Trauma and Substance Abuse in South African Women: A Qualitative Study

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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 my own work, or works, of other people has been attributed, and has been cited and referenced

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ABSTRACT

South African society is very violent, with many people using violence as their primary problem solving strategy. Much of that violence is directed at women and children, which is exemplified in the shockingly high rape figures and estimated numbers of femicide, wife-battery, and sexual assault. Substance abuse is rampant in every layer of society, although there seems to be an inadequate representation of women in treatment centre statistics. Internationally a connection between trauma and addiction is claimed, with little consensus around the nature and directionality of this connection. This thesis entails a qualitative study into the life-stories of addicted women with a special focus on the place they accord to trauma in their lives. This hopes to shed light on the underlying dynamics that connect trauma and addiction, to give voice to these women's stories, and empower them by providing a better understanding. Trauma and addiction were conceived from a Freudo-Lacanian perspective, which defines trauma as a lack of words in face of a shocking event. Substance abuse constitutes a short-circuit to avoid the necessary elaboration, which makes it understandable why many traumatized people almost automatically seek recourse in substance abuse. But if this initial coping-strategy is continued, the substance can take control, replace any wish or desire, and cover up the initial trauma. This state is called addiction. The present study focused on the acute and chronic individual traumas as recounted by addicted women.

Fourteen interviewees were recruited from two inpatient rehabilitation centres, and were asked to tell their life-stories. A psychoanalytic discourse analysis was conducted on the transcripts and fieldnotes of the interviews after the women had been grouped according to similarities in their life-stories which seemed linked to type of substance abuse (single or combined), type of trauma (acute or chronic, or combined), and elaboration of trauma (covered-up, raw, processing). The psychoanalytic discourse analysis examined how trauma, the gap in language, crystallized in the life-stories of these women, and how the indicators of unelaborated trauma, namely repression and denial, could be recognized in the interview data and served as defences against threatening contents (emotions, thoughts, memories). Repression could be retrieved in shape of motivated forgetting, focus on safe topics, reinterpretation, labelling without elaboration and paralinguistics (immediate repression). Indicators of denial were reversal into the opposite, nonverbal communication, denying the impact, externalisation, minimizing and key words. In the combined user group a combination of acute and chronic trauma and an equally complex addiction was indicated. Similar techniques to repress and deny were manifest in enlarged format. In cases of extreme abuse from an early age on the more extreme survival mechanisms of dissociation and fragmentation were found, as well as wordlessness and jouissance (something higher than the self that enjoys in spite of the self).Certain trauma-remnants found in the life-stories of the addicted women demonstrated the deep impact of a range of traumata: negative self-concept, guilt and shame, relationships problems, compulsive repetition, numbing strategies, silence, somatic complaints, depression and anxiety.

All these traces of trauma combined with the earlier discussed signs of repression and denial indicated that trauma takes in a major place in the lives of the interviewees. Hence the concept of trauma might add an extra dimension to the understanding of addicted women's life-stories and can possibly constitute a useful metaphor in the treatment of addicted women.

CONTENTS

ACKNOWLEDGEMENTS

At the onset of this project "conducting research and writing up a thesis" sounded fairly simple. What started as a vague dream soon became a poignant reality. Getting settled in a country which is not mine, gaining access, formulating a research project and getting the proposal passed, were challenging at the least. Not only did I come from a different academic and linguistic background, I also had to make sense of the broader context namely living and studying in South Africa. Many people facilitated this process and helped me grow towards completion of this thesis.

My first words of gratitude will be addressed towards the people around me, my personal support structure: I want to thank my family of origin, for teaching me some very valuable lessons, for putting the foundation of who I am today, and accepting the person I became. Special thanks go to my partner for accompanying me on this journey and our many other travels, for being my emotional and moral stronghold. In his own way he always brings me back to the main point and pushes me to reach my full potential. I want to express my gratitude towards my dear friends in Belgium for sticking behind me with love, care and concern, and I. for his witty remarks that helped me pronounce my thoughts better. My friends in Cape Town were excellent in letting me vent my frustrations about writing in a third language with the right words always slipping through my fingers. Thanks for the dinners, nights-out, and chats at the moments I needed them most.

As far as my mental growth is concerned I am in debt to the following people. Both my mentors and my training at RUG once awakened and honed my critical thinking which initiated my intellectual search for understanding the world and people around me. Deep recognition goes to Prof. Foster, who carefully guided me draft after draft, putting me back on track after yet another digression, assisting me through the whole process of sharpening my academic skills from clinician to researcher, and helping me to make sense of this whole research project. His constant energy and activity worked inspiring and contagiously, promoting self-determination buttressed with motivating comments and challenging discussion points.

Sincere thanks go to the two inpatient treatment centres who allowed their clients to become part of this study and their staff who supported me during the interview process.
The numerous people who spoke to me during my preliminary investigations deserve my appreciation as well, with special thanks to Letitia Bosch at SANCA and the Rape Crisis Cape Town team. I also want to express my gratitude towards MRC's Drug and Alcohol Group, and Andreas Plüddeman more specifically, for providing me with local statistics for women addiction treatment.

The last lines of these acknowledgements are reserved to extend my expression of gratitude towards all 14 women who voluntarily participated in this study and without whom my thesis would have been impossible. I treasure the memory of each one and felt truly privileged that they wanted to share their story with me. I wish them good luck on the long path of recovery.

Chapter 1 : Trauma and Addiction as Research Topic

1.1 INTRODUCTION

1.1.1 Clinical observations

> *The addict's life is filled with trauma. Either self-inflicted or imposed on others as well as being a witness or having endured it.* (Vos, 1996: B6330-19, transl.).

Clinician Vos's statement accurately described my own clinical observations, which aroused my curiosity about the connection between substance abuse and trauma. Both in substance abuse treatment and crisis/ trauma treatment people present with the dual problem of trauma and substance abuse. In Belgium I studied clinical psychology and did my practicals in addiction treatment. There I noticed clients present multiple problems and utter numerous vague complaints but treatment focuses primarily on substance abuse and recommends referral to deal with trauma. Drawing from my experience as a volunteer counsellor in a crisis shelter I can say that in trauma and crisis treatment an equally confusing and complex picture emerges where clients battle with temporary or long-term substance abuse. Substance abuse is termed a counter-indication for trauma-counselling, and the subject will be referred to first handle the substance abuse problem. Generally there is a poor understanding of the connection between trauma and substance abuse in both types of settings, resulting in unnecessary frustrations on the side of both client and counsellor.

1.1.2 Honours thesis

Those clinical observations confronted me with addicted women relating and repeating previous abuse. Especially the personal dramas encountered during my practicals inspired me to have a closer theoretical look at this phenomenon and write my thesis in partial fulfilment of the degree 'Licentiate in de Klinische Psychologie' at the University of Ghent, Belgium, about the connection between trauma and addiction in women. The thesis consisted of a very broad review of trauma and addiction literature, summarising it through psychoanalytic lenses, and trying to construct a possible explanation by means of the Lacanian concept of 'jouissance' for the connection between trauma and addiction in women as 'encountered' in practice and described in psychiatric, medical, neuropsychological, and clinic psychological literature. I relied heavily on post-Lacanian ideas from Verhaeghe (1994a, 1994b, 1996, 1997, 1998a, 1998b, 1998c, 1998d, 1999), which constitute a further elaboration of Lacanian discourse theory, but also drew on ideas from André (1995), Mooij (1987), Moyaert (1994), Campbell (1995a, 1995b), Soler (1994, 1997); the book of the clinicians Vos & Bos (1996) and the thoughts of feminist scholars such as Wright (1998, 1999) and Grosz (1995). To describe the clinical stages after trauma, Herman's book (1996) *'Trauma and Recovery'* was of great help.

I re-read trauma and addiction literature through Freudo-Lacanian lenses because I found that mainstream literature predominantly reflects a medicalisation of trauma[1] as well as addiction. This medicalisation and psychiatrisation is especially linked to females in Western society (see Verhaeghe, 1996). Although the description of symptoms can be useful to assess people and thereby provide them with adequate help, it also serves to distinguish them from 'the normal', and in the end the presumed category never fits the individual experience. This bankruptcy of diagnostic categories emanates from the impossibility of language to fully cover real-life experience, the lack of room for a developmental approach, and disregard of individual choice and agency of the subject. Verhaeghe (1994b) demonstrated that psychoanalysis, and more specifically Lacanian discourse theory, can serve as a framing theory, a structure empty of content, through which clinical diagnostic practice can be re-interpreted. The focus lies on the underlying structure, moving away from the multitude of contents and meanings, in order to determine where assessment runs short. This line of thinking can be broadened to research psychology. Doing research involves some kind of assessment, interpretation, and analysis; therefore this thesis will consist of a combination of techniques as an attempt to gain insight in the complex picture presented by traumatised addicted women in clinical practice.

The complexity of addicts' presented problems also urged me to use the general term 'trauma' to describe a wide range of disturbing experiences. Most of the focus of research in addicts and substance abuse populations has been on sexual abuse in childhood, at cost of the equally (or more) common physical abuse and neglect, more subtle forms such as emotional abuse and neglect, and a combination of any of the above. Another reason not to specify 'trauma' too much is that I wanted a concept wide enough to cover the ongoing nature of traumatisation, namely, where abuse is enacted, repeated on the self or others in later life.

1.1.3 Why women?

The question why I decided to focus on women is a logical and challenging one, the answer being influenced by a number of factors: in addiction literature, claims are made that female substance abuse differs from its male counterpart (Ansoms, 1988, De Belder, 1990a, 1990b, Nichols, 1985, Lesur, 1989). Therefore the focus will be on female addicts because patterns are more likely to emerge in a small sample when there are fewer within-sample differences; greater intra-group similarities will facilitate conclusions and modest generalisations. According to international literature (see below) the link between trauma and addiction seems especially pronounced in women, certainly if we consider women as having less power and less voice in a male-dominated society. Hence another reason for focusing on women could be termed feministic namely to give voice to women's stories, to enunciate

[1] This idea could be retrieved in for instance Crossley (2000), who argues that making incest the topic of public discourse has resulted in the 'medicalisation' of incest and the creation of an 'incest industry'. The effect of medicalisation has been to reduce incest from a 'crime' to a 'disease'; a psychological illness which involves the entire family.

the thoughts and beliefs of those who are very often voiceless in our patriarchal society, more specifically those who have to cope with victimization, stigma, and taboo: the addicted women. Personal preference had an important impact as well: being a woman myself I find it easier to relate to females and their experience of violence and emotional distress.

1.2 LITERATURE REVIEW AND RESEARCH QUESTION

In a short review of overseas literature I will present research evidencing the link between traumatic experiences and substance abuse, followed by a brief discussion of a problem encountered in this type of research, after which the research question will be defined.

1.2.1 Literature Review

This review was by no means meant to be comprehensive and only serves to give the reader an idea of what is published about the topics of our interest. Hagglund & Pylkkanen (1977) found in adolescent substance abusers more traumatic experiences in their youth in relation with their parents, which undermined their self-esteem. Psychiatric illness of the father requiring admission, most likely associated with alcoholism, which provoked violence, unemployment and/or divorce was abound. More than half of the studied population encountered a trauma related to loss of the mother or her admission to psychiatry. Caviaola and Schiff (1988) found that 30% of the 800 adolescents (boys and girls) admitted to inpatient rehabilitation for alcohol or substance problems were abused in their youth. Research conducted by Kilpatrick, Acierno, Resnick, Best and Saunders (1998) shows that victims of violence have a higher risk to develop problems with substances, and people who abuse substances have a higher risk of victimization. Therefore there seems to be a dangerous reciprocal relation between victimization and substance abuse. According to Bordieri, Glover and Janikowski (1997) there is a clear connection between substance abuse and incest, but it is difficult to stipulate a causal relationship: victims of sexual abuse have an increased risk of developing and maintaining substance abuse, and people who abuse substances are more likely to experience incest.

Especially in addicted women a traumatic history can be found. Miller, Downs, Goudoli, and Keil (1987) studied alcohol-abusing women and found that 67% were abused in their youth. Barrett and Trepper (1991) noted that 75% of the studied women that were in treatment for alcohol addiction were abused in their youth. Swett, Cohen, Surrey, Compaine and Chavez (1991) found that 24% of the women in outpatient psychiatric treatment experienced sexual abuse before their 18th birthday. Martens (1995) noted that many borderline addicted women had encountered severe loss of people who played an important role in their education (parents or grandparents). These women often experienced incest or sexual violence in their youth or users phase. Prostitution was the most obvious way of income, which most likely resulted in a traumatised sexuality.

1.2.2 Directionality

Although there is some quantitative evidence indicating a connection between trauma and addiction, there is little literature trying to explain this relationship. The direction of the relation between trauma and addiction, the matter of causality, constitutes a topic of debate: not all the women who were sexually abused in their youth abuse substances, not all women who have problems with substance abuse were molested as a child. But research in that area evidences that the chance that one aspect is linked to the other is extremely high (Meulenbelt & Wevers, 1994).The relation between Post Traumatic Stress Disorder (PTSD) and substance abuse is probably cyclic. Russell and Wilsnack (1991) concluded that "A vicious cycle probably exists in which the painful consequences of sexual abuse as child... increase the woman's need for the self-medicating effects of alcohol...which in turn can make the consequences worse, leading to an increased use of alcohol" (Russell & Wilsnack, 1991: 61).

1.2.3 Research problem

This short review of literature demonstrates the high amount of confusion and debate regarding the connection between substance abuse and trauma in women and a lack of literature representing subjective experience. In South Africa, addiction and trauma seemed equally (or even more) relevant topics so I decided to extend my initial interest (what was published around these topics) to a more practical level, focusing on the women themselves, as this might provide interesting data about the mechanism linking trauma and addiction in women. My research project was defined as qualitative research into the life-stories of traumatised substance abusing women. Listening to the women themselves I hope to shed light on the connection between substance abuse and trauma in women, with some of the initial questions being: how they construct their life-story, what they define as key-events, and which impact these had on their life and their later addiction. The aim of this study will be to provide an in-depth view of the traumatised addicted woman, to give voice to these women's personal experiences, empowering addicted traumatised women by creating a better understanding of the underlying dynamics, and formulate some implications towards practice.

1.3 QUALITATIVE RESEARCH

Qualitative research recognizes the impact the researcher has on the research process; therefore this section will be dedicated to clarify my own theoretical/ academic background because this had a major influence on how I constructed my general research interest in a more focused question and planning.

1.3.1 Background

I studied Clinical Psychology in Belgium at the University of Ghent, which takes 5 years[2]. Common procedure is to choose a major and a minor subject in the 4th year of the course. My first choice was Client-Centred & Experiential Therapy, because this best approximated my idea of what 'a psychologist' should be like. I especially valued the training and counselling sessions and what they imparted to me: the basic attitudes of a therapist, difficult issues in the therapeutic relationship, personal growth, the merits of both individual and group sessions; and incorporated many of these aspects in my way of being. The lecturing professor strongly encouraged own initiative and critical eclecticism, which had a deep impact on my academic and life choices, and motivated my search for a combination of theory and practice. Although I enjoy working with people, I also like analysing the underlying dynamics and broader context of my experiences and observations. Inherent there is a desire to contribute to the body of knowledge through writing, creating a model or theory, something to reflect upon and learn from. This search for a sound theoretical framework directed me towards my second major, Psychoanalysis. I found the Freudo-Lacanian theory, especially as taught by Professor Verhaeghe, provided me with a frame of reference where I could accord a place to all practical experiences and create other, different meanings and learning experiences.

1.3.2 Psychoanalysis as background

Psychoanalysis is typically known as a theory, method, and therapy for a very select public and is said to focus rather on the intra-individual aspects of unconscious wishes and desires, and inter-individual strategies of defence mechanisms, transference and counter-transference. Because I discuss two topics, trauma and addiction, with very real repercussions in the lives of the people considered, I chose to integrate many terms I encountered in trauma- and addiction-literature for the following reasons. Typical psychoanalytic terms have been subject to wide misinterpretation and misuse, and especially Lacanian psychoanalysis has been termed highly controversial and eccentric. Hence, for the sake of clarity and in order not to discourage possible interested readers I have tried to formulate my thoughts in more widely accepted terms. In this thesis I hope to demonstrate that many of the terms used in psychoanalysis can be retrieved in writings from a different theoretical starting point, and although

[2] I am well aware of the convention to spell out all numbers under ten in full, but in order to save space I preferred to use the numerical presentation where it didn't hinder the legibility.

using different terminology still describing the same phenomenon. In addition I will try to demonstrate that a highly debatable theory like Lacanian discourse analysis can serve as a frame to understand phenomena in clinical practice and incorporate other theories. The strength of Lacanian discourse analysis is to show how daily language usage, on study, reveals slippages of understanding and subjectivity, and to deconstruct the assumptions which underlie the apparently simple ideas expressed through a statement. Summarizing, even though I won't adhere strictly to typical psychoanalytic notions in the body of this text, the core of the analysis is perceived through psychoanalytic lenses with terminology adjusted to less debate-evoking language.

1.3.3 Myself and other subjects

Since this thesis focuses on female experience the female personal pronoun will be used to refer to the subject. Many statements are equally true for men but for the sake of simplicity and legibility, I opted to write only from women's perspective.

Because this dissertation describes qualitative research I preferred the personal pronouns 'I' and 'me' above the more often used impersonal 'we' in traditional scientific publications. Qualitative research such as discursively oriented approaches and narrative psychological research believes that the material used in any kind of analysis is deeply influenced by the researcher (Crossley, 2000) and that all knowledge is context-bound and thus works with the research situation by theorizing contextual influences (Banister, Burman, Parker, Taylor & Tindall, 1994). This is in contrast to more scientific approaches, which aim to achieve a state of objectivity and neutrality in which the analytic material exists and can be interpreted in isolation from the researcher (Crossley, 2000). More specifically, this thesis combines two qualitative approaches, namely narrative psychology and Freudo-Lacanian psychoanalysis. Both perspectives pay a lot of attention to the subjectivity of both researcher (analyst) and interviewee (analysand). Psychoanalysis concentrates on transference and counter-transference between analyst and analysand, and narrative psychological research acknowledges that rather than collecting 'neutral' data, the researcher frames the question, picks the participants and interacts with them to produce data that are then used for analysis.

1.4 CHAPTER OUTLINE

Chapter 2 introduces the theoretical frame through which trauma and addiction are theorized, namely the Freudo-Lacanian approach. Chapter 3 documents my preliminary investigations in the areas of trauma and addiction. In order to get an idea of the South African context and the South African research done in these areas, South African literature on violence against women is reviewed, Medical Research Council (MRC) data is consulted to draw up a profile of addicted women who come to treatment, and two mini-analyses are conducted indicating the connection between trauma and substance abuse in South African women. The following chapter illustrates the methodology of my research into the life-stories of 14 addicted women. Ways to combine psychoanalysis with the narrative approach are discussed, and my stance towards the question of the Real is clarified. Chapters 5, 6 and 7 present the results of this study. Chapter 5 documents certain characteristics found in the research population and a preliminary grouping. In chapter 6 the interview transcripts and field notes are combined and a psycho-analytic discourse analysis is conducted. Chapter 7 explores the remnants of trauma as recounted by the interviewees. The final chapter first discusses interview dynamics, from which it draws implications towards clinical practice, a general conclusion is presented and the limitations of the study are indicated. A brief personal note finally closes the narrative of the thesis. In the appendix pen-portraits of the 14 traumatised addicted women who were interviewed for this study can be found.

Chapter 2 : Freudo-Lacanian Perspectives

In this chapter some theoretical background notions will be clarified, as an abbreviated and updated version of my Honours' thesis. First I will try to define what I mean by 'trauma', 'substances', 'substance abuse' and 'addiction'. Although I claim to take on a psychoanalytic, and more specifically a Freudo-Lacanian, perspective I need to remark that I consulted post-Freudian and post-Lacanian writings in order to compensate for the lack of discussion around substance abuse by both masters (Freud discussed it briefly and Lacan's discussion was limited to one sentence) and to contextualize some discrepancies in Freud's and Lacan's statements about trauma. Post-Freudian and post-Lacanian authors follow the same line of thinking as the masters but elaborate more on the topics of our interest.

After these definitions the different kinds of trauma people encounter will be discussed, and the focus of this study will be indicated. Subsequently the question of who is more likely to become traumatised and which clinical stages presumably follow trauma will be considered. And attention will be paid to often published after-effects of trauma. From there on I will have a look at the nature and function of substance abuse in the lives of traumatised women, and how addiction and substance abuse are connected with trauma.

2.1 DEFINITIONS

'Trauma' will be defined as every shocking emotional experience to which the subject cannot accord words, that can't be symbolised (De Roover, 2000). According to Lacan, trauma concerns the always-missed encounter with the Real. Traumatic is not the Real but the inadequacy of the signifier in face of the Real. It is a lack of words, narrative constructions, and stories in face of a shocking event. The trauma is a symbolic construction, an attachment of the signifier onto something that can't be represented. Therefore it can only be defined in retrospect (Campbell, 1995a). Freud also marks in *'Hemmung, Symptom und Angst'* that the external danger is only traumatic after interiorisation (Soler, 1997).

Translated in common sense language: if we cannot put the shocking event in words, if we fail to construct a solid story about what happened, then the event is traumatic and leaves us puzzled in a wordless, indescribable, meaningless void. Only after the event happened, maybe even many years later, when a new setting allows us time to reflect upon, and reinterpret what happened, when we make sense of what we experienced in the construction of a story, then we will label it as 'traumatic'.

An important feature of trauma is that it is sudden and unexpected, making it very ego-dystone, bizarre, alienating and frightening for the subject who experiences it. Therefore Soler (1997) describes trauma as

> *"one of the names we call the accident that comes from outside and that can't be ascribed to the subject who suffers from the consequences. Trauma is the Real that befalls the subject, a Real that can't possibly be anticipated or modified, that expels the subject, that has no relation with the unconscious or the desire of the subject, a Real unaccordable to the subject except for the ineffaceable traces of its consequences".* (Soler, 1997: 48, trans.)

In face of this wordless Real the subject experiences massive fear, extensively described by the existentialist philosopher Heidegger (1962) in his concept of 'Angst', namely some kind of intense anxiety or dread, the feeling and experience of disintegration[3].

The term 'substances' will be used to describe any mood-altering product such as alcohol (in all its forms, shapes, flavours and colours); drugs (those mentioned during the interviews were dagga, Mandrax[4], cocaine, crack, heroin, and club drugs such as XTC and liquid E); and medication (sleeping tablets, nerve tablets/ panic suppressants, anti-depressants and painkillers) or a combination of the above.

In my Honours' thesis I used the psychoanalytic term 'toxicomania' to refer to both substance abuse and substance dependency because toxicomania focuses on the underlying dynamics namely the urge, the drive, the centrality of the substance, the duality between escape (intoxication) and destruction. But for the sake of simplicity the more common terms substance abuse and addiction will be used intermittently. This does not mean that I have poor understanding of the difference between the two, but demonstrates how a pure descriptive approach leads to arbitrary quantifications. In the following text 'substance abuse' is defined as every excessive use of any of the above mentioned substances, resulting in intoxication, and several negative effects for the subject on physical, legal, social and interpersonal level. 'Addiction' lies a step beyond and includes abuse of substances and addictive behaviours, characterised by loss of control, tolerance, preoccupation and withdrawal symptoms.

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[3] The experience of Angst is like that of vertigo, when a person is brought face to face with the presence of an abyss and the absence of a supporting ground, the experience of groundlessness, and the absence of anything holding one in place and anchoring one's place and anchoring one's actions (Cooper, 1990, in Crossley, 2000).

[4] Mandrax consists of a combination of methaqualone (primary ingredient in the sedative Quaalude) and diaphenhydramine (an antihistamine found in Nytol) or alternatively, diazepam, and constitutes a strong sedative when taken orally. Mandrax is mostly smoked as a 'white pipe', namely through a bottleneck with the pill crushed and sprinkled on top of a tobacco and low grade dagga (marijuana) mix. The effect is a powerful rush, loss of consciousness, and a continued intoxication and sedation dependent on the potency and quantity of the consumed drug.

2.2 TRAUMA

2.2.1 Trauma as starting point of subjectivity

Nowadays 'trauma' is a popular signifier receiving a lot of media-attention, resulting in many different descriptions of this concept: in terms of the type of event, in terms of effect (symptoms, cause-effect), and phenomenologically (see Hoffmann, 2002). Despite the media's focus on the extreme and violent forms, traumatic experiences are actually very common. According to Crossley (2000) traumatising events and experiences and the sense of disorientation accompanying them are likely to happen to most of us at some point in our lives. They can be termed traumas precisely because they do not confirm our more everyday, normal sense of reality. This, instead, can be characterized as having a more stable, ordered structure, or at least by the fact that we constantly struggle to create and maintain such stability.

In literature and clinical practice the most frequently used word for trauma is PTSD, but for the purpose of this study I will differentiate trauma along the terms acute and chronic, and individual and collective trauma, as described by Verhaeghe (1997, 1998d); because this provides a better view on the range of traumatic responses seen in different subjects and cultures, triggered by different circumstances. This rather broad definition moves away from the often too rigid DSM-IV categorisation (Fourth Diagnostic and Statistical Manual of the American Psychiatric Association) and tries to encompass a whole range of experiences.

Freudo-Lacanians like Verhaeghe start from the notion of a fundamental divide in the subject. The core of the subject is constituted around a void, a fundamental gap. And exactly the fear in face of the indescribable and unknown motivates any form of growth and development. At a specific moment in the personal history (the Oedipus event) every subject has to deal with the brutal confrontation with the Real and face its own inability to formulate an adequate answer on three basic questions concerning sexual identity, gender relations, and authority (Who am I as a male/female?; What do I desire in an other and how will I try to get that?; and Where do I come from?) which reflect the three discursive positions the subject has to adopt[5]. This structural trauma concerns an internal conflict, a gap in language in face of the drive, more specifically the realization that there are things in the Real that can't be put into words (Verhaeghe, 1994b, 1996, 1998b).

[5] The unarticulated, unspoken answer to these questions constitutes the subject's most private core, what psychoanalysts call the fantasy (le fantasme). It is the subject's actual sculpture of the Real and determines how the subject acts and behaves in the world. The fantasy is a trial to accord meaning to a reality that resists significantisation (process of according meaning through signifiers).

For the scope of this study I will focus on accidental trauma, which concerns a conflict with something outside the subject that didn't have to happen. If the subject is confronted with a situation that seems indescribable, in face of which her personal way of making sense of the world (the Symbolico-Imaginary system, condensed in the fantasy) fails, the experience will happen in another mode. This accidental trauma is put on top of the structural trauma, implying that the previous solution for the structural trauma and private construction of the self and the world will influence the outcome of the new crisis. Who you are as a person, how you dealt with, and what you learned from your previous experiences, will determine the outcome of the new personal crisis induced by the encounter with a shocking event.

2.2.2 Basic Trust and Commonality

Core notions in discussing trauma are 'basic trust' and 'commonality'. Basic trust is the feeling of trust, safety, and love for the self and others, one develops whilst growing up. According to Herman (1996) this sense of safety is acquired in earliest life in the relationship with the first caretaker. It forms the basis of all relationships and spiritual systems. Basic trust is the foundation of belief in the continuity of life, the order of nature, and the transcendent order of the divine. It can also be described as a feeling of 'grounding', of things making sense. According to Crossley (2000) a traumatic experience highlights the way in which we routinely take for granted the sense of implicit connections between events, people, plans, aims, objectives, values and beliefs. When one 'element' in the chain disappears, for example, if a loved one dies or leaves, the whole complex configuration of memories, associations, plans, hopes, and fears shatter like shards of glass, and with it our sense of who we are and why we are here. Frank (1995) uses the metaphor of 'narrative wreckage' to characterize this process.
Commonality is the feeling of being part of a meaningful whole, belonging to a group. In case of trauma the subject is thrown back on herself, she feels isolated in her individual, particular experience which can't be shared with others; the bonds between individual and community are destroyed.

2.2.3 Types of Trauma

Verhaeghe (1998d) further differentiates accidental trauma along the lines of individual versus collective and acute versus chronic. Acute collective trauma can be seen after a plane crash or a natural disaster. Chronic collective trauma includes the widely researched war neurosis. The detentions and other apartheid-related violence can be perceived as a South African variant. The characteristic of collective traumas is that they are experienced in a group. Language and basic trust are most of the time sufficiently installed to handle the shocking event. It concerns a shared experience survivors can talk about with fellow survivors until they master it. This form can be treated effectively with trauma-debriefing within group therapy.

An acute individual trauma is limited in time and space (e.g. rape, assault, theft, car-accident, witnessing a crime, and loss of a beloved one). The consequences and possibilities for treatment depend on the psychic structure of the individual, the way in which language and basic trust are installed. Chronic individual traumas (e.g. long-time abuse and incest) are difficult to treat because the effects disturb the inner most structure of the subject. Basic trust is missing, and substituted by basic distrust, the individual doesn't succeed in establishing an integrated identity and struggles with severe feelings of guilt.

Of note here is that trauma has to be considered in a cumulative mode, meaning that the more shocking events remain unprocessed, the more traumatised the subject is expected to be, even though there has been an apparent adjustment.

In this study my attention will go towards the acute and chronic individual traumas that women experience. Although the four types of trauma can be found in both genders, women are more confronted with and suffer more from individual traumas[6], and especially from those experiences where sexuality or a male-female power struggle is central: namely domestic violence, sexual traumas and women as emotional caretaker in the family. The underlying assumption here is that women are in a precarious situation because they are living in a male-dominated society. We understand and accord meaning to the world around us through language. But our language reflects the patriarchal, logical, binary, reductionist norms, where women are only conceived in terms of their male counterparts. This will have ongoing effects on women because they don't have an own place and own voice, which will make them more prone to traumatisation.

2.2.4 Vulnerability and resilience

We can ask ourselves the question why certain events are traumatic for one person and not for another. Apart from the above mentioned personal history and learning experiences, basic trust and commonality, attention has to be paid to the shocking event, the stressor. The severity of a traumatic experience can't be quantified by one particular criterion. The subjective experience of the event is the clue (Vos, 1996). The core of the traumatic is the inability to find and accord words to what happened, which produces fear and helplessness and leaves the subject passively subdued to it.

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[6] Kessler et al. found in their National Comorbidity Survey into the current and lifetime prevalence of PTSD in the US population that the most common causes of PTSD in men were combat and witnessing death or severe injury, whereas rape and sexual molestation were the most common in women. There were significant sex differences in the types of events experienced. For example, 25% of the men had had an accident, in contrast to 13.8% of the women; 9.2% of the women had been raped, in contrast to 0.7% of the men. The capacity of these events to produce PTSD in victims varied significantly, ranging from 48.8% of female rape victims to 10.7% of men witnessing death or serious injury (in van der Kolk, Mc. Farlane & Weisreth, 1996).

The age of the subject during traumatic exposure has an important influence as well, because (a series of) shocking events during childhood are remembered in a different way due to the developing mental, emotional physical capacities and language.

In my Honour's thesis I considered literature around protective and risk factors and summarized possible 'traumatogenic factors'[7] according to the underlying dynamics: being caught off guard, too much too long (overexposure), acts on the body (physical damage), and extreme violence that leaves the subject wordless (De Roover, 2000).

Other factors described in literature that determine the outcome of trauma are: the reaction of the environment, and the pedagogical and affective atmosphere in the family (Vos, 1996). This was earlier described as commonality and basic trust. Thus trauma depends on the ability to construct a story and on having somebody trustworthy to tell that story to, and is determined by the severity of the stressor and the specific capacities of the individual.

2.2.5 Clinical Stages of Accidental Trauma

In her book *'Trauma and Recovery'* Herman (1996) gives an excellent representation of all symptoms associated with 'Complex PTSD'. I will therefore only retain the main lines as background for the later analysis. After a traumatic experience certain stages can be recognized: the traumatised person will suffer from hyper-activation and the continuous dialectic between compulsive re-experiencing and avoidance (Herman, 1996).

Psychological consequences of trauma are the loss of bonds and attachment, and a messed up basic trust, resulting in an existential crisis[8], characterized by meaninglessness and personal vulnerability (De Roover, 2000).The self-image, psychic as well as bodily, will be damaged. Shame and guilt are prominent as result of the intrusion of bodily integrity, and can be understood as an attempt to gain control over what happened. On top of that the subject constantly doubts the reality of the personal experiences (Herman, 1996).

According to Herman (1996) the victim strongly becomes a danger to herself in traumatic neurosis, showing an active tendency to harm herself in a range of ways (chronic suicide attempts, auto-mutilation, eating disorders, impulsive risk-behaviour, substance abuse, repetitious engagement in

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[7] For instance, Herman states that being overthrown by the event, inability to escape, being inexhaustively exposed, physical damage or harm, exposure to extreme violence, witnessing a gruesome way of dying (Herman, 1996), and emotional abuse increase the likelihood of harmful consequences.

[8] In case of seriously traumatising events such as bereavement and other forms of loss such as relationship breakdown, divorce, terminal illness and depression, existential crises nothing 'makes sense' anymore (Crossley, 2000).

dangerous and abusive relations) and a passive neglect of self-protection. A lot of these self-destructive behaviour patterns can be conceived as symbolic or literal recreations of the initial abuse.

In chronic accidental trauma these symptoms show themselves in enlarged version, the serial traumas have a cumulative effect. The early onset of the traumatisation deforms the development in such a way that a negative identity is created. Common survival strategies of early traumatisation are dissociation, fragmentation, and pathological regulation of emotions. These survival mechanisms will limit the survivor in her adult life and increase the chance on re-traumatisation (Herman, 1996).

2.2.6 Working through trauma

Trauma is a lack of words in face of a devastating reality, the inability to accord words and therefore meaning to a shocking event. It is a disruption of the narrative chain. The process of working through a shocking event consists of attaching a signifier, a word, a label to what happened. This label is the first attempt to cover the horrifying real and indescribable bodily sensations provoked by the event, and forms the start of a signifying chain. Gradually more words can be attached; clauses and sentences can be constructed covering emotions, sensations and thoughts, eventually resulting in a narrative around the traumatic event that can be fitted into the life-story.

The traumatised can adopt a number of strategies to manage traumatising experiences. Cognitive strategies such as determining the cause, rationalization, self-blame, comparison with others, denying the impact of the event, and emphasising own control, can be adopted to redefine the experience in order to reduce helplessness. Action strategies such as all forms of avoidance can improve the sense of control and safety. In case of severe or chronic trauma these strategies are insufficient, which throws the subject back onto inner survival mechanisms such as repression, denial, reversal into the opposite, and dissociation. These strategies serve to make elaboration impossible and allow the person to function in situations that resemble the traumatic event.

2.3 NATURE AND FUNCTION OF SUBSTANCE ABUSE IN TRAUMA

It is common knowledge that for many people substance use will bring some sort of relief immediately after a trauma. But intoxication causes impaired judgement, diminished control over physical and emotional reactions, which will put the intoxicated more at risk for traumatisation. I will argue that in women the link between trauma and substance abuse is more complicated. Female substance abuse is often part of repetition compulsion after trauma. Addiction in traumatised women can be conceived as a failed coping- or survival-strategy with the substance abuse problem substituting the initial trauma. The nature of substance abuse is discussed and from there on the function of substance abuse in trauma will be explored.

2.3.1 Nature of Substance Abuse

Addiction is called a short-circuit-symptom because it aborts the necessary psychic elaboration (Verhaeghe, 1994b). The accent shifts to the urge and the product, the fusion with the own body as self-medication for all kinds of 'Unlust'-feelings. Addiction implies another relation towards enjoyment (jouissance), in that the addict finds relief for her problematic relation with language and society in a symbiosis with her own body, which provides her with an illusion of control. But this experience of transgression is very dual; it entails escape and destruction. The 'I' disappears; there is a merging, a changed notion of time and space, a blurring of boundaries leading to boundlessness. The meltdown of bodily borders, the foregrounding of certain parts of the body, the disintegration of categories and shapes that attach the subject to her body and accord bodily integrity, endanger the subject in alarming and frightening ways, but are also most appealing. There is always fascination and anxiety, emerging and disappearance, at the same time alienating but attracting, estranging but enchanting. The reverse side of the intoxication, however, is the fact that the subject as subject ceases to exist, most notable in the lack of identity, the dearth of words and story. This subjectless state results in a loss of being and meaning, and produces massive fear. In facing this fear, administration of another dose of the substance is highly warranted. The attempted solution fails, repetition is installed, increasingly raising the dose, which not only threatens the subject's psychic life but can provoke her Real death (Verhaeghe, 1998b).

