Portfolio of Academic, Therapeutic Practice and Research work

Including an investigation of trauma therapy in a landscape of suffering:
Towards a grounded theory

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Introduction to the Portfolio

This portfolio contains academic, therapeutic and research work submitted as a requirement for the fulfilment of the Psychology Doctorate in Counselling and Psychotherapeutic Psychology at the University of Surrey. The first section will show some academic pieces, the second section gives an idea of my placement experiences and the third section contains my research. These sections will be discussed at further length below. The work displayed here is a flavour of where I have come from, the processes that I have gone through on this course and who I am, in this moment, as a counselling psychologist and a human being. Perhaps to give you an idea of what brought me on to the counselling psychology path I will start off with some of my background experience.

The road to counselling psychology

I come from a fairly analytical and interested family. My parents (biological and step parents) are all attorneys who spend a lot of their time wondering about the law and about how human interaction works. On the one hand this spurred me on to be curious and interested. On the other hand there was always a right or a wrong way of doing something. That also applied to the way I was brought up. I was allowed to question as long as I did it the right way. Perhaps my desire to be able to question and wonder, and continue to remain open to whatever I find has partly brought me to counselling psychology. Moreover, because I seemed to get things ‘wrong’ so often I think I wanted to find a way of trusting myself and my own responses. This desire to individuate led me to want to travel when I entered into my teenage years.

When I was 19 I left Sweden to live in California where I completed my B.A. in Psychology and I also spent some time working as a behavioural therapist for children with Autism. I met so many interesting and challenging people who were so different from me. I learnt so much from these people. Additionally, California is one of those places where I could be totally and utterly myself. It was a wonderful place for me to begin nurturing my identity. When I completed my B.A. I became restless and I moved to London to do an M.A. in International Conflict Analysis. It was here I began to cultivate my interest in the impact of socio-political forces on the individual. I focused my thesis on conflict resolution based on Palestinian and Israeli children and
youths meeting. This led me to move to Lebanon for six months to do some volunteering for Save the Children and also work as a behavioural consultant and therapist for children with Autism. When I came back to the UK it was becoming evident that what I really wanted was to work with groups or individuals and their struggles. At the time I was not equipped to do that. So whilst working as a behavioural consultant, I began researching what the next step would be for me. The choice was between counselling and clinical psychology. I applied and interviewed for both. However, because of the relational philosophy behind counselling psychology, it became evident that it was in the this camp I belonged. I do not think it was this clear to me at the time, but it is now. For me it has been about symbolization and finding a way to express myself. In this way being able to hear and work with other people in an open and congruent way and at the same time always keeping the socio-political context in mind. I hope this will become clear in the three dossiers below.

Academic Dossier

This dossier contains three essays. Each essay represents a topic I wanted to gain more theoretical knowledge of and which I have a strong interest in. What they have in common is connectedness and a focus on the relational.

The first essay explores intergenerational trauma through projective identification. In this essay I suggest that projective identification is one important aspect of transmission of intergenerational trauma. It looks closely at trauma experienced during extreme social violence such as, the Holocaust. What is specifically focussed on is unprocessed trauma that is undigested and not symbolized. In essence, what happens to unprocessed and unspoken trauma within the family. This essay acknowledges that there are many other ways of trauma being transmitted, but that projective identification warrants closer exploration. My interest in projective processes are that of breaches of boundaries. It seems that when we try to keep a secret or hide difficult experiences and feelings it can be powerfully transmitted into someone else. It is too unbearable for the person to hold on to. I can personally feel it very strongly when my own boundaries are breached and I feel invaded. Moreover, I think I have recently come to realize that I gave away my more vulnerable aspects to people who could easily hold it for me. The lesson this essay had for me was about
learning to own all aspects of the self. More theoretically, projective identification is an abstract concept that I wanted to understand better.

The second essay looks at Mindfulness-Based Cognitive Therapy (MBCT) within a connectedness model. Mindfulness is something that I have been interested in for a long time in my meditation and yoga practices. In my third year I also began to play with it therapeutically and I wanted to gain a better understanding of its underpinning. What was particularly interesting to me was the idea of connectedness. Thus, this essay explores the fundamental aspects of MBCT. Firstly, it considers MBCT's assumptions of mental health. It locates itself within a model of connectedness, which suggests that mental ill health emerges when there is a part of the system that is imbalanced. Secondly, the essay then goes on to explore how well-being develops. It does this by gaining an understanding of how the system becomes balanced again. Lastly, it considers MBCT on a relational level and the impact the model has on the therapeutic relationship. Moreover, there are some concerns and wonderings about MBCT as a 'new' model of working.

The third essay critically explores some aspects of the Cognitive-Behavioural model of depression. Firstly, the essay gains an understanding of the Cognitive-Behavioural Therapy (CBT) model of depression and how this model suggests working with depression. In particular it questions the assumption that people suffering from depression have lost touch with reality. In particular, it explores the idea that perhaps people suffering from depression are actually in touch with the existential realities of life, and considers the implications this has for practice. This essay is in some ways a representation of my own struggles to come to terms with the CBT model of working. As I mention in my clinical paper it took me some time to come to terms with the CBT model and finding a way of integrating it into my practice. This essay was helpful in that process.

**Practice Dossier**

The practice dossier outlines my three placements here on the course. It also clarifies that my client/process studies were written while I was in these placements. This dossier also contains my clinical paper.
Firstly, it outlines my first year placement which was in a large GP’s surgery in London. I saw clients referred to primary care suffering from difficulties such as, depression, anxiety, Post-Traumatic Stress Disorder PTSD, intimacy/relationship breakdown and bereavement. As will be outlined in the clinical paper, my first year was a time of tremendous growth and a safe base where I learnt to ‘be’ with my clients, rather, than ‘doing’ therapy. This was a place where I was able to play around with unconditional positive regard, congruence and empathy. In actual fact it was playing that I discovered this year.

My second year placement was in a psychotherapy department. I was working psycho-dynamically with people suffering, perhaps, more severely from depression, anxiety, PTSD, intimacy/relationship problems, bereavement and personality disorder. I also got a better insight into the NHS mental health system by sitting in on ECT treatments and ward rounds. Again, the clinical paper will provide a deeper understanding of my processes that year. More generally, this placement was a place of enormous growth for me on personal, professional and academic levels. My growth within these areas was about getting a stronger sense of my core strength, worth and ability to cope in emotionally charged situations.

My third year placement was within a day centre in the South East. In particular, working with people suffering from personality disorder and psychosis. I was also involved in the depression and anxiety service. Additionally, I also worked with people suffering from PTSD and Obsessive Compulsive Disorder (OCD). The clinical paper will go into more depth of my experience in this placement. Overall, this year allowed me to be creative and also allowed me to shape my identity as a counselling psychologist.

Lastly, this section contains my clinical paper. As mentioned above it will contextualize my therapeutic experience and give a flavour of my journey through these three years.
Research Dossier
The research dossier contains a literature review, the second year research and the third year research. I feel as though these three pieces should be viewed as a funnelling down of my research interest.

The literature review concerns itself with the symbolization of trauma in the context of the South African Truth and Reconciliation Commission (TRC). By referring to, empirical literature, clinical observations, opinion and TRC banners, the literature review explores psychological themes that emerged during the TRC process and considers them in relation to psychological trauma theories. It firstly, explores that some people may find it difficult to speak about their trauma. The paper then goes on to investigate how important it seems to be for people who have suffered severe political violence to be able to symbolize their experiences. The paper then wonders about the language the TRC may have created for people to speak about Apartheid. Lastly, this paper considers some of the difficulties with language and speaking in front of the TRC. This issue of how the socio-political impacts individual trauma is an important aspect of working as a counselling psychologist. The issue looked at is how trauma is embedded in a specific socio-political context and how that particular context may determine expression of suffering.

The TRC and South Africa provided a fairly contained situation to study the interplay between the socio-political and the individual. It has been particular interesting to get an idea of how the dominant discourse impacts individual expression of internal processes. In this literature review I am specifically passionate about the need to be heard, how symbolization is a large part of asserting ones identity and power. The literature review also highlights that symbolization has to be true to the person and if a language is enforced it can be damaging. I can personally relate to this, because being able to speak and express myself is immensely important to my sense of self. Moreover, as a counselling psychologist this is highly relevant as it demonstrates what an important role we can have in helping people heal, but at the same time that we need to let people find their own words. Thus, we have a responsibility to become aware of where we are positioned in the socio-political so that we do not impose a discourse onto our clients or our own experiences, but at the same time being able to
give them a language when it would be helpful for them. This issue of language and symbolization is relevant to the development of the literature review as well. The first time I wrote it I failed it because I was struggling to find the words. However, with guidance and support I found a way of expressing what I wanted to say and I managed to put together a solid review. I also got the opportunity to present this paper at the British Psychology Society Division of Counselling Psychology conference in 2008. Following the literature review are the slides used for the presentation.

My second year research built on the literature review in that it went further in exploring trauma theory within the South African context. This study used Grounded Theory (GT) to explore South African mental health professionals' understanding of trauma within the South African context. This was to deepen the knowledge of how trauma theory is embedded within a particular socio-political context. The emerging categories focused on the ordinary experience of trauma (past abuses, shattered communities, ongoing exclusion and crime trauma); meaning of trauma within its context (the idea of trauma is dividing people along racial groups); shared symptoms across a population (including feeling anxious, insecurity and dissociated; dissociation as a way of being; the focus of therapy and a sense of helplessness and frustration with the success of therapy. It was also around this time that I was trying to explore what it is about trauma that I am so interested in. Through personal therapy and work with a client of mine, Mrs. P., it was becoming evident that my interest lies with disconnection. How we defend against knowing but disconnect from whatever it is that is unbearable.

That is how I came to explore peoples' experiences of disconnection in my third year research. This study aimed at getting a deeper and clearer sense of how people make sense of their experienced disconnection. Using Interpretative Phenomenological Analysis (IPA) disconnection was explored. The developed themes were, triggers of disconnection, the disconnected experience, function of disconnection, reactions to disconnection and emerging connection. As you will notice a common theme running through my research is that of symbolization and disconnection/connection. Perhaps this reflects my own journey to finding my own way of symbolizing and embodying my sense of self.
In conclusion, I hope that this portfolio will give readers of an idea of who I am as a counselling psychologist and my on-going journey.

NB. All names of clients and participants have been changed, throughout the portfolio, to protect their confidentiality. Moreover, names of any other people mentioned, has be changed, as well as any other identifying material in order to protect confidentiality.
Introduction to the Academic Dossier

This dossier contains three chosen essays that were submitted during my three years on the course. The first essay explores projective-identification within the context of intergenerational trauma and its implication for therapy. The second essay investigates Mindfulness-Based Cognitive Therapy (MBCT) within a model of connectedness. It also explores some of my own thoughts around the emergence of MBCT and its implementation. Inspired by my clinical work, the third essay critically evaluates some of the Cognitive-Behavioural assumptions of depression.
Intergenerational transmission of Holocaust trauma through projective identification.

Psychological literature has suggested, that if trauma is not dealt with in the current generation, the next generation will have to deal with it (Duran, 2006). Moreover, Israeli studies with Holocaust survivors have shown that trauma can have an accumulative effect, leaving the next generation suffering severely from the transmission of trauma (Shoshan, 1989; Solomon, Kotter & Mikulincer, 1988). In the case of the Holocaust, children often knew that their parents had traumatic pasts, but did not know details about it (Danieli, 1998). So in remembering their parents’ and families’ war histories, they only had pieces of information to confirm the constant presence of the atrocity. In some cases children have reported that they absorbed the omnipresence experience of the atrocity through ‘osmosis’ (Danieli, 1998). It is as if the traumatic past remains unexplained and mysterious. This essay explores possible transmission of unprocessed trauma through projective identification. It focuses specifically on trauma experienced during extreme social violence such as, the Holocaust.

Trauma is of course transmitted through symbolization in many ways. For example, through writing, painting and drama. For symbolization to happen, the trauma has to be processed in some way by the sufferer. This kind of public expression of trauma can be a source of dialogue for the sufferer and for outsiders. However, what is tackled here is the trauma that is undigested and not symbolized by the sufferer. More specifically, what happens with trauma when it is unspoken within the family? By focusing on projective identification as a way of transmitting trauma, this essay highlights only one aspect of the transmission of trauma. Intergenerational trauma is a complex matter that cannot be explained merely through projective identification. Rather, it could be discovered through concepts such as breaches of trust or attachment styles. Additionally, an understanding of trauma transmission should not be restricted to intra-psychic processes of the sufferer because it involves highly relevant social and cultural processes (Suárez-Orozco & Robben, 2000). By focusing on projective identification it is not the intention of this essay to negate the resilience of survivors. Additionally, it is not suggested that there is some universal pathology in children of survivors. Rather, this essay aims to speculate how projective
identification may work in this context. Exploring how unprocessed trauma can be transmitted through projective identification, can help therapists understand how this unprocessed trauma may enter into the therapy room with their ‘second generation patients’.

The focus will remain on the Holocaust as there is limited literature relating to other conflict societies. This essay explores the potential impact of unprocessed Holocaust trauma on the second generation. It will briefly draw parallels between the infant experience and the Holocaust survivor experience of projective identification. It will then move on to the heart of the essay delving into projective identification as an object relation and its impact on the second generation.

**Silence: Protection or Projective Identification?**

Following an atrocity such as the Holocaust many choose not to talk about their past history. Denying any long-term psychological effects may have played an important role for the survivor’s sense of victory. Acknowledging traumatic suffering could be viewed as a ‘posthumous victory’ of the oppressive regime (Danieli, 1998). Silence may also play a role in protecting the survivors from any potentially re-traumatizing threats that imply loss of control (Danieli, 1998). Furthermore, in the interest of protecting the coming generation from their experiences of suffering, horror and fear, survivors of political violence may choose to keep the past securely disconnected from the present (Danieli 1998). Thus, silence may embody an important sense of control that the survivor did not have during the traumatic experience. However, it is also possible that the traumatic experiences are split off from consciousness. The unbearable pain is stored away in the unconscious where it can be kept safe from overwhelming the self (Auerhahn and Laub, 1998). Auerhahn and Laub (1998) tell of a woman who was forcibly separated from her infant during her imprisonment in a concentration camp. Shortly following the traumatic separation the woman met a doctor who had treated her before the separation:

“*And when she [the doctor] saw me there she was so happy to see me, and right away she says, “What happened, where’s the baby, what happened to the baby?” And right*
there I said, "What baby?" I said to the doctor, "What baby? I didn't have a baby. I don't know of any baby" (p. 24).

For this woman the unbearable loss of her child is stored away, keeping her functioning in times of severe distress. Moreover, this essay suggests that some people who were victimized during extreme social violence such as, the Holocaust, may have experienced regression to a paranoid-schizoid position, similar to what an infant experiences in early development.

The infant experience of projective identification
According to Melanie Klein (1946), in the early months of development the infant experiences internal and innate conflict between the life and death drives. This creates anxiety and fear that annihilation can happen at any time. This paranoid anxiety of imminent annihilation is experienced as coming from the external reality. This may be experienced when the mother is unable to satisfy the infants immediate needs. It is in this paranoid-schizoid position that projective identification develops. Projective identification involves warding off anxiety and impulses by splitting the self and projecting the split off parts into the object, who then identifies with these split off parts (Joseph, 1988). As the infant is entirely dependent on the mother for survival, the infant cannot bear that the mother is unable to satisfy her/his needs. For the infant, not being fed or protected may mean death. One of the purposes of projective identification is that it defends fully against the anxiety created by inner loneliness and the confusion between good and bad parts of the self (Young, 2005). Projective identification is an unconscious fantasy of being at one with the object and avoiding separateness (Ogden, 1979). The infant guards against the external fear of annihilation by splitting the ego into good (gratifying, nurturing, kind) and bad (persecutory, cruel, rejecting), retaining the good and projecting the bad into the mother. The infant is then able to identify with the retained good parts and ignore the anxiety provoking bad parts. The mother contains the bad parts, she is not felt as being a separate individual, rather she is felt like being the bad self (Klein, 1946). However, good parts can be projected into the object as well and is vital for the infant's ability to develop good object relations (Klein, 1946). The danger of forcefully projecting good parts is that the self becomes depleted and there is a loss of the self (Rosenfeld, 1988). With a
containing and nurturing mother the infant is expected to move into the depressive position where she/he accepts the anxieties of life. However, regression to a paranoid-schizoid position is possible at any stage in life. For example, when faced with severe and life threatening trauma.

