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**Psychology Interns' experiences of working with survivors
of violence at psychiatric hospitals in Cape Town**

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award of the degree of Master of Arts in Clinical Psychology

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DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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ABSTRACT

South Africa has very high rates of violence and many people who are treated within psychiatric hospitals have been exposed to interpersonal violence. However little has been documented about trauma interventions in the South African context. Twelve clinical psychology interns completing the second year of their clinical masters training at Valkenberg, Groote Schuur and Lenteguur Hospitals were interviewed. The interviews were recorded, transcribed, coded and analysed according to grounded theory methodology, in order to establish: the kinds of violent experiences to which patients are exposed; patients' presenting complaints and diagnostic trends that were noticed amongst patients; the therapeutic work that is being undertaken with patients by interns and the theoretical models on which their work is based; the various challenges that interns encounter in their work with survivors of violence, and the training issues that arose for interns during the course of their work. The findings were compared with the available literature regarding the impact of exposure to violence and models of intervention, which is based predominantly on research conducted in economically developed countries. It was established that rates of exposure to violence are very high amongst the psychiatric patients seen by these interns and multiple traumatisation was felt to contribute to the complexity of their patients' presentations. Despite having received some training in working with survivors of violence during the course of their generalist training, interns felt ill-equipped to work with many of these patients because of the degree of complexity of patients' problems, including the contextual issues which continue to impact on patients. Most interns reported that they would have benefited from more specialist training. Existing theoretical models formed the basis for the interns' understanding of the psychological impact of exposure to violence but established intervention models were felt to be mostly inadequate with this patient population. In light of these findings areas for further consideration and research are suggested.

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CHAPTER 1

INTRODUCTION

1.1 Background

South Africa has very high rates of violence, when compared with statistics from other countries, including other developing countries. In South Africa the incidence of political violence has reduced, however people continue to live with the effects of previous exposure to violence under the Apartheid regime (TRC, 1998), rates of homicide are among the highest in the world (Altbeker, 2007), the rates of non-accidental injuries outnumber accidental injuries (Matzopoulos, Myers, Bowman & Mathews, 2008; Norman, Matzopoulos, Groenewald & Bradshaw, 2007) and most crimes are committed with the use of weapons (Altbeker, 2007; Donson, 2007). The number of victims of gender-based and intimate partner violence, as well as children who are abused, although difficult to accurately gauge, is considered to be prolific (Artz, 1999; Dunkle, Jewkes, Brown, Gray, McIntyre & Harlow, 2004; Jewkes & Abrahams, 2002; Jewkes, Sikweyiya, Morrell & Dunkle, 2009; Seedat, van Niekerk, Jewkes, Suffla & Ratele 2009). Furthermore, it has been established that South African victims of violence are more likely to have experienced multiple traumas than once-off events (Williams, Williams, Stein, Seedat, Jackson & Moomal, 2007). Many of the people who are most vulnerable to exposure to violence also experience varying degrees of social and economic hardship, including poverty, unemployment, homelessness, limited access to social support, and substance abuse (Goosen, Bowley, Degiannis & Plani, 2003; Seedat et al., 2009).

This is quite a unique picture, when compared to most other countries. Although much therapeutic work has been undertaken with trauma survivors in various settings in South Africa this there has been very little research undertaken to formally document the work that has been done and the impact that such exposure to violence has on the South African population. Until now we have had to rely on international literature, predominantly from research undertaken in economically developed countries, regarding impact and models of treatment for victims of violence. Considerable data has been generated, evidencing the effectiveness of interventions

for working with trauma survivors (Foa, Keane & Friedman, 2000; Wilson, Friedman & Lindy, 2001), however it is uncertain how useful or relevant these models are in our unique context.

Whilst the effectiveness of the majority of interventions has been established in work with people diagnosed with posttraumatic stress disorder (PTSD), their utility when working with people who have a more complex symptom presentation has been challenged (van der Kolk & Courtois, 2005). Chronically traumatised individuals often have comorbid Axis I or Axis II disorders, however research which is undertaken to assess the effectiveness of interventions for PTSD often screens out individuals who suffer with comorbid conditions (Courtois, Ford & Cloitre, 2009).

Furthermore, it is important to consider the limited mental health resources available in this country and who is providing these services to service users. Kaminer, Grimsrud, Myer, Stein and Williams (2008) state that this country's mental health system is under-resourced to meet the needs of the large numbers of multiply traumatised people that come into contact with support services. In South Africa there are several Non Governmental Organisation's (NGO's) which offer support services to female survivors of gender-based violence, however there is little by way of specialist state mental health services for this population. Furthermore there are only a few specialised state or NGO services for people who have experienced other forms of trauma, for example childhood abuse or political torture, which all require somewhat different intervention approaches. At primary health care levels, mental health services are provided by a Specialist Psychiatric Registrar and an Intern Clinical Psychologist for a half day each week, although there are not enough to allow for one of each at every Community Clinic or Day Hospital. At tertiary level state psychiatric hospitals, psychological services are offered by qualified Clinical Psychologists, but primarily by the Intern Clinical Psychologists under supervision.

Although models of trauma intervention developed in economically developed countries are known to many local practitioners, it is uncertain whether they are being implemented, and if so, whether they are utilised in their original format or whether they have been adapted to be more appropriate for the local population and local mental health resources. It would be useful to learn what mental health practitioners

working with survivors of violence are doing, what challenges they face, how have they tried to overcome these, what resources they have accessed to support them in their work, what they have found to be helpful and what has been less helpful.

The Clinical Psychology Masters programme in South Africa is a two-year general clinical training. Models of trauma and trauma interventions comprise a limited component of the coursework in most training programmes, which aim to produce generalists rather than specialists. Clinical psychology students are required to complete a year internship in the second year of their Masters training. The internship includes three four-month rotations through various inpatient wards as well as the outpatient department of a tertiary level psychiatric hospital. In addition, they are required to spend a half day per week at a community-based primary care facility, where they provide the only psychological service available to patients.

Following graduation there is limited availability of postgraduate training specifically within the field of trauma. The majority of postgraduate training courses or workshops held locally are offered by foreign 'experts' in the field. However the training is largely inaccessible to practitioners because the courses are run infrequently and are prohibitively expensive. This results in many practitioners being unable to engage with ongoing skills training following their departure from formalised education. Enhancing the trauma intervention skills of clinical psychology interns is an important part of improving mental health service provision in South Africa.

1.2 Research aims

It is the intention of this thesis to explore the ways in which psychology interns in psychiatric hospitals in Cape Town are currently working with trauma survivors. Anecdotal reports from staff at psychiatric hospitals in Cape Town indicate that a substantial portion of both the inpatient and outpatient population have histories of violence exposure and/or are living in conditions of continuous exposure to violence. Psychiatric hospitals therefore provide an important site for both mapping the impact of trauma and exploring approaches to trauma intervention. While psychiatric patients may not be representative of the general population, they likely represent the more

severe end of the spectrum of trauma-related sequelae and therefore the segment of the traumatised population most in need of interventions.

It is anticipated that the data obtained from this exploratory research will later be used, along with the results of qualitative research in other sites serving trauma survivors, to develop a survey instrument that will allow for a more large-scale documentation of the experiences and practices of clinicians and counsellors working with trauma survivors in South Africa. In addition the information obtained can also serve to inform programme planning for the Clinical Psychology training in the future.

1.3 The structure of the thesis

This first chapter has introduced the problem which the thesis aims to address. Chapter Two will review the relevant literature, establishing rates of exposure to violence in the South African context and the kinds of violent experiences to which South Africans are exposed. This is followed by an exploration of the literature detailing the psychological impact of exposure to violence following single incidents as well as following chronic and repeated exposure. The utility of a PTSD diagnosis amongst patients with a more complex trauma presentation is debated. Theories regarding the aetiology of simple and complex traumatic responses are detailed, followed by a review of the literature on treatment interventions for patients who have experienced single versus multiple violent events. The applicability of these models of intervention in the South African context is considered. The chapter concludes with a section on the impact of working with survivors of violence.

The third chapter details the methodology used in conducting this qualitative research project and analysing the data obtained through the interviews. The fourth chapter provides a detailed description of the results obtained and an analysis thereof in the context of the available literature. The fifth chapter includes a synopsis of the results and the conclusions that can be drawn. Limitations of the study will be discussed and some suggestions for further research will be made.

CHAPTER 2

LITERATURE REVIEW

This chapter will explore various aspects regarding exposure to interpersonal violence in general and in the South Africa context. Prevalence rates of violence exposure both internationally and in South Africa will be explored, with comparisons made between the various findings. Thereafter the psychological impact of exposure to interpersonal violence will be considered, including an exploration of the clinical presentations of people following exposure to violence, with commentary on the usefulness of current diagnostic categories in the context of multiple exposures to violent trauma. Theories of traumatic stress both for posttraumatic stress disorder (PTSD) and complex posttraumatic stress disorder will be presented, followed by a review of the various interventions that are utilised for working with survivors of both simple and complex traumas. The applicability of using the various trauma intervention models, as well as their limitations within the South African context, are finally considered.

2.1 Prevalence of violence exposure in South Africa

There is a common belief, both within South Africa and in the international community, that South Africa is one of the most dangerous places in the world due to high levels of interpersonal violence, including murder and armed robbery, rape and intimate partner violence (Kaminer et al., 2008; Kapp, 2006; Williams et al., 2007). The available statistics for different forms of violence in South Africa will be reviewed below.

2.1.1 Political violence

During the Apartheid era, many thousands of South Africans experienced repeated incidents of trauma as a consequence of politically motivated violence (Edwards, 2005a; Williams et al., 2007). Hirschowitz and Orkin (1997 as cited in Williams et al., 2007) established that 23% of respondents from their nationwide probability sample had experienced some form of political violence. Although the incidence of political violence has reduced following the democratisation of South Africa, there remain a

large number of people in South Africa who continue to live with the psychological consequences of the human rights abuses that occurred during the Apartheid regime. The Truth and Reconciliation Commission of South Africa record in their final report that a total of 46 696 violations involving 28 750 victims were reported to the Commission during the course of the proceedings (TRC, 1998). Whilst victims of abduction, detention, torture, murder and widespread incidents of violence that erupted as a result of political unrest were predominantly young, black males, few adult South Africans of colour have not been affected directly by the legacy of the country's violent political past (TRC, 1998).

2.1.2 Criminal violence

In post-apartheid South Africa, rates of criminal violence remain high. The national homicide rate is amongst the highest in the world. Data from the South African Stress and Health (SASH) study show that over a third (38%) of South Africans have been direct victims of violence (Kaminer et al., 2008). Criminal assault was found to be the most common form of violence experienced across the sample (18.2%) and men the most likely victims of criminal assault (25.9%) (Kaminer et al., 2008). SAPS figures for homicide rates for the 2008/2009 period are 18148, which equates to 37.3 per 100 000 (South African Police Service crime statistics, 2009). The National Injury Mortality Surveillance System (NIMSS), which collects data from 39 mortuaries in 7 provinces in South Africa and accounts for approximately 48%-56% of all non-natural fatalities, found that of the 33 484 deaths that occurred as a result of injury in 2007, the majority (35.8%) were the result of interpersonal violence. The ratio of men to women who died as a result of interpersonal violence was 6.5:1 (Donson, 2007). Most of these deaths occurred within or near to private homes (Donson, 2007). When these figures are compared with prevalence rates of homicides in other developing countries, for example India, Chile and Nigeria, the rate of homicide in South Africa is double to ten times their rate (Altbeker, 2007).

The injury profile in South Africa is of significance because it is one of the few countries in which the rates of intentional injury outnumber the rates of non-intentional injuries (Matzopoulos et al., 2008; Norman et al., 2007). High rates of injury may be partly due to the frequency with which weapons are used during

assaults or violent crime, in addition to which high levels of alcohol are frequently found amongst both perpetrators and victims of violence (Donson, 2007; Norman et al., 2007).

Taxi violence, gang related activities, car hijackings, robberies and cash-in-transit heists are common occurrences in South Africa and commonly involve the use of weapons, which in turn increases the risk of injury to the victim (Altbeker, 2007; Donson, 2007). A strong gun culture has developed particularly amongst gangs but also amongst individuals in the general population who are increasingly buying guns for their personal safety. According to the NIMSS, of the 11 983 violence-related deaths recorded, almost 40% were the result of sharp objects and just over one third were the result of firearms (Donson, 2007). For many, particularly within gangs and amongst unemployed youth, guns have come to represent power and status and as a consequence they have become a part of everyday life in which they are used to enforce hierarchies and in defence of honour, often resulting in injuries or mortalities (Seedat et al., 2009)

2.1.3 Gender-based violence

Although police statistics report decreases in the numbers of violent assaults and homicides between 2003 and 2009 (SAPS), the incidence of rape and sexual assaults are not showing the same downward trend (Seedat et al., 2009). The SAPS statistics for all sexual assaults for 2008/2009 are 71 500 or 146.9 per 100 000, whereas the figure for the 2003/2004 period was 66 079 or 142.5 per 100 000 (SAPS). In a review of research conducted with different populations of rape survivors in America, Rozee and Koss, (2001) established that the prevalence of completed rape amongst U.S women has remained consistent, at around 15%, since the 1980's. In 1999 a comparison between the number of rapes recorded in South Africa and those recorded amongst 89 Interpol member countries concluded that South Africa had the highest ratio of reported cases per 100 000 of the population (Bollen, Artz, Vetten & Louw, 1999). It is important to note that accurate predictions of actual incidents of rape and sexual assault are very difficult to make, however this is particularly difficult in the South African context for various reasons. Firstly, the legal definition of rape has recently changed so that many of the sexual assaults that were previously recorded by

the SAPS as indecent assaults would now fall under the category of rape, thereby making comparisons between current figures of reporting and previous figures more difficult. Secondly, rates of reporting to police are substantially below the actual number of incidents which occur (Edwards, 2005a; Seedat et al., 2009). Finally, the SAPS process of recording and counting incident numbers has been challenged in the context of lack of public confidence in the police and the pressure for police statistics to show improvements in crime prevention (Seedat et al., 2009). In fact it is argued that the incidence of rape and sexual assault in South Africa is considerably higher than is officially recorded, largely based on research that has been undertaken with both survivors (Jewkes & Abrahams, 2002; Kalichman, Simbayi, Kaufman, Cain, Cherry, Jooste & Mthiti, 2005) and perpetrators (Jewkes et al., 2009; Kalichman et al., 2005). Several reasons for this have been proposed, including lack of faith in the criminal justice system due to corruption and low conviction rates, fear of reporting to the police, victims' lack of access to police resources, varying opinions regarding the definition of rape and women's perception that intimate partner abuse is not rape, and entrenched views regarding the social and gender roles of men and women (Armstrong, 1994; Jewkes & Abrahams, 2002; Kalichman et al., 2005). In their research on rape homicide Abrahams, Martin, Jewkes, Mathews, Vetten and Lombard (2008) established that more women are killed in South Africa as a result of rape homicide than the total number of female homicide victims in the United States, indicating that it is not just the prevalence but also the severity of sexual assaults that is unusually high in South Africa.

Intimate partner violence is a common feature within the lives of many South African women. It is argued that South Africa has amongst the highest incidence of intimate partner violence with some studies establishing rates of intimate partner abuse ranging from 50% - 80% (Artz, 1999; Dunkle et al., 2004; Jewkes et al., 2009). According to the SASH study violence by an intimate partner was the most common form of abuse amongst women (14%) (Kaminer et al., 2008), a figure which rises to 24.3% in research conducted by Williams et al. (2007). In their research, Matthews, Abrahams, Martin, Vetten, van der Merwe and Jewkes (2004) found that half of all women killed by a known perpetrator are killed by an intimate partner. Research studies conducted with South African men have found significant associations between their having witnessed domestic violence against their mothers in childhood and their own

perpetration of violence against intimate partners in adulthood (Abrahams & Jewkes, 2005; Gupta, Silverman, Hemenway, Acevedo-Garcia, Stein & Williams, 2008), which contributes to the cyclical nature of violence in this context.

SAPS statistics for the 2008/2009 period show that domestic related issues were the most prevalent cause of female homicide and accounted for 29.6% of female deaths (SAPS). However, these figures are likely to be below the actual rate due to the recording of statistics. In particular, when types of crimes such as murders and assaults are recorded, there is no procedure for identifying whether the perpetrator was an intimate partner of the victim. In reference to the appropriateness and usefulness of the Domestic Violence Act, the ex- National Commissioner of Police, Jackie Selebi commented at a seminar in Pretoria that, 'it, [Domestic Violence Act] like the smoking and cellphone laws...cannot be policed. Many of our own members are involved in domestic violence. They come home tired and stressed and want to be left alone.' (2001, as cited in Chabedi, 2003).

Despite the data that is available, it is very difficult to make direct comparisons between local and international data. This is because statistics are collected at different times, different measures are used and the data that is obtained comes from a variety of sources. What is consistently reported in the local and international literature however, is that there is a considerable under-reporting of gender-based and intimate partner violence.

2.1.4 Child abuse and maltreatment

Children make up a large proportion of victims of violence in general and of sexual abuse in particular (Matzopoulos et al., 2008). Seedat et al. (2009) describe child abuse as "ubiquitous" (p.1013), with boys being the more likely recipients of physical assaults whereas girls are more likely to be sexually abused. In accordance with this, the SASH study established a history of physical abuse during childhood amongst 12% of their respondents, with male respondents reporting a slightly higher incidence of abuse than the female respondents (Kaminer et al., 2008). In a study conducted in Gauteng, 41% of rape victims were found to be under the age of 18 and 15% were under the age of 12. Of significant concern is that for the majority of the victims of

sexual assault (84%), the perpetrator was known to them (Protecting children against violence in schools, 2003, as cited in Edwards, 2005). SAPS statistics for rape indicate an increasing trend in the number of reported cases related to children between the 2003/2004 and 2007/2008 period, from 36% to 44.4% (Waterhouse & Porter, 2008). In the 2007/2008 period, SAPS figures indicate that more than half (52%) of all indecent assault cases that were reported to the police were against children (Waterhouse and Porter, 2008). Dawes, Long, Alexander and Ward (2006) established from hospital records that the majority of physically abused children who require hospital treatment are under the age of five. More than half of those who require treatment are boys and the perpetrators of the abuse are usually males from within the family system (Dawes et al., 2006). In South Africa, according to the NIMSS for 2000, the homicide rate for children under the age of five years was 14.0 per 100 000 for boys and 11.7 per 100 00 for girls, which is more than double the rates found in low- and middle income countries (Norman et al., 2007). Again, however, it is very difficult to establish actual rates of abuse against children due to the underreporting of incidents within families to the police, and the fact that data has to be obtained or estimated from a variety of different sources (Dawes et al., 2006), a finding which is consistent with international literature (Perry, 2001).

In mental health settings in the United States, the rates of women who have a history of childhood abuse (sexual or physical) range between 35% and 50% (Cloitre, Cohen, Han & Edelman, 2001, as cited in van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005). It is important to note however that comparable data within the South African population is lacking.

Several research studies have made a link between parental exposure to high levels of community based violence and the type of parenting styles used. Notably, parents living in high-violence communities are more likely to employ a harsher style of parenting and there is a higher incidence of neglect or abuse of children in these families, due to the influence of multiple adversities (Krenichyn, Saegert & Evans, 2001).

2.1.5 Multiple trauma exposure

A national epidemiological study in South Africa found that almost 56% of their sample had experienced multiple traumas, with 15.9% experiencing four to five traumas and 9.2% experiencing six or more (Williams et al., 2007). Dinan, McCall and Gibson (2004) examined the prevalence of 10 types of trauma amongst a sample of South African women. They established that two thirds of respondents had experienced more than one trauma in the previous year. International research (Breslau, Kessler, Chilcoat, Schultz, Davis & Andreski, 1998; Kessler, Sonnega, Bromet, Hughes & Nelson, 1995; Resnick, Kilpatrick, Dansky, Saunders & Best, 1993) has also established high prevalence rates of multiple traumatisation amongst respondents. Several research studies have demonstrated that multiple exposures to interpersonal violence and trauma is associated with cumulative effects on levels of emotional distress and subsequent symptom development (Green, Goodman, Krupnick, Corcoran, Petty, Stockton & Stern, 2000; Williams et al., 2007). Data obtained from the SASH study established that those individuals who experienced six or more traumatic events were five times more likely to be severely distressed than those people who had no experiences of trauma (Williams et al., 2007).

It is clear that there is a very high incidence of violence in South Africa. Several reasons have been given for this, including socioeconomic inequality and a history of political oppression, ongoing gender inequality and the dominant culturally sanctioned beliefs about male power and control that condone and reinforce the abuse of women by men in this society, the prolific use of weapons, and the relationship between substance abuse and violence (Jewkes & Abrahams, 2002; Jewkes, Levin & Penn-Kekana, 2002; Kim & Motsei, 2002; Norman et al., 2007; Seedat et al., 2009).

Whilst a direct link between poverty and high rates of violence cannot be made, it is generally understood that there is a non-linear and complex relationship between these factors which cannot be ignored.

Parry (2005) found that 25% of adult men and 10% of adult women experience alcohol related problems. Alcohol and drug abuse are significant contributors to the incidence of interpersonal violence and high rates of injury (Sawyer-Kurian,

Wechsberg & Luseno, 2009; Seedat et al., 2009). In 2001, 52.9% of fatal and 73.4% of non-fatal patients treated for interpersonal violence injuries tested positive for alcohol (Norman et al., 2007). In 2007, of the 5567 homicides which were tested for blood alcohol concentration, 3207 (57.6%), tested positive for alcohol (NIMSS).

2.2 The psychological impact of violence exposure

This section will review the literature regarding the psychological impact of exposure to violence following acute and isolated incidents. This will be followed by an exploration of the psychological impact of exposure to repeated and prolonged experiences of abuse.

2.2.1 Clinical presentation of traumatic stress following acute exposure to violence

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (APA, 2000) defines Posttraumatic Stress Disorder (PTSD) as a syndrome which comprises a cluster of characteristic psychological, physiological and behavioural symptoms, which develop following exposure to a traumatic stressor. During the event, the individual believed that they were at risk of dying or being seriously injured or they witnessed the death or injury of another person(s) and they experienced feelings of intense fear, helplessness, or horror. Characteristic symptoms following the trauma include the persistent reexperiencing of aspects of the traumatic event (for example flashbacks, nightmares and persistent intrusive thoughts), avoidance behaviour and emotional numbing (for example avoiding people or places associated with the traumatic event), and persistent hyperarousal (for example hypervigilance, sleeping difficulties and irritability). These symptoms need to last for longer than one month.

The diagnosis of PTSD was first included in the DSM-III in 1980, following observations of predominantly soldiers returning from the Vietnam War who displayed serious psychiatric symptomatology. The diagnosis attempted to account for the symptoms they experienced, which were clustered into avoidance, hyperarousal and reexperiencing symptoms (Courtois, 2004; Herman, 1992; van der Kolk, 2005). However, its usefulness in describing the symptom picture and capturing the

complexity of individual presentations amongst those people who have experienced chronic, prolonged, interpersonal trauma, such as victims of child abuse and domestic abuse, has been questioned (Courtois, 2004; Herman, 1992, 2001; van der Kolk, 2005; van der Kolk et al., 2005). Ford and Courtois (2009) use the alternative term ‘complex psychological trauma’ to describe the consequences of exposure to traumas that are, “repetitive or prolonged, involve harm or abandonment by caregivers or other ostensibly responsible adults, and occur at developmentally vulnerable times in the victim’s life, such as early childhood or adolescence” (p.13).