2.3.2 Function of Substance Abuse in Trauma

Directly after accidental trauma substance abuse can play a number of roles. The traumatised person wants to abort the whole elaborating process of constructing a signifiers' chain (ultimately constructing a narrative/ a story) because there is an unbearable amount of fear attached to it. Therefore the subject will look for other short-circuit-symptoms (strategies to avoid psychic elaboration) in the Real, an act on the body, such as auto-mutilation, substance abuse, and psychosomatic symptoms[9] as attempts to block out the traumatising Real (Verhaeghe, 1994b). Both trauma and substance abuse are marked by the incapacity to accord words, but substance abuse seems like a more controllable regulation of the body and the enjoyment. Hence traumatised subjects will almost automatically seek relief in substance abuse. The subject tries to master and control the overwhelming, uncontrollable physical and emotional state after trauma (the wordless drive arising from the body) by intervening immediately on the body, but this time she will determine the dose, frequency and hence the effect

[9] The only way to deal with the unbearable tension in the body that overwhelms the subject seems to be an acting-out on the body: In psycho-somatics there's an intoxication of the organs; auto-mutilators cut; toxico-maniacs swallow, inject, and inhale ... Lacan called this bizarre form of higher enjoyment 'jouissance'. This 'other' enjoyment is intrinsically indescribable. Because the subject can't accord words to it, she can't place, master, control it. The subject is overwhelmed and stays perplexed, which has a psychotic and estranging effect. The self-harm seems to be the last desperate trial of the ego to get hold of this other enjoyment. When the subject hurts herself the accumulated tension can flow, after which the subject gets a grip on reality. This process is more pronounced in the pathological regulation of emotions in abused children.

herself through intake of a psycho-active substance (De Roover, 2000). Substance abuse will be actively employed to maintain a state of silence, avoidance, non-elaboration. There are no words accorded, the traumatic experience doesn't get a verbal, linear narrative structure that is part of the life history. This leaves the subject in a passive position where she is exposed to the wordless, indescribable trauma time after time (De Roover, 2000). After a while the substance takes over, resulting in loss of control and ending in addiction. Hence addiction can be conceived as a failed mastery attempt[10].

In acute individual trauma the traumatised will occasionally -in moments related to the trauma- engage in binge-use of the product in order to completely evacuate the subject (Verhaeghe, 1998d). The intoxication will inhibit the compulsive repetition of traumatic experiences, abort (or in case of ongoing danger, reinforce) the signals of hyper activation; numbness is counteracted on one side[11], and on the other side dissociation is induced if it doesn't appear spontaneously[12] (De Roover, 2000). On a biological level illicit and licit drugs influence the nervous system and bring about changes in emotional reactions, making the addict feel intoxicated, relaxed, happy, far away from the world that is painful and unacceptable for her (Dominiak, Hess & Shapiro, 1992). According to Singer and Petchers (1989) substance abuse causes a chemical dissociation, which is the continuation of an earlier learned dissociate coping-style. Alcohol and drug use is a kind of avoidance behaviour; an intentional trial to escape from thoughts and feelings associated with the event; to restrict and reduce the affect (emotional numbing).

By means of addictive behaviour the woman will try to heal or deny the psychic effects of the traumatic experience. The intoxication repairs the damaged image of the self, the bodily integrity, and the feeling of community. After traumatic experiences a lot of survivors suffer from severe guilt and feelings of shame, which makes them especially prone to substance abuse (De Roover, 2000).

Here the woman is in danger of getting caught in a vicious circle. In most cultures there is a big taboo on women and substance use closely linked to sexuality, with intoxicated women being depicted as more promiscuous and loose. These beliefs and expectations contribute towards many men perceiving

[10] Herman (1996) writes about the dual nature of addiction as a self-medicating device for unbearable affect, and as a compulsion to repeat intolerable dysphoria and 'provide implicit psychophysical suffering (Wurmser, 1974)' resulting from addiction itself, fuelled by an insatiable determination to 'control that which has been overwhelming, chaotic, disorganizing and bewildering (Wurmser, 1974)', to master that which has been destructive and cruelly out of control.

[11] Psychoactive substances can also be used as auto-medication to relieve the emotional numbness after trauma, for instance Kosten & Krystal (1988) claim that the euphoric effects of alcohol fight the emotional inhibition.

[12] The biological factors that determine the changed state of consciousness in hypnotic trance and traumatic dissociation are unknown. But in practice we notice that traumatised people who don't experience spontaneous dissociation will try to obtain a similar sedating effect using alcohol or narcotics. Hilgard (1977) claims that hypnosis as well as morphine induces a state of dissociation that separates the perception of pain from the normal emotional reaction to pain. Hypnosis and opiates decrease the torture of ongoing pain without ending the experience itself (in Herman, 1996).

the intoxication of women as an exploitable weakness (Blume, 1990), which puts women in danger of subsequent traumatisation. The feelings of guilt and shame connected to substance abuse can motivate the troubled woman to hide her use, which will reinforce her isolation. Often the substance problem is only recognized when the woman is already in a deteriorated stage.

The wordlessness of both trauma and addiction puts the subject more at risk for acting-out on a Real level. Substance abuse can help 'setting up a new scene' (Verhaeghe, 1998d), where the intoxicated woman fails to recognize certain threatening signals and cues or re-enacts previous trauma, making her end up in an equally threatening situation. Because she is intoxicated she can't deal adequately with the new challenge either, which puts her at risk of getting hopelessly trapped in a downward circle of accumulating trauma.

In chronic individual trauma, substance abuse can be part of the pathological regulation of emotions (De Roover, 2000). After the intrusion of the body the drive (which is called arousal or hyper activation in trauma literature) becomes visible in enlarged proportions (Verhaeghe, 1998d). The intake of a substance will discharge the vague tension and overwhelming unnameable emotions; the suffered abuse is repeated on the own body and conceals an illusion of control because it is self-inflicted (De Roover, 2000). The intoxication will facilitate dissociation. On a psychological level the substance abuse constitutes an attempt to integrate the fragmented image of the self: early traumatising relations impeded and deranged separation and individuation. Because an empathic supportive environment was missing during childhood, the subject developed a basic distrust, resulting in lack of a solid psychic structure, strikingly named a *'dorst naar heelheid'* (thirst for whole-ness) by Grof (1996). Intoxication thus provides the woman with a temporary sense of unity and identity (De Roover, 2000) which allots substance abuse the status of a dubious survival-strategy[13].

Addiction as initial survival-strategy will soon become re-traumatising. The original trauma will be concealed under multiple layers of continuous self-inflicted traumatisation, either by setting up the scene or by the traumatising nature of addiction itself. Kaufman and Kaufman (1979) argue that the emotional reactions to physical withdrawal mirror the original psychological torment which motivated the addict to self-medicating in the first place. The re-traumatising behaviours will take on a life of their selves, making the whole even more incomprehensible and intangible. This increases fear, and the feeling of helplessness, powerlessness, being overwhelmed, meaninglessness and detachment, equals a new trauma, which leaves the subject trapped in a downward spiral of trauma and addiction.

[13] The term 'strategy' was favoured before 'mechanism' which carries a more logic-positivistic connotation. 'Strategy' refers to any (conscious or unconscious) defence from the organism towards a threatening content, and often boils down to an involuntary, automatic response, lying outside the subject's conscious control.

Chapter 3 : Preliminary Investigations

The following chapter presents an outline of the broader social situation in which this research was conducted, namely South African society. South African literature about violence against women and children is considered. SACENDU-data (South African Community Network on Drug Use) is used to sketch the profile of South African female addicts found in treatment. Literature about the connection between substance abuse and trauma in South Africa is reviewed and the results of two preliminary studies I conducted are presented.

3.1 SOUTH AFRICAN TRAUMA LITERATURE

3.1.1 Introduction: Culture of Violence

South African society is very violent. Decades of apartheid state-sponsored violence and reactive community insurrection (Simpson, 1991) and the deregulation of state control during the negotiations period, as well as the perception that there will be no serious consequences for criminal activity, and the opening of South African borders to criminal syndicates and operations since the shift to democracy (Hamber, 1997; NCPS, 1996; Simpson, 1993), all contributed to the situation in which for many people physical violence is a first line strategy for resolving conflict and gaining ascendancy (Simpson, 1991). The root of much of this violent crime lies in social inequality and enormous deprivation caused by the apartheid system (Hamber & Lewis, 1997). Numerous dimensions are related to high levels of community violence including over-crowding, family disruption, weak social structures, high population concentrations, population transiency and social norms which encourage the use of violence to cope with difficulties (Mercy, Rosenberg, Powell, Broome & Roper, 1993). This makes all forms of interpersonal violence very common[14].

Normally the focus of the media and research goes towards the more public forms of criminal and political violence at the expense of more 'private' or 'hidden' forms of violence generally targeted towards women and children such as child abuse, wife battery, domestic assaults and acquaintance rape (Hamber & Lewis, 1997). Although democracy brought about an improvement in the legal status of women, with new, progressive legislation, giving women reproductive rights (Choice in Termination of Pregnancy Act, 1996) and protecting women against domestic violence (Domestic Violence Act, 1998), the actual observance in day-to-day life seems yet a far and distant future (Jewkes, Levin & Penn-Kekana, 2002).

[14] Violence is used regularly, for example, in disputes between neighbours (Department of Health), male and female peers (Wood & Jewkes, 2001), nurses and patients or their relatives (Jewkes, Abrahams & Mvo, 1998) and fellow workers (Abrahams, Jewkes & Laubscher, 1999).

3.1.2 Violence against Women and Children

Gender-based violence is viewed in Government and civil society as a major problem (Usdin, Christofides, Malepe & Maker, 2000). Although South African statistics on exact numbers of violence are somewhat problematic, as the research base and definitions of the commonly cited ones are unclear (Wood, Maforah & Jewkes, 1998), quoted figures are that 1 in 4 South African women are regularly beaten by their male partner (Angless, 1992); 1 in 3 will be raped at some time in her life (POWA, 1995) and every six days one woman is killed by her intimate male partner (Pillay, 1997; Shifman, Madlala-Routledge & Smith, 1997)[2]. According to the National Research Council 1 in 3 girls will be sexually assaulted before the age of 18, compared to 1 in 8 boys.

Physical violence is a prominent feature of sexual relationships from the start of dating during teenage years (Wood, Maforah & Jewkes, 1998; Jewkes, Vundule, Maforah & Jordaan, 2001). Forms of violence have been described as lying on a continuum between slapping, 'persuading' a woman to have sex, threatening to beat, hitting with sticks or other objects, pushing, assaulting with fists, violent rape, stabbing with a knife or shooting (Wood & Jewkes, 2001). Physical violence is very often accompanied by a range of emotional abuse by men, particularly including deliberate belittling, attempts to control a girlfriend or wife's social interaction and movement, bringing other girlfriends to the shared home, evicting the woman and her children, and not providing money for essential items at the home when money is available (Jewkes, Penn-Kekana, Levin, Ratsaka & Schrieber, 2001).

Research among adolescents has shown that one of the most common areas in which control is exerted is over women's sexuality. Women are beaten for refusing a proposal, wanting to end a relationship, having other partners and sometimes to make sure they do not even think of having other partners, resistance to men's attempts to dictate the terms of a relationship, and acts which undermine a boyfriend's success with other women (Wood & Jewkes, 2001).

Rape Crisis Statistics (1998) inform about absolutely staggering figures[15], and predicts that reported rape will likely be higher once the definition is broadened[16].

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[2] I am well aware of the convention to spell out all numbers under ten in full, but to save space I preferred to use the numerical presentation where it didn't disrupt legibility.

[15] In 1998 there were 49280 reported rapes and 4851 reported sexual assaults; in addition there were 179 incest reports, resulting in a total of 54310 in 1998. Rape Crisis arrived at a present estimation that there is one rape every 26 seconds (based on reporting rate of around 1 in 20).

[16] The report rate in cases of rape and sexual assault are very low, which can be ascribed to a number of reasons. Secondary victimization by police insensitivity and ill-treatment of survivors, in combination with ignorance of the legal provisions protecting women reporting a crime (Jackson, 1997); lack of confidence in the police and difficulties in obtaining convictions (London Rape Crisis Centre, 1984; Vogelman, 1990; Vogelman & Eagle, 1991); the shame experienced in describing assaults, particularly of a sexual nature; social stigma and self-blame (Goldblatt & Meintjes, 1997); emotional and financial vulnerability, guilt by reporting a family member (Hamber & Lewis, 1997); fear of reprisal by the perpetrator (Vogelman & Eagle, 1991); and belief that the perpetrator, by virtue of his or her authority

Role violence plays an important role in maintaining traditional gendered sexual roles in the South African context (Shefer, Strebel& Foster, 2000). This starts at an early age during socialization with children being both witness to and victim of violence. Female children and teenagers are at high risk of being sexually abused or assaulted by intimates who seem to misuse their familiarity and intimacy with young women (Vetten, 1997). This was confirmed by Swart' Gilchrist, Butchart, Seedat & Martin (2000) who found that 54.6% of the rape survivors under the age of 19 knew their perpetrator (either by sight only, or current or ex-partner, or friends and relatives), further data showed that the older the women became the more likely they were to be raped by a stranger. It has been indicated that 50% of men who abuse their wives, frequently abuse their children (Domestic Abuse Project, 1996). Madu & Peltzer (1998) as well identified high rates of child psychological (80.7%), physical (19.8%), emotional (26.3%) and ritualistic abuse (8.0%) among high school students in the Northern Province of South Africa.

3.1.3 Patriarchy in South Africa

To an outsider, one of the most remarkable features of gender-based violence in South Africa is that, within certain boundaries of severity, the society is extremely tolerant of it (Soul City, 1997; CIET-Africa, 2000; Wood & Jewkes, 2001). The roots of violence against women can possibly be found in the patriarchal nature of South African society, where women are viewed as inferior to men, often as their possessions (Vogelman & Eagle, 1991), devalued and vulnerable (Hamber & Lewis, 1997) and in need of being led and controlled (Wood & Jewkes, 2001). According to Goldblatt and Meintjes (1997) women are relegated to a secondary status within South African society, which is divided into a public and private sphere where the world of business and Government is seen as the male realm. The home falls within the private sphere and what happens between men and women is regarded as outside the realm of the state and public authorities. This division allows violence against women to occur unchecked because what a man does to his wife 'in the privacy of his home is his business'. Cultural stereotypes reinforce this position as do desperate economic conditions which put pressure on family life and create limited opportunities for women to remove themselves from these oppressive situations.

Research in other subgroups of South African society has shown that male control of their women, their women's sexuality and their households, lies at the heart of the meaning of being a 'real' man in those groups. Violence is used not just to maintain control and dominance but to counter real and imagined threats to 'manhood' (Wood & Jewkes, 2001; Mager, 1998). One extreme example of violence as a means of regulating women's sexual behaviour is gang rape, where a gang of men rapes a woman as 'punishment' for stepping out of their traditional roles (Conco, 1996). Many women themselves accept the ideas that women are subservient to men in relationships (Jewkes, Penn-Kekana, Levin, Ratsaka & Schrieber, 1999), and often tolerate intimate partner violence, as part and parcel of 'normal' sexual

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in the home, was justified in the abuse (Hamber & Lewis, 1997) are all factors that contribute to the level of underreporting.

relations (Lewis, 1997; Shefer et al., 2000). This is notable in the reluctance of teenage girls to leave violent relationships even when they have no children or financial dependence on the relationship, and in the way in which being known to be violent seems to carry little stigma and interfere little with a man's ability to get another partner (Wood & Jewkes, 2001). This should rather be seen as a testament to the 'success' of patriarchy. It would be difficult to see how men could continue to be abusive towards women if it were not for the fact that many women, at some level, perceive this as their entitlement and women as deserving this at times (Jewkes, Penn-Kekana, Levin, Ratsaka & Schrieber, 1999). This widespread tolerance of violence against women and children reflects both ideas that the use of violence is often 'normal', inevitable; and ideas about gender which legitimate the use of force by men in establishing hierarchical control over women (Jewkes et al., 2002).

3.1.4 After-Effects of Trauma

In accordance with trauma-literature, the above-mentioned staggering figures and details on violence against women and children in South Africa compel us to reasonably expect numerous documentations of the after-effects[17] on individuals and society. Compared to the high rates of violence, the literature on after-effects seems quite meagre.

The health consequences of violence against women are manifold. Injuries and death are the most visible and immediate consequences, but studies have shown that abused women attend services more frequently for a range of non-injury related medical problems (Jewkes et al., 1999). Battered women rarely report the abuse but present many unexplained physical symptoms at the G.P., and both PTSD and major depression are significantly more common in patients with a history of domestic violence than in controls (Marais, de Villiers, Möller & Stein, 1999). These non-injury related symptoms (such as chronic pelvic pain, stomach pains, headaches, disability) can be described as somatisation of the distress (Jewkes et al., 1999). The internationally reported association between abuse and mental distress was also found in South Africa. Frequently mentioned mental health problems included (para-) suicide, depression, anxiety and sexual dysfunction. Although the relationship between suicidal thoughts and attempted or actual suicide is not straightforward, research internationally has shown it is one of the ways in which abuse of women can lead to fatalities. Women suffering severe mental distress also work less well, both in their roles at home, in the community and in employment. In addition teenage pregnancy (Vundule, Maforah, Jewkes & Jordaan, n.d), sexually transmitted diseases and HIV have been associated with sexual coercion (Jewkes et al., 1999).

[17] The common term 'after-effects' implies a simple cause-effect relationship between a stressor (trauma) and an effect. Clinical practice and day-to-day experience illustrates that it is more complex. Therefore I preferred to use a range of (less determinate) terms such as traces of trauma, trauma-remnants and trauma-remainders, which leaves space to recognize the agency of the subject besides a possible involuntary defensive response of the organism. The term 'after-effects' will be reserved for discussing literature.

The most described after-effect of traumatic exposure in clinical literature is PTSD. In a school survey of exposure to violence and PTSsymptoms in secondary schools in the Western Cape, for boys, physical assault by a family member was associated with the highest risk of PTSD (50% of exposed boys); for girls it was sexual assault (30%). Such sexual difference in PTSD might reflect greater vulnerability in females to the PTSD-inducing effects of traumatic experiences (Seedat, van Nood, Vythilingum, Stein & Kaminer, 2000).

Other literature documents the short-term and long-term effects of child sexual abuse: in his discussion of the short-term effects of child sexual abuse Robertson (1989) apparently focused on what is known in trauma-literature as male trauma responses: namely acting out and externalising behaviour[18]. A widespread idea is that sexual abuse of a child constitutes a major risk factor for later psychopathology (Lewis, 1997). The long-term effects of child rape and sexual abuse that have been documented include: depression, self-destructive behaviour, suicide, substance abuse, self-mutilation, prostitution, sexual promiscuity (risk of AIDS), and running away (Robertson, 1989), guilt, negative self-perception, distorted beliefs, problems in intimacy and interpersonal relationships, sexual difficulties, relationship problems and a tendency to re-victimization (Browne & Finkelhor, 1986; Cahill, Llewelyn & Pearson, 1991; Eth & Pynoos, 1986; Jehu, 1988; Russell, 1986). This re-victimization puts the subject more at risk for pathology. And early traumatic experiences (during childhood), especially if these are prolonged or repeated, may increase the risk of developing PTSD after traumatic exposure as an adult (Baldwin, 1996, in Hamber & Lewis, 1997).

During my review of the topic 'violence against women in South-Africa' it became clear that this type of violence is widespread. Part of it can be explained through 'the culture of violence' in South Africa, and the typical patriarchal society. In the last section, literature about after-effects was discussed and we came across substance abuse as one of the after-effects of trauma. The next section will present a brief profile of South Africa's female substance abusers who attend treatment centres, after which South African literature about the link between trauma and addiction will be explored in more detail.

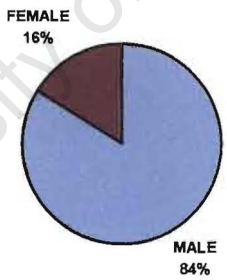
[18] According to Robertson (1989) many of the child victims are labelled as under-achievers by their teachers, failing to reach anywhere near their potential, be it in the classroom, on the sports field or in other extramural activities. Robertson (1989) also ascribed these survivors a lack of moral and religious values, which opens them up to even greater exploitation. He continued that they are frequently subject to abrupt mood, attitude and behaviour changes, other worrying behaviour includes their tendency to run away from home, to become involved in substance abuse, and commit petty or serious crimes merely for the challenge and the message that they think this behaviour conveys to society. In case of our females, quite a different picture emerged and only the tendency for substance abuse was found.

3.2 SUBSTANCE ABUSE IN SOUTH-AFRICAN FEMALES

Since 1996 MRC's Alcohol and Drug Abuse Research Group has published the results of the SACENDU-project (South African Community Network on Drug Use) which aims to monitor alcohol and drug abuse trends in South Africa. For this study I had a closer look at phase 11 (eleven), which discusses data from July till December 2001, for the Cape Town area, and was provided with more specific data for women[19] seen in the Cape metropole treatment centres in the same period.

A first glance at the treatment population data (Fig. 1) shows a huge discrepancy compared to overseas literature, namely in South Africa females constitute only 15,5% of the 1561 people in treatment during the last six months of 2001 (internationally female to male ratio approximates 30/70 or 40/60). Day to day experience of South African life makes it highly questionable that South African women have fewer problems with substance abuse and substance dependency than elsewhere in the world, but a solid explanation for women's absence hasn't been published yet. The SACENDU Research Brief, Vol. 4 (2), 2001 suggests that the inadequate representation of women in treatment centre statistics probably reflects an unmet service need as well as the fact that substance abusing males may act out more and may thus be more likely to be encouraged or forced to go into treatment.

Fig 1: Total population
% according to Gender



During my first contacts with the South African rehabilitation sector the following reasons were given by counsellors: the taboo and stigma associated with being labelled alcoholic or junkie, especially for women it is morally derogatory, with attributions such as bad and/ or neglecting mother, and promiscuous, adulterous wife or soliciting slut. A high amount of unawareness is asserted as well, especially under the historically disadvantaged groups (in (sub)urban areas), where alcohol or other substances are incorporated in the daily life with the infamous binge each pay day. Some of these people lack basic things like food, proper shelter and a steady job, many of them are without education. Therefore fulfilment of basic needs is given priority. Another explanation goes hand in hand with the first: namely the internationally recognized tendency for women to choose a more socially accepted disorder or illness, many of the addicted women can be found under treatment of a psychiatrist, psychologist or G.P. for depression or unexplainable tremors, panic attacks, and

[19] Referred to as Sacendu 11, w.

headaches. Various practical factors can account for the low number of women in residential treatment. Combining motherhood, childcare, household, a job and rehabilitation is hard for many women, making them definitely very reluctant to be admitted, and only prepared to go to residential treatment when there's no other option left.

Fig. 2: Total population % according to Race

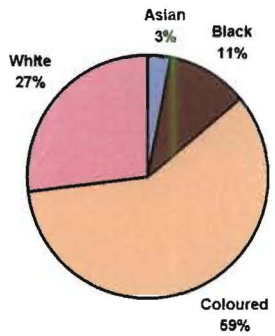
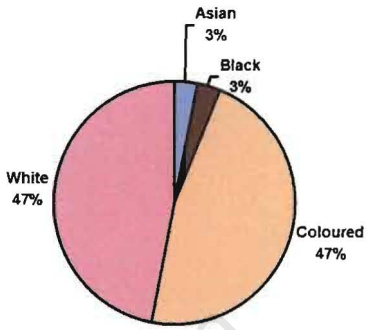


Fig. 3: Female population % according to Race



The most striking aspect is the lack of black women in treatment (3% of the female population, Fig. 3). Although the African population in treatment was generally low (Fig. 2), black women only constituted 0,5 % of the total treatment population. The SACENDU Research Brief, Vol. 4 (2), 2001 recognized that black South-Africans continued to be under-represented in the treatment population in all five sites, which probably reflected greater accessibility for other sectors of the population rather than a lesser propensity towards substance abuse by Africans. Compared to the 1996 publications of Rocha-Silva, De Miranda, and Erasmus about alcohol, tobacco and other drug use among black youth there is a distinct difference: they found approximate numbers of 40% males and 20 to 30% of the females admitting current alcohol use with slight differences according to residency. Rocha-Silva et al. (1996) further assert that female wine drinking seems linked to 'adulthood' and attendance of festivities. Female use of beer and distilled spirits was intertwined with being married or having a boyfriend and thus possibly with so-called maturity and maintaining or facilitating the relationship between members of the opposite sex. Parry and Bennets (1998) attribute the low alcohol misuse and consumption among young black women largely to internal cultural taboos against black women drinking, but these taboos are decreasing with increasing urbanization.

Fig. 4: Total population % according to Occupation

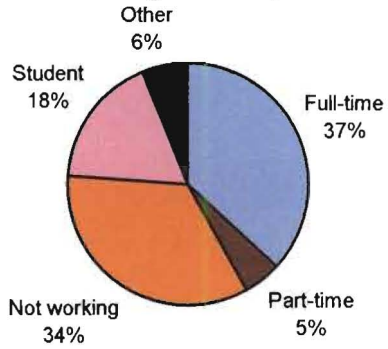


Fig. 5: Female population % according to Occupation

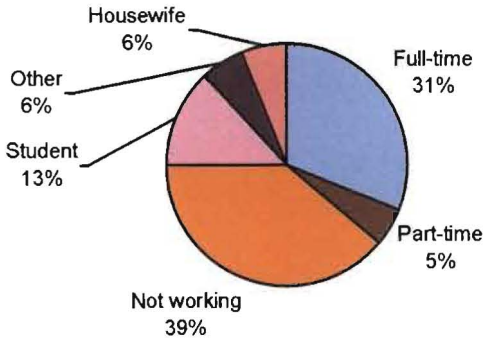


Fig. 6: Total population % according to Marital Status

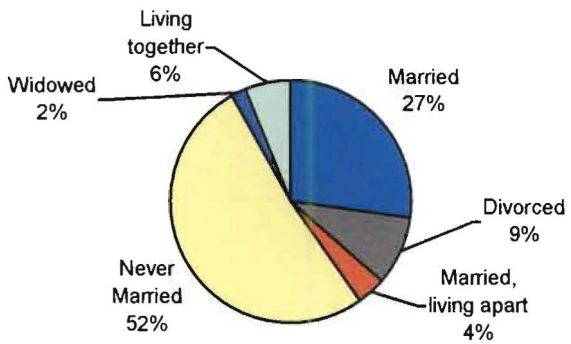


Fig. 7: Female population % according to Marital Status

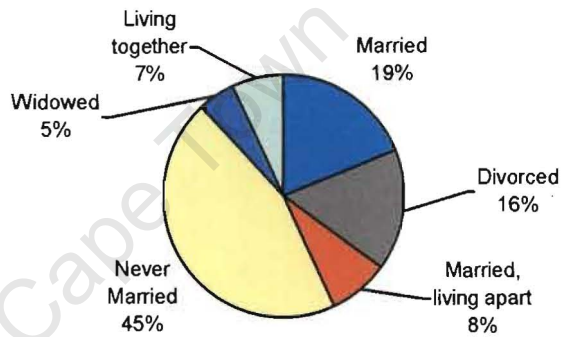


Fig. 8: Total population % according to Education

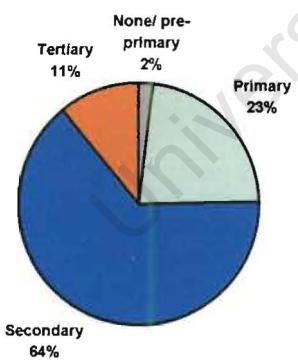
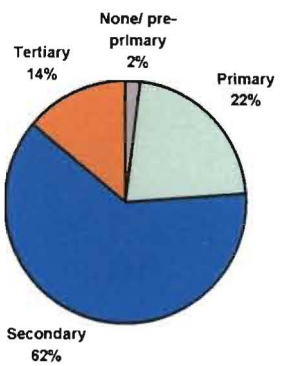


Fig. 9: Female population % according to Education



One out of three addicted females is working (Fig. 4-5), a bit more than one third is unemployed, 13% are student. Only one in four females is engaged in a relationship (Fig. 6-7), 74% are currently single or living apart. One in three of the total population, however, is involved in a relationship, whereas two thirds are single. This indicates some consistency with the international finding that wives of addicts tend to support their partner, whereas female addicts are more likely to be abandoned by their partner or supported in their denial by their husbands. When we have a further look at the MRC-statistics we find that education (Fig. 8-9) seems to play a role in threshold fear for coming to rehabilitation. It appears that treatment rather attracts women with at least secondary schooling (76%). Rehabilitation is also known to have a high level of repeat patients, which was demonstrated in the data where one

patient out of three was a repeat admission (Sacendu, 11: 68). For women this number constituted a figure of 40% (Sacendu, 11,w.).

To have a broad idea of which women do show up in treatment centres I had a look at the SACENDU (11) data for women according to race and substance, compared to the whole treatment population of that period (Fig. 10-11).

Figure 10: Total Population in Treatment

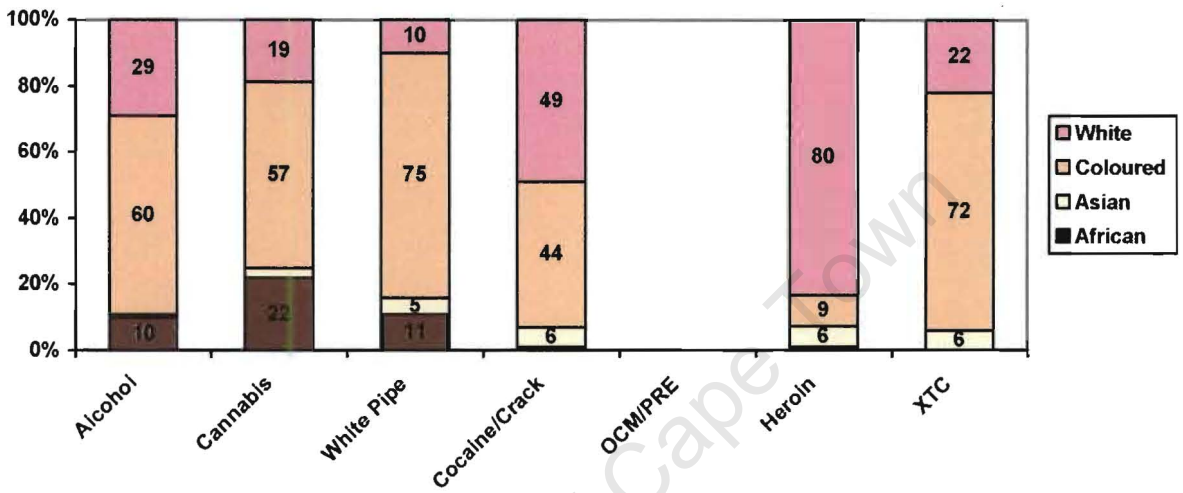
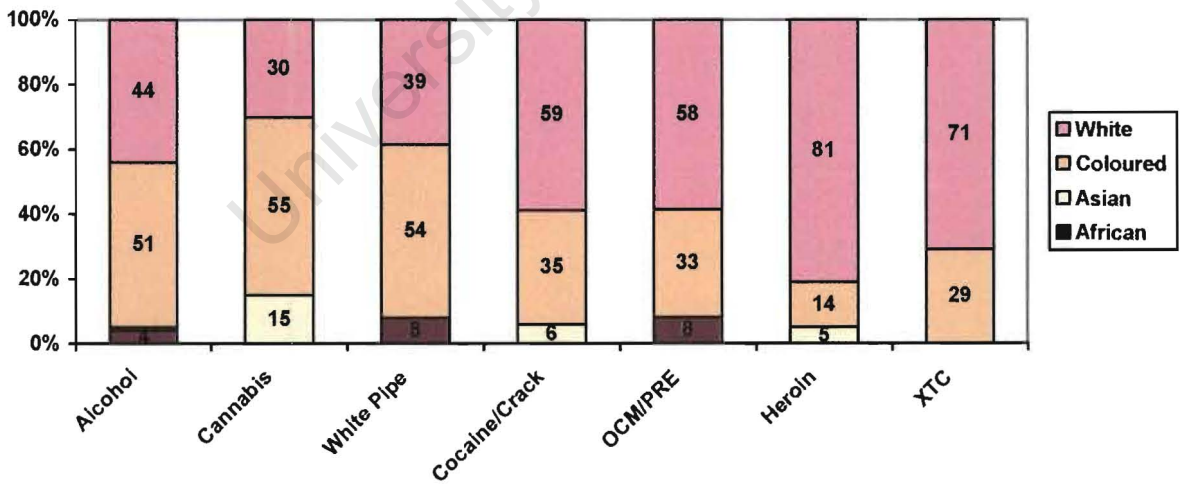


Figure 11: Female Population in Treatment



Compared to the whole treatment population black women come to treatment for Mandrax, medication abuse (over-the-counter and prescription), and alcohol abuse. There were no cases for cannabis, cocaine/crack, heroin, and XTC. Coloured women were somewhat better represented in the rehabilitation statistics in Cape Town (47% of female population) and constituted the largest group of women being treated for alcohol, cannabis and Mandrax. This resembles the percentages of the total

coloured group in treatment. Asian women consist of 3% of the female population, in accordance to the percentage of Asians in the total population. Compared to the total Asian population Asian women are more admitted for the treatment of cannabis dependency (3%), and none for XTC and Mandrax. White women constituted the highest percentage of females having: heroin (81%), crack/cocaine (59%), XTC (71%) or over-the-counter medication and prescribed medication (62%) as their primary substance.

During the last six months of 2001, alcohol, Mandrax and dagga were the most commonly used substances by people in treatment centres. XTC was most used as secondary drug (Sacendu, 11: 73). For women alcohol, heroin, cannabis, crack/cocaine and over-the-counter/prescription medicines were the most often abused (Sacendu, 11, w.).

Typical in women as well is poly-drug abuse such as the combination alcohol-tranquillizers/ anti-depressants. This was described more in detail in Myers, Siegfried, and Parry's study on Over-the-Counter (OTC) and prescription medicine misuse in Cape Town[20].

All age groups are represented in the female population profile (Fig. 12). Remarkable is the early onset of the problematic substance abuse (20% under 19y., this is even more remarkable in the total group with 24% being under 19y.). One in three females in rehabilitation is younger than 30y. (compared to total group 48%), 52% is 30-50y. (total: 44%), and 13% is older than 50 (total: 8%).

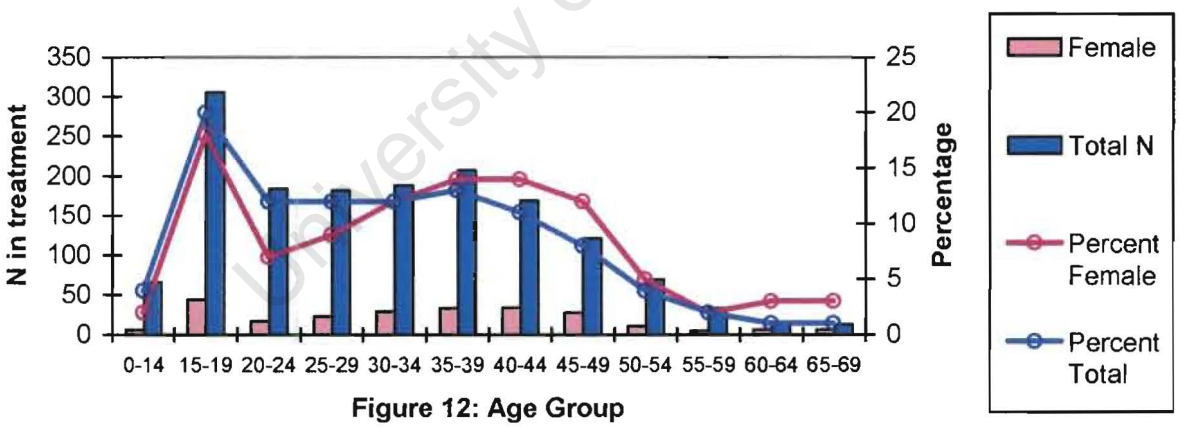


Figure 12: Age Group

[20] Myers, Siegfried, and Parry (in press) found that patients using OTC/ prescription medicines as their primary substance of abuse are significantly more likely to be female, and aged over 40. Patients using OTC/ prescription medicine as an additional drug of abuse tend to be male. The most common primary drug of abuse in patients reporting benzodiazepines as their secondary substance of abuse was alcohol (57.5%), followed by cocaine (14.3%), heroin (5.5%), and Mandrax or white pipe (Mandrax smoked together with cannabis) (5.5%). Of the patients reporting analgesics as secondary drugs, the most common primary drug of abuse within this group was alcohol (46.2%), followed by benzodiazepines (17.9%), heroin (8.3%), cannabis (8.3%), and Mandrax (8.3%), on top of that more than one third reported the misuse of codeine-containing preparations, and a quarter reported the misuse of prescribed opioid analgesics.

3.3 LINK BETWEEN ADDICTION AND TRAUMA

3.3.1 South African Literature

Not many South African publications document the link between addiction and trauma, which stimulated me to conduct two sub-analyses in order to determine the validity of my topic. But first I will present what has been published. Sometimes cross-references are made in either trauma- or addiction literature to the other topic of our interest.

Some articles on violence reflect upon substance abuse as precursor to abuse and violence: in South Africa the majority of injuries and fatalities are alcohol related (Lerer, 1992; Rocha-Silva, 1992; van der Spuy, 1993), with an analysis of murders in the Eastern Cape in 1996 revealing that 93% of murder cases were linked to alcohol and drugs (CIMC, 1997). Increased risk on domestic violence was associated with alcohol use and, particularly, the woman's alcohol drinking being perceived by the man as a problem (Abrahams, et al. 1999). Violence perpetrated by someone who was drunk was often described as occurring after a "drinking spree", suggesting that the husband, by going off and getting drunk, cannot be held responsible for his behaviour (Watts, Osam & Win, 1995).

Trauma literature documents substance abuse as one of the after-effects of trauma, and the substance can fulfil an important function in the trauma dynamics of self-destruction: Marais, de Villiers, Möller, & Stein (1999) researched domestic violence in patients visiting general practitioners and found a significantly higher number of suicide attempts and a tendency (not reaching statistical significance) towards increased substance abuse in 'battered women', certainly in those women reporting sexual violence (instead of physical abuse). According to Robertson (1989) a common form of self-destructive behaviour after child sexual abuse is the abuse of substances, including drugs, alcohol, thinners and glue. He continues that the child is not really concerned about the damage that is caused by the substances, but enjoys and needs the escape that the intoxicating substances give and believes that this makes a clear statement to the world.