The survivor's experience of projective identification
Survivors of the Holocaust were exposed to an external reality that was severe and life threatening. As with the infant, an individual imprisoned in a concentration camp would have been completely dependent upon the mercy of the other. However, what differs here is that the other was a persecutor and not a nurturing mother. The threats of death and torture are not everyday experiences that the individual can accept and live with. Rather, for their own survival they have to maintain a split ego, inhibiting them from moving into a healthy depressive position where one accepts everyday anxieties. It may be that the only way of coping with such trauma was to split the ego into good and bad objects in an attempt to survive. There is a split between the me and the not me. In a sense the ego takes account of reality, finds it unbearably painful and detaches the ego from reality (Cohen, 2001). It is as if the individual does not know the trauma she/he has suffered because the experience deifies all comprehension and language (Auerhahn & Laub, 1998). The act of denying reality is an unconscious process, banishing the traumatic experience from awareness.

Similar to the infant, the survivor could unconsciously resort to projective identification as a means of relating. To maintain any kind of self the individual has to retain the good parts, there cannot be any bad parts that justifies the violence inflicted. All the bad parts are projected into the persecutor, who will identify with and confirm this "badness" by engaging in terrifying acts of violence. Here it becomes complicated because we are all inherently both good and bad but this is impossible to acknowledge for those victimized. Any kind of badness could represent a threat against their sense of self. The bad parts identify with the persecutor and in turn becomes an inner persecutor (Kalched, 1996). To identify with any bad parts of the self becomes unbearable for the survivor as it poses a threat to the self; a threat of annihilation. Thus, the good parts of the self needs to be kept safe from the bad parts. Either, the good parts are retained and the bad parts are projected out of the self into the other or
the good parts could be projected to be kept safe from all the internal badness. The other is, thus, narcissistically needed to carry the split off and unwanted parts of the survivor (Young, 2005). During the atrocity this object relation made perfect sense as the other represented death and annihilation. After the war and the massive trauma ended some people continued to live with a split ego. As shown by the woman’s inability to remember her lost baby.

The Next Generation

In the aftermath and even during the persecution, many people found comfort in creating new families. Giving birth to the next generation may have fulfilled a need to replace those who had perished in the camps (Gampel, 2000). Creating life could also be interpreted as an act of victory against persecutors and annihilation (Danieli, 1998). Despite each survivor’s family tree being “steeped in murder, death and losses “ each child was expected to “reroot that tree and re-establish the extended family, and start anew a healthy generational cycle” (Danieli, 1998, p. 5). Accepting the above suggestion that certain survivors may continue to split the unbearable past and projecting unwanted parts, it may be that the parents unconsciously transmitted their traumatic past to their children. The indigestible trauma is disconnected from the survivor but unconsciously seeps through to be acted out or passed on to their children (Gampel, 2000).

Compulsory identification with the projections.

In fear of identifying with the perpetrator, survivors fail to accept feelings of hatred, anger, cruelty, violence or aggression within themselves (Gampel, 2000). The recipients of the projections often became the children of the survivor. In general, projections are ‘normal’, they happen every day and are usually rectified by either the subject or the recipient (Bion, 1967). However, the projections become ‘pathologically’ dangerous when the subject compulsorily identifies the object with the projection, stripping it of any independence (Hardtmann, 1998). The children of survivors did not have any possibility of escaping or rejecting these projections. Rather they were compulsorily identified with the projections as if they were real. Secondly, these children had not known any other reality than this and, thus, developed a self based on these projections; they identify with the projections as real
and true. Moreover, the parent's own ego is so depleted by the loss of many parts that reality testing becomes impossible (Main, 1975). The child then develops a self that is based on unwanted parts of the parent.

Projected parental parts
Unconsciously the parent may not be parenting the child. Rather, it is the unwanted and split off parts of the self that is parented. In order to protect the good parts of the self they may be projected into the child to keep them safe. In order to protect these good parts the child is anxiously protected against the world. Many Holocaust survivor parents have been described as over vigilant, overanxious and overprotective (Halik, Rosenthal & Pattison, 1990). The child becomes the carrier of precious goods. As one child of a survivor put it:

"...I was the perfect child...I did everything right" (Rowland-Klein, 2004, p. 127).

If, on the other hand bad parts have been projected into the child the parent may need to control and regulate the child so that the bad is kept in check. The child is unable to express anger, aggression or any emotion that may be perceived as bad or negative. In an interview one child of a survivor said:

"If I did well at school it was all I lived for, to do well for them...I think that comes a lots from wanting to...please them because of all that stuff they'd been through...I felt I just wanted to make them happy" (Rowland-Klein, 2004, p. 127).

To make up for the badness that the child embodies, the child may do all they can in their power to be a good child. The child then identifies with these all-good projections or the all-bad projections. In the absence of a sufficiently well developed self-love (Winnicott, 1958), the self fluctuates between under- and overestimating the self (Hardtmann, 1998). The child is either idealized or discouraged, there is nothing in between. Through projective identification the child and parent are in a symbiotic relationship. The boundaries between the self and other become blurred. The parent needs the child to represent the good/bad parts of the self. The child has become the
parent containing and holding the actual parent’s projections. The parent needs the child for “pathological narcissistic purposes” (Main, 1989, p. 101). One woman says:

“The way I related to my mother was with extreme care, and [in] our relationship... in a lot of ways, I guess, I became the parent. As I grew older, I used to often feel my youth was the youth that she had missed out on” (Rowland-Klein, 2004, p. 125).

It could be said that there is a silent demand of the survivor for oneness with the child that later results in difficulty for the child to individuate. The second generation base their identity on projections of the past generation. Thus, it becomes challenging for them to develop an identity of their own, “to live a different history, and show a different face” (Hartmann, 1998, p. 92). In psychodynamic clinical work with children of Holocaust survivors Chazan (1992), suggests that because they are burdened by the intense fusion of self and other, the child resorts to dysfunctional defences such as, denial, avoidance and splitting, inhibiting the integration of feelings, leaving the child with disturbed representations of the self in relation to the other.

Children become locked into a cycle of suffering that is essentially the parent’s desperate battle to disconnect themselves from the experience of severe trauma. Baronowsky et al. (1998) found that children of Holocaust survivors had considerable more traumatic symptoms such as, re-living imagined traumatic events, nightmares, anger and social withdrawal, than children of non-survivors. Seifer-Abrams (1999) demonstrates the seriousness of projective identification in her work with Holocaust survivor families in her article:

“A young woman in her thirties commits suicide by choking herself on an aerosol can. Her mother, a Holocaust survivor, tells of having survived the camps by singing to the guards.” (p.225).

It is as if the new generation takes over the mourning and grief that actually belongs to the generation before (Halik, Rosenthal & Pattison, 1990). To the survivor transforming the unbearable into conscious expression feels impossibly painful,
however, not to express traumatic suffering is likely to produce unbearable pain in the
next generation.

**Therapeutic Implications**

Firstly, special attention must be paid to the projective mechanisms, either as a
projection of unwanted parts of the self into the therapist or as projective transference
where the patient sees the therapist as a 'real' person of the past (Hardtmann, 1998).
Blum (2007) highlighted the dichotomous nature of transference whilst working with
an adult child of a Holocaust survivor. He suggests that as a transference object he
became split either as helpful/harmful, protective/punitive or as a prisoner/Nazi.
Secondly, therapy should provide the opportunity for the patient to reconstruct the
past to make it more integrated. Thus, enable them to work through the undigested
trauma that has radioactively contaminated the second generation (Gampel, 2000). In
essence the therapist should allow for the patient to confront the past traumatic
experiences. By doing so allowing them to distinguish between external and internal
reality, gaining an identity and allowing them to gain some measure of control over
their lives (Gampel, 2000). According to Hardtmann (1998), the most important
quality required by the therapist is to be constantly open and stable to establish self
and other boundaries. This is much more than avoiding premature interpretation. It is
about the therapist knowing his/her boundaries and sense of self to allow the patient to
individuate. This is so important because in childhood the patient was not allowed to
individuate and develop free of projections.

In conclusion, this essay has attempted to explore the impact of unprocessed
Holocaust trauma on the second generation. In the limited space available, it begun by
drawing parallels between the infant experience and the Holocaust survivor
experience of projective identification. The main focus of the essay was to speculate
about the impact projective identification as object relation can have on the second
generation. In essence, when a parent's object relation is based on projective
identification the parent-child relationship becomes an intertwined system where self
and other is one. The massive trauma suffered by the parents has a fluid presence
lacking space and time, void of a beginning, a middle and an end, internalized by the
coming generations as an unconscious organizing principle (Auerhahn & Laub, 1998).
This in turn impedes the child’s the very important individuation process. Finally, it is this individuation process that may become the focus in therapy.
References


Connecting with what is now: Working through disconnection using Mindfulness-Based Cognitive Therapy (MBCT).

Mindfulness is a growing psychological intervention (Braer, 2003; Kabat-Zinn, 1982; Kabat-Zinn, Lipworth & Burney, 1985; Kabat-Zinn et al., 1992; Segal, Williams & Teasedale, 2002). It is used for depression, anxiety and within the treatment of Borderline Personality Disorder (BPD). For example, mindfulness is an inherent part of Dialectic Behaviour Therapy (DBT) in the treatment of BPD (Linehan, 1993). Moreover, Mindfulness-Based Cognitive Therapy (MBCT) is now recommended by the NICE guidelines for those suffering from recurrent depression (NICE, 2004). This essay focuses on MBCT in particular.

MBCT is about turning inwards in silence. This in some ways contradicts traditional interventions for mental health that are defined as talking therapies. However, at the same time “turning inwards” resonates with more traditional therapeutic models such as, existential and other humanistic forms of therapies (see below for exploration). Mindfulness has a simple message, “paying attention in a particular way: on purpose, in the present moment, and non-judgementally” (Kabat-Zinn, 2005, p. 4). In essence, connecting with what is in the immediate here and now. This connection is taught through guided body scans, sitting and walking meditation, and yoga. Of course the concept of mindfulness is not a new one. Rather it is based on the ancient Buddhist meditative tradition that is about working on being awake and aware, as opposed to our disconnected sleepy state that we are so often immersed in (Kabat-Zinn, 1990; Brazier, 2003).

It is argued that mental health and, indeed, physical health depends on bringing your whole being into the process. The attitudinal foundations of mindfulness include, non-judging, patience, a beginner’s mind, trust, non-striving, acceptance and letting go (Kabat-Zinn, 1990). Due to limited space, it is beyond this essay to discuss all of these attitudinal foundations in detail. However, some are touched on below. For example, non-judging refers to learning to pay attention to the judgements you make about yourself, others and the world. Mindfulness suggests that it is not about trying to stop judging. Rather observe with a curiosity, maybe saying “ah, there is judging.” An
integral part of meditation training is to develop a trust in yourself. For example, when the body tells you to stop, you stop or back off, you do not push further.

This essay is looking to explore the MBCT perspective on mental health in terms of disconnections of certain parts of the self. Secondly, it will discuss how healing is approached by connecting with what is happening here and now. In some sense recovering those lost connections to the self. Lastly, the essay will note the impact MBCT has on a relational level.

An MBCT Perspective on Mental Health: A Matter of Connectedness

Mental ill health

MBCT has located mental illness within the model of connectedness (Swartz, 2002). This model argues that a system, in this case a human being, maintains “inner balance, harmony, and order” (Kabat-Zinn, 1990, p. 227) through their capacity to self-regulate via feed-back loops between particular functions and systems (Kabat-Zinn, 1990). Each part of a system is crucial to maintain balance in the system as a whole. Thus, when part of the system becomes disconnected from the overall system, it may lose its inner stability and become disordered. The specific disorder depends on which subsystems are ‘dysregulated’ (Kabat-Zinn, 1990). For the purpose of this essay the emphasis will be on the psychological effects of disconnection (although this can often manifest physiologically).

The major cause of disconnection in people is inattention to certain feed-back from our body and mind. Swartz & Begley (2002) suggest, it is this inattention (or avoidance) that leads to disconnection, that in turn leads to ‘dysregulation,’ and finally leads to disorder. If we consider depression for a brief moment, we can conceptualize it as an extreme flux between the past and/or the future. A striving to attach to experiences, body, emotions and thoughts that are pleasant and there is bitter disappointment when we are unable to do so. Depression is also the constant avoidance of experiences, body, emotions and thoughts that are unpleasant and anger that it just does not seem to go away (Segal, Williams & Teasdale, 2002). Sarah (pseudonym), a client of mine expressed the attempt to avoid difficult emotions: “I
said to myself that it was going to be ok...but it wasn’t ok. I was still crying and it didn’t go away.” Another way of describing attaching or avoiding is, as inattention to what the self is experiencing right now. This leads to disconnection from one's own current experiences. The depression that follows, when certain parts of the self are disconnected, is a symptom of an unbalanced system. Moreover, trauma (i.e. sexual abuse, war and accidents) is often characterized by forceful disconnection from emotions, body, thoughts and experiences. The person suffering makes desperate efforts to avoid reminders of the past trauma and ultimately disconnects unwanted parts from the feedback loops. The effects of trauma implicate a sudden rupture in the familiar and underpins the phenomenological sense of being disconnected, “whether in the body/self, and gives rise to the feeling of derealisation and depersonalisation” (Straker, Watson & Robinson, 2002, p. 147). Additionally, the information received by traumatic experience cannot assimilate with the existing schema, consequently, the traumatic information is disconnected from the familiar and the current schema (Straker, Watson & Robinson, 2002). Another client of mine, Marie (pseudonym), who has suffered sexual abuse, exclaimed: “I wish I could feel something, I just don’t want to feel this way anymore.” What depression and trauma have in common is the continuous inattention of the here and now and the continuous striving to attach and/or avoid, emotions, thoughts and experiences. “[W]hen we neglect the perspective of wholeness and connectedness, we only see one side of being alive” (Kabat-Zinn, 1990, p. 166). Moreover, paying only partial attention to ourselves is likely to prevent us from making informed, creative and novel ways of approaching problems and our health.

Healing begins
Healing can begin when the process is reversed: inattention into attention; disconnection to connection; ‘dysregulation’ to regulation and disorder to order (Kabat-Zinn, 1990). Balance and harmony is restored when the quality of connectedness with ourselves and the world is improved. Healing begins when we are able to accept our whole being with gentle kindness. It is important that to highlight that the aim of MBCT is not happiness. It is to connect with whatever the experience might be and in that way realize the freedom we have to respond to distress, rather than reacting to it. MBCT is a move away from fragmentation and isolation, towards
wholeness and connectedness (Braer, 2003). It entails connecting with emotions, thoughts and physical sensations, without judgement, as they arise. During our time together, Sarah expressed: “When I was trying to pay attention to my thoughts in meditation, they just didn’t come. It was amazing cause I usually try to get rid of them, but they seem to come at more force.”

Now, meditation is much more than a mere technique, it is a way of being in the world. Meditation is unlikely to facilitate healing if it is used as a means to get somewhere or to achieve another state of mind (Brazier, 2003). This is because getting somewhere or achieving another state of mind is contradictory to the philosophy of MBCT. From an MBCT perspective they would ask: What is the point of trying to become who you already are (Kabat-Zinn, 1990)? Rather, healing is letting go into being and letting the inherent wisdom of the mind develop (Segal et al., 2002). For my client Sarah, who suffers from depression and is inattentive, thus, disconnected from her present being, healing entailed her embodying her own depressed experience. This may not be different from other therapies. Rather, most therapies aim to enable the client to ‘own’ their experiences. However, the difference is the journey there, MBCT involves a silent observation of the self and talking about that particular experience.

At this point you are probably wondering where the Cognitive Therapy (CT) comes in? Contrary to being talked about as a cognitive therapy with a little bit of mindfulness, MBCT, is really mindfulness with a little bit of CT. First awareness is highlighted through mindfulness and then CT is emphasized to enable the client to make choices about how to respond, rather, than reacting to distress. Hence, it is here the cognitive aspect comes in. The cognitive model of, for example, depression suggests that if we can change our thoughts then we can change how we feel (Clark & Beck 1999). Essentially, if you think you are useless, then you will feel useless, this then leads to inaction that then provides evidence for the thoughts of feeling useless. However, do note that research has also found that sad mood can lead to negative thinking patterns (Teasdale et al., 2000). Thus, the uselessness loop can be triggered by thoughts as well as emotions. Cognitive therapy argues that if we can become aware of this loop of ‘uselessness’ then we can see a thought or emotion for what it is. A thought is an interpretation of an event, that would probably be interpreted
differently depending on your mood. For example, if you are feeling happy and confident on a day when your boss tells you to do a task differently, you would probably think something like “oh yeah, I’ll try that.” However, if you are sad and upset and the same thing happens you might think “I’m useless. I can’t do anything right.” In the latter statement there is an added judgement, whereas, the first statement was a mere observation.