People who have experienced traumas of an interpersonal nature are likely to have more, and more severe, psychological symptomatology than those who have experienced non-interpersonal traumas (Dinan et al., 2004; Green et al., 2000). Resnick et al. (1993) established rates of PTSD amongst survivors of interpersonal violence at between 31% and 39%, whereas for those who had suffered non-interpersonal trauma, the rate was 9%. Williams et al. (2007) and others (Suliman, Mkabile, Fincham, Ahmed, Stein & Seedat, 2009) assert that with each additional trauma experienced, there appears to be a cumulative negative effect on an individual’s degree of emotional distress. Furthermore, survivors of early interpersonal violence appear to be at a greater risk of further victimisation in the future and of developing more severe symptomatology following subsequent traumas (Briere & Spinazzola, 2009; Follette, Polusny, Bechtle & Naugle, 1996). In South Africa, results obtained from the SASH study indicate that rape, followed by intimate partner violence, carries the highest risk for PTSD compared with other forms of violence, a finding which is supported by international research (Norris, Murphy, Baker, Perilla, Gutierrez Rodriguez & Gutierrez Rodriguez, 2003).

Despite the high levels of exposure to violence, the SASH study established that the prevalence rate of PTSD in South Africa (2.3%; Stein, Seedat, Herman, Moomal, Heeringa, Kessler & Williams, 2008) is low relative to many other countries with comparable levels of trauma exposure, for example the United States (Kessler et al., 1995) and Mexico (Norris et al., 2003). There are several possible reasons for this, in addition to methodological issues such as the translation of SASH instruments into several languages.

Firstly, it has been suggested that the use of DSM type categorisation of symptoms into psychiatric disorders does not accurately represent people's responses to multiple and continuous trauma, particularly in economically developing countries where the incidence of multiple trauma is more commonplace (Edwards, 2005*b*). Herman's (1992) proposed diagnosis of complex PTSD better describes the broader range of non-PTSD symptoms commonly found in adult survivors of multiple and prolonged abuse in childhood, however a comparable diagnostic category for the effects of repeated and continuous trauma in adulthood is lacking.

Secondly, the impact of even single traumas is not limited to PTSD. The DSM IV identifies disorders other than PTSD that may be diagnosed following traumatic events, including Acute Stress Reaction, Adjustment Disorder, Brief Depressive Reaction, or Reaction to Severe Stress, unspecified (Kessler et al., 1995; O'Brien, 1998). A traumatic event can also trigger the development of mood and somatoform disorders and anxiety disorders other than PTSD (O'Brien, 1998; Pimlott-Kubiak & Cortina, 2003). Besides the information that has been obtained through the administration of PTSD symptom checklists with trauma survivors, there has been very little documented regarding other sequelae of trauma, and particularly of multiple or continuous trauma, within the South African context. Furthermore, because most research regarding outcomes of interpersonal violence in adulthood has focused on women, there is very limited literature which looks at psychological outcomes for men (Pimlott-Kubiak & Cortina, 2003).

Several risk factors have been identified that predispose certain individuals to developing PTSD following incidents of violent trauma in adulthood, besides the type of trauma exposure. These include being female (Breslau et al., 1998; Norris et al., 2003), younger age of exposure to trauma (Breslau et al., 1998), lower socioeconomic status (Breslau et al., 1998; Brewin, Andrews & Valentine, 2000), exposure to multiple traumas (Breslau, Chilcoat, Kessler & Davis, 1999), and a previous history of psychiatric illness (Brewin et al., 2000). It has been suggested that because women are more likely to have histories of childhood sexual abuse and sexual assault in adulthood, they are more vulnerable to developing PTSD in adulthood, however this hypothesis remains largely unsupported (Breslau et al., 1998) and continues to be debated (Norris et al., 2003).

Research has been undertaken regarding the impact of repeated exposure to community based violence on children (Perry & Pollard, 1998; Proctor, 2005) and the risk and protective factors associated with the development of psychosocial difficulties amongst children as a result of repeated exposure (Krenichyn et al., 2001; Lynch, 2003; Proctor, 2005). Perry and Pollard (1998) identified a defeat response amongst children and adolescents exposed to ongoing domestic and community violence. This develops as a result of consistent and repeated experiences that fight or flight responses and behaviours are unsuccessful in eliciting assistance from others or in ensuring their safety in dangerous situations (Perry & Pollard, 1998). The defeat response is characterised by non-reactivity, passivity and compliance, likened with an ongoing form of dissociation, where one might otherwise expect a more active response with heightened distress (Perry & Pollard, 1998). Other research has found that ongoing exposure to community violence amongst children and adolescents results in problems with hyperarousal, as opposed to hypoarousal (Lynch, 2003). However, there are no South African or international studies that explore whether similar kinds of responses occur within an adult population similarly exposed to ongoing community based violence.

2.2.2 Clinical presentation of traumatic stress following exposure to prolonged abuse

Several authors have proposed various trauma syndromes in order to better identify and discriminate between the symptoms and subjective experiences of those people who have been exposed to multiple and prolonged interpersonal traumas. These include Developmental Trauma Disorder (van der Kolk, 2005; van der Kolk & Courtois, 2005), Complex PTSD (Courtois, 2004; Ford & Courtois, 2009) and Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (Herman, 1992; Herman, 2001; van der Kolk et al., 2005). Whereas PTSD accounts for responses to acute trauma incidents, these conceptualisations attempt to encapsulate the complex emotional, behavioural and neurobiological sequelae of pervasive childhood trauma including physical, sexual and emotional maltreatment and neglect over critical developmental periods (van der Kolk, 2005). van der Kolk (2005) asserts that chronic trauma, “interferes with neurobiological development and the capacity to integrate

sensory, emotional and cognitive information into a cohesive whole” (p.402) and that the majority of children who experience early developmental trauma do not meet the criteria for a diagnosis of PTSD. Because early developmental trauma is most likely to occur within the parent or caregiver-child relationship, it also significantly negatively impacts on the attachment relationship (van der Kolk, 2005). Furthermore, since the security of the attachment relationship serves to moderate the experience of trauma within the context of childhood abuse, where the attachment relationship is disorganised, particularly if the parent is the source of the trauma, severe difficulties develop in the child’s capacity to regulate their emotions and manage internal and ongoing external stress (van der Kolk, 2005). Intense affects including rage, betrayal, fear, defeat and shame are common and often result in hyperarousal and avoidance behaviours. Difficulties with emotional regulation also manifest in cognitive, behavioural, physical and relational dysregulation (van der Kolk, 2005). Specifically, one would anticipate such individuals to have a pervasive sense of the world as an unsafe place, persistent negative self-attributions, display evidence of dissociation, exhibit behavioural reenactments of traumatic events, report multiple somatic complaints, and show disorganisation in their relationships based on a deep mistrust of the reliability of others contrasting with a desire for intimacy and closeness (van der Kolk, 2005).

The psychopathology arising out of chronic developmental trauma as well as chronic interpersonal trauma in adolescence or adulthood has also been identified through Herman’s (1992) Complex PTSD and includes a description of the differences in clinical presentation as compared with people with a PTSD diagnosis. Amongst people who have suffered severe and ongoing trauma, there may be additional, more complex and diffuse symptoms. There is likely to be characteristic personality change and a particular vulnerability to repeated harm both from themselves and from others (Herman, 1992). DESNOS is the diagnostic term that relates very closely to Herman’s Complex PTSD and has been used in the DSM-IV-TR, where it is included as an associated feature of PTSD (Taylor, Asmundson & Carleton, 2006; van der Kolk & Courtois, 2005). The DESNOS/Complex PTSD diagnosis is based on 7 categories of symptoms. These include: Alterations of affect regulation and impulse control, for example difficulties with the modulation of anger and the presence of self-destructive behaviours; alterations in attention and concentration, for example amnesia or the

experience of dissociative episodes; somatisation, including physical symptoms which may relate directly to the kind of abuse experienced or the presence of non-specific pain; alterations in self-perception, for example persistent feelings of guilt and shame; alterations in perceptions of the perpetrator, which may include idealisation of the perpetrator or adopting the belief systems of the perpetrator; alterations in relationships with others, which may include the loss of ability to trust others, and alterations in systems of meaning, including chronic despair and hopelessness regarding the changes in themselves as a consequence of their experiences (Courtois, 2004; Herman, 2001, van der Kolk et al., 2005). Complex PTSD and DESNOS, usually diagnosed in adult populations, have been shown to have their roots in earlier childhood interpersonal traumas (van der Kolk et al., 2005).

Terr (1991) differentiates between two categories of trauma, namely Type I and Type II. She defines Type I traumas as those which occur as a result of unanticipated, one-off or isolated events that may result in the development of PTSD symptoms of reexperiencing, avoidance and hyperarousal. This is in contrast to her concept of Type II traumas, which are long-standing, repeated incidents of interpersonal violence against somebody, usually perpetrated by someone known or closely related to them, and which result in the victim's use of specific coping strategies, notably denial and psychic numbing, the use of self-hypnosis and dissociation, and extreme rage or passivity that become recognisable in adulthood as character pathology and are not seen in people who experienced Type I traumas. Exposure to Type II traumas places the victim at greater risk of developing PTSD than if they were only exposed to a Type I traumatic event (Ford & Courtois, 2009). However additional posttraumatic sequelae commonly seen amongst people who have experienced such longstanding and pervasive trauma include symptoms of affective, anxiety, psychotic, dissociative, eating and somatoform disorders, substance abuse, and borderline and antisocial personality disorders (Ford & Courtois, 2009; Kessler et al., 1995; van der Kolk et al., 2005). These symptoms are not included in the PTSD criteria and thus instead are usually referred to as comorbid Axis I or Axis II conditions. Doing so distinguishes them from the posttrauma response and undermines their aetiology as a psychobiological consequence of, or adaptation to, trauma. Whether diagnoses are deemed separate in causality has significant implications for assessment and treatment (van der Kolk & Courtois, 2005; van der Kolk et al., 2005).

2.3 Theories of traumatic stress

The following section will explore the different theoretical understandings of how trauma responses develop. Each model provides a different explanation for traumatic responses depending on whether exposure has been chronic or acute. Different interventions are based upon these various models of understanding.

2.3.1 PTSD

Neurobiological theories

Declarative (explicit) and non-declarative (implicit) memory are the two main memory systems affected by experiences of traumatic events (van der Kolk, 1996a). The hippocampus is responsible for the encoding, storage and retrieval of declarative memory, which is the conscious memory of the story or details of an event. Non-declarative memory, which includes trauma related physical and emotional responses to an event, somatic sensations, fear and sensory perceptions, requires no conscious memory of the event experienced and is more accurate and reliable over time (van der Kolk, 1996a). Researchers have proposed that the accuracy of a memory is affected by the emotional valence of an experience, so that memories of personally significant, particularly traumatic, events are remembered more accurately and tend to be fixed and enduring over time, whereas memories of everyday events degrade with time (Bremner, Krystal, Southwick & Charney, 1995; van der Kolk, 1996a). Because of the qualitative differences noted between the imprints of traumatic memories compared with memories of everyday events, it is argued that changes in hippocampal functioning under states of heightened arousal may cause the declarative memory aspects of traumatic memories to be encoded differently (van der Kolk, 1996a). Thus, whilst the sensory and perceptual information regarding the event remains intact, the person's ability to create a narrative of the traumatic event is impaired (van der Kolk, 1996a).

Emotional and sensory cues related to a traumatic event can trigger associated traumatic implicit memories through priming, but additionally retrieval of trauma

memories can occur involuntarily when the affective state at the time of retrieval matches the affective state when the memory was initially encoded (Bremner et al., 1995). This results in trauma memories initially occurring as “somatosensory flashback experiences” (van der Kolk, 1996b, p.289), accessible through the different sensory modalities. Repetition or re-enactment of the traumatic event without conscious awareness or memory of the event itself can be explained by the difficulty in integrating sensations and perceptions from implicit memory into explicit memory (van der Kolk, 1996b). The implicit memory of the traumatic event, comprising the somatosensory experiences, emotions and cognitions that were triggered at the time of the traumatic event, need to be interpreted into declarative memory, so that a verbal narrative of the trauma can be constructed. Neurohormones that are released in times of stress (adrenaline and cortisol) affect the strength of memory consolidation. Where adrenaline has been shown to strengthen the memory trace associated with emotionally significant events through its effect on the amygdala, cortisol has been shown to inhibit memory traces being laid down (Elzinga & Bremner, 2002). The amygdala, in the limbic system, is responsible for interpreting the emotional valence of incoming sensory information and attaching emotional significance to it. The more significance the amygdala places on the information received, the more strongly the memory will be retained (van der Kolk, 1996b). van der Kolk (1996b) argues that when sensory information is sent to the amygdala from the thalamus it has not yet been processed within the cortex. The amygdala attributes significance to the sensory information which occurs before the incoming information has been consciously appraised and thus results in an immediate physiological response. It is proposed that frequent re-experiencing of nightmares or flashbacks causes a re-release of adrenaline that may serve to further strengthen the memory trace (van der Kolk, 1996b).

It has been observed that people with PTSD have high levels of amygdala activation and decreased hippocampal volume (Kolassa & Elbert, 2007; van der Kolk, 1996b). The hippocampus is integrally involved with the regulation of cortisol levels and it is argued that the hippocampus is particularly sensitive to high levels of stress (Elzinga & Bremner, 2002). Extended exposure to stressful situations and high levels of cortisol have been linked with structural changes to the hippocampus, which may, in turn, explain the observed deficits in declarative memory amongst highly traumatised individuals (Elzinga & Bremner, 2002; Kolassa & Elbert, 2007). These physiological

differences can result in lasting changes in personality and behavioural functioning, which in turn can change the way these structures respond to stimuli that is perceived to be threatening (van der Kolk, 1996b).

Cognitive-behavioural theories

Cognitive behaviour therapy explains the development of emotions and behaviours as a result of thoughts or cognitions regarding a particular event, that is, what is most important are the beliefs about the event as opposed to the event itself (Corey, 2001). When a traumatic event occurs, the individual ascribes meaning to the event, which then determines their reaction to the event. According to this model, PTSD occurs when the individual processes a traumatic incident and the consequences thereof in such a way that they continue to believe that they are under serious, ongoing threat and do not conceptualise it as a time-limited event (Ehlers & Clark, 2000). This belief is created as a result of “(1) excessively negative appraisals of the trauma and/or its sequelae and (2) a disturbance of autobiographical memory characterised by poor elaboration and contextualisation, strong associative memory and strong perceptual priming” (Ehlers & Clark, 2000, p.319). Negative appraisals regarding the traumatic event include overgeneralising so that the individual then comes to anticipate danger in all types of situations, and exaggerating the likelihood that they will experience further events because of something that is innately problematic in themselves (Ehlers & Clark, 2000). These cognitive misattributions lead to avoidance behaviours, including avoidance of thinking about the event and of people or places related to the event, which further exacerbates the fear response. The individual may also negatively appraise their responses to the event at the time, for example their perceived failure to act in a way that may have protected them or a belief that they should have been able to anticipate the event and thereby prevent it from happening (Ehlers & Clark, 2000). Negative appraisals of the sequelae of the event including the physical and emotional impact on the victim and the resultant disruptions in other areas of functioning, as well as the responses they receive from the people around them, in their family and their greater community are all significant factors in maintaining levels of distress and PTSD symptomatology.

Victims have difficulty voluntarily retrieving memories of a traumatic event that are complete or that are temporally accurate and they are also likely to experience the involuntary recall of intrusive, unwanted memories, triggered by various trauma-related cues (Halligan, Michael, Clark & Ehlers, 2003). Ehlers and Clark (2000) propose that these characteristics of memory difficulties experienced in people with PTSD arise because of the way that trauma memories are encoded and laid down. They further argue that stimuli that were temporally associated with the traumatic event are strongly primed so that cues that are associated with the event are more likely to trigger traumatic memories (Ehlers & Clark, 2000). The victim's negative cognitive appraisals will influence how they selectively interpret aspects of their memory of the event and the 'here-and-now' quality of the memory allows for the misperception of the victim's ongoing sense of danger to be maintained (Ehlers & Clark, 2000).

As the victim increasingly perceives themselves to be under threat, their use of various cognitive and behavioural coping strategies that are intended to reduce their levels of distress and perceived danger, in fact serve to maintain or exacerbate their symptoms (Rothbaum, Meadows, Ressick & Foy, 2000). Some of the cognitive and behavioural strategies utilised include thought suppression, rumination, excessive safety behaviours such as hypervigilance or avoidance and the use of alcohol or drugs to suppress heightened emotional states (Ehlers & Clark, 2000).

Psychodynamic theories

Central to the psychoanalytic view is the premise that exposure to a traumatic experience will evoke "the unresolved pains and conflicts of childhood" (Garland, 2007, p4), even for those people who have had relatively good early experiences. Freud (1962, as cited in Kudler, Blank & Krupnick, 2000) hypothesised that traumatic memories, as a result of early experiences, are defended against through the use of repression, which serves to keep these memories outside of conscious awareness, although they remain present at an unconscious level. Where cognitive behavioural theories refer to cognitions that are accessible to conscious thought, psychoanalytic theory focuses on unconscious cognitions. Freud (1920, as cited in Garland, 2007) described how the mind is protected by a kind of shield or 'stimulus barrier', which

has a crucial role in selectively shutting out excessive external stimuli and thereby maintaining internal equilibrium (Garland, 2007; Lemma & Levy, 2004). Trauma causes a rupture in this protective shield and overwhelms the individual so that this capacity for equilibrium can no longer be maintained, resulting in a significant disruption in functioning (Garland, 2007). The trauma shatters the individual's fundamental beliefs about themselves, their internal objects and the world, as well as disrupting their established defence mechanisms, causing overwhelming anxiety both internally and from the external incident (Garland, 2007; Rose, 1991). The anxiety relates to a resurrection of primitive fears of the power of bad objects and a lack of trust in both the internal and external good objects' ability to protect the self from annihilation (Garland, 2007). The trauma "overwhelms existing defences against anxiety in a form which also provides confirmation of those deepest universal anxieties" (Garland, 2007, p.11). The ability to distinguish between past and present is disrupted and earlier traumatic memories, which until that point had been sealed off from conscious awareness, become reactivated (Garland 2002, as cited in Lemma & Levy 2004). Once the ego has been traumatised, it can no longer rely on its capacity to differentiate signal anxiety from automatic anxiety, or the difference between actual threat and potential threat, so that in situations that resemble the traumatic event or any situational cues, the ego becomes overwhelmed with automatic anxiety, as if the event was happening again (Garland, 2007). Garland (2007) proposes that what has been lost is what Bion (1967, as cited in Garland, 2007) conceptualised as the 'internal container'. The container provides the distance needed to be able to think about what happened, to separate the person from the traumatic event, and the capacity for symbolic thinking. As a result of the failure of the internal container, symbolic thought is lost and the individual can no longer differentiate between then and now so that everything feels as though it were happening in the present (Garland, 2007). According to Klein (1940, as cited in Garland, 2007) an inability to mourn the loss of the good object can have a detrimental impact on personality. Freud explains the intrusive and avoidant symptoms experienced by trauma survivors as an attempt to cope with the trauma. Through the repetition compulsion, the survivor attempts to gain mastery over their traumatic memories (1920, as cited in Kudler et al., 2000).

2.3.2 Theories of complex traumatic stress

Integrated neurobiological and developmental approaches

Advances in the field of neurobiology have resulted in scientific evidence of what was theorised several decades ago regarding the importance of Bowlby's attachment relationship and Winnicott's facilitating environment to provide the context in which the infant is able to develop the capacity for learning and self-regulation through the shaping of the brain's neural networks (Ford, 2009; Schore, 2001). Ford (2009) conceptualises the impact of early, prolonged trauma as causing a shift in emphasis in the developing brain from learning, to survival. Where the learning brain can focus on exploration of the environment and is open to new experiences, the survival brain is preoccupied with harm avoidance, anticipating and protecting itself against perceived or real dangers. Ford (2009) describes the negative physiological and neurological consequences of such a shift which include a reduction in the efficacy of the immune system, compromised distress tolerance and poor development of executive functioning. Repeated experiences with the environment combine with the infant's innate temperament, resulting in the development and strengthening of particular neural networks and the pruning of neural pathways that are unused (Ford, 2009). There is much neural plasticity during childhood and adolescence, and particular critical periods during which neural pathways develop more rapidly or are consolidated. Because early social events imprint into the neurobiological structures that are maturing during this time, the kinds of experiences infants have are particularly significant as they can positively or negatively influence the physiological development of the brain (Schore, 2001). If the child experiences psychological trauma during these critical periods, the negative sequelae thereof are likely to be more complex (Ford, 2009). Over time these pathways become more fixed and variation becomes less likely, which results in the predictable responses that many survivors of childhood abuse display in situations throughout their lives.

Brain development which occurs prenatally and during infancy is predominantly related to the experience, expression and modulation of emotions (Lewis, 2005, as cited in Ford, 2009). Emotion regulation involves the interplay of innate affect regulation processes as well as self-directed emotion regulation, through the various

structures that constitute the limbic system in the brain as well as areas within the prefrontal cortex (Ford, 2009). Through repeated experiences of coping with brief and infrequent situations that cause distress, the infant consolidates their ability to self-regulate their emotional and somatic reactions. However, when the infant's experiences of stressful situations are so frequent and of lengthy duration, their experiences of being able to modulate their heightened states of arousal are limited and novel experiences take on a particularly frightening quality (Ford, 2009). Whilst in a state of emotional dysregulation the infant is unable to focus their energies on anything else until they have been able to return to a state of homeostasis. Infants for whom this return to baseline is much more challenging lose out on opportunities for socio-emotional learning as a result (Tronick & Weinberg, 1997, as cited in Schore, 2001). Without the necessary experience-dependent neurochemical changes that would assist the sensitively cared for infant to develop the maturational capacity to cope with external stressors, the maltreated infant's neurochemical circuits may become organised around stress reactivity, leading to ongoing states of heightened emotional distress (Ford, 2009; Schore, 2001). Emotions and bodily sensations come to represent signs of imminent danger or are experienced as actual threats to self so that the child then develops other strategies for self-regulation, including avoidant and other dysfunctional behaviours, as well as persistent affective states and somatic complications that are characteristic of children with a disorganised attachment (Ford, 2009; Schore, 2001). These alternative strategies develop at the expense of the promotion of more developmentally complex self-regulatory functions which the infant requires as they grow older, for example problem-solving, impulse control and the capacity for self-awareness and self-reflection (Ford, 2009).

As a consequence of ongoing interpersonal trauma experiences, where the infant develops a preference for harm avoidance over attachment to others, the individual's capacity to relate to others becomes severely compromised (Ford, 2009).

Relationships are perceived as sources of danger or threat and so become frightening rather than being a potential source of comfort. As a result interpersonal relationships, the development of which are necessary to promote recovery, are the very thing that becomes avoided amongst such traumatised individuals (Pearlman & Courtois, 2005).