In individual case-studies previous trauma and later substance abuse can be mentioned. In her book on incest in white South Africa Russell (1997) discusses five individual stories; two of those experienced a problem with substances or addiction at some stage in their life. One woman had eating disorders and was addicted to appetite suppressants and laxatives. The other woman was addicted to sleeping pills and tranquillizers.

The fact that substance abuse can be part of a cycle of repetitious trauma is most clearly described in writings about sex workers. Pauw and Brener (1997) published a case-study of a sex-worker in which the link between substance abuse and previous trauma was made, and the danger of re-traumatisation was emphasised:

> *"Some sex workers turn to drugs to help them relieve their fear and anxiety and help them cope with their work (De Graaf et al., 1995; Green et al., 1993). Unfortunately, this could increase sex workers' vulnerability to violence and abuse. Substance abuse has been noted to be common among sex worker populations (De Graaf et al., 1995; Plant, 1990)"* (Pauw & Brener, 1997: 81).

In his book "Rainbow Vice" Legett (2001) also discusses the link between sex work, substance abuse and previous trauma and provides some case examples[21]:

> *"Sex workers come from a wide range of backgrounds, many of them quite surprisingly mainstream. Abuse is an awkward issue to broach in a short interview, so it is difficult to gauge how often this is a major factor in women entering the profession. Although some sex workers are quite candid about early molestation, others are equally convincing in their claims to have had a relatively normal childhood"* (Legett, 2001: 101).

The connection between trauma and substance abuse is not very clearly described in South African literature. Therefore I conducted two sub-analyses: a small survey in outpatient rehabilitation centres asking about the presence of previous trauma in female substance abusers; and an analysis of Rape Crisis case files in order to find how substance abuse was mentioned during the counselling sessions.

3.3.2 SANCA

SANCA (South African National Council on Alcohol and Drug Dependence) Western Cape consists of 10 outpatient treatment facilities. During the period April 2001 till March 2002 social worker Letitia Bosch circulated a small survey about trauma in addicted women among the counsellors in the different SANCA-branches. The survey consisted of three questions. In one graph (a detailed cross-table) the counsellor (social worker) had to tick the appropriate boxes detailing the number of women that were seen according to cultural background (white, coloured, Indian, African), with trauma or without trauma, and substance (alcohol or drugs), by age. The statistics and case files of the local branches were consulted for that purpose. The second question asked for comments "Issues you think should be taken into account with regards to the research topic: trauma and women's substance abuse". The last question was "Please include one relevant case-study." The lack of definition of trauma in the questionnaire resulted in every branch adopting their own definition, with examples of trauma ranging from emotional and physical abuse, rape, divorce, death of child/spouse, to retrenchment and severe physical impairment after a stroke. The range of interpretations of the concept 'trauma' might have led to under-estimation when compared to my very broad definition of trauma. Due to the small sample

[21] For instance on p. 102-103 Legett described a case example of 'a woman driven by her need to escape the pain of early victimization'.

not many conclusions could be drawn apart from an indication that trauma was present in numerous cases (Table 1-2).

Table 1: Substance Abuse and Trauma in women April 2001-March 2002

SANCA branch	Traumatised addicted women	Total women
Khayelitsha	2	2
Atlantis	3	8
Paarl	3	6
Tygerberg	3	6
Mitchell's Plain	15	26
Cape Town	2	3
Athlone	19	28
Gugulethu	3	18
Total	50	95

Table 2: Distribution according to age and race of 97 treated women by SANCA

Yes= Traumatised, No= Not traumatised

Missing number= 2

AGE	White		Coloured		Asian		African		Total		Total
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
<13			2	2					2	2	4
14-19			4	15			1		5	15	20
20-29		1	12	3				2	12	6	18
30-39	2	1	11	9			1	4	14	14	28
40-49	2		9	1			2	4	13	5	18
50-59	1		2	1			1	2	4	3	7
>60											
Total	5	2	40	31	0	0	5	12	50	45	95

One in four women was younger than 20, 19% were in their twenties, 29,5% were thirtiers, 19% were in their forties, and 7,4% was older than fifty (Table 2). Compared to the SACENDU data we notice that the women in outpatient treatment seem to be younger and mostly coloured.

One of the typical case-studies described by the counsellors demonstrated a clear link between addiction and trauma, namely addiction as failed coping-strategy after trauma:

> *Miss M. lives with her mother in Philipi East. She is 17 years old. Our first contact was when her mother brought her to our offices for drug abuse. According to the mother she had run*

away from home, although she had a stable family and her mother was trying her best to meet their needs. She started sniffing glue then dagga and Mandrax. She did drink at one stage. Assessing the client we established that she was suffering from depression which stemmed from an underlying traumatic event that had happened to her of which her family was unaware that it was still affecting her as it had happened when she was 12 years old. She was raped by a neighbour and although the case went to court the man was acquitted as he had a lawyer. The sound of somebody pulling up or down a zip triggers her into screaming and she would want to lock herself up. She used drugs to escape.

3.3.3 Rape Crisis Cape Town: Case Files 2000-2002

Another way of gaining information about the connection between substance (ab)use and traumatic events (such as rape and sexual abuse) in women, was the exploration of the case files of Rape Crisis Cape Town. These case files report on face-to-face counselling conducted at Rape Crisis Cape Town by trained volunteers and professionals with rape survivors and their significant others. I explored the more recent files namely those from January 2000 till August 2002.

All the files were browsed through with a focus on any mentioning of substance use, substance abuse and addiction, prior to, during, or after the rape; how this topic was part of the counselling sessions and how the substance use was related to the working through of the rape. Rape crisis focuses on counselling rape survivors; if other problems arise the most adequate referral will be searched. For that reason if there are substances involved, this will not be described in much detail in the case files.

During the research, special attention was paid to completed Rape Trauma Syndrome (RTS) symptom lists. This checklist was imported in the counselling sessions in 2000 and is filled out by the counsellor during a session where the rape survivor is asked to indicate physical, behavioural, and psychological symptoms associated with Rape Trauma. One of the behavioural items is 'increased substance abuse'.

503 case files were looked at, 471 of these concerned counselling sessions with rape survivors and formed the scope of the analysis. 99 had a completed RTS symptom list, 25 indicated increased substance abuse. Less than one fifth of the cases had a completed RTS symptom list, so the second point of attention was the description of the rape scene, the initial complaints and questions that the client utters, and the problem presentation. It appeared that 61 women used a substance before the rape, and 22 of these could be described as drug rapes. It is rather difficult to determine whether or not it was a drug rape, because if typical date rape drugs (such as Rohypnol) are used, the victim can black-out and will have huge gaps in her memory, combined with serious doubts about what actually happened. If she didn't get a medical examination immediately after the rape then other clues (torn clothes, venereal disease, physical injuries, etc.) might give an idea about what happened. In most of Rape Crisis's drug rape cases there was a strong suspicion but no conclusive evidence.

If the rape scene, the initial complaints, or the problem description indicated any kind of substance use (alcohol, drugs, medication) the whole file was carefully read to see how this was further mentioned and treated. In total 116 case files where substances were involved were analysed (substance abuse as part of the rape scene, substance abuse as coping-strategy after trauma, pre-traumatic addiction,...).

Table 3: Summary of Substance Abuse in Rape Crisis Files.

2000	2001	2002
182 case files 170 rape survivors, 12 other. 30 RTS symptom lists: 9 increased substance abuse, 21 no increased substance use substance use before rape = 22, of which 5 drug rapes.	200 case files 188 rape survivors, 12 other. 38 RTS symptom lists: 9 increased substance abuse, 29 no increased substance use substance use before rape = 26, of which 11 drug rapes.	121 case files 113 rape survivors, 8 other 31 RTS symptom lists: 7 increased substance abuse, 24 no increased substance use substance use before rape = 14, of which 6 drug rapes.

TOTAL JANUARY 2000-AUGUST 2002:

503 case files.
Rape cases = 471; 32 other

Increased substance use indicated on RTSS = 25 out of 99

116 cases analysed where a substance was involved
Substance use before rape = 61, of which 22 drug rapes,
no later mentioning of substance abuse in counselling

In 55 cases the substance abuse was mentioned during counselling:
22 had a problem with alcohol
3 mentioned using a drug (dagga, coke, XTC)
10 abused medication
16 mentioned a combination of the above:
(drugs = 1, alc.+ med. = 1, alc.+ drugs = 10, drugs+ alc. + med. = 2, drugs+ med. = 2)
4 used an undetermined substance

Summarizing the report the following points stand out:

1. In the case files it appeared that being intoxicated at the time of the rape constituted a risk factor for trauma. This intoxication could be self-induced (mainly young girls who went to a party and got drunk/stoned; or older women where intoxication is part of a substance abuse problem or the occasional binge) or induced by the perpetrator. The latter is commonly known as 'drug rape', which is characterised by the perpetrator tricking the woman in a vulnerable, defenceless situation by serving her a 'spiked drink' or forcing her to take a pill or drugs, in order to sexually abuse her. For some women the rape seemed to be part (or the start) of a trauma sequence where victimization and

substance abuse are tightly interwoven. In other cases the rape constituted a trigger to stop abusing substances.

2. Where the woman had an existing addiction or substance abuse problem, counselling became more difficult, noticeable in the fact that many of these women only came for one session. If they are still under the influence or active users, they are very difficult to work with because the substance numbs their feelings and memories, there is no clear (sober) thinking. At other times the focus of the counselling shifted to the substance abuse instead of dealing with the rape. There is a very fine line between what is tolerable and intolerable to discuss and the survivor typically has difficulties drawing safe boundaries. Even if she claims to be ready to tell her story, the first thing that should be provided is safety on a physical, emotional and mental level, preventing precocious in-depth disclosure. Displaying an incoherent story can be read as a defence mechanism, to deal with the fear of not being believed, but finally it can turn into a self-fulfilling prophecy where the woman is considered a liar and a fraud. The picture is further complicated by suspected substance abuse during therapy, the feelings and senses are dulled by substances, with no access to feelings. If things get too confronting the substance abuse is likely to increase, making counselling sessions unproductive. The counsellor can be subjected to extreme testing, where the woman first recounts her horrific story and indicates the need to use a substance because she explored too much too soon. She will act out against the counsellor and seek comfort in what she knows best, the substance.

3. Different stages in substance abuse could be recognized reading through the case files: increased substance abuse as part of rape trauma syndrome, with the numbness of feelings after trauma being enhanced/ maintained through substance abuse, and the sessions being marked by superficiality and avoidance of rape issues. In other cases the initial relief the substances produced soon turned into a coping/ survival strategy. It also seemed that if a woman had this same survival strategy for a number of years she couldn't abandon it unless the support and benefits she got from the substance could be replaced by something equally rewarding. Sometimes the woman was prepared to let go of this coping strategy but was not yet able to deal with the trauma so she found something (e.g. medication, other substance, self-mutilation) to replace the initial substance.

4. Some rehabilitated women came to Rape Crisis because they wanted to clean up the mess in their past and finally tackle the traumatic events in their life. These women, however, were found at great risk of relapse, because the uncovering of the past brought about a lot of emotions that had to be dealt with. If the woman hadn't yet found an effective coping mechanism, chances were that she sought recourse in her old behavioural pattern of abusing substances. Some recently rehabilitated women had a new coping mechanism ready that was as destructive as their former drug or alcohol abuse (e.g. self-mutilation), and demonstrated a constant shift from one to the other during therapy.

3.4 CONCLUDING REMARKS

Violence is very widespread in South Africa, it is used as a first-line coping strategy in many situations, and is often targeted at women and children. Documentations of the larger effects on the victims of this violence and society as a whole are rather limited, and very little is written about the connection between addiction and trauma. Looking at the SACENDU data we established very low numbers of females in rehabilitation. In order to determine the relevance of the research topic two mini-analyses were conducted namely a survey amongst outpatient addiction counsellors at the different SANCA branches, and a study of Rape Crisis case files. Both studies illustrated that a link can be found between substance abuse and trauma, and that a qualitative exploration of addiction and trauma in women might be to the benefit of both sectors. Hence the next chapter will clarify the research methodology underlying this study.

Chapter 4 : Methodology

This chapter will explore the methodology of my research and deal with some problems I came across. I chose clinical practice as starting point, therefore my perception of both topics is focused on the subjective experience, because in the practical psychological field the individual construction of reality is the reality in which the subject lives and where she suffers from. Getting to know this construction, and making changes, is more relevant than presenting an exact, historically correct account. One of the aims of therapy is to create a more satisfactory subjective reality, integrating narrative truth and historical truth. In this research I had no means to obtain historical truth (and didn't aim to), therefore I will focus on the narrative truth, more specifically on the subjectively constructed reality of traumatised female addicts. The topic of the Real, and how I make sense of combining qualitative information focusing on subjective experience with logic-positivistic symptoms and phenomena, will be dealt with extensively in a separate paragraph.

4.1 LIFE-NARRATIVES AND PSYCHOANALYSIS

4.1.1 Why Life-Narratives?

In my search for a sound research method I wanted to move away from the traditional question and answer method of interviewing because this tends to suppress the respondents' agenda in favour of that of the interviewer (see for instance Mishler, 1986) and to invite discursive rationalizations. One of the options to obtain qualitative data on this topic is to conduct semi-structured interviews with practicing counsellors on their experience with traumatised substance-abusing women. This can give an idea about the prevalence of trauma and addiction in women, but might result in questioning the beliefs and expectations of these practitioners without providing the same in-depth information as in talking with the women themselves, and cannot illuminate the underlying dynamics.

Considering the wordlessness of both trauma and addiction, I felt that a traditional question and answer approach would never work. Many people are reluctant to speak about emotional or sexual topics, and especially in dealing with rape, sexual assault, domestic violence, incest, and child abuse we have to consider shame and guilt, loyalty to perpetrator, and fear of secondary traumatisation. In every culture there is a taboo on women and substance abuse, which will make women want to hide their drug problem, resulting in a lack of representation in the survey statistics of many cases who struggle with the dual problem of trauma and addiction.

Hence I decided to focus on the individual life-stories of traumatised addicted women. It seemed logical to me that if you want to put your finger on how substance abuse and trauma are intertwined in an individual, without imposing a preset structure, that you ask that individual to tell her life-story.

My interest in individual life-stories meant that I was attracted to approaches which put the interviewees' narratives -their experiences, what they think is important and relevant, in their own language and sequencing- to the foreground, like the clinical psychological field (and psychoanalysis more specifically), and narrative psychology.

The narrative approach was the most obvious choice because according to Cohler (1988) a personal narrative is the most helpful research approach available to gain a subjective perspective on and understanding of whatever the scope is of the topic or issue under consideration. Life-stories follow a natural tendency of arranging the events and circumstances of a life in a way that gives them a coherent order. As a way of meaning making, identifying life influences, and interpreting experience, and really connecting with another's experience, there may be no better method than the subjective narrative of the life-story to help the researcher understand a life from the insider's point of view (Atkinson, 1998). People tell their story in order to make sense of their experience, past, presence, and imagined future, which makes narrative a useful conceptual and empirical tool (Henriques, Hollway, Urwin, Venn & Walkerdine, 1998). Moreover, how people remember their life history and how they relate their history is a potentially valuable way of understanding them as they are now, or at the point of time in which they are telling their story (Jacobs, 1989). Through the recounting of stories, people reveal what they perceive as the dominant influences which have shaped the course of their lives (Andrews, Day Sclater, Squire & Treacher, 2000) as well as their beliefs and interpretations of the past (Stille, 2001). Telling stories is one of the primary means through which we constitute and reconstitute our very selves. Personal narratives not only describe experience, they give shape to that experience; narrative and self are thus inseparable (Ochs & Capps, 1996), making stories the very cornerstone of our identity (Andrews et al., 2000).

4.1.2 Problems with the Narrative Approach

Although my first interest went to life-narratives, there are some problems with this approach, urging me to combine other methodologies. Narrative analysis remains rather superficial, only focusing on the readily available text, and not on more subtle cues in speech that are of high importance if we want to get an idea of the interviewee's relationship towards topics that are 'indescribable or undiscussable'[22].

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[22] The duality between wordlessness (on an individual level) and taboo (on a societal level) is better described by Bar-On (1999) in his book '*The Indescribable and Undiscussable. Reconstructing human discourse after trauma.*' Although he focused more on collective trauma, male variants of accidental trauma, and the implications on a broader societal level of child sexual abuse, the notions of trauma being 'indescribable' (the impossibility to accord words, inadequacy of the signifier) and 'undiscussable' (taboo) are very appropriate to the whole field of trauma.

On top of that narrative psychologists conceptualise the self as constituted in narrative and narrative also constituting the self. This means that what is not told (e.g. psychoanalytic concepts such as unconscious desires and wishes) goes unaccounted for. Malson (2000) elaborates on this by stating that narrative work does not examine the constructing effects of individual, symptomatic words, or silences, or cross-textual 'discourses'. All of these have to be placed in the context of a 'story'. A narrative is itself an accumulating construction, as you follow it, you hear meanings and realities accrue.

Andrews et al. argue that the narrative approach needs to include socio-historical context and intra-psychic processes in order to represent an adequate picture, and that much contemporary work on subjectivity now takes for granted that a narrative is drawn from social, cultural and perhaps, unconscious imperatives, which it at the same time reveals (Andrews et al., 2000). Narratives of the self, as temporal constructions, are anchored in local institutional cultures and their interpretive practices. These practices shape how self-narratives are fashioned. The material world acts both as a facilitator and constraint on the lives that we live and the stories we tell.

It can be concluded that the type of story you tell and how you formulate it are decisions that you make as a narrator, be they conscious or unconscious. These choices are largely determined by your personal background.

4.1.3 Narratives and Freudo-Lacanian psychoanalysis

To be able to pay attention to interaction with the broader social context, available discourses and more in-depth material such as the unconscious wishes and desires I will try to integrate the narrative approach with psychoanalysis and Lacanian discourse analysis.

In face of trauma the normal beliefs about the self and the world are shattered, the subject experiences an existential crisis, and is thrown back on herself. Therefore subjectivity will constitute the starting point of the discussion, arguing that identity is inextricably tied to interpretation, language and narratives. Facts are not neutral and knowledge always involves interpretation. According to narrative psychologist Crossley (2000) understanding language as one of the vehicles which makes experience meaningful, is central to grasping the unique 'order of meaning' characteristic of human consciousness. The basic principle of narrative psychology is that individuals understand themselves through the medium of language, through talking and writing, and it's through these processes that individuals are constantly engaged in the process of creating themselves.

This emphasis on the importance of language was established by Freud, on a practical level in his talking cure and on a theoretical level in his impressive body of work. Freud was one of the first to pay attention to the stories his patients told him and understand subjectivity biographically, meaning that the present day relations, experiences, actions, and identities that form subjectivity are given meaning

and salience in face of past experiences, actions, identities and relations, be they conscious, unconscious or imaginary. One of the many important discoveries Freud made is the concept of 'Nachträglichkeit' (in English: deferred action, or afterwardsness). By this insight, Freud discovers that infantile experience and the meaning of that experience are not related in a simple one-to-one relationship. Incidents can be experienced as unremarkable or even satisfying while they occur, but can later be reinterpreted- or maybe interpreted for the first time- and become suddenly traumatic.
Human beings are first and for most speaking beings, who actively create, recreate, and accord meaning and sense to the world around them through language.

In his 'retour à Freud', Lacan went back to the basic ideas in Freud's writings using a structuralist approach and adding a strong emphasis on language as mediator for any knowledge (focus on signification). Lacan aimed to deconstruct the notion of the unitary subject as a myth and put in its place an account of subjectivity which is fundamentally decentred from consciousness. Lacan (1977) claims that subjects are themselves 'spoken' by language. But he tended to over-emphasise a universal and timeless symbolic order resulting in a rather universalist and pessimistic view. In their book '*Changing the subject*' Henriques, Hollway, Urwin, Venn & Walkerdine (1998) demonstrate that the Lacanian account can be reworked in such a way as to produce a more historically specific reading -one that is consonant with the emphasis on the importance of understanding the unconscious as central to approaching subjective change- shifting the emphasis to discursive relations, viewed in their historical specificity instead of Lacan's Symbolic. They further adopt the concept of 'positioning' within discursive practices meaning that discursive relations are produced through positioning in discursive practices. Verhaeghe (1994b) engaged in a similar endeavour applied to clinical practice. Both approaches share that the subject is interpellated (or hailed) by a variety of discourses, taking up (or having imposed upon her) a multiplicity of discursively constituted subject positions from which to speak and be spoken to.

The Lacanian subject is constantly constituted and reconstituted in talk and text and only shows itself through the gaps in language, which implies a constant interaction between subject and the bigger whole (the social context as represented in the different discourses). This bridges the gap between post-Lacanian psychoanalysis and the contemporary narrative approach. Using narrative, the 'self' can be located as a psychosocial phenomenon, and subjectivities seen as discursively constructed yet still as active and effective. Material social conditions, discourses and practices interweave with subjectively experienced desires and identities and people make choices, reconstruct pasts and imagine futures within the range of possibilities open to them (Andrews, Day Sclater, Rustin, Squire & Treacher, 2000). The particular story told, the manner and the detail of its telling, the points emphasised, the morals drawn, all represent choices made by the story-teller. Such choices are revealing, often more so than the teller suspects (Andrews, et al., 2000). This focus on language, meaning, and interpretation, and the characteristic of story-telling to contain significances beyond the teller's intentions, is yet another similarity to psychoanalysis. The same idea can be retrieved in Hollway and Jefferson (2000) who motivate their combination of psychoanalysis and narrative research through arguing that some

autobiographical narratives express, to an interpretive researcher, a 'story' of unconscious affect, spelled out in associations, gaps and idiosyncrasies of language rather than in its overt narrative content and structure.

Due to this focus on language, however, the notion of a fragmented subject emanates, a subject divided by the various discourses it takes on. Juliet Mitchell describes this Lacanian subject as follows:

> *"The analysand's unconscious reveals a fragmented subject of shifting and uncertain identity. To be human is to be subjected to a law which decentres and divides: sexuality is created in a division, the subject is split: but an ideological world conceals this from the conscious subject who is supposed to feel whole and certain of a sexual identity"* (cited in Henriques et al., 1998).

The same fragmented identity can be retrieved in some narrative approaches: human subjectivity itself is diverse and fragmented, and carries within it the pushes and pulls of various available narratives, which are contingent upon social and cultural positioning (Andrews et al., 2000). However, this divided subject constitutes a problem because from a post-structuralist perspective, then, not only are we not the authors of our 'own' words but further, we cannot be said to have any (authorial) identity independent of our subjectivities, of our own, and others' texts. We are the discursively constituted sites from which we 'fiction' ourselves in a multiplicity of culturally available ways (Henriques et al., 1998). This appears to be in sharp contrast to narrative psychologist Crossley (2000)'s stance, who argues that if we examine the full range of experiences, knowledge and understandings of the self that people live and struggle with, therein a sense of unity, continuity, and coherence can be found which simply does not gel with the radical fragmentation, disunity and absence promoted in the theoretically and methodologically confined agendas of postmodernism and discourse analysis. Crossley (2000) further argues that postmodernist approaches considerably overplay the disorderly, chaotic and variable nature of contemporary human experience. On a routine, daily basis, there is more order and coherence than such accounts suggest. She claims that this is nowhere more apparent than in case of trauma because traumatising experiences have the capacity to painfully highlight the normal state of narrative coherence which is routinely taken for granted and thus remains 'unseen'.

Both ways of conceiving the subject are valuable. In order to reconcile the postmodernist divided subject with the inner coherence as promoted by Crossley, I will emphasise that although the subject is fundamentally divided, some kind of sense of the self, a private construction of who she is in the world is created. This imaginary sense of coherence, continuity, unity and meaning will be called 'subjective reality'[23]. In post-Lacanian psychoanalysis this is described as a complex Symbolico-Imaginary construction around the core that constitutes the subject namely 'le fantasme' (the fantasy). This very

[23] Bar-On (1999) claims that in order to move ahead in life by approximation, we tend to behave and construct our identity as if it were all of one piece, rather than voicing our lack of coherence. We are so committed to our constant expectations of ourselves and others that unless and until these are severely damaged by our normalized discourse, we will prefer to go on as if the coherent image is the only valid one.

private construction guards the subject from the potentially traumatising Real and provides the subject with an illusory sense of identity.

4.1.4 Some psychoanalytic notions

In this thesis certain psychoanalytic concepts will be used implicitly or explicitly. In my analysis I will adhere to Hollway and Jefferson (1997)'s notion of a psychosocial subject, which stresses that an individual is simultaneously psychic and social, and suggests equal respect has to be paid to the particularities of each human being. Therefore psychoanalysis' core notion of a dynamic unconscious is adopted, conceptualising people's actions as unconscious, motivated and conflictual. And it is acknowledged that the social is equally determining, according to the Foucaldian idea that subjectivity is a product of positioning in discourses. Following Hollway and Jefferson (2000) I attempt to move away from discourse determinism[24] (the increasing tendency to read subjectivity only through the discourses) by focusing on the question why discursive positions are occupied by the subject.

Another important psychoanalytic notion is the one of 'defended subject'. This implies understanding the effects of defences against anxiety on people's actions and stories about them. Based on Freud, 'investments' are described as someone's desires and anxieties, probably not conscious or intentional, which motivate the specific positions they take up and the selection of accounts through which they portray themselves (Hollway & Jefferson, 2000).

In the analysis of trauma and addiction narratives the psychoanalytic concept of repression is very valuable, especially as operationalised by Billig (1999). His main argument is that language, or rather dialogue, provides the means of repression. The objects of repression are themselves formed in language, the psychic battleground exists within language, between what is permissible to be said (and to be thought) and what is impermissible. Because we speak, we have desires which must be repressed. If these desires, which are evoked by language, are not repressed then language, and the moral order, would be threatened. Language is fundamentally both expressive and repressive. According to him, basic repression might be considered as a form of changing the subject. It is a way of saying to oneself 'talk, or think, of this, not that'. One then becomes engrossed in 'this' topic. So 'that' topic becomes forgotten, as do the words one has said to oneself in order to produce the shift of topic. Changing the topic of conversation is not necessarily a sign of repression, but further signs might be suggestive. An observer might suspect that the movement *away* is dominating the movement *towards*, especially if the speaker continually changes the subject when a particular topic is mentioned. The observer might surmise that the speaker is not fully aware of what they are doing, so the avoidance appears automatic rather than deliberate. Perhaps, the speaker shows outward signs of resisting any invitations to talk on

[24] This is in line with Day Sclater (2000) who states that human subjects, far from passively slotting into the positions provided for them by a range of dominant discourses, are more likely to actively interpret and negotiate, or even challenge and resist, the prescriptions for acting, thinking and feeling the dominant discourses imply.

the avoided topic. And, maybe, what the speaker actually talks about betrays tell-tale signs of the topic they seem to be avoiding (Billig, 1999).

In the subsequent analysis, defences, investments and repression will be bundled in the term 'Motivated forgetting', meaning that the forgetting is not deliberate but certain topics are omitted, silenced or avoided in the life-story, because they are invested. The forgetting serves to defend the subject. Other important strategies are: reversal into the opposite, where a reaction formation against a threatening content reverses the anxiety provoking content into its counterpart (hate becomes love, resentment becomes interest, fear becomes passion); condensation, meaning thoughts or feelings are accorded a tag with elision of its primary referent, in order to negate the possibly disturbing impact; and displacement, which concerns a continual substitution of emotions or thoughts where the original referent still exists but is socially unacceptable and therefore transferred onto a safe issue.

Thinking of trauma and addiction another important term comes to mind, namely dissociation. Dissociation is an automatic coping or survival response to traumatic experiences, and entails a mental escape when no other escape is possible; a slipping of thoughts and functions out of control of everyday consciousness (Janet, 1889, 1898). Most often awareness of thoughts and functions disappears, resulting in memories inaccessible for everyday consciousness. This can be partial (certain aspects of the trauma, emotions or cognitions) or complete (total amnesia). Experiences that are disconnected from everyday consciousness are difficult to assimilate into the personality, resulting in fragmentation.

Further on, interviewer reflexivity will be used namely attention to transference and counter-transference processes. Transference is the subject's unconscious projection of repressed wishes and desires on the person of the analyst, often through identification of the analyst with an important childhood figure. In Lacanian terms it is the subject's demand for love directed towards the Sujet Supposé Savoir, the one who is supposed to know (Lacan, 1973). Counter-transference is the whole of the analyst's unconscious reactions to the individual of the analysand, especially to the analysand's own transference (Laplanche & Pontalis, 1973).

By using all the available evidence, respecting core psychoanalytic notions of defences, investments, unconscious wishes and desires, repression (as operationalised by Billig, 1999), reaction-formations such as reversal into the opposite, condensation and displacement, combined with Hollway and Jefferson's psychosocial subject, and reflexivity of the interviewer, I will try to explain otherwise contradictory material. For that purpose I will conceptualise the structure of a narrative by free association, following Hollway and Jefferson (1997). Free association means going further than whatever chronology or logical sequencing can be found in the told narrative and trying to access the underlying meanings via links based on spontaneous association, thus following an emotional rather than a cognitively derived logic. Free associations defy narrative conventions and enable the analyst to pick up on incoherencies (e.g. contradictions, elisions, avoidances) and accord them due significance.

4.2 TRUTH VERSUS NARRATIVE: THE QUESTION OF THE 'REAL'

4.2.1 The Private versus the Public

How reality is conceived and which value is attached to certain statements or data depends on the setting from which one starts and the broader aim. On a societal level we can distinguish two fields namely: the private (individual) versus the public (social), or the clinical versus the juridiciary. These domains mutually influence each other, but start from two different paradigms (humanism/ discourse-analytic/ psychoanalytic versus logic-positivistic).

The logic-positivistic approach aims to represent a quantifiable account of reality, adopting a cause-effect approach to explain observed phenomena and bundle quantifiable symptoms in a syndrome that can be treated. Applied to the field of trauma and addiction we can find a number of quantifiable criteria described in the DSM-IV that form Acute Stress or Posttraumatic Stress Disorder and Substance Abuse/ Dependency.

This emphasis on tangible, external causes and objective, observable facts, and a set range of affective, cognitive and behavioural responses contradicts the focus on subjective interpretation and the role of intrapsychic processes as mediator of the individual's engagement with external reality as described in humanism/ discourse analysis/ psychoanalysis. The narrative approach stresses the fact that reality is (re)constructed in the stories we tell: "The event is not what happened. The event is that which can be narrated." (Feldman, 1991); "Everything can be narrated. But what is narrated is no longer what happened" (Daniel, 1996). Experience, if it is to be remembered, and represented, must be contained in a story which is narrated. We have no direct access to experience as such (Denzin, 2000). Historical reconstruction and 'objective' accounts of events occurring across time, may not be the primary concern in a life history; what is, is how people see themselves at this point in their lives and want others to see them (Atkinson, 1998).

The assumption that all experience and knowledge is mediated by language is shared by psychoanalysis, but apart from that psychoanalysis presupposes unconscious processes and focuses on fantasy, desires and wishes. Lacanian psychoanalysis also presupposes a Real unattainable for the subject and potentially traumatising at each encounter. The duality between honesty and fabrication, reality and fantasy and ambivalence and splitting are issues that are dealt with in psychoanalytic therapy, but the question about the 'Real' will become highly weighty when legal actions or other societal changes are supposed to follow disclosure of certain memories. In a therapeutic environment the focus lies on individual reality, which clashes with court's focus on historical reality and quantifiable data.

An excellent example of the inappropriate blending of two different paradigms is provided by the entire 'Recovered Memory' debate. The confusion of the facts (historical truth) with story (narrative

truth) constituted the core of the discussion, serving as a demonstration of the consequences of uncritically transferring knowledge gained in one field into another field. The regained memory movement triggered fiery discussions about the reality of memories of childhood abuse that were retrieved during therapy. The false memory group argued that these memories were suggested by the therapist to the client. This exemplifies a major paradigm-clash where the juridiciary frame (quantitative, causal, rational, logic-positivistic thinking) is confused with a therapeutic setting (qualitative, associative, emotional, empathic, supportive). Mc Farlane, Weisreth, and Van der Kolk (1996) argue that the false memory debate is, at least in part, a product of the adversarial environment of the courtroom, where selective attention is paid to only one side of the argument in order to defend the accused and to promote doubt about the accuracy of the victim's testimony (which included reintroducing the old issue of suggestibility in women who seek redress for their claims of past abuse). The 'false memory' issue illustrates that when the discoveries of psychiatry come into conflict with society's cherished beliefs, psychiatry has traditionally been vulnerable to giving up the pursuit of science and, instead, to conforming to predominating societal attitudes.

4.2.2 Which Reality should Prevail?

Psychotherapy deals with subjective reality, the individual construction of a person to make sense of her life. Crossley (2000) questions which account should prevail in clinical practice: the narrative truth, the construction of a pleasing, coherent and persuasive story, or the historical truth[25]. She concludes that in interests of both psychological growth and in recognition of the imbalanced power relations intrinsic to many human relationships, therapy is committed to the pursuit of narrative reconfiguration but also maintains a commitment to the 'historical truth' (Crossley, 2000).

In this research there was no single historical truth available, beyond one's feelings and internal reconstructions. In case an externally verifiable truth is unavailable, we typically seek recourse in moral judgement and normalizing discourse[26]. Earlier on I elaborated the link between interpretation, language and subjectivity, which has as logical consequence that the recounted story is never a simple reflection of the individual experience. The social construction of individual experience, and the way in which such stories are embedded in social and political relations of power, have to be taken into account. But there is however a big difference between acknowledging that a variety of frameworks can fit the same set of facts rendering them differentially significant, and denying the existence of

[25] For instance a woman who suffered severe emotional abuse as a child at the hand of her parents might find it more pleasing to imagine that she had a wonderful childhood in which she was loved and cared for. Or the woman who is beaten up by her husband every night might manage to convince herself that everything is hunky-dory, her husband totally loves her, the future will be bright and so on. Yet neither of these images conforms to the 'historical truth' of the past and the 'life' of the future (Crossley, 2000).

[26] If we grant that there's no possibility of simply speaking of 'objective' historical facts, a historical 'truth' which exists independently of the way we construe it, then we are left with the fact that this question cannot be separated from the 'moral visions' with which we operate (Freeman, 1993).

those facts. Therefore I will argue that there is a complex relation between 'historical reality', or in Lacanian terms the 'Real', and 'subjective reality' or 'narrative truth'.

4.2.3 Subjective Reality and Scientific Knowledge

Whereas I conducted qualitative research, listening to the subjective accounts of the lives of traumatised addicted women, I consciously chose not to abandon certain parts of the logic-positivistic literature completely and used them as a model to make sense of certain phenomena in the practical field. The link between this 'Real' and the subjective reality can be found in the following process: scientific publications lead to medicalisation and psychiatrisation of certain concepts which later filter through in lay-psychology as adopted by (women's) magazines and other media, after a while these concepts are accepted as common knowledge, and are actively used by individuals to name and make sense of their subjective experiences, in either defying or complying with that knowledge. The main point is that the medical, psychiatric discourses become popularised and are adopted by lay-persons who actively (re)construct their experience according to the popularised discourse. This became obvious to me while conducting my research through the fact that not one of my participants asked me what I meant with 'trauma' and 'addiction'.

I will adopt these logic-positivistic notions with caution because a psychiatric diagnosis never goes without implications in the broader social context. The whole process of medicalisation and psychiatrisation can have detrimental effects on the individuals involved, and has in the past served to stigmatise and subdue women. Verhaeghe (1996) demonstrated this extensively in his book on women, hysteria, and psychoanalysis[27]. Ann Levett (1988) made the same point but added a link with over-protection and perpetuation of existing power-structures. She argues against the determinism of the cause-effect approach in mainstream trauma-literature and cautions against a too frequent labelling of traumatised people because this might have severe consequences for the self-agency of the individual[28]. This same tendency to 'blame the victim' was noted by Crossley (2000). She documents that in recent years 'therapeutic' or 'healing' discourses have become very popular in informing the way in which we experience ourselves in the aftermath of various traumatic events and experiences. With this healing narrative the emphasis shifted away from the social, moral, and political context of patriarchal power and exploitation, on to a concern with the psychological dynamics of individual family history.

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[27] Verhaeghe (1996). Tussen Hysterie en Vrouw: Van Freud tot Lacan: Een weg door honderd jaar psychoanalyse. Leuven/ Amersfoort: Acco.

[28] "In the area of child sexual abuse most effort has gone into the care of casualties. However, what we have are discourses and discursive practices which are intended to be helpful but in fact perpetuate existing power structures. A great deal of attention is paid to victims of one kind or another, little to the perpetrators (equally caught up in the problem). Little attention is directed at notions of resilience and active resistance which always need to be recognized and characterize the strategies of the socially powerless" (Levett, 1988: 4-5).

4.2.4 Trauma as Metaphor

The question of the Real and the construction of subjective reality constituted my first stumbling block in establishing contact with addiction treatment. The counsellors seemed rather protective of their clients and feared that by talking about 'trauma' I would suggest 'trauma', which could then be used as an excuse to continue abusing substances. Blaming addiction on life-events is unlikely to happen only under influence of the research. Another remark is that for some addicted women trauma can serve as a useful metaphor to describe oppressive life-situations many women encounter (Karsten, 1993), the first signifier that can constitute the beginning of a whole chain of signifiers that elaborate the event, in other words, trauma can be a label to describe numerous events and can serve as a starting point for working through these experiences by gradually according more words.