Marie said that: “It was like all these thoughts came at me, but this time I didn’t tense up and tried not to have them, but I thought to myself, oh hello there you are.” In a way this interrupts the immediate link with emotions and provides us with a choice of how we are going to respond to the thought. Mindfulness allows us to connect with our being as a whole and CT can enable us to make more helpful decisions about how to respond to ourselves, others and the world. However, the marriage of mindfulness and cognitive therapy is a difficult one. Essentially, there is a struggle of beliefs. One is about being and the other is about doing. Unfortunately, there is not enough space in this essay to explore this clash fully. Moreover, as a model of therapy used within the NHS it becomes problematic. How do you practice a model of therapy that is about being and not changing, when the system (NHS) is about quick, cost-effective and efficient change? From my own experience of setting up a MBCT group it is a culture clash for both professionals and clients. Professionals are used to doing and clients are used to receiving. As one group member exclaimed: “How is this going to help me? I don’t get how this will help me in my everyday life. I don’t want to feel anxious I want it to go away (Paul).” This fear of anxiety is something the traditional CBT-models have been very good at defending against by using structure and with MBCT we are inviting it in again. This essay suggests that it will be a struggle to maintain the ethos of MBCT and not allow it to become another technique to fend off anxiety. As a practitioner an important issue remains, what is the role of the therapist and how does MBCT impact on the relational level?

The Relational: Embodied Trust

This essay has explored the inherent wisdom of the mind within the MBCT model. This model suggests that if we can take time and effort to mindfully pay attention to ourselves, it would be possible to live our lives more fully. Thus, an MBCT therapist
embodies a trust in the client’s own wisdom. Essentially, if the client together with the therapist can learn to pay attention to their own processes then mental health can follow. A non-CT/CBT practitioner may ask if trusting in the client’s wisdom is new. Existential and humanistic therapy strongly emphasize that the client is the expert on themselves and that they are ultimately driven by their self-actualizing tendency (Rogers, 1951; Mearns & Coopers, 2005). Thus, therapy is about letting the client take the lead towards healing. Moreover, psychodynamic theories also highlight that when a client becomes aware of their own processes and conflicts they will be able to make choices about how to respond to difficulties (Bateman & Holmes, 1995). However, if one puts MBCT within its original context, its emphasis on the clients inherent wisdom becomes a bit clearer. MBCT was developed within a cognitive therapeutic context where the therapist is collaboratively responsible for problem-solving any difficulties the client is having. Thus, CT or CBT in some way ask the question: How can I not feel the way I am feeling? It then becomes clear why the client’s inherent wisdom is highlighted. Although MBCT has a cognitive aspect, its assumptions about well-being and human potential is in sharp contrast to traditional CBT/CT. The MBCT therapist is not responsible for problem-solving. Rather, the therapist embodies a trust in the client’s own wisdom.

“[T]he work...involves...helping them to mend the wounds of disconnectedness and the pain of feeling isolated, fragmented, and separate, to discover and underlying fabric of wholeness and connectedness within themselves” (Kabat-Zinn, 1990, p. 162).

Of course many clients will, initially, not like the idea that the therapist is not fixing them or giving them something to do to get rid of how they are feeling. Sarah (who suffers from depression) expressed: “I guess I don’t see how this is going to do anything for me. I’ll still be depressed.” This is probably because they are perceiving their mental health problems within a medical framework: “This has happened to me, now you should give me something to get rid of it.” However, with time and direct focus on barriers to the practice, the client tends to slowly find her/his own strength, balance and empowerment to trust their own wisdom. Towards the end of the MBCT training Sarah said that: “I don’t really get it, but I feel much softer and calmer (short pause). Maybe happier.” Overcoming barriers to the practice is facilitated by the
therapists own experience of mindfulness and having faced similar or even the same barriers themselves. Essentially, MBCT argues that all minds are alike. Ultimately, all minds tend to operate in similar ways and there is no point in distinguishing between the minds of those seeking help and those offering it (Segal et al., 2002). Segal et al. (2002), argue that mindfulness will not be as effective as an intervention if the therapist is not practicing mindfulness. If, for example, you are learning to rock climb and your instructor has never attempted rock climbing before, would you trust him/her to teach you? To teach rock climbing, the instructor would have to have extensive experience to know the pitfalls, difficulties and how to help you on your way. The climbing instructor would not be able to teach using purely 'intellectual' knowledge. Similarly with mindfulness, the therapist has to embody mindfulness. This is not an issue of competence or credibility, but an issue of the therapist living mindfully from the inside out to convey the attitudes that the clients are invited to integrate (Williams et al., 2006). Marie expressed this in her final session: “I think one of the things that helped me get mindfulness, was you (the therapist). The way you thought, acted and talked to me.” Moreover, MBCT may be particularly interesting to counselling psychologists because our ethos is about being connected and meeting our clients on a relational level. If working within the NHS, a system sparse on connectivity and relational depth, MBCT becomes a bit of a lifeline.

Perhaps the emergence of MBCT is also a reflection of the CBT/CT practitioner’s search for connection and relational depth. As a counselling psychologist I have a love-frustration relationship with MBCT. On one level I am pleased to see that connection is being emphasized within mainstream therapy. On the other hand, as I am writing this I am also embodying frustration. My frustration is that most of the inherent aspects of MBCT is already inherent in more traditional models such as, Gestalt therapy and Existential therapy to name a few. For example, Gestalt therapy focuses on the person’s experience in the here and now, understanding that process to enable the person to take responsibility and be aware of the choices that are available (Perls, Hefferline, & Goodman, 1951). Does it ring a bell? The frustration is that these models are not receiving similar recognition with mainstream practices. Nevertheless, MBCT is a helpful development for clients and practitioners.
It has been suggested that it is disconnection of parts of the self that leads to mental health problems and prevents well-being. Working within this framework, MBCT’s focus is on connecting with what is here and now and in this way working through this disconnection. It has been the intention of this essay to highlight the depth of MBCT. MBCT does not have to be a stand-alone therapy, but can work in conjunction with other psychological therapies (Segal et al., 2002). A client may need more explorative one to one therapy to help process early experiences. Moreover, when MBCT is implemented it is essential that mindfulness as a whole is adopted in order to prevent possible disintegration and disconnection of its elements. It is on the one hand positive that it has become ‘the flavour of the month’ in the NHS, however, there is a danger that its potency gets diluted if its depth is disconnected and fragmented by becoming a mere watered down technique.
References


Overcoming depression: An exercise in self-deceit?

This essay is inspired by some therapeutic work with a client, Will (pseudonym), who suffered from major depression. He had a history of feeling like a failure and had also lost his twin brother at birth. At the time of our meeting he was highly suicidal and made continuous preparations to commit suicide. He presented as hopeless, helpless and extremely anxious. Working with him created anxiety, frustration, a desire to get rid of him and at times, strong compassion. He activated the care system to say the least. Within four months he had been hospitalized, offered Cognitive-Behavioural Therapy (CBT) group-work for anxiety, another CBT group for low-self esteem, time with a support worker who took him out in the community, ECT, and some CBT for depression with me. Finally I referred him for long-term psychotherapy. Will has inspired this essay because his difficulties could not be addressed by problem-solving and practical solutions that CBT offered. I was surprised at the amount of CBT that was offered to him and how impotent this model seemed to be in relation to his difficulties. Rather than hearing him and staying with his expressions of hopelessness, death and meaninglessness, professionals wanted to fix him. His difficulties seemed unbearable for us and as a hot potato he was sent around for someone else to work with him.

Depression is a wide spread difficulty in our society. The lifetime prevalence rate of major depression is between 10% to 25% of women and between 5% to 12% in men (Leahy & Holland, 2000). It is estimated that people born after 1945 are at greater risk for major depression alongside other mental health problems (Clark, 1995; Roy, 1995). Depression is defined as low mood, loss of interest, low attention, difficulties sleeping, poor appetite along with strong feelings of helplessness and hopelessness (Segal, Williams & Teasdale, 2002). The diagnosis of major depression is only given when a number of these symptoms have lasted for at least a two week period and there is an infringement on the person’s life (A.P.A., 2000). Clark (1995), showed that the suicide risk increased by 15% for each new episode of depression endured by a person. Depression is clearly a difficulty faced by a large proportion of the population.

This essay will explore the CBT model of depression. Although this essay recognizes that CBT is just one model and cannot suit everyone, it is argued that the focus on the
CBT model of depression is appropriate as CBT has become the mainstream way of understanding major depression within public health. “When considering individual psychological treatments for moderate, severe and treatment-resistant depression, the treatment of choice is CBT” (NICE, 2007, p. 29). Moreover, it was within a CBT context that I encountered Will and his difficulties. This essay will then look at the CBT intervention for depression. It then goes on to consider and challenge some of the underlying assumptions of the CBT model of depression. Lastly, it will consider the implications for practice.

The CBT Model of Depression: Stuck in a cycle

Beck (1976) writes that depression is essentially about loss and the paradox of self-blame and external locus of control. He refers to a loss of parts of the self that are required for the person to be happy. The depressive paradox is the contradiction between feeling as though one is to blame for everything, yet feeling that all control is external to the self (Abramson & Sackeim, 1977). Moreover, the CBT model of depression argues that a person may come to suffer from depression as a result of past experiences, vulnerabilities and precipitating factors (Beck, 1967; Beck, 1976; Beck, Rush, Shaw & Emery, 1979; Fennell, 1989; Padesky, 1995). Past experiences may include, living with a depressed mother, loss of a parent or bullying at school. Consequently, the person then becomes vulnerable to interpret new experiences through these previous experiences. Assumptions are formed based on these experiences. These assumptions are referred to as maladaptive assumptions, because it is argued that they are distorted and do not reflect reality (Leahy & Holland, 2000). When a maladaptive assumption is activated then a loss may be considered unbearable and a lack of interest may feel as total rejection (Beck, 1976). Another maladaptive assumption could also entail the person’s assumption that they have to be perfect and in control so that they will not have to endure past experiences (Fennell, 1989). When they are faced with the inevitable disappointment of life, of not being able to live up to their assumptions, they eventually land in depression. For example Will, mentioned above, explained that he felt like a complete failure in his father’s eyes and he never felt “good enough.” He said he spent his whole childhood trying to get his father’s attention. Will formed the assumption that “if I please others then I will be good enough.” Thus, he is relating to himself as a failure and interprets interactions with
others as evidence supporting the maladaptive assumption that he is not good enough. However, assumptions alone do not account for depression. Generally there are precipitating factors that encourage depression to appear. This may include events like a loss of a job, reaching a certain age, a car accident or the loss of a relative or a close friend. However, the onset of depression is often unclear and does frequently not have a clear start (Beck, 1976). Instead it is something a person may have suffered on and off for an entire life time. For example, Will was unable to report when he first started to get depressed. He expressed that it happened at some point in his childhood. According to the CBT model, it is the precipitating event that activates the dysfunctional assumptions. Once activated these dysfunctional assumptions jump start two other levels of cognitive distortions, firstly a surge in negative automatic thoughts (NATs) and secondly, negative schemas about self, others and the world (Fennell, 1989). The NATs are considered negative because they are associated with negative events or unpleasant feelings and are considered automatic as these thoughts seem to just appear in the mind (Fennell, 1989). The depressive mood is seen as rooted in a distorted negative world view, negative self-image and negative evaluation of the future (Beck, 1976). It is this thinking that stands in the way of happiness. Essentially, the CBT model argues that Will is stuck in a cycle of thinking he is a failure, leading to him feeling like a failure, feeling depressed, hopeless, helpless, numb and despairing, which leads him to feel physically lethargic, tired, heavy and tense and this elicits suicidal behaviour and decreased activities. This in turn feeds back into him thinking he is a failure. This is a cycle that continues to reinforce itself. It is important to note that the CBT model does not suggest that depression begins with cognition. Rather, it is a cycle with no clear starting point.

**The way out: Fake it till you make it.**

Having considered the CBT model of depression it becomes essential to consider how depression is engaged with therapeutically. There are many outcome studies supporting the efficacy of short-term CBT treatment for depression (Williams et al., 1997). However, these are studies with so called clean clients that have a single disorder (Yalom, 2001). Furthermore, Weston and Morrison (2001) also found that there is little follow up after a 12 month period and none after 24 months. They also found that there was no evidence that therapists actually follow the CBT treatment.
guidelines. Hence, such evidence-based results should be questioned. Unfortunately, it is beyond this essay to discuss this further. Nevertheless, within this type of treatment, depression is approached as a problem that needs to be solved. The CBT task is to solve these problems collaboratively with the client (Fennell, 1989). Prior to treatment starting, the client has to accept the treatment model and feel that it fits for them (Fennell & Teasdale, 1987). Moreover, the collaborative relationship between the client and the therapist is emphasised in most CBT texts (Fennell, 1989; Padesky, 1995; Leahy & Holland, 2000). The collaborative relationship implies that both the therapist and the client contribute to the therapy. Perhaps not a novel concept within psychotherapy, however, within CBT treatment it might mean completing a behavioural task or filling in a mood diary. It is argued that if the client is unable to form a collaborative relationship with the therapist, treatment is unlikely to work.

There is a heavy emphasis on the behavioural symptoms in the treatment of depression. This is because of the often apparent physical symptoms that come with depression, such as, lethargy, tiredness and passivity. Will for example, rarely went outside, watched TV and walked slowly with slumped shoulders. The emphasis is on "acting better before feeling better" (Leahy & Holland, 2000, p. 14). This is done through activity scheduling, graded tasks and reward systems (to name only a few). It is argued that through ‘doing’, clients feel a sense of achievement and this can then be used as evidence that disproves the depressive thinking. Will often explained how he could see no point in getting better, because he could not see how the future would be any different. In essence, it is thought to combat hopelessness and helplessness. Moreover, when implementing behavioural tasks the client’s distorted thinking can become clear and, thus, provide ample data to work with in therapy.

The distorted thinking is also challenged within the CBT model. It is the negative thinking that needs modifying to enable the client to come out of their depression by realizing that it is the interpretation of themselves, others and the world that is creating the depression. Essentially, that NATs are not reality, but an individualized (negative) interpretation of an event. In Will’s case it could be said that he is severely depressed because his beliefs, assumptions and thoughts are clouding reality. Somewhere along the line he formed the impression that he is a failure and not good enough. Thus, he
now sees the world through this shroud of failure and collects evidence that fits his self-image. Beck (1996) states that the emphasis in CBT is on the negative thinking and how these thoughts seem to maintain and perpetuate depression. It is suggested that because of their distorted thinking, clients are unable to solve these life problems on their own. The goal of CBT is to help the client find a solution to their problems, to help them act differently and prevent future episodes of depression (Fennell, 1989). Essentially, it is about finding a way to feel differently from what is being felt right now.

**Avoiding the unbearable through self-deception.**

The CBT model essentially argues that a person suffering from depression has in some way lost touch with reality. “Depressives, they claim, believe false ideas about themselves and others” (Livingstone-Smith, 2004, p. 27). They have distorted thinking and negative beliefs about themselves, others and the world that, according to CBT, are not true. So it may be, however, what if we flip this on its head and argue that people suffering from depression actually are the people that have a grip on reality (Lewinsohn, Mischel & Chaplin, 1980; Livingstone-Smith, 2004)? Essentially, they have for some reason connected with what existence really is. Livingstone-Smith (2004) argues that “...’normality’... may rest on a foundation of self-deception (p. 28). Normality is then disconnected from meaninglessness, isolation, uncontrollability and death.

