at higher-than-average risk of being victimised by criminals, especially in respect of violent crime." Although some adolescents who experience violence may come to terms with or overcome the experience, many others suffer considerable damage. Osofsky (1997), who writes on violent communities in the United States, reports that some adolescents who have been victims of violence-induced trauma appear to give up hope, expecting that they may not live through adolescence or early adulthood. Others may be deadened to feelings and pain, with resultant constrictions in emotional development.

It is clear that exposure to community violence is commonplace in South Africa, which suggests that high levels of post traumatic stress are likely to be reflected in clinical settings. The need for ongoing support services for adolescents exposed to violence therefore remains a national priority.

2.1.2. Epidemiology of post traumatic stress reactions

This section covers some of the background in research on trauma and post traumatic stress with particular emphasis on adolescence.

Recent research on trauma has placed greater emphasis on an individual's subjective response to trauma than on the severity of the stressor itself (Kaplan & Sadock, 1998). As a result, the growing consensus is that the experience of trauma has a great deal to do with the stressors's subjective meaning. For instance, Rubin (1999) stated that the extent of trauma-induced helplessness can only be assessed through understanding the

individual's inner experience. Furthermore, the nature of the stressor is being discussed more and more as one in which the "victim" felt that his or her life was under threat or in which such a threat was perceived in relation to a loved one (Yule et al., 1999). Kaplan and Sadock (1998) state this is different from earlier formulations in which the stressor was seen as one that would cause significant distress in relation to almost anyone.

There have been a number of different studies of adolescents' age and gender as predictors of post traumatic stress. In a study of older adolescents in South Africa by Seedat et al. (2000), females reported more traumatic events than males, and approximately 3% of females versus 1% of males satisfied criteria for the clinical diagnosis of Post Traumatic Stress Disorder (PTSD), as conceptualised within a psychiatric framework of reference. Giaconia, Reinherz, Silverman, Pakiz, Frost, and Cohen (1999) found that males and females were equally likely to experience the effects of trauma; however, females were six times more likely to develop subsequent PTSD. They felt this was consistent with the male pattern of reporting symptoms less frequently than females. There may also be developmental effects. According to a review by Dawes, Tredoux, and Feinstein (1989), boys tend to be more likely than girls to display symptoms of stress before adolescence, but, by adolescence, proportionately more girls than boys have symptoms of PTSD. It has been found that the risk of exposure to violence increases with age and is a function, not of race, but of socio-economic status (Cooley-Quille, Turner, & Beidel, 1995). It would therefore appear that socio-economically-disadvantaged adolescents have higher rates of trauma exposure and are more likely to present with PTSD symptoms. As adolescents at different stages of development experience trauma differently, those living in different socio-economic environments will probably experience violence differently as well.

Further findings which appear to affect all adolescents regardless of age and gender, have found that depression is a significant variable in the relationship between exposure to violence and trauma symptoms (Mazza & Reynolds, 1999). Giaconia et al. (1995) found that more than 40% of adolescents with PTSD met criteria for depression. Pynoos et al. (1996) suggest that screening for depression may be a way to predict the long-term

outcome of traumatisation. Boney-McCoy and Finkelhor (1995) found that victimisation leads to an increased vulnerability to related distress, such as sadness. Clearly there are other problematic variables evident from research on trauma and adolescence that have a bearing on how trauma is subjectively experienced.

In addition, research has found that certain attributes and/or predisposing factors may render adolescents more vulnerable to the effects of trauma. Sugar (1999) believes that because adolescents' cognitive ability is greater than that of children, they can assess and perceive trauma more readily. He also states that those who are geographically closer to the site of the trauma or disaster usually have a more extreme or severe reaction; this also applies to adolescents intruded on by strangers. Pynoos et al. (1996) also found proximity to the traumatic event as well as severity of the trauma to be factors in response to severe trauma. In a study by Smith and Holford (1993), factors associated with greater vulnerability to symptomology following exposure to traumatic events in adolescents include developmental age, meaning attributed to the event, pre-existing psychiatric disorder, related parental reaction to the trauma and being female (already mentioned).

Exposure to the initial trauma itself is not the only stressor adolescents have to face, as multiple, or secondary, traumatic events often occur during or after extreme trauma and have a cumulative effect (Sugar, 1999). All too commonly attitudes and beliefs regarding the criminal justice system are sorely challenged following violent crime experiences. According to Miller (1998), interacting with criminal justice representatives may become a traumatic reminder of the painful and humiliating crime experience. He states that the prevalence of PTSD is higher among victims who wade through this system than among trauma victims in general, and those suffering is associated with violent crimes, such as physical or sexual assault. Other secondary traumatic events may include physical pain or handicap following injury, intrusions (such as by the media, lawyers, etc.) and loss of home or community (Sugar, 1999). According to Pynoos et al. (1996) secondary stresses also include changes in family finances, alterations in role performance and/or school performance and the stress of responding to questions from peers and others. All these

factors contribute to emotional response, may disrupt development in adolescence and lead to clinical features of PTSD.

The literature points to the complexity of the trauma response in adolescence and underscores the fact that the “whole person” can be affected by overwhelming life events. This complexity will be explored in greater detail in the analysis of the case.

2.2. Explanatory models of trauma

In the literature on trauma various treatment modalities and approaches have been compared for their efficacy. To provide a starting point for understanding how trauma affects adolescents, it is helpful to explore some of the ways in which theory has attempted to define and explain symptoms of trauma. This section will outline the psychiatric, cognitive-behavioural, psychodynamic and developmental frameworks used to make sense of responses to trauma. Various contributory factors, such as individual and social factors that may influence the development of traumatic reactions in adolescence, will also be examined.

According to Carbone and Spano (1999), the word *trauma* usually refers to psychic damage suffered as a result of a negative external act. Broader qualitative definitions of trauma combine both medical and psychological symptomology. Van der Kolk (1996) for example considers trauma to be life experiences that overwhelm both psychological and biological coping mechanisms. This is in keeping with the awareness that an individual needs to be treated in his or her entirety.

Until 15 years ago it was widely accepted that the majority of children and adolescents only responded to frightening events with transient stress. The prevailing view around 1985 was that their responses to severe stress were less complicated and short term than those of adults. This view was supported by the noted lack of symptoms of amnesia, psychic numbing and intrusive flashbacks usually present in adults after a severe traumatic event (Rutter, Taylor, & Hersov, 1995). It was thus argued that there was no need for a specific diagnostic category for stress reactions in children and adolescence to

parallel that of PTSD in adults. In the past decade this view has been challenged due to the publication of more studies of post traumatic stress reactions in children and adolescence. Several researchers have cautioned that trauma as experienced by adults may not be applicable to adolescents (Finkelhor, 1990; Pynoos & Nader, 1993). The argument centers on differences observed in adolescents' emotions and behaviours following various traumas.

2.2.1. Psychiatric perspective

Post Traumatic Stress Disorder (PTSD) is unique among psychiatric disorders because diagnosing it requires the presence of an etiological event, i.e., an extreme stressor or traumatic event (J. Cohen, 1998). It is important to bear in mind that the clinical diagnosis of PTSD is one way of conceptualising trauma and its effects, and that there may be other ways in which trauma is manifested, such as clinical depression or difficulty in adjustment. Over the last 30-40 years there has been ongoing refinement of the definition of the stressor criterion as pertaining specifically to PTSD. According to the Fourth Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association (1994, p. 427), the diagnosis requires "exposure to an extremely traumatic event that poses a threat to life or physical integrity, and at least 6 symptoms from 3 different symptom categories (re-experiencing of the traumatic event, numbing of certain responsiveness and avoidance, and symptoms of autonomic hyperactivity), within a minimum duration of 1 month." The traumatic event may be re-experienced through recurrent distressing dreams of the event, flashbacks and intrusive distressing recollections of the event.

Psychiatric contributions to this field are noteworthy as most work on trauma has been done through this field. Biological findings have helped to understand what happens to an individual on a physical level when under severe stress, the epidemiology, etiology and clinical features of PTSD are succinctly set-out in textbooks and literature, and intervention which often includes pharmacotherapy, is useful in the treatment of many patients with PTSD. J. Cohen (1998) cites an example of a typical psychiatric intervention; brief outpatient psychotherapy is considered the preferred initial treatment

with adolescents affected by trauma, with psychotropic medications prescribed as an adjunctive treatment in adolescents with prominent depressive panic symptoms.

It has also been acknowledged that there is a paucity of methodologically sound studies in this area and too many vague descriptions of how major stresses affect children and adolescents of widely differing ages (Yule, 1995). This has raised many questions for adolescent psychiatry, such as: what sort of stressors carry an increased risk of psychiatric sequelae, and whether these vary according to developmental level. The clinical diagnosis of PTSD has also been a focus of debate. The following symptoms which pertain to adults are not included in the diagnosis of PTSD and are of specific importance to the adolescent: depressive signs, self-abusive behaviours, suicidality, aggressiveness and rejection by peers, attachment difficulties, sexual problems and guilt or shame at surviving or in some way being responsible for the event (Armsworth & Holaday, 1993). These symptoms have been found to have a debilitating effect on an adolescent after trauma has been experienced.

The discussion of traumatic response needs to go beyond the symptoms, included and excluded in the psychiatric diagnosis, when dealing with adolescence because of trauma's impact on an adolescent's emerging personality and intrapsychic life. Pynoos et al. (1996) suggest that diagnostic symptom criteria need to be conceptualised as reflecting a layering of effects over time, because different symptoms may represent the outcome of disturbances in developmental expectations, disturbances in normal biological maturation or secondary adversities, including poor caretaking. This is in line with Khan's concept of *cumulative trauma* (as cited in Carbone & Spano, 1999) who believes that trauma can build up silently throughout childhood right up to adolescence.

Another question regarding the diagnosis of PTSD raised by J. Cohen (1998) is whether this disorder represents a normal reaction to abnormal stress or whether it is a less prevalent psychiatric disorder with clear predisposing factors and distinct physiological abnormalities. In other words, are trauma survivors with PTSD psychiatrically and psychologically damaged, or are they just experiencing normal adaptation? Furthermore,

the DSM presumes a causal path from exposure to a stressor to the development of PTSD, but that does not always seem to be the case, as risk factors play an important role in the development of PTSD after exposure to trauma (Silva, Alpert, Munoz, Singh, Matzner, & Dummit, 2000).

Apparently purified of any subjective bias, there remains the problem that the study of objective data in the DSM has become the preferred focus of study by many psychiatrists and psychologists. This undermines the value of understanding internal feelings and states, the very dynamics of trauma. On the other hand, Clare (1976) argues that some clinicians pay too little attention to objective symptoms and too enthusiastically immerse themselves in an exploration of the client's inner world. Clare believes the balance between descriptive and interpretative psychopathology must be acknowledged, allowing for a better understanding of individual cases. In other words, although clinicians are obliged to organise knowledge in ways that can help similar clients in the future, it is not sufficient to simply establish the form of a disorder. What is needed is an interpretive psychology in which understanding gained from empathising with the client is formulated in terms of psychological theory. Unfortunately it appears that trauma work with adolescents inspired by various forms of psychological theory, in particular psychodynamic thinking, is uncommon, or, as criticised by Adelson and Doehrmann (1980, p. 112) "the realm of psychodynamic theory and the realm of empirical inquiry into this area exist separately and fail to recognise and support each other."

In conclusion, despite more than a decade of research using DSM criteria, not enough is known as yet about the scope of traumatic experiences and PTSD during adolescence (Ciaconia, Reinherz, Silverman, Pakiz, Frost, & Cohen, 1995). Yule (1995) states that even though it is now well established that adolescents can manifest adult-like PTSD after experiencing an acute stressor, there is still uncertainty about the extent to which the DSM category accurately reflects the range of symptoms presented by adolescents, and on the way symptom presentation varies with developmental age. It therefore becomes extremely difficult to propose a single profile to describe a traumatised adolescent.

2.2.2. Cognitive-behavioural perspective

Cognitive-behavioral theory (CBT) in its various forms (exposure therapy and desensitization, and anxiety management training) is possibly the most studied treatment modality in dealing with PTSD (Rothbaum & Foa, 1996). CBT, in its general form to treat PTSD in adolescence, can be identified by direct exploration of the trauma, use of specific stress management techniques and the exploration and correction of inaccurate attributions regarding the trauma (J. Cohen, 1998).