Ann Levett (1988) acknowledges the fact that certain women use trauma as a metaphor but doesn't necessarily name it positive:

> *"...the term trauma also offers a convenient peg on which women may hang a diverse range of complaints and difficulties related to gendered subjectivity and interpersonal problems."(p. 325) "Complaints about (or disclosure of) experiences of childhood sexual abuse among women serve as a focusing symbolic communication to convey a woman's sense of helplessness in the face of the problems of being human and a woman" (p. 332). "Within dominant paradigms of explanation, the presumed consequences of sexual abuse are used to understand current problems -in relationship, in sexuality, in self-perceptions. Many of these problems have to do with being a woman, a member of a group for whom a wide range of daily experience is conflictful and difficult in particular ways. In certain of these, oppression takes a specific form in what are experienced as inescapable aspects of gender-based subjectivity and sexual relating." (p. 326). "The metaphor of trauma is a powerful one in discourses of control. It may evoke emotional investments in victimization, and contribute to the discourses of protection of those defined as vulnerable. Ideas of psychological damage produced by certain experiences- the traumatic effects of child sexual abuse- are subtle manifestations of the discourses of control of women and children, and need to be recognized as such." (p. 318).*

Whereas Levett focused rather on the negative implications associated with the label child sexual abuse, I will argue that the more general metaphor of trauma to cover day-to-day oppressive situations for women can work in empowering ways for female addicts because it can serve as a first labelling of otherwise indescribable and undiscussable experiences.

4.3 APPLIED METHOD

After this long detour in which I tried to clarify the theoretical and methodological framework of this study, I will describe how I practically conducted the actual research.

4.3.1 Selection of Subjects

Fourteen interviewees were recruited from two different inpatient addiction treatment centres. The counselling team was informed about my research and either they would suggest or recommend a suitable candidate, or I would briefly present myself and my research in front of the female population at a certain moment in treatment and inquire who was interested in being part of the study. Both the treatment centres have a program with an approximate duration of 3 to 4 weeks. For a number of reasons the counselling team preferred the research to begin in the second week of treatment, which would accord me sufficient time to conduct my interviews within the containing setting of the treatment centre. If there was not enough time available during treatment, the woman was seen at another agreed upon location (e.g. her home or a coffee house) and some back-up system was provided. Namely, in case the interview procedure brought about uneasy memories or unprocessed emotions the woman was informed about the possibility of further counselling, in the form of a referral list that was discussed in detail and handed over to her. To guarantee anonymity all cases are referred to with pseudonyms that match their cultural background. These were chosen out of a list of women's names a third party drew up.

4.3.2 Safety

After the initial acquaintance procedure a date for the first interview was agreed upon. When discussing topics as trauma and addiction safety is an important issue because traumatised people typically suffer from a sense of alienation and a disruption of the basic trust, and most addicted women are isolated and suffer from lots of shame, self-blame and guilt (see above). Therefore the first session aimed to create a safe environment in a number of ways. Information about the interview procedure, the method, and the research was provided. Each woman was informed at the onset how much time we had available, and that she was in control of the actual duration and the brakes. A confidentiality contract was signed by both parties, stating that the interviews would be strictly confidential but feedback would be given to the counselling team in order to assist the woman in case the interview procedure was disruptive; the referral list was discussed; and if the woman seemed to feel comfortable with the whole setting the actual interview could start. Interviews were conducted in such a way that the interviewee had primary responsibility for structuring the account, generating its content and moving the narrative onward.

4.3.3 Procedure

The first interview started with only one question namely: "Tell me your life-story and anything you think is important for me to understand who you are at this moment". After that the interviewer would interfere very little, mainly displaying empathic listening responses and asking clarifications if needed. Each interference tried to stay as close as possible to the interviewee's meaning frame by using both the ordering and phrasing of the interviewee.

Recounting the life-story in front of a group is part of the treatment program in the two inpatient treatment centres, therefore most women felt more at ease that they could talk about a subject they already had to think about beforehand. In some cases I was part of this actual life-story presentation. This preparation could be conceived as contradictory to a spontaneous account of the life-story but many women told me afterwards that they added information and took another trail than during the life-story-presentation in front of the group. In the individual sessions there was more time available, allowing for more detail and elaboration, and possible immediate clarification (or in one of the later sessions) resulting in a fuller picture of the life-story.

People's individual capacity in story-telling differed a lot. Normally once an enabling, non-threatening atmosphere was set the stories came quite easily, certainly when the women realised that it was my aim to hear their account, and that they were allowed to divert and elaborate wherever they wanted. But in four cases the story-telling didn't go that fluently, therefore more questions had to be asked.

The first session took between 1 and 2 hours depending on the available time in the program, the pacing and willingness of the interviewee. The primary goal was to make the interviewees feel at ease and set the right climate for disclosure to an interested, non-judgmental listener. The voluntary nature and control over end/ pauses was repeatedly made clear to each interviewee. A lot of time was spent as well on closure of the session (what was it like?; any comments/remarks?), in order to reduce the disruptiveness of the interviewing process and ensure cooperation in the further interviewing process.

Immediately after the first session extensive notes were taken, documenting non-verbal communication, para-linguistics, remarks, and feelings evoked in myself during the interview process, because these provided indispensable clues on how to interpret certain verbal expressions. Subsequently the audio-tape was transcribed and a preliminary analysis was conducted, paying particular attention to incoherencies and contradictions in the story; places where the divided subject erupts throughout the attempt to produce a consistent narrative or life-story. The first interview enabled me to pick up the contradictions, inconsistencies, avoidances and changes of emotional tone. The second interview would act as a further elaboration of these inconsistencies and voids. It also gave the interviewees a chance to reflect.

Out of this preliminary analysis further open-ended questions or topics of interest were generated in order to elicit stories for the second interview, again with minimal interference of the interviewer and using the wording of the subject. For instance, "Last time we spoke you mentioned a suicide attempt/ your father's temper/ a car-accident, could you elaborate a bit more on that?". In the second or third interview seven topics were discussed with each interviewee, not necessarily in the given form and order. The first four topics constituted a different way to create a fuller picture of the person being interviewed and her personal style of story-telling:

1. What is your first memory? This question explored possible screen-memories[29], which might provide a route for recovering forgotten and decisive experiences of early life.
2. What is your happiest memory? This probe aimed to get to know the interviewee a bit better and provided a possible counter-action for the following question and the disclosure of trauma.
3. "What is your saddest memory?" tried to reveal the emotional salience of previously shared experiences or allowed forgotten events to be narrated.
4. Probes around self-description aimed to get an idea of the self-image.

The other three topics were more focused on the personal experience of clinical practice:

5. Did they encounter trauma in their lives, and what would they call traumatic? These questions were used to compare the researcher's perception of trauma with the participant's and tried to establish the usefulness of trauma as metaphor for addicted women's life-experiences.
6. "Opinion on addiction treatment?" aimed to elicit helpful information towards addiction treatment, namely how do they think treatment can be improved for addicted women and how effective do they think the overall treatment programmes are?
7. Treatment history? This probe was another way to gain less obvious information about previous psychological or physical treatment.

The second interview was generally shorter (in between 45 minutes and 1, 5 hour). After the second interview the same procedure was followed and if warranted a third and fourth interview was conducted. The interview process took place until the whole life-course was covered including some detected incoherencies and contradictions, with respect for the wishes of the interviewee. In the majority of the cases one or two interviews were sufficient to gather enough data, in two cases a third and in one case a fourth interview was warranted. Typical termination consisted of evaluating the personal experience of the interview process, confirming their knowledge of the support system,

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[29] Billig (1999) argues that Freud's hypothesis of 'screen memories' which he outlined in a paper published in 1899 and developed in '*Psychopathology of Everyday Life*' suggested that a person's earliest childhood memories seem frequently to have preserved what is indifferent and unimportant. Yet one must ask why such insignificant memories have survived the general oblivion. Freud's answer was that they expressed earlier, repressed experiences, just as dreams express hidden desires. Such memories are like a screen, on which earlier memories are projected in distorted form. These screen memories are to be distrusted. The so-called earliest childhood memory is not a 'genuine memory-trace, but a revision of it, a revision which may have been subjected to the influences of a variety of later psychical forces'. The screen-memories provide the route for recovering the forgotten and decisive experiences of early life.

thanking them for their help and reinforcing my appreciation of their help. The process was brought to a close if the interviewee had nothing to add.

All interview sessions were recorded and transcribed following simple transcribing conventions as listed below:

(.)	pause
(...)	silence, an extensive pause
...	conversation trailing off, or trailing in
[.]	words or sentences are left out
[..]	more than one paragraph of the text is omitted
italic	the word or sentence was emphasized by the interviewee; a markable change in tone of voice, which makes the word or sentence stand out
Bold	word or sentence is exclaimed
((remark))	unspoken remark, observation, clarification from interviewer to enhance the reader's understanding of the quote
question	spoken intervention of interviewer (question, remark)

After describing the methodology underlying this study and addressing some methodological problems, the actual analysis of the interview material will be discussed. A chapter on pen portraits was written which tried to restore respect for each woman's individual story. Due to space constraints this chapter was transferred to the appendix, but can still be read as an introduction to the analysis.

Chapter 5 : Discursive Patterns and Groupings

5.1 INTRODUCTION

The uttered discourse and narratives only make sense when each case is considered as a whole and read as statements coming from a defended subject (see Methodology). Reading through the whole story several times elicited meaning and gave me an idea how far the woman was on her way to work through her trauma, certainly when combined with the 'fieldnotes' on non-verbal communication, para-linguistics, remarks and comments, and own input. Pen portraits of each interviewee can be found in the appendix and comprise an introduction and a supplement to the analysis.

In the following chapters the interview material will be approached from different angles.
First I will have a look at the characteristics of the research population in order to trace certain patterns and similarities in the life-narratives across life-events and substance of abuse that might set them apart from their non-addicted counterparts. Categories are constructed, based on similarities in life-experience and type of drug abuse, and groupings for analysis of the interview data will be introduced. The next chapter will analyse the interview data on a surface level, the discourse and narratives in the interviews are looked at in order to see how certain things are expressed or silenced in language. Chapter 7 confronts the well-known after-effects of trauma as described in literature with my interview data.

In chapter 2, substance abuse was described as an active way to maintain the silent state of non-elaboration after trauma. The subject doesn't form a story that can be integrated in the life-story, leaving the woman in a passive position where she is exposed to the wordless, indescribable trauma time after time. Therefore addicted women can be conceived as stuck in a repetitious, unchangeable story, suffering from a stagnated, fixed subjective reality, ever intensifying their need for an absolving substance. In order to get an idea why these women seem trapped in this narrative deadlock I focused on how addicted women give meaning to their lives, which life-events they state as being important in constructing the person they are today and what impact this had on the course of their addiction. In their stories I expect to find clues of certain unintegrated, unprocessed experiences and emotions, what I called 'trauma'.

As earlier discussed in the methodology section, in this type of qualitative research we are dealing with subjective reality, narrative or discursive facts. For the sake of fluent writing and reading, narrative facts are sometimes described as historical facts in the body of the text. However, I want to make absolutely clear that any claims about the reality of the experience will be dismissed. My focus on 'subjective reality' presupposes a reality that is ever changing, where the past is always (re)constructed in face of the present, the possible future, and according to the listeners. Although this

might be a distorted version of 'reality', the 'subjective reality' is the reality we live by/ in and which is most salient if we want to gain better insight in the world of the research individuals.

5.2 CERTAIN CHARACTERISTICS IN THE RESEARCH POPULATION

Due to the limited research group it is not appropriate to draw conclusions about discursive patterns for the whole population, but I can report on some narrative trends found in this study:

5.2.1 Trauma

When recounting childhood experiences certain similarities could be retrieved. Most of the interviewees described one or more of the following situations that could be termed as:

- Being an adult child, where the child is not allowed to be a child but fulfils the function of one of the parents or takes over certain adult responsibilities like child-rearing, counselling her mother, and doing domestic chores (two were raised in a single-parent family).
- Insecure or ambivalent attachment, a situation where the child receives inconsistent affirmation and disapproval, positive and negative reinforcement, without a link to external cues. This leaves the child doubtful about the parental love or hate. Most women found a lack of physical contact, absence of one or both parents, and inability to communicate, very damaging.
- Being the Benjamin of the family, with three or four siblings being a lot older than them, thus growing up alone with parents from an older generation who have difficulties letting go of the last one. Those women felt left out and envied by their siblings, over-protected by the parents, and pressurized to fulfil high expectations. Another recounted phenomenon was a big age gap between the siblings, which often resulted in similar effects; and if the woman additionally was the middle one she described herself as being the mediator or scapegoat of the family.
- Being the only girl amongst three or four boys. These women describe feeling "different" than their siblings and experiencing more difficulties blending in a group of females and assuming sex-role-stereotypes.
- Social promotion: Many women narrate being raised in a poor family and now managing to build up a better standard of living. Following reactions were shared: breaking with the poorer rest of the family, splitting them off as "common people" and looking down on them; experiencing the self as "not deserving" of this better situation and trying to sabotage the gained benefits; keywords such as "glamorous/classy", "Cinderella", "image/looks" which indicate that a fake self or the perfect appearance takes in a prominent place in their life-story.

In the second interview session women were asked what kind of traumas they had encountered in their lives. A general finding was that they didn't term their chronic negative child-rearing conditions as

traumatic. The section 'acute individual trauma' (see below) represents a better picture of what these women called 'traumatic'.

Some of the Chronic Individual Traumas that were recounted were:
Emotional neglect and abuse: Three women related emotional neglect and abuse by father only (2 of them now struggle with authority), one woman was severely physically abused by her father (2 others seemed to have been treated quite violently by their father but do not explicitly call it abuse); one woman was emotionally and physically neglected and abused by her mother; six women recounted some form of emotional neglect and abuse by both parents, three of them related physical abuse by both parents.
Other narrated events were sexual harassment by the father (1) or brother (1), witnessing parental physical violence (3) or emotional abuse (7).
Addicted family: Eight women had an alcoholic father. All female alcoholics had a drinking father. In four cases the mother was addicted to alcohol and/or pills.
Absence of care taker: In two cases the mother was absent due to a chronic illness.
Divorce: Three women's parents got divorced during their childhood or teens.
Adoption: Three women were adopted as a baby and were brought up knowing they were adopted.
School: Three women were teased/bullied at school.
Repetition in later life: In their later lives two women got divorced, five of them experienced partner violence, and eight were co-dependent with their partner (all young drug-addicted women were involved in a co-dependent relationship).

Summarizing, we could say that 12 women recounted experiencing some form of parental abuse during their childhood, which might suggest a lack of stable grounding and 'basic trust'. The lack of a solid background in case of chronic trauma seems to show through in later life where these women term themselves as incapable to trust their partner, and relate ending up in abusive relationships or highly ambivalent dependent (clinging-rejection) relationships. Only two in 14 claim to have had a normal, nurturing childhood with warm and loving parents, but described experiencing what I call an acute trauma.

Acute Individual Trauma:
Life-events that the women called traumatic in the course of their lives were: being rejected by their boyfriend (4), sexual harassment (4), rape (3), having an abortion or miscarriage (3), being involved in a car-accident (4), and harm to loved ones (9) such as illness, accident, death.
Frequently reported as traumatic was the immediate precursor of the decision to come to rehabilitation (car-accident, confronted by parents/husband, fight with partner, etc.) and having to admit that they need help.

5.2.2 Previous Treatment

Twelve women received previous treatment in mental health care[30]; the most frequent complaint was depression. This is in accordance with international literature claiming that women initially come to treatment for a more socially accepted disease. Additionally we learned from the previous characteristics that trauma takes a major part in the life-stories of women. This makes it equally understandable that they want to do something about their depression, which some of them experience as the trigger for their drinking, drugging or eating problems.

Only two women did not receive previous treatment. Some went for individual counselling with a psychologist or psychiatrist (who didn't really pick up the substance abuse), others had a whole history of treatments, substance related or not (combined drugs group).

5.3 GROUPING ACCORDING TO SUBSTANCE

According to substances I divided the women in three groups - 'Alcoholics', 'Drugs addicts', and 'Combined addiction to alcohol, drugs, and other'- because different substances achieve a different effect and fulfil a different function. Therefore it is expected that the individuals in one grouping will have certain characteristics in common and will display more intra- than inter-group similarities. I will also indicate the categories used in the further analysis.

5.3.1 Alcohol (Marie, Joanne, Ruth, Kate, Lorna)

Members of this grouping were mostly older women (mean age 36,2), which is consistent with the internationally accepted idea that alcoholism in females is 'telescopic', namely it has a later onset (middle and late 20s) but quickly progresses to reach damaging effects (marriage problems, work position threatened, and damage to the liver). Drinking excessively is a private action, it happens secretively.

All these women relate having (had) an alcoholic father, and four of them narrated verbal (and physical) abuse by him. Two of them recount emotional and verbal abuse and neglect by their mother. The fifth one (Lorna) didn't grow up with her biological parents. The four abused women (Marie, Joanne, Ruth, Kate) grew up in a chronic negative environment characterized by powerlessness, lacking possible agency to change anything except from moving out and/or getting married. Typical is that the negative educational situation seems internalised, stagnating further growth, reinforcing their negative

[30] See Appendix B

self-concept, and curtailing the capacity to break the self-fulfilling prophecy that they are no good and not contributing to the world or anybody's life.

> Joanne is genuinely baffled about the support her family gives her: "Through all of this, one thing I can't come to grips with is 'why is my family still there for me?' Give me an instance, give me a situation, and ask about abuse and yes, I can, I abused them in every way."

One woman (Lorna) is different from the rest of the group in that she grew up in what she described as a stable, nurturing environment. She experienced two seriously disruptive events in her adolescence that shook her self-image and world-view: at age 13 she discovered the real reason for her adoption namely being an illegitimate child, at age 17 she was involved in a life-threatening car-accident that had a deep impact on her body and looks.

All female alcoholics were full-time employed most of the time, with alternate periods of being housewife while child-rearing (3). This contradicts the picture of the uneducated, dependent housewife who secretly drinks to cope with boredom. One of the factors contributing to their admission was ill-health (liver) or tremors threatening their employment and independent income. Two of them have university degrees, two completed secondary education, the oldest (Marie) only went to school till age 14. Most of them are married or engaged, one was a single divorcee (Marie).

According to their particular stage in life, part of the interview focused on their partner-relationship, marital problems and the damage they have done to their family. This can be read as the usual shame and guilt alcoholics experience once they become aware of the impact the alcoholism has had on the people living around them. In the beginning of the treatment alcoholics typically play down their alcohol abuse. There's a constant movement between denial and awareness of the alcohol problem.

Alcohol is used as a coping-strategy, the substance serves as self-medication for negative emotions such as low self-esteem, depression, stress, anger, grief, and gets out of hand after a while:

> Marie: "My alcoholism is depression- and stress-related. [.] I only drank at night, to go to sleep, but obviously I drank too much."
> Joanne: "I had my first glass of wine at 26. I didn't like it very much, but the feeling, the way it made me feel, so chilled and laid-back, that was nice, that was really nice."

5.3.2 Drugs (Sandy, Tracy, Elsie)

This group consists of three young women (mean age 19) who got hooked in their adolescent experimenting phase. Looking at their life-story we encountered either chronic trauma such as verbal abuse, physical abuse and emotional neglect, or a series of acute trauma.

Elsie recounted experiencing several acute traumas (2 car-accidents at a young age and 2 events of sexual harassment) but claimed to have grown up in a nurturing environment.
The rest of the group was fairly similar to the alcohol group in terms of childhood and adolescent experiences of chronic trauma, both absorbed lots of negative comments they continuously heard while growing up and tended to blame themselves for everything. However, the drug-women were a lot younger than the female alcoholics. The age difference resulted in other topics being more significant to them and emphasis given to other topics.

The identity-question took in a much more prominent place in their discourse because the development of an own identity was curtailed by their drug abuse. The drug functioned as a short-circuit for the normal process, and substituted the self and any identity-question, therefore they were more at a loss about who they actually are. Once in treatment the identity as 'junkie' or 'druggie' and identification with their drugging peers was questioned and proven defective. Therefore these young women were confronted with all adolescent developmental tasks such as self-assertion vs. attachment, emancipation vs. loyalty, and freedom vs. responsibility. All three of them used substances to rebel against their parents, a way of doing things independently, an attempt to fit in a group. For them the loyalty issue was even stronger because after treatment they would return to live with their parents (who were paying for their treatment), which definitively influenced their discourse about their parents. The description of the home-situation was marked by great ambivalence, denial, and contradictions. For instance when Sandy was asked about her parents' relationship, she claimed that it's "fine, very good", followed by a contradicting elaboration, eventually complying with her father and putting the blame on her self:

> Sandy: "My dad is a verbal abuser. So he verbally abuses mom and me quite a lot, calling us names, bossing around, and (.) he's very loud, very aggressive. He has always been like that. He also drinks quite a lot. But not like beer (.). He doesn't drink like a whole amount he just drinks when he comes home from work, [details drink], pretty heavy stuff. He built a tolerance for it. But he was called he has to stop drinking because of high or low blood-pressure, or one of the two, because it's causing him heart problems. But he blames me for that, you know, the reason his heart fails is because of all the trouble I'm putting him through (..)."

The search for an own identity and a purpose in life was further illustrated in their unfinished schooling, frequent job changes and co-dependent relationships. Two out of three dropped out of school and weren't able to keep a steady job. All of them had been involved in a co-dependent relationship. None of them had children.

The autonomous effect of the drugs, namely the physical dependency and impact on the neurochemistry, combined with the early onset (12-16y.) resulted in stronger consequences compared to the alcohol users. Even if active use had ceased, the after-effects lingered on: for example, while

Sandy rushed through her life-story it sounded as if she was still on speed (her preferred substance), she rattled on, trembling, and finished her story in less than 5 minutes. In these three cases the admission was motivated by a deteriorated health condition. Their bodies couldn't handle the high amount of substances any more. An additional motivating factor was the break-up of their co-dependent relationship. The impact of anti-social behaviour should be accounted for as well. Being addicted to drugs is much more expensive than alcoholism; therefore the threshold to break the law to fulfil their urge became lower. Typical anti-social behaviour such as shoplifting, petty-theft, and removing small notes from parents' wallets were frequently disclosed.

The neurochemical effect of drugs possibly inhibited mental and emotional development and had an impact on their capacity to tell stories resulting in a rather superficial account where extensive probing was needed to illicit stories. Their life-story had an associative rather than a chronological structure with the content of the associations being a mystery open for speculation to the listener. This seems rather unexpected because they had a shorter and less complex life than the other addicts. A possible explanation was that self-reflexivity happens from the present to the past, namely that it is more difficult to construct a story if you are still in the middle of it; or that self-reflective capacities didn't yet get the chance to fully develop. It also takes longer to recover from hard-drugs than from alcohol and extensive drug-use has a severe impact on logical thinking and remembering. The lack of chronology might also have to do with the fact that these girls are avoiding to think about possible unpleasant memories.

Although the narratives sometimes give the impression of being rather superficial and nonsense, there is a feeling that in this manner they reveal more than intended or than that they are aware of. Shreds of information are there but it is up to the listener to assemble the picture. This is illustrated in Sandy's story, which first provides details (her date of birth, the age of her siblings, and her parents' age) without mentioning the main point (I could deduct that there's a big age gap between the siblings, with Sandy growing up as the baby of the family, alone with rather old parents). This is followed by a sudden condensed unelaborated statement without real precursors or relation to stories or anecdotes, functioning to cover-up the past and present.

> Sandy: "My dad is head of the family. We don't see him much as he used to associate his well brought up children with trash".

Without any indication an associative sequence of sentences, a narrative, is stuck on to that, a story about her uncle who tried to recruit her at her grandmother's funeral to work in his escort agency. The meaning and value of this particular story could not be determined. It might give an idea of the ambivalent relationship with her dad who used to treasure her as his little princess when she was small (the baby of the family), but increasingly verbally abused her when she reached her teens and his drinking got worse. Her father broke off contact with his brother because of this incident which might induce self-blame in the interviewee, but it can also be read as a reconciliation attempt towards her

father because his standing up for her might mean he did love her, and maybe still does. After that she rattles on: Her grandfather died when she was 2 years old, so she never knew him (probably as opposed to her siblings), and details are provided about where her maternal uncles and aunts live. Facts and details are preferred above thoughts, emotions, and stories, serving to divert attention to 'safe' topics.

Overall the function of the substance is initially escape from negative emotions (I never felt good about myself), but the autonomous bodily impact and addictive nature of the substance itself have a more immediate effect (the feeling grabbed me), which is largely reflected in the incoherence of their life-story.

> Sandy: "I got into substances because of friends, the scene at the time. It got me really hooked and then I think I just used it as an escape route in the end. To escape my father and to escape like all his bullshit and his arguments and his nonsense. And he used to continue at me, and I just used to go and sit on the bathroom and have a session. I felt it sometimes was an escape because of my father, because I couldn't take all his criticisms or his comments."
> Tracy: "I already started with drugs before I went to live with my brother. But then it got worse because I had complete freedom. [.] It got worse because I felt rejected. [.] I had this break-up with Glen. [.] I got hooked to heroin for one month and then I stopped that because I couldn't cope and it was fine. But coke just *grabbed* me. The heroin I was not craving it or anything because I was doing it because my friends were doing it. I didn't need it and hated doing it. Coke I *loved* doing it and the feeling grabbed me. I was really getting addicted to it."

5.3.3 Combined (Nancy, Helen, Yolandi, Rachel, Nicky, Sadeedah)

This is a much more diverse group with an age ranging from 20 to 40 (mean age 30.7). Their life-stories exemplify accumulated trauma, a combination of chronic trauma and acute trauma, whereas in the other groups we had either chronic or acute trauma. Here we encounter complicated stories and equally complex addictions. Typical is an early onset of drug, alcohol and medication abuse (early teens or before).

The most significant feature that distinguishes these women from the other groups is the way in which they use substances. From the very first moment they pick up a substance they go completely overboard. There is a lot of poly-substance abuse, and every substance they use is entirely out of control. Even if their first experience with a substance was bad, they persist and try it again. The substance use is self-destructive right from the onset, as if looking for complete oblivion. But at the same time it should be considered as some dubious survival mechanism: by temporarily wiping out consciousness (and hence pain and emotions) they can continue their life as if everything is just fine.

The addiction is not only limited to substances but includes other mechanisms as well such as eating disorders and shoplifting. Nancy used fasting to deal with rejection, Helen goes days without food if she is struggling with emotions, Rachel developed anorexia to compensate her poor self-image and after therapy she moved to binging and purging to deal with rejection because she "can't sit with emotions". For Nicky her anorexia gave her a different sort of 'high' after her normal substance abuse was taken away. Rachel really loved the thrill and excitement shoplifting gave her.

The combination of chronic and acute trauma demonstrates a broad array of trauma-remnants, which will be discussed in chapter 7.

The function of the substance is to reach a state of complete numbness, unawareness, a bodily state without consciousness of the self as a thinking and living being/subject (anaesthesia):

> Nancy: "I often numb myself with drugs to feel better. In the end I couldn't cope with my job without the cocaine. [..] I discovered here that I'm drinking and drugging to cover up for any problems, thinking they would get better, made me feel better about myself. I actually wasn't making it that way."
> Helen describes her first alcohol binge as: "I drank that whole bottle of Whiskey and looked at the dress the whole night. And I mean, I think it was grief because I knew I couldn't get into that dress and. And then the next morning I was still drunk and now I think I was out of control completely. I got a second bottle of Whiskey and was even vomiting in between. But I was not eating at the time. Well I was sick, I think, at that time, but I went and bought another bottle of Whiskey and bought a dress.[..] Alcohol I no longer enjoy what happens to me. I still love the anaesthesia, but only for a very short time because once I'm beyond my third or fourth drink I can feel the fear and the compulsion and wanting to get sick and still not being able to stop. But with dope it's always made me feel kind of more relaxed. Really, I felt very few paranoia, feelings of fear. And maybe that's why I've been doing it, to control my fear."

5.4 GROUPINGS FOR ANALYSIS

In the following chapter a psychoanalytic discourse analysis will be conducted on the interview material and the field notes. The first two substance groupings namely alcoholics and drug addicts will be considered as one group because even though the substances attain different effects, similar life experiences (either chronic or acute trauma) and similar techniques to repress and deny the impact of those experiences were found. The alcoholics were typically women in their late twenties till late fifties presenting some sort of chronological narrative focusing on their partner-relationship, family and work as present problems. The drug addicts were chiefly young women, hence the interview data are influenced by certain characteristics of adolescence. Content-wise the importance of peers,

ambivalence and struggle for autonomy in relation to the parents, identity crisis, identification and strong ambivalent attachment to sexual partner, stand out. The structure of their narratives was more associative than chronological (compared to the alcoholics) emanating from the short attention span, little self-reflection, many contradictions, and problematic long term memory during adolescence combined with the stronger neurochemical effect of drugs.

The combined group differs from the two others, presenting an accumulation of chronic and acute trauma in each life-story, with an equally complex survival strategy, a combination of addiction to substances and acts (shoplifting, various eating disorders).

A further distinction will be made according to the level of working through trauma. This can be conceived as a continuum with a coherent narrative covering the whole life span including appropriate emotions being indicative of high level of working through; the lack of words and incapacity to create a comprehensive narrative constituting an expression of raw trauma; and the complete covering up and unavailability of memories indicating stagnation.

5.5 FUNCTION OF THE SUBSTANCE

Addiction and substance abuse have a specific function in the process of working through trauma, which can be summarized as a means to achieve the following effects:

1. Substance abuse can function as self-medication or coping-strategy. Initially it relieves feelings of displeasure but equally enhances avoidance and inhibition of the working through. Eventually there is a loss of control over the substance, ending in addiction. In the extreme situation the addiction will completely cover up and substitute the initial trauma.
2. Addiction can become part of the trauma-dynamics: repetition and reliving versus numbing and dissociation. The clearest example will be discussed in Sadeedah's fragmented story.
3. Addiction consists of some dubious survival strategy. The substance or behaviour is used in such a way that the same wordless, alienated state of non-being can be reached.

How drug use functions to repress any unpleasant feelings or memories is demonstrated clearly in the case of Nancy. Being a call-girl increased her drug habit ("My work was hectic" popped up several times during the interview) but the substance abuse served as a motive to continue being a call-girl, which left her hopelessly trapped in a downward cycle. Remarkable is the fact that the entire narrative circles around substance abuse, substituting a trauma narrative. When she recounts her story she gets very choked up, clears her throat a lot and starts coughing. This suggests that something of her past is surfacing and that she is craving for her usual problem solving substance at that time namely cocaine. This idea was reinforced later in the interview where she explicitly denied any craving for cocaine since she was admitted.

Nancy: "I was also doing (.) it became more involved than just table dancing. In the end I was doing call-girls to support my drug habit, you see, and it became more call-girls. It was a whole situation which wasn't very good. It was the beginning of my destruction with drugs [.] My work was hectic. I was working every day a period of 8 hours shifts and weekends as well. And now daily I would pop an XTC and drink half and snort the other half up my nose as it had a different effect that way. I was getting very little sleep so I was often popping them to stay awake and to cope with my feelings to often numb them for the work I was doing. My weight dropped drastically, I suppressed my appetite, and my addiction to laxatives was a daily thing too. Cocaine started shortly after that. I had an after-party with some girl from work. ((clears throat)). Sorry... The cocaine going around and the people who threw the party were offering it freely.[.] Because less I was snorting in the beginning, maybe a line now and then. Then it became more frequent ((clears throat, starts coughing, can't catch breath)). Sorry, what's wrong?... As the months went by and the weeks went on I eventually started to buy my own. I was still dancing and my work was hectic. I was working to pay for my habitual drug addiction. They also coincide with each other, my drugs. If I was doing cocaine I would not drink, or if I was going to dance I after work would pop an XTC... ((clears throat)) Sorry... It would make me party more. My on and off tendency to stop and start again, and tended to happen regularly without success... Whooo ((choked up, can't catch breath))... I was taking E on a daily basis." You can take a break hey... Is it because... "It's tough on me?... Maybe a bit. [.] Cocaine did make me really sexual, was an aphrodisiac for me. It made me do things that I didn't even want to do when I was in a situation and there was cocaine it would make me very uninhibited, sexually. [.] Here I discovered that drinking and drugging is to cover up for my problems, thinking they would get better, and made me feel better about myself. I actually wasn't making it that way."

As long as the underlying dynamic is not dealt with the need for addictive substances or behaviour remains very high with the addictions being mutually interchangeable. In Nicky's case if the drugs and alcohol were taken away, she started dieting and developed anorexia. When she was treated for anorexia and substance abuse, the addictive behaviour shifted to her partner relationship. And now she is physically clean, but still mentally addicted because for her addiction concerns some sort of survival-strategy.

Nicky: "I just feel like so much, to carry on. That's like *hectic*".

Chapter 6 : Psychoanalytic Discourse Analysis

Different substances attain different effects and have a different impact on people therefore I will analyse the interview transcripts and field notes according to the above-mentioned groupings. In each group the cases are discussed along their place on the continuum of elaboration of trauma, going from covered trauma- raw trauma- processed trauma, because in each different stage we can expect to find distinct ways of repressing and silencing shocking experiences. Later on I will argue that the failure to compose a coherent narrative will indicate an increased chance to relapse.

6.1 ALCOHOLICS & DRUG ADDICTS

All alcoholic women managed to construct a coherent story about their lives, but many events or emotions are silenced, denied and repressed. The narratives of the young drug addicts all seemed rather superficial and are characterized by a lack of narrative thread, having an associative rather than a chronological structure, with similar signs of repression, denial and omission. In the following section I will explore how this 'unspeakable and indescribable' manifests itself in the narratives of these women.

This group of women experienced either acute trauma or chronic trauma, therefore cases will be discussed according to this division. Two women experienced acute individual trauma, namely Lorna and Elsie. Lorna's case provides a clear picture of what happens if a person with a normal background experiences a shocking event and which strategies can be used to deal with it. Elsie's case reflects the severe impact the early onset of a sequence of two acute traumata can have on the personal development, resulting in an inability to accord words and early susceptibility to substance abuse, which again lead to a vulnerable position and retraumatisation.

The section 'chronic individual trauma' contains two subdivisions: some strategies of elaborating and avoiding elaboration are described under 'working through', which bundles the stories of Ruth, Kate, Joanne, Sandy and Tracy. Marie's case is discussed separately because she is a case-example of a referral-patient, the extreme of failing to construct an integrated story. Her initial trauma(s) is (are) covered under multiple layers, resulting in a superficial life-story characterized by gaps.

6.1.1 Individual Acute Trauma

6.1.1.1. Individual acute trauma narrative

The fact that trauma is a disruption of the narrative chain is clearly exemplified in the case of Lorna, who experienced two events that turned her life upside down. In the beginning the overall tone of the life-narrative was very positive. Lorna recounts how she grew up in a normal family, being the fifth child. The fact that the other children were a lot older, that she was adopted by her uncle, and her adoptive parents could just make ends meet, didn't seem to impact on her much. She accentuates the normality of the environment in which she grew up, her happy youth, taking away any possible blame on her adoptive parents and extensively documenting her carefree childhood.

> Lorna: "I was brought up in a normal family [.] I was brought up believing that, well, the story they told me was that my mother couldn't afford for me to stay with her [.] I had a normal childhood as normal children do [.] I didn't have any problem with them then. We weren't abused or anything, we were a normal family with normal alcohol use, nothing hectic. And, ya, and I think it wasn't actually the high life, we stayed on a farm, we were living in an area of farmhouses and everybody could read and we used to live on the farm and have lots of fun there. Normal things like [.]."

A whole series of anecdotes is recounted about quests and mischief she and her brother/cousin committed: pestering the gardener, going hunting, stealing food from the kitchen to make braai or 'potjie', making 'mors' and selling it to the farm workers.
This happy childhood narrative forms a prelude to the subsequent events, serving as a contrast to convey the disruptiveness of the key events at age 13 and age 17.

The build up to the statement about her adoption that severely shocked her is very dense and complicated. Lots of sub clauses and unfinished sentences are used, followed by a rationalization that could be read as an attempt to illustrate the impact of that single sentence that threw her world upside down. All these verbal strategies are actually used to divert attention from the series of thoughts that were presumably triggered (disgrace of being an unwedded mother in a small farmer's environment, being 'an accident', being unwanted by the mother). The initial trauma is covered under a load of words:

> Lorna: "The end of standard 5 or the beginning of Standard 6 I visited my uncle and my grandmother. My uncle lived with my grandmother at that stage because my niece's mom had just passed away that year. So I went to visit them and we (.) she was like 1or 2 years younger than me (.) and ya, at that stage we had an argument (.) I can't remember about what (.) and she said: '**You shut up**, your mother didn't even get married when she got you'. But for a 13-14 year old that's quite a thing to find out at that stage and hm that also added

to what I have. I always want to be a step ahead of the crowd. So you could *never* rule me out because I was quick and I could think and talk off my feet, and I always had an answer ready. But *that* day she just took the wits out of me. I didn't know what to say and what to do."