Frankl (1959) writes that those who are unable to find a purpose and a meaning in their lives are the ones who fall into despair and depression. These are the people who cannot find hope and reasons to stay in this life. Will is one of these people. Will’s birth was intertwined with death. When a child has to face ‘too much too soon’ it creates an imbalance (Yalom, 1980). Will was faced with how unpredictable his own annihilation could be. He did not have enough defences to cope with the death of his brother. In some ways this could fit neatly with the CBT model of depression in that it would argue that Will needs to gain coping skills which will in turn improve his depression. However, what the CBT model does not take in to consideration is, that life is messy, unpredictable and ultimately will end in death. Beck (1976) does suggest that loss does impact depression, but it is the distorted thoughts that become the focus
of this model. Even though the thoughts are the focus, people suffering from depression are connected with unbearable emotions of hopelessness, helplessness and meaninglessness. Perhaps by focussing on problem-solving and ‘doing’ the CBT model perpetuates the anxiety that there is so much to fear from death. In other words the CBT model of depression attempts to superimpose an order to an unpredictable world. However, it is not reality that is gained, rather, it becomes an exercise in self-deceit or what Sartre (1956) might have described as ‘bad faith.’ It is the attempt to construct a structure onto something entirely random and uncontrollable. This illusionary structure can be seen within the CBT treatment for depression through the use of manuals, activity schedules and ‘doing.’ As a result this model may end up advocating dissociation from that which is unpleasant, rather than coming to term with what life is really like.

Perhaps this illusionary structure of what depression really is, is not just for the client’s sake. It may also protect us practitioners from facing our own struggles with hopelessness, meaninglessness, death and isolation. I am sure we have all sat with a depressed client and felt overwhelmed by frustration and total helplessness. It is not a pleasant feeling and these feelings are more easily dispersed if you hand over an activity schedule to the client rather than choosing to ‘be’ with the unbearable emotions. Will provoked an intense frustration, hopelessness and a strong desire to get rid of him. In our CBT work together we did cost/benefits, activity schedules and challenged NATs, but it was not until we paid attention to process and both entered into the murky waters of depression that he was able to connect with me. It was amongst death, meaninglessness, hopelessness and helplessness we could begin working together.

**Implications for practice**

The implications this has on practice are manifold. We would have to look at depression from the bottom up, instead of the top down approach. Thus, prior to teaching skills and problem-solving we would get down in the mud with our clients. It is about meeting on a relational level and letting go of techniques. According to Mearns and Cooper (2005) this is important for a number of reasons. Firstly, techniques strip attention away from the client, the human being in front of you, and
the work becomes about outcomes and 'doing'. Secondly, techniques and problem solving stops us from relating to the actual experience of the client and we end up looking for responses. Thirdly, techniques drains away our own authenticity and we begin to relate in a standardized and rehearsed way. This all comes in the way of an immediate and authentic human encounter (Mearns & Cooper, 2005). It allows us to ignore the dark side of the human psyche. It is again, beyond this essay to discuss this fully, however, there is one more point that is essential in the therapeutic encounter. It is the openness of the therapist. Yalom (2001) writes: “I urge you to let your patient matter to you, to let them enter your mind, influence you, change you - and not to conceal this from them” (pp. 27-28). For a true relational meeting the therapist has to be prepared to be fully open and receptive to the client. The Jungians might say that we have to be willing to enter into the bath with the client to experience their messiness and disavowed aspects of the self (Stevens, 1986). Thus, the therapist has to know and be intimate with his/her own dark side. This is likely to entail a journey into personal therapy.

In some ways paying attention to that which might be unpleasant is being addressed by new developments within CBT such as, Mindfulness-based cognitive therapy (MBCT) and Acceptance and Commitment Therapy (ACT). Both these interventions are grouped into the third wave of cognitive behavioural therapy (Öst, 2008). The heart of MBCT lies with ‘being’ in the world rather than doing. The driving force behind MBCT, Kabat-Zinn, (1990), asked the question: what is the purpose of becoming who you already are? It is suggested that rather than problem-solving your way out of depression healing is letting go into being and letting the inherent wisdom of the mind develop (Segal et al., 2002). These are certainly positive developments. However, it is time to give some elbow room for those who have been playing around with death, meaninglessness, freedom, isolation and unpredictability for some time now: the existentialist.

In conclusion, it has been the intention of this essay to highlight where the mainstream CBT model of depression may be lacking in depth and may benefit from paying attention to the darker side of the human psyche. Essentially, this essay is suggesting that mainstream CBT is only paying attention to fractions of the client by focussing on
how to dissociate from the existential realities. This essay has even suggested that CBT treatment of depression may be engaging in self-deceit by defending against unbearable emotions. This essay has suggested that perhaps those suffering from depression are those who are in touch with reality, whereas the CBT model suggests that those suffering from depression have a distorted view of reality. Lastly, this essay briefly touched on the implications of this on practice.
References


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Introduction to the Therapeutic Practice Dossier

This therapeutic practice dossier contextualizes my therapeutic practice and experience throughout my three years on the course. It provides a description of my three placements and the client base that I have worked with. Additionally, it also contains my clinical paper, which represents my continuing personal and professional journey.
Description of Clinical Placements

My first year placement was based in a large primary care practice in South-West London. The psychological services offered were divided into three tiers. The first tier offered brief integrative therapy for up to six sessions. The second tier was mid-term integrative therapy up to 22 sessions. Lastly, the third tier included courses and groups that aimed towards reducing symptomology and developing coping skills for anxiety and depression based on cognitive-behavioural theory. Clients referred were from varied backgrounds, ethnicity, gender and between 18 and 65 years of age. Clients were referred by their GP. Following a psychological assessment they were either offered therapy in-house or referred on to more appropriate services. Clients seen, suffered from a range of difficulties reaching from depression, anxiety, identity and intimacy difficulties and trauma. The psychological department was managed by the director of psychological services who ultimately decided who would be seen in-house.

I was involved in all three tiers of the service. I mostly saw people for short-term integrative therapy. However, I had the opportunity to see some clients up to 22 sessions. I also co-ran a Cognitive Behavioural Therapy (CBT) anxiety management group with a qualified counselling psychologist over the span of eight weeks. I also had the opportunity to conduct assessments and together with my supervisor decide what treatment was appropriate for a particular client. My supervisor came from an integrative background. Although I worked closely with my supervisor the role required independent working as I only saw my supervisor for supervision and assessments. Otherwise, I was the only mental health practitioner present. It was in this placement my first two process/client study reports were written.

The second year placement was based in a large mental health trust in the South-East. More specifically, the therapeutic work took place in a tertiary care psychotherapy department. The team consisted of psychiatrists and psychotherapists. The psychotherapy department offered both individual and group therapy within the psychodynamic framework. They also offered intensive Mentalization-Based Treatment (MBT) for patients with Borderline personality disorder (BPD). Permanent staff saw patients for up to two years and as a trainee I saw individual patients from
November 2007 to August 2008. Patients seen suffered from a range of difficulties reaching from depression, anxiety, identity problems, relationship problems, personality disorders (PD) and Post-Traumatic Stress Disorder (PTSD). My patients difficulties stemmed from childhood emotional, physical and/or sexual abuse. Some patients felt that their difficulties were a result of emotional neglect and not having their basic emotional needs met in childhood.

I had a total of two hours of supervision each week. One of my supervisors came from a Kleinian background and the other came from a Jungian background. Thus, I gained broad psychodynamic experiences. Any patient between 18 and 65 years of age considered suitable for psychotherapy was referred. Patients came from a range of ethnic, cultural and socio-economic backgrounds. Patients were referred by their GP, psychiatrists or Community Mental Health Team (CMHT). Following an assessment they were either offered therapy in-house or referred on to more appropriate services. The psychotherapy department was managed by the consultant psychiatrist in consultation with the consultant psychotherapists. During this time I also presented patients in team meetings and participated in weekly business/clinical meetings. During this year I also had the opportunity to observe Electroconvulsive Therapy (ECT) and attend ward rounds on the in-patient ward. Whilst in this placement I also wrote my next two process/client study reports.

My third year placement was based in a day service in a large mental health trust in the South-East. The service provided specialist services for people suffering from Psychosis, Personality Disorders (PD) and also an anxiety/depression service. The multi-disciplinary team consisted of, counselling psychologists, clinical psychologists, psychiatric nurses, occupational therapists, art therapists, music therapists, psychotherapists, psychiatrists, support-time workers (STR) and administrators. Both individual and group treatment was available. The anxiety/depression service ran multiple CBT groups for anxiety and depression. Moreover, there was also a specialist art and music therapy service for PD and psychosis. Clients were referred by their GP, psychiatrist or Community Mental Health Team (CMHT). Following an assessment they were either offered individual and/or group therapy at the day service or referred
on to more appropriate services. Clients referred were from varied backgrounds, ethnicity, gender and between 18 and 65 years of age.

My main role was to work within the psychosis and PD services. However, I have also organised, prepared and run a Mindfulness-Based Cognitive Therapy (MBCT) group for depression. My role within the Psychosis service was to see people on an individual basis. I have worked with people who hear voices, see visions and have delusional beliefs about themselves, others and the world. Several of these people had a diagnosis of schizophrenia. The work has entailed psycho-education, CBT for psychosis and Person-Based Cognitive Therapy (PBCT). However, the most important task has been engagement and facilitating social inclusion as many of these clients tended to be socially excluded. I also co-ran a CBT group for people suffering from bi-polar disorder. My role in the PD service was to see clients suffering from PD on an individual basis. They were mostly clients who were diagnosed with borderline personality disorder and dependent personality disorder. The work generally entailed implementing Dialectic Behaviour Therapy (DBT) and core belief work. I have also worked with CBT for anxiety, depression, Obsessive Compulsive Disorder (OCD) and Post-Traumatic Stress Disorder (PTSD). During this year I have also gained experience in risk assessment and risk management. Both in terms of risk to self and others. Many of my clients presented with suicidal thoughts and plans. Some had thoughts of harming other people. My role also entailed assessments and attending Care Plan Approach (CPA) meetings. In this year I wrote assessment reports, CPA reports, end of therapy reports and many referral reports. Moreover, I have also written many letters to other services and to clients.

I tended to have a case load of five to six clients and a group at any given time. Two hours of CBT supervision and continuous consultations with other members of the team involved in my client’s care. Most of my clients had a care-coordinator and a psychiatrist involved in their care. Before the end of this placement I will also have the opportunity to observe/administer a WAIS. My last two process/clients reports were written in this placement. Additionally, logbooks were kept for all three placements.
I share this story because it symbolizes my journey through this doctorate in psychotherapeutic and counselling psychology and also how the journey will continue for a life time. It has been about learning that there is no end goals, but that the goal is to engage in the process. The process of life and of therapy, my own and that of my clients. I came on to this doctorate thinking that to succeed here I have to ‘do’ brilliant therapy, complicated research, covering many epistemological stances and do it perfectly from the start. Of course this is impossible and I have met my edges over and over again. Reflecting on my background that is not surprising. I come from divorced parents who are highly driven. If I would have given my family a motto when I was younger it would probably have been: “Do it perfectly or don’t do it at all.” I always fluctuated between striving for perfection and rebelling totally against it. In the deepest, darkest and most secret space in my heart I always felt that I was not enough, not important. Others were prettier, smarter, more intellectual, funnier and
more confident. However, if you met me three years ago you would not have known. I seemed confident, strong, forceful and focussed. Don’t get me wrong, I am that too, however, the trouble was that I did not quite believe it.

Doing this course I have found out that I want to live and I do ask myself, ‘why am I so scared?’ and I learn from it; over and over again. The very sense of me as a human being, as an academic and a practitioner has been reconstructed over these three years. I am the same person, but not the same at all. As instructed for this assignment I will attempt to outline who I am as a counselling psychologist, chronologically I will share what I believe to be some important experiences throughout my three years of this course, but I think it is so much more than that. By doing so I also outline who I am as a person at this point in time. I believe and hope that who I am will forever change as I integrate new experiences because I am in no doubt that I will continue meeting new edges.

**Discovering my wings: Year one**

There we were 13 new counselling psychology trainees nervously glancing at each other wondering “can I trust you?” More than anything I was thinking “I don’t belong here.” Despite feeling like an imposter I began my therapeutic experience in a primary care setting with a integrative supervisor, focusing mostly on the basic therapeutic skills. The integration of the person-centred principles (unconditional positive regard, congruency and empathy) provided me with some of the most important skills. Coming from a position of doing I was prepared to ‘do’ therapy and I was reading Mearns & Thorne (1988) and Roger (1951) to figure out how to do it. After some time the ‘doing’ faded away as I begun to recognize the importance of these principles because I was experiencing it in my personal therapy and in supervision. When I lost sight of my abilities and worth my therapist continued to believe in me. I remember thinking that this was odd, there was no criticism or suggestions on how I could be different and better. I felt the power of the unconditional positive regard, congruency and empathy. Interestingly, it was not what my therapist did that was so powerful. Rather, it was her ‘being’ with me that was healing. It was through experiencing ‘being’ that the ‘doing’ began to move into the background. I suppose I was beginning to allow myself to ‘be’ who I am with kindness and acceptance.
I agree with Mears & Thorne (1999) when they suggest that it is impossible for the therapist to offer genuineness, empathy and acceptance if this is withheld from the therapist’s self. Thus, self-love is imperative for the therapeutic practice. I was able to begin to self-actualize and reach my potential on my own terms. Some say that you teach what you most need to learn and perhaps that is what I most needed to learn, kindness and self-compassion. This was also a time when I started pursuing my interests in mindfulness, yoga and expanded my sports as a way of including my body on my journey towards self-compassion and kindness.

There were many little edges that year, but the sharpest edge I came up against was learning to play with theory. Something my supervisor helped me realize by introducing me to the Winnicottian idea of ‘playing.’ Winnicott (1971) suggests that “[i]t is in playing and only in playing that the individual child or adult is able to be creative and...it is only in being creative that the individual discovers the self (pp. 72-73) and he also wrote that “[i]f the therapist cannot play, then he is not suitable for the work (p. 72).” In hindsight, I also needed to learn to play in my academic work. At the time I was writing my literature review and I was petrified of failure. I had in my mind that the result had to be excellent, however, because I put such pressure on myself I did not enjoy the process of writing it. I even rebelled against myself, perhaps like I would have rebelled against my parents when I was younger. A part of me was saying “well, fine, if you tell me to do this perfectly then I just won’t do it.” Not surprisingly I did not do well, I failed it. However, it was one of the best things that happened to me. I had come up against my edge and with the help of therapy and research supervision I was able to learn and grow from my experience. I learnt to have fun with theory and the result was a good paper.

Returning to my therapeutic experience. I had begun to play around with existential theory. I found I had a soft spot for death, freedom, meaninglessness, responsibility and isolation. It made complete sense to me that I will face death, I am alone yet paradoxically connected to others, this life is desperate without a meaning and I have a choice in how I live this one precious life. This also allows me to let my clients take responsibility for their lives and make the choices they need or want to make. As I write this I am sitting next to a couple of women in a coffee-shop who are discussing
God and one of them is low because she is struggling to hold on to God. I can feel and empathize with her fear and this has brought home to me that although I believe in existential ideas and to me that means I do not believe in God, I am also able to work with people who are different from me because I strive for a relational meeting. This way I don’t meet ‘parts’ of my clients, but the essence of their being and the totality of themselves. Of course that does not mean I am without judgement, however, it means that I can notice and reflect on my judgements. This enables me to work in an honest and truthful way. Mr. K. (please see attachment), a 56 year old client, was one of my teachers in existential therapy and the power of a relational meeting. We worked together over 12 sessions trying to understand his experience of his life after a heart attack and near death, but the work moulded into understanding his experience of how he sees himself in relationships. Below is a snippet of a relational meeting.

**Mr. K:** I don’t meet many people anyway so I mean it’s not much of a problem but it’s like I am being boring to myself. You know you think oh.

**T:** So if you are boring to yourself how can you be interesting other people?

**Mr. K:** Yeah.

**T:** So how do you think that comes in here?

**Mr. K:** Ahm, whether what I am saying to you is useful for you, to ah analyze me basically.

**T:** So it sounds in some kind of way you are kind of concerned about me. And and that you might be boring me.

**Mr. K:** Yeah to a certain extent yeah.

Mr. K. made some important shifts for himself in that he begun relating and talking to his girlfriend, joined a gym and started a healthy diet. Mostly, I believe this is due to how he threw himself into the therapy and engaged, but I also wonder if it had to do with him experiencing acceptance and a real meeting with me. A relational meeting can have a corrective impact on a person because it accepts the client and counterbalances previous rejecting experiences (Mearns & Thorne 1988). Although I
feel that the humanistic ideas are at the core of my work, they are sometimes not enough. I agree with van Deurzen (2002) when she writes that the problem with the humanistic approach is that it sometimes only "represents...one side of the inevitable polarity. This polarity is one of love and hate..." (p. 70)." In essence, we as human beings have the capacity to be everything, loving, hateful, dominant, resentful, evil and good. If these paradoxes are not acknowledged that is when indifference and incongruent caring sets in (Sartre, 1956). Our capacity to be anything is something I also looked closer at in my literature review where I explore the psychological issues such as, the banality of evil (Arendt, 1963) in relation to the Truth and Reconciliation Commission (TRC) in South Africa.