Kalodner (1995) explains that CBT differs from classical theory in that it does not incorporate a developmental approach. This model posits that people suffering from PTSD are unable to process or rationalise the trauma that precipitated the disorder (Kaplan & Sadock, 1998). They continue to experience the stress and attempt to avoid re-experiencing it by avoidance techniques. There is also a stated assumption that behaviour is learned and maintained by external reinforcers or internal processes such as cognition. The use of the “here and now”, a non-historical perspective, highlights the emphasis on the present in understanding the problem. This approach therefore tends to focus on the individual’s intellectual capacity for dealing with an incident of trauma, and, unlike psychodynamic theory, does not attempt to describe underlying dynamic processes and how these internal structures react to external events. In other words, CBT has been criticized for paying too much attention to cognitive factors while minimizing affective ones (Kalodner,1995). This may lead to an intellectual understanding of the problem but may not change the feelings associated with the thoughts.

The emphasis in medical-oriented psychiatry and CBT on a tangible external event as the origin of psychic trauma clearly poses problems for a theoretical framework such as psychoanalysis in which the subjective interpretation of the world is usually viewed as paramount. Dissatisfaction therefore with technique-oriented strategies, coupled with a wish to increase the use of self in the therapeutic process (Corte, 1995), has led to more interest in psychodynamic perspectives.

2.2.3. Psychodynamic perspectives

In psychodynamic theory, as with other approaches, concern is based on the assumption that violence is a stressful experience that requires psychological adaptation and may give rise to psychological sequelae. However, in comparison with competing theories, the psychodynamic is distinctive in its emphasis on personal history. It holds that in truly important moments of one's life, one is unwittingly held captive by the past (Adelson & Doehrman, 1980). According to Kaplan and Sadock (1998), the psychodynamic model hypothesises that trauma reactivates a previously quiescent, yet unresolved psychological conflict of the past. They further explain that this revival of the childhood trauma results in regression, and the use of the defense mechanisms of repression, denial and undoing. The ego relives and thereby tries to master and reduce the anxiety. In other words, psychodynamic theorists adhere to the belief that trauma resonates with internal structures already built and in this way makes contact with a painful experience of long-standing. This process will be explained in more detail with reference to various theorists and the historical development of the understanding of trauma.

Freud in his 1915 *Studies on Hysteria* (as cited in Rubin, 1999) introduced the concept of trauma when he considered sexual traumas to be the result of real seductions (generally regarded as incest), and later recognised the conflictual potential of inner fantasies. His work draws attention to the existence of the death instinct; he viewed traumatic anxiety as linked to a fear of annihilation and believed that such experiences forced individuals to confront their unconscious sense of immortality. In 1920 he proposed the concept of the stimulus barrier, that is, the ego defenses that provide protection from overstimulation. His addition to the definition of trauma in 1926 continues to be useful. He stated (Freud, 1986, p.238) that trauma is the result of "a sudden overwhelming stimulation that immobilises the ego functions and results in a state of helplessness." His observation was that, over time, traumatic responses may be less visible as symptoms and may silently become embedded in ego functioning, thereby playing a significant role in shaping character. Khan's concept of cumulative trauma (as cited in Carbone & Spano, 1999), mentioned earlier, is in keeping with this view.

Rubin (1999) refers to further psychoanalytic writing on trauma; prominent psychoanalysts such as Furst (1967) emphasised that regression is not only a reaction to the flood of anxiety, but an adaptive attempt to master and bind the tension. Greenacre (1976) believed that trauma in early childhood, especially preoedipal trauma, sensitises the youngster to the repetition of trauma during adolescence. She added to the concept of trauma her clinical experience that an outer, real and potentially traumatic event may become traumatic to the ego if the event touches upon inner anxieties or wishful fantasies. This is in line with Furst's (1967) belief that when overt traumatic experiences touch upon underlying fantasies, there is a greater tendency for fixation of the conflict. The fixation of a traumatic incident may as a consequence lead to adaptive and defensive struggles. These early definitions view the cause of traumatic stress as involving the interaction of pathogenic experiences in childhood, in which lies the origin of the fixation, and the triggering event. In sum, classical conceptualisations of trauma tend to emphasize drive theory based on the central preoccupation of the organism with survival, the presence of an overwhelming threat and the role of the ego in dealing successfully with anxiety. These ideas are still highly relevant to the appreciation of the impact of trauma but have been enriched by the addition of object- relational perspectives.

In contrast to the classical formulations on trauma, Eagle and Watts (2000) state that *object-relations* theory has tended to focus more on developmental history, the importance of the internal world and the subjective processes of introjection and projection in the individual's engagement with the external world. Winnicott (1952, 1960) believes that to the extent that optimum developmental conditions are met in a "good-enough" manner, the internal world of the individual is thought to be intact (as cited in Brothers, 1995). Where conditions are dysfunctional as in early maternal failure, identifiable adverse consequences may be identified. Subsequently, the ego in a vulnerable mode is less capable of defending against impingements and individuals are forced to adapt to the demands of the environment that may result in the development of a false self.

Melanie Klein (as cited in Eagle & Watts, 2000)) defines trauma in relation to the anxieties engendered by the phantasy relations between good and bad objects. The Kleinian development of the term *phantasy* refers to the primary content of unconscious mental processes and does not refer simply to a repressed fantasy (Smilansky, 1994). Klein believes that to safeguard against trauma, the ego needs projective and introjective mechanisms in order to protect the good object and keep the internal world in equilibrium. Eagle and Watts (2000) hypothesise that when objects attack in reality, the ego mechanisms operate to distort reality internally and externally in an attempt to restore equilibrium; the result of this process is often mental illness. In "Mourning and its relation to manic depressive states" (1940), Melanie Klein says:

The poignancy of the actual loss of a loved one is in my view greatly increased by the mourner's unconscious phantasies of having lost his internal good objects as well. He then feels that his internal bad objects predominate and his inner world is in danger of disruption. (Cited in Williams, 1994, p. 164).

This could be true for the *threatened* loss of a loved one or even extended to include the threat of physical trauma to the self.

Carbone and Spano (1999) discuss the writings of other authors within the psychodynamic framework, such as Balint (1952, 1969), Bowlby (1960), and Fairburn (1952), who consider trauma as a potential psychic organiser, and challenge the exclusivity of viewing trauma only as negative. The implication is that trauma may serve as an organiser involving the nucleus of the adolescent's condition. In other words, the trauma may establish inner contact with some split off and isolated dysfunctional parts of the self, which have been suppressed. In therapy, which brings these together, the youngster may then move on to improved functioning and involvement with the environment.

Brothers (1995) refers to the work of Heinz Kohut, the forefather of *self-psychology*, a branch within the psychodynamic framework. Kohut (1987) believes traumas are clues that point to the unwholesome atmosphere to which a child was exposed during the years when his self was established. Thus developmental arrest or deficit may occur as a result

of failures in selfobject relations and precipitate regression. However, unlike many object-relations theories in which maturity is equated with separation, individuation and independence from others, self psychology sees the developmental line of selfobject relations as extending from birth to death (Brothers, 1995). In other words, we never stop needing selfobject experiences that, as Brothers states, make room for trust as a key concept. The experience of being able to trust again after a traumatic experience is an essential requirement to fulfillment in relationships with others. Object-relational perspectives thus appear to replace the negative notions of classical analysis that trauma may lead to perpetual intrapsychic conflicts; notions, according to Brothers (1995), incompatible with a view of trust as fundamental to psychological life.

Van der Kolk and McFarlane (1996), emphasise that confrontations with violence challenge the most basic assumptions about the self as invulnerable and intrinsically worthy, and about the world as orderly and just. According to Eagle and Watts (2000) it is those complex trauma situations in which there is deliberate degradation of the victim or the use of gratuitous violence that affect individuals most powerfully. After experiences with trauma and violence, the survivor's view of self and world can never be the same again: it must be reconstructed to incorporate the trauma experience. In this process the survivor needs to confront a range of difficult emotions such as anger and loss. Herman (1992) believes mourning is an integral part of this process, and to the extent that the survivor is unable to grieve, she is cut off from a part of herself, leaving her unable to discover her indestructible inner life.

P. Cohen (1998) states that perpetrators are often demonised and become the targets of intense narcissistic aggression, whilst their victims become the focus of no less intense and narcissistic identification. The world is then neatly divided into heroic and innocent victims and their allies on one side, and evil on the other. The Kleinian term for this process is "splitting." From an object relations perspective, the experience of breaches in the societal structures that are meant to provide containment, resonates with the victim's lack of internal containment (Eagle & Watts, 2000). The anger at the object that is meant to protect but appears uncaring, inept or even damaged is understandable and may even

transfer to treatment centres. This may lead to increased disillusionment in the good object's protective capacity, whereas inaction may be perceived as further abandonment.

Some of the consequences of violence-related trauma have been noted in the psychodynamics from projective tests of adolescents suffering from traumatic stress: the environment is perceived as hostile and unsafe, individuals feel acutely insecure and in need of protection, self is viewed as helpless and vulnerable, overwhelming anxiety is experienced, there is anger at adults and parental figures who failed to protect, there are feelings of being intrinsically damaged and finally, an intense wish for revenge is experienced (Smith & Holford, 1993). Herman (1992) states that although the traumatised person imagines that revenge will bring relief, repetitive revenge fantasies actually increase the torment, and in addition may be highly frustrating as revenge or compensation can never change or compensate for the harm that was done. Feeling guilty about somehow being responsible for the event may lead to defenses such as repression, as noted by Sandler (cited in Pynoos & Nader, 1993).

In researching the different ways in which trauma is expressed by males and females, psychoanalytic theory has observed the following in terms of defense mechanisms: the defenses of internalisation of anger and identification with aggressors have been noted in traumatised boys; girls have been observed to internalise hopelessness and helplessness and identify with victims (Green, 1985; Terr, 1985; Wohl & Kaufman, 1985) (as cited in Armsworth & Holaday, 1993). Herman (1992, p. 175) describes the difficulty with which survivors of trauma tell their stories. The initial account of the event may be repetitive and emotionless, "like a series of still snapshots or a silent movie". These observations contribute to the body of understanding of adolescents affected by violence-related trauma.

Psychodynamic understanding of trauma has implications for the way treatment is conceptualised. Perret-Catipovic and Ladame (1999) observe that among the methods to understand and treat trauma, the psychoanalytic treatment approach is rarely considered, and yet is described as an invaluable modality and often used in clinical practice. They

say that a small number of studies have examined the impact of psychoanalysis and psychodynamically oriented psychotherapy, nevertheless there remains a dearth of research on this approach.

The core of the psychodynamic treatment approach lies in the use of the transference relationship between therapist and patient and the interpretative process based upon this as the means to change and development (Copley, 1993). Self-psychologists tend to view the entire treatment process in terms of the establishment, unfolding and working through of what Kohut identifies as “self-object transference.” These are therapeutic relationships in which the patient perceives the therapist as providing mirroring experiences that were absent or traumatically aborted in the selfobject relationships of childhood. In the Kleinian approach, attention is given in the transference to infantile feelings that influence the adolescent in the drive towards adulthood. Winnicott (1965) extended his notion of the “holding environment,” by which he meant all of the provisions by the “good-enough” mother, to include the analytic setting as well (as cited in Brothers, 1995, p. 28). Bowlby also shifted the emphasis from the classical psychoanalytic approach to the dynamics between the patient and therapist. Countertransferences, which refer to the therapist’s feelings and unconscious reactions experienced in relation to the patient’s transference (Smilansky, 1994), present more of a problem in work with adolescents than in that of children or adults. Holmes (1991) states that the reason for this is that adolescent’ emotions are often very powerful and poorly defended. Moreover, they bring experiences and attitudes revived and re-enacted from both the past and current family relationships.

However, as Box (1994, p. 46) says:

It is clearly not a matter of therapists soaking up all the pain themselves and being left with it, but rather of working on it inside themselves in order then to give it back verbally so that their clients have a better chance of integrating and managing it for themselves.