At age 17 Lorna got involved in a huge car-accident. She begins the narrative with a detailed description of her bruises, meanwhile explicitly showing this on her body. She carefully gauges the reaction of the listener, as if she finds pleasure in describing how horrible she looked. Any anger towards the driver is curtailed by "but that's that" and an association with her own drinking, after which the narrative thread can be retrieved.

Lorna: "In Standard 8 I was involved in a big car accident. I've still got scars here ((shows)) my cheeks, I had no cheeks. My lip was cut in two, my blood flow was cut, I had no skin on my stomach from my breasts till where my pants began. My arms, my nose, everything was raw and it was like a *huge huge* accident and we were 4 in the car and the driver was drunk but that's that. I did drink but at the party and it was still experimental. Hm, and ya, I lost everything I was used to, my whole face, my skin..."

Apparently the accident changed the woman's outer appearance completely, but she never really elaborates on the consequences and her feelings, not even when asked directly. Although all scars have disappeared for those who are uninformed, later in the interview process it appears that Lorna sees herself as irreparably damaged. The story continues describing the severity of the event. The parents' interpretation is documented, but lacks temporality, which makes her repeat the sentence that indicates the threat to her life:

Lorna: "I was rushed to the X-hospital because that was the nearest hospital to where we were partying. And then my parents arrived and the doctors said they had to be quick or they wouldn't see me anymore and I wasn't going to make it to the next day. I had lost a lot of blood and no matter what they'd do I had this *huge huge* head injury. I don't know if you know but head injuries bleed more than all other injuries but ya I went in and my mother said that when she entered the hospital she could hear me scream and wanted to go in and the doctor called them away and said that I was, that they won't see me again, so that they must come say goodbye and so on. But then eventually I *did* make it through the next day and the 3 to 5 days to follow. They transferred me to the Y-hospital and ya, they operated on me and everything, and hm they said I was going to be there for a *very very* long time because of the head injuries and they thought I would have brain damage as well. I woke up, I eventually woke up, and I didn't know where I was."

The following part recounts her waking up, the initial shock. The present tense is used, sensations are described in a very real way. Interwoven in the narrative is the hear-say story describing the accident scene. This is an attempt to make sense of her physical state and move away from the shocking reality.

> Lorna: "Looking around me and *feeling* and *looking* and *blood* all around my nails, everything *scarred*, because it was in the bush. It was back in a very steep bent and there was this *huge* (.) *Jesses* I don't know what's it called in English, but was like a steep down thing, very bolding down, so I kind of fell out of the car and was thrown through bushes and rocks and sticks and things in my hands. I can't remember anything but they told me afterwards. So ya, I woke up in this hospital bed and I've got this *huge* bandage all around me. I haven't got any hair. They shaved it all off. It was bare skin. My eyes was, after the injury, was like blue and hanging. It was like in (.) my eyes (.) everything that you do, if you have done plastic surgery or anything, then the eyes are usually like all blue rounds, so I had that, and ya, all scars. But after that I asked the doctor [.]."

Subsequently a story about her amazingly courageous recovery is told, which she eventually plays down by focusing on her motives to leave the hospital. Her parents didn't have medical aid and were rather poor. The doctor promised her she could leave the hospital as soon as she could walk, so she had the nurses sit her up and she walked to the toilet, where she was confronted with her reflection in the mirror. This section as well consists of a rather long introduction compared to the short unfinished description of her looks and her thoughts after this first confrontation with the visual reality of her damaged body.

> Lorna: "I asked them which side of the room is mirrors because I wanted to see myself. And they had mirrors all over on *that* side ((shows)). So I walked in, and instead of walking *straight* into the toilets I faced the mirrors and I got quite a shock when I saw myself. The way I looked, my face was like all swollen, and my eyes, and all my skin was open, and my nose (..). It was quite hectic. So I sat at the loo and thought: 'OK, buckle up, either you lie down and then you are going to be here for a very long time or you stay up and do your thing'".

Further remainders of this event are silenced. She managed to convince the doctor and went home to recover, where she apparently just went back to normal life. The presumed lengthy recovery process, the impact on her social life, the many operations and skin reconstructions are barely mentioned, and were only retrieved after direct questioning in the third interview. The reality of the loss of her outer-looks, walking around with bare skin for one year, were browsed away, apparently denied, or at least not integrated in the spontaneous life-narrative.

> Lorna: "Standard 9 and Matric and everything is normal. The usual social thing, everything, and I went along with that".

However, the disruptiveness of the two events seeps through during the three sessions in different ways:

- When asked for her self-description, the interviewee focused on looks, outer-appearance (as opposed to all other women) and presented a very bad picture of her self (fat, not sexy, ugly), even personality wise: "My personality now is like a puke in a tumble dryer".
- When asked about schooling she concluded that she "never wants to go back there" because "I used to be very bony and skeleton-like and now I'm fat". Later she recounted she used to be very active in sports, doing lots of exercises, being involved in the orchestra and party committee, things that were most likely interrupted by her recovery but Lorna makes no mention of this.
- She suffers from depression and is under medical treatment of a doctor.
- She tried to commit suicide two times in her adult life. If asked about the precedents of the suicide attempts she replied with "a lack of attention from her boyfriend, being depressed and been drinking too much". Later in the interview procedure Lorna recounted the second attempt happened after she phoned her adoptive mother to tell her she was going to rehabilitation. Her mother reacted very hurt, blaming herself and her daughter. The impact of this could be related to her first trauma, being a disgrace to the family.
- Negative emotions are transferred onto another event: There's a lot of anger and frustration coupled onto the numerous neurological tests she had to do:

"A lot and lot of fucking tests and reading cards and you know all the type of psychological and physical exercises to see whether my brain was damaged [.] make kiddies puzzles [.] *really* pissed me off [.] made me go crazy".

6.1.1.2. Unprocessed individual acute trauma

Elsie experienced a series of acute traumata, namely two car-accidents at a very young age and two incidents of sexual harassment/assault during her active addiction in her teens. Elsie's case is characterized by a general inability to construct a life-story. She presents very incoherent, superficial anecdotes, and has to be asked a lot of questions before she can construct any kind of narrative. There are big gaps in her story; denial and key words without elaboration are used. When the narrative stops, extensive probing unexpectedly elicits a screen-memory which brings us closer to her forgotten childhood.

Right at the onset of the interview this 20 year old girl makes the following statement indicating a gap in her memory: "I can't remember really anything much about my childhood. I remember I was (..) I can't really think that far". Her life-story only starts at her high school years. Other memories seem to be unavailable, but later in the interview we get a possible explanation for this gap. In-depth information about parents, family life, and inner state remain unapproachable topics.

One of her key words is "funny", which gets a different meaning every time because it entails an attempt to accord a word to an uncomfortable emotional situation, embarrassment and hurt. In this instance Billig's (1999) comment could be in place when he claims that what is pushed from consciousness, or avoided, is not a bodily feeling, but a means of interpretation, the danger- the guilt, the shame, the pain- lies in the label and is therefore avoided. Without words there can be no guilt, shame, or pain.

> Elsie: "From there I went into school X. Me and my best friend, they always used to be funny with us because we were hippies and we used not to brush our hair and stuff like that. [.] Then I started smoking Mandrax and then I moved to using heroine and stole a lot off people and I did a lot of funny things but it's not in my personality to do things like that. [.]
> Elsie: "He'd be like: 'Can you take 50 box from your mom's purse? And I didn't want to do it and then he'd be all funny about it." ((In this instance 'funny' was later described as)) "calling me names, make nasty comments, very rude, we didn't have a good relationship."
> Elsie: "He'd touched me in some funny place and I was just so embarrassed." ((Funny here was later clarified as)) "I don't know (.) I don't (.) you know like in private parts (.) he just started fiddling."

Elsie is rather shy and very compliant which has to be accounted for whilst interpreting her story. For some reason she had the impression that the interview was about sexual abuse only, which she clearly denied to have experienced, but later on she presents three stories that could be defined as sexual harassment or abuse. The investment in this discrepancy is revealed in the following paragraphs.

Elsie: "I never had any sexual abuse but when I started taking Mandrax [.]"

She tells a confusing story about her former boyfriend who used and manipulated her, concluding the story with two very stereotypical clauses, and a negation that turns out to be a denial:

> Elsie: "He just manipulated me. But I only realized it was because of drugs and because love is blind. And then I never had anything sexual and then we broke up and it was like the end of the world."

Elsie continues her story with "Other sexual abuses" which seems quite bizarre because she denied any sexual experience in the previous sentence. Later on in the interview she recounts her boyfriend coerced her into having sex with him and breaking her virginity, and that she's terrified that her counsellor, and even more so her mom, will find out that she has sexual experience.
The topic 'other sexual abuses' consists of two stories: one describing an attempted rape at a party, when she was spaced out a guy took her by the hand, to the bush, she passed out and woke up with him on top of her with his pants down; she was saved by her friends who came looking for her. Elsie never told anybody about it, because she thought it was her fault. The other incident was when she was high

and a "Rasta guy" lured her into his apartment under pretence that he wanted to clean her aura, but fondled her "private parts" instead.

After this her spontaneous story-telling stops and the interviewer has to ask questions to elicit stories. When asked about her family Elsie recounts how she got involved in a car accident at age 4, which inflicted brain damage on her 2 year old brother:

> Elsie: "I don't remember anything because I was very small. But from what I heard he screamed all night and had brain damage. He stopped speaking for a couple of years. And slowly he started speaking like pff pff and then like after a while he started speaking, saying words and made progress saying sentences."

During the interview it became clear that a lot of the family's attention goes towards the brother. Although Elsie claims that her parents are very loving and supportive of anything she does, she might have difficulties asserting her own wishes in the shadow of her handicapped brother.

When asked for her first memory Elsie describes sitting on the couch in their house in Jo'burg:

> Elsie: "Sitting on the couch, that's all I remember. I only remember that I felt fear on that couch. I honestly can't remember much about my childhood. I just have a back flash of that and that's it. An other thing that I remember is, I don't know if it's fear or paranoia but I remember say for instance my father will go out, or my mother, and I'll sit and I'll be so scared that they'll die that I'll sit and wait, worrying the whole time."

For the attentive listener this can be seen as a screen-memory, the memory seems linked to the accident with the fear being a trauma-remnant, the description of the scene (sitting on the couch and being anxious, "paranoid") is preferred instead of elaborating 'the cause' of the fear. If asked whether this memory was situated before or after the accident another story pops up:

> Elsie: "We were in another accident also, it was the year before. We were in the car on our way to Durban and there was this huge accident where my mother wrecked the car. I remember sitting there with my brother and I were sitting in the back. I just remember blood coming from my mother's arm and I think something must have happened to my 'grootjie ou', you know my grandma's mom. She broke her hip and everybody had pieces of glass in their eyes and that's all I could remember at age 5. The other accident was at age 4. I thought my mother was dead or something."

The description of both accidents makes it certainly understandable why, as a child, she was terrified every time her parents left the house. The interviewee herself doesn't make any connection between the three described scenes and seems very much estranged from everything.

6.1.1.3. Comparison

These two cases present a radically different reaction towards a similar event; the first one being quite a verbal adolescent at the time of the trauma, the other one being a toddler unable to name and understand what happened. Whereas Lorna managed to construct a coherent although not complete story, Elsie only managed to produce fragments in an indirect way.

6.1.2 Individual Chronic Trauma

6.1.2.1. Processing trauma

All these women experienced a chronic negative atmosphere during their upbringing. Now that they are sober/ clean they started working through some of their past hurt. Because it concerns a long-term situation in which basic things (continuous love and care) were missing these women experience difficulty to find words that cover the whole experience.

This stage is characterized by avoidance of painful issues and inability to face the reality of the abuse alternated with an awareness that the full picture isn't there and a wish to deal with past hurt. In the life-stories this ambivalence between avoidance and reliving can be recognized in various denial and repression strategies as illustrated in the following section.

6.1.2.1.A Repression

1. MOTIVATED FORGETTING: The interviewee indicates gaps in her memory or forgets about crucial events that are supposedly associated with shame, guilt or a lot of hurt, grief and pain. Later in the interview process the woman recounts fragments that can explain this apparent amnesia as a defence against distressing thoughts, emotions, and memories. Typical is that the woman herself doesn't make the link.

In case of a chronic unpleasant situation the forgetting becomes generalized. Ruth starts the interview by indicating a gap in her memory. The motivation for forgetting seems to lie in emotional neglect from both parents' side and psychological abuse from dad's side:

> Ruth: "I remember very little about my early childhood. [.] Mom and dad were quite distant, especially my father. [.] Mom used to hand us over to the maids a lot.[.] If we cried we got handed over to the maid and we were taken for a walk in the park as opposed to getting showed love and hugs."

Sometimes the woman herself will explicitly indicate her motivation for forgetting. For Kate her daughter is the most important thing in the world, she therefore explains her forgetting by wishing her young daughter won't remember any of her alcoholic behaviour:

> Kate: "I don't actually remember anything before that ((granduncle's burial at age 4)) and I hope my three year old doesn't remember any of my previous life.[.] I don't remember being... (..) Ya, I don't know".

Crucial events can initially be forgotten, not mentioned during the recounting of the story but are later quickly told without much detail, because they are needed to understand the rest of the story.

> Kate: "And we went and lived in the UK for about probably just over a year and a half. I I oh... I actually didn't mention (.) just after we got married that in fact 20 months later my grandmother passed away and that was very very traumatic for me. And I didn't get much support from Richard ((husband)). And I don't think he knew how to, you know. I felt quite isolated there. Anyway, now we're travelling overseas and eh... it was good."

For the drug addicts as well, the negative atmosphere of upbringing and continuous verbal abuse is not incorporated in the life-story, with the only indication being a single probe during the actual life-story presentation and other clues (e.g. retraumatisation) indicating that something might be silenced. After various questions aimed at specifying this general statement (who, what, where, how) a shallow narrative can be retrieved. When asked about the situation at home, Tracy replied that her parents couldn't control her since age 16. After further probing she said she "used to get hidings as a child, never abusive ((quickly followed by)), just on the bum, just hidings" but these occurred quite frequently and without explanation mostly related to the many rules her father (a practicing Jehovah witness) imposed on his family. She continues: "I didn't know why I was punished. I can't remember half of my childhood." Her emotional investment for the forgetting lies in the fact that fully remembering the past would mean facing the impact and reality of the verbal and physical abuse she experienced by her parents. Instead of talking about the abuse she focuses on her own input, her self-blame being another way of giving meaning to her past experience (it's better to be guilty than to be helpless)[31].

> Tracy: "They would always be saying things like that. Friends would come to the house and they would be screaming and shouting at me and I would be screaming back. '*I wish I never had you kids*', '*I wish I wouldn't have bore you children*'. My friends would look at me and say 'Doesn't that hurt you?' but I'm used to it. It was always like that and there was always

[31]According to Herman (1996), guilt may be understood as an attempt to draw some useful lesson from disaster and to regain some sense of power and control. To imagine what one could have done better may be more tolerable than face the reality of utter helplessness.

verbal abuse. Because they were verbally abusive because I abused them verbally too. If I was a nice and kind child they would have been nice and kind too."

2. LABELLING: A name-tag, a label is accorded to a chronic situation of abuse which creates a certain distance and is therefore safer. But after a while, the label doesn't seem to cover the load, and becomes quite unsatisfactory because it doesn't represent the intensity of the initial experience. Hence further elaboration is needed, which can boil down to limited illustrations that are used in exactly the same way during successive sessions, functioning as some kind of rhetorical device and as justification for the reality of the experience. Ruth provides an example of this when she tries to convey some of the past hurt her father caused her and her siblings:

Ruth: "Because we've been betrayed as little children by my father, constantly through our lives *betrayed betrayed betrayed*. [.] We've been led to believe, from childhood, that if it's not perfect it's not right. Nothing was ever good enough for my dad and lots of times when he was drunk he'd say things as in [.]"

She illustrates her point with three stories of two sentences documenting how her father was a tyrant and negated her achievements by making nasty comments. Striking is that these illustrations give the impression to stand on themselves in that sense that they are recounted in the exact same wording in the second interview and have to represent a chronic (and ongoing?) situation of emotional abuse. In the second interview she states: "I don't know how bad it was cause I actually can't remember", later followed by the same three examples in the exact same wording, a general statement and further labelling:

Ruth: "No matter what, when I was a little girl, when I think of the time he said such things and it happened all the time [.] There was never sexual abuse, no real physical abuse but I was scared if he hit because he was a big man [.] But there was definitely emotional abuse".

According to Billig (1999) remembering involves forgetting. Once the memories are constructed, the forgettable becomes even more forgotten. Reproduction of particular memory-stories ensures that alternative stories, even if they are more accurate, become less likely to be produced. In short, one works up a standardized memory, which encapsulates some features and consigns others to oblivion.

3. FOCUS ON SAFE TOPICS: The only elaborate narrative during the whole session is on drug use. Describing the course of the drug use seems to be the only safe topic. Sandy's memories of an unhappy childhood are repressed through focusing on the feelings drugs gave her.

Sandy: "I loved the feeling and the rush I used to get when I was with him ((boyfriend Mike)) and my pills. My teeth and my jaws used to chatter and my eyes used to shake from side to side so fast that you couldn't see where you were going. I loved that feeling."

4. REINTERPRETATION: Facts are told in one way in the first session but are given a different interpretation in the second session in function of self-agency. Tracy relates her decision to move out of the house because it was too strict:

> Tracy: "Things weren't alright at home. I felt too strict. I couldn't handle it and wanted my freedom so I said: 'I'm going to move out and stay with my brother'. So after a big fight they let me stay with him. That was when I was about 16."

In the second interview it appears that the immediate onset for her moving out of the parental house was her father beating her up severely because her mom had a nervous breakdown and blamed Tracy for it. This is quite a different interpretation from the one she first gave. This distortion of the abusive scene is most likely motivated by avoidance of painful memories and more specifically her mom's incomprehensible behaviour.

> Tracy: "She told me I was to blame for that. When she left for Jo'burg she wrote my father an SMS, a letter and he beat me up *really bad*, *so* bad. He did it and afterwards he was *so* sorry he never touched me again, *ever*. But he didn't make up. When he saw the letter, she said it was *all* my fault, because of the fighting between me and my father all the time."

Later in the interview process this is confirmed:

> Tracy: "My father beat me like that, that was quite traumatic, quite traumatic. I couldn't believe he did that. Straight hectic, that was quite hectic. I'd forgotten about that, not actually forgotten."

In Joanne's narrative some of the successive stories are told with an interwoven dialogue of victory, or at least a strong emphasis on self-agency as an attempt to reverse the powerlessness she presumably experienced in her youth.

> Joanne: "So she used to hit me because she believed in hitting without asking. She used to hit *real hard*. I used to go to school with like 5 pairs of stockings because it was so bad, the bruises. But I never ever cried. And the less I cried the more she used to hit me."

5. INDICATORS of IMMEDIATE REPRESSION: Trauma is a discontinuity in the narrative chain and the narrative thread has to be (re)constructed. If the woman is still in the process of doing this we can find para-linguistics indicating the difficulty to construct or tell the story: speech is interrupted frequently and at other times sentences are tightly sutured/ stitched together, in an effort to repress the emotions or events that are still too threatening at that moment.

> Kate: "And he used to embarrass me terribly because when I would be on the phone he'd shout and call me a whore, a slut, and eh... (..) My dad and I just eh- he was shouting at night. You could always hear my dad's voice, you could never hear what my mom was saying. I can't remember what he was saying but he would just shout at my mom and putting the pillow over my head trying to block it all out and try to go to sleep."

When Joanne recounts her story, one episode of abuse is quickly alternated by a different one, the episodes are tightly stitched together which leaves no space for elaboration or emotion, not allowing herself the time to get sucked in or overwhelmed by memories. Joanne labels her childhood experience ("plain neglect") and immediately relates another shocking event namely the night her oldest brother tried to fondle her.

> Joanne: "Anyway things with her ((mom)) and my step dad were bad. I slept in every evening imagining we were a family. I used to sleep in the pigeon coop, in the fowl run, come out with lice and flees, didn't wash, go to school, no supper, not just me, the three of us that still lived at home. I got scabies that bad one time my feet were wrecked up, my hands were like boxing gloves. We had just plain neglect, just plain neglect. When I was 13 I remember waking up in the middle of the night, my brother is sitting on my bed and he's trying to fondle me. It was just fondling, but it's something I'll *never* forget. He apologized about it being high on dope and drinking, but that memory will never go away."

When ambivalence, uncertainty or unprocessed emotions are likely to pop up, speech falters; the woman begins to stutter and the same word is repeated until she can shift to another topic or catch the narrative thread again. Kate has an ambivalent relation towards her deceased father. Although her father abused her mother and his children Kate presents an idealized picture of her dad, repressing all negative thoughts. She gets back to her story by focusing on her mom's behaviour.

> Kate: "And I I I was starting to look forward to leave the house again because it just started... (..) I didn't enjoy this at all. Anyway I finished Matric I I I enjoyed school but still I had this inferiority complex and started disliking my father and couldn't speak to my mother because he always... he knew always the... told her... she always kinda tell us: 'Oh, your dad 's not feeling well today' or she always played it down: 'That's just dad's way' and 'It's your fault' and hm... So my grandmother actually became more of a mother to me [.]".

6.1.2.1.B Denial

Memories are further blocked off and in case of direct questioning other strategies are used such as denial, reversal into the opposite, externalisation, and minimizing.

1. DENYING IMPACT: For instance when Tracy was asked in the second interview about the verbal abuse at home, she first denies it, then specifies the verbal abuse, and finally denies that it had an impact on her because she blocked it off:

> Tracy: "*Nobody*. Well, mostly my parents. They were just normally shouting at me and calling me names, and like *'you're stupid'*. Always calling me names. So I'm used to it. I think I got it from there and that's why I verbally abuse my boyfriend. My dad is very negative and has always been saying [.]. My mother also sometimes she would lose it and say things like 'I wish I never had you kids'. It never used to hurt me because I grew up with it. It was kind of natural. It didn't went, when she said it, it didn't go through. I wouldn't feel anything."

Acknowledging the abuse would bring along anger and grief and possibly threaten the relationship with her parents. Once this young woman comes out of treatment she will return to the same home situation which makes it understandable why she needs to block off the topic. It's her reality where she has to live in and deal with. But the ambivalence slips through at the end of the first interview:

> Tracy: "I got them back quite badly (.) not on purpose".

2. Lots of NONVERBAL COMMUNICATION indicating nervousness, unease, and discomfort (such as wiggling legs, tapping feet, fiddling hands, no eye-contact), or an outward calm expression but coughing, clearing one's throat, getting choked up, chain smoking, accompanied by a statement that denies the impact of certain events.
Ruth had to end her relationship with her boss because he didn't want to give up his involvement with the mother of his disabled son. Although she previously described how much she loved him, how he was her emotional stronghold and best friend, she reduces this in the statement: "That's all finished now, there's nothing left", after which she is troubled by a fit of coughing.

3. REVERSAL INTO THE OPPOSITE: Some women are left with a bunch of unresolved emotions towards one of their significant others but have no way to vent them because either the person is dead or disclosing these feelings would hamper the relationship. Common is that an idealized picture is presented and the anger, hurt and frustration are transposed on another person or event. Kate, for instance, diminishes her alcohol use and presents an idealized picture of her pregnancy that is disrupted once more by another life-event that makes the couple drift further apart and spoils her happiness.

> Kate: "I cut out on my drinking completely and I'm a smoker too, but I must admit I did have my glass of wine in the evening so I couldn't cut out completely hm.(.) But I felt it relaxed me and to be relaxed is very important as well. (.) And I *breezed* through my pregnancy. You know I had a *wonderful* easy pregnancy. You see, my husband was thrilled, very excited and his parents excited, my mom first her daughter having children. And I I I I had my daughter but about 10 days prior to her being born my husband lost his mom."

4. MINIMIZING and KEY WORDS: The impact of past experiences is played down, and certain words and labels are accorded that put the problem within one self. Throughout her life-story Kate repeatedly claims to have "felt odd" and has a big "fear of feeling left out", which eventually motivated the onset of her drinking. But to the listener, "feeling odd" seems like a serious reduction of the complex and ambivalent feelings she must have had as a child:

> Kate: "But there ((beach cottage)) I started really getting embarrassed because my father would never leave the house and hm he would just drink from 12 o'clock and pass out in the afternoon and start drinking in the house. When friends would come to our house he would stumble around, you know what I mean, shouting abuse at everyone, my mom, and ya... I was very embarrassed and therefore I always felt inferior to everyone else in X ((holiday resort)) in particular and then to everyone in Y ((home town)). I always felt our family was a bit odd and didn't fit in and felt quite ashamed". [....] "So he and I grew really close and I pursued my athletics about which my dad was really enthusiastic but he embarrassed me terribly because he would shout at the referee if he gave me a false start. All this sort of things. We were quite a humble, poor family and I never had the nice tracksuits that all the other girls had but I always wore my brother's clothes and I always felt odd, you know."

According to Billig (1999) during the period of forgetting people avoid memory-work. The subject might have a minimizing account of the episode, which helps to dismiss the matter from thought: the original event becomes something trivial, not worth discussing or thinking about, not even to be considered when serious subjects are being discussed. In this way, repression can be constituted and maintained in a pattern of avoidance. The claim to forget- or alternatively the claim to remember the event as unimportant- can be part of avoiding engagement with memory-work.

The past can be minimized, denied and compensated in a narrative. Tracy was born and brought up as a Jehovah's witness. Her unhappy childhood and teenage years are covered under sentences as:

> Tracy: "My life was alright [.]. Although it was very strict [.] I was never allowed to do anything. Never allowed to go to parties, to do sports, because it was against the religion. [..] I've got lots of love and got basically everything I wanted except for the freedom that I wanted."

5. EXTERNALISATION: Another way of diverting attention towards safer and unchangeable topics consists of explicitly pointing out unresolved issues that are beyond the subject's control. Joanne focuses on her mother's denial, and why her husband and children keep supporting her. Hence other unresolved issues (e.g. natural father died when they were still at odds, and being blamed for stepfather's handicapping fall) are covered up and her own responsibility in dealing with these issues is avoided:

> Joanne: "Throughout all of that I come to realize and accept to a certain extent I continuously ask my mom '*why*' she did this and that. Mom will never say she's sorry. She doesn't have the capacity to say she's sorry. You can never talk to my mom about any problems that might in some direct or indirect way put blame on her or she takes a role in the kind of person I am today. You just can't do that."

6.1.2.2. Covered-Up Trauma: Referral Patient

The term 'referral patient' is used to denote those patients who go from doctor, to psychiatrist, to psychologist, to psychiatry, rehabilitation,... These are mostly older women, repeat patients, who have been in numerous treatment programs before without much effect because they utter many diffuse complaints, as if they are not exactly sure where and how to start. They avoid every attempt to go deeper than the surface. The 'wrong' issues are put central at the 'wrong' place (e.g. rape in addiction treatment, and addiction in rape crisis centre), resulting in yet another referral. The initial trauma, the shocking memories and emotions are covered under multiple layers and diffuse complaints and can't be reached. The only expression of this hidden sore is the urge and need for any kind of self-medicating substance, as long as it numbs what is possibly working underneath. Everything is covered up therefore the actual story is very short, not coherent. The listener gets an overall impression of superficiality, with lots of gaps, sudden changes of topic, condensation, lack of emotion and transposed emotions. Only after extensive probing a more solid and coherent picture can be obtained, but many questions remain unanswered. A safe topic seems to be the course of the alcohol-use; previous abuse is negated, and substituted by a discourse loaded with displaced emotions around a current stressful situation e.g. the stress at work.

1. CHANGING THE TOPIC

Marie, our oldest interviewee, is a typical example of the referral patient. She describes her childhood in short sentences, "oldest of three girls", "mom sickly", "I had to do chores" after which the topic is immediately changed to a description of the scene where she had her first contact with alcohol. Striking is that the woman herself didn't actually drink at that time. But this anecdote succeeded in diverting her own and the listener's attention to a different and safer topic. This description functions as a bridge towards the story of the onset and the course of her addiction. The addiction, her drinking problem, is the reason why she is in treatment and that is the topic that is given the most importance.

But if you want to explore this in depth, Marie changes the topic to her depression, anxiety or work stress.

2. TRANSFER OF EMOTIONS

The only elaborate narrative informs us about the immediate onset of her current problem: namely the work stress and subsequent depression. Lots of anger and frustration are vented that seem to be out of place but take away the shame and guilt associated with loss of control and being addicted. It motivates the alcohol abuse and takes the emphasis from the previous problems and underlying pain she experienced in her childhood and her abusive marriage.

3. FLAT RECITATION OF EVENTS

Whereas her work situation is recounted with strong emotion, the way in which she was referred and referred and ended up in an addiction treatment centre after going for smoking therapy is told completely void of emotion.

4. CONDENSATION

Marie ends her story with a strange concluding comment:

> Marie: "The fact that my father beat me constantly with the whip or sjambok when he was drunk, which was constantly, to the state that I was off school for one week at one stage and went to stay with mom in the hospital hasn't got anything to do with my alcoholism and is completely stress and depression related."

In this very condensed sentence we learn that Marie suffered severe physical abuse from dad's side, but the last subordinate clause attempts to negate the first part of the statement. It can be read as an attempt to deny the impact or even the existence of horrible childhood experiences. Sentences are sutured, supposedly motivated by a fear of overwhelming memories emerging through the gaps and silences. Further answers to questions reveal or suggest severe physical abuse by her father, emotional abuse and neglect by both parents, and domestic violence (physical, sexual, verbal abuse although she's never very clear about it, every probe intended to go deeper is successfully repelled). She started drinking to be able to sleep, and drinks every night.

5. SUPERFICIAL

The second interview as well didn't change much in the level of disclosure. Emotions are referred to as 'issues', difficult life-events and memories can't even be looked at:

> Marie: "At this stage I'm really struggling with recovery... There's a lot of feelings that's got nothing to do with alcohol and that started long before I even knew the alcohol and those are the issues I have to deal with. It is very difficult to deal with those issues. The alcohol is one

thing. I know it's bad for me so I can leave it. But the other issues I can not deal with. That's going to be very very difficult."

From there on she continues talking about medication and concludes with a statement which reveals her high hopes on her new anti-depressants to solve all her problems. This evokes the impression that she's already announcing her new substance.

6.1.3 Conclusion

Whereas the section acute trauma served to instruct us on the impact of single traumatising events on a person with a 'normal' background, the section on chronic trauma explored how this group of women tried to repress, deny and silence certain events, cognitions or emotions. All alcoholic women managed to construct a coherent story about their lives, but many events or emotions are silenced and repressed. The stories of the young drug addicts all seemed rather superficial and contradictory. They were characterized by a lack of narrative thread and have an associative rather than a chronological structure. Repression occurs in shape of motivated forgetting, contradictions, labelling combined with a shallow narrative, reinterpretation and para-linguistics. Denial can be recognized in nonverbal communication, denying impact, externalisation, and minimizing combined with key words. Those signs in their story indicate a stagnated working through of past events urging for their normal coping-strategy namely substance abuse. Techniques used by the referral patient were changing the topic, flat recitation of events, displaced emotions, condensation and superficiality resulting in a very compact story.

6.2 ALCOHOL & DRUGS COMBINED

This grouping uses a combination of addictive substances and addictive behaviours. Therefore I expect to find similar repressing and silencing techniques in their stories in enlarged format. This section is subdivided in different parts. First Helen's case will be discussed which represents an example of a woman on her way to recovery after a long life of trauma and substance abuse. The cases of three other women (Yolandi, Nancy, Rachel) are bundled under the section 'premature foreclosure' because the repression and silencing take on a life of their own constructing a cover-up life-story. The story of Sadeedah is discussed under the section 'fragmented story' exemplifying the inability to integrate experiences of extreme violence from an early age on. The last case to be considered is the one of Nicky who demonstrates the clearest case of how substance abuse can be a survival strategy after chronic trauma, and how it also serves to remain stuck in the wordlessness of trauma. This young woman can only continue her life by numbing with or without substances.

6.2.1 Working Through Accumulated Chronic and Acute Trauma

Helen's story is indicative of high-elaboration and self-reflection. She constructed a coherent narrative where different traumas are incorporated in a fluent story including precursors and trauma-remnants. Crucial is the flexibility of the story and narrating process, an integration of all previous abuse, accompanied by adequate emotions.

Helen experienced a series of chronic and acute trauma, but compared to her fellow-interviewees she is furthest on her way to recovery. Helen is working hard to accord meaning to all the shocking events (sexual abuse, abortions) and the chronic emotional abuse she experienced while growing up and in her later relationships. She has constructed a coherent life-narrative and during the sessions she is actively reflecting on the impact of these events on her life, trying to structure and place them, in order to obtain a fuller, more complete picture. Deferred action and therapeutic discourse help her to make sense of what happened.

By means of 'Nachträglichkeit' (deferred action) a coherent story is constructed. Helen reinterprets past incidents in function of the present or more recent past and attributes them a new meaning in accordance with the actual trauma. Striking is that the 'victim' becomes the author of her own story which gives her back the power and agency she was robbed of during the initial event. Helen recounts two incidents in her teenage years where her father stares at her developing breasts in an uncanny silence and tries to approach her. She describes this as confusing and the first time she felt loved by this stranger who was her father. These events function as an introduction before the plot will unravel. She gets really emotional when she tells the following:

> Helen: "I said: 'I love you' ((cries)). I just find it so hard to say that now, because every year the damage carried on. But I didn't see it as damage at the time. In fact, it took me a *long* time to remember."

Much later in the interview the emotional value of this is explained. There were two more incidents where her father approached her, but these stories are preludes to what will follow, a violent rape where her father was involved and which she experiences as the starting point of her self-destruction with drugs and alcohol. The trigger-event was when Helen's father came to visit his 22y. old daughter and touched her breasts. This was the first time Helen remembered the previous incidents, which completely enraged her:

> Helen: "So it was again *very very* bewildering, but because I wasn't Standard 9 any more I was just so angry and just said [.]".

Helen made a big scene and had him thrown out of her apartment by the police. After an alcohol binge of three days she decided to take revenge. She went to a big function of her father's company, dressed

up like a vamp, and made him feel completely paranoid. He took vengeance as well by setting her up with a friend of his who beat her up and violently raped her. A detailed description of the whole set up, the horrible rape and the after-effects are provided. And a link to her self-destruction is made:

> Helen: "But it destroyed, well it was, on a long line of bad things that was the highlight of destruction. I went on to use a lot of drugs, a lot of alcohol and to choose very abusive relationships, very abusive, mostly verbal but certainly physical abuse as well, and moved out of Cape Town, and went to live in Jo'burg, and got very into cocaine, free-based it a lot. [.]"

During the first interview Helen told her story non-stop until her first child was born and then ended the session. Two more interviews followed with extensive use of therapeutic discourse. The words of the program are adopted and provide meaning for the course of her life, her overwhelming emotions, and the way she is right now. These words are utilized as tools to attempt to make changes in her inner and outer life. The treatment discourse functions as a stronghold, a new language to talk about previous experiences.

The rape narrative doesn't seem to differ from what we might expect from non-addicts. Helen's struggle seems to stem from her childhood, and more specifically, the relationship with her parents. This remains a difficult topic on which she is diligently working during the three sessions. Right at the beginning of the interview, fragmented speech shows how difficult and confusing Helen's childhood was. This is in sharp contrast with the rest of the interview in which Helen came across as an excellent speaker, very intelligent and self-reflective:

> Helen: "My name is Helen X. I was born in Y. I have- my father lived- I have an older sister and a younger brother."

Helen has always had a strong bond with her mother, being an 'adult child' and trying to rescue and counsel her mother from an early age on. This also means she incorporated a very rigid black and white picture of her parents, with her mother being idealized. Now, in treatment, she starts to acknowledge that her mom's behaviour has deeply impacted on her life. These thoughts and feelings are dealt with through black humour and rationalization. The feelings of abandonment, anger, hurt, and frustration she repressed for all these years are fended off by transferring them onto other issues. If these defences fail she gets very 'uncontained' and struggles to put it into words.

DARK HUMOUR is used to make sense of her mother's irrational behaviour:

> Helen: "My mom was programmed to be married [..] she was on the shelf [.] She was the last one to be taken of the shelf."

After her second marriage her mom clung to lots of other men but it never worked out:

> Helen: "There were lots of others - in and out - but they were all very short time and my mom would get really excited that maybe this would be '*the one*'. For us, by that time, we were just scared because none of this praying, none of these '*men from God*' were helping. As children, in our different ways, we knew that."

RATIONALIZATION is adopted in an attempt to make sense of overwhelming emotions and irrational behaviour. Her father left her pregnant mother when Helen was one year old "because he wanted space and everything had happened too fast." This is quickly followed by a focus on the impact this had on her, which takes away any question about the mother's input: "That affected me a lot because I've grown up very cynical and very untrusting of men". Helen's father would keep her mother hoping for his return, but meanwhile was living together secretly with another woman. The marriage was dissolved 5 years later when an announcement was published in the newspaper stating that some woman was changing her name to Helen's father's because she had been his common-law-wife for 6 years. In the intermediate period Helen's mother kept hoping and would keep a vigil three times a week with her three children where they would be praying for the father to come back. After the divorce the same type of vigil was held, now praying for a man. The interviewee cites her mother's exact words. This illustrates the deep impression this made on the young children, and on the other hand it indicates a reinterpretation through adult eyes confirming the absurdity of the whole process and the impact on her life:

> Helen: "...we'd light candles, and my mother and us -her 3 children- would expect us all to pray. It was a very awkward feeling because she would pray very very anxiously 'Please, God, could we just have a man to come and help and be a father to my children and be with me. We don't have enough money and we need a man', you know. And that left an- a very strong myth with me that the man is the thing that will change everything".