Overall, I have to admit I was very happy within the existential and humanistic frameworks, I finally was letting go of having to be perfect. I was not looking forward to the psychoanalytical model, it frightened me. Looking back, my transference with the psychoanalytical model began at my interview for a space on this doctorate course. My transference was feeling inferior, insecure and wanting to prove my worth. During the interview I was asked how I thought I would manage to sit in silence when I was used to a very active behavioural model. Prior to the doctorate I worked as a behavioural therapist and consultant for children with Autism and their families. My answer was "I think it will be a challenge." I was right, it was a challenge.

**Hurricane winds: Year two**

My second year placement was in a tertiary care psychotherapy department and was described by our professional tutors as "challenging, but a great experience." This sparked my interest, possibly due to my unresolved conflict around authority and being good enough. My super-ego firmly told me that "to be good enough I have to choose the most difficult option out there, otherwise, I have not achieved anything." However, before I even got to start my placement I lost my grandfather and soon after my grandmother. I went to Sweden twice within a span of two months. Both times to attend funerals. I was devastated and faced with my own mortality and the fragility of life. Simultaneously, my supervisor almost lost her husband to a chronic illness and was off work for about six weeks. I arrived at my placement lonely, lost, dissociated and intimidated. Despite these difficulties I had it firmly in my mind that my growing
edge was to learn to play with theory and that expressing emotions and self-reflection came naturally to me. I soon learnt nothing is constant. I got even more confused when my supervisor told me "don’t be afraid to show emotions." I thought "this is what I am good at and if I can’t do that then what am I doing here?" Moreover, at this time I was also re-writing my literature review. Although I was enjoying writing it much more than the first time I was finding it stressful. Moreover, my supervisor and I seemed to misunderstand each other most of the time. I felt unsupported and was unsure of my future at this placement. I had to draw from many sources this year to enable me to cope. I eventually expressed my concerns to my supervisor. It gave her the opportunity to express her thoughts and feelings about our relationship. It emerged that we both had been struggling to come to terms with our personal lives and we both felt overwhelmed by life. My supervisor and I were able to meet on a relational level and it was a powerful meeting that enabled me to own my space without blaming, judging or cutting her off. This experience has made me feel safer in my own body and as a practitioner. My transference with the psychoanalytical model was broken and I could play again. I felt a weight lifted off my shoulders as I stopped striving for approval and praise. I was truly coming into my own and I dared to play in the unknown and bare the anxiety of not knowing. This way the patient and the therapist can jointly discover what is needed in the patient’s therapy (Casement, 1985).

That year all my patients taught me valuable lessons, however, two stand out in particular, Mrs. P (see appendix) and Jackie (see attachment). Mrs. P. was a 53 year old woman I saw for nine months. She explained that she had flashbacks, nightmares and memories of her childhood sexual abuse she suffered at the hands of her father. Not surprisingly she suffered from severe anxiety, depression and difficulties in her relationships. She explained her difficulties intellectually, however, her emotions were absent. Together we discovered the usefulness of the psychodynamic model and working in the transference. When I was slowly able to access my emotions I began to understand and love the psychodynamic dance. When she expressed no fear when telling me about gruesome abuse, I felt it, and I could give it back to her in digestible pieces. Mrs. P. also taught me that the psychodynamic frame can be a healing experience. She said that she knew that I would not touch her and that made her feel safe. However, one of the most powerful interventions was when I picked up her cane.
after it had fallen. She expressed that it felt like she can trust me because I catch her when she falls. I do not think this would have been so powerful was it not for the psychodynamic frame. The frame allowed us to give space for the meaning of my action. Towards the end she expressed she had finally begun to feel emotions and that she could be touched by her husband again. Mrs. P. is a woman I remember with great hope and admiration. She showed me that a human being can endure great suffering and continue striving for connection. She is no longer a victim, she is a true survivor. Mrs. P. also helped me focus my research for the third year. My interest is war trauma or trauma in general, however, after my work with Mrs. P. it was becoming clearer that I was interested in dissociation or perhaps the absence of emotion. More specifically I was curious about how much distress it seems to cause people and myself when we are unable to feel. I wanted to find out more about this strive for connection

Jackie, in her late twenties, gave me some papers to read about different diagnosis, taught me about the psychodynamic frame and what can emerge within it. She wanted me to understand her difficulties.

**T**: I have read the papers that you gave me and while I was reading them I thought to myself “these are things that Jackie has told me. I recognize most of these experiences”

**P**: Oh (looks at me with an open mouth and looks shocked – 10-15 secs).

**T**: How is that to hear?

**P**: Strange (silence for a few seconds). Ahm, because I don’t know these big words (points to the papers).

**T**: It seems as if you don’t trust that others can possibly understand you.

**P**: No, I mean a bit but how can you understand me? How can anyone understand or not judge someone like me that sniffed anything off the bathroom floor. I was so desperate to score I sniffed anything. I mean I don’t think (looks up at me), I don’t think you would have done anything like that...

The frame helped Jackie and me to understand how she has always felt that there is something wrong with her and explore the therapeutic relationship.
During my work in the psychotherapy department I integrated psychodynamic thinking into my way of being as a counselling psychologist. Especially, Winnicott (1989), some Kleinian ideas of projective identification (1946) and Ogden (1979) and also Gerhardt (2004). However, there were times when I felt that it would have been clinically responsible to give Mrs. P and, in particular, Jackie, some strategies to cope with their anxiety such as, relaxation or mindfulness. They were likely to have benefited from using strategies such as, emotion regulation and distress tolerance. Something that Dialectic Behaviour Therapy (DBT) (Linehan, 1993) could have offered her. Moreover, for both Mrs. P and Jackie the ending was premature and it would have been helpful for us to continue our work together. Perhaps, time, is a limitation of the psychodynamic model within in a time limited system such as the NHS. Nevertheless, at the end of this year I felt empowered having embraced this model and built on my humanistic base. I had also been able to present my literature review at the British Psychology Society Division of Counselling Psychology conference. It was paying off to play and to have fun. There were so many edges this year in my personal life, therapeutic life and also my academic life, however, because I had started to play and be curious I was able to ask myself what it was I didn’t see and what I was so scared of. This way of being also enabled me to ask for help and let people know that I needed them. At the end of this year I felt ready to move on to the cognitive behavioural year. I was beginning to feel a bit like a counselling psychologist.

**Spreading my wings: Year three**

In my last year, this year, my placement is based in a day-centre working with people suffering from psychosis or personality disorders. The minute I put my foot in the door I faced the politics of the mental health service. In a day centre there are many disciplines coming together. Who is going to do what with whom and at what time? It was a culture shock from the well contained psychodynamic bubble. I was given responsibility for assessments, client work and low and behold other professionals were asking me for my opinion. I fluctuated between feeling empowered and out of my depth. I thought to myself “Do these people know that I’m not qualified yet?” My sharpest edge this year was about saying no. I found myself in meetings with
professionals, with much more experience than me, asking about my opinion about a
highly suicidal client. I had assessed him and recommended psychotherapy as opposed
to CBT. My supervisor had agreed with me, however, I got the sense that no one else
wanted to take responsibility for the recommendation in case he was to kill himself. I
expressed this to my supervisor and she agreed that she should have taken this client
from me much earlier. I was relieved that it was out of my hands, but there was also a
lesson to be learnt. I have to look after myself and saying no can be a strength. My
edge I came up against was thinking that I have to do it all to be good enough, but
actually what I did was to recognize my edge and make choices from there. I feel I
made a clinically responsible choice and that I feel increasingly able to trust myself.

I am finding writing about the third year the hardest because I am still trying to make
sense of it. Another reason why it is difficult is that, to me, the CBT language is
lacking and disappointing. It leaves me thirsty and yearning for more. This is in
comparison to the inherently exciting and rich psychodynamic language. When the
human experience is spoken in psychodynamic language it comes alive and you can
live it, touch and almost taste it. I suppose this language sometimes means that the
person gets lost in it. Nevertheless, I was struggling to speak this new CBT language
and I also faced a crisis of belief. How was I to work congruently within this model
when I believe that the CBT model can be a way of denying reality. CBT was to me a
way of creating an artificial structure around existence. Sartre (1956) might have
described this as ‘bad faith.’ The attempt to structure something entirely random.
Initially, I kept CBT separate from my practice and avoided using it. However, as I
played around with it I found alternatives to traditional models such as, Mindfulness-
Based Cognitive Therapy (Segal, Williams & Teasdale, 2002), schema-focused
therapy (Young, Klosko & Weishaar, 2005) and DBT (Linehan, 1993). It was through
these models I found my way to the more traditional CBT models such as, Beck &
Freeman (2003) and Padesky (1995). For example, Rachel, a client suffering from
difficulties known as borderline personality disorder taught me the value of CBT and
DBT thinking. Initially I spent time letting her tell her story, however, she became
overwhelmed by her own experiences. Applying more structure to our sessions
allowed Rachel to think about her experiences and become more aware of her own
patterns. This in turn made it possible for her to make more informed choices in her
everyday life. Moreover, Aaron another client who, as a result of hearing a voice and having a delusional belief, withdrew from social contact, was able to gain more confidence by engaging with behavioural experiments. Aaron expressed during a session that: “I...had confidence with people more when I came away from it...” However, I do not think I would have been able to use the cognitive models successfully without my humanistic and psychodynamic experience.

This year has also allowed me to run groups for people suffering from bi-polar disorder and a MBCT therapy group. I have been able to find ‘my way’ of practicing CBT and I have also been able to locate those models that are more relational such as, MBCT and Person-Based Cognitive Therapy (PBCT) for voices and delusions. It has become another dimension of me as a counselling psychologist. MBCT emphasises the inherent wisdom of the mind and that the therapist completely trusts the client’s own capacity to evolve (Kabat-Zinn, 1990). PBCT focuses on relationship building and unconditional positive regard (Chadwick, 2006). Having said that I have to add my scepticism to these new models of cognitive therapy. As I suggest in my CBT-essay, MBCT seem to adopt discarded aspects of more traditional models such as, person-centred, existential and psychodynamic models but, without acknowledging it.

I feel CBT has an important place in my practice, however, not as the sole and encompassing model. Rather, it is a model I can apply when necessary and choose not to apply if the clinical situation asks for it. For example, one young man I worked with in this placement did not engage with CBT, but wanted his narrative to be heard. He explained that “this homework and techniques just misses what I am trying to tell you.” So I listened to him and I was able to hear his story and he felt that it was what he needed from therapy. That I am able to listen to my clients and mould a new therapy for each client is the power of being a counselling psychologist.

**Letting go into the wind: Who I am now**

I would like to share the rest of the quote I started with. It symbolizes where I see myself and where I strive to always be as a human being and a counselling psychologist.
I feel I'm better equipped to face whatever is coming my way. Be it a hurricane or a soft summer's breeze. It does not mean that I can always manage what comes my way perfectly. Rather, it is about being able to keep a hold of my sense of self and continue coming 'home'. Van Deurzen (2002) wrote that “The personal world is the home world: the place where you feel at ease with yourself...It encompasses everything that is felt to be part of oneself (p. 78).” With the help of therapy I am closer to encompassing anything from love, hate, care, selfishness, evil, good, arrogance and humbleness. Of course this is going to be a continuing journey with many twists and turns. Nevertheless, this sense of who I am, allows me to be a relational counselling psychologist. To me that means I am as aware and open as I can be to my own projections, prejudices and judgements so that I can fully hear who my client is. Fromm (1963) wrote that to be wholly yourself and let the other person be themselves, the following statement would be true ‘I need you because I love you,’ rather than, ‘I love you because I need you.’ In essence, this way I am able to let my client be what she/he is and not what I want her/him to be at that time. The relational also stretches to the cultural and the political.

Where we locate ourselves within these relationships have major implications for therapy. Whilst writing this there are two aspects that come to mind. My first year research where I was exploring the understanding of trauma within in the South African context. This research was imperative for my understanding of how individual therapy interacts with the political environment. Especially, that the therapeutic contract is influenced by what is happening in the socio-political arena. Secondly, I have a client who currently finds little motivation to get well because financially she
would be worse off than what she is now. Thus, the political comes crashing into the therapy room, actually, halting progress. So I am not just a relational counselling psychologist in terms of the individual, but also a political-relational-counselling psychologist (perhaps a bit long to include in my title).

On a physical level the ‘relational’ pays attention to the relationship we have with our bodies, our environment and nature. Paying attention and being compassionate towards my body has enabled me to listen out for my clients’ experiences and attitudes of their bodies. In turn, it can help me understand how they are in the world. Dealing with the physical world is about becoming flexible with the material demands of existence and about balancing activity with passivity and being prepared for life and death, illness and health and security and insecurity (van Deurzen, 2002).

As a counselling psychologist I am not integrated enough to refer to myself as an integrative practitioner. Rather, I am an eclectic counselling psychologist. At this point I am building my home in the existential model (I’m still learning) and from this safe base I can play with other theories depending on the needs of the client. Along with clinical judgement I base my treatment contract on evidence-base, time constraints and the client’s goals for therapy. For example, with some of my clients who are diagnosed with personality disorder, psychodynamic thinking is vital to conceptualize generated dynamics, however, their goals and the evidence base suggests they may gain from DBT skills (distress tolerance, interpersonal efficiency and emotion regulation).

I finish the paper with hope, joy, sadness and regret. The hope is of the future and what it will bring me, the people I will meet and the experiences I will have. I feel joyous having almost completed this course, this paper, having found more parts of myself and the close friends I have made. I feel sadness because it is near the end and I don’t want it to end. I regret not being able to write more about the people I have met along the way, my fiancée, family, my therapist, clients, colleagues, supervisors and friends. It is because of these people I am who I am today and I am eternality grateful.
References


**Introduction to the Research Dossier**

This dossier contains three pieces of research that were submitted during my three years on the course. The first is the literature review which explores psychological themes that emerged during the Truth and Reconciliation Commission (TRC) in South Africa. Following the literature review are also the slides used when I presented the review at the British Psychology Society Division of Counselling Psychology conference in 2008. The second year research uses Grounded Theory (GT) to investigate trauma therapy in South Africa. Lastly, the third year research uses Interpretative Phenomenological Analysis (IPA) to explore participants' experiences of disconnection.
Participation in the South African Truth and Reconciliation Commission: Implications for well-being

Running head: TRC participation: Implication for well-being
Abstract

In the aftermath of Apartheid, the Truth and Reconciliation Commission (TRC) was commissioned to transition South Africa into a peaceful future. At the heart of the TRC process were testimonies of people who suffered severely from Apartheid violence and it was promoted as healing. This literature review explores psychological themes that emerged during the TRC and the complexities of using traumatic testimonies in a political endeavour. However, what stands out in this paper is the lack of research into the psychological well-being of those taking part in processes such as the TRC.
Introduction

When Apartheid came to an end after 45 years of oppression, and about 30 years of resistance against the state the country had suffered massive trauma. Many of the South African people had experienced massacres, killings, torture, rape, illegal imprisonment, displacement and social and economic discrimination. Many of those experiencing such violations suffered sustained trauma (Hayner, 2001). In 1994, Nelson Mandela was elected president of South Africa and began talks of instituting a Truth and Reconciliation Commission (TRC) (TRC, 1998). The TRC was charged with writing an official history to complete the whole picture of atrocities committed between 1960 and 1993 in South Africa.

After considerable negotiations and international input on transitional justice, the South African parliament approved the ‘Promotion of National Unity and Reconciliation Act’ in 1995 (Hayner, 2001). In essence, it was decided that restorative justice rather than punitive justice would facilitate a peaceful transition of the South African society. Archbishop Desmond Tutu was elected chair and along with seventeen commissioners the TRC was inaugurated in 1996. At the heart of the TRC process were testimonies of victims and perpetrators of political violence. The TRC was given power to grant amnesty to individuals who had committed an offence in exchange for the full truth concerning their deeds (Ross, 2001). The narratives of victims were heard and acknowledged in a public space breaking a long standing silence. The TRC encouraged victim and perpetrator to meet face to face in a court like setting, and through this meeting, the exchange of testimonials was said to facilitate a process of reconciliation - a major aim of the TRC.
The Reconciliation Act did not charge the TRC to heal those people participating. Rather it was a political mission to usher South Africa peacefully into the post-Apartheid era. However, the message sent to the people was that participation in the process was healing. The TRC slogan ‘Revealing is healing’ was spread on banners along the walls of public halls (Slovo, 2002). Radio, television and paper media continued to air the TRC message that taking part is healing (Humphrey, 2000).