In general, it can be argued therapeutic approaches to trauma differ from traditional therapy where the patient is encouraged to assume greater responsibility for life’s

problems, whereas trauma survivors are encouraged to assume less responsibility for the trauma (Herman, 1992). Therapists who work with adolescents, regardless of the approach, are also mindful of the developmental tasks that may complicate recovery, for example, an adolescent's struggle to separate may be intensified after trauma has been experienced. The premise for working psychodynamically however is based on the understanding that when a traumatic event has been experienced, therapy using psychodynamic understanding allows the individual to become aware of the experiences that are unmanageable, to process the memories and reintegrate them into his or her world without being overwhelmed by terror of traumatic memories (Sheppard, 2000).

Classical psychoanalysis has lost favour as a treatment option in many urban areas, because it is recognised as a depth psychology that requires multiple sessions over an extended period of time (Corte, 1995). Nevertheless, despite predictions of its demise, there is continuing interest in the field, due in part to the result of a dedication to dynamic theory that seeks to understand psychopathology as well as the forces operative in the therapeutic process.

2.2.4. Developmental perspective

The developmental perspective offers an important supplement to the psychodynamic approach in understanding the traumatised adolescent. This is an integrative model that represents an attempt to organise theories and approaches within a developmental framework (Rigazio-DiGilio, Goncalves, & Ivey, 1995). This approach was built on a synthesis of several philosophical, developmental and psychological perspectives. The psychological foundation is rooted in the work of Piaget, but moves beyond his linear, stage-oriented framework by drawing partially on Kohlberg's hierarchical model, the psychoanalytic work of Freud (1986), Erikson (1950, 1963), as well as holistic and systematic cognitive approaches (Rigazio-DiGilio et al., 1995). Psychiatric research has also incorporated a developmental approach to the understanding of adolescence and the development of psychopathology (Ebata, Peterson, & Conger, 1990). This perspective suggests a framework for organising the study of adolescence in relation to the major cognitive, physical and psychosocial changes that occur during this period (Ebata et al.).

Rigazio-DiGilio et al. (1995) emphasise the cultural boundaries of developmental structures, stating that clients carry with them specific sociocultural and historical backgrounds that influence the course of therapy.

In understanding trauma it is important to consider the objective nature of the stressor and the subjective way in which the threat is interpreted. As stated earlier, a subjective threat is also determined by the developmental stage the adolescent has reached, in addition to circumstances surrounding the incident and the subsequent supports offered. Pynoos et al. (1996) elaborate that a traumatic experience can upset the developmental balance in child-parent relationships between independent and dependent behaviour, in addition to disrupting a parent's confidence in their ability to protect the child. This jeopardises the transition to more peer involvement and may create embarrassment and shame for the adolescent. These are all factors born out of psychological development which are impacted upon by trauma and thus have the effect of disrupting normal development.

Within this framework the concepts of risk, resilience and vulnerability are considered. In this perspective the process of adolescence may not necessarily be tumultuous for all young people (Ebata et al., 1990), as some may be more at risk for experiencing difficulty than others. This notion is a departure from classical psychoanalysis. According to Rubin (1999), the early life experiences of the adolescent, and how he or she coped with inner and outer stimuli, have a bearing on vulnerability during adolescence. Rutter (1995) points to a strong association between psychosocial stresses and adversities that have environmental causative influences. Anthony (1974) explains this more fully; he states that whereas risk is a function of the actual physical and psychological environment, vulnerability and invulnerability are states of mind induced in the adolescent by exposure to these risks. Relatively invulnerable adolescents may for example understand illness both as a personal experience invading their lives, and as a phenomenon to be investigated and treated; testing their strength even against overwhelming odds. Also, experience with trauma might be significant to a developing system, producing a tendency to gain considerable insight from coping with the crisis (Tedeschi & Calhoun, 1995). According to Ebata et al. (1990) social support is a

mediating factor between stress and well-being and certain people are better at procuring, perceiving and accepting this support from others during times of stress. In especially vulnerable individuals on the other hand, physiological and emotional systems may become so severely compromised by trauma that there may be a resulting tendency to break down under later stress. This in turn also interferes with the mastery of important developmental goals. Ebata et al. (1990) believe that in adolescence, as opposed to children, individual capacities and characteristics play more important roles than other risk factors, such as an adverse environment, that may influence further development. Rubin (1999) says there is the possibility that stressful developmental struggles within the psyche of the traumatically sensitive individual, may result in psychopathology.

An interesting study by Cuffe, Addy, Garrison, Waller, Jackson, Mckeown, and Chilappagari (1997) on a community sample of older adolescents found that family cohesion is not associated with PTSD risk. However, there is strong empirical evidence indicating that parental emotional reaction to the traumatic event and parental support of the adolescent are powerful mediators of subsequent PTSD symptoms (J. Cohen, 1998; Pynoos et al., 1996). Silva et al. (2000) confirm that better family functioning is found to help adjustment after a traumatic event has occurred. General protective factors in the adolescent include high self-esteem, internal locus of control, high IQ, personal competency and good social and problem-solving skills (Jenkins & Bell, 1997). Jenkins and Bell decry the absence of sufficient developmental research focusing specifically at protective factors for exposure to violence.

To complicate matters, in South Africa the stress of normal developmental transitions might mask the impact of exposure to community violence. It would help if risk factors that pertain to adolescents could be clearly identified, as much can be learnt from relatively resilient adolescents who go on to have warm, satisfying relationships in spite of having experienced severe trauma in their lives.

2.3. Definition and understanding of adolescence

“Who are you?” asked the Caterpillar.

This was not an encouraging opening for a conversation. Alice replied, rather shyly, “I – I hardly know, Sir, just at present – at least I know who I was when I got up this morning, but I think I must have changed several times since then.”

“What do you mean by that?” said the Caterpillar sternly. “Explain yourself!”

“I can’t explain myself, I’m afraid, Sir,” said Alice, “because I’m not myself, you see.”

“I don’t see,” said the Caterpillar.

“I’m afraid I can’t put it more clearly,” Alice replied, very politely, “for I can’t understand it myself, to begin with; and being so many different sizes in a day is very confusing.”

“It isn’t,” said the Caterpillar.

“Well, perhaps you haven’t found it so yet,” said Alice; “but when you have to turn into a chrysalis – you will someday, you know – then after that into a butterfly, I should think you’ll feel it a little queer, won’t you?”

Carroll, 1991, p. 73.

Adolescence is one of the most dramatic phases in the course of development, marked by profound changes in biological, psychosocial and social functioning (Marans & Adelman, 1997). In defining the concept of adolescence for this study, emphasis will be placed on the developmental process and how this affects adolescents intrapsychically, which in turn affects how the individual deals with a traumatic incident.

Court (1997, p. 3) aptly describes the basic drama of adolescence: “the adolescent is caught between a lost childhood and an unrealised adulthood, trying to cope with new types of friendships, burgeoning sexuality, changing interests and an awareness of self in relation to others. It is a time of transition from a place in the family to a place in the outside world, a time of great anxiety, apprehension, expectation of the fear and thrill of the unknown.” Most importantly, he adds that it is a time when physical growth is

occurring more rapidly than at any other stage and alongside that changes in mental and emotional growth are most insistent and demanding.

Adelson (1980) defines adolescence as a phase of development that has varying degrees of stress, and which offers the individual a chance for a major restructuring of personality. This may be seen in the adolescent's more tumultuous relationship with parents, involving struggles between the wish to remain dependent and close and the urgency to achieve independence and new relationships. Marans and Adelman (1997) found that as the adolescent withdraws from the parents, the intensity of attachment to them is shifted to the peer group and new intimate relationships. According to Herman (1997), this shift is also influenced by abstract questions such as the order of the world and the adolescents' place in the community, which are normal preoccupations of adolescents. Resolution of these questions of meaning therefore requires the engagement of the adolescent with the wider community. Josselson (1980) believes each gain in ego separateness from the family of origin is followed by efforts at reassurance that the parents are still there. And with each gain in ego autonomy, the adolescent becomes less reliant on the parental ego for the approval sought. There still remains some ambivalence in that the adolescent may alternate between feeling oppressed by the adult from whom he or she is trying to separate, in order to deal with hostile and sexual fantasies and feeling abandoned and left to struggle on their own (Bronstein & Flanders, 1998). It is proposed that the ambivalence over autonomy is what contributes to much of the so-called pain of this period of development. As Josselson states (1980, p. 195) "the struggle for autonomy is, in the main, not against the parents, but against the adolescent's own wishes to deny his aloneness and his own wishes to believe that parents do know best and will always protect him." According to Rubin (1999) the struggle is frequently expressed as a conflict between idealising these adults and disappointment in them. He adds that in an attempt to deal with this conflict, the superego temporarily loses its functional structure as the adolescent lets go of his or her parents and attempts to integrate a more personal conscience. This can lead to occasional delinquent acts or a seeming loss of values and standards.

Adelson and Doehrman (1980, p. 105) describe an adolescent's life in the family as being "akin to life on the psychoanalytic couch in the midst of a transference neurosis." They comment on regressive aspects of this phase of development such as oedipal revival, dark rages and narcissistic grandiosity, as well as a brooding sense of unbridled power. Psychodynamic understanding of adolescence has described the ego as being relatively weak vis-à-vis the powerful drives considered typical for this phase of development. Adelson and Doehrman (1980) describe these drives as being of a sexual, dependent and sadistic nature. The ego is threatened not only by these drives, but also by the threat of losing contact with reality. Adelson and Doehrman refer to Peter Blos, an influential writer on adolescence in the psychodynamic tradition (1962, 1967, 1972, 1974), who states that the narcissistic defenses in particular weaken reality contact. He believes that adolescent acting-out is nothing more than a frantic attempt to keep in touch with reality and to ward off a surrender to infantile greed and dependency. Adelson and Doehrman believe that it is the very task of defending against the emergence of these drives that is understood as the central intrapsychic problem of adolescence in the psychoanalytic view. A quote by Anna Freud (as cited in Adelson & Doehrman, 1980, p. 104) explains this process in more detail:

The danger is felt to be located not in the id impulses and fantasies but in the very existence of the love objects of the individual's oedipal and preoedipal past. The libidinal cathexis to them has been carried forward from the infantile phases, merely toned down or inhibited during latency. Therefore the reawakened pregenital urges or, worse still, the newly acquired genital ones, are in danger of making contact with them, lending a new and threatening reality to fantasies which had seemed extinct but are, in fact, merely under repression.

Psychic processes common to adolescence, such as regression, are an integral part of normal development and should not necessarily be seen in a negative light. As Blos notes (as cited in Adelson & Doehrman, 1980, p. 101): "Regression in adolescence is not, in and by itself, a defense, but it constitutes an essential psychic process that, despite the anxiety it engenders, must take its course." According to Blos, what appears as a defense can turn into an adaptive process and contribute essentially to the formation of character. This is enhanced whenever ego functions become isolated from object relations, that is, whenever the desexualisation of ego functions is achieved. This will protect the ego from

being drawn into the life of the instinct and thus contribute to the extension of ego autonomy. In moving towards this level of ego continuity, a more mature structure of self may be achieved.

Blos (1983) divides adolescence into early, middle and late adolescence and states that each of these phases is characterised by a dominant theme, a typical conflict, a personal crisis and an adaptive solution. What the various stages have in common is the simple fact that all through the second decade of life a process of personality differentiation takes place that transforms the child into an adult. As implied by Anna Freud's quote, this process is often experienced as traumatic to the psyche. According to Blos (1983) heterosexual object finding indicates the giving up of the incestuous object and is a decisive break from childhood; this marks the end of early adolescence. Middle adolescence can be defined as the period in which ego development focuses primarily on sexual identity and individuation. The emphasis is thus on the recognition of the self as an emerging man or woman and exploration of the psychosocial capacities of the individuating self (Josselson, 1980). There is also an increase in narcissism, reflected in the self-absorption and extreme touchiness so often observed in adolescents at this time (Adelson & Doehrman, 1980).

For the purpose of this dissertation the main focus will be on late adolescence, an area in which the anxious question "who am I" is nearing its way to resolution. Josselson (1980) states that greater emotional maturity, considerable growth of the adaptive ego processes and the increasing dominance of the reality principle are some of the processes which characterise this area of adolescence. The adolescent begins to think in terms of the future as self-esteem becomes stabilised. More importantly, in late adolescence the capacity emerges to understand the limits of the parental ego and the usefulness it has to protect and maintain. According to Sugar (1999), this is the reorganisation phase, with the need to test omnipotentiality and to arrive at a sense of commitment to self and object choice. There remains however a sense of precariousness of this new-found "maturity." According to Adelson and Doehrman (1980), the young man must come to terms with his

father image and the young woman with her mother image before each of them is finally able to move into postadolescence and maturity.