The prefrontal cortex and limbic system are also integrally involved with the development of the child's capacity for self-awareness, self-reflective thought and the capacity to consciously modulate emotions, thoughts, behaviours and somatic states, which develops into the capacity to 'mentalise' (Fonagy, 2003 as cited in Ford, 2009). Early interpersonal trauma or problematic caregiving are hypothesised to compromise the formation and strengthening of the neural pathways that would enable the development of these capacities (Ford, 2009)

Cognitive-behavioural theories

Infants and young children's capacity for logical and rational thought is undeveloped and thinking is largely egocentric until middle childhood. If a child experiences an assault perpetrated against them, by someone other than their trusted caregiver, the impact that the event can have on the child's core beliefs can be minimised within the context of their otherwise normally sensitive caregiving environment. However when this assault occurs at the hands of the very people whom the child would normally have trusted to keep them safe, they may try and make sense of the traumatic experience by understanding it as a consequence of something that they have done or of their innate badness (Briere & Elliott, 1994, Cohen, 2008). If they develop such negative assumptions, believing that they are bad and they deserve such treatment, further abuse or neglect may then serve to confirm this misperception. Furthermore, because the experiences of children who are subjected to trauma and abuse are predominantly negative, they start to generalise these experiences to all situations. Negative assumptions about the trustworthiness of others are likely to develop and the world becomes a dangerous and frightening place in which they have no sense of control and are helpless to effect change (Cohen, 2008). Their sense of self-blame further complicates the picture as they are likely to attribute the cause of negative events to internal factors within themselves or their behaviour and attribute good experiences to factors located externally (Briere & Elliott, 1994). Such cognitive distortions may persevere into adolescence and adulthood and impact on the individual's ability to accurately and objectively assess situations. Instead they will react emotionally and behaviourally to events based on their established belief systems or schemas about themselves and about the world.

Psychodynamic theories

The role of the caregiver in relation to the infant is initially to adapt to the needs of the infant so that they can gradually learn to tolerate periods of frustration and thereby develop the capacity for affect regulation. The infant can only achieve this developmental task if it has learned that its needs will adequately be met. In an environment in which the infant's needs are consistently unmet, for example as a result of neglect or abuse, the caregiver's lack of capacity to initially externally regulate their infant's emotions results in the infant being unable to modulate and regulate their own internal emotion states and causes a rupture in the infant's developmental task of affect regulation (Winnicott, 1960). As a result, the infant experiences the environment as attacking or withholding and high states of affective arousal remain unmoderated (Winnicott, 1960). Khan (1963, as cited in Lemma & Levy, 2004) describes the function of the infant's caregiver as a protective shield, linked to Freud's conceptualisation of the stimulus barrier (as explained previously), without which the infant is directly and prematurely exposed to overwhelming and anxiety-provoking experiences, which it does not yet have the capacity to tolerate, thereby resulting in 'cumulative trauma'. Bion (1962, as cited in Lemma & Levy, 2004) describes this process in terms of 'beta elements', which is the raw, unprocessed emotional material which the infant projects onto the caregiver and which the caregiver needs to digest and transform into 'alpha elements' that can be reintegrated by the infant. If this is done successfully, the infant internalises a relationship with a containing object, which becomes equated with parts of the self and the caregiver is experienced as concretely in the self (Lemma & Levy, 2004). To move from this position of symbolic equation to symbolism proper, requires the infant to have developed an awareness and acceptance of their separateness from their caregiver, a process which is greatly facilitated through the use of symbols to form mental representations of the caregiver (Lemma & Levy, 2004). An infant whose caregiver has been unable to tolerate these attacks and give meaning to them is forced to internalise their hostile projections. These become fused with their experience of a hostile caregiver, which impacts on their ability to think about or process mental experiences or develop the capacity for symbolic thinking (Lemma & Levy, 2004). Thus the ability to tolerate trauma is dependent on the quality of early attachment relationships. Without symbolic thought and the capacity to symbolise attachments, it

is not possible to see the self and others as separate, with individual thoughts, beliefs and intentions. A lack of symbolism compromises the individual's ability to ascribe meaning to thoughts and feelings and create a verbal narrative of them (Lemma & Levy, 2004).

Children who are exposed to chronic abuse or neglect may learn to dissociate as a defensive strategy, creating a split between their thoughts, feelings and bodily sensations (van der Kolk, 2005). Steele, van der Hart and Nijenhuis, (2005) explain that dissociation creates conflicting parts of the personality, namely those that become fixated in the early trauma of environmental failure and fear its repetition and those that avoid the trauma at all costs. Identification with the aggressor is often observed amongst chronically traumatised children. A malignant identification occurs either when the child introjects the aggression of their perpetrator as a defensive reaction against their experience as a victim (Lemma & Levy, 2004). Alternatively, the identification manifests as the child taking on the role of helpless victim where, through projective identification, the child splits off and projects their aggressive parts into the perpetrator, which then continues to persecute the self (Lemma & Levy, 2004).

2.3.3 Limitations of theories

Whilst there is a growing body of literature regarding the impact of early developmental trauma on the development of psychopathology or psychiatric symptomatology in children and adults, encompassed in the Developmental Trauma Disorder and Complex PTSD/DESNOS diagnoses, and there is literature examining the impact of ongoing trauma on already traumatised children (van der Kolk, 2005), a comparable diagnostic category and theory for the effects of repeated and continuous trauma in adulthood is lacking. Some international research has explored the impact of exposure to continuous and repeated environmental trauma on children (Perry & Pollard, 1998), however there is no available literature that explores the impact of ongoing exposure to community based violence amongst adult populations.

2.4 Intervention approaches with survivors of violence

The following section will describe the intervention approaches that have been formulated for survivors of single event and prolonged exposure to violence, based on the models previously described.

2.4.1 Interventions for survivors of single traumas

Critical incident stress debriefing

Critical incident stress debriefing (CISD) was first described by Mitchell (1983, as cited in Bisson, McFarlane & Rose, 2000). It is a group intervention used with both survivors of traumatic incidents and emergency personnel who have been exposed to such events, although it can be conducted with individuals as well. It is a crisis intervention which aims to prevent the long-term negative impact of exposure to a traumatic event rather than treating pathological responses to trauma (Bisson et al., 2000). The intervention consists of a debriefing session of approximately 2-3 hours, held optimally 1-3 days post-incident (Arambasic & Adjukovic, 2001; Carlier, 2000), which ideally forms just one part of a more comprehensive support programme for the management of traumatic stress incidents (Bisson et al., 2000). Facilitation of the group is undertaken by two group leaders who have experience in this kind of intervention and who were not, themselves, exposed to the particular traumatic event. This is particularly important because of the emotional intensity of the work and the skills required to facilitate the process (Arambasic & Adjukovic, 2001; Carlier, 2000). The participants are guided through an analysis of the event during which there is a focus on their “thoughts, sensations, emotional responses and behaviours”, (Arambasic & Adjukovic, 2001, p.128). The session consists of several stages which include establishing factual information regarding the event, providing psychoeducation about the consequences of exposure to trauma, normalising symptoms, and giving participants an opportunity to share their own experiences of, and feelings regarding, the trauma incident, which can be highly emotive for both the person sharing their story and those listening (Arambasic & Adjukovic 2001; Bisson et al., 2000).

The use of debriefing as an effective technique for treating survivors of single traumas has been challenged (Carlier, 2000). In several impact evaluation studies it was found that of those individuals who received debriefing after a traumatic event, a significant percentage experienced considerable PTSD symptomatology when compared with control groups (Carlier, 2000). Several descriptive non-controlled studies have also found an increased incidence of PTSD symptomatology following CISD however some studies have documented satisfactory outcomes (Carlier, 2000). A generally poor quality of research and several methodological shortcomings has resulted in limited evidence regarding the overall efficacy of psychological debriefing in reducing the incidence of psychopathology following trauma (Bisson et al., 2000), however it has been noted that there may be benefits to utilising this kind of intervention within the context of a comprehensive management programme and as a means of identifying individuals who are at risk of developing PTSD symptomatology and may require further psychological input (Bisson et al., 2000).

CBT interventions

There is considerable empirical evidence which supports the assertion that cognitive and behavioural interventions that focus on anxiety management, cognitive restructuring or exposure, or a combination of these, are considered to be the most effective treatments for PTSD following exposure to acute traumatic events (Cohen, 2008). Because many individuals who experience unpleasant physical and psychological symptoms, as a normal consequence of exposure to traumatic incidents, employ coping strategies that may in fact serve to maintain or exacerbate their symptoms, some CBT interventions (for example, Stress Inoculation Training, Cognitive Therapy) focus on a reduction in these maladaptive cognitions and behaviours, which causes a resultant reduction in symptoms, without necessarily focusing on the trauma itself (Beckerman & Pass, 2008; Rothbaum et al., 2000). However several other CBT interventions (for example, Prolonged exposure, Systematic Desensitisation, Cognitive Processing Therapy, and Eye Movement and Desensitisation Therapy (EMDR)) work directly with the trauma memories under the premise that activating and confronting the trauma memories provides an opportunity for the patient to habituate to them, thereby reducing anxiety, and to integrate new information in order to correct the pathological elements contained therein (Cohen,

2008; Rothbaum et al., 2000). Foa and Rothbaum (1998) argue that the benefits of exposing the individual to their traumatic memories are that it serves to reduce the use of unhelpful coping strategies such as cognitive and behavioural avoidance, shows that remembering the experience is not dangerous, reduces the individuals likelihood of generalising the fear of danger to all situations by linking it to the specific event, and reduces the tendency to attribute the experience of PTSD symptoms to inherent flaws in themselves.

Exposure therapies require the patient to be exposed to the anxiety-provoking stimuli without relaxation or techniques to reduce anxiety, until the anxiety abates of its own accord (Rothbaum et al., 2000). Systematic desensitisation also uses exposure but pairs it with relaxation techniques that the patient is encouraged to implement when anxiety levels become too distressing (Rothbaum et al., 2000). Cognitive Processing Therapy combines elements of cognitive therapy, notably the identification and alteration of cognitive distortions, with exposure, through detailed, written accounts of the trauma which are then read several times over (Resick, Galovski, Uhlmansiek, Scher, Clum & Young-Xu, 2008). There is considerable empirical support from randomised controlled trials for the efficacy of exposure therapies in treating PTSD amongst a variety of trauma survivors and thus it is recommended as the primary intervention for the majority of survivors of trauma (Rothbaum et al., 2000).

EMDR is a desensitising treatment which requires the patient to be exposed to their traumatic memory and make alternative cognitive appraisals thereof, whilst tracking the movement of an object with their eyes, which has been shown to reduce the unpleasantness of traumatic thoughts (Beckerman & Pass, 2008; Chemtob, Tolin, van der Kolk & Pitman, 2000; Scheck, Schaeffer & Gillette, 1998). There is empirical support for the efficacy of EMDR in treating survivors of one-off traumatic incidents, however it's efficacy within a population of multiply traumatised individuals has yet to be established (Chemtob et al., 2000).

Meaning making/Rebuilding shattered assumptions

Janoff-Bulman (1985) describes the impact of trauma on an individual's fundamentally held belief systems, notably those related to their sense of

invulnerability, that the world is a fair and just place, and that they, as a human being, are essentially good, worthy and decent. Trauma shatters these basic assumptions and requires the individual to integrate their experiences as a victim with their pre-existing assumptions, to generate more realistic views of themselves and the world (Janoff-Bulman, 1985). It has been noted that people who held onto their beliefs with a particularly strong conviction are more likely to struggle to incorporate their new experiences with their previously held beliefs and thereby may be at a greater risk of developing PTSD symptoms (Janoff-Bulman, 1985). Janoff-Bulman (1985) identifies several coping strategies that facilitate the process of integration following trauma, including: redefining the event so as to minimise the significance of the impact of the event thereby largely protecting previously held assumptions; making sense of what happened by finding causal explanations for the victimisation; taking steps to change behaviours that will promote their greater safety in the future, and approaching others for social support. The use of self-blame, either regarding behavioural or characterological factors, to explain how a traumatic situation could have been caused, is described as a common feature in survivors of trauma (Janoff-Bulman, 1985; Janoff-Bulman & McPherson Frantz, 1997). However the use of self-blame as a means of reducing a sense of meaninglessness has been found to be unsatisfactory in the long-term and Janoff-Bulman and McPherson Frantz (1997) argue that with time, trauma survivors move towards re-evaluating their lives, prioritising what is important to them and placing greater value on their daily existence. This process of meaning making can be integrated into any kind of therapeutic intervention.

Psychodynamic approaches

“The process of making sense of the senseless, while in some ways recreating order and meaning in the internal world, will inevitably imbue the event in the present with disturbing meaning from the past” (Garland, 2007, p.13). Psychodynamic psychotherapy works on the understanding that trauma triggers early traumatic memories and as a result, therapy aims to develop the patient’s understanding of their unconscious pre-existing conflicts, in the context of a supportive therapeutic relationship, to develop ego strength and to resolve the current conflict (Kudler et al., 2000; Rose, 1991). The role of the therapist is to be a container, whose function is to tolerate and modify what is so unbearable for the patient and what is projected into

them, facilitating the patient's capacity for symbolic thought which has been lost as a result of the traumatic experience, in order for the patient to be able to think about the trauma without being overwhelmed and retraumatised and to develop a coherent narrative regarding the trauma (Garland, 2007; Levy, 2004).

With patients who have been severely traumatised, it is important for the therapist to be conscious of the patient's tendency toward the repetition of trauma within the treatment situation. It is for this reason that the transference and countertransference relationship becomes an important part of the working through of the trauma by providing information about possible unconscious reenactments, anxieties and defences that need to be identified and explored in the therapy, as well the nature of early object relationships which are played out in the transference (Garland, 2007; Lindy, 1996). Lemma and Levy (2004) argue that people will have different responses to the same event and that an individual's particular response will provide some indication of the nature of their internal world and the quality of their attachment relationships. However, this cannot be divorced from their external cultural and social context, as the two mutually influence one another. Rose (1991) describes the rage that rape survivors feel towards the maternal introject and holding environment which they believe has abandoned them, and which may be either projected onto others or turned onto themselves, resulting in a complex array of feelings including guilt, a deep mistrust of self and others, shame and anger. Countertransference responses that therapists may experience when working with survivors of interpersonal violence may include being in the role of the perpetrator or being in the role of the victim. These responses provide clues as to the patient's subjective experiences of their interaction with others around them (Rose, 1991). Rose (1991) highlights the importance of resolving the conflict over aggression, which inevitably arises in survivors of trauma. It is often the case that the patient identifies with the perpetrator in an attempt at regaining some power and control and defending against their experience of helplessness during the trauma (Garland, 2004). This conflict is resolved by acknowledging the patient's retaliatory fantasies and facilitating the verbalising of anger towards the aggressor, which may have been defended against and projected onto others, and mourning the loss and acknowledging the distress that is being defended against (Garland, 2004; Rose, 1991). Analysis of the defences used, for example avoidance and repetition, that have resulted in the development of particular

symptoms is an essential component of this work and is facilitated through the process of making meaning of the trauma incident for that individual (Kudler et al., 2000). Lindy (1996) and Rose (1991) caution against the use of interpretation and the exploration of trauma memories prematurely, when the therapeutic alliance between the patient and therapist is not yet sufficiently established.

Although psychodynamic psychotherapy is traditionally considered to be a long-term intervention requiring a considerable time and financial commitment on the part of the patient, brief psychodynamic therapies have been developed for individuals with more acute experiences of trauma, for example Horowitz (1974, as cited in Kudler et al., 2000).

2.4.2 Interventions with survivors of prolonged abuse

CBT

CBT aims to identify problematic beliefs, feelings and behaviours and modify them through an interrogation of their aetiology and the processes that reinforce and maintain them (Jackson, Nissenon & Cloitre, 2009). CBT approaches previously used for the treatment of simple PTSD have evolved in order to become more relevant to working with patients with a complex trauma presentation. This has involved an increased recognition of the significance of the therapeutic relationship in the healing process due to the patient's primary difficulties with interpersonal relationships (Jackson et al., 2009). CBT work with abuse survivors also entails a shift in the foci of intervention, notably either working initially to prepare the patient to confront traumatic memories through the development of their self-regulatory capacity, or working to address PTSD symptomatology without necessarily focusing on the recall and processing of memories (Ford, Courtois, Steele, van der Hart & Nijenhuis, 2005). Empirical findings have found support for the efficacy of several CBT-based interventions for reducing the incidence of PTSD symptomatology and improving bodily and emotional self-regulation amongst patients with a complex trauma presentation. These include: Cognitive Behavioural Therapy for Women with PTSD Secondary to Childhood Sexual Abuse (CBT-CSA), a short-term intervention adapted from exposure-oriented CBT; Cognitive Processing Therapy (CPT), which has a

greater focus on altering traumatic beliefs than memory recall work, and Skills Training in Affect and Interpersonal Regulation with Modified Prolonged Exposure (STAIR-MPE), which initially focuses on developing skills in affect regulation followed by a modified traumatic memory exposure intervention (Ford et al., 2005). Dialectical Behaviour Therapy, which has been used extensively in treating women with Borderline Personality Disorder (BPD) who have a history of childhood abuse, also emphasises skills training including distress tolerance, affect regulation, interpersonal effectiveness and mindfulness, and has been found to be a particularly effective intervention with chronically traumatised individuals (Ford et al., 2005).

Psychodynamic Psychotherapy

Psychodynamic psychotherapy with people with a complex trauma presentation emphasises the relationship between the therapist and patient as an essential aspect of the therapy. According to Klein (1946), patients with personality pathology use primitive defence mechanisms of splitting and projective identification, which involves the splitting off of unwanted and destructive parts of the self and the projection of these parts into another person, so that in their mind, the projected elements now become attributes of the other. The person who is projecting then identifies the other person with the split off parts of themselves and relates to the other person as the embodiment of these disowned parts of the self. How the therapist responds to their patient is dependent on their capacity to make sense of and tolerate these projections. The dyadic relationship is essential for activating the attachment system so that a secure attachment can develop between patient and therapist, which is a developmental prerequisite for affect regulation and mentalisation to occur (Fonagy & Bateman, 2006; Herman, 2001). The relationship offers the patient a model for the containment of anxieties and overwhelming affect that was lacking in the earliest relationship. Furthermore, with time the therapist is able to model that the therapeutic relationship can survive empathic errors, which enables the patient to develop more realistic expectations of other relationships (Herman, 2001; Steele et al., 2005). Psychodynamic psychotherapy with this population tends to be longer than with people who have experienced single traumas because the establishment of the therapeutic alliance takes considerably longer, on account of the deep and fundamental mistrust of others that has developed following chronic and repeated

exposure to interpersonal violence or neglect. Issues of transference and countertransference that get played out in the therapy room are particularly important to monitor and analyse as they form the foundation of the therapist's understanding of the patient's unconscious conflicts. Through the transference relationship the patient is assisted in developing insight and awareness into unconscious processes by receiving feedback from the therapist on the therapist's observations of the patient's characteristic and repeated patterns of relating (Gabbard, 2000). The therapist provides the patient with a different, objective perspective, thereby exposing the patient to the 'real world' and challenging the patient's subjective 'reality'. By developing the patient's awareness of and insight into how their behaviour impacts on others and elicits certain responses from others, the patient can then reflect on these before automatically reacting in this same way, in future similar situations (Gabbard, 2000; Gaylin, 2000). Because reenactments within the therapeutic relationship can have devastating consequences the therapist needs to be acutely aware of the unconscious dynamics that become activated (van der Kolk, 1996b).

Mentalisation-based therapy

Bateman and Fonagy (2008, p.187) define mentalisation as, "the process by which we interpret the actions of ourselves and others in terms of underlying intentional states such as personal desires, needs, feelings, beliefs and reasons". Mentalising occurs preconsciously and requires the capacity to imagine that other people have their own thoughts and feelings and that these are separate to one's own (Bateman & Fonagy, 2008). The ability to mentalise is an important developmental achievement which develops in the context of a secure attachment relationship. Bateman and Fonagy (2008) propose that interpersonal trauma in childhood inhibits mentalisation through various mechanisms, notably: the infant's defensive avoidance of thinking about their own vulnerability and the malevolent intentions of others towards them; disruptions in the arousal system in the frontal cortex resulting in excessive hyperarousal, and trauma within the context of the attachment relationship, particularly where the attachment figure is the source of the trauma. Fonagy and Bateman (2006) identify certain neurobiological structures that they argue are likely to be particularly important in the development of attachment relationships and the capacity to mentalise. Thus mentalisation-based treatment emphasises the need for the therapeutic

relationship to provide the context in which mentalisation can develop. It sees the role of the therapist as encouraging the patient to focus on their current mental state, their own thoughts, feelings and behaviours and how these influence the way they relate to others and how misunderstanding one's own and other's intentions leads to actions to recreate stability (Bateman & Fonagy, 2008). The therapeutic relationship provides the context in which the patient experiences their mind being held in the mind of an other (Fonagy & Bateman, 2006).

Narrative therapy

Working within a narrative therapy framework with survivors of prolonged and multiple exposures to violence places primary importance on restoring the patient's sense of themselves (White, 2006). Narrative therapy with traumatised individuals interrogates the dominant, problem-saturated stories that constitute the reality of peoples' lives (Merscham, 2000). Whilst listening to the patient's stories about their experiences of trauma, the narrative therapist also listens for a parallel story, for those moments or periods, unique outcomes, when the individual was not governed by their problem-saturated story. These are the times when they acted in ways which may have helped to protect them or modified the impact that the trauma had on them (Merscham, 2000; White, 2006). These moments are then linked together to create alternative, strength-based stories, which foreground the patient's personal agency (Merscham, 2000). Narrative practices invite other people, who are in some way connected to the patient, to listen to the patient's story through 'definitional ceremonies'. The patient's experience of having others witness their story is empowering as it serves to validate their trauma experiences and facilitates deeper social connections where the patient has been previously isolated (White, 2006). As the process of re-authoring stories is a collaborative one between patient and therapist, it fits with the principle of shifting the power imbalances that were previously experienced by survivors of violence (Merscham, 2000). The re-authoring continues through ongoing therapeutic conversations which serve to strengthen the alternative story and diminish the significance of the previously dominant, problem-saturated story (White, 2006).

Integrative treatment models

The WITS trauma model of brief-term early intervention (Eagle, 2000) integrates principles from CBT (for example exposure techniques, cognitive restructuring and relaxation techniques) and psychodynamic psychotherapy (for example catharsis, ego strengthening and use of interpretation to make links) and has been proposed as a more culturally relevant and effective intervention method for the South African population, based on qualitative investigations undertaken with clients and counsellors. Eagle (2000) argues that it is the fact that it is an integrated model that makes it such a success in the treatment of patients who have been affected by violent trauma because it takes into consideration the complexity of the impact of exposure to trauma. However several difficulties with implementation of the model have been reported (Hajiyannis & Robertson, 1999). One important point of speculation raised by the authors is the suitability of using this intervention with chronically traumatised individuals as opposed to those who have a more simple PTSD presentation (Hajiyannis & Robertson, 1999), a point with which Eagle (2000) herself concurs.