"However painful the experience, the wounds of the past must not be allowed to fester. They must be opened. They must be cleansed. And balm must be poured on them so they can heal" (TRC, 1998. p. 10).

In the final report issued by the TRC, Desmond Tutu wrote: “[i]t has been an incredible privilege for those of us who served the Commission to preside over the process of healing a traumatized and wounded people” (TRC, 1998, p. 1). The assumption was that healing “the body politic” would heal the psychological injuries of the individual bodies (Swartz & Dennan, 2000). Unfortunately, the component of the TRC accorded least funding was the psychological support team (TRC, 1998). Although the TRC seemed aware that there was not enough psychological support for people suffering from trauma, committee members, authors and the media promoted the process as healing as revealed by the quotes above.

By referring to empirical literature, clinical observations, opinion and TRC banners, this paper will explore psychological themes that emerged during the TRC process and consider them in relation to psychological trauma theories. In accordance with the TRC, this review will use the term victim and perpetrator to refer to those
participating in the TRC process and will briefly explore these terms below. However, due to time and space constraints this review will mostly focus on the experiences of victims of trauma rather than providing an encompassing review for all those involved in the conflict. Firstly, it examines the difficulty some traumatized people have with speaking about their experiences. Secondly, it explores the importance for victims of severe violence to be able to speak about their experiences. Thirdly, it investigates the possibility that the TRC may have created a language for those unable to speak. Lastly, this review considers the problems with language and speaking in front of the TRC.

The review is important for counselling psychology as it explores the impact of a social process on individual trauma. It will highlight how trauma is embedded in a specific socio-political context and how that context may determine the expression of suffering. Counselling psychology may also grow from further understanding the importance of language for those suffering from trauma. This review will enrich a counselling psychologist's understanding of the South African context, leading to better provision when working with a South African client group.

Absence of Language
Many South Africans were silenced for decades and this enforced silence contributed to the difficulty in symbolizing traumatic suffering. Krog (1998) quotes from one participant's testimony during the TRC process. He said “[t]his inside me...fights my tongue. It is...unshareble. It destroys...words. Before he was blown up, they cut off his hands so he could not be fingerprinted...So how do I say this? – this terrible...” (p.
40). For many South Africans, years of political oppression and violence conspired to leave them with personal nightmares, silenced into isolation and secret worlds, created to maintain the power of the Apartheid regime (Humphrey, 2000).

Scarry (1985) writes about interpersonal psychological trauma as language-destroying, leaving the person suffering outside of the social. Many trauma researchers suggest that severe trauma can cause an inability to verbally express the traumatic event or the suffering in the aftermath of the event (LaMothe, 1999; Laub, 2005; Rauch et al., 1997).

Three pieces of literature concerning the absence of language are presented below. It is important to keep in mind that they are not based on a South African population and attempts to generalize to other populations should be considered carefully as people from different cultures may have different experiences and emotions around the absence of language. However, the literature explores how some sufferers of trauma may struggle to verbally express their painful experiences. This is particularly interesting to explore in this review as the TRC process was centred around traumatic testimonies. Symbolization in this context refers to a way of representing something that has been previously unformulated (Stepakoff, 2007).

The Problem of Symbolization

LaMothe (1999) explores the inability for some Holocaust survivors to symbolize their traumatic experiences decades after the trauma occurred. He does this by conceptualizing three published accounts by individual trauma survivors through the use of psychoanalytic theory. He also refers to his own clinical experiences with
trauma survivors. Firstly, he explains that the development of symbolization is not necessarily an automatic process, rather, is dependent upon the respectful and appropriate response of the other. Thus, relationships can either facilitate or cripple the ability to symbolize personal experiences. Hence, if recognition of expression is absent, the individual will eventually remain silent. Secondly, symbolization is dependent upon trust between individuals. Consequently, if trust is absent, the individual will not risk expression in the fear of uncertainty. Lastly, he suggests that symbolization is emergent upon a sense of the other’s faithfulness to the individual’s sense of self. LaMothe (1999) goes on to argue that trauma can become “unspeakable” because symbolization is contingent upon these three experiences: obliged other, trust and faith of the other. These experiences are not necessarily conscious processes or decisions, rather it may be experienced on an unconscious level. When there is an absence of an appropriately responsive other - in the instance of physical abuse - the traumatic experience cannot be symbolized. Due to the absence of the obliged, trustworthy and faithful other, traumatic experience remains internally unformulated. During the Apartheid regime a large proportion of the population suffered long-term oppression and continuous physical and psychological abuse which may have been experienced as an absence of an obliged, trustworthy and faithful other. If this is the case, the person may find speaking about the trauma difficult.

The notion that trauma can cause difficulty with symbolization is supported by Laub (2005). His study uses clinical vignettes to illustrate the problems individuals may have with symbolization in the aftermath of massive trauma. The writings have emerged from clinical work with trauma from the Holocaust, Russian slave labour camps and torture of political prisoners, suggesting some commonality across
different cultures. The author suggests that during massive trauma there is an annihilation of the survivor’s sense of self and a destruction of any personal narrative. Thus, similar to LaMothe (1999), Laub (2005) describes that some people find their traumatic experiences “unspeakable.” The notion of “unspeakable” trauma is also supported by Kalched (1996), in his work with trauma survivors. He argues that trauma is language destroying because the traumatic experience creates such strong defences from the real world (the world that provided the traumatic experience). These defences are so strong that they shield the sufferer from the ‘real world,’ leaving him/her unable to communicate about the traumatic experience and thus avoiding repetition of the trauma. Laub (2005) goes on to suggest that through testimony and language a personal narrative is rebuilt. As mentioned above, people in South Africa suffered from severe political violence and oppression. It is, therefore, possible they may have experienced this violence and oppression as a sense of annihilation of the self and the trauma as “unspeakable.”

In maintaining a critical stance towards the literature it would seem there is little transparency into the data collection in the studies of LaMothe (1999) and Laub (2005). It is possible that the participants were selected as they demonstrated difficulty in communicating their traumatic experiences. Suggesting exclusion of those who were able to express themselves. By merely including those with the inability to communicate trauma, these studies may present one-sided evidence supporting the “unspeakable” of trauma. Although this criticism is possible, it is important to recognize that selecting a homogeneous population is commonly used in human science research methods. Rather than engaging in a research endeavour to uncover ultimate truths, human science research aims to gain deep understanding of the
participants' experiences. Thus, the value of above studies lies with the homogenous sampling as it provides an in depth understanding of the difficulty of symbolization.

It is problematic to scientifically explore a phenomenon that is unspeakable, as research is mostly contingent upon language. In essence, anecdotal observation is a hermeneutic process requiring the unspeakable to be interpreted and represented through language. The hermeneutic process in itself is not a reason to discard the literature, as it is a commonly accepted method in qualitative research methods. However, within positivist-empiricist discourses, there is something deeply problematic about something that does not lend itself to measurement. Even within critical psychology, something that claims to be unspeakable, could be seen as protecting itself from critical analysis (Coyle, forthcoming). However, in a positivist-empiricist study, Rauch et al. (1997) have found evidence for the inhibition of language in sufferers of trauma. This study will be examined more detail in the following section.

*Organic Link to Decreased Language*

Rauch et al. (1997) examined 23 right-handed 22-55 year old outpatients meeting the criteria for; obsessive-compulsive disorder, simple phobia, or posttraumatic stress disorder (PTSD). Of relevance to this literature review are the suffers of PTSD. Positron emission tomography (PET) was used to monitor brain activity while participants relived traumatic experiences. This study showed biological changes in the brain during and following traumatic experience recall, such as decreased activation in Broca's area (which has been well documented as vital in language production), suggesting that traumatic experiences alter the brain's capacity to access
language. Furthermore, they found increased activation in the limbic system, in the right hemisphere. This implies that reliving traumatic memories can emotionally overwhelm the person and leaves the person unable to analyze what is currently happening (Rauch et al., 1997). The individual may be physiologically inhibited to find words to express their experience. While referring to these findings, van der Kolk (2007), suggests that when a victim recalls traumatic memories they may suffer from "speechless terror" in which they can be physiologically disconnected from using language to analyze their emotions. This is relevant to the TRC process as it required participants to relate to their traumatic memories during testimonies.

Rauch et al.'s (1997) study shows empirical evidence of decreased verbal ability when recalling traumatic experiences. Finding an organic link for trauma has facilitated the recognition of the seriousness of trauma and its physiological impact. However, the danger of relying too heavily on biological explanations of trauma is that it may suggests a certain degree of abnormality, which then can serve to marginalize those who suffer from it. Unfortunately, it is beyond the scope of this paper to engage fully with this debate.

There is a wide variety of studies and literature suggesting that those suffering from trauma find it difficult to symbolize their experiences. This is relevant to this review as TRC process was based around verbal communication as a means to reconcile a fragmented population. This is the crux of this review. Many people seem to suffer from the inability to symbolize their traumatic experiences, yet it is just symbolization that the TRC required of them. Laub (2005) suggested in his study that testimony can help rebuild a personal narrative, but testimony requires language. So without
language how do people participate in and hopefully benefit from participation in the TRC? And also in therapy? The next section will explore the ways of finding words to symbolize traumatic experiences. It will also highlight the importance of being heard in the aftermath of severe violence.

**On Finding the Words**

In relation to healing, research has highlighted the importance of having traumatic suffering acknowledged and heard by others. Papadopolous (1998), writes, about his work with war refugees, that language has the ability to re-establish humanity to the person in the light of inhumane traumatic experiences. This section aims to explore the role of being heard through the use of testimony.

**Being Able to Develop a Testimony**

Cienfuegos and Monelli (1983), Weine (1998) and van Dijk, Schoutrop and Spinhoven (2003) have found that the inability to speak about traumatic experiences is one of the main characteristics of trauma for victims of political violence. Additionally, they have found that developing a testimony about the traumatic experiences can decrease traumatic stress in victims. Cienfuegos and Monelli (1983) engaged Chilean victims of political violence in testimony therapy. This aimed at developing a personal testimony that encompassed the subjective experience in a specific political context. The testimony was given in a one to one therapeutic setting from three to 12 months. Testimony therapy is based on the assumption that catharsis is at work, facilitating self-expression with the aim of decreasing traumatic suffering. Simultaneously, it was argued that the testimony brought meaning to the traumatic experience by acknowledging the importance of the political context for the trauma.
is unclear how Cienfuegos and Monelli (1983) measured any decrease in traumatic stress. Thus, it is difficult to know what exactly was measured and what they meant by a decrease in traumatic stress. However, Weine (1998) and van Dijk, Schoutrop and Spinhoven (2003) have found similar results in their empirical study with victims of political violence. Van Dijk, Schoutrop and Spinhoven (2003), write that the importance and power of the testimony lies in that it is witnessed by others. Consequently, the use of language re-establishes shattered connections with others enabling them to begin the process of healing. Weine (1998), highlights that through testimonies the politically oppressed are given a voice. He also suggests that this may be healing on an individual level and also aid a society to heal after a traumatizing period. That victims of political violence are given a voice through testimonies, echoes the intention of the TRC where victims were heard and acknowledged. In order to come to grips with a social crisis of enormous suffering, the TRC process was centred around traumatic testimonies.

There are some criticisms to the comparison between testimony therapy and the TRC process. For example, testimony therapy is set in a one to one setting over a three to twelve month period, whereas the TRC was set in a court setting allowing victims to testify only once. Although the healing effects may not be as favourable in the TRC process as in testimony therapy these studies suggest positive aspects of testifying. Being heard seems particularly important in the aftermath of political violence. Consequently, in the light of the massive crisis faced by the South African society, the TRC may have been the closest the country could come in hearing those who were victimized. Although the studies by Cienfuegos and Monelli (1983), Weine (1998)
and van Dijk, Schoutrop and Spinhoven (2003) are not based on a South African population, the participants came from similar politically oppressed backgrounds.

**Being Heard in a Restorative Justice Setting**

As mentioned above the TRC process emerged from the concept of restorative justice. It is, thus, relevant to explore some key pieces of research that have investigated the healing impact for the victim after being heard by the perpetrator within a restorative justice framework. Poulson (2003), Strang and Sherman (2003) Umbreit (1998) and Umbreit, Bradshaw and Coates (1999), addressed the issues around healing in a meeting between victim and perpetrator. These studies showed changes in victims that participated in a meeting with a perpetrator. Some changes experienced by victims included: finally feeling heard, that the perpetrator no longer had control over them, they felt less fear, they felt at peace and they felt less angry (Poulson 2003; Strang & Sherman, 2003; Umbreit, 1998; Umbreit, Bradshaw & Coates 1999). In a qualitative study, Umbreit (1998) found that 91% of victims found that being heard by the perpetrator helped in their healing process. This finding was further supported by Umbreit et al. (1999) in which case studies depicted interviews with victims who had participated in a meeting with a perpetrator. Poulson (2003) found in a quantitative study that as long as the perpetrator took responsibility for the crime, the positive healing effects persisted over a 20 year period. In another empirical study, Strang et al. (2003) showed that victims considered the restorative meeting with the perpetrator facilitated healing. The studies by Poulson and Strang et al. are problematic in that they applied a standardized measurement to psychological healing. It is difficult to measure a phenomenon such as, healing, with standardized measures as it is a subjective experience. Thus, healing may not hold the same meaning for all those
participating in the studies. Moreover, Wemmers (2002) concluded in her review of restorative justice literature, that the evidence does not appear as conclusive as the above studies suggest. She argued it is important to acknowledge that victims of severe violence (such as murder and rape) do have the most to gain from a meeting with the perpetrator, but are also the most vulnerable to re-traumatization. Nonetheless, if considering all of these studies together, they seem to support the importance for the victim’s process of being heard by the perpetrator as part of the healing journey. Thus, along this line of argument, it could be said that the TRC offered the opportunity for the victim to be heard by the perpetrator and by bystanders. Victims were given the chance to communicate their hurt and perpetrators were given the opportunity to take responsibility for their actions.

There are some criticisms of generalizing these findings to the TRC process. For example, Umbreit et al. (1999) suggest that a meeting between a victim and a perpetrator has to be carefully planned. The TRC process did include pre-testimonies and preparation for participants. However, Umbreit et al. suggest that certain questions need to be answered such as: When is the use of victim-perpetrator meetings most appropriate? How are the victim and perpetrator supported? These are important questions to be answered prior to a meeting in order to prevent re-traumatization of the victim (see below). The TRC may have had good intentions in the preparations of victims and perpetrators and may have been a factor in some people’s experience of catharsis and healing – this however has not been questioned empirically. The TRC was unable to ensure that the time was right for those testifying as it operated under a specific time limit and testimonies had to take place during this time. Moreover, victims and perpetrators were poorly supported both in terms of length of support and
poorly trained staff (Fourie, 2000). The minimal psychological support may be one of
the TRC’s most serious short-comings, which may have left victims and perpetrators
vulnerable and exposed. This is in sharp contrast to the above studies where
participants were engaged in long-term psychotherapy before and after the meetings.
Furthermore, the TRC created a court room setting with media, audience and other
court room staff present during the testimonies. Thus, this contrasts from the above
studies in that the meetings took place in a carefully controlled environment with only
a few support staff present. Nevertheless, the TRC’s intention was for both victims
and perpetrators to be heard, and in particular, for the victim’s traumatic testimony to
be acknowledged. This highlights a major gap between being heard in the TRC and
healing from the process. As well as their role in the consulting room, counselling
psychology could play an important role in bridging this gap in future truth
commissions. Counselling psychologists can advocate the importance of mental health
provisions for participants and for staff working in the TRC. Additionally, this review
emphasizes how important it is for victims of political violence to have their
subjective experiences and their socio-political context acknowledged. This can
provide counselling psychologists with a better understanding of how to conceptualize
politically motivated trauma. The next section will explore the language of the TRC.

The Language Construction of the TRC

Although there is little research into the language constructed by the TRC, this review
will explore some suggestive literature. The TRC language seems to mirror the TRC’s
attempt to organize national reconciliation around subjective traumatic suffering. This
section will firstly explore forgiveness and reconciliation which was used to
symbolize the purpose of the TRC. It will then explore the use of the label victim and
perpetrator and lastly, it will then consider the psychotherapeutic language that was applied to the process of testifying.