To conclude it may be said that exposure to violence places an additional and special burden on the adolescent's attempts to feel competent, autonomous and safe, given the enormous demands, both of a psychological and social nature, that are already inherent during this phase. The adolescent years present us with significant opportunities and challenges to integrate research and theory based on a better understanding of development during the second decade of life. The delineation of childhood and adolescence in research and the acknowledgement of differences of age and developmental level remain critical for future work.

2.3.1. Adolescence in the South-African context

The many threats that may affect adolescents of today have manifested themselves in South Africa in the following areas in particular: domestic abuse, substance abuse, HIV/AIDS, exposure to violence in the community, unemployment, criminality and unwanted pregnancies, which sometimes result in incomplete abortions (Women's Health Conference of 1994). It appears that there are areas of concern which are more specific to boys, such as alcohol misuse and/or abuse (Morojele, 1997). Morojele states when adolescents drink, they do so with greater intensity (binge drinking) and are more likely to become victims of crime or perpetrators thereof. It was noted at the Women's Health Conference that the incidence of young people killing each other to settle their differences was increasing, and of the 114 047 people in prison in 1993, 45 623, mostly male, were aged between 7 and 25 years.

The conference further emphasised that girls have areas of specific vulnerability; the number of new HIV cases for example is highest among young women between 15 to 24 years. There is also an exceptionally high rate of unwanted pregnancies. According to the conference, 330/1000 of pregnant women in S.A. are under 19 years, and need a comprehensive support system to cope with the challenges. A recent article in the Cape Times (2001, August 22) reported that the highest number of adolescent pregnancies in

S.A. are in girls aged 16. In Gauteng alone more than 700 high school girls fell pregnant between 1999 and March this year, indicating a high level of early sexual behaviour and not enough use of contraceptives such as condoms. De La Rey and Carolissen (1997) state in South Africa there are higher incidences of pregnancy in adolescents who have low socio-economic status, but the stability of a family and support given during and after the pregnancy can contribute to family cohesion. They also point to the tension between the acceptance and support of the baby at one level, while at another level there is often condemnation of premarital sex and pregnancy. American researchers also note difficulties inherent in adolescent pregnancy. Berkovitz and Sugar (1983) believe that an unplanned pregnancy may disrupt the smooth transition into young adulthood, which causes frustration and helplessness due to premature identity closure. They add that adolescent pregnancy involves important identity issues and therapy often needs to extend beyond the period of pregnancy alone, as previously unresolved issues may come to the fore and hinder further development, as would a traumatic incident.

The Women's Health Conference of 1994 criticises the lack of government policy in South Africa to provide services in the areas of life skills, health and sexuality education which would empower adolescents with knowledge and skills so that they could make informed choices in their lives. Health services have traditionally been unequal, inaccessible and inappropriate which has affected adolescents from lower socio-economic backgrounds in particular. In this context of community violence, early sexual activity and lack of health services, the adolescent is extremely vulnerable.

2.4. Understanding adolescence and trauma

In this section an attempt will be made to integrate an understanding of adolescence with the specific ways in which this phase of development is affected by trauma.

Our increasing clinical knowledge about adolescents exposed to violence is, as a consequence, stimulating a greater understanding of the impact of violence-related trauma among adolescents in the community. There is an acknowledgement that past and present exposure to violence among adolescents needs to be understood in the context of

continual trauma, as is often the case in South Africa, as well as the developmental impact of these exposures. Of interest here is Winnicott's concern with the development of the core of true self, described as being uncompromised or intruded upon by the external world (as cited in Brothers, 1995). In adolescence this core self is in a state of delicate and partial formation, hence the likelihood of trauma severely compromising the development of the self is extremely high, bearing in mind the need for a certain amount of stress to be present in the adolescent's life to facilitate and ensure normal development.

It is understood that the adolescent's response to an acute episode of interpersonal violence will largely be determined by the nature of the violence itself. It is, however, also affected by the negotiation of past and current developmental tasks. According to Pynoos et al. (1996), the experience of trauma in late adolescence may result in a rapid thrust toward self-sufficiency, or postponement of plans to leave home out of concern for other family members' safety and security. There may also be abrupt shifts in an adolescent's interpersonal attachments, including sudden dissolution or heightened attachment. Marans and Adelman (1997) state that trauma in adolescence can give rise to uneasy, dreaded feelings of helplessness or neediness, which threaten to override the developmental thrust toward autonomy and burgeoning sexuality. The experience of internal and external threats is influenced by subjective appraisals (Pynoos et al., 1996), as well as the unique coping style and psychological profile of each adolescent. Pynoos et al. conclude that the appraisals and efforts at coping with life vary with the developmental and experiential maturation of the adolescent, especially in regard to the degree of reliance on parents, adult caretakers and peers.

The recent contribution of Rubin (1999), a psychoanalyst, to the understanding of trauma and how it affects adolescence in particular has its premise in the belief that trauma from the infantile period may result in ego restriction and avoidance, which then causes increased tensions and difficulty for the restructuring experiences of adolescence. In other words, with early childhood trauma and pathological interactions, a faulty foundation is set up that makes the youngster vulnerable to difficulties in emotional

functioning in adolescence. The traumatic potential of a real life incident therefore rests with its inner psychic effect to produce a state of overwhelming anxiety and partial or total ego discrimination and disorganisation. This is in line with classical and contemporary psychoanalytic thinking.

By their very degree and nature of personal impact, traumatic experiences can skew expectations about the world and negatively affect the way adolescents view their life. These expectations noted by Bowlby (as cited in Pynoos et al., 1996), contribute to the adolescent's inner plans of the world, shape concepts of self and others, and lead to forecasts about the future that can have a profound influence on current and future behaviour. As Herman (1992, p. 176) states: "after a traumatic incident a sense of alienation and disconnection pervades every relationship, from the most intimate familial bonds to the more abstract affiliations of community and religion." Developmental conflicts over autonomy, initiative, competence, identity and intimacy are all brought to the fore and exacerbated; conflicts which the typical adolescent needs to deal with in everyday life. On the other hand, healthy development prior to the traumatic event, family support and additional help may aid negotiation of and recovery from the traumatic experience.

The different theories regarding the understanding of trauma in adolescence have provided important contributions, but psychodynamic theory has emphasised the validity of evaluating the role of past relationships forming a meaningful contribution to the way that the incident may be exacerbated and/or clinically complicated. To this end the case study hopes to reveal a greater understanding of the factors implicit in the psychodynamics of a traumatised adolescent.

CHAPTER 3: METHODOLOGY

Only from his actions, his fixed utterances, his effects upon others, can man learn about himself; thus he learns to know himself only by the roundabout way of understanding. What we once were, how we developed and became what we are, we learn from the way in which we acted, the plans which we once adopted, from old dead letters, from judgements on which were spoken long ago.....we understand ourselves and others only when we transfer our own lived experience into every kind of expression of our own and other people's lives.

Dilthey (1895) (as cited in Stake, 1995, p. 35).

This section will discuss the qualitative case study methodology with particular reference to the psychodynamic approach. The structure of the case and contextual setting will then be outlined.

The intention here is not to debate the validity of quantitative, statistical versus clinical research methodologies, but to help fill a gap created by the tendency to investigate the effects of trauma exclusively by statistical methods such as standardised interviews and surveys. These may discount or minimise the psychological sequelae of trauma, or, as noted by Armsworth and Holaday (1993), the degrees of variance of response to traumatic events may be lost in the analyses. They state that in standard quantitative testing with traumatised adolescents, subtle emotional manifestations, which are not quantifiable, have been noted. On the other hand, the psychodynamic interview by its very nature deals with the emotional life of individuals or groups affected by trauma. As Honig et al. (1999) notes, it is specifically these negative symptoms that are more likely to evolve into long-term character traits when there is little opportunity for working through the psychological aspects of the trauma. Honig et al. further emphasise that a methodology in the form of a psychodynamically focused clinical interview with adolescents is the most appropriate technique to explore questions of adaptation and emotional development after trauma. Van der Kolk (1996) suggests that the associated features of trauma, such as depression, and difficulties with trust and intimacy, may

respond best to psychodynamic approaches, which draw on psychodynamic phenomena such as transferences, defenses, the inner world of individuals as well as their developmental histories in the family context. In this way, the reconstruction of the trauma story can occur (Herman, 1992), providing the context within which the particular meaning of the trauma can be understood.

The number of trauma-related symptoms not currently included in the diagnosis of PTSD increases the importance of research that focuses on the qualitative importance of these symptoms. According to Armsworth and Holaday (1993) qualitative analyses may be useful in helping to understand what aspects of a traumatic event create psychological distress or lead to maladaptive responses. Similarly, qualitative methods could allow researchers to “disentangle the sources of trauma” as described by Browne and Finkelhor (1986, p. 76). As discussed earlier, these sources may involve factors that predispose an adolescent to greater risk for traumatisation as well as being at risk for developing a dysfunctional internal model of the world. Tedeschi and Calhoun (1995) suggest that the greater use of qualitative approaches can convey much about the growth that many individuals experience following major crises. A psychodynamic case study, qualitative by nature, validates an individual’s own understanding of the struggle and growth process after trauma has occurred.

3.1. The case study

The qualitative case study is one method whereby attention is drawn to the relevance of the subjective experience of trauma, and has for that reason often been the preferred choice for research in the psychodynamic arena. In general, case studies are the preferred strategy when “how” or “why” questions are being posed, and when the focus is on a contemporary phenomenon within real-life context (Yin, 1984). He explains this further: “the instinctive need for case studies arises out of a desire to understand complex social phenomena. Case studies have a distinctive place in research according to Patton (1980) and Guba and Lincoln (1981) (as cited in Yin, 1984). They are particularly helpful when used to describe the real-life context in which an intervention has occurred and to explain causal links that are too complex for surveys or experimental strategies. In brief, the case

study “allows an investigation to retain the holistic and meaningful characteristics of real-life events” (Yin, 1984, p. 14).

Abrahams (1996) notes that the nature of psychotherapy with its foundation in the multifaceted relationship between therapist and patient is presumed unique and not necessarily reproducible for other cases. Stake (1995) says the quality of case study research is not based on its reproducibility but on whether the meanings generated, by the researcher or the reader, are valued. He emphasises that “the real business of case study research is particularization, not generalization” (1995, p. 8). However, case study strategy has been criticised for providing little basis for scientific generalisation. Yin argues that case studies, like experiments, are generalisable only to the extent of theoretical propositions although not to populations or universes. In this sense, the researcher takes a particular case and comes to know it well; the focus is not primarily on how different it is to others. The emphasis is on uniqueness; this implies knowledge of others from which the case is different, but the emphasis remains on understanding the case itself.

For the above reasons, it was considered appropriate to employ a single case study design to illuminate aspects of violence-induced trauma in adolescence by focusing on an individual experience. Various issues around the ethical nature, confidentiality and academic value of the case were considered. Permission to write about the trauma was firstly requested and granted by patient and her family. Since the work fell into the hospital requirements of the clinical internship, permission was also obtained from the senior clinical psychologist within this system who deals with ethical concerns. A similar letter was drafted to the psychologist in charge of such matters at the university who recommended that numerous changes be made to disguise recognizable features of the case. Every care was therefore taken to conceal biographical details and protect confidentiality. The research further complies with the American Psychological Association’s ten ethical principles in the conduct of research with human participants (Christensen, 1980, pp. 332-340).