A stage-oriented approach to treatment of survivors of complex traumas which is multimodal and draws on an eclectic mix of theories and interventions including psychodynamic, cognitive, behavioural, attachment and neurodevelopmental, is proposed as the most helpful, as it is able to meet the various complex needs and address the various difficulties that arise with survivors of complex traumas (Courtois, 2004; Ford et al., 2005; Steele et al., 2005). Herman's model of treatment and recovery, widely recognised as the benchmark for working with survivors of complex trauma, consists of three stages (Courtois, 2004). The first stage focuses on the establishment of safety, both internally and externally, the second stage is concerned with remembrance and mourning through the reconstruction of traumatic memories and the development of a coherent narrative, and the third stage aims to reconnect individuals with ordinary life (Herman, 2001). Herman (2001) explains the principle of recovery as involving the empowerment of the survivor and the reconnection with others. Through the development of new relationships or the working through of difficulties with existing relationships, the survivor is able to master the developmental task of learning how to relate to others, a process which was ruptured as a result of the trauma. Often survivors do not work through each of these phases

sequentially. For some, therapy may be terminated after the first or second stage because they have achieved what has been of greatest importance to them, whereas for others the basic concept of creating safety is not possible to achieve (Courtois, 2004). Furthermore, return to conflicts and difficulties that were addressed in previous stages is also common, although it is anticipated that when previous issues do arise subsequently, the patient will have already made shifts in their capacity to deal with the resultant anxiety and self-dysregulation (Ford et al., 2005; Herman, 2001). Despite the fact that others will have had similar traumatic experiences, treatment needs to be individualised and based on an assessment of the needs of the particular patient at that time.

Steele et al. (2005) propose several treatment principles that should be adhered to during the course of any therapeutic intervention but particularly with survivors of complex trauma. Firstly, the treatment must focus on the development of the patient's capacity to tolerate states of extreme heightened arousal. This includes identifying, labelling and managing different affective states and particularly hyperarousal. Secondly, the treatment should serve to promote the patient's sense of self-control and efficacy. Thirdly, the patient's level of functioning needs to be adequately maintained. Although there may be periods during the therapy process when functioning is compromised, this should be a temporary experience during which the patient may require additional support. Fourth, the therapy should work towards developing the patient's tendency towards confronting and mastering experiences, that would have previously triggered heightened states of arousal, rather than avoiding them. This is done by bringing into awareness the patient's use of both unhelpful and more effective coping strategies. Lastly, the therapist needs to be acutely aware of transference and countertransference issues that arise during the course of therapy insofar as they impact on the efficacy of the therapeutic relationship through the therapist's exposure to the patient's trauma history (Steele et al., 2005).

Family therapy

Riggs (2000) identifies two particular philosophical approaches to family therapy following single events traumas. On the one hand there are systemic approaches which aim at addressing the systemic disruptions that occur as a result of one or more

family member's exposure to a traumatic event and the symptomatology that they present with as a consequence of the trauma. On the other hand there are supportive approaches which aim to elicit support from within the family to help reduce the number and severity of symptoms in the traumatised individuals (Riggs, 2000). Where there has been intrafamilial trauma, it is likely that several family members would have been directly or indirectly exposed to the trauma, impacting differently but profoundly on each person (Ford & Saltzman, 2009). Family relationships are significantly altered across the entire family system, as a result of familial abuse or violence, however particular difficulties may develop within the spousal and parent-child relationships when the perpetrator is a parent (Ford & Saltzman, 2009). Aside from Child-Parent Psychotherapy (CPP), none of the existing approaches to family therapy have been adapted or evaluated for working specifically with survivors of complex traumatic stress (Ford & Saltzman, 2009). Ford and Saltzman (2009) describe the function of family systems therapy within the context of complex traumatic stress disorders as: making explicit the family rules and roles that have developed and may be maintaining problems in family functioning; identifying and exploring family myths and secrets; working towards re-establishing appropriate relational boundaries and interrogating existing patterns of communication and problem solving styles that may be particularly problematic.

Group interventions

Many of the characteristics of group psychotherapy that have been identified as potentially therapeutic for the general population of people with psychiatric or psychological difficulties are also thought to be of benefit to survivors of both simple and complex traumatic stress disorders, particularly the social integration and cohesion elements (Ford, Fallot & Harris, 2009; Foy, Glynn, Schnurr, Jankowski, Wattenberg, Weiss, Marmar & Gusman, 2000). Working within a group context provides the opportunity for survivors of trauma to share the disruptive and deeply personal consequences of their trauma experiences with others whilst in a supportive peer group, as well as allowing them to hear the experiences of others (Ford et al., 2009)

Group psychotherapy can provide psychoeducation for group members as well as offering a space in which they are able to learn practical skills regarding the regulation of emotions and behaviours and other social cognitive skills (Ford et al., 2009). Being in a group setting encourages interpersonal dynamics to come to the fore, which can then be interrogated by both group facilitators and group members, provided the setting is sufficiently containing and supportive (Ford et al., 2009).

Groups can be supportive, process oriented, cognitive-behavioural or interpretive. However for people with a more complex trauma presentation, supportive groupwork is recommended over more interpretive approaches (Ford et al., 2009). Where CBT oriented groups aim at symptom reduction and the development of coping strategies, psychodynamic groups focus on meaning-making regarding the trauma experience and individual reactions to the trauma, but both require an 'uncovering' of the trauma memories and experiences (Foy et al., 2000). The use of exposure techniques in a group setting is cautioned against when working with survivors of complex traumatic stress experiences due to the emotional arousal that it is likely to generate within the group as well as the potential risk of further traumatising group members (Ford et al., 2009). However in groups where membership is composed of survivors of single event traumas with PTSD symptoms, exposure techniques are effectively used although the group is then more likely to be 'closed' (Foy et al., 2000).

Ford et al. (2009) recommend the thorough assessment of any potential group member as severely dysregulated individuals have been shown to negatively impact on the group process. It is suggested that group psychotherapy may be most beneficial for more emotionally dysregulated individuals following an initial period of individual therapy in which their capacity to manage their own levels of arousal has been established and that it may work best as one part of a comprehensive approach to treatment (Ford et al., 2009).

2.5 The impact of working with survivors of interpersonal violence

People who work in the caring professions are deemed to be at a particularly high risk of developing work related stress when compared with other occupation groups. Whilst this may be the result of a combination of organisational and workplace

factors, more significantly it is related to the demands on workers as a result of the kind of work that is undertaken (Sabin-Farrell & Turpin, 2003). Secondary traumatic stress, compassion fatigue, vicarious traumatisation and burnout are all terms used to describe the psychological and emotional impact on workers of working within the field of trauma (Jenkins & Baird, 2002; Way, van Deusen, Martin, Applegate & Jandle, 2004).

Maslach (1982, as cited in Jenkins & Baird, 2002, p.425) defines burnout as, “a syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who do people-work of some kind... response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems... A pattern of emotional overload and subsequent emotional exhaustion is at the heart of the burnout syndrome. A person gets overly involved emotionally, overextends him or herself, and feels overwhelmed by the emotional demands imposed by other people.”

Secondary traumatic stress focuses on the symptoms and emotional responses that result from working with traumatised clients. The symptoms of secondary trauma very closely resemble those of PTSD and include reexperiencing, avoidance/numbing and hyperarousal (Figley, 1995, as cited in Jenkins & Baird, 2002). However due to the stigma that has become attached to this presentation, the concept of compassion fatigue was formulated, which sees this kind of response to the constant exposure to other peoples' trauma stories as normal (Jenkins & Baird, 2002).

Vicarious traumatisation is defined as, “the permanent transformation in the inner experiences of the therapist that comes about as a result of empathic engagement with clients' trauma material” (Pearlman & Saakvitne, 1995, as cited in Jenkins & Baird, 2002, p.424). They identify the main symptoms as being related to disturbances in the therapist's cognitive schemas regarding their “identity, world view, and spirituality... affect tolerance, fundamental psychological needs, deeply held beliefs about self and others, interpersonal relationships, internal imagery, and... physical presence in the world” (Pearlman & Saakvitne, 1995, as cited in Jenkins & Baird, 2002, p.424).

Sabin-Farrell and Turpin (2003) identify several processes which may play a part in the development of vicarious traumatisation amongst trauma workers. These include: countertransference reactions to the client and their narratives; empathy, which requires the worker to engage very closely with the client's material and understand their subjective experiences of distress; emotional contagion, where the therapist becomes drawn into the client's emotional experience; and challenges to the therapist's existing cognitive schemas and beliefs as a result of their exposure to the client's narrative. Furthermore, exposure to a patient's experiences of trauma can revive a therapist's recollection of their own previous experiences of trauma from the past (Herman, 2001). In a South African study conducted with therapists working with survivors of trauma who were at great risk of retraumatisation as a result of their social and political context, Straker and Moosa (1994) found several emotions common to the therapists. All the therapists interviewed in their study expressed feelings of overwhelming powerlessness and anger, the powerlessness related to an inability to change the situation and to ensure the client's safety within a continually unsafe environment and the anger related to the shattering of their belief in the innate goodness of humanity. Fear and anxiety were also reported but to a lesser extent.

The significance of having an external space in which one can reflect on and be helped to understand the many countertransference feelings that arise as a result of this kind of work is well recognised. Because the therapist comes into the therapeutic encounter with their own relational history it is understood that some of the countertransference reactions that are experienced by the therapist are triggered through their own early object relationships (van den Berg, 2002). The supervisory relationship and intern's own therapy provide the intern with the opportunity to differentiate between which countertransference reactions belong to the patient and which aspects the therapist needs to explore further in themselves (van den Berg, 2002).

Because the impact of working with traumatised populations is potentially so significant, it is particularly important that workers monitor their own health constantly and receive the support they need, for example through regular supervision, their own therapy, and by ensuring they have some variation in their caseload in order

to limit the potentially negative impact of this kind of work on them (Herman, 2001; Walker, 2004).

In the context of chronic and ongoing exposure to violence amongst the South African population, a better understanding of the particular experiences and clinical presentations of survivors of violence who come into contact with mental health services is necessary. This needs to be coupled with a more thorough interrogation of the work that is currently being undertaken by clinicians working with this population, alongside a critique of the relevance and utility of local and international interventions.

University of Cape Town

CHAPTER 3

METHODOLOGY

3.1 Motivation for this study

The purpose of the research was to explore the experiences of clinical psychology interns of working therapeutically with survivors of interpersonal violence in the state mental health system in Cape Town. Having received limited training in specific trauma interventions during the course of their clinical masters training, for both single and multiple or ongoing trauma experiences, it is important to establish how these clinicians have been working with survivors of interpersonal violence, what intervention practices have been most useful, what theoretical bases have been drawn upon to inform practice, and what challenges and struggles they face in their work. The information obtained will assist in the formulation of best practice guidelines for clinicians working with this population of traumatised individuals within the hospital or community clinic setting, which can then be shared with other clinicians working with clients with similar violent experiences in different settings. It will also serve to inform programme planning for the Clinical Psychology masters training.

3.2 Study design

Qualitative research, which is largely post-positivist in its philosophy, is contrasted with quantitative research which has a predominantly positivist philosophy to studying particular phenomenon (Ryan, 2006). Positivism aims to establish the objective truth. This is achieved by using empirical research methods to explain observable phenomena, aiming to establish cause and effect relationships between variables and using deductive reasoning to test hypotheses, also referred to as hypothetic-deductive methods (Pidgeon & Henwood, 1997; Ryan, 2006). Post-positivism recognises that knowledge is not neutral but subjective, and that relationships between variables are complex and need to be seen within their greater social context (Ryan, 2006). Post-positivism uses inductive reasoning to detect patterns and generate tentative hypotheses based on the data obtained rather than imposing pre-generated hypotheses onto the data (Ryan, 2006). A qualitative research

paradigm was used for this research because the aim was to ascertain individual thoughts and perceptions regarding the area under study, through the use of narratives, rather than to try and establish one particular 'truth' or examine a specific hypothesis. Qualitative descriptive studies are particularly helpful in establishing answers to questions of what, who, when and why (Sandelowski, 2000), and focuses on developing a greater understanding of usually very complex human issues, as opposed to quantitative research, which aims to produce results that can be generalised to a larger population (Marshall, 1996). There has been very little qualitative research undertaken in the field of trauma and interpersonal violence in the South African context, thus it was deemed most appropriate for this study.

This descriptive, exploratory study was undertaken through the use of collective case studies. The use of a case study approach enables the investigation of ordinary phenomenon within their real-life context (Stake, 2000; Yin, 2003). Case studies allow us to understand something in particular and to get to know it well, through in-depth investigation (Stake 1995; Tellis, 1997). Yin (2003) recommends the use of case studies when one proposes to study current events in which the behaviours under investigation cannot be manipulated by the researcher. Merriam (1988, as cited in Janavara Sarroub, 2001) identifies the four main characteristics of case study research as "particularistic, descriptive, heuristic and inductive" (p.502), generating interest and understanding, through the rich verbal content that is elicited from the viewpoints of the respondents (Tellis, 1997). Case study research does not aim to make generalisations regarding the population. However the selection of cases needs to be done thoughtfully as it is important to try and maximise the information that can be generated from the selected sample (Tellis, 1997). Stake (2000) highlights that accessibility to subjects can influence whether they are included in the sample but cautions against using accessibility as the only selection criteria, due to the potential risk of losing out on variability amongst cases. In this research all the potential respondents, that is psychology interns at Valkenberg and Lentegur psychiatric hospitals, were interviewed, making the data that is obtained more representative. Collective case studies are preferable over single case studies because they provide more compelling data, which is believed to be more robust than that which is obtained from a single data source. Furthermore, the use of collective case studies enables the researcher to find both particularities and commonalities between individual cases

(Stake, 2000; Yin, 2003). However, Stake (2000) identifies a tension that exists between finding the atypical features of a single case through its interrogation, and comparing the data obtained with that from additional cases, which enables the researcher to begin to understand and possibly even theorise about an even bigger collection of cases (Stake, 2000). As this is an area of study in which little is currently known, particularly in the South African context, the advantage of conducting collective case studies is its capacity to make accessible a wealth of detailed information from which we can begin to think about the complexity of trauma interventions in South Africa and from which further research can be generated (Yin, 2003).

3.3 Sample

Purposeful sampling requires that respondents are actively selected according to the degree to which they are able to provide rich and detailed information about the issues that are integral to the study (Mason, 1996; Patton 1990, as cited in Coyne, 1997; Strauss & Corbin, 1990). Respondents that are chosen are considered to be particularly knowledgeable about the research area and thus are able to provide information that may both support or be in conflict with the developing theories (Marshall, 1996). Strauss and Corbin (1990) argue that sampling in this way is not aimed at developing generalisations but rather identifying specific conditions under which the phenomena occur, thus the findings and theories generated are relevant to this particular set of circumstances only. According to Stake (2006), multicase studies should consist of no less than four and no more than 15 studies because this provides the optimal variation in obtainable data. In this study there were 12 participants, out of a possible 12, as nobody declined to be interviewed. It was deemed appropriate to select all 12 potential participants for the research because of the small sampling frame. The respondents who were identified and approached were the second year Clinical Psychology Masters programme students who had recently completed their internships at Valkenberg and Lentegur psychiatric hospitals. Of the 12, six of these interns were registered with the University of Cape Town (UCT) and the remaining six were registered with the University of the Western Cape (UWC). In both groups this was the total number of interns from each university for that year. In accordance with the designated placement of interns, the students from UCT had completed their

internships at Valkenberg Hospital and the UWC students had done so at Lentegeur Hospital. The internships included placement of one half day per week at a community clinic situated within the greater Cape Town area.

The respective Heads of Psychology at Valkenberg and Lentegeur Hospitals were informed of the study and gave their consent for the interns to be interviewed and a list of contact details for the two groups of interns was provided. The interns were approached individually. Each was contacted telephonically, by the researcher. The purpose of the study was explained to them, as were the logistical details regarding how the data would be recorded, issues of confidentiality, that they were able to choose whether they would participate in the research, as well as the need for their informed consent to inclusion in the research. On agreement to participate, arrangements were made individually regarding where and when the interviews would be held. Respondents were interviewed independently and not as representatives of the hospital.

Of the 12 interns interviewed, 10 were female and the remaining two were male. The ages ranged from 25 to 48 years with five being under the age of 30 years, four were between the ages of 30 and 39 years and three respondents were over the age of 40. Nine of the respondents are first language English speaking, one is first language Afrikaans and two have a foreign language as their mother-tongue, notably German and Losi; however all are fluent in English. The majority are able to converse in Afrikaans. Only one of the respondents can converse in another South African language.

3.4 Data collection

A semi-structured interview was compiled specifically for the purposes of this research and was administered face-to-face with each respondent in a setting of their choice. Semi-structured, qualitative interviewing enables the researcher to gain access to the interpretations and understandings of the respondents, which are less accessible through the use of more structured interviews or questionnaires (Mason, 1996). Because it is an interactive process, it enables the researcher to be sufficiently flexible that they may respond to cues for further probing and clarification during the course

of interviewing, thereby providing greater depth and complexity to the data generated (Mason, 1996). A semi-structured interview provides for some consistency with regards to questions asked of respondents and the areas which are covered during the course of the interview, facilitating comparison between responses. However semi-structured interviews do not impose answers on respondents, as structured questionnaires do, thereby enabling respondents to answer freely and thereby potentially provide a much greater variety of responses (Mason, 1996).

The interview schedule (Appendix A) was constructed in such a way that respondents were asked predominantly open-ended questions, particularly at the beginning of a new category of questions. When the respondents had given their responses, more specific questions were used for clarification of certain points, for example:

When working with survivors of violence, what kinds of experiences of violence are being presented?

Followed thereafter by the question:

Are they (experiences of violence) chronic or acute, current or historical?

Four questions in the interview schedule provided the opportunity for the interviewer to offer respondents a list of possible response options to the questions. Only some of the respondents were offered the more structured response options, and this depended on whether or not they had given a rich description initially.

Because the interviewer was familiar with the content and subject matter of the interviews it was possible to include 'technical' psychological or psychiatric terms in the questions. This meant that the respondents did not have to restrict their answers to what they may have perceived would not be understood by the interviewer.

The questions in the interview schedule explored the following areas with the respondents:

- The demographic characteristics of clients who present at the hospital with histories of interpersonal violence, including information regarding trends in living circumstances, educational achievements, socioeconomic status and identification of chronic and ongoing stressors

- The different types of violence that clients have experienced
- Whether, according to participants clinical observations, violence exposure tends to be associated with particular psychological effects
- The models of intervention that have informed the therapeutic methods used by the interns in their work with violence survivors and what these interventions have consisted of
- The average duration of the interns' interventions with patients and what factors determined this
- What it was that clients reported was most useful to them in the intervention process
- Struggles that the interns faced in their work with survivors of violence and how they attempted to manage these
- What additional training would be useful to clinicians working in this kind of setting with clients who are survivors of violence

3.5 Procedure

The researcher conducted all of the 12 interviews. The interviews were all conducted in English as all of the respondents are fluent in English and as students selected for professional training in psychology in South Africa are generally required to have proficiency in English. Stake (1995) recommends conducting pilot interviews. One representative from each university was interviewed as part of the pilot, using the interview schedule that had been compiled. Small adaptations were then made to the schedule in order to ensure that the questions that were formulated were able to elicit the kinds of responses that would meet the aims of the study.

Each respondent identified a venue of their choice, thereby ensuring their comfort and satisfaction with the physical setting. Venues varied and included the researcher's office, public venues and private residences. The respondents each signed a consent form (Appendix B) prior to the commencement of the interview. Included in the consent form was notification that the interview would be audio-recorded and transcribed as well as confirmation and assurance that confidentiality would be

maintained. Interviews lasted between one and a quarter and two and a half hours. All interviews were conducted over one session only.

Eight of the audio-recordings were transcribed by the researcher and the remaining four were sent for transcription to an independent individual who has no conflict of interest with the research. The transcriptions that had been done independently were received by the researcher and checked for accuracy prior to the start of the analysis.

3.6 Data Analysis

A qualitative approach to data analysis was chosen for this study because it allows for the exploration of complexity and contradiction in the data through analysis of broad themes arising through the verbal content of the respondents' accounts (Pidgeon & Henwood, 1997). The collective case studies were analysed using analytic techniques from grounded theory, in particular the initial labelling and subsequent coding of themes, identification of categories and 'constant comparison' of these categories (Charmaz, 2000; Pidgeon & Henwood, 1997; Strauss & Corbin, 1998). The aim of this qualitative method is to generate theory inductively, through the systematic, simultaneous collection and analysis of data: the theory is then 'grounded' in the data (Charmaz, 2000; Strauss & Corbin, 1998). Grounded theory incorporates aspects of post-positivism through the importance that it places on obtaining and including the perspectives and voices of multiple respondents and in acknowledging how their subjective reality may be in conflict with those held by the researchers (Charmaz, 2000; Strauss & Corbin, 1998). It is phenomenological because it taps into the respondents' subjective experiences and their interpretations and unique understanding of the phenomena under study. Constructivist grounded theory moves further away from positivism in that it "assumes the relativism of multiple social realities, recognises the mutual creation of knowledge by the viewer and the viewed, and aims toward interpretive understanding of subjects meanings" (Charmaz, 2000, p.510).

The analysis proceeded in three steps, as detailed below.

Step 1: Open coding

The process of naming and categorising phenomena contained within data starts with the labelling and open coding of the data. This required that the data be broken down into smaller units for analysis, which was done phrase by phrase (Charmaz, 2000, Corbin, 1986). This facilitated the identification of actions, incidents or events that were then coded as concepts in the data, whilst ensuring that the views of the respondents remained in the foreground (Charmaz, 2000; Corbin, 1986). Finding labels that fit the data is an important part of this process and it can take some time to identify a label that adequately describes the particular action, incident or event (Pidgeon & Henwood, 1997). Through this process of close examination, previously held assumptions regarding the identified phenomena can be explored and new hypotheses generated (Strauss & Corbin, 1990).

Strauss and Corbin (1998) highlight the importance of theoretical sensitivity, which they describe as knowledge held by the researcher regarding the particular area of research being undertaken. Theoretical sensitivity is actively developed throughout the research as it is considered to greatly facilitate the process and efficacy of the coding process. It allowed for the coding to be done inductively, by generating codes from the data contained in the transcripts as opposed to using a deductive approach, whereby pre-existing codes would be used, which have been formulated according to existing theory.

Step 2: Axial coding

As the process of coding continued, long lists of concepts were identified and several repetitions in concepts became apparent. Strauss and Corbin (1990) identify two procedures as integral to the process of coding to formulate concepts and categories, namely constant comparison and the need to continuously ask questions. By developing broader concepts, it becomes easier to include a greater number of incidents within this concept (incidents of similarity and of difference) which highlight the degree of variation and complexity within each concept (Pidgeon & Henwood, 1997). However this is only possible through asking specific questions regarding observations and incidents, which serve to create relationships between concepts (Strauss & Corbin, 1990).