Helen's sister was a difficult child, her brother was sickly, but her mother always referred to the interviewee as 'her mother's blessing'. While illustrating this, Helen shifts between the reasonable adult's perspective and the confused child's experience:

> Helen: "I learned very young to be easy and look after other people, and mostly my mother. So once that first breakdown of my mother came I tried everything to help her and was obviously too small. My daughter now is 9, I was 6. I was counselling my mother. I mean, every night I would sit at her bed because she couldn't sleep and I would say: 'it's ok, we are going to get a man'. Which I can laugh about now, but which wasn't funny at all [.] *No fun no fun*. I don't remember any playing [.] Everything was very dark. I was loved for helping and listening to her. I got a lot of love from her for that. So I learned to be very articulate, to be able to counsel and let her talk and me saying 'It's going to be ok, you are a good mother'.

> [..] The rest of my childhood, until I left home- I left home when I was 15- was marked by my mother's loneliness and anger".

She describes how her mother engaged in binge-eating as coping strategy for the stress associated with rearing three children by herself and having to wait for the maintenance money that was always late:

> Helen: "But if we (.) if she got tired, or we were not behaving, or I don't know. She would say, she would sit and cut this loaf of bread in front of us and eat it and eat it and eat it and tell us '*she can't cope, she can't cope, she can't cope*' and she'd be eating. That was also not so... We would be very scared about that part of her, very angry part of her. I can't remember being beaten or any of that".

SUMMARY: She concludes her childhood narrative with a summary. Striking is that any emotion associated with the mother's behaviour is left out.

> Helen: "My life is marked by 6 marriages between 2 parents. They each married 3 times. So I think my fear of trust, deceit, adultery, comes from there and that a man never means what he says and growing up like that".

DISPLACED EMOTION: At other moments Helen's anger towards her mom shifts onto something else. From when she was 4-5 years old she and her siblings were put on the plane to visit her father, which she found very scary. She is angry about the permit and not about mom's behaviour, for which she assumes responsibility.

> Helen: "You actually weren't allowed to put children that young on an airplane but my mother got a special permit for that, which I have a lot of anger about because those visits were just terrible. Both leaving, going there, and coming back. The whole thing was just terrible because my mom would weep and sob and cry at the airport and she'd tell us that everything was just fine. That it was *fine* to go and see my father but her teeth were always clenched. She'd say: 'You can see your father any time you want to', but she was never free about it. She was always bitter and angry, which was very confusing, because I never knew if she'd love me afterwards. So I would try to be very good at the airport and say 'Don't worry, mommy. It's fine, mommy. We're coming back. You don't have to be scared.' And meanwhile (.) I mean (.) I I learned (.) I think from a very early age to not have any feelings of my own because I was really taking care of hers and my sister's and my brother's."

EMOTIONALITY: If she can't justify or explain mom's behaviour and has to face the reality of her mother being very hurtful and harmful towards her children Helen really struggles to tell the story and she gets very emotional:

> Helen: "That stepmother cut my sister's and my hair short. We both had this long hair where we could sit on. And she cut it and I actually liked it. But when we got back... oooh... at the airport m... my mother... from the moment she saw us... and I'd actually forgotten about my hair... I just saw my mother and ran to her... and she just pulled me all the way back to the car by my hair... because this other woman who took my father away from my mother (.) or that's how my mother understood it (.) ((cries))."

When she gets herself together she immediately starts to rationalize and explain why she became intellectual and controlling, again making her mother's behaviour her own problem and responsibility.

6.2.2 Covering the Gaps, Premature Foreclosure

Miller (1994) writes that in therapy, addicts can be engaging, superficially verbal but often unable to identify and talk with any real emotional salience. Therapists have observed a striking disturbance in how they experience their internal lives. They are out of touch and cut off from their feeling lives, what McDougall (1984) describes as "disaffected". In the cases of Nancy, Yolandi and Rachel it was noticeable that although these women managed to construct a chronological life-narrative and integrate some of their previous experiences, much is left unprocessed which increases the need for a relief-bringing substance or behaviour. For instance Yolandi managed to construct an integrated narrative around her abortion by means of 'Nachträglichkeit' but fails to incorporate the full experience around her rape and her adoption. The past event that gets new value and is reinterpreted according to a present experience is Yolandi's abortion. Two years after being raped Yolandi got pregnant with her first boyfriend, who convinced her to have an abortion. At the time being she dealt with it quite well, but now, in a movement of afterwardsness, it is seen as the onset of all her misery. The situation that was considered as part of her life-flow became traumatic when the subject had time to think about it and other clues (parents open up the possibility to choose, babysitting a baby girl shows she's capable of nurturing a child) triggered a reinterpretation of the event.

> Yolandi: "So I went for the abortion and went to the doctor, to hospital. He gave me 4 pills to take, 1 ah 2 at night and 2 the next morning. That was the biggest pain I ever had in my entire life. Five days after that I went to the hospital to have my womb scraped out. I had to sit there from the morning 12 o'clock till the evening 5 o'clock with a drip in my hand. So I had to wait for the doctor. Which I really think was not nice to do. My boyfriend was really supportive because he was sitting there the whole day with me. I came out of the theatre and I think that day- that's where all my unhappiness started cause I felt like I killed someone. [.] I didn't tell my mom and dad. The next year they found out by my mom's sister. So they told me they would have given me a choice. So I think that's also where my hurt and anger comes from. I'm babysitting a child that's 2 years old, the same age my baby would have had. So I think, and I love that child very much, so I think that's like God gave me almost a, some kind of punishment or something like that."

These three women adopted the same techniques of repression and denial as found in alcoholics' and drug addicts' narratives, but the combined group uses these devices more frequently and in more extreme fashion. Similarities between the drug addicts and the referral patient are found as well, in the sense that they all shut down the narrative trail too soon, constructing a reality full of gaps. The following indicators of unprocessed emotions and events could be recognized in the stories:

6.2.1.1. Stagnated Narrative

This is the wordily repetition of another's story, the construction of some kind of narrative about the shocking event by means of a hear-say story, void of personal input, emotions or thoughts. The story exists outside the personal life-sphere of the individual. This makes control during disclosure absolutely essential and the woman is very reluctant to divert from the given ordering and sequencing and is unable to answer questions that would disrupt the recounting.

Nancy's best friend cum sister-in-law was killed in a car-accident, something she experienced as a big loss and very traumatic. The story is told very matter-of-fact like. When asked for a clarification, Nancy avoids the question and tries to rationalize, after which she asks if she can 'go on' with her story. In the second interview, she recounts fragments of the last phone-call with this friend in detail and in exactly the same wording, which indicates an unprocessed memory.

6.2.1.2. Repression

Repression happens in numerous ways such as blocking off, numbing, forgetting, generalising, humour, and focus on safe topics, resulting in an overall picture of superficiality and many gaps without a fluent, logical narrative line.

1. BLOCKING OFF AS NORMAL COPING STRATEGY: Some women incorporated repression and forgetting as their normal coping strategy resulting in unavailability of certain memories and feelings. The gaps in the story are typically covered up by drawing attention to the substance abuse, making a circular movement each time a probe urges them to go deeper.

> Rachel: "I can't remember my childhood at all. All I got is like a pitch of photographs. I can't remember anything until I was 14 or so. Seriously, I think I blocked out so much. The solemn struggle to look back so far [.] quite annoying because a lot of my childhood is gone. They try to counsel me here as well and it's quite difficult. [..] That's again a memory I just switched off. [.] So, I honestly can't remember. I have a great capacity of switching things off. Just pushing it into a box of things and letting it not ever come out. That's the way I just forget about things."

Her motives for drinking cover the rest of the story and eliminate further questioning.

> Rachel: "I drink to obliterate any pain or any uneasy memories."

Nancy as well exemplifies how she normally deals with unpleasant emotions: ignoring their existence, using food as coping mechanism and moving on.

> Nancy: "But then I just left it and I met a guy after that, Johan, I think I liked him a lot. He was very good-looking and we had a bit of a relationship. That was the time I even became vegetarian, the time of my bulimia, and then I had intercourse with him again and it was not so bad, I started enjoying it more."

Most of Nancy's feelings are numbed, which creates an overall impression of superficiality and more importantly even raises doubts about the reality of her labels e.g. 'abuse'. This sense of addicts' emotional disassociation is termed "non-feeling responses" by Sashin (1985). Nancy starts her story with a lot of irrelevant details (names, age, extensive information about material things and locations), after which words are randomly accorded as if functioning as a lid to cover unprocessed emotions, creating distance and presenting a vague picture of continuous verbal and physical abuse:

> Nancy: "Mom and dad didn't really have a happy marriage. In fact it was an unstable, dysfunctional and rocky one. [..] They were often fighting and insulting one another in front of us. My dad would often push my mom around and take her into the bedroom and do this. I was the only girl and became extremely protective and remember telling my mom to take our bags and 'lets leave dad and then it will be OK'."

2. GENERALISING: The impression of superficiality is further enforced by describing (individual) experiences in plural. Relating things in general takes the focus off the individual experience. Being part of a group that experiences hardship reduces the impact of the hardship on the individual.

> Rachel: "Us children were to be seen, not heard".
> Nancy: "We went to mass every day and we had to wear our school caps. If any of us did anything out of line we would have to stand on top of a desk and say a decad of a rosemary for our penitence. [..] We ((the call-girls)) are lonely people."

3. MOTIVATED FORGETTING: Nancy seems to have forgotten about certain emotional key events in her life, such as the break-up with her first love. Later in the interview this apparently 'triggered' her bulimia, which suggests the break-up had a big impact on her life.

> Nancy: "I can't remember the exact reason why we broke up. He just stopped calling me and then met someone else. I can't remember the exact break-up, how he did it. But I know he

> just stopped calling and then rang me to tell that he didn't want to see me again. I can't remember exactly so far back."

A couple of sentences later we hear what motivated the forgetting, and again the emotions are reduced by focusing on the addiction, disease aspect:

> Nancy: "I was very upset, couldn't handle the rejection, I thought we were getting married. Like all my hurts were just dieted away. I felt very unhappy at the time."

4. INDIRECT CLUES: When blocking off is used as normal coping-strategy, trauma is not consciously available and can only be approached in an indirect way; stories or fragments are elicited unexpectedly. For example when Nancy's opinion on addiction treatment is asked she answers that:

> Nancy: "There should always be a woman's group that women can talk alone about woman issues. Because sometimes these things are private and I think there are a lot of private things that happen in drug addiction while we're active that you can only tell sometimes to a woman because you're embarrassed".

When asked to specify this statement a story follows documenting her being raped by an acquaintance and two of his friends while they were all trashed (drugged and drunk).

> Nancy: "One night we were drugged on XTC, together with an old acquaintance of mine. And I went home with him. Then two of his friends showed up. And as far as I'm concerned I was raped, and they were not wearing condoms. All of us were trashed, I had bruises, and reported it to the police. I knew the guys but their behaviour made me really uncomfortable. I was under XTC, had been drinking heavily, had bruises all over my body and had to go for anti-retrovirals. I reported the rape but dropped the case because of the trauma I was going to go through. In a way we were (.) they all apologized (.) we were all drunk and drugged".

5. ELABORATION of PRECURSORS substitutes elaboration of actual trauma: At age 16 Yolandi was raped by a fellow student on school premises. The interviewee has some difficulty in telling the story, she seemed calm, but started coughing, cleared her throat many times, and there was no eye-contact. She described what went on before (after the exams she was waiting for her mom to pick her up, and she agreed to go and smoke a cigarette with a guy), but from there on only the rudiments are told:

> Yolandi: "So ya he raped me in the school in the cloakrooms. I was... I think I was also cross at my mother because she wasn't on time. So he just pulled up his pants and told me I mustn't tell anyone. That was like very very hectic for me."

The event is labelled and attention is diverted by specifying the setting, the unprocessed emotions are transferred into 'safe' feelings of anger towards her mom for being late. The closest attempt to represent an emotional state lies in the words 'very very hectic'.

6. SUBSTANCE ABUSE narrative substitutes TRAUMA narrative: Embarrassing topics (such as sexuality) are typically avoided and attention is drawn towards substance abuse. Focusing on the substances or addictions, diverts attention and reduces the importance of what is said before.

> Nancy: "At that age ((college)) I had my first boyfriend. The first love of my life was called Geoffrey. I was crazy about him. I remember he drove a Mustang Convertible car. I also shared my first sexual experience with Geoff. And I smoked a joint with his sister for the first time. But I did not like it or the effect it had on me."

In the second interview we get a better picture of what might be concealed, namely a traumatised or at least ambivalent feeling around sexuality:

> Nancy: "Mom didn't tell me much about sex because she is a practicing catholic. [.] My parents normally wouldn't show any affection although I once caught them in the act as a kid and it sort of stuck in my mind for years. I don't know *why*, because in the end it's just a sexual act, and I didn't actually *know* my mom could do that, or make the sounds she was making. I think that sort of affected me and then I was a bit naïve with Geoff. He promised me we would get married. I didn't enjoy it the first time, it was very painful and I just fell for some stupid line that we were going to get married. I didn't enjoy it and was really sad I did it. I thought to myself I was supposed to be a virgin when I got married and now I've ruined it, what am I going to do".

Growing up in a violent domestic atmosphere and then walking in on the parents having sex might have linked sex with abuse and violence for this woman. And being 'tricked' into having sex with her boyfriend, a painful experience that probably left her disillusioned, hurt and feeling abused, must have only reinforced that picture.

6.2.1.3. Denial

1. RECONSTRUCTING THE PAST: Some women are so stuck in denial that they construct a different, ideal picture, existing as a parallel world in which they truly believe (reversion into the opposite). Hints about another past filter through, although a full picture can never be obtained. Rachel indicates a big gap concerning her childhood memories. Later on in Rachel's childhood narrative the possible explanation for the memory gap can be read through the contradictions and the tightly stitched sentences:

> Rachel: "I believe I had a happy childhood. [.] I was adopted at birth, raised in a beautiful house with swimming pool and 2 dogs, had all material possessions and anything we wanted, had a lot of affection but were hit quite a lot. [.] Dad was away a lot for business ((in the second interview this becomes "dad was away a little bit and mom was always busy")). We were raised by nannies and au pairs. [.] Us children were to be seen, not heard".

Rachel's childhood narrative carries many negations and small words that contradict a previous statement (e.g. amazingly) suggesting a different picture than she communicates, with especially her description of her parents carrying an ambivalent undertone:

> Rachel: "They have both very strong characters. My dad is quite old now so he's not as strong as he used to be. Very quiet man since he's retired, we don't talk an awful lot, [.] we don't hug, he freezes. My mother and I have a fairly good relationship. I can talk to her and she's been supportive about this whole thing, *amazingly*. So I have a good relationship with her although it could be better. She loves my dad a lot and I have lots to be thankful for. [.] We were raised in Victorian style, very strict, we don't show affection or share. [.] They wouldn't understand, they wouldn't talk about it ((anorexia)). [.] They mentioned nothing about the alcohol. And they said: 'Yes, she's anorexic, we had to get her back to the family and it's all forgotten about now, end of story.' So that's what they're like [.]. So I adopted that attitude 'Forget about it- Move on'".

Although Rachel relates how she was teased at school because of her looks (chubby with glasses) and wetting herself, how one of her teachers gave her the nickname "sausage" and how she felt odd because she was the only one that was adopted, she still claims she had a happy time at school: "I believe I had a happy time at school, made some friends".
She tries to remember a normal happy time at school but here and there in the narrative certain words slip through:

> Rachel: "But I remember my parents sent me to boarding school and I felt rejected *again* because I had to go to school and all my friends were staying at home."

2. NEGATION and CONTRADICTION: A more overt ambivalence is demonstrated in a story full of negations and contradictions as a way of denying the past. Nancy recounts how she went full back into her dancing career but ended up in a private club doing professional table dancing and later being a call-girl as well. There's a lot of shame and guilt associated with this part of her life-story. This topic is highly defended, noticeable in various ambivalent remarks.

> Nancy: "We *never ever* had to do anything uncomfortable. I still remember... I used to earn R1500 for 2 hours while most clients just wanted a backrub. It was good money. I have done 1 or 2 things, but nothing I didn't want to do. [..] I didn't like myself anymore, very empty,

very lonely. [.] if you tell friends about it you're an outcast... Actually it's not such a bad job, your clients are wealthy men [.] It became an art to me, a lot of it was sound effect... *never ever* did anything that made me uncomfortable... I was really unhappy, I had no feelings, I often go numb, and I often numb myself out with drugs. In the end I couldn't cope with my job without the cocaine. I never really had a bad experience while doing it, like unsafe. In the end I was tired of it, sick of it. I couldn't form a normal relationship."

3. HUMOUR: Humour, laughter is used to hide embarrassment, guilt, shame, emotional issues, and counteract hurt and sadness. Troubling thoughts are laughed away and therefore denied to have had any impact:

Rachel: "20 oh 29 I got married and divorced at 30 ((laughs)). I shouldn't laugh at it. It wasn't the best marriage on earth."
Nancy: "I went to a convent school and my schooling was very strict or as I can put it 'The nuns were really harsh tuns' ((laughs))".
Rachel: "It was my first, no it wasn't my first boyfriend. It was a boy from school and he was the best looking guy at school, David ((laughs)). He was also very shy like me. So we started dating and he was lovely, really nice. We saw each other a couple of months and then we decided we'd try it ((laughs)). In his parents' house when they went to X on a Sunday afternoon. So we did it and it was very unspectacular. I don't really get much out of that ((fit of laughter)). Oh dear, that was it. We finished shortly after that. It didn't last. He's a very successful man now in X, very successful man."

6.2.3 Fragmented Story

Sadeedah, who witnessed and experienced extreme violence from an early age on, can be seen as a case example of chronic individual trauma in which each violent event has the capacity and intensity of an acute trauma. Hence we can expect that the story will be more fragmented, that experiences are split off, and that the subject has to make a deliberate effort to go back to the reality of telling the story. On top of that we expect to see the subject fighting full-blown overwhelming emotions with numbing, whereby the autonomous hyper arousal is converted into non-verbal communication. During her course of life Sadeedah used any kind of substance to block off memories and emotions, making the need for a substituting product or behaviour at this stage very high.

FRAGMENTS OF VIOLENCE

Sadeedah's story consists of a compilation of episodes of extreme domestic violence. Nonverbal communication indicating enervation and unease is alternated by staring in an empty space and numbing. The undigested part of the memory consists of sentences that are stitched together. Sadeedah begins her story with her date of birth, narrates that her father is alcoholic, and her mother takes pills, after which the first violent episode is recounted. She loses track of the story, not really

having an ending, focuses on an after-effect of the shock she went through and relates another incident soon after this:

> Sadeedah: "My father used to be *very very violent*. Hm, I remember when I was 3 years old I watched him beat my mom with a metal pole of a stool and I looked down at her leg and I saw this flesh hanging loose and **blood** and I ran to my grandparents' house which was a block away from us and I tried to speak to them but I couldn't. I couldn't tell them what was going on. I could only make some kind of noises and pointing to like the house and, eh, then they went and then (.) But I lost my voice for 6 months. I couldn't speak and then then then they sorted that out. But ya, at that time I watched my mother trying to commit suicide. She took a knife at my grandma's house. She took a knife and she started slitting her wrists and I was standing outside and I was watching this and I didn't know what was going on but I remember just looking. And then. What else?"

Sadeedah tells her story about being raped in a rather detached manner, whilst staring in the void. It seems kind of mechanical; sticking words onto what comes into her mind. The story is very fragmented and sometimes it seems by making it more concrete, stating the names of those involved she can convince herself of the reality of the event. Attention is diverted to her friend who wanted to help her and got hurt. Confronted with the raw memory of the rape she looks at the interviewer and labels it. Her eyes drop and she doesn't succeed to accord more words, she begins to stutter and finds another peg in 'the pain' she experienced:

> Sadeedah: "When I was 16, a friend of mine, there were two good friends of mine. My friend and I were there at home. And my parents never allowed me to take friends to our house. But I did, because they would go to work. So it was two friends and so this guy Michael, he started forcing himself on me and his cousin (.) another thing was his cousin Brian (.) and he was helping (.) to hold me down, and my friend Jenny, she's passed away now, she came and jumped on his back and trying to get him away. And he pushed her back and *bleeding* cause I had a deep freezer in my room and because of the handle, the *handle* got her... And then he raped me. I st..o..a.. the *pain*, the *pain*, I thought I was going to die. It was *so* sore. And... And then... he went."

Remarkable is the fact that after some silences she concludes the story in a childlike voice with 'he went', as if she's saying, it's all over now, it's all in the past. It also curtails further questioning.

SILENCE

Every time Sadeedah finishes an episode she gets back to her self a bit confused and needs to find a different episode. There were a lot of silences and initially the interviewer tried to facilitate the process by occasionally asking a question but realized that it was best to allow the silences and let

Sadeedah recount her fragments at her own pace. The silences seemed to point at fending off, repressing troublesome emotions associated with the pictures in her head around her violent childhood.

> Sadeedah: "There was always violence *violence* and *abuse* and **blood** and it was always hectic and then (..). [..] I completed high school... and in Standard 7 my mom stabbed me in the back, and I don't remember when *this* was ((shows scar of 3 points on her arm)), '*the fork*' and she also used to jump on my back. She used to jump on my back so many times I couldn't get my breath. I found out a couple of years ago that - about 4 years ago - that I had an injury when I was young and it has affected my spine completely. And I know what it was but I didn't tell them. I told them I fell. And hm, what else..."

DISSOCIATION

Certain clauses are told in a child like voice, as if she's thrown back into the situation, e.g. watching her mother piercing her father's arm with a knitting needle. Sadeedah seems to be aware of this detachment.

> Sadeedah: "Once I saw my mother (..) and she was knitting and my father was doing something and going on. And she took this knitting needle (..) and **stuck** it right through his arm.[...] It's like sometimes like I'm telling somebody else's life. Now that I've been sharing in groups I can share it more easily..."

UNPROCESSED NARRATIVES

Most of her memories are in the initial stage of conversion into a narrative structure. The introduction and end of the fragment are somewhat elaborated and the whole fragment is described in the past tense, but the centre of the fragment consists of a very real representation of what happened:

> Sadeedah: "We used to wait for my father to come home. Certainly in weekends we used to worry that he'd come home drunk cause we were **petrified**. And he'd park the car. And we'd wait for him to get in and we'd wait in the room and we'd wait if we'd hear plates smashing or something when he takes the food out of the microwave. And he'd start throwing, *throw*, then we'd know: '*Here he comes*'. We used to like *rush*, and I was holding the door back. I was holding it so my mother could push this big old dressing table in front of the door and as I was standing there *this knife* came through. It was missing me all the time. But I just was waiting for it to come into me, you know. And there were so many times when I had to jump out of the window and go round to the neighbours and *ask* for help or *ask* them to call the police or something. My father also used to break the phones so we couldn't use them, and..."

DISPLACED EMOTIONS

Sadeedah was molested at age 5 by a friend of her parents. All her anger goes towards her parents who left her alone with the perpetrator. The OK-sign she could see from her room functions as a screen memory for the actual experience of being molested, and gets a double meaning, diversion of attention and dissociation versus consent with sexual abuse. Most of the narrative attention goes towards the guilt and self-blame attributed to the OK-sign and to the self. The scene is described in some detail but the event itself is silenced and only receives a label after a probe from the interviewer:

> Sadeedah: "When I was 5 years old my parents left me at home with a friend and, hm, *I would* ***never*** *do that*, and he (.), *but I don't know* why *they left and where they went to.* I don't know why they ever left us or me. It wasn't my sister, it was only me. And I still told them today. I still ask them *where the hell* did they go. I don't know, or how they could have left, I mean I would *never* leave my children with someone. And he, he told me to come and sit on his lap, and he wanted me to touch him and stuff like that. I didn't want to, because I had this '**No**'-feeling, that '*No*'-feeling but, and he was still. I jumped off him and I ran to my bed. We had these double bunks and the room was dark. And I was looking from inside my bed and I was scared. And then he came and he stood in front of the, by the door, in the doorway, and he still said to me: 'Your parents will be very angry with you' and 'You're going to get a hiding' and all that stuff. And I was so **petrified** of my parents as well, so I remember seeing the sign of the shop OK Bazaars. And I said, I saw in my mind this sign O and K and I said '*OK*'. Only now in this little time can I finally forgive myself for saying OK from when I was 5 years old. I always had the guilt. I've always known that because I said 'OK', that thing catched my mind, *how* could I have done that. I always had a lot of self-hatred for that." Were you raped? "No, he molested me."

ALTERNATE FOCUS on substance abuse and trauma.

The trauma and addiction narratives are used alternately as a means to reaffirm self-agency after recounting completely helpless and hopeless victimizing situations. The story of childhood molestation is immediately followed by a story about substance abuse: the first time she smoked a cigarette she coughed her lungs out but she still became addicted. The first time she used alcohol she went on a binge and got seriously sick, but she started liking it more afterwards. During the first interview each subsequent fragment (raped, blamed for rape, bullied at school, marriage, depression and suicidal tendencies) is followed by a story about her total substance abuse (marijuana, XTC, morphine, anti-depressants and calming tablets). Even though she immediately experiences the negative effects (because she immediately overdoses?) something urges her to use again. This drive that is stronger than herself will be explored in Nicky's case.

6.2.4 Raw Trauma- Absence of Story

The case-study of Nicky is an example of unprocessed trauma. This young woman just doesn't succeed in finding words to describe her experience, which results in very discordant speech. The fact that the perpetrator of the abuse, her mother, denies everything that happened and has depicted her child in previous treatment as the one that is crazy, certainly inhibits any possibility for Nicky to try and handle what she experienced[32]. She can't go back to the memories without being completely overwhelmed and reliving them and is terrified to do so. There is basic distrust, nobody seems to be able to provide a safe enough environment to explore these hectic memories and contain all the hurt. The only thing that kept her standing all these years was numbing her self out with drugs, obtaining that state of careless non-being, disappearing as a subject. No adequate substitute for this coping-strategy is found, which leaves us with a very bad prognosis.

WORDLESSNESS

Before age 13 this interviewee suffered a lot of verbal, emotional and physical abuse by her mother. Words like 'chaotic', 'hectic', 'turmoil' serve as a band-aid for all indescribable experiences and hurt. Nicky starts the story very confusingly and almost like in one breath. Sometimes the sentences switch to the present tense and are very fragmented which makes it difficult to follow, but it also conveys an idea how real this still is in her memory. The present tense is followed by a description of her normal coping strategies which takes the story-teller and the listener away from the threatening reality. Lots of sentences are left unfinished but without space or silence in between, tightly sutured:

> Nicky: "Ya, basically I've always been (.) probably from when I was around 5 (.) I grew up in Jo'burg in the city, and a lot of my (.) eh, when I look back at my past, it's been very very *chaotic*. There's a lot of *chaos*, a lot of *confusion*, always a lot of *fighting*, and *pain*, and family life was pretty (.) quite *hectic*, you know. Like my dad, used to travel a lot and my mom had to bring us up on her own a lot of the time. My mom, she's quite a hectic person. She's an artist and she's *very erratic* and she has like, she's *very temperamental* and I think I was like a very easy target for her to vent a lot of her anger out on. So that was quite a bit of hell but I'd say I'd had pretty much of ya, a lot of *abuse* in my upbringing from when I was very young , *emotional and physical* from my mother's side mostly. And it was *very very hectic* and ya (.) I've just got a lot of *hectic* memories. *Very hectic memories* and those kind of override all the good ones and I all struggle to... It was also *hectic* for me at home that, well also, I spend most of my time a lot of time in my room. She... I'd start beating myself up and I don't know how to deal with it all. I started like, at that stage, like, I must cut myself

[32] According to Bar-On (1999) the undiscussability builds upon the indescribable. What we don't want to know merges with what we have difficulty making sense of. This maintains the family's normalized reality in which the abused child's experience and pain have been crushed; things can go on "as if normal", in a new social reality and its normalized discourse which did not want to or just could not contain such experiences.

> of emotionally, like from *feelings*, from everything. I just used to *numb myself out*, and I lost total communication with like, whenever, I find like very difficult to *communicate*, like people, *right* from where I started going to school. I really didn't think I fitted in. I'll struggle to communicate. I was always isolated and a lot of time. I used to self-mutilate quite a lot. I was always beating myself up, hurting myself or I I just always remembered just feeling like I had *so much*. I was always very *confused* about me, and life, and just. So I'd say, ya, hm, it's, it was just like a *wild freaky*."

After this childhood narrative the story gets more coherence until she has to describe her relationship with her mother, where she seems again at a loss for words (kind of, like,...) and adopts words she might have heard during her history in mental health care:

> Nicky: "My relationship with my mother, up till now, is very bad and I've become this kind of *split person*. I was like *dual personality*. I was, for them I was this one person and I was this complete other person when I was myself. Now I've got my own life it's like going very well but before, it was like completely shutting off. And I mean I was like, my own life, my own lies, my own like, my own world but I used to just completely shut everyone else out."
> Nicky: "Mom is in complete denial about it. She's got a lot of her own stuff where she's not dealing with. Like I've talked to her, about twice in my life, and it's like a complete disaster. She doesn't even remember it. There's no, like- I'm **sick** and *I can't make up stories like that* and- and that alone made me feel like I was completely losing it. *Very very hectic*. So ya, I just left it. I'm sitting with all this hectic stuff and everybody says: 'You've got to deal with it. You will always go and abuse. You will never- because- so ya, I mean it's..."

In analogy to Bar-On (1999) we could say that the daughter was pressed into social isolation in which she had to give up her experience as a socially constructed fact, as part of an unwritten social agreement, legitimising the made-up reality constructed by her mother and the rest of her family. She thereby submitted herself to a discourse and way of life in which her real experience became an unknowable social fact, while the made up-reality constructed by her mother became the knowable and therefore only available facts.

JOUISSANCE

Her past experiences are so overwhelming that there are no words for it. It is like something lying outside the realm of speech and the subject; something that overtakes, is completely uncontrollable, and wipes out conscious thinking and being. Lacan named this state "jouissance": something inside the self that is enjoying in spite of the self, with complete self-annihilation as a result (here described as 'get out of myself', 'loss of control', 'numbness', 'stop having to deal with anything', 'a breath out'). And exactly that same feeling is repeated during active use of a drug or alcohol, a desperate attempt to master that where the subject was once subjected to, by now determining the dose and hence the effect herself.

> Nicky: "It was always like, whatever I used, I always felt I had to go *completely overboard* and maybe just like, *very hectic*, and I always needed more. And it was just *never enough* and... But the thing is I used to try and *get out of my self* so much that because the substances I used they gave me a feeling of like basically *loss of control* but also just *numbness* and stop having to deal with myself and any emotions or anything like that and just. It was just like I suppose *a breath out* and I think that's also where I've become addicted to. Is that whole right feeling of just being like *not having to deal with anything* and, eh, I went to school and I mean I went through a lot of *hectic hectic stuff* at school and I was in hospital [.]".

SPLIT OFF

When she starts talking about her substance abuse, she seems thrown back in that situation, unaware of the interviewer, staring in the void, uttering mechanical speech. She has been to several treatment centres and uses the words she learned there with an emphasis. But the last clause demonstrates that she feels abnormal, the words the program provides her (e.g. addiction is a progressive disease) don't fit her reality:

> Nicky: "I started drugging when I was 14. I started abusing substances. Before that I was also in *turmoil*, *being*, I was also. When I was 15 I had *anorexia* very badly and all these problems started to come up for me, hm, and hm. I went to boarding school when I was 13 and basically I had to *get away* from my family. And I struggled in school. And I wanted to go *away* and just like *going down*. I actually had a *depression* as well, very... lots of depression. Hm, and then I went *right from the first minute* I got, I was at High School, *right from the first minute* I picked up like any substance. I started with alcohol. And it was like right from the first sub, like *just like*, it was like *total*, you know, *non-stop*, like, *right in a straight decline*, like, like *full-down* get *very sick*. It wasn't even *a process*, it was just like *go* where others *end*, like *total abuse* and every time I drank it was the same story."

The day following the first interview, her parents, who are paying for the treatment, would fly in from Jo'burg for a conjoint session. When asked how she feels about that we get an idea of her normal coping strategies, namely going numb, blocking it off.

> Nicky: "I've got like all this *hectic feelings* that I'm carrying around *guilt*, *selfishness*, like, you know. [.] So ya, I feel quite *hectic*. I can't run, I can't hide, I can't do anything. So ya, you could say I'm the whole time, I'm *anxious*. I'm sometimes just going numb or feeling hectic or just like *block it off*. I'm very good at that. At completely detaching myself and getting in some kind of trance, sitting there and stare and like *nothing*."

THERAPEUTICAL DISCOURSE

The program does provide a language for some of her experiences. When Nicky talks about her boyfriend with whom she had a 'hectic' relationship she uses the words the program made available namely: the definition of co-dependency and 'geographicals'.

> Nicky: "Then I met this guy, Tim. I had a relationship with him for 3 years but it's been very... We both needed each other to help each other. But it's been actually a very *sick* relationship because I'm heavily *co-dependent*... because basically I just lost myself and I just lived through him and I lied for him, and the *motions*, ya, it was just crazy. It was just being like *crazy*. And it started, last 3 years I've been doing *geographical* all the time, you know I moved from- I really believed I fucked up in Cape Town very badly. I dropped out of Art College and I was using very badly and I was still *fighting a lot of stuff* and I was moving from house to house and there was *turmoil*. And my boyfriend and I said 'Well, things aren't going to get better' so we packed up and moved. So we moved to Jo'burg and we got trapped in Jo'burg. I tried again for another year. I worked in a coffee shop. I got a job there. I managed, well, not managed, to retain one for 8 months but you know. We were using heroin and crack and that was also, became like *total chaos*. I was very ill at the time. All that was just, doing the most *hectic* things, you know. It was just *totally crazy* a lot of the time. *Total total extremism*."

In this case the treatment discourse cannot be effective because the basic condition of safety could not be supplied, this girl isn't safe for herself, let alone that it is safe for her to share with someone else. Addicts are asked to surrender to the program and admit their powerlessness over their addiction and over their lives, but for this young woman who lacks basic trust and rather has a basic distrust, surrendering to anything and getting in touch with this condensed block of uncontrollable emotion is really off limit.

> Nicky: "I don't think I ever surrendered enough to deal with any of the *issues* that happened to me when I was young. They were actually very like just *caused* by all these *hectic* issues for me. Emotional issues and issues about not having logic and struggling to do that but not having a logical way, always being in *confusion*, and trust issues. Because the trust, I lost trust with my mother when she was always erratic. There was always either *abuse* or just like *total alteration*. Trust issues... A lot of hectic issues I didn't deal with."

SARCASM

When asked about the sisters' ages, one is 4 years older and the other is 3 years younger and Nicky describes this as "the middle child syndrome", she tries to joke about it but in her laughter the hectic pain and confusion sound through.

6.2.5 Conclusion

In this section Helen's story gives an example of a woman actively working to overcome her traumas and addiction. The other combined users didn't present such a positive picture. Three cases were grouped under the section 'premature foreclosure' because the repression, denial and silencing techniques are used in a stronger sense to cover up what they cannot deal with, cutting out large chunks of their lives. Sadeedah's life-story was discussed as an example of a fragmented narrative where dissociation plays a big role. The last case gives a better insight into raw trauma and the complete inability to find words that can cover the tremendously frightening emotions and memories, leaving numbing and substance abuse as the only survival mechanisms.

6.3 OVERVIEW

In the interview material certain clues could be found that trauma is being processed, which makes these women's life-story little different from ordinary life-stories on a surface-level. Indicative of this working through is a flexible, fluctuating story that is subject to change and reinterpretation, demonstrated in the use of Nachträglichkeit and the normal strategies of rationalization, minimizing, generalisation, humour, to deal with difficult issues. Most of the interviewed women however were stuck in their story. This stagnated story is characterized by rigidity, inability to change and wordily repetition of the fixed story.

I started this discussion with the presentation of two cases where a series of acute trauma were recounted. Lorna, a 27 year old alcoholic, experienced two events that she called traumatic. Her case gives a good example of how an individual tries to make sense of a single shocking event. Elsie, a 20 year old drug addict, experienced two severe car-accidents when she was 4 and 5 years old, during her adolescence she frequently used drugs and experienced two events of sexual harassment while under the influence. Her story is marked by a lack of coherence, labelling without elaboration, denial and contradiction, and lack of spontaneous narrative production. This is in sharp contrast with Lorna who managed to construct a coherent story but failed to integrate any kind of emotion. Elsie could be described as a typical example of the young drug addict who suffered early shocking events and during adolescence re-traumatises herself, going back to the same wordless, powerless state by registering herself some kind of drug. This intoxicated state puts her at risk for re-traumatisation.

After these cases individual chronic trauma was discussed in both alcoholics and drug addicts with the major difference being the more verbalizing, chronological style of the alcoholics versus the lack of chronological structure and spontaneous narrative constructions of the drug addicts. Apart from these differences the same strategies were used namely repression under the form of motivated forgetting, focus on safe topics, para-linguistics (interrupted speech, repeating same word and sutured sentences),

shift in emphasis, and labelling without elaboration. Denial was recognized in non-verbal communication, reversal into the opposite, externalisation, minimizing and key words.