The case material is drawn from my understanding of a young trauma survivor, gained through family therapy, which commenced on 1st May 2000 and terminated in December

of the same year. Sessions were held weekly at a government psychiatric outpatient adolescent centre. Although the focus was on the intrapsychic life of the adolescent who had experienced the trauma, I thought the family would provide an important context in which her conflicts could be understood. To this end I carefully observed her emotional responses in the sessions, and gained an understanding how the interaction between her, other family members and myself were indicative of her internal dynamics. I also chose family therapy with my adolescent client, Leila, because I believed I could gain considerable insight into the ways she presented her symptoms of trauma to other members of the family, who had also been adversely affected. Furthermore, adolescence is a period during which intergenerational conflicts are expected to arise, and I assumed a traumatic event would exacerbate these developmental conflicts. Wynne (as cited in Offer & Vanderstoep, 1975) states that exploratory family therapy is best suited when dealing with adolescents' separation issues. These issues arose in Leila in response to the trauma. Wynne adds that family therapy is also useful when there is a need for clarification and resolution of intrafamilial difficulties, and when the family is experiencing problems of integrating with society. Offer and Vanderstoep (1975) say it is helpful "when the here-and-now-struggle with interpersonal conflicts of the family potentially affects the outcome of coping with intrapsychic conflicts." The advantages of family therapy, which will be more comprehensively explained in the analysis of the case, clearly outnumbered the disadvantages. A disadvantage of working with the family as opposed to Leila on an individual basis, was the fact that she was reluctant to disclose information about her relationship with her boyfriend in the presence of her parents, as well as reveal feelings of hostility towards them. These issues were partially addressed in an individual session with Leila.

For the purpose of this case study, certain material taken from a total of 23 sessions was used. Interpretations were based on my intuitive responses to the various therapy situations, and were also informed by my understanding of psychodynamic theory. According to Lindy (1996, p. 526), the unconscious elements of transferences and defenses such as splitting and dissociation come to be "personal stories of tragedy, trauma and loss." He adds that the management of these elements, which are often

traumatic repetitions within the psychodynamic context, is crucial for the recovery process. A psychodynamic understanding and management of a trauma case therefore allows for a subjective reconstruction of the memory that has adversely affected the survivor's inner sense of self.

It was with this awareness that I recorded my observations of the sessions, along with comments and reflections on what I thought had given rise to particular feelings. A reflective ability to draw on my own emotional responses in relation to the trauma aided understanding of the case. I discussed these in regular clinical supervision that aided the understanding of the process of therapy as well as being the forum for dealing with countertransference issues evoked by the case. A potential area for countertransference was the cultural differences between myself as a White therapist and the family, which are Indian. These differences however faded in relation to the dominance of trauma material, which had the effect of bringing us all closer together. However, at the end of therapy I needed to visit the home of the family to request permission for therapy material to be used for this dissertation. Other staff at the centre alerted me to the fact that a visit to the home, which was located in a "Black area," may put my life at risk. Although segregation in housing has been outlawed in South Africa, the races remain largely separated from one another, and the crime rate is more prolific in disadvantaged areas. I drove to the area and felt unable to relax for the duration of my visit. In the exploration of this event, it became apparent that my response betrayed a stereotyped view that it is entirely unsafe for a white person to be in a black area. This skewed perception did not provide the opportunity to become aware of the broad diversity in values, education and stability in these areas. The general fear of crime that white people feel in their own communities may also have bolstered my apprehension. A countertransference of the family feeling unsafe since the traumatic incident contributed to the anxiety I experienced.

I felt overwhelmed at times with the enormity of the trauma's effects on the family, but felt supported within the hospital context I was working. According to Offer and Vanderstoep (1975), having a stable and structured treatment setup is essential for

psychodynamic family therapy. Even though I did not actively discuss session material with the multi-disciplinary team at the adolescent unit, the permanent presence of the psychiatric nurses, social worker, consultant psychiatrist and psychologist, was comforting. My role as intern clinical psychologist had advantages and disadvantages. Interns have a reputation in the hospital for not being hardened by the rigorous demands of the mental health profession. Furthermore they often allow themselves to become more emotionally involved with their patients than more experienced therapists, as they are still learning the importance of emotional boundaries. This involvement often leaves a patient feeling extremely contained and cared for but an intern exhausted. On the other hand, interns may overlook or not sufficiently explore features of their cases due to inexperience. There may also be difficulties moving from the dependency of the training to the responsible autonomy required to function as a mature and competent clinician. Giovacchini (1992) compares having one foot in the training setting and another in the clinical arena to transitions inherent in adolescence. Furthermore, I was aware of the possibility of a reactivation of my past adolescent struggles, which are commonplace in therapy with adolescents.

The patient's diagnostic profile reflected PTSD (chronic type) on Axis 1, representing a clinical disorder according to the multi-axial classification of the DSM-1V, injury and a hysterectomy due to complications of childbirth was noted on Axis 3. Economic problems and problems related to interaction with the legal system were noted on Axis 4. Differential diagnoses included Adjustment disorder and a Major Depressive Episode. Background information regarding the patient and the traumatic incident was taken in the initial interview in which all members of the immediate family were present. Validity of the incident was confirmed by collateral obtained from the social worker who had referred the patient and a consultant psychologist who specialises in forensic work. Termination of therapy was prompted by the end of the internship and the Health Professions Council of South Africa's ruling that interns are prohibited from seeing patients without clinical supervision until they have completed course requirements and registered with the Council.

CHAPTER 4: THE CASE ANALYSIS

4.1.1. Relevant background information

To live is to suffer, to survive is to find meaning in the suffering.
Frankl, 1959, p. 105.

Leila was a beautiful, fragile looking teenager of 17 with a gentle manner who dressed fashionably and showed no outward signs of the brutality of the attack that had been inflicted upon her. She had already been through a difficult time emotionally before the trauma by falling pregnant unexpectedly. She seemed an intelligent young woman, spoke quietly and related her story with little expressed emotion. This was not congruent with the content of the story, which was filled with frightening and distressing details, but it seemed that she needed to distance herself from the horror in order to tell her story effectively. This defense forms part of the clinical diagnosis of PTSD, which views emotional constrictedness and reexperiencing the trauma as occurring in cycles coexisting in the same individual (Kaplan & Sadock, 1998).

The traumatic incident that Leila experienced occurred on the 20th February 2000. A woman met Leila, who was 7 months pregnant at the time, at a friend's house. She observed her boyfriend talking to Leila and mistakenly thought Leila was flirting with him and had given him permission to visit her. Later that afternoon, after arguing with her boyfriend, she waited for Leila who left the house alone to walk home. She followed her until they neared a deserted field. Once there, the woman held a knife to Leila's throat, handcuffed and gagged her. Motivated by rage and jealousy she stabbed Leila several times, inflicting deep wounds to her pregnant body. Fortunately, an older person walking nearby saw what was happening and called the police. Weak with the loss of blood and fearing for her baby's safety, Leila was taken to the nearest day hospital where her father, who had been contacted, was waiting. She said she only felt safe once she saw him. She was transferred to a major university hospital where her baby, 2 months premature, was delivered and placed in an incubator. Due to the damage to her uterus, Leila underwent a hysterectomy and remained in critical condition for several days because of the large amount of blood she had lost. She experienced physical pain in the

region where she had been stabbed for a year after the attack and suffered from symptoms of chronic post traumatic stress disorder as conceptualised within a psychiatric framework of reference (DSM-IV). Her symptoms included recurrent and intrusive recollections of the event and nightmares that her baby was taken away from her. According to Armsworth and Holaday (1993), persistent intrusive traumatic dreams are often reported by trauma survivors and are seen as the hallmark of PTSD. She also experienced flashbacks, irritability and outbursts of anger, especially towards her boyfriend, anxiety about the future, her safety, and fear of strangers. Leila avoided the area where the attack had occurred and even though she was aware of her distress, she had difficulty crying or showing anger for some time after the incident. Symptoms Leila experienced not included in the DSM-IV were depression, attachment difficulties, especially with her mother, and feelings of guilt and shame; symptoms also consistent with the findings of Armsworth and Holaday.

Leila's mother, Nadrah said that Leila had a friendly and trusting nature throughout childhood. The family described Leila as having been a confident, energetic, smiling and talkative person who rarely experienced difficulties with friends or within her family before the incident. This changed; after the incident she became afraid of strangers and refused to go out unless accompanied by someone in her family. She became more sensitive and afraid of people hurting her emotionally or physically. At home she was described as moody, irritable and withdrawn. These symptoms will be explored in greater detail in the analysis of the case.

Her mother attempted to shield Leila from the public exposure and publicity the horrific nature of the incident generated. The perpetrator, following psychiatric evaluation, was found unfit to stand trial by the court, and was incarcerated for an indefinite period in the forensics unit of a local mental hospital, where she was diagnosed with schizophrenia. The family felt let down by the justice system and was angry and shocked that the perpetrator had not received a life prison sentence. They believed she fooled the authorities and feared she would escape and attempt to harm Leila again. Like many survivors of trauma, their beliefs regarding the criminal justice system were sorely

challenged, and as Miller (1998) points out, interaction with the system often becomes a traumatic reminder of the crime experience.

4.1.2. Description of the family

Leila was born into an extremely close knit, relatively conservative and religious Indian family. The family, which consists of Leila, her baby boy, her 2 sisters and parents, live in a small house in an area of relatively low socio-economic status. Leila and her sisters share one bedroom and their parents sleep in the other bedroom. For 8 months after the incident Leila and her baby slept with her mother in the same bed, while Rafiek, Leila's father, slept on the floor. Leila's mother, who presented as a competent and caring mother and grandmother, left her work at a supermarket to remain at home with Leila and the baby. The family was placed under additional financial strain due to this loss of income. As Pynoos et al. (1996) note, one traumatic event may be associated with multiple adversities such as a change in the family's financial status. Leila's father, a worker at the railway, stated that he felt inadequate because he could not support his family sufficiently. On a more positive note, her mother said since the incident he had become more interested in spending time with them as a family and was easier to talk to.

The family appeared to have suffered a great deal of emotional distress due to the trauma Leila experienced, but managed to remain extremely close and emotionally supportive of her. Relationships within the family were nonetheless affected and altered. Leila's parents experienced enormous guilt at not having been able to prevent the attack. They stated on numerous occasions that they had always done their best to care for their children, yet the worst had happened. This led to doubts as to whether they could protect their children in the future. According to Osofsky (1997), parents who realise they may not be able to protect their children from violence are likely to feel anxious, frustrated and helpless. In addition, Leila's mother felt anger towards her husband for not fetching Leila from her friend's house on the day of the attack. She was especially preoccupied with fantasies of vengeance and stated that she would not be able to cope should further harm befall her children, particularly Leila, and that she would stop at nothing to protect her family from future violations. Smith and Holford (1993) report that the survivor

often experiences an intense wish for revenge. In this case, however, it was Leila's mother who fantasised about revenge. One such fantasy involved the sending of a letter bomb to the perpetrator. Her fantasies of revenge frightened Leila, who said that she would not want to see her mother in prison.

Leila's mother also indicated that previously she had difficulty in trusting individuals outside of the family, and that she placed great emphasis on unity and solidarity within the family. Nevertheless, Leila was fortunate to experience a loving and secure childhood, which may have created an unconscious notion or phantasy that she would always be protected from harm by her parents. In addition, she enjoyed a closer relationship to her parents than her sisters. This may indicate a greater need for attention and recognition, a common trait among middle children. After the attack Leila said she became even closer to her mother and even though she would get angry or annoyed with other members of her family, she had difficulty allowing herself to express any negative emotions toward her mother. She explained that the reason for this was gratitude for all her mother's support, and concern that she had become a burden to her mother. Sandler (1967) has an interesting explanation for the way in which guilt instigates repression following trauma. He quotes (as cited in Pynoos & Nader, 1993, p. 538): "The motive for the repression stems, not from the traumatic experience proper, but from fear of punishment, which is reflected in internal feelings of guilt, shame and humiliation." The guilt felt by Leila will be further examined in the analysis of the case.

Leila had always been the "apple of her father's eye," and she said it had been difficult for him to come to terms with her pregnancy and the fact that she was now a mother. She missed the times she would sit by her father and chat in the evenings, and expressed concern that she had disappointed her parents. Leila's mother added that after her initial shock she had accepted Leila's pregnancy and had looked forward to the birth. She had reasoned with her husband, who had initially been furious, and they had "stood by" Leila. Leila's father said that he prayed often and found strength in God to help Leila. All family members appeared to dote on Leila's baby, believing it was a miracle that he

survived the traumatic attack and was alive and healthy. Leila's mother stated she had always wanted a boy and that at last she had "her boy."

Leila breastfed her baby and enjoyed these times of closeness. On the other hand she feared she had harmed her baby because she had been unable to protect him at the time of his birth. She became frustrated when he cried and believed it was her fault and feared that he may not love her. She observed that he would stop crying when her mother cuddled him, which made her feel inadequate.