Charmaz (2000) explains that the process of axial coding enables frequently appearing codes to be grouped together so that they can eventually become subsumed within a category, which is a higher order and more abstract concept (Strauss & Corbin, 1999). Corbin (1986, p.95) explains that “a category remains no more than a conceptualisation of several similar incidents until it is more fully developed and densified by discovering (through data analysis) its properties, the conditions under which it occurs, the strategies used for getting there, and the consequences of those actions for all involved”, and suggests that making constant comparisons between incidents enables the researcher to identify similarities and differences, which further facilitates the process of discovering and building more complex categories (Strauss & Corbin, 1990). Categories have certain properties, characteristics or attributes, which can be dimensionalised along a continuum. Properties and dimensions are discovered through the process of asking basic questions of Who? Why? When? Where? etc. Identifying the characteristics of a category and coding for variation helps to densify the categories (Strauss & Corbin, 1990; Swanson, 1986). To assist with finding the relationships between categories, Glaser (1978, as cited in Swanson, 1986, p.25) formulated the “6 C’s’ family of theoretical codes, which includes: 1. Causes; 2. Contexts; 3. Contingencies; 4. Consequences; 5. Covariances, and 6. Conditions”. Each of the identified substantive categories are then compared with these theoretical codes until saturation has occurred and higher level, more abstract categories have been generated (Swanson, 1986).

Step 3: Selective coding

Linking of categories occurs later in the analytic process, once the majority of categories have been identified. This is done through selective coding (Strauss & Corbin, 1990). The aim of selective coding is the emergence of a core category, around which the other identified categories revolve and the refinement of existing and/or the introduction of new categories, in order for a theory to emerge which is grounded in the data (Corbin, 1986).

3.7 Ethical considerations

Stake (2000) highlights the importance of considering the ethical issues related to case study research, not least because it requires that respondents provide detailed

information about their personal views and opinions, which can be experienced as exposing and could evoke anxieties regarding anonymity. Due to the nature of the study it was considered unlikely that this kind of research would have a negative impact on any of the participants involved. Informed consent was obtained from each participant, which was signed following their agreement to participate in the study. The consent form (Appendix B) stipulated that each participant had the right to withdraw from the study at any time and that their personal details would remain confidential and the transcripts would be anonymised in order to ensure that neither they nor their patients could be identified from the text. Participants were also advised that they could refrain from answering any questions they were unwilling, or felt unable, to answer. Only the researcher has had access to the raw data. The audio recordings were stored securely, electronically on computer. The written transcripts were also stored electronically whilst paper copies were kept in the researcher's possession.

University of Cape Town

CHAPTER 4

RESULTS AND DISCUSSION

The following chapter will present an analysis of the data obtained from the interviews conducted with the participants. An overview of the patient demographics is followed by a discussion of the contextual factors that impact on the lives of patients and on their capacity to manage the violent incidences to which they are exposed. Thereafter the different experiences of violence to which patients have been exposed is discussed. This will be followed by sections on the patients' presenting problems, and the therapeutic work that interns undertake with them. The remaining sections of this chapter will look at the impact that working with survivors of violence has on participants, the various practical challenges that interns and patients have to overcome, and finally, training issues that interns have identified during the course of their work.

4.1 Demographics of patients

An overview of the demographic characteristics of the patients whom the participants treat is provided in order to contextualise the participants' experiences of their work. Interns working at the Valkenberg, Lentegur and Groote Schuur hospitals were exposed to a large number of patients, in addition to those who presented at their various community clinics. For the purposes of this research, although several of the interns completed a rotation in one of the two Child and Adolescent Units, information regarding patients under the age of 18 will not be presented for analysis.

The ages of patients seen by interns in the adult wards varied from 18 years of age until approximately 60, with the majority of patients being between the ages of 25 and 50 years old. Most of the patients who were seen were women, both in the hospital and the community clinic settings. The languages spoken by patients were predominantly English and Afrikaans. Some patients had Xhosa or another African language (not specified) as their mother tongue, however participants reported that all the patients could converse in either English or Afrikaans and thus the therapy was conducted in either English or Afrikaans. Issues of culture or language did not emerge

in the data as presenting any difficulty for the interns during the course of their therapeutic work with patients.

Patients presenting at Valkenberg, Lentegeur and Groote Schuur hospitals came from all over greater Cape Town, including the city of Cape Town and surrounds, the Cape Flats, Mitchell's Plain, Khayelitsha, Strandfontein as well as areas along the Southern and West Coasts such as George and Vredenburg, and inland to Ceres, the Boland and Worcester. The community clinics were also situated within these areas thereby serving more localised communities.

The educational levels of patients appeared to vary between the three hospitals and between the different clinics. The interns working at Valkenberg and Groote Schuur hospitals reported that many of their patients had completed high school, particularly those patients seen in the therapeutic wards. Some patients had completed or were in the process of completing their tertiary level education. An exception was noted amongst the forensics patients at Valkenberg, the majority of whom had not completed high school. At Lentegeur and at all of the community clinics, except Woodstock Clinic, interns reported that patients were unlikely to have completed their high school education, with the majority leaving school by Grade 10.

All of the interns from Lentegeur and most of the interns from Valkenberg and Groote Schuur noted that the majority of their patients were unemployed. Of those who were employed, the majority engaged in unskilled to semi-skilled work, working as labourers, machinists, domestic workers and factory or shop workers. Under these circumstances work was often on a contract or temporary basis and people would work as and when it became available. There were however some patients who were working in a professional capacity, in accordance with their level of education and training, although they were in the minority.

4.2 Contextual factors impacting on patients

All twelve of the interns reflected that the majority of their patients struggled with varying degrees of poverty. For many, the only source of income was from social care grants, including disability or child care grants. Accordingly, financial difficulties

were highlighted as one of the main ongoing stressors affecting patients and their families.

Intern 4 “I think that the financial thing was ubiquitous; I think basically everybody that I saw at the community clinic was struggling financially”

Intern 5 “Very poor, I would say a large proportion of those we saw at the hospital didn’t work, were unemployed, so a lot of them were dependent on grants, some of them disability grants, others of them lived off child grants, or some even sort of dependent on older members of the family who got pensions and then those who did work, there was minimal income”

Intern 6 “Yes. I think the financial stressors, that is ongoing. Just basic needs, I mean more often than not that seems to be, a lot of patients are just making ends meet, basic needs are not met and that is chronic”

Seven interns talked about issues related to accommodation, predominantly overcrowding and four identified unemployment as ongoing contextual factors impacting on patients.

Beside financial difficulties and poverty, nine interns talked about relationship difficulties or interpersonal conflict as an ongoing stressor. Seven interns highlighted the significance of substance abuse – which could be either the patient’s own difficulty with substances or substance use of one or more family members in the home. Five interns stated that patients struggled with ongoing community violence and four interns mentioned domestic violence.

Eleven interns spoke about the pervasive nature of violence affecting patients both within their homes and in their communities. Ten interns said that interpersonal violence had affected almost all of the patients with whom they worked. Six interns reflected that their patients were always anticipating some kind of exposure to violence whilst nine interns expressed the view that patients consider violence to be a ‘normal’ part of their lives, which should be dealt with accordingly, as opposed to

violence being something that occurs infrequently and is out of the ordinary, with potentially devastating psychological and emotional consequences.

Intern 1 “And in some homes I think that the abuse is chronic but it is not recognised as such because that’s just what is known”

Intern 2 “The shadow of violence remained present regardless of whether there were regular violent encounters on a daily basis”

Intern 3 “I don’t think I saw a single person who said they’ve never been abused by a parent or a sibling or by, just in life or gangsterism or something so they were all affected.”

Intern 4 “The amounts of people that came with a history of trauma was staggering for me, from the beginning, when I was working at X (ward) and outpatients, is just how ubiquitous it is to have either sexual or physical violence as a child or both”

Intern 4 “It didn’t take that long, but it was quite confusing at first, why she would be presenting like this and yet denying that she had had a particularly bad childhood, it had just become so normal for her, and for everybody it was like that”

Intern 6 “...but predominantly I would say the majority of patients I have had, as young as some of them had been have had experiences of violence”

Intern 7 “So often I would only find out later on, in deeper sessions, that there was this constant level of abuse going on, that had never been mentioned, because it was never thought to be something worth mentioning”

Whilst there is consensus that acts of violence have become increasingly ‘normalised’ in the South African context, particularly violence against women which remains largely accepted and unchallenged (Wood, Maforah & Jewkes, 1998), there is no

literature which explores the psychological impact that such ubiquitous violence and the constant threat or anticipation of violence has on this population.

4.3 Experiences of violence

Patient histories of sexual assault and rape were reported by all the 12 interns who were interviewed and it was also noted to be the most common form of interpersonal violence reported to them by patients. Every intern also recalled incidents of intrafamilial violence, including intimate partner or domestic violence and child abuse amongst patients. Interestingly, it was noted by four interns that some of their female patients who were subjected to violent attacks from their intimate partners would also sometimes reciprocate that violence. Social or community violence, including gang violence or witnessing violence in the community, was reported by nine interns. Seven interns commented on the prevalence of intergenerational trauma, described as exposure to violence in childhood being continued into adulthood, through the maltreatment of the next generation of children.

Gender differences in experiencing violence were identified by 11 interns. It was noted that men were more likely to report having been physically abused as children by their parents or caregivers, whereas female patients were more likely to have been sexually abused in childhood. Sexual assault or rape of boys or young men was reported by two interns to occur as part of gang related activities or during periods of incarceration in prison. Females frequently reported domestic abuse and rape in adolescence and adulthood, and males were more often involved in gang related violence. Most often the perpetrator of violence against women was somebody known to them within their immediate or extended family, a friend or acquaintance in their community. All 12 interns commented on the early age at which their patients were exposed to violence and that usually this was in childhood.

Intern 7 “Quite a few, at some point in their early adolescence, had been raped by family members or friends of family”

Intern 12 “...she had been raped by an uncle, as a child, probably since about 6 or 7”

Intern 12 “...was repeatedly raped by a step-grandfather, over a period of years, when she was in junior school”

The prevalence of sexual assaults amongst the participants' patients appears to support existing arguments in the literature regarding the link between the experience of rape and the subsequent risks for developing psychiatric disorders (Norris et al., 2003), as well as the high representation of victims of childhood sexual assault and rape accessing mental health services (van der Kolk et al., 2005). The early age of exposure to violence, coupled with the experiences of violence being within the family context or perpetrated by a familiar adult, as indicated in the interns' statements, suggest that one would anticipate a more complex symptom presentation amongst those patients being seen (Herman, 2001; van der Kolk, 2005).

All 12 interns who were interviewed expressed their opinion that the violence experienced by their patients was predominantly chronic, starting in childhood and continuing through their lives, as opposed to isolated incidents of acute trauma. It was not necessarily the case that patients would be involved in one particularly violent relationship, although this was commonly reported, but often patients would find themselves moving from one abusive relationship to another, so the violence would continue but the perpetrator would change. In addition, interns reported that high levels of community violence or the constant perceived threat of exposure to community violence left many patients feeling unsafe all the time.

Intern 3 “The ones that I saw in X (ward) it was domestic violence, constantly and just the cycle would be repeated in childhood, in the family, the father would be abusive to the mother or to them and their relationships just continued they would begin a relationship with someone who would be abusive”

Intern 5 “I would say what makes the Cape Flats in particular, so traumatised, is that the abuse is chronic, its not one incident which happens once off and that's it and you know, people sort of learn to deal with that incident and get over it with time and heal, the fact is that its everyday, its

ongoing, and a lot of the patients I worked with didn't have anywhere that they could really feel safe. So their home wasn't a refuge, it wasn't somewhere that they could retreat to and feel protected and safe, they were constantly on edge, whether at home or in the community, and it was ongoing, so a lot of them had numerous incidences of some sort of trauma, so it wasn't a once-off, it was ongoing since an early age and throughout their lives and I think that makes it even more difficult to recover”

If we consider that many of the patients seen in mental health settings appear to be exposed to ongoing violence in both their home and community environments, then how does the existing literature assist with our understanding of the challenges that patients face on a daily basis and of the ways in which they may have developed compensatory behaviours or defences to allow them to continue to function? Most of the literature assumes that at the point that patients present for help they have been able to identify that they are living in situations of danger and have been able to remove themselves from the situation or can be assisted in moving themselves into a position of safety. However the participants' reports suggest that many survivors of violence in the state mental health system do not self-identify as victims or survivors of trauma and abuse.

4.4 Presenting problems

At the point that patients come into contact with mental health services the patients, or those around them, have identified considerable disturbances in their daily functioning to the point that they require specialist intervention. Although interns reflected that almost all of the patients they saw during the course of their internship year had a history of exposure to violence and that often this was longstanding throughout the course of their lives, all 12 interns reported that patients would often provide other complaints as the reason for their seeking assistance. Some of the most common presenting problems that interns identified were: interpersonal difficulties (12 interns), substance abuse by either the patient or somebody within their immediate family system (10 interns), symptoms of anxiety or depression or both (eight interns), somatic complaints (six interns), suicidality or self-harming behaviour (five interns), and bereavement (four interns). All of the 12 interns said that many of their patients

would present with multiple complaints which were compounded by ongoing practical issues such as accommodation or financial stressors. Only eight interns could recall seeing patients who came into the system explicitly wishing to talk about their experiences of violence and the difficulties they were experiencing as a result thereof.

Intern 1 “Because violence is not on their minds all the time, it’s about, mother doesn’t want me, or this one treats me badly, and it’s Eid and no-one came to fetch me. It’s not about that I was raped two years ago. Its about the here and now stuff that becomes very painful which may be more painful because of the traumas they’ve had but that is not really what they want to ruminate on.”

Intern 3 “...and then what else...social isolation, feeling forgotten, feeling rejected and huge interpersonal difficulties”

Intern 3 “...I mean often people would come in with a suicide attempt and that was why they would be brought but it was very superficial suicide attempts, it was much more a cry for help than anything, impulsive”

Intern 7 “Bereavement often was quite a trigger and then eventually you could uncover too, this trauma that they actually didn’t regard as traumatic because it was just something that happened but in fact was a trigger”

Intern 5 “...so it was often quite a complex picture, where there wasn’t just one symptom but quite a few... And then a lot of them also had social difficulties, so along with all of that then the context was so important, because they didn’t feel safe at home, they didn’t feel safe in the community, and they didn’t have money, and they’re worrying about their next meal and they’re worrying about their children, so it was often a very complex picture

The range of complaints identified by interns above is consistent with the literature (Ford & Courtois, 2009; Kessler et al., 1995; van der Kolk et al., 2005), which states that people who have experienced longstanding and pervasive trauma may present with a range of symptoms of depression, anxiety, eating and somatoform disorders,

substance abuse and borderline and antisocial personality disorders, although they may not necessarily meet the threshold for a particular diagnosis.

When trying to differentiate between the presentations of patients who came following a recent traumatic event from those who had experienced historical violence or abuse, few interns were able to recall having seen anybody with a purely acute presentation. One intern commented that even those presenting following an acute trauma usually also had a long history of violent experiences. Those interns who were able to describe the acute presentations explained how the patient might struggle to integrate their experience of the event within themselves. They would also be more likely to present with symptoms of PTSD. This is in contrast with patients who have a chronic history of violence where the violence has become a part of them and has shaped their personality development and who they are. Patients with a chronic history appear to present with a much wider variety of symptoms and multiple complaints.

Intern 3 “Someone who has had a long history of trauma would have a much more complex presentation of, like if someone has sort of one recent violent incident it’s actually quite easy to work with, in a way that it is one incident that you can identify and you can really just work focusing on the trauma... A longer history or a sort of suppressed history is just much more difficult, much more vague, you’re never quite sure, and I think after all this time a lot of other things have come up, it’s much more integrated into their personality.”

Intern 4 “People who present with more recent violence, its quite clear what is going on, they can give you a history of what happened, it might not be that clear, but you get some kind of story, even if its second hand, from somebody else, about what happened, and they appear, quite often, to meet the criteria for posttraumatic stress disorder, whereas people who present with histories of abuse and violence present with very much more non-descript symptoms and an inability to cope in the world without really being able to make any sense of it, just vague feelings of loss and emptiness that they don’t really understand, failed relationships, just an inability to connect with other people in the world, an inability to trust, particularly trust themselves, and just a low

level dysthymia as well... and also just difficulty tolerating their own emotions, emotion regulation is a big problem for these people and they don't really understand why"

Intern 8 "... so there was a total... they would talk about these horrific things that had happened and there would be no emotion in the room"

Albeit limited, the interns' comparisons between the presentations of patients following an acute versus more complex trauma experiences seem to match what has been described in the literature. Terr (1991) described the development of classic PTSD symptoms as a consequence of exposure to Type I traumas, whereas people who are exposed to what Terr defined as Type II traumas present with more complex personality pathology, of which an important characteristic is difficulties with emotion regulation and interpersonal relationships (Courtois, 2004; van der Kolk et al., 2005), as indicated in the descriptions from interns, above.

All the interns would routinely clerk their patients on admission to the inpatient wards in the three hospitals, however this procedure was less rigorously followed in the outpatient settings and at the community clinics. In the clinic or outpatient setting it was felt that completing a thorough clerking was often too time-consuming in light of the fact that patient attendance at subsequent appointments could not be guaranteed so it was necessary to maximise the work done in each session. Two interns described having independently compiled their own mini questionnaire for clerking purposes in these settings. A thorough Maudsley or clerking includes asking the patient direct questions regarding their past experiences of violence, including particular details regarding early family relationships and any incidents of sexual assault. Despite being questioned directly, it was reported that some patients would not divulge such information at this initial point of contact. Ten interns reflected that information about violent experiences was often only shared later in the therapeutic relationship, once rapport and trust had been established with patients. Seven interns said that patients would also sometimes disclose the details of events spontaneously. Whether or not a patient had been previously admitted, or treated as an outpatient, at one of the hospitals also had a bearing on whether, and how, they disclosed their trauma history. Although details of a patient's previous experiences of violence might become

apparent during the course of the clerking or over time as the therapy progressed, this was not necessarily an indication that it was something which the patient wished to focus on in therapy.

Intern 8 “Usually in the first two sessions I would take a history and it would be something that I would ask. And sometimes people would say and sometimes people wouldn’t say”

Intern 9 “I think that in the history taking there is space for that but not always the patients bring it out, and as I mentioned earlier, only once building rapport, will patients maybe feel comfortable enough to speak about something that they find particularly painful... for those that I did do a history taking, as time went on you realise you didn’t tell me this, you didn’t tell me that, and things come up, you know”

Intern 7 “In some cases you could pick it up through the clerking process, that there was violence in the past, but again, the way it was revealed tended to be quite matter of fact, this is not something I want to focus on, and often you would get that response where I don’t want to go there.”

Herman (2001) states that it is not uncommon for patients to deny a history of abuse even with direct questioning, particularly when the abuse they experienced was chronic, through childhood. This is partly because patients may not have made the links between early childhood abuse and current symptom expression, as reflected in the statements made by interns, above. This implies that one of the goals of therapy should be facilitating the process of creating these links and developing the patient’s insight into their difficulties.

Nine interns said that they noticed a gender difference in the way that patients reported their experiences of violence. Women were found to be more likely to disclose a history of violence as compared with the male patients.

Intern 2 “most of the time the male patients don’t fully recognise or are cognisant of the sheer scale of violence that they are working with. It almost

felt like, well, this is part of life and I need to figure out how to deal with that. There was less focus on that with the men.”

Intern 3 “And then the males... a little more hesitant. A male would never say I have been abused, they would just say that my home life has been tough or my dad was very strict, he would hit us. Males would sort of be more ok with it in a way, they would say but that’s how it is, that’s how it was and that’s what males do, and they were brought up like that whereas females would be more distressed by it and not know what to do about it...less happy about it but almost just as accepting.”

Intern 4 “I think there were some men that reported sexual abuse but I think they were less likely to report it”

In their study, Breslau et al. (1998) established that men are more likely than women to report incidents of physical assault including attacks with weapons, whereas women are more likely than men to report incidents of sexual assault and rape. However comparative studies with local populations are lacking.

When thinking about the types of diagnoses that patients were given in the hospital or clinic setting, it was apparent that different wards had patients with particular diagnoses. In the acute wards, patients presented with predominantly psychotic disorders with an increase in the incidence of substance-induced psychoses amongst the male population and a smaller cohort with mood and/or anxiety disorders. All 12 interns reflected that the therapeutic wards and outpatients settings were represented by patients with personality disorder diagnoses, mood disorders (notably depression and bipolar disorder) and a range of anxiety disorders including generalised anxiety disorder, PTSD and panic attacks/disorder. Of the personality disorders, borderline personality disorder was the one most commonly referred to by interns and the one which 11 interns said was likely to be given to patients with a more complex symptom presentation and a longstanding history of interpersonal violence. It was also highlighted that a large percentage of patients are often given diagnoses on both Axis I and Axis II. A diagnostic pattern that was noted was a mood disorder on Axis I and borderline personality disorder on Axis II amongst the women and narcissistic or

antisocial personality on Axis II for the male patients, although all interns saw some variations of these and commented that diagnoses could be changed during the course of an admission.

Intern 1 “I found that with the psychiatric patients there was a history of some kind of abuse, whether severe neglect or abandonment and then often some kind of sexual abuse, especially with patients with a borderline diagnosis”

Intern 2 “borderline predominantly with females, narcissism predominantly with males”

Intern 9 “Gender trends tend to be in terms of male diagnosed with antisocial but female is borderline, but that’s also not true because sometimes you can have it vice versa, but that was, in terms of the trend of diagnoses, males who are more likely to be diagnosed, in terms of Axis II, antisocial, and females would be borderline”

Nine interns commented on the debates that exist regarding the utility of the borderline personality disorder diagnosis. They were all familiar with the complex PTSD diagnosis and two interns said they would have preferred to use it for many of their patients because they felt it to be a more helpful diagnosis.

These findings are supported by the literature, which states that people who have experienced chronic interpersonal violence and neglect throughout their lives but particularly from an early age, are likely to be given a personality disorder diagnosis on Axis II with a comorbid Axis I diagnosis, when they are seen in a psychiatric setting (Herman, 2001). Providing comorbid diagnoses on Axis I and/or Axis II can be understood as an attempt to fully encapsulate the range of presentations that a simple PTSD diagnosis does not cover, including emotion dysregulation, possible features of dissociation, somatic complaints, disturbances in information processing and disruptions in one’s sense of self (Ford & Courtois, 2009). Epidemiological studies have shown that PTSD commonly co-occurs with comorbid anxiety and mood disorders, psychotic disorders and substance abuse on Axis I and up to a third of PTSD diagnoses have a comorbid personality disorder (Ford & Courtois, 2009). A

comorbid diagnosis of borderline personality disorder is often given to patients who present in this way, although it has been criticised by many as being a pejorative term that evokes strong feelings in mental health professionals as a result of the meaning and associations that have become attached to it (Herman, 2001). Brown (2004) challenges the implicit meaning of the borderline diagnosis, which locates the pathology in the character of the individual, as opposed to considering their responses to be attempts at survival and coping within the context of a traumagenic environment.