In the combination users I also made several distinctions. Helen's case was discussed as exemplary of a high level of working through a series of shocking events. By means of afterwardsness and active use of the healing discourse she managed to construct a coherent narrative about rape. Her relation towards her mother was the point of inner struggle, noticeable in displaced emotions and her use of common cognitive coping strategies like rationalization, dark humour and summarizing. The cases of Nancy, Rachel, and Yolandi were described as premature foreclosure. Their stories were characterized by a stagnated narrative. Repression was found in blocking off, generalising, motivated forgetting, elaboration of details and the addiction narrative substituting the trauma narrative. Denial consisted of reconstructing the past, negation and contradiction, and humour. Sadeedah's story clearly presented the impact of early confrontation with continuous violence resulting in a very diffuse fragmented story, dissociation, filmic representation of events, displaced emotion, and substance abuse functioning as a safe topic. Nicky confronts us with raw trauma. Her story was characterized by wordlessness, splitting off, jouissance. Frequent readmissions, however, have enabled her to construct some kind of narrative in which she used therapeutic discourse and sarcasm to accord words to a fragment of her complex block of emotions and memories.

Chapter 7 :

Trauma-Remnants in Addicted Women's Life-Stories

In literature the most described "after-effects" of trauma are those related to sexual abuse[33]. Sexual abuse is described in literature as having a severe impact on the later life of the victim and constituting a major risk factor for later psychopathology. In my interviews, however, most women related physical or emotional neglect and abuse as a child, which had a similar impact. Before discussing this in more detail I want to repeat that there is no simple cause-effect relation between a shocking life-event and its possible remainders[10].

7.1 APPARENT ADAPTATION

Trauma is always constituted in some kind of hind-sight. At the time of the events the individual seems to handle it quite well (survival), but when she's removed from the traumatic situation the whole event can manifest its full impact. Some people might start the process of working through; others will use avoidant coping-strategies such as substance abuse which restricts their chance to deal with the situation.

In most cases there was first some kind of latency phase, marked by equilibrium, an apparent adjustment to the events void of trauma-remnants. This is demonstrated in the schooling career of most women, who were known to be compliant and conscientious students, and well- to good-achievers. Joanne formulated this as: "I excelled at school because at least that was something I could control". Only later, when the subject has to define an own identity and actually has the time and emotional space to reflect on her own past, traces of trauma start to filter through.

Most of the women who were severely traumatised, however, started to mix with the wrong people at school, rebelling against authority and began abusing substances or food. Any possible elaboration of the past is substituted by excessive use of a substance. Hence the addiction is closely interwoven with the trauma dynamics of repetition compulsion, avoiding, numbing and dissociation. In case of Rachel, Nicky and Sadeedah, remainders of their childhood abuse showed through in an early stage, with truancy, rebellion, expulsion, and anorexia-drinking-drugging in their early teens. Helen started rebelling a bit later, she excelled at school but clashed with her male teachers, she got expelled and was assessed for another school where she was found bright enough to skip one year.

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[33] See for instance Browne & Finkelhor (1986), Cahill, Llewelyn & Pearson (1991), Eth & Pynoos (1986), Jehu (1988), Russell (1986) and chapter 3.

[10] See chapter 3 on use of after-effects, trauma-remnants, and remainders or traces of trauma.

In many cases schooling was fine until they started abusing substances: Sandy excelled at school until she started taking drugs, Elsie en Tracy were medium students until they started mixing with the wrong people and drugging, with failing to pass and school drop-out as result.

7.2 REMAINDERS OF ACUTE AND CHRONIC TRAUMA

The combination of chronic and acute trauma demonstrates a broad array of possible remnants. But in case of one of the trauma-types as well, the shallower and more superficial the story the more I will expect to find other clues indicating unprocessed emotions or events. Therefore I will systematically discuss some of the well-known after-effects of trauma that I could retrieve in the interviews. Although addicts typically suffer from low self-esteem and guilt, shame and blame, the concept of trauma gives these characteristics an extra dimension.

7.2.1 Negative Self-Concept

Trauma has a severely damaging impact on the self-image and the way one makes sense of the world around her. Especially in case of chronic abuse by primary care-givers this has deleterious effects on the constitution of the sense of self and bonding, the basic trust, resulting rather in a 'negative self-concept (Herman, 1996: 146)' and basic distrust. Indicators of a negative self-concept are poor self-esteem, self-hatred (e.g. Lorna's suicide-attempts), feeling different/damaged, with a typical tendency for perfectionism and people-pleasing to compensate for this defective self-image.

- Negative self-image is demonstrated in quotations like

> Sandy: "I've never felt good about myself."
> Nancy: "I didn't like myself as a child. It was terrible, insecure, I could never feel good about myself because I was always worried about how I looked. I had to be prefect and I was always obsessed with this."

- Continuous criticisms are invariably internalised resulting in a bad picture of the self:

> Kate: "I started feeling like the whore and slut my father called me."

-Fragmented self-image: In case of severe physical and emotional abuse by primary care-givers there's a general incapacity to formulate any coherent sense of the self.

> Nicky: "I never had really time to formulate any sense of myself or like a kind of self-esteem, because what happened till the age of 13. [.] I'm like this split person, like dual personality".

In Sadeedah's case so many things are split off that she can shift from one way of thinking, acting and feeling, to the complete reverse in a matter of seconds. Although there is some awareness about this splitting, it is very ego-dystonic, so she can't quite grasp what other people mean by mood-swings because as far as she is concerned she is genuinely herself all the time:

Sadeedah: "I have a very aggressive nature [.] I'm a very friendly person, I love to give. Here they say I have mood swing, but I just can't pretend I'm something I'm not. It's *real* pain, but I love attention and affection."

- Big mouth but small heart: The insecure sense of self is shielded from exposure by presenting a tough, outspoken picture of the self.

Tracy: "I'm very strong-headed, I want it my way. I'm very warm and friendly to other people but in a relationship that person has to be mine. Very insecure, a lot of things about myself and... I'm very, not arrogant, but if I want something I will do it a.s.a.p, [.]."

- Feeling odd, different, damaged: Most traumatised people feel different from their peers, other than the others. This is one of the indicators of what is described more broadly under 'loss of commonality' in trauma-literature.

Kate: "I felt inferior to everyone else. I always felt odd, left out".

Ruth: "I'm confused, alone and depressed [.]. The person that sits on the fence and doesn't make any decisions".

Yolandi feels left out at family gatherings and struggles with her adoption; her differentness is described as an inherent quality: "being a lonely person":

Yolandi: "They are all the same and I'm different. You know like the ducks, the ugly duckling. [.] My grandmother always made me feel like a member of the family at family parties. [.] I'm really shy, I like to be alone, I'm very 'rustig', very quiet, very 'teruggetrokke', very lonely, that's just the way I am."

Marie: "I'm a very tense person and I don't like mixing with people. I'm very much a loner. [.] I don't have friends because I'm reluctant that they get too near to me."

- Poor self-esteem

Kate: "I've always been a tomboy. My husband says that I'm not a woman, not sexy".

Rachel: "I have a very low self-esteem. I don't think highly of myself. So I often don't do things because I feel I will fail while doing them. So I don't push myself to my full potential."

Yolandi: "I don't think anything of myself."

Lorna: "I've never been a doll-girl, I've always been a bush-girl. I'm a rather large-built woman, a 'boeremeisie', 'lekker fris'. I have a big body built, very large hands. I'm a huge woman, fat, not sexy, beautiful. [.] right now my personality is like a puke in a tumble dryer."
Ruth: "I just look down on myself".

7.2.2 Guilt, Shame and Self-Blame

Guilt, shame and self-blame are attempts to make sense of trauma. Shame appears after the unexpected and unwanted intrusion of body and inner world, the violation of the bodily and psychic integrity. Guilt stems from utter helplessness and powerlessness; and by focusing on the own input (feeling guilty and blaming the self), the individual tries to regain a sense of agency and therefore coherence and integrity. According to Bar-On (1999) guilt provides a shelter for reason (meaning, contingency between events) instead of chance (no meaning, independence of acts and outcomes), but also exposes victims in a negative light, as if sharing responsibility for the horrendous acts and results. Behavioural self-blame suggests some kind of secondary self-control: what I may try to do or not to do differently in a future similar situation (Bar-On, 1999).

- Nicky partly justifies her mother's hectic behaviour by relating that her mom had her own issues and that Nicky was 'a difficult child from an early age on.'

Nicky: "At the moment the relationship with my family [.] And they're not getting a grip and my mother is just completely hectic. It's just, I mean, I've put a *very very* hectic amount of strain on my parents and my family and it's very *hectic* to them now causing like complete chaos in their lives. As much as I'm doing that I'm still out there looking: '*Why me*'. I just feel like so much, to carry on. That's like hectic. [.] She's like in complete denial about it (.) she's got a lot of her own stuff where she's not dealing with. Like I've talked to her about twice in my life and it's like a complete disaster, she doesn't even like, she doesn't even remember it."

- Yolandi manages to repress and transform any feeling of anger or resentment into guilt and self-blame combined with a serious reduction of any problems existing in the family.
What preceded is told in detail, with an emphasis on what she did wrong. The event itself is dealt with rather quickly, and typically only showed up at the end of the second interview.

Yolandi: "When we were naughty dad used to hit us with this leather thing with a wooden handle, but that's normal. Ah ya, nothing major. Just my mother when she was so hoaxed out she'd beat me in the face. And my dad, when I pierced this eye (.) that's not a good thing (.) he wanted to take it out with a 'tang'."

> Yolandi: "My parents are very down-to-earth people, very straight, [.], very nice people, it's just me who puts them in a bitchy mood. One thing I don't like about them is when I'm doing something, when I'm busy and then mom or dad used to call me 'Do this' then I'm busy I work or something. Then they get crossed. There's a big communication problem in our house. Everything started when I took drugs. I can't say anything from them. They're really good people. It's just me that started drugs and messing everything up."

- Joanne's most extensive discourse is about the alcohol abuse. There's a lot of self-blame, shame, guilt and hard self-criticism. This can be read as an attempt to make sense of what happened to her, and focusing on the alcohol abuse is a means of gaining control over her life, the alcohol is an apparent self-inflicted harm, something she did to herself (which gives her space to vent her self-blame, guilt and shame) therefore it seems controllable, as opposed to her childhood that just happened to her.

7.2.3 Ambivalence: Anger and hostility towards or idealization of key persons

- Helen and Sadeedah both idealized their mother when they grew up. But in treatment a different picture, the one of an abusive neglecting mother, starts to appear, which is very difficult to deal with. In Sadeedah's case splitting is one of her early coping strategies, which is demonstrated in the narratives around her mother and her in-laws.

- As a child Lorna idealized her natural mom who would come and take her for holidays where she was spoilt rotten. On the last visit that fantasy was destroyed when Lorna was confronted with the reality of an irresponsible alcoholic mother, with all hell breaking loose when Lorna found out the reason for her adoption was that her mother was not married.

- Kate presents an idealized picture of her father who died a couple of years ago from lung cancer. During the preceding illness she grew closer to him by ignoring the past. Her memories about her father are invested, in the sense that it's not proper to speak bad of the dead; on top of that certain similarities between her and her father are confronting and threatening, making it virtually impossible for her to acknowledge that her father was an alcoholic who terrified, tyrannized and verbally and physically abused his wife and children. Kate claims not to remember any of this (although she documented this extensively before) and shifts all her negative feelings towards her mom who is too controlling and interfering. During treatment this idealized picture starts to crumble and reality filters through the cracks:

> Kate: "I don't know if I blocked it off (.) I remember (.) No, I do remember those holidays were very embarrassing. [Followed with examples]. I didn't know him. I mean he was someone at night whom we had to stay away from. And mom always sort of kept us away. I just remember him sitting in a dark room, drinking. [...] he was never... I don't remember him being verbally or physically abusive to us but certainly at night he'd shout and we couldn't

> hear what it was all about, certainly when I went back to X when I did my last three years of school. Very verbally abusive and you know, calling names and just complete nonsense you know. And just, just horrible, and he'd become this completely different personality."

- Yolandi was adopted at birth and doesn't know her biological parents. She has an insecure attachment and ambivalent relation with her adoptive parents. This seems to be the story of an adolescent trying to find an own identity and stand on her own two feet, but in this case the separation-individuation is complicated by the adoption, where the need to be independent is regarded as a disloyalty to and rejection of the adoptive family. Past experiences that might have been negative, are blocked off:

> Yolandi: "I can't really remember. I've got such a bad memory loss. I couldn't actually remember I had a bad childhood before I started my shit. My only happiest moments were when I took drugs. When I walked into my house I was always down."

Certainly the 'taboo' around her adoption is hard to digest and makes her more attentive to all the differences between her and her adoptive family. Being adopted might mean having other issues to deal with on top of the normal developmental ones, making it even more difficult to rebel because the adoptive parents' love is not guaranteed by blood ties.

> Yolandi: "There was some time in our life when I didn't know if they loved me. [..] My brother had put them through hell [.] I was the cherry on top."

7.2.4 Relationship Problems

After chronic abuse partner relationships can become the stage of re-enactment of former abuse. The strong ambivalent relationship with the caretaker can be repeated with the partner, the most obvious form being the co-dependent relationship. This co-dependency even substituted the drug addiction in Nicky's case: after her first rehabilitation episode she stayed clean for a couple of months, but the relationship with her boyfriend substituted the drugs, the same amount of preoccupation and obsession could be recognized. After the first treatment she went into secondary and into tertiary care but she was still in her relationship and it got very

> Nicky: "hectic….I was practically *psychotic* because it was a severe case of *co-dependency*. It was just driving me wild. And things I was *doing* so I could just *be* with him, you know, he *was* my drug, you know. It was like *my total drug* and I was just *exactly*, I would do the *most crazy things* to get to him and be with him and also it was as if I was using."

When they eventually broke up, she relapsed.

One of the only elaborated narratives in Tracy's life-story presentation was the relationship with her boyfriend Justin. The way she grew up (verbal and physical abuse by both parents) was reinstalled and her insecure attachment repeated. In the end she obtained a confirmation of her self fulfilling prophecy that she's not worthy of respect and love. The whole relationship is marked by ambivalence:

> Tracy: "Very loving boyfriend... He loved me very much and I never cheated on him *never ever*. He *did* lie to me once... quite a lot [.] very dishonest. [...] I would do anything for him[.] I wouldn't compromise".

The compulsive repetition of her past abuse in her present partner-relationship is attributed to the use of drugs. She truly believes her boyfriend never did anything abusive because that would be a wrong thing to do.

> Tracy: "There was no communication, we were always using drugs, it affects me terribly. I get aggressive, go mad, hit his face with a shoe. [.] I used to verbally abuse him but he *never ever* verbally abused me. [.] He never hit me although I provoked him. But he pushed me off the bed, threw me against the cupboard and strangle me. He never physically abused me because I think that is so wrong to do that".

7.2.5 Repetition Compulsion

Severely shocking events that are repressed and remain unprocessed are looking for another way out. On the one hand constant drugging will help to keep any uneasy feeling or thought away from consciousness, on the other hand certain ways of reacting will increase the chance on reinstalling the same powerless condition and thus setting the scene for retraumatisation. The substance abuse is typically a disinhibitor for actually putting the previous abuse back in scene. Due to a lack of basic trust these women experience difficulties engaging in relations. Own neglect and abuse is repeated towards loved ones, either being the perpetrator themselves or otherwise reproducing an equally abusive situation with their partner.

- Joanne emotionally neglected her second child the first 5 months of its existence. When she was drunk she verbally abused her children and her husband frequently and would get into huge fights with her husband where she would be throwing anything she could lay her hands on. This carries a lot of similarity to the situation in which she grew up.

- Nancy as well used to verbally abuse her husband, just like her parents who were constantly fighting.

- In every relationship Helen engaged in, she acted out her deep mistrust in males, eventually confirming her own picture that all men are untrustworthy. After being violently raped, she got involved in a series of equally abusive relationships.

- How substance abuse can adopt an active role in repetition compulsion is demonstrated in Yolandi's story. At age 13 she was nearly molested by her neighbour, a couple of years later she was raped by a fellow-student. Whilst drugging she would always overdose resulting in a complete lack of control, which made her an easy target for people with bad intentions and put her at risk for retraumatisation. For example she took an overdose of liquid E in a group of peers with a guy constantly trying to approach her in her unconscious state. It was sheer luck that the guy didn't succeed.

- Rachel was hit 'quite often' as a child and ends up in a relationship where she was frequently beaten. When drinking, she repeats something unresolved of a sexual nature (unprocessed sexual harassment and amnesia about her childhood) and adds new traumas on top of that. She was dumped by her first boyfriend, and started fasting and drinking a lot. At a sober moment a man fell in love with her and married her. But she got bored and picked up drinking again, which "made her morals drop" and she committed adultery with one of her colleagues. She ended up in an abusive relationship, terminated this after a couple of years and went on drinking binges always ending in sleeping around. Now she has found a steady partner again but the repetition of the same event (cheating on her partner with a colleague while drunk and him walking in on them) made her end up in treatment.

- All women who recounted regular physical harm re-enacted this abuse by either self-mutilation (Nicky, Sadeedah), or frequent suicide attempts (Rachel, Sadeedah).

7.2.6 Depression, Anxiety

Most of the women (10) experienced some form of depression during the course of their lives. Lorna, Marie, Joanne, Nancy, Ruth, Kate, Nicky, Sadeedah and Tracy sought professional help for this. Yolandi is going through an extended mourning process for her friend's and grandmother's death. Previous treatment history is discussed separately in appendix B.

7.2.7 A Number of Numbing Strategies

- In case of extreme violence (Sadeedah) dissociation, balancing between numbing and re-experiencing was found, resulting in a fragmented life-narrative.

- Nancy experiences an extended mourning process for her deceased sister-in-law because previously she used substances all the time to numb her grief, resulting in overwhelming sadness and anger once she got sober. During therapy she keeps avoiding and numbing all these emotions (counsellors refer to this as 'dry drunk'), resulting in a flat story, a compilation of unchanged hear-say stories.

7.2.8 Various Somatic Complaints (sleeping disorders, gastro-intestinal problems, head-aches, migraine attacks, nausea, vomiting,...)

- Sadeedah started taking a number of pills from an early age on because she didn't feel well.

- Some women adopted numbing and blocking off as their normal coping strategy. Their life-story was typically characterized by superficiality, flatness and a lack of narratives. But their lives seem to be ruled by symptoms that could be interpreted as possible traces of trauma. These symptoms then serve as justification to continue using drugs and as motivation for their desperate need. Any link between symptom and initial trauma however is erased: Marie describes herself as very shy and suffering from anxiety attacks every time she has to meet new people. She finds herself a normal person, nothing special, just very tense, a loner. Significant is that whilst growing up she was never allowed contact with anybody, and the one who was always there horribly mistreated her. Marie drinks to be able to sleep at night and hopes her anti-depressants will fulfil the same function. Rachel presents some symptoms during childhood that might suggest that something happened to her: She describes herself as a very shy girl that was terrified of men, and of her grandfather in particular. She suffered from enuresis for quite a long time but has no explanation for that. She presents a very negative self-image namely "a shy chubby child with glasses that constantly wetted herself". Rachel claims not to have "an awful lot of self-confidence" so she "drinks to compensate for that".

7.2.9 Silence

Lack of basic trust induced by emotional neglect (Yolandi) or abuse (Helen) combined with excessive physical violence (Sadeedah) forms the basis for an accumulation of trauma. Because there is no trust, further shocking experiences are kept a secret. Remarkable was that the three women who were raped didn't talk to anybody about this for years. All three ended up in an abusive relationship and two of them had one (Yolandi) or several abortions (Helen).

Crucial in these stories is not the fact that they were raped but rather the years of silence around the whole event. Yolandi didn't tell anybody for 4 years, she was petrified because the rapist threatened her, and she blamed herself. Sadeedah and Helen equally blamed themselves for what had happened. Typical is that when they finally disclose the event they do it under such conditions that they are at high risk of being disbelieved. Yolandi told her mother during a fight, who didn't believe her. But because she insisted the mother finally acknowledged the event but blamed her for it. Helen never spoke about it with any of her family, only with her present husband. Sadeedah told her mother about it more than one year ago, who equally blamed her for it.

> Sadeedah: "I only told my mother about this, now about 15 months ago, only told her about it then. So she said to me hm. I don't know the exact words but something like 'Can you see what happens when you don't listen, because you were not supposed to let your friends in.'

> So that was the reason why I got raped. Because I wasn't allowed to let them in. Even though it happened so long ago it really hit me. He broke my virginity and I was raped. Even now I'm still asking 'Why? Why? Why?'."

This silencing results in repression reflected in unawareness of how certain events in life link up: after 2 years Yolandi changed school because she "couldn't handle the 'black' guys any more, I seemed to attract them". She makes no link with the fact that she was raped by a 'black' guy and that he gossiped and bragged about his act to his friends.

7.3 CONCLUSION

In the life-stories certain traces of trauma could be found, although many women didn't make a direct link between traumatisation and its sequelae. Trauma can shake the beliefs in the self and the world as illustrated in a negative self-concept (internalisation of continuous criticisms, fragmented self-image, wearing a mask, feeling odd/different/ damaged, poor self-esteem), with guilt, shame and self-blame as an attempt to make sense of what happened and to deal with the powerlessness. The disruption of basic trust and loss of commonality after trauma can be recognized in the ambivalence (anger and hostility towards or idealization of key persons) and problematic relationships. Part of the trauma-dynamics are repetition compulsion (re-enactment of previous abuse resulting in retraumatisation or becoming perpetrator; self-mutilation, suicide-attempts), numbing strategies (splitting, substance abuse), and silence; with somatic complaints, depression and anxiety as possible indicators that something is being covered-up.

All these trauma-remnants combined with the signs of repression and denial (as discussed in chapter 7) indicate a stagnation in the elaboration of trauma and form a strong argument for the impact trauma might have on the lives of addicted women. This will be further explored in the final chapter.

Chapter 8 :

Concluding Remarks and Implications towards Practice

8.1 INTERVIEW DYNAMICS

Own Input

> *"The narrative psychological researcher, as in other qualitative and discursively oriented approaches, believes that the material used in any kind of analysis is deeply influenced by the researcher. This is in contrast to more scientific approaches, which aim to achieve a state of objectivity and neutrality in which the analytic material exists and can be interpreted in isolation from the researcher. Rather than collecting 'neutral' data, the narrative psychological researcher frames the question, picks the participants and interacts with them to produce data that are then used for analysis"* (Crossley, 2000: 103).

The subsequent section will have a look at the personal influence of the interviewer on the interview process and the analysis. Interpretation of life-stories is a highly personal matter, even intuitive and empathic at times, in which each narrative is considered a unique story. Like clinical psychoanalysists, I tried to pay attention to counter-transference as well as to transference dynamics, to my defensive blind spots and those of my interviewees.

As described in chapter 4 a substantive part of the interview process was spent on creating a good atmosphere and safe environment. My overall impression was that the interviewees quite enjoyed talking to me and telling their story to a non-judgmental interested listener. Being a non-South African counsellor with Dutch as mother-tongue seemed to help in lowering the normal threshold between interviewer (academic) and interviewee. Straight from the onset they noticed my 'funny' accent, making them smile at some of my pronunciation mistakes. Certain women liked explaining 'the South African way of doing things' to me. The Afrikaans speaking women thought it nice as well that the interviewer could understand Afrikaans words used during the interview and loved trying to communicate in Dutch - Afrikaans, which made the whole interviewing process more relaxed and pleasant for both parties.

Transference, Counter-transference and Counsellor Tests

In this limited interview-procedure it is quite difficult to get a clear idea on transference and counter-transference issues, apart from the obvious. The interviewer tried to keep a low profile which might have contributed to some women having difficulties placing me either as a researcher, who has expert

knowledge, or as yet another counselling opportunity, or as a potential friend to whom they reported a very private part of their lives. There seemed to be a continuous shift among these different positions. Transference was recognized as three women explicitly told me I reminded them of a good friend of theirs. Regarding safety and transference the interviewer aimed to respect the pace and sequencing of the interviewee, and to be as attentive as possible to relationship dynamics as described in client-centred counselling such as 'tests of trustworthiness, knowledge and experience, boundaries, empathy, and containment'.

> Ruth: "You remind me of a friend of mine from school. She looked just like you [.] You're from Belgium. [.] Did you hear about that Belgian girl that ran into someone? It was last Sunday or the Sunday before. She was driving around Camps Bay, a 35 year old Belgian woman, she was drunk and on drugs. She knocked someone over, a very well-known Cape-Townian guy and she drove off from the scene. And people pulled her over and she didn't even know she ran over someone at the time. That's how high she was. She's now in for murder. But isn't that just another typical example of the trouble you can get yourself into. And now she's in big trouble. Huge trouble. Shame, I feel sorry for her [.] Do you drink, though?"

A 'test of empathy, safety' indicates that the client is unsure about the counsellor's integrity and ability to understand her particular problem, resulting in an attempt to control uncertainties which can take on numerous forms:

> Helen: "I feel funny about being recorded because I work in the voice industry and normally I'm the one taping other people. Is this your microphone? Ok, I will hold it. I'm switching it on right now."
> Nancy: "I've just done my life-story here, should I go and fetch it quickly? Can I read it to you?"
> Ruth: "What was I saying again?"

In Lorna's case a humoristic, light tone was set at the beginning of the interview as a way of diverting difficult topics. There was lots of interaction with the interviewer as a means of regulating the depth of disclosure.

> Lorna: "I was born on the 14th of February 1976 and it was on Valentine's Day [explains South African custom]. I was born out of wedlock and my biological mother is my adoptive father's sister. Are you with me? [explains more clearly]".

Using a 'test of knowledge and experience' the client wants to assess if the counsellor has enough mental capacity and background knowledge to deal with her specific problem:

> Ruth: "I read an article in Femina about a girl who is addicted to heroin. And she took heroin and she carried on taking heroin while she was pregnant with two children and then she said that she thinks addiction is an internal negativity, like an absolute (.) you're just negative about everything and only coming off drugs you actually have the ability to start being positive again."

A 'test of trustworthiness' tries to determine to which extent the client can rely upon and trust the counsellor. For instance, Elsie suddenly started to laugh uncontrollably in the middle of the interview. Apparently this laughing fit functioned as a means to fend off confronting or embarrassing topics. Answering to my puzzled look Elsie apologized and explained she always starts laughing when she is nervous. When asked if talking to me makes her nervous she replies:

> Elsie: "I just laugh about the questions you have to ask me. I just want to tell you that I don't want you to talk about that Rasta thing because I feel really uncomfortable about that".

Nancy is very avoidant of feelings, stays superficial and includes a 'test of the counsellor' in her statement that prevents further questioning. Because if the interviewer asks to specify her general statement then this will mean that the interviewer didn't listen properly to what the woman recounted before:

> Nancy: "Sometimes things are coming to me [.] feelings, unmanageable life, things I did, significant ones. The ones I told you about."

A 'test of containment' aims to determine how much horror the counsellor can take and is closely linked to tests of empathy and trustworthiness. Lorna carefully gauged my reaction when she narrated how horribly her body was damaged by the accident while she kept absolute control over her emotions. Joanne managed to construct a chronological story covering all disturbing events she experienced (a trail of chronic and acute trauma) but subsequently became really protective of her construction, curtailing criticism and judgment before anybody could even think about it. The narrative was brought in a detached manner as if relating someone else's story. To the listener this sounds as a completely shocking horror-story while the 'survivor' continues to recount new stories of abuse, neglect, violence, in a calm voice as if she's talking about someone else's life. In counselling this is described as 'emptying the dustbin', the client comes for one session when her personal dustbin runs over, pours it out over the therapist and leaves, because she feels temporarily relieved on one side but over-exposed and uncontained on the other side as she is now confronted with all the overwhelming emotions associated with telling the story before a safe environment for disclosure is established. Being and remaining in control, mastery is essential whilst recounting the life-story.

The limitations of the counsellor and the counselling situation are tested through a 'test of boundaries'. When Sadeedah walks in she displays enervation and boredom in her attitude, although she volunteered to do the interview. After the introduction and explaining the purpose of the session she exclaimed: "But I just did my life-story here. I can read it to you." When replied that I preferred her to do it on the spot, at her own pace and in her own wording, she immediately started her story. At the onset of the second session she remarked: "You are under-weight, I know because I've always been anorexic myself so I know the signs." Ruth implicitly conveyed she wouldn't mind me being her counsellor by frequently affirming my listening skills and comparing them to her own experience with counselling.

From my part, I think I related well to all the interviewees, but Elsie left me somewhat perplexed as there was something about her that I could not grasp. Talking to Rachel felt somewhat like hitting a brick wall when I was confronted with all her defences, but I tried to respect her way of presenting herself.

8.2 CONCLUSION

The scope of this study was to conduct qualitative research into the life-stories of addicted women, with a special focus on the place these women accord to trauma in their life-narratives, to shed light on how trauma and addiction can be intertwined in the lives of women.

Trauma and addiction were conceptualised using a Freudo-Lacanian perspective, which starts from the notion of a divided subject. Language mediates all experience, but the problem is that there is a fundamental gap in our symbolic system, resulting in the inability of language (the Symbolic) to cover reality (the Real). The initial confrontation of the infant with this gap forms the primary trauma, and in a defensive elaboration to cover this trauma the subject is constituted and ever reconstituted in speech. Because the subject takes on different discourses, it is fundamentally divided. On top of this structural trauma an accidental trauma can be put when the subject is confronted with a shocking event (acute) or a series of shocking events (chronic) which can't be put into words. This study focused on the acute and chronic individual accidental traumas addicted women recounted.

Trauma is a lack of words in face of a devastating reality, the inability to accord words and therefore meaning to a shocking event. It is a disruption of the narrative chain. Experiencing trauma is certainly not unique to (addicted) women but is part and parcel of a human life. The normal way of working through a shocking event consists of attaching a signifier, a word, a label to what happened. This label is the first attempt to cover the horrifying real and indescribable bodily sensations provoked by the event, and forms the start of a signifying chain. More words can be attached gradually; clauses and sentences are constructed, resulting eventually in a narrative around the traumatic event that can be fitted into the life-story. Substance abuse constitutes a short-circuit in the normal elaborating process

and consists of a choice outside the realm of language. Acts on the body, attaining a certain physical and subjectless state are preferred over working through. In addiction this initial coping-strategy has become the problem itself, covering up what is lying underneath. The substance substitutes the self, subjectivity, relations and any need or desire.

Literature and research were consulted to get an idea of what is known about trauma and addiction. International literature claims there is a connection between substance abuse and trauma, and even more so in women. South African literature on violence against women obviated that this type of violence is widespread. This might suggest a high level of trauma in South African females, so we could reasonably expect to find a lot of substance abuse as well. SACENDU-data helped us to draw up a profile of the female addicts found in rehabilitation centres in the Cape metropole and demonstrated very low numbers of females in treatment. In order to determine whether the link between addiction and trauma is less likely in South African women two sub-analyses were conducted. A short survey in SANCA outpatient rehabilitation demonstrated that trauma took in a prominent place in many addicted women's lives. And analysis of Rape Crisis case files showed that substance abuse was an issue for many rape survivors.

The methodology underlying this thesis is a combination of psychoanalytic discourse theory and the narrative approach in an attempt to combine the merits of both approaches and hence create a more complete picture and deeper insights into a person's unique meanings and the topics of our interest. Narrative research starts from a question about a person's inner, subjective reality and her particular way of meaning-making. But in order to pay attention to preoccupations, meanings, conflicts, contradictions, omissions and defences of which the interviewee is probably unaware, the structure of a narrative was conceptualised by free association (following the emotional-associative sequencing instead of the chronological-logical ordering) and core psychoanalytic concepts of defences, investments, unconscious wishes and desires, repression and reaction-formations such as reversal into the opposite, condensation, and displacement were incorporated. Other methodological problems (such as narrative truth versus historical truth) were addressed. The actual procedure was described namely the selection of 14 addicted women in two inpatient rehabilitation centres and the subsequent interview process.

The connection between addiction and trauma on the one hand, and trauma and trauma-remnants on the other hand, lies far beyond a simple cause-effect relationship, hence the research findings are also rather complex. It is not because some women recount experiencing situations like verbal and physical abuse or neglect, rape, sexual assault that they end up with an addiction. But rather because these situations are silenced, repressed, denied, leaving them undigested and unintegrated in the life-story, the need for some kind of coping- or survival-strategy like substance abuse will increase. Hence addicted women can be conceived as stagnated in the process of working through trauma. It logically follows that the more unprocessed events are accumulated, the deeper the addiction will be rooted.

The interview-transcripts were read extensively and in combination with my fieldnotes pen portraits of each case were constructed. Analysis according to discursive patterns resulted in three groupings that coincided with the type of abused substance (alcoholics, drug addicts and combined users). These groupings were reorganized according to type of trauma (single; or combined acute and chronic trauma) resulting in two groupings (alcoholics and drug addicts; combined users) on the basis of which a psychoanalytic discourse analysis was conducted. Each grouping was discussed along their place on the continuum of processing trauma varying from covered trauma- raw trauma- elaborated trauma.

In the alcohol and drug group the two women who recounted acute trauma were discussed first because these cases exemplified the unspeakable and indescribable impact of trauma on their individual lives and their attempt to deal with it. Lorna made an active effort to change the attention to something else (repression) and used loads of words (dense statements with many subclauses, unfinished sentences, etc.) to cover up distressing contents. Although she managed to construct a narrative about an acute traumatic event, emotions were left out. This contrasted with Elsie's story who was traumatised at a young age and only managed to construct a narrative full of gaps, denial, labelling and a screen memory. Having illustrated the impact of single trauma(s) on the life-narratives of addicted women, the attention shifted to the impact of chronic individual trauma and which indicators of unelaborated trauma can be found in the stories of these women. After trauma there is a continuous dialectic between avoidance and reliving and alcohol and drugs can help to increase avoidance and inhibit reliving. When becoming sober, the subject needs to defend herself against threatening contents (memories, feelings, thoughts) by means of repression and denial. These defence-mechanisms can be conceived as some sort of linguistic strategies. Repression could be recognized in motivated forgetting, focus on safe topics, reinterpretation, labelling without elaboration and para-linguistics (immediate repression). Indicators of denial were reversal into the opposite, nonverbal communication, denying the impact, externalisation, minimizing and key words. All these narrative strategies point at an undigested and therefore traumatic content, a stagnation in working through trauma. Addiction initially functioned as self-medication or coping-strategy, bringing relief from any feelings of displeasure, but eventually resulted in increased avoidance and inhibition of the working through. The referral patient illustrated how addiction can serve to completely cover-up the past, to maintain the silence and repress uneasy memories and feelings resulting in a short, incoherent and superficial life-narrative full of gaps, lack of emotion or transposed emotion, frequent change of topic and condensation.

In the combined user group a more complex life-story (with a combination of acute and chronic trauma) and an equally complex addiction was found. Similar techniques to repress and deny were manifest in enlarged format. Helen's case was discussed separately to illustrate the process of working through an accumulation of acute and chronic traumata. By means of afterwardsness, rationalization, humour and summarizing she managed to construct a coherent narrative, but the high emotionality and displaced emotion indicated she was actively elaborating the associated emotions. Subsequently three women's cases were discussed under the title 'premature foreclosure' because their narrative had stagnated,

with repression, denial and silencing taking on a life of their own and constituting an alternative, cover-up story. Blocking off, generalising, motivated forgetting, indirect clues, humour, focus on a safe topic with the substance narrative substituting a trauma narrative, were forms of repression. Denial techniques were reconstructing the past, negation and contradiction. In those cases we saw that addiction can become part of the trauma-dynamics: repetition and reliving versus numbing and dissociation, avoidance of and escape from distressing emotions, memories or flashbacks. This defective mastery attempt also increased the chance on re-victimization, with possible installation of a vicious circle of trauma and addiction. This was better expounded in Sadeedah's fragmented story. Sadeedah's case constituted an example of the inability to integrate early extreme violence, resulting in a fragmented story marked by dissociation, unprocessed narrative fragments, displaced emotions and an alternate focus on trauma and substance abuse in order to regain some sense of agency. Nicky's case represented raw trauma where addiction served as some dubious survival strategy. Her story was marked by wordlessness and jouissance (something higher than the self that enjoys in spite of the self). Memories and emotions were split off and frequent admission in mental health care had enabled her to at least construct some kind of story. Nicky used the substance or behaviour in such a way that the same wordless, alienated state of non-being could be reached. The subject as storyteller had disappeared, with as result no words and no story.

Trauma literature pays a lot of attention to short-term and long-term after-effects of (sexual) abuse at cost of more common forms of abuse (emotional abuse and neglect, verbal abuse, physical abuse and neglect) and disregarding notions of resilience. On top of that the term 'after-effects' has a strong causal connotation, therefore I opted for a range of terms to retrieve how trauma (chronic and acute) impacted on the lives of the interviewed women. In the life-stories certain traces of trauma could be found, namely trauma can have a deep impact on the beliefs in the self and the world as illustrated in a negative self-concept, with guilt, shame and self-blame constituting attempts to make sense of what happened and to deal with the evoked powerlessness. The disruption of basic trust and loss of commonality after trauma can be recognized in ambivalent and problematic relationships. The trauma-dynamics of avoidance versus reliving could be retrieved in compulsive repetitious acts (self-harm; retraumatisation or becoming perpetrator), numbing strategies (splitting and substance abuse), and silence; with somatic complaints, depression and anxiety as possible indicators that something is being covered-up.