4.1.3 Personal relationships

Like many young South African girls in lower socio-economic areas, Leila's schooling was interrupted by an unplanned pregnancy (Women's Health Conference of 1994), as well as the subsequent traumatic event. Leila completed grade 11 in spite of her pregnancy, but did not register for grade 12. She was 6 months pregnant by that stage and planned to take a few months off to have the baby. This time frame was extended by the occurrence of the trauma to the end of the year, but Leila nonetheless intended returning to school in 2001 to complete grade 12. Pynoos et al. (1996) confirm that secondary stresses of trauma often include alterations in role and school performance.

Leila said she was still able to enjoy the company of her friends but believed they had become more tentative in her company, that is, "they joked around less." She was also anxious that her peers would respond to her with trepidation and treat her differently once she returned to school. In the literature Pynoos et al. (1996) also highlight the stress involved in dealing with peers after a traumatic incident, as conforming to a peer group and social acceptance is extremely important for adolescents.

The relationship between Leila and her boyfriend began 2 years before the traumatic incident; she stated that since the traumatic incident and arrival of their son they had experienced difficulties in maintaining an intimate relationship. Since the traumatic event she went out with him less often and became upset and jealous when he went out with his friends. She also admitted to taking out most of her frustrations on him, saying

he was like her “punchbag.” Her parents believed she could “do better” as he had not completed high school and was struggling to find work. They clearly blamed him for impregnating their daughter. De La Rey and Carolissen (1997) point to the tension between acceptance and support of the baby by the family and condemnation of premarital sex and pregnancy.

4.1.3. Intervention

A social worker at a local public hospital saw Leila and her family for 1 session, 2 months after the trauma had occurred, in which she was told the story of the traumatic event. She urgently recommended that Leila and her family be seen at the psychiatric adolescent unit for intervention, as in addition to Leila’s distress and symptoms of PTSD, the family was apparently suffering from the effects of the trauma, experiencing a degree of vicarious or secondary victimisation. I met the family a week later at the adolescent unit for an assessment. I had read about the attack in the newspapers and the horror of the incident had shocked me. As a result I felt anxiety and trepidation about how I would cope hearing a first hand account. These feelings lifted and were replaced with compassion once I met Leila and her family. Leila’s good physical appearance helped me deal with my own fears of how she was actually damaged, emotionally and physically, by the trauma. In this first session the entire family, except Leila, was in tears and clearly needed to express their helplessness, distress and anger. I decided that family therapy would indeed be the appropriate therapy, hoping that in the process of Leila’s parents being held and understood in the therapeutic process, this would in turn increase their capacity to provide such an experience for Leila. As J. Cohen (1998) points out, emotional containment of the family in turn helps them provide containment for the adolescent outside of the therapeutic space. The fact that Leila was fearful of being alone with me was also taken into consideration. Family sessions always included Leila, her baby and her mother. At various stages in the therapy her father and/or one of Leila’s sisters joined us.

Due to the quality of Leila’s support system, relatively good pre-morbid functioning and the fact that a single overwhelming incident results in severe but usually transient

disruption of ego functioning, it was hypothesised that her recovery would be satisfactory. My task was to help her to find ways and resources within herself to begin to relate to the world, and ultimately to turn the devastation of a critical developmental period in her life into something greater or productive. The process of therapy therefore provided the possibility of unbearable feelings being made bearable, clearing the way for integration and growth. The description of how this was achieved in therapy is however not the objective of the following discussion; the focus, as stated earlier, will be on an observation and exploration of the way in which trauma was individually experienced.

4.2. Case discussion

It has been illustrated in the literature review that developmental influences can enhance or impede trauma resolution (Pynoos et al., 1996). With this in mind I shall explore the difficulties Leila had in confronting certain developmental tasks after the traumatic event, which may have been difficult for her in her family of origin. Paradoxically, the trauma also provided a channel for her to resolve issues and take them forward. After severe trauma in adolescence, there is always the danger of fragmentation of the developing personality, but at the same time there is a chance to integrate the unmanageable aspects rather than deal with them via projection and acting out. This is in line with the views of Balint (1952, 1969), Bowlby (1960), and Fairburn (1952) that consider trauma to be a potential psychic organiser. Features unique to this case, such as Leila's relationship with her baby and her mother, will be brought to the fore, due to the impact of these on the understanding of trauma and adolescence.

At a glance, there seemed little pre-existing psychopathology that could complicate efforts at trauma mastery in spite of the pregnancy that had temporarily disrupted family relationships. However, there were signs of some difficulties in the family before this event, such as sibling rivalry, a preoccupied father and a mother who was by nature suspicious of "outsiders," which were exacerbated by the pregnancy and the subsequent trauma. In addition, the developmental tasks of adolescence, such as separation from the parents and the negotiation of a new kind of relationship with them, individuation and identity formation, and the acquiring of a stable and helpful peer group (Adelson, 1980;

Court, 1997; Josselson, 1980)), provided challenges that needed to be managed in order for Leila to successfully meet the next developmental stage of early adulthood. As noted earlier (Court, 1997; Herman, 1997; Marans & Adelman, 1997; Rubin, 1999), these tasks already involve a degree of inner turmoil, anxiety and a temporary disintegration of the personality, and provide a series of complex personal, occupational, sexual and ideological choices. The adolescent is often compelled to mobilise powerful defenses against experiencing the discomforts of this phase, such as acting-out behaviour or a regression to infantile feelings of greed, fears of annihilation and loss of love (Holmes, 1991). An example of acting-out behaviour may have been Leila's relationship with her boyfriend, of whom her parents disapproved. This may also be understood as an attempt to break out of her enmeshed family and establish a sense of autonomy, as a precarious balance between the identity of Leila and the diffusion of that identity within the family was observed. The struggle between the wish to remain close to her parents and the urgency to achieve new relationships is acknowledged by Adelson (1980) in the literature. The ways in which trauma impact on the dichotomous nature of the tensions and conflicts inherent in adolescence will be looked at in greater detail in the following sections.

4.2.1. Togetherness vs. Separateness

It was at the time when Leila was already experiencing a developmental crisis by being pregnant, and her family was trying to come to terms with an imminent birth that severe trauma was experienced. The deliberate violation of her and her unborn child occurred when her still developing personality was at the stage of exploring a separate identity. This precipitated overwhelming terror and a need for safety and attachment to her mother. The world in effect ceased to be a safe place, and her mother's view on not being able to trust those outside of the family (which had been impressed upon Leila since childhood) was confirmed. This resulted in Leila placing enormous emotional demands on her mother, as she was unable to feel safe unless her mother was with her at all times. As noted by Pynoos et al. (1996), the distress caused by severe and persistent PTSD symptoms exacerbate symptoms of anxious attachment, including increased clinging in an effort to obtain comfort from the caretakers. Furthermore, the fact that the

family already had little tolerance for separation and demanded unity and bonding appeared to be exacerbated by the trauma and may have contributed to Leila's mother in particular becoming overprotective. She mentioned on numerous occasions that she would be happy for Leila to remain at home "for the rest of her life" so that she could watch over her. Leila's need for greater closeness had the effect of colluding and supporting these dynamics, leaving her unable to fulfill her developmental tasks of separation. As Pynoos et al. comment, trauma upsets the developmental balance between independent and dependent behaviour. This need to separate is one that operates paradoxically; even though Leila needed to separate, she still needed her mother's support. In light of the trauma that occurred, some of the overprotectiveness by the family would be considered a normal and appropriate response.

It is further hypothesised that Leila's mother becoming increasingly over-protective and assuming the role of the baby's mother, made it even more difficult for Leila to emotionally move away and left her prone to feelings of incompetence and doubt. This is in line with Marans and Adelman (1997), who state that the experience of violence threatens to override the developmental thrust towards autonomy. Her parents' preoccupation and anxiety also served to reinforce her counter-dependent behaviour and the extent to which this was based on a lack of differentiation within the family. She was therefore trapped; she either continued looking for intimacy outside the home which no longer felt like a safe option, or chose to remain within the family and suffer the fantasised and /or part reality threat of massive regression to early intimacy experiences she knew as a young child and as an infant. These are defenses noted by A. Freud and Blos in the literature (as cited in Adelson & Doehrman, 1980) which defend against the emergence of powerful drives, and despite the anxiety they engender, need to take their course to enable healthy development. Leila's symptoms in sum had the effect of interfering with inner resourcefulness that in turn affected successful resolution of developmental tasks, such as her sense of identity formation. It was also possible that to spare herself the painful work of separation and growth, it was easier to hold onto her victimisation, as separation clearly evoked the terror of retraumatisation.

Towards the end of September, after Leila had been in therapy for 4 months, important shifts towards 'separateness' took place. Leila's mother returned to work earlier due to financial difficulties; she said she wanted "to be in the position to give" and that the baby was "old enough and attached to Leila." She looked excited at the prospect and positive that Leila and the baby would be fine. Leila's nightmares had ceased by this stage, and even though she still experienced 2-3 flashbacks per day, she was more confident about going out and seeing her friends. However, she did not want to be alone during the day while her mother was at work, so she moved in temporarily with her grandmother, who would care for her in her mother's place. There was much discussion in therapy about how much they would miss one another, but Leila said she felt "stronger." The move gave her the opportunity to test some measure of her autonomy at her grandmother's home, where it still felt safe as she remained within the family environment, but without the array of fears of her immediate family. In a sense, her grandmother became a "transitional object." At this home Leila also spent time with her cousin who had a baby; this helped lessen her feelings of alienation. She stated in therapy that she missed talking to her mother during the day, but talked to her cousin and her granny instead, and sometimes called her mother at work. She also spent weekends at home. It was at this time that she considered returning to school the following year, a decision she had previously shunned. This marked the beginning of her interest in the outside world, and the restoration of the balance between autonomy and remaining connected to others. After 5 weeks she returned home but slept with her sisters instead of her mother, which was another important shift.

4.2.2. Adolescent vs. Adult Roles

Leila's ability to assume a developmentally appropriate and active role in addressing issues relating to the changes in her life was eroded by traumatic anxiety and fear. Her passivity may have stemmed from a sense of powerlessness to affect her life, and is in keeping with the findings in the literature which state that female victims are more likely than males to internalise hopelessness and helplessness (Armsworth & Holaday, 1993). The fear Leila felt affected her ability to view her future in a positive light, as the incident reduced many of the normal options an adolescent could hope to face in later years, such

as her chances of having a second child. This “sense of a foreshortened future,” as mentioned earlier, is one of the symptoms of PTSD (Kaplan & Sadock, 1998). Leila stated another fear was that she would marry someone who would at a later stage “throw in her face” her inability to have more children. She therefore needed to come to terms with her grief regarding the loss of childbearing capacity.

As Adelson and Doehrman (1980) note, the development of sexual identity and the adoption of an adult sexual role are major tasks of late adolescence. This provided Leila with certain dilemmas, such as psychosexual conflicts, which the traumatic event picked up and amplified even further. Fears of sexual inadequacy emerged, with Leila fearing that no man would want to marry her once the consequences of the traumatic incident became known. As Bowlby confirms, negative forecasts about the future can have a profound effect on current and future behaviour (as cited in Carbone & Spano, 1999). The life event of pregnancy also has its own stress quotient, and further complicated resolution of developmental tasks by propelling her into early adulthood. In other words, there was a blurring of the role definitions of adolescence and adulthood. In addition to the need to resolve the complex tasks of adolescence as well as attempt the enormous task of working through the trauma, Leila had to take on the adult role of motherhood with its concomitant responsibilities. This involves important identity issues as Berkovitz and Sugar (1983) pointed out. In this regard, there needed to be a certain amount of repair to her self-esteem and a rebuilding of ego-strength for her to feel competent as a mother; if she could feel cared for and esteemed, she would be better equipped to deal with the challenges of motherhood. The Woman’s Health Conference of 1994 emphasised that support of adolescent mothers is imperative, in part for the emotional reasons described above.