There is very little literature which focuses on the psychological outcomes of exposure to trauma amongst male patients (Pimlott-Kubiak & Cortina, 2003). Few male patients were seen in the wards relative to females. The majority of males who were seen had been admitted to the acute wards where they were predominantly diagnosed with a substance-induced psychotic episode, where it would have been difficult to elicit their experiences of violence. Under these circumstances their use of substances is likely to have been considered the precipitant to their psychotic breakdown. However the context of substance use may not have been explored in detail despite the fact that substance abuse is used as a coping strategy amongst victims of violence, substance abuse can mask symptoms of PTSD, and the use of substances increases the risk of incidents of interpersonal violence occurring (Kilpatrick, Acierno, Saunders, Resnick, Best, & Schnurr, 2000; Sawyer-Kurian et al., 2009; Seedat et al., 2009).

4.5 Working therapeutically with survivors of violence

The following section will explore how interns worked with survivors of violence, including: the structural and practical difficulties interns encountered and which impacted on their ability to provide a therapeutic service; the goals they worked towards with their patients; the theoretical models on which interns based their interventions; issues influencing the reconstruction of trauma narratives with patients; the provision of a corrective emotional experience; particular challenges related to the impact of interns being constantly exposed to their patients' histories of trauma, and the experience of being an intern working within a hospital setting.

4.5.1 Constraints on therapeutic work

There is a developing body of international literature regarding evidence based, best practice psychological interventions for survivors of both acute and chronic violence. As interns received some input during the course of their training specifically with regards to working with people exposed to violence, it was interesting to establish that eight interns struggled with feelings of incompetence and did not feel that they were able to find a way of working with these patients, particularly those who had experienced chronic violence or abuse. Some of these feelings of incompetence were linked to constraints regarding patient safety, as well as the time constraints imposed by individual placement settings.

Intern 3 “I mean they were all abuse cases so just a lot of emotion, a lot of emotion but then what was also really difficult was when there was no emotion, actually that was the worst, now that I’m thinking about it when you’re dealing with someone and they’re giving you this whole history and its horrific and there is just no emotion, there is nothing, they are just like and that’s that, its fine and trying to work out how to access something that has been packed away for so many years. That was really challenging for me.”

Intern 4 “I understood where the person was coming from, I understood what they were going through, the whole theoretical sense, but I found the practical, this is what you do in the room, I actually didn’t know what to do”

Intern 10 “in those instances I really felt like I was floundering and you know, battling in the dark for a technique to work with these people”

Nine interns were familiar with and felt that a complex trauma framework facilitated their understanding of the issues faced by these patients.

Intern 3 “I like Judith Herman’s stuff, which was really useful in just understanding the patient”

Intern 8 “I think the complex PTSD made more sense to me”

Intern 10 “I don’t necessarily think that Judith Herman’s stages of trauma therapy is necessarily helpful for them all, but I do think that it is a fairly new way of thinking about mental illness”

Nevertheless it was reflected by three interns that trying to implement a multi-stage model of intervention, as is conceptualised within a complex trauma framework, is highly problematic when working with the South African population. Herman’s (2001) model argues that work with survivors of violence cannot progress until safety has been established. However, as the majority of patients who were seen by the interns continue to live in violent contexts, the establishment of safety was very difficult to achieve.

Intern 4 “you can read all of the stuff that you want and it will all tell you that the first rule is to establish safety, and you can’t, so you know that your client is going right back into an unsafe environment”

Intern 11 “we have all read Judith Herman’s ... and you know that establishing safety is the first thing, before I should even try and do any psychological kind of work with them. Now in most, I would say all these situations, maybe I am exaggerating a little bit, it was impossible to establish physical safety you know”

The time that an intern had to work with their patient was a significant factor in determining what could be undertaken in therapy. The length of intervention was largely dependent on the setting and ranged from one session up to two years. Interns were allocated community clinics where they would be based for the whole year. Participants reported that at the community clinics patient attendance was unpredictable for a variety of reasons, and as such patients might be seen just once or twice. However some interns were able to contract with patients to see them for up to 10 sessions or longer. This was also somewhat dependent on the clinic waiting list. In the hospital setting, interns rotated through the various wards every four months. In the acute admission wards the length of intervention was dependent on how long the patient remained on the ward before being discharged. Sometimes work would

commence but then be terminated, prematurely and without any preparation, as patients would be discharged without the intern's knowledge. In the therapeutic wards, patients undertook a 4-week inpatient programme at Lentegeur hospital, a 6-week programme at Valkenberg hospital and an 8-week programme at Groote Schuur hospital. During their admissions, interns would see their patients individually twice weekly and then in groups once or twice a week. In the outpatient wards patients were seen on average three times at Valkenberg but at Lentegeur they could be seen for longer periods. The fact that interns rotated wards every four months was experienced as a considerable disruption in the therapeutic process and as a factor in determining the type of therapeutic work that interns undertook with their patients.

Intern 10 "I had to say to him, just think very carefully about whether you want to bring this up now, knowing that we have only got this much time left you know, which is sad because like he is on the brink, and now you get the story anyway because they are on the brink, but then you leave them high and dry... I think they had the experience of being abandoned in that experience, which is kind of like re-enacting the original trauma, which I got a big issue with. You know, it just didn't feel right"

Intern 11 "it did feel a bit like, yes short term psychodynamic models, not waiting two years for them to come to the connection that this and this is linked, but asking questions about do they think they are related. So yes, that kind of working through it, not as open ended and more directive"

Intern 12 "...but there was so much there that in a short-term intervention like in a 6-week therapeutic program, there wasn't much point in delving into that"

The consensus was that very little in-depth, exploratory work could be undertaken in six or eight sessions, which was the average length of intervention depending on the particular rotation, and so interns felt they had to proceed with caution.

Intern 4 "the focus is really on what is stopping the person getting back to some kind of a manageable normal life. So if it is that the main problem is at

work, then that will be the focus, or if the main problem is the relationship, intimacy, then that will be the focus and then maybe you will refer on to FAMSA or something like that, so its really about fire fighting actually, putting out the biggest fire in the persons life at that time, rather than really unpicking the deep-rooted sort of personality alterations that have taken place”

Intern 6 “the consultant there would say stuff to me like, X (psychology intern), it is short term intervention; you don’t want to elicit the trauma. But there was this, yes, this general sense that you don’t touch the trauma, stay away”

4.5.2 Therapeutic goals

In light of these findings, it was important to then establish what interns and patients determined to be the goals of therapy and how they worked with patients towards achieving these goals. After clarifying what the patient’s main struggles were and what the focus of intervention would be, the goals of therapy were conceptualised as: providing information and opportunities (12 interns); developing self worth and resilience (11 interns); developing reflexivity and insight (11 interns); developing coping skills (11 interns); offering containment (nine interns); encouraging emotional expression (seven interns), and strengthening positive relationships (five interns).

Providing information and opportunities

The goal of providing information and opportunities was achieved by informing patients about symptoms and about resources available to them, advising them about their rights and making referrals on their behalf to other hospital or community based resources.

Intern 3 “so it would also be psychoeducation and legal education on their rights, I mean some of them had no idea that they weren’t supposed to get abused, you know and on the process of getting grants for their kids and applying for restraining orders...if they request information then you tell them

what their options are, because for some of them it wasn't even an option...trying to link them up with resources, even clinics or groups or things that were happening outside of the hospital, so, yes, there was also that aspect and trauma symptoms, psychoeducation about symptoms of trauma, normalising it a lot and saying its ok, there are other people that feel that way, you're not insane"

Intern 5 "then where there were social problems as well, giving them advice on that so that they could take steps in terms of that or contact social resources in the area"

Intern 12 "we had had a reading about the physiology of the way in which trauma memories are laid down and I found that very useful for psychoeducation purposes, to try and help people understand why this would just happen, you know suddenly they would be almost ambushed by a memory, by re-experiencing, I suppose. I found this very normalising, that there is actually a bodily reason why it happens this way"

Herman's (2001) process of establishing safety includes naming the problem, which she describes as providing patients with information about symptoms and how they may be likely to experience disruptions in their functioning as a result of their experiences. Herman (2001) argues that the sharing of information is empowering for the client because it allows them to develop a greater sense of control, something which was previously taken away from them. Thus, although the process of establishing physical safety is problematic with this population per se, aspects thereof can be worked towards, as indicated above.

Developing self-worth and resilience

The development of self-worth and resilience encompassed highlighting the patient's existing strengths and fostering their internal resources so that patients could start to think differently about themselves.

Intern 1 “...it really was about strengthening, if I can use psychodynamic language, strengthening ego strength, building on a core which felt enough, so that they wouldn’t land up running towards a failing relationship or an abusive husband or a not interested mother or whatever. There was always someone whom they wanted love from but who would not give it to them...so I think one of the main aims and goals in therapy was how do you give that to yourself.”

Intern 1 “...just to take the bones of what they have and put the meat on it. It was so much about putting the meat on the bones and giving them a little bit of resource. I’m sure they’re going to be back a lot of them because that resource runs but something to hold onto, something in them keeps surviving”

Intern 3 “They do have resources internally, no matter how much they don’t have access to them at the time or how much they feel that there is nothing, there is always something and if you go back far enough or you think hard enough or just look at the smallest of things like what is your day, like what do you do in a day and they will be like, well I wake up and I make breakfast and I get the kids to school and you’re like, well there you go, you’re able to do that. There is always something that you can find that they’re doing that’s ok, and that’s really important, not to forget that they’ve got resources, they’ve got to be there, everyone has got something”

Intern 9 “to kind of validate what was working for them, rather than what was wrong”

Tummala-Narra (2007) defines resilience as an individual’s capacity to successfully adapt to or cope with traumatic or stressful events. Resilience is multidimensional, so that following a highly traumatic event one might be able to continue functioning ‘normally’ in some areas of their lives but display complete dysfunction in other domains (Harvey, 2007). By assisting the patient in recognising and mobilising their resilient capacities, the patient may then be better able to reflect on their positive qualities and their capacity to effect change. The development of a sense of self-worth is consistent with the process of meaning making, which challenges the individual’s

tendency to identify characteristics in themselves that explain why the traumatic event happened to them or that make them in some way deserving of the trauma (Janoff-Bulman, 1985). Janoff-Bulman and McPherson Frantz (1997) argue that part of the process of healing includes re-evaluating the patient's life, prioritising what is important to them and placing greater value on their daily existence.

Developing insight and the capacity for self-reflection

The capacity for self-reflection and insight includes starting to think about the possible links that exist between one's past experiences and current difficulties. It also involves developing the capacity to look at how the current patterns and ways of thinking and behaving may be perpetuating, in particular, relationship difficulties and how one might go about changing these.

Intern 1 "it was to develop in them their own internal perspective taking mechanism"

Intern 2 "If the patient was apsychotic and had some degree of ego strength, a lot of the work was really looking at linking the psychotic experience which was particularly really violent and connecting it with violent early experiences in real life"

Intern 7 "...and later on, through the psychoeducation process, might come and realise that actually what they were going through [domestic violence] wasn't the norm, or wasn't what was regarded to be the norm, because often it actually was the norm"

Intern 7 "Because of the nature of the presentations, even the trauma, when it came up, it came up in the sense that patients were relating to other people in this specific way and so try to figure out why that relationship was happening in that way, identifying what was happening or even what was happening in the transference in the actual room, commenting on it and then maybe thinking about reacting in a different way."

Intern 11 “then would try, through the history and asking questions, helping them to try and link and see where this is coming from”

The development of insight is a very important therapeutic objective for most models of intervention. CBT approaches rely on the development of insight into the patient's existing irrational thoughts, beliefs and feelings by challenging these with information that is based in reality (Jackson et al., 2009), whereas a psychodynamic or mentalisation-based approach to therapy relies on the development of insight into the patient's characteristic and repeated patterns of relating and how these impact on others and maintain relationship difficulties (Bateman & Fonagy, 2008; Gabbard, 2000).

Developing coping strategies

The development of coping strategies is about the development of problem-solving skills and the identification of positive coping strategies in order that patients can reflect on what strategies they have been using to maintain their functioning but which may have been unhelpful and to learn ways of managing situations that they identify as highly stressful.

Intern 2 “ there was a continued threat of violence and a continued threat of sexual abuse, not to her particularly but through her daughter who was a similar age to her when she was abused. So there was a major threat that was present and because of her dependence she couldn't get out of the home... but really looking at other ways for her to cope with her particular situation. So one was really looking at insight in terms of helping her to understand her experience of when the father arrives, she could feel similar emotions, when he would arrive, even when he wouldn't do anything... and then looking at coping mechanisms of how does she manage her own behaviour in that situation. How does she create alternate plans to deal with this person who is coming into her particular space? So it would be, you can't get out of the house but maybe you can remove yourself from the room and go to your own bungalow at the back of the home, which are very concrete steps but that seemed to be quite helpful in terms of helping her”

Intern 3 “with the inpatients the one thing I used to do was ask them, if they were faced with an option, or faced with a difficult situation... I want you to think of pros and cons and different options that you can use and different reactions and write them down. And it worked quite well because then we used to practice them together”

Intern 4 “it’s about finding out like what do you like doing and are you still doing those things, are you getting pleasure out of your life in other ways”

Intern 9 “so they had had a history of violent trauma but we’re not going to be dealing with that now, we’re actually going to be dealing with why you came in: you came in because you had a nervous breakdown because your husband was wanting to sleep with someone else, for example. So we deal with that, how do you get that person to cope, because you’ve got 4-6 weeks that that person has to go through and so the focus is really on how to develop coping mechanisms with that person. So you don’t want to go too deeply into upsetting things in the past...so it was more around focusing on the here-and-now and how she would cope”

Steele et al. (2005) propose several treatment principles that should be adhered to particularly when working with survivors of complex trauma. In particular they highlight the need to challenge the patient’s tendency to avoid experiences that would have previously raised considerable anxiety by identifying and implementing more adaptive coping strategies, as well as developing the patient’s sense of self-control and efficacy through the use of effective problem-solving strategies. CBT targets the patient’s maladaptive behaviours and cognitions that lead to avoidance of traumatic stimuli through the implementation of more helpful coping strategies (Rothbaum et al., 2000).

Offering containment

The interns identified the need to provide patients with a therapeutic space that felt physically and emotionally safe, reliable and predictable because this was something

that many of them were lacking in their lives. Several interns reflected on how important it was for patients to have this experience, particularly those who were returning to situations of violence.

Intern 3 “You need to hold the emotions and you need to control the emotional side of things to hold the person but you don’t need to control the process”

Intern 3 “having structure and having the boundaries and knowing what the next hour is going to hold, which is something that I think in people in violent relationships they never know one minute to the next what is going to happen, so I think that is the hugest thing, is having a holding space and most of them say that that has been really useful and they do, a lot of them acknowledge, the patients, they say thank you for sitting through this”

Intern 5 “I think initially, depending again on how raw the trauma is, allowing the person to feel safe, firstly, safe and secure”

The concept of ‘containment’ (Bion, 1962, as cited in Lemma & Levy, 2004; Bion, 1967, as cited in Garland, 2007) is used predominantly within the context of psychodynamic approaches to therapy. The therapist, as a ‘container’, must be able to take in and tolerate the unbearable material brought to them by the patient, which the patient feels unable to manage on their own. For many patients there may be nobody around them who is able to offer this kind of containment, which can add to their sense of hopelessness and their belief that the material is powerful, overwhelming and potentially damaging (Casement, 1985). The therapist who is able to survive the patient’s attacks and modify what is projected into them, facilitates the patient’s ability to reintegrate a more tolerable version of their material, and restore or develop the patient’s capacity for symbolic thought (Garland, 2007; Levy, 2004).

Encouraging emotional expression

Interns identified the need to assist patients with acknowledging, and finding ways of communicating, their emotions.

Intern 6 “but I want to know about ‘wat voel jy’ you know, and she is beginning to talk more about being ‘bedruk’... but what was fascinating was how it moved from the somatic to talking about “ek voel so sleg” you know, and where empathy again was back in the room”

Intern 9 “...so for her then the goal would specifically be to, lets see if we can maintain a goal for a week or even stay near to the feelings, because she would do a lot of that, you know if you would talk in the session about one thing, then she would veer off to the one side, you know she wouldn’t stay with it. I would try to stay with it and she would make it very hard for me to stay with the feelings. So that would be a goal: to stay with the feelings or to acknowledge that you are feeling in a certain way, or to even say that you are feeling sad or angry.”

Intern 10 “Other goals were more, you know like when people came with anger issues and those are usually the men, was to find ways to express that anger in healthier ways”

Gaylin (2000) argues that in disclosing something to somebody, it is not necessarily the disclosure of the issue itself which brings relief, but rather it is the release of the emotion that has been attached to the disclosure. Feelings of rage, guilt and shame are intricately linked and vehemently avoided and projected onto others (Gaylin 2000). When considering that a large proportion of these patients have experienced physical violation, often from a young age, it is understandable that feelings of guilt and shame will predominate. Some of the patient’s avoidance of expressing strong emotions, particularly anger and rage, may be understood psychodynamically, as related to fears about the fantasised consequences of so doing (Rose, 1991). Fears of being overwhelmed by retaliatory wishes and impulses and the guilt that is associated with these feelings, along with the distress, which have all been defended against, need to be acknowledged, explored and resolved within the context of a containing therapeutic relationship (Garland, 2004; Rose, 1991). Because survivors of violence often avoid strong emotions, anxiety management, emotional self-regulation and affect tolerance are also important components of CBT as well as the more integrated therapeutic approaches (Cohen, 2008; Eagle, 2000; Ford et al., 2005; Herman, 2001).

Strengthening positive relationships

By recognising the limitations inherent in the therapeutic relationship interns were aware of the need to assist patients with identifying people who were already in the patient's life or had previously been important to them and who could offer encouragement, protection and support outside of the hospital or clinic setting.

Intern 1 "what I would ask them to share is tell me a story about someone with whom they want to build a relationship and then from there just give very concrete tips... so what would it be like if you phoned and then what would the person say and she would say this and that and I would say what would you say and she would say oh I don't know, well could you say this or could you say that?"

Intern 3 "important also was who was there, in terms of was there a family member or friend, almost like the buddy system, you know when you leave the hospital, when you go home for the weekend, who are you going to contact, what are you going to do if this happens, if that happens."

Intern 4 "...just connecting them with people that they do trust, encouraging them to maintain relationships that are healthy and to get support from people, to ask for help."

Herman (2001) argues that recovery following exposure to interpersonal violence and trauma cannot occur in isolation but requires reconnection with others, which is achieved in the context of the therapeutic relationship but also in reconnecting with supportive others. Furthermore, Harvey (2007) argues that because resilience is transactional in nature, in order to promote resilience, interventions must aim to enhance the relationship between the individual and their environment, which includes forging links with supportive individuals and organisations.

4.5.3 Intervention models

The interns had various theoretical models on which they based their interventions with survivors of violence to a greater or lesser degree. Eight interns referred to having worked intuitively, which meant that they did what they felt was needed in a particular situation, as opposed to being fixed to a particular theoretical model at all times. All of the interns felt comfortable with their knowledge of psychodynamic theory and 10 interns considered themselves to think predominantly in a psychodynamic way, even when they were not working psychodynamically with their patients. A purely psychodynamic approach to therapy was not considered to be entirely appropriate, particularly as many patients were felt to need brief, more practical and solution-focused interventions, based on the types of difficulties with which they were presenting. Nine interns perceived psychodynamic psychotherapy to be better suited to working with patients who were able to attend long-term therapy where the patient could be socialised into this way of working, over time gradually developing insights into their patterns of thinking and behaving.

Intern 2 “you may always think of a patient in a psychodynamic term but it may not necessarily be the right method for them”

Intern 3 “the other one I would see weekly and she presented with a lot of trauma and abuse, a lifetime of abuse also, but she was fantastic because when you’ve got a year with someone you can start off being quite concrete and as it goes on as you get to know them better then you can really slowly start shifting into a much more psychodynamic and by the end of the year we were working really well and just understanding her”

Intern 8 “although I tried to understand most of the clients psychodynamically, with CBT, the patients that I worked with with CBT was patients that needed a lot of structure”

All of the interns were required to use group therapy in the wards, although it was experienced as more or less useful depending on the particular ward the intern found themselves in. Group therapy was found to be effective in the therapeutic wards at

Lentegeur and Valkenberg hospitals where it was based on a Dialectical Behaviour Therapy (DBT) model of intervention, including skills building to develop the capacity for mindfulness, interpersonal skills, emotion regulation and distress tolerance. As such it required patients to be fully present in the group process and to be able to tolerate the often quite confrontational experiences in the group. In the acute wards, group therapy was less structured and themes would often be based on issues that had arisen in the ward or planning for discharge. In these wards more creative methods were employed by interns as they felt appropriate according to the patients' level of functioning.

Intern 4 "I really do think it is worthwhile, particularly the relationship stuff, and that is where I think the value of groups really came in at ward 1. It's understandable that people have developed a narcissistic rage towards the world, that life is unfair and the world owes me, and it does, but its not going to get, mom isn't going to come and kiss it better, it just isn't actually ever going to happen. And people need to mourn that process but they need to see who they have become and what they look like to the outside world and what that is doing to stop them from actually getting responses that they want from other people, and which can be nurturing and how they are holding at arms length what could be possibly nurturing responses. So I think that for trauma that has resulted in personality disorders I think that the group, I actually found the group to produce the biggest shifts"

Only the six UWC interns were formally taught to use DBT whilst at Lentegeur because the therapeutic ward there bases their intervention on this model. Although two of the three UCT interns who were in the Valkenberg therapeutic ward developed some knowledge of the model through the group therapy structure, it was not used in other contexts by UCT interns. It was reflected that the 'here-and-now' focus of the model is helpful with patients who have a long history of violence exposure because it does not dwell on the experiences of violence although it does acknowledge these experiences and focuses on the impact thereof and how it affects the patient's functioning on a day-to-day basis. The interns who were immersed in the model found the skills development to be particularly helpful to patients.

Eleven interns incorporated CBT into their work and found that it was effective with both survivors of chronic and acute trauma. Some of the benefits stated by interns were: they considered CBT particularly useful in reducing symptoms; it was deemed to be a more structured therapy thereby making it more accessible for a greater number of patients; the homework element was felt to be useful in establishing patient's commitment to therapy and monitoring their progress as well as providing them with greater responsibility for the therapeutic process; and it could be used for brief interventions.

Intern 3 "I think it worked well for two reasons: one was it gave them something to do, so they felt like something was happening and there was a shift and it also forced them to be involved in the therapy and it was concrete for them, they felt like something was moving and it was nice to do because it also helped me to gauge how much they were involved themselves"

Intern 5 "so looking at ways of thinking and ways of acting, that sort of thing, so I suppose using a bit of CBT, trying to modify those or trying to get them to see that maybe the way they are thinking, maybe that isn't so true or looking at self-defeating thoughts, is there actually evidence for that, is there actually evidence for what you believe"

Intern 10 "Well like with the lady who couldn't get into cars, just to get her to get into a car and go on a trip. And it was so sweet watching the thing unfold you know, like I say, I am not a CBT fan, but it really worked in her case, it really did."

Exposure therapy was used or considered for use by four interns, predominantly because patients were seldom presenting with an acute trauma experience.