*Nation Building through Forgiveness and Reconciliation*

Archbishop Desmond Tutu chaired the TRC with a powerful discourse of reconciliation as understood by Christianity. Van der Walt, Franchi and Stevens (2003) write in their discursive study of the TRC that a language of reconciliation, sameness, forgiveness and harmony was constructed to enable people to look to the future and appease feelings of revenge. As mentioned above, reconciliation was the prime reason for the TRC. In essence, if South Africa did not reconcile the differences within its populace, then civil war was much more likely. In one sense, sameness within in the TRC language emphasized how dependent Apartheid violence was on the social context in terms of separating various members of society. Another meaning of sameness may have been the Christian value that all people are the same in God’s eyes. Thus, the TRC attempted to give people an alternative framework in which to view Apartheid oppression and to avoid expressions of revenge and blame. The TRC language was impregnated with the strong Christian value of forgiveness. By naming forgiveness as the ultimate goal for testifying, the TRC could contain the terrible pain and suffering by giving the testimony a framework to operate within. The TRC’s long-term wish for South Africa was that of harmony. This was expressed by Desmond Tutu throughout the hearings by referring to the New South Africa, as the rainbow nation, where people of different colours get along in harmony (TRC, 1998). Thus, for people taking part in the TRC process, the language of reconciliation, sameness, forgiveness and harmony may have provided a sense of structure and purpose to their participation. It may have provided them with a contained framework from which they
were able to speak. The Christian language may also have been particularly appropriate as the majority of the South African population are Christians. Thus, the language may have been familiar and slotted in to their value system.

Labelling Victim and Perpetrator

Important to the TRC language was the use of the labels victim and perpetrator. Although the label victim makes many mental health professionals uneasy the TRC may have used this term to empower those suffering to speak about their experiences. The TRC explicitly used the label victim in the TRC Act, however, it did not label those who had committed illegal acts as perpetrators. Even though the label perpetrator was not explicitly defined by the Act, the label perpetrator was commonly used by senior TRC members (Allan, 2000). Using the label of victim in the TRC process served to symbolize the first step to acknowledging their massive trauma. It is possible that this added to the sense of containment as there were clearly assigned roles for those participating. This review explores the some of the problems with the victim-perpetrator dichotomy below. However, being assigned the role of a perpetrator may have allowed for those having perpetrated political violence to assume accountability for their action. As mentioned by Poulson (2003) this is one of the most important aspects for healing in a restorative justice meeting.

A Psychotherapeutic Language

In their work on a TRC discourse Anthonissen (2007) suggests that the TRC language was considered an instrument to confront a traumatic history, to negotiate conflict, and to initiate processes of healing for specific people as well as in communities. Additionally, it is proposed that the language used in the TRC process was designed to
talk about pain, suffering and hidden truths about state violence. Falk (2007) writes in a review of psychological literature regarding the TRC, that a psychotherapeutic metaphor is embedded in the TRC fabric. This metaphor refers to the assumption made by the TRC that revealing is healing. Perhaps this metaphor is a rather simplistic way of perceiving the psychotherapeutic process, where talking about pain may lead to some relief. Nonetheless, this metaphor was invoked by the TRC. On the same line of argument, Humphrey (2000) and Swartz and Drennan (2000) suggest in their reviews of the TRC that the TRC slogans; ‘Revealing is healing’ and ‘Truth: the road to reconciliation’ are inherently psychoanalytical concepts. Within a psychotherapeutic framework it can be argued that speaking about one’s pain and suffering can be a step towards healing. Moreover, a goal of psychoanalysis is to be able to reconcile disowned aspects of personal experiences (Bateman, Brown & Pedder, 2000). Perhaps, psychotherapeutic aspects of the TRC language emerged to enable everyone within the TRC to hold a dialogue about tremendous pain and suffering that had previously not been spoken about.

**Difficulties with the TRC Language and with Speaking**

*Concerns Regarding the TRC Language*

Although the creation of a new language may have enabled some to speak out for the first time, it may have created a prescriptive style of communication that inherently excluded those who were unable to utilise the TRC language. The TRC language was constructed around reconciliation, sameness, forgiveness and harmony and those struggling with more aggressive emotions such as; hate, anger and revenge remained unheard in the process (Van der Walt, Franchi & Stevens, 2003).
It could be that the TRC produced a language that did not allow for symbolization of hatred, anger, revenge, 'stuckness' and pain. Moon (2006) writes using a Foucauldian framework, that in the scramble for reconciliation, the TRC did not provide the language to say 'I am not reconciled and I am still suffering.' Van der Walt et al. (2003) present a study whereby individuals who used the language of South African nation building (such as, forgiveness, understanding and reconciliation), were allowed to speak for longer than those who spoke from their subjective experience of suffering. In the same study it was acknowledged that those struggling to verbalize their traumatic memories were interrupted more frequently with references to pre-testimony statements. That some people struggle to express their trauma echoes LaMothe (1999), Laub, (2005) and Rauch et al. (1996), in that some people who suffered extreme trauma may suffer from “speechless terror.” Although the intention for interrupting those testifying is unclear, it could have contributed to silencing them further. Consequently, the TRC may have inadvertently negated their traumatic experiences.

Han (2004) investigated the impact of a new language in Chile following the completion of the Chilean Truth commission 1991. Her case study suggests that language containing references to suffering from past trauma became an untimely discourse. In essence, traumatic narratives were no longer heard. She suggests that those still suffering from the trauma inflicted upon them existed in personal exile, in a gap between two historical discourses. They were in limbo between the oppressive discourse and discourse of the 'new' Chile. This review proposes that those still suffering were encouraged by the TRC discourse to leave their suffering in the past. In the final TRC report it read: “Having looked the beast of the past in the eye, having
asked and received forgiveness and having made amends, let us shut the door on the past...” (TRC, 1998, p. 25). It is possible that leaving suffering in the past may have reinforced the sense that trauma is unspeakable in the new South Africa. Mourning takes place in a past discourse, incomprehensible to the next generation. Those still clinging to their suffering could be considered mad because their “disconsolate discourse of mourning is seemingly out of joint with local and national realities.” (Han, 2004, p. 173). In South Africa the TRC intended to break the silence to bring the past into the open and to encourage moving away from the past. However, it is likely that those who endured severe trauma will never be able to leave their trauma behind, in fact, counselling psychologists would argue that coming to terms with the trauma as part of the self enables personal growth and subsequently will overcome the silent suffering of the trauma (Joseph, et al., 2006).

Han (2004) and Van der Walt et al. (2003) present interesting criticisms of languages constructed by truth commissions. Han’s (2004) work is based on a case study and the conclusions drawn from this literature are limited due to the sample size used and applicability to the wider public. However, small sample sizes are common practice in qualitative research and offer deep understanding of lived experiences. Han does suggest a possible impact by a shift in national discourse on those suffering from trauma inflicted by a previous oppressive regime. Healing becomes a way of reconciling the accounting book of past memories, it has to balance out in the end or the TRC will have failed. There is a sense of the Christian concept of forgiveness and reconciliation of “drawing a line in the sand” and moving on, and perhaps for some people, they are just not ready to do so, yet the pace of the political discourse puts them back into their unheard prison of suffering and mourning.
Issues with the Victim-Perpetrator Meeting

In the majority of research and writings about the TRC, the label perpetrator and victim are used to refer to those who inflicted pain and those who were subjugated to it. Van der Walt et al. (2003) argue that the TRC constructed the Apartheid discourse into two protagonists: perpetrators and victims. The intention is to investigate the psychological consequences of constructing the TRC process around a polarization of victim and perpetrator.

In the aftermath of the TRC the issue of polarization is especially relevant to counselling psychology. A meeting with a client always involves power issues, however, in the light of the TRC and the conflict the meeting with a client may involve even more difficult power concerns. It is possible that the meeting becomes an re-enactment of the dichotomy created by the TRC; one constructed as good and one constructed as bad. The counter-transference of a white counselling psychologist working with a black client may become blurred with their own issues of guilt, shame or frustration, deriving from being positioned in the perpetrator category. It is also worth speculating that a black counselling psychologist may find that working with a white client may distort the counter-transference with issues of hate, anger and even revenge. This would be particularly relevant if the white client participated in Apartheid activities. A more directive therapeutic model may be perceived by a black client as authoritative and even oppressive, if the therapist is white. Ultimately, these examples relate to issues of power inequality and trust. Counselling psychology suggests that it is the therapeutic relationship that is healing for the client (Clarkson & Wilson, 2003). To establish a therapeutic relationship the client needs to be able to
trust that the therapist will not abuse his/her power over the client. The TRC could inadvertently have made it harder for the client and therapist to establish a therapeutic relationship because of the polarization of victim and perpetrator. This discussion is not exhaustive as this is a complex issue. However, it shows the difficulties of practicing as a counselling psychologist and how the TRC may have reinforced the split between therapist and client. This paper will now further explore some difficulties with constructing the TRC process around the victim-perpetrator dichotomy.

The label victim as invoked by the TRC was intended to capture the lived experiences of a people at a specific point in time. However, there is a danger in labelling people as victims. According to Lamb (1996) referring to someone as a victim may imply a certain passivity, harmlessness and an inherent goodness. By referring to people suffering from trauma as victims also ignores the resilience of these people (De Ridder, 1997). Entirely good is an impossibility, especially in a national conflict situation that contained multi-faceted complexities of destructiveness. As mentioned above the TRC chose the label victim to ensure that oppression and pain had a forum to get acknowledgment (TRC, 1998). However, another function this may play is to grant the victim a political role. Victims may have become social representations of morality which could have enabled the TRC the power to assign the new government of South Africa with credibility that the old regime did not have. In a sense victims and their traumatic narratives could be seen as being used by the new government to reach a moral high ground and this may have empowered the newly formed government.
In South Africa 7,000 perpetrators and 21,000 victims testified in front of the TRC (TRC, 1998). By empowering a few to speak, the TRC constructed a specific history of events. Moon (2006) highlights that a selective truth is narrated when selected people are authorized to speak, emphasising the probability of a different narrated truth if the TRC would have authorized others to speak as well. “The political effect of this delimitation was to elide other histories which may have claimed to be equally ‘true’ and ‘complete’…” (Moon, 2006, p. 270). It must be acknowledged that personal memory, upon which the TRC truth rests, is a social product mirroring the agenda and social positioning of those that invoked it (Cohen, 2001).

Although the TRC attempted to take a historical view of the creation of destructiveness, it is as if perpetrators were positioned to represent the evil of the past regime, absorbing blame projected by those not taking part. The label perpetrator is constructed as someone inherently evil and powerful (Smedes, 1996). They become the entity into which society dumps its evil acts thus purifying themselves of any blame. Letting a few individuals or perpetrators represent destructiveness avoids the issue of how tragically ordinary destructiveness is (Papadopoulos, 1998). Hannah Arendt brought attention to violence as terrifyingly ordinary acts committed by ordinary people. She referred to it as ‘banality of evil’ (Arendt, 1963). It is this ordinary terror that escapes the TRC by focusing on specific crimes committed by specific individuals (Bundy, 2000). By pathologizing evil as inherent in only a few, it makes it possible for everyone else to construct themselves as good and thereby shift their own responsibility (Papadopoulos, 1998). The TRC narrative becomes a binary construct alluding to a conflict including only perpetrators and victims. The TRC allows a binary switch to take place where the victims are liberated from the
oppressive position and the perpetrator is shamed in public. The role between the powerful and powerless is swapped between the two.

The perpetrators represent the stigmatized ‘other’ which is needed by the rest of the people in order to construct a positive identity. It allows for victims, bystanders and witnesses to attribute oppression, aggression and violence to another identity group. It frees other groups from feelings of guilt and responsibility. In South Africa this group, the ‘bad other,’ is the Afrikaners. Antjie Krog (2007) writes in an article about the Afrikaner sentiment currently:

"Do some South Africans need the notion of “bad racist Afrikaners on the rise” to bring to the fore the best in themselves in a country where right and wrong has become more ambiguous? Is there a need for “us” to be bad, so that “they” can be good?"

The preceding paragraph highlights the problem with an all or nothing approach. This binary view overlooks the fact that conflicts are complex and multifaceted. Neither literally nor figuratively could the matter be considered black and white. However, victims of trauma may see their experience as black and white. Boundaries of self and other become polarized and rigid (Chazan, 1992). The victim is allowed to project their own anger, violence or aggression onto the perpetrator allowing them to perceive themselves as all good. The perpetrator becomes stigmatized as pathological and beyond redemption (Allan, 2000). The TRC process may have strengthened the fragmented split between good and bad. Thus, the TRC could be seen as unable to emancipate the traumatized from this dichotomized way of being. Rather, it has
reinforced it by maintaining the arbitrary distinction between victim and perpetrator. As mentioned above, for counselling psychology this may mean additional layers of splitting to work through in order to establish a therapeutic relationship. The next section will explore the possible difficulties with speaking.

Problems with Speaking

Cienfuegos and Monelli (1983), van Dijk, Schoutrop and Spinhoven (2003) and Weine (1998) have gathered evidence to suggest it is useful for those suffering from trauma to tell their story. This is also supported by Poulson (2003), Strang and Sherman (2003), Umbreit (1998) and Umbreit, Bradshaw and Coates (1999). As explored above, the TRC rests on promoting that revealing is healing. For some telling their story is healing but some psychological literature suggest that harm may come from re-experiencing the original trauma. Revisiting the trauma can be healing but for some it re-awakens the pain (Orr, 1998).

Van der Veer (1998) has worked extensively with refugees from war torn countries and writes that revisiting the traumatic experience is only healing if the emotions evoked are adjusted so that the individual can cope with them, however it is impossible to predict this beforehand. If the sufferer is overwhelmed by traumatic memories then the individual is at risk in becoming re-traumatized. Thus, the individual is regressing as opposed to starting the healing process. In Hayner (2001) a counsellor talks about re-traumatisation as people taking their clothes off in front of the TRC and not getting an opportunity to put their clothes back on.
Research has shown that, for some participants, sharing their subjective narrative of pain and suffering in front of the TRC opened up old wounds. Hayner (2001) tells of a woman who testified about her experience of surviving a massacre of thirty-eight people in her home. She was unable to complete her statement because describing the atrocity in detail led to her developing a panic attack. The day following her statement she began to have nightmares, flashbacks, dizziness and constant headaches. Moreover, in further interviews the author found that additional individuals had suffered similar symptoms following their testimony. Although the evidence of re-traumatisation has not emerged from a psychological framework, it could be suggested that speaking in front of the TRC could have been harmful.

Byrne (2004) interviewed thirty TRC participants using a qualitative method to gain in-depth understanding of their experiences. 24 of the participants described testifying as overwhelmingly stressful. One participant explained that “going back to the pain...killed me inside” (p. 246). Moreover, they found that four of the participants experienced severe physical distress following their recall, notwithstanding, seven participants had found testifying as beneficial. For those who were able to access their painful narratives, it may have re-awakened the pain they had disconnected from for so long. In its attempt to heal trauma, the TRC may in actual fact have facilitated re-traumatisation for some, by allowing victims to connect with their dissociated narrative.

Kaminer, Stein, Mbanga and Zungu-Dirwayi, (2001) conducted an empirical study with 134 participants who were interviewed using a structured interview, which included; the Mini-International Neuropsychiatric Interview (MINI), the Enright
Forgiveness Inventory (EFI) and the Composite International Diagnostic Interview (CIDI). The participants were divided into three groups: those who testified in the TRC court setting, those who testified in the TRC but, in a closed setting (no audience) and those who did not testify at all. The study found no significant difference between the three groups in depression or PTSD. This study showed that testifying as a process had no significant effect on psychiatric health. Thus, in contrast to Byrne (2004), this study did not find any evidence of re-traumatisation. Considering the evidence it would be easy to conclude that the TRC had no impact on mental health. However, as with most empirical studies it is based on standardized measures developed for and tested on a western population. This may suggest that the tests are not suitable for a South African population as they may miss culturally specific nuances in the expression of trauma and forgiveness (Keane, Kaloupek & Weathers, 1996). Moreover, this study did not specifically explore re-traumatisation, but the overall mental health of the participants. Thus, it is difficult to draw the conclusion that re-traumatisation did not occur as it could have occurred across all groups. However, despite these limitations this study suggests there is neither damage nor health gains for those participating in the TRC.