It is possible that Leila may have initially experienced underlying resentment towards her baby, whose presence precipitated a premature closure of identity formation, as noted by Berkovitz and Sugar (1983). She seldom went out with her friends, preferring to remain near her baby, and believed for a while that she should look for a job rather than return to school. The fact that she appeared to blame herself for causing harm to her baby gave

rise to conflicting feelings that may have resulted in an ambivalent and fragile relationship with her baby. She spoke of her concern that he would “hate her in the future” when he heard the story of how violently he had come into the world. There also existed the potential for her to harbour severe resentment and anger towards her baby, but with an adequate support system at home and the opportunity to work through her trauma in therapy, the resentment did not become unmanageable. During the course of therapy, in fact, Leila became more confident around her baby and the bond between them deepened. This became apparent 3 months into the therapy, early September, when she stated emphatically that she was ready to take on the role of motherhood. Until this point her mother had played the role of mother to both Leila and the baby. Leila’s mother looked hurt by her daughter’s decision, but said she was happy to give her full support in the capacity of grandmother. Leila’s ability to handle her baby increased from this point, for example, she no longer handed him over to her mother every time he cried. The fact that she was successfully breastfeeding also helped her confidence in this regard. This in turn freed her parents to spend more time together and restore their bond. On their wedding anniversary Leila and her sisters encouraged them to go out for dinner to celebrate, which led to Leila’s mother feeling confident enough to leave Leila and her sisters alone at home for the first time since the traumatic incident.

At a later session Leila’s mother stated that: “he (the baby) is a mistake, but we love him.” Leila looked distressed and said directly to me: “I still feel like they (her parents) are disappointed in me.” It seemed that even though her family unwaveringly showed their love and support, Leila felt as if they wished nothing had happened. She came to see her baby as “a gift,” in spite of the trauma she had experienced, and interpreted her parent’s views as a rejection of her baby. This may have stemmed from an unconscious belief that she was loved conditionally, that is, as long as she was a good girl and did not go “gallivanting” with her boyfriend (i.e. grow up too soon), her parents would love her and her baby. This insecurity was also reflected in her extreme reluctance to talk about her boyfriend in her parent’s presence, or to make comments such as the one above, directly to her mother. Here it was evident that in many respects she still remained her parents ‘little girl,’ anxious that she had disappointed them by falling pregnant, and

ambivalent about becoming independent from them. Ambivalence over autonomy is noted by Josselson (1980) and Rubin (1999) in the literature, and is a normal part of adolescent development. However, since falling pregnant and later being traumatised by the attack, it seemed as if Leila needed permission and reassurance from her parents, implicit and/or explicit, before she allowed herself to individuate. At the same time, through the relationship with her baby she was beginning to establish an adult identity and gradual autonomy, as she and her baby were bonding well.

4.2.3. Guilt, Anger and related Depression

It is important to understand that adolescents, unlike children, have an abstract understanding of alternative action and can accurately identify how their choices influenced an outcome (Pynoos & Nader, 1993). In addition, they are exquisitely sensitive to their own imperfections, as observed by Adelson and Doehrman (1980). Leila's relationship with her boyfriend, in spite of her parents' disapproval, is a relatively common behaviour in adolescence and does not in itself lead to extreme distress within the family. In this case however, her act of rebellion resulted in an unplanned pregnancy, leaving Leila with enormous guilt and ambivalence at having disappointed her parents. These factors possibly contributed to Leila blaming herself for the attack. As mentioned earlier in the literature (Herman, 1992), trauma survivors need to be told that they are not responsible for what happened to them; this was particularly difficult for Leila to believe. The impact of broader social forces came into play when Leila's mother needed to leave her job in order to care for Leila emotionally at home, which led to a financial crisis. This may have increased Leila's guilt and struggle with simultaneously needing her mother and feeling like an emotional and financial burden. Pynoos and Nader (1993) note that guilt significantly increases post traumatic distress.

Other symptoms of post traumatic stress that Leila experienced included depression, low self-esteem, anxiety, recurring nightmares that her baby would be taken away from her and extreme difficulty in showing her emotions in initial therapy sessions to the point of emotional bluntness. Emotional constrictedness may be understood psychodynamically as a defense against the breakthrough of intrusive images of the trauma, and, as Herman

(1992) observes, it also reflects the numbing response of surrender. It was interesting that the times Leila found it difficult to express herself, her mother would be the one who expressed the anger, pain and anxiety. She became in effect the spokesperson for the feelings the family could allow itself. An object relations perspective explains this process as feelings being split off and transferred to another for the purpose of being understood. In other words, Leila may have used projection as a way of dispelling or disowning bad thoughts and feelings, and getting her mother to feel and take responsibility for them. Klein points out that while this plays a necessary role in normal development, the result, when carried out excessively, may be an “overstrong dependence” on those who represent the projected parts (as cited in Box, 1994, p. 76). This notion can also be linked to the more classical term of countertransference. Leila’s difficulty with expressing her feelings lessened as therapy progressed and she began to feel safer.

Depression is significantly tied to violence-related trauma in the literature (Freedman et al., 1999; Giaconia et al., 1995; Yule et al., 1999). The depression Leila experienced was tinged with anxiety, and at other times, anger. When her feelings of guilt and rage were particularly powerful, she tended to turn her anger inward, which resulted in concomitant symptoms of hopelessness and helplessness. Her rage against the injustice of what happened to her was also indirectly related to inner struggles over autonomy that could not be safely projected onto her parents because they were in essence keeping her safe after the incident.

4.2.4. Tragedy, Loss and Mourning

Herman (1992) believes that the descent into mourning is at once the most necessary and most dreaded task of recovery. The following examples illustrate feelings of mourning and loss, born out of the tragedy of the trauma. On the day of her sister’s 21st birthday party, Leila felt extremely distressed. She explained in therapy that she felt her party would not be “as special” one day because she was a mother and therefore her situation was “more messy.” Her mother had felt “shut out” as Leila refused to tell her at the time what was wrong, and had instead spent most of the day in tears. On reflection in therapy,

it seemed as if Leila was in mourning for the girl she used to be before the pregnancy and traumatic incident, who used to spend time with her friends discussing light-hearted topics, such as what to wear to their high school graduation party. She had wanted to wear a revealing and sexy dress, but since the attack felt ashamed of her body with its scars. Her mother in turn mourned the loss of “her little girl,” and needed to adjust to the changes in their relationship and her new role as grandmother. This discussion led to one of the most poignant moments in therapy; with her mother’s encouragement, Leila lifted her top and showed me the scars. She also gave me a photo of herself and her baby, a happy and smiling one. The contrast between the two images was enormous and seemed symbolic of both tragedy and hope.

The family’s relief that they had a space to vent their frustration, anger and grief led to the unrealistic hope that I could make everything well again. Strong persecutory feelings and anxiety within the family hindered Leila’s ability to move from a passive role in dealing with the trauma to an active one. These factors led to myself becoming an idealised object in the transference that would fix current difficulties on a practical and emotional level, as well as counteract the dread of further trauma. I could not meet this hope, which would imply collusion at the level where persecutory and idealised objects remained split. This observation is in line with P. Cohen (1998) who commented on the phobic construction of the world that often occurs after the experience of trauma. It was important however that I understood the anxiety that exerted pressure on me to fulfil the idealised role. This was a process in which I, myself experienced anxiety and pressure to help the family. I dealt with this for a while in practical ways. One such example involved my arranging follow-up appointments for Leila with the specific doctor who had helped Leila on the night of the trauma; this is unusual in a large public hospital where doctors move wards frequently.

At one point Leila’s mother became hopeful that with my help, Leila could receive financial support/ reparation from the state in the form of a disability grant. This neediness led to a realisation on my part that for many people psychological support is not sufficient; there remains a symbolic need for reparation and concrete

acknowledgement that they are the “heroes” in the tragedy. This issue also raises questions about what kind of compensation is ultimately more effective, psychological or practical/financial, because both are not easily accessible in areas where mental health workers are overworked.

There was initial anger that Leila could not receive a grant, then gradual acceptance. Herman (1992) believes that the fantasy of compensation, like that of revenge, often becomes a formidable impediment to healing, and may represent a defense against facing the full reality of what was lost. Later acceptance of being unable to qualify for a grant, led to the shift from Leila being seen as a “victim,” and wearing her pain like a “badge” that would keep her isolated and feeling special in her suffering, to that of being a “survivor.” In other words, a disability grant would have had the effect of Leila being seen as a helpless child, as one of the conditions are an inability to work in the future, which would have interfered further with her struggle with independence and autonomy. I also wondered whether the family’s insistence on wanting a grant was about being “special” and not having been treated in a special way, or whether it was about a reluctance to become independent. To conclude, in the words of Herman (1992, p. 190): “mourning is the only way to give due honour to loss; there is no adequate compensation.”

4.2.5. Safety vs. Exploration

According to Herman (1992) a rudimentary sense of safety after trauma can generally be restored within a matter of weeks if adequate social support is available. This process as Sugar (1999) points out, may be disrupted if the victim encounters an unprotective environment and/or intrusions, such as the press or legal proceedings outside of the survivor’s control. Pynoos et al. (1996) refer to this as “secondary injury” and emphasise its role in increasing the risk of comorbidity. In Leila’s case her symptoms were further maintained and exacerbated by the intrusion of the press, the family’s perceived failure of the judicial system and the belief that the perpetrator received too lenient a sentence. This belief seemed sustained by the premise that retribution and/or “attacking” the perpetrator would protect them. Naturally the family would also feel physically safe if

the perpetrator was sent to prison, which would then help to restore their faith in the community. Fantasies of “attacking” the perpetrator however often have the adverse effect of increasing the fear of retaliation, which became apparent in this case. The desire for retribution may also have stemmed from an unconscious belief that a prison sentence, as opposed to a psychiatric hospital, would have confirmed that the perpetrator was entirely responsible for what had happened, and the family’s own guilt at not having been able to prevent the attack would then be alleviated. Feelings of anger at Leila’s suffering not having been sufficiently legally acknowledged may as a result have reinforced their own feelings of guilt and helplessness. I was asked many questions regarding medico-legal issues which, being beyond my scope of reference, I was unable to answer. This led to my countertransference feelings of helplessness and being trapped in the face of their anger. I subsequently arranged for a psychologist who specialises in forensic work to see the family and answer their many questions; he became a target for their fury as he could not specifically say how long the perpetrator would be kept at the forensics unit.

As Carbone and Spano (1999) state, trauma sits in an intermediate area between the individual’s outer and inner worlds. In this context, the developmental task of the engagement of the adolescent with the wider community comes into play, which may understandably have been one of the most difficult challenges for Leila to confront after the attack. Given the extraordinary high level of violence prevalent in low socio-economic areas in South Africa (Ensink et al., 1997; Hamber, 2000), it is imperative to acknowledge how the environmental context in which the incident took place impacted on Leila’s recovery. The fear of future trauma, (which was understandable given the high rate of crime in her area), had the effect of damaging her ability to reconnect with the outside world, no longer perceived as orderly and just (Van der Kolk & McFarlane, 1996). This further compromised her sense of autonomy by limiting opportunities for new relationships.

There were acute reminders of the trauma that occurred sporadically throughout the year that caused both Leila and her family distress and disrupted fragile attempts at venturing out into the community. An example of this occurred on an evening during August when

Leila was watching a movie on television that depicted a female killer. This led to an emotional catharsis; for the first time since the attack Leila broke down. Her mother spoke of how Leila had cried and screamed for hours that night, and how frightened and helpless the family had felt. Leila described acute feelings of terror and pain; similar to those she had experienced during the attack. This incident marked the point at which she was ready to actively work through her trauma. On another occasion, Leila saw a lady near her home who closely resembled the person who had attacked her; this had scared her to the extent that she felt unable to go out for a few days thereafter.

Her family experienced similar fears. Leila's mother heard from a neighbour that the perpetrator was allowed home over weekends from incarceration in the forensics unit, and became extremely distressed at the possibility of Leila being hurt again. On further investigation it turned out this was only a rumour, but it had fueled her mother's anger and desire for revenge to such a degree that a few sessions were needed to contain her rage and feelings of helplessness. This was a shared nightmare within the family. The individual members all felt the anxiety to different degrees, but there was a shared internal object that took different forms, of which images of damage and vengeance mostly predominated. Herman (1992) states that the revenge fantasy is often a mirror image of the traumatic memory, in which the roles of perpetrator and victim are reversed. Continued therapeutic support led to the gradual undoing of the premise that attack could protect, which needed to be realised for Leila and her family to attempt to trust the world again. This involved the coming to terms with the impossibility of being entirely safe, and finally, the impossibility of getting even.