Intern 4 "I mean there was one woman I saw that never came back. I only saw her once, she had been raped by a family friend... and she was now afraid of all men to the point where, she was so terrified of men that she actually couldn't see her own brother, she hadn't seen her own brother for 2 years... she actually wasn't even able to speak to him on the phone, to hear a man's

voice, she was terrified about hearing a man's voice... she missed her brother terribly, she sms'd him, but she couldn't... and I really wanted to, with her, what I thought would be really nice would be, as a first thing to do a systematic desensitisation for her, and as a first step to maybe get her, to prearrange with her brother that he would maybe sing her something and so that it was not a voice, it was her brother but it was not like, hello, and this voice that she knows... but I never got to do anything with her.

Intern 6 "I once again would exercise caution around what patient to do that with. The patient that is in our catchment area that would have access to admission, if there was fragmentation, those are the kind of patients I would, but the patients that I might be seeing for a few sessions and might not access... you know I would be quite weary of doing that"

Nine interns considered their therapeutic approach to be supportive psychotherapy, including aspects of positive psychology, whereby there was a greater focus on a patient's achievements and areas of psychological strength and existing resources than on their difficulties. The approach was described as non-threatening, non-confrontational and was perceived to facilitate the development of the therapeutic relationship, providing the patient with an experience of feeling heard, respected and supported.

Intern 1 "She's very creative so she drew pictures and tried to visualise the parts in her that are good to try and build up in her the parts of her that are good because she felt herself to be no more worth than a 20c piece."

Intern 3 "The whole sort of idea of positive psychology we used a lot, so trying to look at, what have you overcome, how did you do that? How did you get to the hospital, was always a point of strength, well you got here, how did you get here and if you got here it must show some kind of ability to shift your life, to shift your circumstances"

Intern 12 "Something I became aware of in X (ward) is what incredibly negative views of themselves people had. So when they did do something well

or handle a situation better than they thought or survive something better than they thought I gave quite a lot of affirmation, and I used to also often try and end the session by just remembering, repeating that affirmation about something. It had to be something real and congruent... I just found that people always responded so well to an affirmation of something, hopefully not just a bland, oh that was nice, but where something they had done well had been noticed”

Each intern made reference to working with families, however it was evident that whether a family-based intervention was used was dependent on the particular ward, on the therapists’ sense of competence in using this type of intervention, whether the patient wanted their family to be involved and whether the family were able to attend sessions at the hospital. Those interns who worked in a child or adolescent setting were required to use family based interventions as were those who worked in the acute admissions wards, although sometimes contact was only made with families in the acute setting in order to obtain collateral information. The use of family work was inconsistent in two of the three therapeutic wards, but was a prerequisite at the third hospital.

Intern 1 “In female admissions where I did quite a lot of family work it made a real, real, real difference to have the whole system there because I think a lot of times there was just a whole lot of miscommunication.... Maybe also because I have a love for it and I enjoy the energy and the challenge but I can also see how the patient feels validated”

Intern 4 “I think partly also that is partly my preference, I don’t like, I’m not comfortable working with families. Sometimes its just necessary, you have to but no, it was mainly with individuals”

Intern 10 “So it depends on the ward, how much it is emphasised. It is actually emphasised at C23 because, well mainly because you have to get collateral because these people are very sick and you are not necessarily getting a realistic account. And a lot of those just turn into family sessions.”

Seven interns felt that they were eclectic in their approach to therapy. This meant that they would integrate different aspects of different interventions, according to what was deemed relevant for a particular patient at a particular time.

Intern 5 “So I would say a mixture, I don’t think there was one way there was psychoeducation, some CBT and then with some patients, longer-term patients, psychodynamic work. I would read from the patient and adjusting with the patient and seeing what way they can work or not work”

Intern 7 “pure psychoanalytic thinking often was a luxury that you didn’t have, because you didn’t have the time and space to do it in so that didn’t help so you tended to work more eclectically”

Narrative therapy was utilised by five interns, often not in its purist form but rather by taking aspects of narrative work that could be incorporated into the therapy.

Intern 1 “...or I might use a little bit of narrative therapy and try and identify the sparkling moments but I think all of it is rooted in a more dynamic way of thinking about things”

Intern 3 “we got people that she was close to, to write letters about her, positive things about her and we would open them in the session and look at them together and then we would talk about them, like what do you think of that. And we did pros and cons, so people would say difficult things about her also.... I think we only got about 2 letters or something in, I mean ideally it sounds amazing, but you know half the people can’t write or it’s this and that but that was helpful”

There is growing empirical evidence to support the efficacy of psychodynamic psychotherapy in the treatment of individuals experiencing a traumatic stress response (Schottenbauer, Glass, Arnkoff & Gray, 2008). It is argued that psychodynamic psychotherapy is particularly effective in treating the difficulties that arise following exposure to complex and prolonged trauma, which are of an interpersonal nature. The goal of developing the patient’s insight into their difficulties is achieved by offering

interpretations and linking characteristics of the therapeutic relationship with the patient's early childhood and current relationships (Schottenbauer et al., 2008). As indicated above, interns felt that this interpretive approach to therapy was something which was best used only with those patients whom the interns were able to see long-term, despite the fact that interns felt most comfortable working within a psychodynamic framework.

The efficacy of CBT-based interventions for treating PTSD following acute trauma experiences is well established (Cohen, 2008; Rothbaum et al., 2000). Traditional CBT interventions have been modified for the treatment of survivors of multiple and chronic violent traumas (Cohen, 2008) and there is increasing empirical support for their efficacy. Despite the empirical support for CBT interventions, of which DBT is one example, these interventions are being implemented inconsistently within and across the various hospitals. This finding is consistent with the results of two surveys conducted in the United States (Becker, Zayfert & Anderson, 2004; Sprang, Craig & Clark, 2008), in which it was established that practitioners working with trauma survivors were less likely to utilise evidence-based approaches, particularly CBT and exposure-therapy approaches, in their treatment of patients because of a lack of confidence in their knowledge of, and skill in, implementing these techniques.

The literature on resilience emphasises the importance of the family system as a source of support and as a protective factor in a patient's recovery following trauma (Tummala-Narra, 2007). It is argued that interventions which aim to promote and sustain an individual's resilience need to engage the support of families if they are to be effective (Harvey, 2007). However it is evident that working with family systems was not applied consistently by the participants.

Integrative interventions combine aspects of CBT and psychodynamic theory and have become increasingly accepted as an effective way of working with patients who have been exposed to ongoing violence because they take into account the complexity of trauma responses (Ford et al., 2005). It is argued that certain integrative models are relevant for use within the South African context because they are time-limited and so are better able to meet the increasing demands on mental health resources (for example the WITS trauma model of brief-term early intervention; Eagle, 2000).

However what the interns are indicating in their statements above is that they are not following a particular integrative model per se, such as the WITS trauma model, rather they are combining aspects of treatment models with which they are familiar and which feel will be helpful within a particular context and with particular patients. This 'integrative' approach to treatment is evident in the interns' reflections regarding their use of narrative therapy techniques. White (2006) provides a clear structure, within a narrative therapy framework, for working with survivors of prolonged exposure to violence. It is a time-limited intervention and would appear to be well suited for working within the hospital or clinic setting however it is not something which interns appear to have made use of. Edwards (2009) argues that, in practice, the integration of various models, particularly in work with survivors of trauma, happens extensively. By attempting to work in a 'purist' way practitioners are wrongly assuming that overlaps do not exist between different models. Edwards (2009) continues by saying that using one model of intervention exclusively could be considered unethical because of the existing literature which supports the use of different treatments in combination.

4.5.4 Avoidance of trauma reconstruction

After having established that a patient had a history of exposure to violence, the direct exploration of a patient's trauma history was uncommon amongst participants. Interns provided several explanations as to why patients do not go into the details of their trauma experiences or why interns are reluctant to actively explore patients' experiences of violence. These included: the patient's lack of recognition regarding the significance of their experiences in relation to their current difficulties (nine interns); patients telling interns that they do not want to discuss their histories of violence or patients' avoidance of such discussion in therapy (10 interns); the fact that a patient may have to return to a situation of violence when they leave the hospital or clinic (four interns); patients often have a multitude of other problems that they feel are more urgent and thus require greater attention than the exploration of their history of abuse (nine interns); at the time that patients present to hospital they may not have sufficient capacity to manage, emotionally and psychologically, the exploration of their traumas (eight interns); uncertainty around how long a patient will attend therapy and constraints related to the intern's time on a particular ward, meaning that

interventions are usually quite brief, thereby making deep exploration of trauma events inappropriate and potentially unethical (eight interns), and lastly, seven interns said they are afraid that exploring the trauma experiences in detail could retraumatise some of their patients.

Intern 3 “you didn’t feel like you could divulge too much at once, it would be much slower, and I think a lot of the time that was from both sides like they didn’t feel that safe because they knew they were going home again so they didn’t really want to break down their defences and I didn’t feel comfortable breaking down their defences because I also knew that they’re not going to back to hospital and stay there, if there is a crisis they are on their own”

Intern 6 “Very rarely I have a referral that was trauma work or related to a particular incident you know, it is much more around symptomatology, particularly in X (community clinic), it was around patients possibly depressed or panic attacks or you know. And then of course as you start doing the history taking do you get the incidents of trauma being highlighted... But a lot of the patients I have seen it [violence] is just so much a part of their frame of reference, that they don’t see it as the reason they’re in therapy. It is about taking away this anxiety or taking away, you know, the fact that I can’t sleep properly”

Intern 7 “...you’d be able to acknowledge it [the violence] and maybe contain around it but you wouldn’t be able to get to exploring and focusing on any specific trauma because again, the case was that there were usually too many to explain and patients had, in their own ways, protected, defended and worked around a specific trauma”

Intern 9 “I’ve been quite sensitised as to what happens if you start unpacking something for someone and what that might mean. So I think, yes, you already go in feeling a bit sensitised as to what you can do and can’t do, especially if the person is outpatient. If they’re inpatient, then at least you know they’re there, so if anything does happen then they are contained in the ward, but if they’re going home every time then you need to make sure that they leave you

with their defences intact. So it does, I think that the context and the time that we have to work with patients does influence how deep you can go into trauma.”

Intern 11 “...but the connection wouldn’t be there for them. It [the violence] is something in the past and it is gone and it is dissociated from them you know, or they have dissociated from it. So I wouldn’t say that that would necessarily be the focus of the treatment, it would all depend on what that person was coming for and asking for”

Intern 12 “...just because the sexual abuse may have been a major factor in how you formulate somebody’s difficulties, it doesn’t mean that that is necessarily what they want to work on, it was the case only in one case for me. You could argue that that is avoidance or you could just say it wasn’t their most pressing concern right then.”

All 12 interns expressed the importance of considering the needs and wishes of each individual patient as paramount when deciding if and when to engage in a deeper exploration of their experiences of violence. All the interns left the choice and timing of when to do so up to their patients and raised concerns that encouraging patients to talk about their experiences, when they were not yet ready to do so, might lead to patients being retraumatised as a result. For those patients who wanted to use therapy to explore the trauma, interns were cognisant of wanting to do so cautiously, working at the pace that the patient set, recognising the potential impact that opening up these old wounds could have on them and the perceived limitations of what could be offered in the therapy space in terms of time constraints.

Intern 5 “I sort of took it from the patients, so if the patient wanted to and was willing to, then yes, but if they didn’t then I didn’t push it because I almost felt that that would be retraumatising or sort of almost voyeuristic. So if a patient wanted to go there I’d let them go there and if they didn’t want to I wouldn’t push it”

Intern 7 “it depended on the specific patient. There were some that wanted to go through it, and that would be mostly catharsis, actually saying it out loud and acknowledging this is what happened...and then there were patients who just didn’t want to go there, they wanted to move on...but again that was very often dictated at where a specific patient was at a time, and because often the trauma wasn’t the focus of the therapy, you wouldn’t go there, because that would be opening a huge can of worms that maybe you wouldn’t have the time or the space to actually contain”

Intern 12 “My feeling with her was that she was very fragile and I didn’t want to go digging into those early experiences for their own sake, for the sake of exploring it, unless it seemed to be what would be helpful to her at the time, and so I said to her that what she had mentioned was really important but she had a choice about whether we were going to talk about it in the sessions or not”

Kudler et al. (2000) explain that analysis of the defences used, for example avoidance and repetition, is an essential component of this work and that this process is facilitated by making meaning of the trauma incident for that individual. CBT models also argue that exposure to avoided traumatic material should be included in trauma interventions (Cohen, 2008; Jackson et al., 2009). Kaminer (2006) argues that the re-telling of the trauma story is a very important component of the therapeutic work undertaken with survivors of both acute and chronic violence and identifies six therapeutic processes which are proposed to facilitate individual recovery following the development of posttraumatic pathology, including: “emotional catharsis; the creation of linguistic representation; the habituation of anxiety; empathic witnessing of injustice; developing an explanatory account, and the identification of purpose and value in adversity” (p.481). Whilst Kaminer (2006) cautions against the indiscriminate practice of recreating trauma narratives with all patients and the need for careful assessment of the patient’s individual needs, the quality of the therapeutic relationship, and the patient’s level of functioning, it would appear that interns have perhaps been overly cautious about engaging in trauma reconstruction work with their patients. However it is apparent that the interns were very anxious about exploring, in-depth, their patients’ trauma experiences, particularly if they were historical, and that

they tended to be led by the patient rather than confronting the patient's avoidance of their traumatic material.

4.5.5 Providing a corrective emotional experience

Nine of the interns reflected on the importance of the therapeutic relationship in the process of change and how they worked towards offering patients an experience of being in a relationship, which is different to what they have come to know and expect from the relationships they have with the people in their lives. Important qualities of the therapeutic relationship that the interns highlighted were: they were fully present, listened carefully and witnessed the trauma of their patients (seven interns); it was a collaborative relationship (six interns); it was non-judgemental (four interns); they aimed at empowering their patients (four interns); and it was respectful (three interns).

Intern 5 “just allowing them space where they can talk about their experiences and have no fear of being judged... giving people back a sense of power and also just knowing that there is someone who does care and someone who is there to support them.”

Intern 8 “I think the one thing that patients say is, or the thing that sort of stays with me is just that I listened to their experiences, that my reaction wasn't that of being critical or judgmental, that I actually just sat and acknowledged that this could happen to them.”

Intern 10 “there was something about that session and just that she was getting support from me, because now clearly, when it seems as though the whole world is against you and one person is on your side, she said it was like a really profound experience for her”

Although the efficacy of a number of therapeutic techniques has been proven, it is becoming increasingly evident that it is the therapeutic relationship that provides the context in which change can occur. This is particularly important when working with survivors of chronic interpersonal violence, where the patient's primary difficulties

are with interpersonal relationships (Fonagy & Bateman, 2006; Jackson et al., 2009; Steele et al., 2005).

When interns received feedback from their patients about which aspects of the intervention had been most helpful to them, eight interns reported that it was the fact that they had been able to provide patients with the space to share their stories and that patients felt they had been heard in a way that was different to what they experience in their relationships with others. According to psychodynamic theory and mentalisation-based therapy, this experience of relating to somebody which challenges the person's previously held conceptions about, and expectations of, interpersonal relationships is the primary component for therapeutic change (Fonagy & Bateman, 2006).

Intern 3 "a lot of them acknowledge, the patients, they say thank you for sitting through this"

Intern 7 "I have had feedback and I think the most was how much that space actually means to them. Often we don't appreciate how much it means to have someone listen to you, give you their full attention for 50 minutes a week"

4.5.6 Worker challenges

The challenges that arose for interns, as a result of working with survivors of violence, represented a considerable focus for discussion. Seven interns found it very difficult to work with patients who were floridly psychotic. It was felt that there was little role for psychology in the acute wards, where patients were predominantly psychotic, because they were considered unable, or too vulnerable to engage in therapy. However once these patients were stable, work could commence either as a result of their referral on to the therapeutic ward, or on an outpatient basis following their discharge. In the acute wards the psychology intern was required to initiate contact with the family, to provide the families with information about the patient's illness that would facilitate their management in the home following discharge, and to facilitate a pre-discharge group, as opposed to offering any kind of individual therapeutic intervention during the patient's admission.

Intern 1 “I think that with the people who were more psychotic it was difficult. I felt at sea where some of them were thought disordered, because their level of disorganisation you never know whether they are understanding what you are saying”

Intern 10 “...so she was very thought disordered. So it was very hard, she wanted to talk about what had happened to her, but could only say so much and like you couldn't prompt and if you did she'd sort of completely go off the rails into her thoughts”

Working with patients with personality pathology also raised challenges for all 12 of the interns. Some of the difficulties that arose included having to manage patients' challenging behaviour, which included their threats of suicide and abuse towards staff, patients being demanding of intern's time and pushing boundaries, dishonesty, testing the intern's commitment to the relationship and patients appearing to be invested in maintaining their sick role.

Intern 4 “I finally managed to find her someone in private and her response was floods of tears and enragement that I was going to abandon her and I obviously think that she is worthless and I don't want to see her anymore, it was just terrible”

Intern 12 “She made suicidal threats and there was constant pushing of boundaries and breaking of rules”

Other considerable areas of difficulty for interns were managing the countertransference reactions that develop within the context of the therapeutic relationship, and the impact on interns of working with survivors of violence. All of the interns identified strong positive and negative countertransferences, most noticeably and powerfully in their relationships with those patients diagnosed with personality pathology

Intern 3 “you dread certain patients and then you just see them for a shorter amount of time, especially borderlines, it happens a lot, I mean these are the patients who fear rejection the most and then you suddenly realise that you’re seeing them for a half hour session twice a week and everyone else gets an hour, its awful”

Intern 4 “I really wanted to rescue her and I really wanted to see her more although part of me really wanted to push her away, she was frightening in the room, she denigrated at the drop of a hat and her mood would just swing all over the place so it was an absolute rollercoaster ride trying to stay with her and just absorb all of the attacks constantly. It was utterly draining”

Intern 6 “I sometimes sat with patients where I am irritated and annoyed and anything but empathic, and I am very aware of how that is their experience in the world and this what they elicit”

Intern 10 “our whole thing is about repairing and making good and being rescuers, so when you become the perpetrator in that person’s eyes, it is incredibly hard to bear, it is incredibly hard, and I can’t bear being misunderstood and being seen as something that I am not intending at all, it is very hard”

Considering that the majority of patients who present for treatment complain primarily of interpersonal difficulties, it is not surprising that these same difficulties will be enacted in the therapeutic relationship. Klein (1946) highlights the use of projective identification amongst patients with personality pathology and the need for therapists to become aware of and make sense of the patient’s projections. Herman (2001) describes how therapists working with survivors of violence can experience a whole range of split off emotions projected into them by the patient including extreme rage and helplessness, which in turn can cause the therapist to identify with either or both the victim and the perpetrator (Rose, 1991), as is reflected in the intern’s comments. The challenge of trying to make sense of and bear these often rapid and unpredictable fluctuations in mood or way of relating in a session without getting drawn into an enactment, as highlighted by Herman (2001), is also clearly indicated.

Eleven interns reflected on the negative impact that working with survivors of violence had on them and on how difficult it was for them to hear of their patients' trauma. Their constant exposure to patients' stories of trauma and violence felt overwhelming at times and caused them to question and alter the previous assumptions they held about themselves, about the people around them and about the world.

Intern 2 "when you sit with, especially sexual abuse, and you know its very horrific, you're hearing about...most of them are sitting with trauma from a early childhood experience and to hear of rape and incest... it makes the world feel very ugly"

Intern 8 "...and because you hear the story from different people over and over again, last year at the end of the year I came to that point where I actually went home one day and just stood under the shower and I cried because it actually became just – there was too many stories and it felt as if it was just the faces that changed"

Intern 9 "it has impacted I think a lot on the way I think of the world differently, how I deal with people and with myself, in my family as well"

There is considerable empirical evidence which shows that repeated exposure to stories of human cruelty and suffering can have a significant impact on the therapist (Herman, 2001; Sommer, 2008). An increasing sense of personal vulnerability is coupled with greater cynicism and pessimism about the intentions and motivations of others whilst at its extreme it can leave the therapist overwhelmed and vicariously traumatised so that they are no longer able to psychologically distance themselves from their patient's experiences and become vulnerable to developing physical and psychological symptoms of burnout (Herman, 2001; Jenkins & Baird, 2002). Within the space of the internship year it is clear from the reflections of the interns, above, that they already were experiencing the effects, predominantly negative, of having been exposed to their patients' trauma.

Two interns said they felt having a depth of understanding of the reasons behind some peoples' behaviours made them more compassionate and understanding. One intern described how his work experiences had given him a more positive outlook, which he described in terms of his own 'posttraumatic growth'.

Intern 3 "I have a lot more patience towards people and much more empathy to people who are in difficult situations and it shifted the way I think in a lot of ways about how everybody is unique, its so difficult to give a structure about well, someone's trauma is this long, they are going to respond like this, one person will do one thing another will do another thing. You just learn that you just can't make any assumptions about people"

Intern 4 "I think that being exposed to so much, so much personality stuff and really, really getting your head right in there and seeing where these difficulties come from, relational difficulties, even though its frustrating, I think that you can develop compassion for people and the limitations with which people have to work with, the limited emotional resources that they have given, their background"

Both of the male interns commented on the challenge of being male therapists and working with female survivors of sexual violence. Both were aware of how the gender issue could impact on the therapeutic relationship and were conscious of not wanting to retraumatise their patients by reinforcing a male/female power differential.

Intern 2 "I would always position the patient by the door, especially female patients with an experience of sexual abuse so that they felt comfortable in terms of getting out of the room quickly"

Intern 9 "she had again experienced sexual trauma but I never dealt with it and I think its maybe because I was a male"

Intern 9 "it took a long time for me to build up rapport and for her to build up trust with me and particularly, I mean I was a male and she was a female"

Male therapists are particularly vulnerable to identifying with the aggressor in their countertransference reactions with female survivors of violence (Herman, 2001). Both of these interns were able to reflect on this process, however it is possible that their caution in ensuring they did not become the perpetrator in the room may have impacted on the degree to which they felt able to explore their patients' violent experiences.

Interns highlighted some of the factors that posed a challenge to the therapy process in addition to the countertransference issues discussed. Five interns identified intermittent patient attendance or sudden and unexpected termination as problematic and five interns described avoidance behaviours either resulting in a patient's non-attendance or their avoiding discussion of certain issues in therapy. Nine interns acknowledged that there were often real practical constraints that prevented a patient from attending therapy, including their being unable to take time off work, other crises arising and needing their attention and financial constraints that meant patients could not afford to pay for transport to attend sessions.

Intern 10 "you do contract with people and you say we are going to work X amount of time and you are expected to come every week or every second week and they just don't come hey, because life happens... and especially when people are struggling with so many other things"

Intern 11 "I mean a lot of them would even tell you why they won't go to certain places, and its transport costs, it is far, it is effort, it is this... especially if they are going to the clinic, it is walking distance for everyone, but anywhere else that they need to have transport money for."

Although all of the interns highlighted the importance of looking after themselves, particularly when being constantly exposed to this kind of traumatic material, seven interns commented on how difficult it was during the course of the year to find time to do things for themselves. Workload pressures resulted in these interns neglecting their own needs and prioritising their work commitments. Five interns talked about how they tried to maintain a balance in their lives, which they achieved by ensuring they

had a day off from doing work at home on the weekend (two interns), making regular plans with family and friends (three interns), and exercising regularly (one intern).