All these traces of trauma combined with the earlier discussed signs of repression and denial indicate that trauma takes in a major place in the lives of the interviewees. These addicted women seemed stuck in the wordlessness of trauma, unable to forget, and in need of a substance or behaviour to cope or survive. Therefore the concept of trauma can possibly constitute a useful metaphor in the treatment of addicted women. Trauma can be the first signifier to be accorded to a complex amalgam of shocking and disruptive experiences in these women's lives, the start of a whole signifying chain, enabling them to pour the undigested shocking events into a narrative format and process this story until it becomes more manageable, allowing their coping or survival strategy to lose its indispensable character. Looking

at their life-stories as marked by trauma and their addiction as a coping or survival strategy provides an extra dimension and deeper understanding of an often complex and puzzling life-narrative and can therefore work in empowering ways for addicted traumatised women.

8.3 LIMITATIONS

The question of how typical these life-stories are of other addicted women is a legitimate and somewhat perplexing one. Due to the fact that this research was only conducted on a small sample of 14 white upper to middle class women recruited from treatment, general conclusions will be avoided. The aim of the research was to provide a qualitative view of the women admitted in inpatient addiction treatment. Upon agreement with the treatment staff of both addiction treatment centres, only the more average cases were selected, with personality disorders related to severe childhood abuse being termed as strong counter-indication and hence excluded from the interview procedure. In these women the connection between addiction and trauma is probably even more pronounced, and would be an interesting research topic in the context of long-term individual psychotherapy. Another point is that clinical samples do not provide an accurate representation of the general population, and a bias in their suffering from after-effects can be expected. In the general population we are more likely to encounter the influence of protective factors such as social support, non-judgmental and helping reaction of the environment, and early nurturing and loving relationships allowing development of basic trust. Therefore conducting a similar project in other, less accessible population groups would be very interesting as well, for example checking outpatient addiction treatment and shelters, or putting an add in the newspaper and spreading flyers in bottle stores.

This research had a clear focus on subjective experience instead of reality, so in order to get an adequate picture of reality, future research should concern a larger sample with counter-checks and cross-validation as part of the research planning.

My research didn't incorporate a long-term perspective, due to the limited time available, and because I believe there wouldn't be much difference if I checked the treatment outcome a couple of months after the interview-sessions. Long-term follow-up would definitely provide more information about effectiveness of treatment and help to determine which people benefit from which type of treatment.

Another limitation of this study is that I only interviewed women. A similar project conducted with males might allow a comparison between the two sexes in how they think certain life-events impacted on their lives and later addiction.

Psychoanalytically the interview data lent itself to much wider interpretations, but since I didn't want to fall in the same trap of misinterpretation and over-analysing as I criticised in the introduction, and had approximately two sessions with each woman I was rather wary of extensive interpretations. These

sessions only reflected a small portion of their actual life-course; hence I believe more inclusive interpretations are better at place in psychoanalytic case-studies documenting long-term psychoanalytic therapy or psychoanalysis.

The discussion of the results can be said to be an oversimplification of a very complex reality. To put all drug addicts in one group and then throw these together with alcoholics in one big group to conduct an analysis, sounds as if the researcher is completely insensible to the different effects the various drugs attain. My study did not aim to provide an in-depth-perspective of the specific types of addictions but rather tried to illustrate the similarity in all these different stories, namely the unprocessed traumas.

AFTERWORD

All the stories these women shared with me were very interesting and touching, and I thoroughly enjoyed getting to know these women a little bit. I hope that telling their story to me was equally beneficial for them. Some women affirmed this when I asked for their over-all impression of the sessions.

Dealing with these 14 life-stories was not always easy, but my method consisted of writing down in detail what the story evoked in me. After finishing a session I would typically take about 20 minutes to an hour to write down all my observations, impressions, feelings, thoughts around the whole interview in a little notebook called "Fieldnotes". Doing that stored it in a safe place where I could reflect upon and re-read it any time I liked, which meant my mind was released from ruminating over everything that was discussed. So most of the time once I finished my writing session, I felt refreshed and looking forward to the next interview.

I felt a sense of drama whilst talking to these women, namely how many had to hit their personal rock bottom before they could reach out and ask for help and hope to find adequate help. This constituted a strong motivator to initiate and continue my search into the connection between trauma and addiction in women.

For one session this whole procedure was not as effective. Nicky's story really grabbed me. Although I couldn't get to an actual specification of her abusive childhood, just the whole picture made me feel tremendously sad. She looked like a really beautiful, sensitive girl with many abilities and astonishing inner strength, but struggling 'hectically' (to use one of her words) to survive, unable to be just Nicky without being overwhelmed by horrendous wordless memories and outrageous emotions. As she was talking about her childhood, it was as if I could hear the pain shouting out loud along with every word she uttered. There seemed to be such destructive power that it was almost frightening coming from this petite young woman. The thing that saddened me most was the fact that she was 'fighting the program', and the consequences thereof. Nicky was already moving away before she had found the courage to even have a look at that complex armoured knobble of unprocessed emotions. The knowledge that her present fight would solely result in a continuation of her self-destruction added on to that. I only managed to have one session with her and truly hope that somehow she will find a way out of her darkness other than self-annihilation. My own unresolved feelings after speaking to Nicky definitively gave me renewed energy to attempt to make the best of this thesis and increased my determination to try to contribute to the knowledge about and treatment of traumatised addicted women.

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* Please note that three references are incomplete. The missing information concerns chapters in books I had at my disposal in Belgium but that I could not find here in South Africa.

APPENDIX A: Pen-Portraits

The pen-portraits consist of a summary of the successive interviews, putting all the information together; and reflect the formulations the women themselves used. An effort was made to delete all information that could reveal the identity of the interviewees. Therefore pseudonyms were chosen for each case out of a list of Afrikaans and English female first names an uninformed friend composed. The titles accorded to the cases are a combination of how these women described themselves and the most salient themes in the interview. Fourteen interviewees were recruited from two treatment centres which will be referred to as 'Courage to Change' and 'The Pilgrimage'.

Marie, the loner 16/09/02; 25/09/02

Marie is a 47 year old, rather skinny, Afrikaans speaking woman. Striking about her outer appearance are her sad big blue eyes that stare in the void so many times, as if she is living in another world. During the conversation she seemed to go numb many times. Marie claims to be a very nervous and tense person, which didn't really show in her outer-looks except for the trembling hands. I would describe her as a shy person, speaking very softly and hesitantly which made her at times very difficult to understand. It seemed as if she was conveying that she is not worth listening too.

During the first interview she recounted growing up in a poor family, where her father (who was an alcoholic) severely physically abused and materially and emotionally neglected her. Marie's mother was in and out of hospitals and psychiatry. She was the oldest of 4 girls, an adult child in charge of housekeeping and nursing her 3 sisters[1]. During her childhood and teens she was never allowed anything pleasant, and not allowed to play with other children. This shows through in her later life where she retired from the world, because she's "not a family-person", "I prefer being on my own".

She married at a young age to get out of her parental home, and ended up in a physically, emotionally and verbally abusive relationship for 4 years. This marriage gave her one daughter. She divorced her husband just after her child was born because he cheated on her and made a complete mess when she returned from maternity hospital. More details about any of these experiences are not provided except for hints in the tone of voice, pacing and body-language suggesting how bad everything was.

Her alcoholism started 6 years after her divorce, socially at first. Her use decreased during her relationship with a German. The relation ended due to him being transferred and him being involved in a divorce. Her drinking increased and her daughter tried to motivate her to do something about it. When she went for smoking-therapy she got referred to a psychiatrist who admitted her to hospital because her liver was 'buggered up'. Just before rehabilitation she encountered a lot of stress at work, and she claims only to drink at night to fall asleep, in combination with sleeping tablets. But her liver tells a different story which makes the denial of the severity of her alcohol and medication abuse a bit harder. She finds her "Alcoholism is stress- and depression-related" and puts all hopes for a happier life in the new anti-depressants her psychiatrist is prescribing.

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[1] I am aware of the convention to write numbers under ten in full but for matters of space limitation I will use the numerical version.

Her daughter and the psychiatrist could finally convince her she has a problem so she was referred to 'The Pilgrimage'.

Joanne, the fallen mother 17/09/02

Joanne is a 39 year old, English speaking, well-groomed lady, who is quite self-reflective but very self-blaming. She remains in control the whole session, something that marked the interview-procedure as well, meaning that a second session wasn't effected.

Joanne experienced severe abuse during childhood and teenage years, from both parents. The first years of her life she grew up with a violent alcoholic father. She was the youngest of four in a very poor family. After her parents divorced her mother became violent, emotionally and materially neglecting, and verbally abusive towards her children. Her mother started drinking and remarried a violent alcoholic with 3 children from his previous marriage. Joanne was involved in her stepfather's accident that left him permanently disabled, for which her mother always blamed her. Later on she was the scapegoat for her sister's rebellion. Joanne married to leave home, and got two daughters (16 and 15 years ago). She emotionally neglected her second daughter the first 5 months of her existence. Joanne seems incapable to accept any happiness coming her way and has self-destructive tendencies: "Everything is my fault. I abused my own family in every possible way. Why are they still there for me?"

Her alcoholism is characterized by a late onset and an accelerated course: She had her first drink at age 26 and hit rock-bottom at age 39. Joanne tried to stop on her own but didn't succeed and after talking to her Christian counsellor she decided to book herself in at 'The Pilgrimage' because her work was at stake.

Nancy, the glamorous table-dancer 18/09/02, 24/09/02

Nancy is a 40 year old, English speaking woman, who looks 10 years younger. At our first introduction she let the whole group wait because she wanted to put on something lighter, after which she showed up in a mini-dress. At first sight Nancy seemed a 'tough' woman who would never be prepared to participate in the research, in the end she was the one most eager to talk to me. Her attitude apparently conveys she looks down on people, but person-to-person she is rather gentle and sensitive alternated with a very detached and superficial manner.

Nancy is the oldest girl of 5, and describes herself as being some kind of Cinderella for her 4 brothers. She grew up in a poor family with her mother being the breadwinner, and her father being "a genuine unambitious low-achiever who verbally and physically abused his wife and children". Nancy was an adult child, being over-protective and closely bond to her mother, nursing her brothers while mom was working. Her first boyfriend, who fooled her into having sex with him, later dumped her, which triggered her anorexia. Excessive fasting was her way to deal with rejection. Later on she got engaged to a rather possessive guy who supported her treatment for bulimia but who cheated on her while she was in hospital. Nancy then met someone else and fell pregnant. She had a shotgun marriage, with her son being born 5 months later. The baby had convulsions which resulted in brain-damage. The marriage didn't work out and she was left alone to take care of her son. Her parents

supported her all the way and even took her and her son back in the house. Her sister-in-law who was one of her best friends, almost like the sister she never had, tragically died in a car-accident, after which Nancy experienced an extended mourning process, certainly not helped by her dependency on alcohol and drugs. When one of her brothers got beaten up badly and nearly died, she went back to her rescuer role and nursed him until he recovered. Meanwhile she drank heavily to cope with her emotions. Slowly she was fed into the clubbing and nightlife scene, where she got addicted to XTC and laxatives and went back to her dancing career. Later on her dancing career evolved to professional table-dancing. Her XTC and drinking habit increased, as well as her anorexia and dependency on laxatives. The table-dancing became more involved and ended in being a call-girl. On one of her jobs she was introduced to cocaine, after which a complete downfall quickly followed. Her parents were involved in a severe car-accident, which added on to her already stressful life. Nancy's drugging, drinking and fasting are closely linked to the sexual scene and emotional events in life.

The immediate onset for her decision to come to rehabilitation was a confrontation about her behaviour and appearance by her mother and aunt. Nancy got really paranoid, fled away and wrecked her brand new car. She was admitted in Rehab1 but was referred to 'Courage to Heal' to deal with her bulimia. When she gets out of 'Courage to Heal' she will continue her treatment in Rehab1.

Little rebel Sandy 23/09/02

Sandy is a skinny, English-speaking, insecure but very friendly 19 year old. She is the youngest of 4, the baby of the family. Sandy mainly grew up alone with her parents because her brother is 10 years older and her twin-sisters are 8 years older. Her father is an alcoholic, who verbally abuses his wife and children. Sandy was introduced to drugs when she worked in her brother's club and met her dealing boyfriend, Robby. At age 17 she took her first pill (XTC, Acid), and became co-dependent with Robby. Sandy did well at school until she started with drugs. She read her final exams high and only just passed. By that time she also received the label 'druggie' at school which she described as very traumatic. Her father had her boyfriend arrested for dealing, which provoked her anger and wish for vengeance. She decided to punish her parents by taking something a bit harder namely speed and crack. After school she started working in the same company as her father and brother. She was smoking before work to get up and keep her up. She started to get paranoid and missing out at the job, the physical dependency became so bad she felt as if she was dying. She moved out of the house and kept drugging. Eventually she went to one of her sisters for help, who brought her to 'The Pilgrimage'. The only spontaneous elaborated discourse is on the effects of the drugs.

Tracy: Surpassed prohibition 22/10/02, 28/10/02

Tracy is a funky dressed 18 year old with an English-Afrikaans background, who looks as if she just walked out of a club. She is number 3 of four children, the only girl with two brothers being a lot older and one being a lot younger. Her father is a Jehovah's witness who brought up his children very strictly. What impacted most on Tracy were the hidings without explanation (for breaking the ever-changing numerous rules her father imposed on her), and the continuous verbal abuse from both parents. "Never allowed anything" as opposed to "freedom" are keywords in her story. At age 15, Tracy was badly beaten up by her father when he found a letter from her mother who had fled to Jo'burg because she had a nervous break-down. The letter stated Tracy was to blame for this. Tracy is still very shaken about that event and can't understand why her mother wrote down such thing.

She started taking XTC and going to clubs at age 15. A couple of months later she went to live with her second brother, where she experienced complete freedom and did lots of XTC, Acid and speed every weekend for 2,5 years. She met her boyfriend Glen in a club and got involved in an abusive co-dependent relationship in which she acted out her own verbal abuse which provoked him to physically abuse her. Together they got into more heavy drugs such as cocaine and Mandrax. They broke up for a while and Tracy got Prozac from her mother to deal with her depression. But she stopped taking those pills because she picked up weight. After that Tracy went on a big heroine binge with one of her girlfriends until she experienced severe withdrawal (cold turkey). Tracy and Glen got back together and tried to get clean but Glen crushed her trust because he was using behind her back. They broke up again. In her despair Tracy sought help with her parents, the family reconciled and they brought her to 'The Pilgrimage'.

Helen: Healing the self 25/10/02, 29/10/02, 21/11/02

Helen is a 38 year old slender English-speaking woman with an attractive face. She's very verbal, well-spoken and intelligent. Her painful story is characterized by a high amount of self-reflection. She is rather directive and controlling, and takes the level of disclosure and pace, timing and course of the interview, in her own hands.

Helen is number 2 of three children with her sister and brother differing only one year in age from her. Her father abandoned her mother when she was pregnant with their third child, stating that he needed time for himself. But meanwhile he moved in with another woman. For 5 years he would occasionally visit the family and claim his rights as a husband. Her mother kept hoping he would come back and kept a vigil thrice a week with her children praying for him to come back. From a very early age on Helen was an adult child, "mother's blessing", counselling and nurturing her mother, and siblings. She described communication and control as her survival mechanisms. After 5 years they found out the father was deceiving them, and her mother had a nervous breakdown. Her mother had the marriage annulled by the pope and after a while she remarried an abusive pilot who cheated on her from the very start. Helen found love letters from other women, which she showed her mother, effecting the desired separation as well as her mother's second nervous break-down. The whole time her mother was very emotionally unstable, clinging to her daughter, pills, and binge-eating to solve her problems. During her childhood there was a constant fear for her mother's desperate attempts to

find a new husband, some of them being really abusive towards the children. Meanwhile the 3 children went to visit their father and his new family in Jo'burg once a year. These visits were very stressful as well because of mom's ambivalent reactions and the fact that her father sexually approached her two times. Helen lost her virginity at age 13 with a friend of her father and slept with three other men during that same holiday.

At age 15 Helen moved out of the house and went to live with her boyfriend Paul, who introduced her to drugs. He was a surfer and into smoking marijuana and Mandrax together with his friends. Although they loved each other very much Helen could not be with him without fighting and constantly testing him. After 8 years together they broke up and Helen was really depressed and not eating. She tried to find support from her father who ignored her but later invited her to a big function of his company. Three days before the event he showed up at her apartment, completely drunk and he sexually harassed her. Helen made a big scene and had the police throw him out of her flat. She went on her first alcohol-binge for 3 days and decided to take revenge by spoiling her father's function. She showed up dressed as a vamp and made him feel completely paranoid. A couple of days later her father wanted to meet her and set her up with a friend of his who beat Helen up and violently raped her with the father's consent. She didn't tell anybody about this and later made up with Paul and married him. This marriage only lasted 2 years because she felt threatened by having to share her life with a typical South-African male.

After her divorce she found consolation in cocaine and moved to Jo'burg where she ended up in a series of abusive relationships. She conceived and gave birth to a daughter 9 years ago. She called it a small miracle that she managed to stay clean during that period. A couple of years later she met her second husband who introduced her to XTC. They married 6 years ago and lost their first baby through irresponsible drug use, after which they drastically cut-down although Helen kept smoking dagga and drinking heavily. Two years ago Helen gave birth to twin boys. She came to 'Courage to Heal' because she lost control over her alcohol abuse and wants to be a good mother.

Yolandi, the people pleaser 29/10/02, 01/11/02

Yolandi is a 20 year old, red-haired, Afrikaans speaking woman. In group she is very open and spontaneous, individually she seemed very friendly, good-hearted, but rather naïve and not too bright.

Yolandi was adopted as a baby, and brought up in a materially well environment. Her parents couldn't have children and adopted two red-haired babies from different families. Her brother is 3 years older than her. She was brought up very strictly, with the parents being frequently out of the house and not open for communication. The biggest silence in the family was around the adoption, which left Yolandi with a lot of unanswered questions. In her experience there was also a lack of attention and interest. At age 13 a well-known neighbour attempted to molest her but his wife walked in before anything really bad happened. Her parents and brother were enraged about this when she told them. Her schooling was fine, but far from great. Her brother always did well and she only barely made it. She had to do Standard 6 two times. She smoked her first joint together with her brother at age 14, which created a strong bond between them. At age 15-16 she started taking XTC when she went clubbing. At age 16 she was raped at knifepoint by a fellow-student on the school premises

whilst waiting for her mother to pick her up after the exams. She didn't speak about it for 4 years. She finally told her mother about it during a fight and wasn't believed. From age 17 she was involved in a co-dependent relationship. Her boyfriend sponsored all her drugs and she regularly used XTC, LSD, magic mushrooms, Chrystal Meth, Liquid E, crack and Mandrax. Every time she used drugs she used alcohol as well and was constantly exceeding the limits. Her boyfriend was verbally abusive. She became pregnant and he convinced her to have an abortion about which she now has a lot of remorse. Her best friend/admirer was killed by dealers half a year before the interview and she's still very much shaken by the whole event.

Two months before she came to rehabilitation she was smoking crack and Mandrax daily. The immediate onset of her admission was the fact that she stole money from her father's wallet to finance her drug habit and got caught red-handed. Her time in 'Courage to Change' was the longest time she was ever clean for the last 6 years.

Rachel: Repressing the past 12/11/02, 14/11/02

Rachel is a skinny, good-looking, well-groomed, English-speaking 37 year old. She is very articulate, but highly defended, Rachel is unable to reach her emotions and give any depth to the interviews.

Rachel was adopted as a baby and when she was 18 months old a baby-boy was adopted as well. They grew up in a materially well environment, had anything they wanted, but were raised very strict (typical Victorian style), and lacked love and attention from both parents. They were raised by nannies and au-pairs. There was physical abuse and a lack of communication. Rachel was teased at school because of her looks. She describes herself as a "chubby child, wearing glasses, wetting herself, being very shy, and feeling odd because she was the only one who was adopted". She was very afraid of men, and her grandfather in particular. She had a good relationship with her grandmother after her grandfather died. When she was 9 her brother was send off to boarding school and he never returned to live at home. At age 12 she was send to an all-girls boarding school where she had difficulties fitting in and was teased again because of her looks. During the holidays she would go home. At their holiday resort she was sexually harassed by the older boys, but never told anybody about it. At age 15 she decided to go on a diet because she wanted to look "as slim and gorgeous" as the girls in her class. After her first victory (being invited to dance) she just kept dieting till drinking only water out of fear to put on weight. She only weighed 40kg and was expelled from school without explanation (afterwards she heard that it was because she was a bad example to the other girls). Her parents sent her to a psychiatrist who forced her to admit that she is anorexic, followed by constant bargaining with her parents until she gained some weight. She tried to commit suicide several times and was finally admitted to hospital for a couple of months. She gained some weight and went to a new school where she mixed with the wrong people and rebelled (smoking, drinking, having sex). The question about her natural family rose as she was very unhappy at home.

Her first boyfriend was very possessive (made her sign a contract to never leave him) and half delinquent, they got into shoplifting together. When she broke off the relationship he kept stalking her until he fell in love with a look-alike. She started drinking heavily at that stage. After her 21st birthday the social services phoned her to tell that her natural mother wanted to meet her. Her natural

mother, Julie, had cancer and hadn't told her new family about Rachel's existence. Her first real boyfriend supported her in this and together they started smoking dagga and drinking a lot. Her boyfriend went on holiday and met someone else, so he dumped her. She couldn't handle the rejection and started binging and purging with food. Her biological mom died of cancer, which completely enraged her. Her binge drinking and eating increased, as she was single and working behind a bar. Her morals dropped and she started sleeping around. At a sober moment she met someone and married him. But one year later they got divorced on the grounds of her adultery. The guy she left her husband for became her drinking companion who verbally and physically abused her for many years. She finally moved out and completely deteriorated, not able to keep a job, drinking, bulimic, sleeping around, and had two abortions.

Two and a half years ago she met her current partner, who is very supportive, but only wants to take their relationship further (live together and have children) once she sorted out herself. The immediate onset of her admission was her kissing a colleague from work after an evening of drinking and her boyfriend walking in on them. Rachel started treatment in another centre but needed to go to secondary care. After her discharge from 'Courage to Heal' she will go to tertiary care.

Elsie: Estranged 13/11/02

Elsie is a 20 year old Afrikaans-speaking girl, rather shy and avoidant in body-language, who left a strange impression, something the interviewer couldn't quite grasp.

Right from the onset she indicates a huge gap in her memory concerning her childhood. She starts her life-story at her high school years, when she moved from Jo'burg to Cape Town and had difficulties fitting in. She started smoking marijuana at age 12-13, and when she moved to Cape Town (age 15) her dagga-use increased because she had easier access. She recounted two incidents of sexual harassment, (attempted rape; fondled by a Rasta guy) both when she was high, and was involved in a co-dependent relationship. Sexual experience was denied, but later in the interview she confessed that her boyfriend coerced her into having sex with him, but that she's terrified that her mother will find out.

After this the spontaneous story-telling stops and the interviewer has to probe to illicit some kind of narrative. During this open question technique it appeared that Elsie, her mother and brother were involved in a big car-accident when Elsie was four, which left her 2 year younger brother with brain-damage. At age 5, Elsie, her mother, brother and great-grandmother had yet another accident with a lot of physical damage to all passengers. During her co-dependency with her boyfriend, she used dagga, Mandrax, coke and heroin frequently, and experimented with other drugs as well. She went to rehabilitation for Mandrax at age 17, but "manipulated her way out", and swopped the Mandrax habit for cocaine. Her boyfriend cheated on her, verbally and emotionally abused her, and used her to steal money. When she broke up with him her drugging increased with a devastating effect on her body. When her parents found the needles in her room they bought her Methadone, which didn't work so she was sent to rehabilitate in 'Courage to Change'.

Ruth: Never good enough 20/11/02, 22/11/02, 25/11/02, 03/12/02

Ruth is 29 years old, English speaking, attractive, organized and clever. She is number 3 of four children, with her older brother and sister being 4 and 5 years older than her, and her youngest sister 6 years younger than her. She hung somewhere in the middle and has always been the mediator in the family. Her father is an alcoholic and practising lawyer, her mother inherited lots of money which gave her more decision power in the family than the father would have liked. The father verbally abuses and emotionally neglected his children, with a certain threat of violence. The mother is over-protective. At school Ruth was doing very well, being popular and good at everything. She won some regional horse-riding competitions, but got only negative comments from her father. She went to varsity, obtained two degrees and was involved in a relationship for 2 years. Here she started acting out some of the verbal abuse she experienced whilst growing up, which eventually resulted in the young couple's break-up.

She had her first drink at age 13-14 and drank socially till age 22y. She went to England to try and find a job there and to travel in Europe. After working for a while just before leaving on her travel her father phoned her to tell that her oldest sister was admitted to hospital because she collapsed due to severe under nutrition, anorexia. This came as a big shock to Ruth who always idealized her sister as the good example. She still embarked on her travels and came back to South Africa 3 months later to nurse her sister who had become suicidal by that time. Ruth stayed with her brother who drank heavily and got violent and abusive. Stress accumulated and when her engagement broke off without explanation and she got retrenched from her job, she decided to move to another town. She started using anti-depressants, sleeping-pills and drinking heavily. In her jobs she clashed with authority every time resulting in many career-changes. In '98 she set up a big fundraising project with international fame. During that time she isolated herself, drinking a bottle of wine alone at night combined with sleeping pills. After this big success she found it virtually impossible to top the experience and launched a marketing business of her own. Later she worked for a company and got involved with her boss. He decided to stay with his current girlfriend and their son so she resigned. But before her resignation she learned about a big corruption scandal involving government officials. She brought it out in the open, was thrown out of her home-town and had to be crown-witness in the court case.

Her whole life fell apart and she started drinking more heavily. She tried to stop on her own but relapsed every time the court case reached the news. She felt her life was in danger and went to hide in rehabilitation. She stayed 5 weeks in 'Courage to Change' and attended after-care for 1 month.

Kate, the restrained tomboy 10/12/02, 12/12/02, 13/12/02

Kate is a 39 year old, slender, spontaneous, very open and friendly woman. She is the oldest girl of 3 boys, and English speaking. Her father was an alcoholic, a very withdrawn man, who emotionally neglected and verbally abused wife and children. Kate presents an idealized picture of her father and has difficulty integrating all these negative experiences because her father died a couple of years ago from lung cancer. Kate's mother is very religious, very critical, controlling, and interfering in the life of her only daughter. While growing up Kate didn't really have a close relationship with her mother and experienced her maternal grandmother more as a substitute mother. The family was rather poor. Kate did well at school and really enjoyed sports, athletics, and ballet. She described herself as a tomboy. After her studies she met her present husband, Richard. Because of her low self-esteem she always doubted his love. And they never had a real good "physical" relationship. Kate described herself as a prude, god-fearing woman, which might have something to do with that. The couple went travelling and worked abroad.

Kate grew up being strongly against alcohol because she could see which impact it had on her family. One of her keywords in life is the fear of "feeling odd/ left out" and the desire to be "part of the team". Therefore her first alcohol-use was also influenced by peer-pressure, namely after work her colleagues would go for a drink and she didn't want to feel left out. The couple came back to Cape Town and got married. Her granny died 1,5 years after Kate's marriage, which Kate described as a real big loss. She felt very isolated and not supported by her husband. Kate wanted to have children, but Richard was avoiding the topic and their sexual relationship was non-existent. Meanwhile her father died and Kate got heavily into drinking. She cheated on her husband when Richard again preferred drinking with his squash-friends above being with her. Kate kept on drinking and when she decided to go back to work, she finally fell pregnant after 5 years trying. She cut down on her drinking and had a "wonderful" pregnancy which brought the couple closer together, but one week before giving birth, her mother-in-law died which again created a huge distance. Her drinking increased once more as she felt trapped at home and had lots of fights with her husband. Her husband typically blamed her and her looks (not sexy, not a woman) for their sexual problems and as a defence she told him about her affair with his best friend. Richard sent her away and they broke up for a while.

Eventually they got back together, under pressure of the family, and then she decided to sort her self out in treatment. She asked her doctor and counsellor advice and they referred her to 'Courage to Change'.

Lorna, the tears of a clown 10/12/02, 16/12/02

Lorna is a 27 year old, Afrikaans speaking, tall woman. As soon as she enters the room she seems to be the entertainer and organizer of the company.

Lorna was adopted by her uncle's family because her mother was unmarried when she gave birth. Lorna found out the real reason for her adoption when she was 13 years old, during a fight with her cousin, and describes this as very traumatic. Lorna grew up in poor family, being number 5 out of 5, with a big age difference between her and her cousins and nephew. She describes a happy youth where she was a "bush-girl" doing mischief with her 4 year older brother/nephew. Her adoptive mother is short-tempered and critical, but compensated this with enough care and attention. While growing up she used to visit her biological mother who lived in town and she was always spoilt. But on the last visit her mother went on an alcohol binge with her friends and neglected and rejected her daughter, which left Lorna very disappointed and confused. Her adoptive mother was shocked and didn't allow her to visit her mother any more. After finding out the truth about her adoption Lorna started rebelling, smoking and drinking. At the age of 17 she got involved in a big, life-threatening car-accident that changed her whole appearance. After her miraculous recovery characterized by great courage and persistence, she got trapped in a fear of dying inexperienced so she focused on trying everything, and lost her virginity. There was no money to continue her studies so she found a job, moved out of her uncle's house and lived alone in a flat experiencing total freedom. Her alcohol use increased drastically. When she started living together with her boyfriend, this became rather problematic. When she drank too much she tended to get really depressed and committed two suicide attempts. Lots of her depression centres around her looks, and her not being worthy of life, which might indicate that she didn't deal with the impact of the car-accident on her life and her illegitimate status.

She currently got engaged to her boyfriend and found a job in which she is respected so she decided to "get her act together" and come to Courage to Change.

Nicky: Hectic 12/12/02

Nicky is a 22 year old, beautiful, petite girl with a very powerful look in her eyes and long black hair which often veils her face and features. In group she seemed rather withdrawn and defensive but she was very sensitive, insecure and friendly on a one-to-one basis.

In the beginning of the session she seemed calm but her story is told in a shrill, piercing voice which contrasted her normal talking tone, as if the pain and hectic experiences were urging to find a way out. There was a nervous spasm around her left eye and left corner of the mouth which relaxed when she finished her childhood narrative.

Nicky is the middle one of three girls (4 and 3 years of difference) and mockingly describes this as the 'middle child syndrome'. Her father was away a lot for his work, which left her mother alone with the care of her three daughters. Her mother was described as an artist, quite hectic, always erratic, and very temperamental. From age 5 till 13 Nicky experienced severe verbal, mental and physical abuse from mom's side. Her mother denies the reality of any such events, which left Nicky feeling crazy. The things that happened to her were so bad that Nicky doesn't manage to accord any words or describe it. The experiences are called "hectic", "turmoil", "pain", "chaotic", and "wild freaky". Numbing and blocking off, self-mutilation, were some of her early coping-mechanisms. Nicky assumes blame for the experienced abuse, calling herself a difficult child, always controlling and obsessive-compulsive. She went to boarding school at age 13 and got really caught up in self-destruction: she frequently self-mutilated, had anorexia, got addicted to alcohol since age 14, later on she abused dagga, heroin, crack, Acid, speed, and XTC, but always immediately in excess she would "go where others end", "go always completely overboard", getting really sick. She was severely depressed as well and caused a lot of problems at school around drug use, and anorexia. She was sent to SANCA at age 14 for her alcohol abuse. They referred her to the hospital because her frequent overdosing of Acid messed up the chemicals in her brain. They put her on a high level of medication to help her detoxify. She moved to Cape Town and went 4 months to university but dropped out because she couldn't fit in and couldn't deal with society. She started Art College but dropped out after 6 months because she became very depressed and suicidal. She was abusing alcohol and dagga. Then she got involved in a co-dependent relation for 3 years marked by lots of geographical changes, inability to keep a job or a place to live and excessive drug abuse (heroin and crack, followed by alcohol, XTC, speed and medication). Her body couldn't take all these drugs any more so she tried hypnotherapy to cure her break-down but the hypnotherapist said she needed to go to hospital.

She eventually admitted herself to Rehabilitation Centre 1, spent a couple of months there and then moved to Rehab 2 for a couple of months but relapsed on her anorexia. They sent her to Rehab 3 and then referred her to Courage to Change for her eating disorder and drug addiction. She went to secondary and tertiary care but when she came out of treatment her co-dependency became so bad that she became addicted to and obsessed with her boyfriend. The relationship broke off and she relapsed, for 5 months, on heroine, crack and alcohol, even worse than before. She booked herself in again at 'Courage to Change' when she realized she couldn't stop on her own.

Sadeedah: Fragments of violence 13/12/02, 16/12/02

Sadeedah is a 27 year old, dark skinned white (Italian grandfather), English-Afrikaans speaking woman. During the interviews she was very fidgety, alternated with numbing and detached telling of her story, staring in the void.

Sadeedah is the oldest of two girls. Her father is an alcoholic, who was extremely violent towards wife and children. Her mother re-enacted her own abuse on her children, which resulted in Sadeedah being emotionally, verbally and physically abused by both parents. Even though her mother was violent and emotionally abusive towards her, Sadeedah was an adult child, trying to help her mother defend herself. Sadeedah has a dual picture of her mother with the idealized good image prevailing over the abusive negative image. In the second interview the ongoing treatment and the interview questions confronted her with the reality of the second image, which didn't please her at all and which she rather avoided. She got angry and didn't want to see her mother the coming days until she could forget about it again. Her whole story is a sequence of fragments of violent experiences from her past alternated with repetition-compulsion, self-destructive tendencies and trauma-remnants (suicide attempt with pills at age 5, taking pills frequently in school in front of other pupils, depression). Her parents got divorced for a short while but they remarried after her father physically threatened and emotionally blackmailed her mother. They became practising Catholics, but relapsed in the same violence after a couple of months.

At age 5 Sadeedah was molested by a friend of her parents. She is very angry about her parents leaving her alone with this guy. When she was 16 she was violently raped by a friend of hers in her own room, in presence of his cousin and a girlfriend of hers.

In every substance she tried Sadeedah would go completely overboard: cigarettes, alcohol, marijuana, XTC, morphine, tranquillizers. She would use them till the stage that she got really sick. And even if she had a negative effect from the first usage she would still persist, re administering the same overdosing amount. When she was 18 she met her present husband, who is Indian. She got pregnant and had to convert to Muslim to be able to get married. His family demanded that she changed her name from Rosita to Sadeedah, and that she changed her dress, her habits, everything. She lost a lot of her friends because at that time it was not easy for a white woman to marry an Indian man. She lived 7 years with her in-laws, who constantly made nasty comments about her colour and background, but she didn't really want to talk about that period because otherwise she would get angry with them as well. She has 3 children (9, 7 and 4years old), she is housewife and studies. A couple of years ago the couple bought an own apartment. Sadeedah got into the clubbing scene and got hooked to XTC. She managed to come off XTC when she had an affair with an alcoholic. Later she got addicted to her grandfather's morphine who gave her a bottle because he could see she was depressed. She overdosed with this, and her grandfather died of cancer, so she quit using morphine.

After that she ended up in a severe depression, being suicidal. Her husband had her admitted to hospital for that. In hospital her doctor over-medicated her and she managed to take anti-depressants and calming tablets as much as she wanted. She had three car-accidents due to black-out caused by too much medication. The third car-accident made her end up in hospital where the doctor referred her to 'Courage to Change'.

APPENDIX B:
Previous treatment history of the 14 interviewees

During the interview process every woman was asked about her prior experience with treatment facilities. Most of them received some kind of prior treatment.

- Marie was treated for depression in a private psychiatric hospital

- Joanne relates counselling for postpartum depression, Lorna saw a doctor for depression after her suicide-attempts.

- Nancy talked about going to a psychiatrist and hospital for bulimia; having one session with a psychologist for extended mourning; and going to inpatient Rehabilitation 1 for alcohol, cocaine, XTC.

- In her teens Rachel went to a psychiatrist and hospital for anorexia; she went to a doctor, Rehabilitation 1 and Rehabilitation 2 for alcohol, bulimia, and marijuana before she came to Courage to Change, and will go to after-care.

- Helen related going to a clinical psychologist specialized in substance abuse just before admission in Courage to Change.

- Elsie mentioned going to a psychiatrist for adaptation problems after her motion to Cape Town; she related going to rehabilitation the previous year for heroin, but 'manipulating her way out', her parents bought Methadone but she relapsed.

- Ruth related going to a psychologist for depression, Kate recounts going to relation therapy with a clinical psychologist, followed by individual sessions. Both claim the therapist didn't pick up the alcohol abuse.

- In Nicky's story we hear she was in hospital for anorexia; in SANCA for alcohol abuse, and referred to hospital for Acid abuse; and then a whole bunch of inpatient addiction treatment centres: Rehabilitation 1, Rehabilitation 2, Rehabilitation 3, Courage to Heal, Rehabilitation 4, Rehabilitation 5; relapse; readmission in Courage to Heal.

- Tracy went to the doctor for depression after her break-up with her boyfriend but she only got calmants, hence she self-medicated with mom's Prozac.

- Sadeedah mentions being in hospital for suicide-attempts; in Private Psychiatric Hospital 1 for depression; Private Psychiatric Hospital 2 for depression; discharged and overmedicated, ending up in hospital after three car-accidents.

- Only Sandy and Yolandi didn't mention any previous treatment.