Towards the end of therapy her mother's anger slowly dissipated. A comment she made "God will deal with the perpetrator," reflected the shift towards her taking less emotional responsibility for the perpetrator's fate. This comment may also have been an acknowledgement of her helplessness in creating a permanent solution to the problem, and points to the ultimate and permanent vulnerability of the human condition. A deep sadness followed this shift in emotion; Leila's mother expressed the desire a number of times in therapy to visit the perpetrator to ask why she had "ruined" her daughter's life.

4.2.6. Trust vs. Suspicion

The psychodynamic relationship was crucial in this case because I provided the counterbalance to the flagrant destruction of trust that she had experienced. In other words, the message that strangers are to be feared and avoided needed to be counteracted in order for Leila to properly fulfil the developmental tasks of adolescence, and the transference reaction was a crucial platform to enable this. As Brothers (1995) notes, the ability to trust again after trauma is essential to fulfillment and future happiness in relationships with others. The reason is that a secure sense of connection with caring people is the foundation of personality development, and when this connection is damaged, the traumatised adolescent loses a basic sense of trust.

Initially, I realised trust was an issue for Leila as she was afraid to be in a room alone with me, possibly because I am of the same gender as the perpetrator. During one of the earlier sessions with the family, Leila's mother left the room for about 10 minutes to walk in the corridor and console the baby who was unable to stop crying. Leila looked terrified, in spite of her sister's presence, and kept her eyes on the door until her mother returned. Therapy was momentarily interrupted; after acknowledging her fears I spoke on a superficial level, feeling anxious that I would inadvertently harm her in some way.

Trust issues resurfaced after 3 months (beginning of September) when I unfortunately needed to change the setting for therapy, and decided to take a week leave before this change. At the following session, Leila informed me she had made the decision not to return to school the following year and would begin working instead. When I reflected that perhaps part of the reason for this was her guilt at having been a "burden" to her family, she became angry with me for the first time. She said she was also cross and disappointed in me for not having been available the previous week. I felt her ability to express her feelings towards me was positive, because for Leila to feel disappointment meant we had built up a relationship and that she trusted me. Winnicott comments on anger in therapy, which he considers a sign of hope as it indicates that enough trust exists to express anger about losses to those most helpful (as cited in Sugar, 1999). This trust

was confirmed at the end of the session, when Leila held out her baby for me to hold for the first time. I felt honoured by this gesture of faith. Other signs that the family was ready to trust were noted. Leila's father arrived late to fetch his family on one or two occasions, and Leila and her mother did not appear anxious or even ruffled by his tardiness. They had also become friendly with the busdriver who drove them to the hospital on the appointed days. A comment Leila made "therapy has become part of my life," indicated that the constancy and reliability of the sessions had begun to give her a fingerhold on life, which would hopefully in time lead to other trusting and rewarding relationships.

Though Leila was more wary and less trusting than she was before the trauma, she no longer felt completely vulnerable. This was indicated when she requested an individual session in October, much to my surprise and pleasure. It was noteworthy that she asked me to inform her mother of this plan, as if she feared either hurting her mother or possible rejection. During this session we discussed her relationship with her boyfriend, her frustration at her parents for not accepting him and her inability to confront them about it. She explained that her parents would not allow her boyfriend to take the baby to visit his family, and did not make him feel welcome at their home. She added that she did "not understand" her father and that it seemed as if he "wanted the baby for himself." She was concerned that her mother would be informed of this discussion, and asked, "does my mother have to know?" At the end of this session, Leila said it had felt good to speak about her difficulties on her own and requested further individual therapy. However, this never took place, as her wish to see me individually was never raised again. This was not necessarily negative, for as Blos (1983) points out, many defenses used in adolescence have an adaptive function and contribute to character formation. At this point I felt that Leila needed to separate more than she needed to bond, and furthermore, I needed to terminate therapy within a few weeks and there may have been the possibility of Leila becoming too attached to me in individual sessions. It appeared that she became closer to her boyfriend instead; she made an autonomous decision to go out with her boyfriend and their baby for the first time and said it had "felt good, like a little family." The example of the outing strongly illustrates the need for adolescents to feel competent on their own

in spite of having suffered trauma (Adelson, 1980), which leads to the ability to successfully negotiate the tasks of young adulthood. The scale at this point was tipped in favour of growth, and I felt she was ready to begin dealing with separation from therapy.

4.2.7. Risk vs. Resilience

The attack had many of the features described in the literature (Smith & Holford, 1993) that rendered Leila more vulnerable to the effects of the trauma. These included being geographically close to the site of the trauma; Leila would take great pains to avoid any route that would entail her having to pass the field where the attack had taken place, intrusions by the media; after the attack, reporters initially printed inaccurate accounts of the attack that upset the family immensely. The fact of her gender has been shown by numerous researchers (Giaconia et al., 1999) to be a risk factor in developing subsequent PTSD. As Sugar (1999) acknowledges, developmental age plays a significant role, as adolescents perceive and assess trauma more readily than children. With regard to the severity of the attack, it was certainly severe enough to cause acute distress to anyone, a criterion specified in the DSM-1V. Furthermore, Eagle and Watts (2000) note that it is the deliberate use of gratuitous violence that affects victims most powerfully. In addition to these factors, the fact that Leila was 7 months pregnant rendered her especially vulnerable to physical and emotional trauma. Recent theorists (Yule et al., 1999) therefore focus on the importance of the subjective nature of the trauma and the understanding of the individual's inner experience. For this very reason, namely, to illuminate the subjective experience of traumatic stress, a case study was employed.

Miller (1998) suggests that in the best cases family members may “grow” from a horrendous experience, but such cases are the blessed exceptions, and many families do well just to survive. As Herman (1992) says, treatment for trauma may never be complete, and for some people extreme trauma may require years of transformation after the initial process of successful coping has been completed (Tedeschi & Calhoun, 1995). Protective factors that aided Leila's ability to cope after the attack included the relatively stable upbringing she had received and emotional support she received from her family, a crucial factor which helped her face the thoughts and feelings that emerged in the months

following the trauma. This may have helped to offset the risk factors inherent in the physical environment. Breastfeeding appeared to play an important role in facilitating bonding between Leila and her baby, and helped heal her damaged sense of worth. The family's willingness to seek outside help in the form of a therapeutic healing relationship was an antidote to the cruel and destructive perpetrator, leaving Leila free to pursue the developmental tasks of autonomy, and consequently, motherhood.

CHAPTER 5: CONCLUSION

The deeper that sorrow carves into your being, the more joy it can contain.

Gibran, 1926, p. 40.

Violence results in physical injury and psychological trauma. In considering the traumatic potential of an adolescent's exposure to violence, I have relied on the concept of trauma defined as an exceptional experience in which a powerful and dangerous external event overwhelms the adolescents' capacity to regulate his or her emotional state (Marans & Adelman, 1997; Van der Kolk, 1996).

Theory has shown that the unique psychological history of each individual, such as difficulties in early childhood and/or the dysfunctional status of intrafamilial relationships cause complicating factors over and above the trauma and the developmental tasks they confront. These need to be explored to substantiate them as indicators of complications that could lead to enhanced trauma-induced disorders in the longer term. Damage to basic trust and its potential effects on development must be taken into account in understanding the traumatised adolescent. The separation from the child-parent relationship to the adolescent-parent relationship may cause ambivalence due to the uncertainty produced by the shift, which may in turn affect ability to trust. Implicit in this shift is the further uncertainty produced by developmental changes, such as the redefinition of ego-status and striving for the balance between dependence and independence. These changes are base level conditions that will be present in all adolescents. Levels of defensiveness, over and above the expected levels of adolescent "acting-out," becomes an indicator of potential complications in trauma symptomology. The presence of some predictable stress in adolescence must therefore be taken into account when evaluating traumatic complications.

The case study highlighted an experience of trauma within an on-going climate of adversity, namely, financial difficulties, an unsafe environment and interrupted schooling. In South Africa adolescents are frequently exposed to chronic adversity and cannot be reassured that life will be back to normal once the danger has passed. Leila's

fear at venturing outdoors after the traumatic incident was justified to the extent that she was living in an area in which levels of crime are high. An understanding of violence and the difficulties inherent in living in lower socio-economic areas provided the context within which an awareness of the relationship between trauma and the environment was facilitated.

Assumptions of trauma symptomology, however, often center exclusively on the external circumstances of the violent event and fail to consider the unique experience and particular meanings attributed by the adolescent to the event. A psychodynamic approach to the case allowed for an exploration of the unique experience that deepened the understanding of the psychic processes affected by trauma. In this way a range of insights into trauma and its integration into adolescence could be demonstrated. In Leila's case, a single traumatic event led to the experience of loss and grief and continued apprehensions about safety. She did not appear to suffer from major external childhood traumas, so developmental definitions of the impact of trauma, which are concerned with the mechanisms of risk and resiliency in adolescence, point to the importance of emotional resiliency in overcoming the negative effects of a type 1 trauma. However, from a psychodynamic perspective, there is always some internal preexisting infantile or childhood trauma, which is re-evoked by a later external traumatic event. Consequently in adolescents, as opposed to adults or children, there may be greater potential for psychic disorganisation, as earlier life experiences are usually strongly re-evoked during this phase of development that render adolescents extremely vulnerable to the effects of trauma. Leila's enmeshed family and her mother's unwillingness to trust those outside of the family were the pre-existing contexts in which the unplanned pregnancy and later trauma occurred.

What the case also highlighted was that the severity of violence-induced trauma in adolescence is no less acute in the context of an individual who has experienced a supportive and loving home environment through childhood. The value of family as support is also an important contribution to the understanding of resilience in adolescence. A supportive family can thus be viewed as a protective factor in an adverse

environment, which may in turn facilitate a reentry into the maturation process. Supportive others may be helpful in this journey, but eventually the individual must make his/her own peace with the event. As Tedeschi and Calhoun (1995, p. 137) state: “paradoxically, a new sense of power must be nurtured; the determination to extract the good from living and to actively contribute to it.”

An analysis of violence-related trauma in adolescence confirmed that ways in which adolescents negotiate the consequences of exposure to violence rely heavily on support structures in the environment. When ignored, overlooked or misunderstood, feelings of helplessness, guilt or shame may have an enduring effect by interfering with optimal development and functioning. These feelings were explored in an analysis of the case study material. The case study highlighted the interplay between an adolescent’s experience, developmental status and the greater environmental context within which the violence occurred. In terms of the adolescent’s subjective experience of trauma, the DSM-IV is not that helpful. There needs to be more flexible ways of understanding the subjective experience of trauma, such as a closer working relationship between the psychiatric and psychological systems. It has been shown that the period of adolescence is a vulnerable time for experiencing trauma, although development can be facilitated if the trauma is effectively understood and treated. In particular, clinicians must be sensitised to the high-risk status of adolescent females, who now experience physical traumas that were in the past believed to be confronted only by males (Giaconia et al., 1995). It is imperative that intervention takes place promptly and not later once adulthood has been reached. At present, however, there are no specialist services for adolescence affected by trauma, as opposed to the already too few centres that work specifically with adolescents or victims of trauma. In this respect further research on trauma and adolescence in South Africa is needed, which may offer insights with direct preventive implications, as well as alert policy-makers to the need for more support structures.

Although this study focused on the subjective experience of trauma, it was evident that the trauma impacted on Leila’s ability to effectively deal with being a mother at such a

young age in both emotional and practical ways. Provision should therefore be made for research that will enlighten policy formulation on options of providing economic support for adolescent mothers, as well as identifying the stresses of young mothers with emphasis on how to ensure that they continue their education. The legal system should be reformed in order to create more user-friendly legal assistance for those adolescents who are victims of violence. Addressing these concerns could help to prevent secondary traumatisation. Other aspects of the case, such as the fact that the perpetrator was female, are unusual and could stimulate professional interest in other areas of violence-induced trauma. This could lead to “filling the gaps” in research currently experienced in this field, thereby providing an important contribution to the body of knowledge relating to adolescents affected by trauma.

The study of the multi-faceted area of adolescence conclusively remains a critical opportunity for gaining understanding of the dynamics involved in this phase of development; and to explore the process of adolescents who are able to grow successfully into adults, able to interact meaningfully and lead rich and rewarding lives. Without this understanding, adolescents’ attempts at recovering from overwhelming fear, uncertainty and helplessness induced by trauma may be at a very high price to their developmental potential as well as to the communities that have been unable to protect or support them.

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