All of the interns were in their own therapy during the course of the internship. Individual therapy and regular supervision were considered to be very important resources for self-care whilst nine interns also mentioned peer support as an invaluable resource to them. Supervision and individual therapy may offer the experience of containment to the container, a very important function if the intern hopes to remain able to provide containment for their patients (Herman, 2001; van den Berg, 2002; Walker, 2004).

4.5.7 Being an intern in a learning institution

In addition to the challenges that interns faced in undertaking their work with patients, a number of institutional challenges were identified. Practical and time constraints were mentioned by 11 interns. These related to: workload pressures; caseload pressures, particularly in the community clinic setting where there were often long waiting lists; the disruption caused by the intern moving through rotations every four months, both to the intern and on the therapeutic relationship, and a lack of access to additional resources, predominantly referral resources.

Intern 7 “then also the time factor, the fact that you couldn’t get to everything because of time constraints or the fact that you were leaving the rotation or it’s the end of the year so you couldn’t go there”

Intern 8 “people wouldn’t come every week, and there was also such a long waiting list that sometimes you sort of just had to not feel pressurised by the waiting list and decide no. And sometimes people just wouldn’t come and if you didn’t come for like two weeks, we couldn’t keep the space for you, so somebody else would then be put in your space, which sometimes meant that you just started forming rapport with somebody and then they are gone.”

The issue of medication was something that interns reflected on as being an important aspect of the treatment of patients. All 12 interns worked with patients who were on

some kind of psychiatric medication. Ten interns felt that it was useful in combination with therapy. Three interns commented that it was difficult to work with patients who were highly medicated or had recently had their medication changed and on these occasions therapy would be cancelled. The issue of medication was regularly raised by patients in therapy and four interns reflected that they did not know enough about medication and so did not feel confident about discussing it with their patients.

Five interns talked about the difficulties that both they and their patients experienced in identifying resources that patients could access following their discharge from hospital. They talked about the gaps they had noticed in service provision and the specific resources that they would have found very helpful had they been available, including social workers and community-based support groups.

Intern 4 “that was a huge frustration is some have been on an intensive 6-week course and then nothing, so for me it was like, this is pointless, so that actually felt quite frustrating and demoralising that there wasn’t some kind of support afterwards, other than medication. There wasn’t nearly enough”

Intern 7 “you would try your best to do that kind of referral but hope for the best because most, if not all of the referral sources were swamped as well with people who were needing assistance”

Despite all of the challenges that interns faced during the internship year seven interns talked about how rewarding the work was at times and how much they were able to take out of their year’s experience.

Intern 5 “It was difficult but it can also be rewarding. X (Hospital) was great, I really enjoyed it. I just feel that I learned a lot, I feel like it was a really steep learning curve. It wasn’t always easy and I would feel tired and exhausted but I feel like I learned a lot.”

Intern 12 “I will always be grateful to her because of everything she taught me. I realised that all this theoretical stuff that I had done, while of intellectual

value, had very little to say about the person she really was and I feel grateful to her for sticking with me and showing me that”

4.5.8 Training issues

All of the interns felt that they gained a great deal of knowledge through their first year of clinical training although 10 interns identified areas of additional training which they felt would have benefited them in their work. Of these 10, five interns would have liked more input around working with trauma, three said they would have liked more input on CBT and three interns felt they would have liked to have been better informed about the potential impact of working with survivors of violence. Three interns mentioned specifically having had previous training experiences, prior to their clinical training, which contributed to their knowledge base.

All of the interns identified supervision as a very important resource for their learning. However, four interns commented on the inconsistency in the frequency and quality of supervision, particularly with reference to the community supervision, which was deemed to be severely inadequate in light of the volume and complexity of patients being seen by interns in the community clinics. Three interns felt that their supervisors were insufficiently knowledgeable in the area of trauma to provide the degree of support that they felt they required. Six interns made regular contact with their peers and/or colleagues for informal case discussion and used this forum to share any knowledge or information they had gathered. Six interns actively sought reading material to assist them through particular areas of difficulty in their work.

Intern 3 “we would all get different readings and stuff from our supervisors and we would pool it and photocopy it and share them out and just constant discussions, and you know, often you would just be sitting at lunch and say like I’ve got this person who I’m struggling with, I don’t know what to do with them and I don’t know where they should go, and they would be like, oh I had someone like that and I referred them to this organisation, and that was really useful”

Intern 11 “it was my first experience with that level of trauma. To have somebody who knows or who has seen more of it tell you it is going to be okay, or that they will be fine, that really helped”

Having developed insight into the pervasiveness of violence amongst patients accessing mental health services in South Africa 11 interns expressed the need for further specialist training in the impact of violence and in working with people who have been affected by violent trauma.

4.6 Summary

The results obtained through careful analysis and coding of the interviews conducted with the 12 interns provide a useful indication of the complexity of working with survivors of violence in the South African context. The majority of these findings are congruent with the local and international research that has been conducted to date. However it is evident that interns in the South African context are faced with several issues including; the ongoing contextual factors impacting on patients; patients' ongoing exposure to violence and experiences of multiple trauma; unreliable patient attendance, and the limited access to resources, which make it difficult for interns to rely on models for intervention which have been formulated elsewhere. The degree of specialist training which interns have received prior to entering the hospital system is limited and so the majority of learning is achieved through working with patients and supervision in the field. Ongoing training and supervision are imperative but access to these resources is limited. Despite all of the difficulties, the work is reflected on as being challenging but rewarding.

The final chapter will provide a synopsis of the most important findings in the context of the limitations of the study and recommend issues for further consideration and possible future research.

CHAPTER 5

CONCLUSION

The conclusion chapter will consider the main themes that have emerged from the data and how they relate to the literature. Questions that have become apparent will be raised for consideration and suggestions will be made for future research. Limitations of the study will be presented at the end.

5.1 Summary of findings

According to the reports of the participating interns, the majority of patients accessing state mental health services present with a history of multiple exposures to trauma and interpersonal violence in particular. For many patients the violence is ongoing rather than being a past once-off event. Despite this, socioeconomic difficulties, a complex mix of symptoms and conflicted interpersonal relationships often present as the most significant problems causing patients the greatest distress and precipitating their admission to hospital. In accordance with the literature, due to chronic exposure to violence, a large proportion of patients present with a complex combination of symptoms and complaints, often in conjunction with personality pathology which, as was reflected by the participants, can make it particularly challenging for interns to determine how best to intervene.

Despite the literature supporting the use of particular interventions with survivors of chronic and ongoing trauma, the Clinical Psychology interns do not appear to be working in a consistent way. Feedback from interns suggests that, although through their training they have developed some understanding of the aetiology of many of the difficulties with which patients present, the interns feel unskilled in working with survivors of chronic and ongoing violence. Theoretical models, for example Herman's (2001) complex PTSD, whilst helpful in understanding the sequelae of trauma, are not always helpful in guiding practical intervention. One aspect of why these models are not always helpful is the context in which many patients continue to live. Ongoing exposure to violence or perceived threat of violence is a major factor impacting on the enduring nature of patients' psychological difficulties and makes the task of ensuring

safety particularly difficult. Furthermore, the violent trauma to which patients have been or continue to be exposed is not always their primary concern or even something that they feel can be resolved. Other, usually more practical difficulties, become the focus of intervention.

Interventions with patients are dependent on the patient attending sessions. Factors impacting on patient attendance need to be considered, for example financial and practical constraints. The development of patients' insight into the impact of their exposure to violence, through the linking of symptoms with past and current experiences, is a process that is preferred in longer-term interventions, where work can progress more slowly and cautiously. As the majority of interventions offered in the hospital setting are brief in nature, interns prefer to work in a more concrete, supportive and solution-focused way, although the development of some degree of insight into the behaviours that maintain relationship difficulties is often facilitated. Interns aim to make their interventions relevant to the patient and so they work intuitively and eclectically, integrating techniques from different models, for example narrative therapy and CBT, as deemed appropriate, and adjusting interventions during the course of therapy if it is indicated. This in itself raises some challenges for interns who are uncertain about whether working in this way is 'good enough' but don't feel that they have any structured kind of intervention or guidelines for intervening that are suitable for the varied and unique needs of a South African population.

Where interventions have felt inadequate, interns have relied on their own personal and therapeutic qualities, including the capacity to simply empathise and thus provide patients with an experience of a relationship in which they feel heard and emotionally contained and which is different to the models of relating that they have developed in their relationships with those around them. Patients reflected on this as having been a positive experience when they gave feedback to the interns. Herman (2001) and van der Kolk (1996*b*) discuss the development of a supportive, caring therapeutic relationship as an essential component of the therapeutic process, particularly when working with survivors of violence whose primary difficulties are in their capacity to form stable and mutually beneficial relationships with others. It is evident from what the interns reflected that this was something they provided intuitively to their patients.

Because few patients are able to commit to lengthy interventions, goals that address the primary identified need of the patient need to be clearly formulated with them. Whether or not this includes a detailed exploration of the patient's experiences of violence is dependent on whether the intern believes that it is appropriate or whether the patient brings it up for discussion themselves. However the trend appears to be that trauma reconstruction does not frequently occur, despite this being a central component of most established trauma intervention models and the considerable amount of literature which highlights the therapeutic benefits of so doing.

Issues of complicated transference and countertransference reactions with patients with a more complex presentation came through strongly in the interviews with the interns. Whilst this is echoed in the literature, it presented interns with particular challenges that required sensitive and thoughtful consideration so that these responses could be understood and not enacted in the therapeutic relationship. Supervision was consistently referred to as an essential source of support and a resource for learning, however the varying quality of supervision sometimes left interns feeling unsupported and out of their depth. The importance of providing containment for containers is well recognised. In light of the lack of emotional and practical preparation for trauma work that some interns felt they had prior to entering the hospital system, the need to provide interns with a supportive and containing relationship within that setting is that much greater.

5.2 Issues for further consideration

Interns reflected that they would have benefited from spending more time in their first year of clinical training learning specifically about trauma and trauma models and being better prepared for what they were going to be exposed to and the potential impact on them of working with a traumatised population. If competence and training is an issue, then how can this best be addressed within the constraints of the existing clinical training programme, ongoing supervision and within the hospital itself? The establishment of trauma reading and peer supervision groups is one possibility for providing ongoing support and skills development to interns.

The interns' fear of doing damage and of retraumatising patients, through the use of exposure techniques, comes through clearly. Their caution is understandable, particularly if the patient presents following an acute incident of violence and is not ready to talk about it. However when the violence has been ongoing, by the interns not bringing it into the room, was there some collusion with patients in avoiding talking about their violent experiences? Might some of the interns' avoidance be related to a fear that they would be overwhelmed by their patients' stories and thereby unable to contain their patients? Is it possible that by not talking through the trauma, the interns are also defending against the pain that the exploration of their patients' narratives may expose? Interns would benefit from having clearer guidelines regarding when to engage patients in exploration about their experiences of violence, and how this can be done in a way that minimises risk of harm to the patient.

The interns make reference to building individual patients' internal resources and resiliencies to deal with their oppressive environments, as opposed to encouraging patients to explore and challenge the status quo by questioning what has become normalised for them and their communities. By not challenging what has become accepted, are the interns feeding into their patients' sense of hopelessness and despair? How does this fit with research which highlights the importance of empowering and conscientising patients as an essential component of the treatment process? Perhaps by linking patients more effectively, following discharge, with resources that are available, patients may be exposed to other ways of thinking about what has become normalised for them. Making these kinds of connections with others may also serve to reduce individual perceptions of isolation and hopelessness and potentially develop individual and community resiliencies.

The interns described the home environments of many of their patients as unsupportive and even dangerous, how does this affect the patient's capacity for resilience? Yet interns seldom actively sought to involve family members in the patient's treatment. Family based interventions are considered particularly important in the development of resilience and in the success of individual interventions with survivors of violence. If access to families is being blocked by patients, then how can that be further negotiated with them? If practical constraints prevent families from attending sessions, does the hospital have a responsibility to assist them? And what

strategies can be used to engage resistant family members? These issues could be addressed during the first year of clinical training in order to prepare interns to work more systematically with survivors of violence.

Part of the difficulty that interns experienced was feeling as though they were working in isolation and that all the work they undertook with patients would be undone once patients left the hospital. However, there are some community based resources that can be accessed for patients once they have been discharged from the hospital. Those resources that are available are not necessarily known about by interns and if they are known about they are not being utilised optimally. For example NICRO can offer support to women in abusive relationships and other victims of violent crime through providing information, promoting safety, and assistance with laying a charge and progressing through court proceedings as needed. However no interns mentioned using NICRO as a referral resource. Do interns see their therapeutic and supportive role ending at the gate of the hospital? What responsibility do interns have in taking more of an active role in linking patients with community based resources or of identifying gaps in resources and seeking to fill these in some way themselves, for example by setting up post-discharge support groups or early intervention programmes? How has the clinical training shaped the way that interns think about themselves as practitioners and where the boundaries of interventions start and end? These are all issues that trainers could consider in their curriculum planning.

5.3 Limitations of the study

While case studies allow for a much deeper understanding and richer content of the data, it is important to acknowledge and bear in mind the criticisms made against case studies, namely that the interpretation of the data is by nature subjective, giving the researcher much room for their own interpretations and thereby compromising on the validity of the data obtained (Flyvbjerg, 2006). It is therefore necessary to apply our minds in a thoughtful manner and interrogate the degree to which subjectivity may have been compromised.

Barbour (2001) highlights the benefits of using multiple data sources to support findings and improve internal validity in a process called triangulation. However

Barbour (2001) concedes that triangulation is difficult to perform properly because although one may obtain similar findings from alternate information sources they are often in a different format, making direct comparisons more difficult. Time constraints, financial constraints and bureaucracy around confidentiality of patient records limited accessibility to alternative data sources.

On reflection, through the process of data analysis, a further limitation became apparent. Certain questions could have been asked during the course of the interview which might have further clarified points that were raised by interns, which would have helped in densifying and enriching the data and may have served to answer some of the questions which have subsequently been raised.

Because the interviews were only conducted with interns from the University of the Western Cape and the University of Cape Town it is important to acknowledge that the results obtained only reflect the opinions and impressions of these specific interns and thus can only really be generalised to their experiences of working with the population of patients attending these hospitals and clinics. It is also important to consider that, as the interviews were conducted with the interns and not the patients themselves, these reflections are based on interns memories of particular patients and cannot be assumed to be an entirely accurate representation of their patients' experiences.

Researcher reflexivity is identified as an important aspect of the qualitative research process, particularly the data analysis, and is defined as, "an attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process" (Malterud, 2001, p.484). Mason (1996) adds that the need for reflexivity is based on the belief that the researcher is never a completely neutral or objective participant in the research process. Using a qualitative research framework requires the researcher to recognise how their own bias could influence the processes of data collection, analysis and dissemination, due to the subjective nature of such research (Stake, 2000). It is also important to consider my role as researcher and how my position may have influenced the interaction between myself and the participants and potentially impacted on the data that was

obtained. The degree to which my own subjectivity may have influenced the way that the results were presented will also need to be considered.

It was important for me to ensure that participants felt sufficiently comfortable with sharing information with me and answering personal questions that they may have experienced as exposing. In order to facilitate this I encouraged participants to identify a venue for the interview with which they felt comfortable. Although the interview was conducted informally I tried to stick to the form and order of questions as much as possible. However on reflection I noticed that by trying to keep a flow in the questioning I sometimes skipped a question or combined questions, which meant that valuable information might have been missed. It is also important to consider the influence that I may have had on the responses I received to particular questions, based on my own experience of the clinical training and the internship. Although I experienced participants to be honest in their responses to questions, it is possible that my position as researcher may have inhibited some of their responses. This may have been an issue for respondents particularly if the feedback they provided was critical of their place of work or their training experiences or if they had any concerns regarding confidentiality.

Through the process of data analysis I was concerned that I stay true to the data and to the respondents' responses, however I noticed that as I was deeply involved in working with these same kinds of patients throughout the period of data collection I needed to be aware of what was being foregrounded in the analytic process and the degree to which this was based on my own bias. I became concerned about including certain information that I felt was significant or interesting, even though it might not have met the criteria for inclusion according to my chosen method of data analysis. It was important that I interrogate in myself what made it difficult to remain strictly objective during this process.

5.4 Conclusion

Feedback from the participants was that this research provided them with an opportunity to reflect on the work they had undertaken during their internship year and how it had impacted upon them, which they felt was very useful to them. Several

expressed an interest in receiving feedback once the thesis was completed, in order to see whether their experiences fit with the experiences of the other interns. This provides some insight into the isolated way in which interns appear to be working in the hospital setting and the uncertainty with which many of them approached their work. It is encouraging that so many continue to be interested in working with survivors of trauma but recognise the need to engage in ongoing and specialist training to ensure their work remains relevant to the patient population.

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APPENDIX A

Interview schedule

Introduction of participants – Demographics:

I'd like to start with some information about who you are but first I will share with you a bit about myself. I am a Clinical Psychology Masters Student at UCT...

- Clarify that this discussion is about trauma as a result of interpersonal violence as opposed to trauma in general. Do they want to clarify what I mean by this? Abuse (childhood, partner) and assault (strangers, others). Early abuses as well as more recent assaults. Specify that the information I want is related to work with adults only

1. How old are you?
2. What is your first language?
3. What languages have you used to counsel in and what determines the language that you use?
4. Did you have any previous counselling experience prior to your Clinical Masters training? Can you tell me about it?

Client Group

The following questions are about the patients that you have been seeing over the past year, who have experienced some form of intentional violence. I would be interested in hearing about both similarities and differences amongst your patients who have experienced violence.

Of the patients you have worked with that have experienced violence...

1. Can you tell me the age range of these patients?
2. What is the age group most represented, if any?
3. Are they mostly male or female or an even mix?
4. What are the languages that are spoken by these patients?
5. Where do these patients come from? What is the catchment area serviced by the hospital?
6. What socioeconomic circumstances do these patients come from?
7. Are the majority employed or unemployed? If employed, what kinds of work are they doing?
8. Do you know about the educational levels of these patients? Can you tell me about them?

9. Do you know whether there are any ongoing stressors that these patients have to deal with in their everyday lives? For example economic or social.
10. Are these patients exposed to ongoing violence? If so, is it community based or domestic or both? Can you give me any examples of these that stood out for you?

Information about violence experiences

1. When working with survivors of violence, what kinds of experiences of violence are being presented?
2. Are they chronic or acute, current or historical? *Elicit details/examples*
3. Have you noticed any gender differences in the experiences of violence?
4. Is it the case that, from the beginning, you are aware of your patient's trauma history and this becomes the focus of the work, or do you sometimes find that the violent experiences becomes apparent only after you have been seeing the patient for a while?
5. If there is any variation in the above, does this have anything to do with differences in gender?
6. In terms of clinical presentation, what identifies a person who has a history of trauma from someone who presents following a more recent violent incident?
7. How do you learn about past trauma? Do you ask trauma-specific questions, are you told about it by the patient or do you have a sense that there is something deeper underlying a person's presentation and then wait to see what emerges?
8. In terms of presentation, are there any obvious ways in which the patients with a history of being abused or assaulted differ from other patients?

Impact of violence on presenting problems.

1. What are the presenting problems of the victims of violence that you have worked with this year?
2. In terms of diagnoses, what are the Axis I disorders that are often diagnosed in these patients?
3. Have you noticed any age and gender trends in diagnosis or presenting problem?
4. What are the Axis II disorders or traits that are often diagnosed?
5. Have you noticed any age and gender trends?

Interventions

1. How do you work with clients who have experienced violence?
2. What determines the way in which you work with these clients?
3. What are your goals of intervention?
 - Support
 - validation of people's experiences
 - helping them to name their feelings
 - trying to establish patients' safety
 - addressing symptoms
 - dealing with relationship patterns or relational difficulties
4. Do you try identify and work with their existing resiliencies and coping skills? Can you give me any examples from the work that you have done?
5. How do you explore the experiences of trauma with patients? Do you revisit the trauma in any detail, asking specific questions about their experiences? If so, what is the goal of this?
6. What methods of intervention have you drawn upon? Do you draw from traditional or non-traditional models of working?
 - CBT
 - exposure therapies
 - behaviour therapy
 - psychodynamic psychotherapy
 - narrative therapy
 - family therapy
7. Do you use these to make sense of what you are seeing or do you also integrate this way of understanding into your ways of working.
8. What sorts of interventions seem to have been useful for your patients? Why do you think they have worked?
9. What sorts of things have not been so useful?
10. Where did you learn these models of intervention?
 - Reading
 - Training
 - Supervision
 - Colleagues
11. Did you ever find yourself working with people other than the patient, for example family members? When do you decide to do this?

12. What is the amount of time that you might spend working with these patients? How does this differ between the wards, OPD and the community clinics?
13. In your work with survivors of violence, how does your timeframe influence the goals that you set with the patient and the kinds of interventions chosen?
14. Amongst those patients who are medically managed, how has the medication helped or hindered the process of therapy or has it had no impact?
15. What have been the challenges or difficulties that you have faced in your work with survivors of violence?
16. What has been the hardest aspect of working with this patient group?
17. What have you found was helpful in dealing with your experiences of being stuck?
18. How has working with these clients affected you on a personal level? Has it changed the way that you think about certain issues or about the world?
19. What are the transference issues that have arisen in your work with survivors of violence?
20. Can you talk me through some of the countertransference issues that have arisen for you?
21. What are the one or two major things that you have learned from your experience of working with this patient group?
22. If there has been any feedback from patients, what have they said was most helpful to them?
23. If there were any further opportunities for training in working with this population group, would you pursue this?
24. What additional training and input would have been useful to you when working with survivors of violence?

Resources that have been drawn upon in the course of their work

1. What are some of the resources have you drawn upon to support you in your work?
 - organisationally based
 - other health organisations
 - the legal system
 - community based
 - existing neighbourhood organisations
 - government agencies
 - community health workers

2. What are the resources that you have accessed for your own self-care?
3. Is there anything else you would like to share about your experiences of working with survivors of violence this past year?

University of Cape Town

APPENDIX B

Consent form

Psychology Intern's experiences of working with survivors of violence at psychiatric hospitals in Cape Town

Aim of the study

Despite high levels of exposure to interpersonal violence amongst the South African population, there is a paucity of local data on both the psychological impact of violence and the effectiveness of therapeutic interventions in this particular context. It is the intention of this study to explore the ways in which psychology interns in psychiatric hospitals in Cape Town are currently working with trauma survivors. It is anticipated that the results of this study will be used to develop a survey that may be disseminated to a national sample of clinicians in order to explore the effects of violence, to establish what the preferred methods of intervention are when working with trauma survivors and to explore further training needs.

Process

Participants will be interviewed individually by the researcher at a time and place that is convenient to them. Interviews will take between 1 and 2 hours. The interviews will be recorded and the sessions transcribed by the researcher. Participants are free to refuse to answer any of the questions asked or to withdraw from the interview at any point.

Confidentiality

Participants' names and personal details will remain confidential and the transcripts will be anonymised in order to ensure that neither they nor their patients can be identified from the text. The data will remain in a secure place and only the researcher will have access to the raw data, thereby reducing any potential threats to participants' privacy.

Risks

There are no anticipated risks to participation in this research however discussions regarding trauma are sensitive and could elicit some feelings of distress.