The studies by Byrne (2004) and Hayner (2001) draw attention to at least a few people that did feel re-traumatised. This could indicate that a negative side effect of the TRC is re-traumatisation through retelling of the traumatic experience. Kaminer et al. (2001) did not show evidence of re-traumatisation. Rather, they found no difference in psychiatric health for those who participate and those who did not. Although the evidence is not conclusive in determining if participants suffered from re-traumatisation, both studies are in contrast to the slogan 'Revealing is Healing' or
'Truth: The Road to Reconciliation.' So perhaps recovering from trauma is not as simple as testifying in front of the TRC. Rather, it is a complex journey dependent upon personal readiness, influenced by those who listen, responses to your story, the ability to create your own relevant personal narrative over time and having the freedom to oscillate between the past and the present without feeling pressured to move forwards.

Conclusion

This review has highlighted the importance for counselling psychology to engage with the socio-political impact on traumatic suffering. The TRC endeavoured to peacefully transition South Africa into a new era. It decided to base this transition upon traumatic testimonies of those suffering from Apartheid violence and oppression. This review has shown the complexities with speaking about trauma. There are, for example, individual struggles with symbolization. Yet, it is suggested that symbolization has the potential to heal suffering. Research indicates that it is healing to construct a personal story; a testimony. Thus, the question remains: How does one construct a personal story when symbolization is difficult? The TRC attempted to answer this question by implying that taking part in the process is healing. Research has highlighted that acknowledgement of traumatic experiences and its context is vital for healing. The TRC was able provide this acknowledgement. It even gave participants a language to express themselves with. There might have been those who did gain from testifying, but there is little research indicating it. Rather there is research suggesting it could be damaging for mental health. However, in any TRC, trauma will be at its heart. It is here the role of the counselling psychology is imperative, to ensure the well-being of the participants.
There are many unanswered questions in this review, however, there are three that stand out. Firstly, what is the long-term effect of participation in the TRC? Secondly, was the TRC enough for people to develop their own testimony? Lastly, and more fundamentally, what shape does trauma take in post-Apartheid and post-TRC South Africa?
Personal Reflections

In 2005, I was walking around Soweto with my guide Max. When approaching the Hector Pieterson museum in the heart of Soweto, Max told me about the struggle against apartheid and the Truth and Reconciliation Commission (TRC). I questioned Max if Apartheid was really over. He coldly glanced at me and said: “Yes it is over.” There I was, a white Scandinavian woman, questioning a black South African man’s truth. My heart sank as I realized what I had just done. I had treated him as if he did not know what was really true, as if he were unable to see the truth, as if I had the real truth to offer him. I wish I would have told him that what I meant was that I could still see so much suffering but my lips felt like lead. I wanted to hide. So I quickly ducked into the museum to be faced with vivid pictures of a dying little boy being carried by friends during a demonstration against the Afrikaans language being a compulsory subject in schools. Perhaps what I proposed to do in this literature review was a way for me to explain to Max what I really meant. I felt I owed him, but also myself an explanation. What was it I was trying to tell him? After much thought about my intention, I realized that what I was really trying to express to Max was my scepticism about the TRC’s impact on psychological healing in post-Apartheid South Africa.

Just as I struggled to tell Max what I meant I have struggled to find the words for this review. I have failed it once, because I was trying to say too much. The difficulty with finding the words seeps through the entire review by its content. It is really about the fine line between words being liberating or damaging. For me writing this review was almost damaging in that I just wanted to give up. I didn’t want to continue on this path anymore. I had so many other ideas that would be easier and more concrete. Writing this now I feel liberated that I stuck with it and somehow found the words. I am
liberated in many ways. To grow from failing the literature review the first time I had to expose my academic insecurities. This has led me to re-constructing not only this review but also the way I perceive myself in academia. I have learnt it is really about the journey and its struggles. It is not about being perfect immediately. I am starting to think that maybe I am not academically flawed but just need to ensure I have the right support network around me to be successful. Maybe I actually belong on this doctorate programme.

I keep wondering to myself why am I writing about the TRC and South Africa? What's it to me? Perhaps it has to do with being Swedish. Perhaps coming from a country where peace and tranquillity is taken for granted, I am intrigued by South Africa where there is so much tension between people. Another aspect of my interest has to do with Hannah Arendt’s “banality of evil.” It symbolizes to me how very ordinary violence and the misuse of power is. How we can all get swopped up into everyday evil or compelled to close our eyes to the suffering of so many. Mostly, my interest lies with the inner world of trauma. It is a fascinatingly complex world. This is what I wanted to talk to Max about. How can a simplistic process such as the TRC claim to be healing when trauma is so complex? How simple these words seem now.
References


Coyle, A. (forthcoming). Qualitative methods and 'the (partly) ineffable' in psychological research on religion and spirituality. Qualitative Research in Psychology.


Appendix 1

I Louise Brorstrom here by state that this manuscript has not been published elsewhere and that it has not been submitted simultaneously for publication elsewhere.

Louise Brorstrom

........................................
Appendix 2

Journal of Loss and Trauma: International Perspectives of stress and coping.

Instructions for Authors

Submission of Manuscripts. Original manuscripts should be submitted to John Harvey, Department of Psychology, University of Iowa, Iowa City, IA 52242-1407; phone (319) 335-2473; fax (319) 335-2799; e-mail: john-harvey@uiowa.edu. Authors are strongly encouraged to submit manuscript files via email attachment. The manuscript should be prepared using MS Word or WordPerfect and should be clearly labeled with the authors' names, file name, and software program. Each manuscript must be accompanied by a statement that it has not been published elsewhere and that it has not been submitted simultaneously for publication elsewhere. Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. All accepted manuscripts, artwork, and photographs become the property of the publisher.

All parts of the manuscript should be typewritten, double-spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. All titles should be as brief as possible, 6 to 12 words. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Each article should be summarized in an abstract of not more than 100 words. Avoid abbreviations, diagrams, and reference to the text.

Manuscripts, including tables, figures, and references, should be prepared in accordance with the Publication Manual of the American Psychology Association (Fourth Edition, 1994). Copies of the manual can be obtained from the Publication Department, American Psychological Association, 750 First Street NE, Washington, DC 20002-4242; phone (202) 336-5500.

Illustrations. Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:
- 300 dpi or higher
- sized to fit on journal page
- EPS, TIFF, or PSD format only
- submitted as separate files, not embedded in text files

Tables and Figures. Tables and figures should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet. All original figures should be clearly marked in pencil on the reverse side with the number, author's name, and top edge indicated.

Proofs. One set of page proofs is sent to the designated author. Proofs should be checked and returned within 48 hours.

Reprints and complimentary copies. Each corresponding author will receive one copy of the issue in which the article appears. Reprints of individual articles are available for order at the time authors review page proofs. A discount on reprints is available to authors who order before print publication.
Appendix 3

Search Methods

1. I have used ASSIA and PsychInfo (see attached print out). Search words for ASSIA that proved fruitful: TRC and trauma*
   Number of hits: 5

2. I have found it useful to ask professionals in trauma, intergenerational trauma and South Africa in order to find appropriate literature. I have been in contact with my supervisor, professional tutor and other professionals within the field.

3. I found many articles by referring to the reference list in articles I had already obtained. For example I found Van der Walt, C., Franchi, V. & Stevens, G. (2003) lead me to many more articles and so on.
University of Surrey
Louise Bristowm

Implications for well-being:
Reconciliation Commission (TRC):
The South African Truth and
The 1976 Soweto Uprising: Killing of Hector Pieterson
Promoted as healing.

Centred around verbal testimonies.

Amnesty.

Restorative justice.

Writing official history between 1960-1993.

What is the TRC?

to preside over the process of healing a traumatized
privilège for those of us who served the Commission

Desmond Tutu wrote: “[I]t has been an incredible

poured on them so they can heal” (TRC, 1998, p.10).

opened. They must be cleansed. And balm must be

passed must not be allowed to taster. They must be

However painful the experience, the wounds of the

It was said to heal.
Examples of Testimonies

- Neck-lacing
- Shooting
- Murder
- Torture
- Death in detention
- Injured in bomb attack
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
"This is...unspeakable. It destroys words. Before he could not be fingerprinted...So how do I say they cut off his hands so he was blown up, they..."
Finding the Words
• Feeling heard.
• More in control.
• Less fearful.
• Less angry.
• At peace.
• Much dependent on perpetrator assuming responsibility for violations.

this beautiful and blessed land as
chapter on our past and to strive together for
black and white together, to close the
“...My appeal is ultimately directed to us all,”

Language of Reconciliation

The TRC Language.

regardless of whether he or she emerged a
committed can only be described as a victim,
the person against whom that violation is
rights violations committed by perpetrators,
however, when dealing with gross human

Victim-Perpetrator
A Psychotherapeutic language.

TRC slogans:

'Truth: the road to reconciliation'

'Revealing is healing'
2006)

reconciled and I am still suffering (Moon,
not provide the language to say 'I am not
in the scramble for reconciliation, the TRC did

A Prescriptive Language?

Speaking

Difficulties with Language and
In the final TRC report it read: "Having looked and received forgiveness and having made amends, let us shut the door on the past..." (TRC, 1998, p. 25). An Untimely Discourse?
correspondence, 2008)

We don't want to talk about it (personal
individual in the first phase after trauma –
collective we are responding like an
community. Unprocessed trauma and as a
amounts of unresolved trauma in the
understanding is that there is huge
Problems with the dichotomy

- A political role.
- Ignoring resilience.
- Assigning passivity.
• A binary construct.
• Pathologizing evil.
• Avoiding ordinary destructiveness.
• Absorbing blame.

Amnesty is not meant for nice people. It is intended for perpetrators (TRC, 1998, p.12).
Antjie Krog (2007) writes in an article about the Afrikaner sentiment currently:

"Do some South Africans need the notion of 'bad racist Afrikaners on the rise' to bring to the fore the best in themselves in a country where right and wrong has become more ambiguous? Is there a need for 'us' to be bad, so that 'they' can be good?"
their clothes back on (Hayner, 2001).

It's like taking their clothes off in front of the

p. 246).

the pain... killed me inside” (Byrne, 2004).

One participant explained that “Going back to

Re-traumatization
Violent uprising in South Africa June 2008

Material redacted at request of University
Violent uprising in South Africa June 2008
A call for research.

How could the process change to serve as more healing?

Who needs the support?

How would we support?

What shape does trauma take in that context?

What are the experiences of those testifying?

What are the long-term effects?

Call for more research into the well-being.
TRAUMA THERAPY IN A LANDSCAPE OF SUFFERING: TOWARDS A GROUNDED THEORY.

ABSTRACT
Although trauma research has attracted much attention in the South African context, the impact of current social forces has been largely overlooked as a research focus. This study presents findings from a qualitative study with ten mental health workers in South Africa who have extensive experience of trauma therapy. The transcribed interviews were analyzed using Grounded Theory (GT). Resulting categories focused on the ordinary experience of trauma (past abuses, shattered communities, ongoing exclusion and crime trauma); meaning of trauma within its context (the idea of trauma as dividing people along racial groups); shared symptoms across a population (including feeling anxious, insecure and dissociated); dissociation as a way of being; the focus of therapy and a sense of helplessness and frustration with the success of therapy. This study can be seen as extending the knowledge base on trauma in the South African context and also more generally, adding to the understanding of how social forces impact the focus of therapy.

Key words: continuous trauma; dissociation; grounded theory; South Africa; trauma; trauma therapy.
When Apartheid came to an end after several decades of oppression and resistance fighting, many South Africans had suffered from traumatic experiences. A large majority of the population had suffered massacres, killings, torture, rape, illegal imprisonment, displacement and social and economic discrimination at the hands of the government. Having been subjected to violations, many experienced sustained traumatic suffering (Hayner, 2001). Moreover, a study carried out in South Africa which surveyed the prevalence of trauma found it to be a threat to public health (Edwards, 2005).

The massive exposure to trauma has made trauma research into an industry in South Africa. Furthermore, the inclusion of post-traumatic stress disorder (PTSD) in the 1980 DSM III spurred on further research into traumatic suffering in post-conflict societies, in particular South Africa (Bracken, Giller & Summerfield, 1995). Although trauma research in South Africa has a wide focus, many researchers view trauma through the PTSD lens including; Edwards (2005b), Labe (2005) and Peltzer et al. (2007). Thus, much research on traumatic suffering in South Africa originates from the assumption that trauma can be explained by PTSD symptoms, i.e.: that the person has been exposed to a traumatic event outside the range of normal experience, has persistent symptoms of increased arousal, has persistent avoidance of stimuli associated with the trauma, numbing of general responsiveness and the traumatic event being persistently re-experienced (A.P.A, 2000).

As yet we do not know whether the definition of PTSD is exhaustive or whether it corresponds to people’s experience of trauma in South Africa. Although there seems to be great awareness of trauma, there is little research developing a theory on what trauma means or how the focus of trauma therapy is developed in the South African context. Furthermore, it has also been argued that trauma in South Africa is not outside the range of normal experience. Rather, trauma has been referred to as a continuous experience (Straker & Moosa, 1994).

Bracken et al. (1995) discuss the challenges of applying PTSD on an international level. One criticism of PTSD is that it assumes that the South African population has the same ideas about the nature of the self and illness as those in the
West. Thus, applying PTSD as a way of explaining trauma may systematically only explain symptoms and not the meaning of trauma within its particular context. This is problematic as, Brorstrom (2007), found in a review of literature that having the socio-political context acknowledged is important for healing in the aftermath of political violence. Unawareness of the impact of social influences on theory and therapy can easily encourage us to hold an inappropriate understanding of trauma which may in turn impede healing (Bracken et al 1995; Breslau, 2004; Han, 2004; James, 2004; Stein, Sedat, Iversen, Wessley 2007; Zarowsky, 2004).

The awareness of socio-political implications on psychotherapeutic work in South Africa has been explored in some studies, including the work by Eagle (2005). This study discusses the implications for practice when having to manage cultural beliefs that seem counter-therapeutic. However, this still assumes that the Western concept of trauma can be applied to non-western people and does not consider cultural variations of trauma. Thus, it seems necessary to explore the possibility of a localised theory of trauma within the South African context.

The idea of a localised theory with regards to the trauma in South Africa is an immensely important issue. On one level it will certainly inform South African counselling psychologists and other mental health professionals of the impact of social forces on trauma therapy; it will also inform counselling psychologists in the UK. The study brings to the fore how therapy is strongly influenced by social forces and how the counselling psychologist is very much a part of the social context. South Africa is well positioned to facilitate a study on how social forces impact trauma theory. This is in part due to the country undergoing a massive socio-political change after the end of Apartheid. It is also suggested that the role of counselling psychology in the UK is not only to concern itself with how a study can add to the discipline, but also that the discipline is privileged and well positioned to add to other disciplines and other contexts.

It was the intention of this study to use grounded theory to explore the meaning of trauma within the South African context, aiming to develop a localised theory of trauma using the insights of South African mental health professionals. Due
to the fluid nature of grounded theory, the data produced a more pressing issue. The data generated an understanding of how the focus of therapy was very much influenced by social forces. Thus, this study aimed to develop a localised theory of the impact of social forces on the therapeutic focus of trauma therapy using the insights of South African mental health professionals.

METHODS

Participants

The researcher began with contacting universities and trauma clinics in South Africa to recruit participants (see information sheet – Appendix 1). After contacting the South African Institute for Traumatic Stress (SAITS) the recruitment process was facilitated as they were connected with thousands of trauma workers around South Africa. It was mostly through this organization that participants were invited to the interview. Consequently, they contacted the researcher via email. Some of the participants were recruited by the researcher via other trauma clinics.

There were 10 participants interviewed for this study. There were 9 females and 1 male. All of the participants were white South African. Their age ranged from 32-60, average age was 47 and the average amount of time they had worked with victims of trauma was 19 years. 4 of them were registered clinical psychologists, 4 were psychotherapists and one of them was a community psychologist. The participants tended to be clustered around Johannesburg and Cape Town. To ensure in-depth knowledge of the understanding of trauma therapy in South Africa the inclusion criterion for participants were that they would have worked with trauma victims for at least a year. All of the participants were also required to currently work in South Africa.

It is the intention of grounded theory to continue to recruit participants within a framework of theoretical sampling (Willig, 2001). It entails approaching participants that could shed new perspectives on the topic studied. The recruitment and interviewing is expected to continue until the study has reached saturation. Thus, it is an iterative process that evolves until there are no new categories that emerge from the interviews (Glaser & Strauss, 1967). The first three participants in this study were
approached because of their general experience with victims of trauma and ability to provide an overview of the area. The next four participants were approached because their therapeutic experiences were with marginalized groups and would be able to enrich the data. New data emerged with these participants as well as confirmation of pervious obtained data. The next three participants were approached because of their experience with marginalized groups, middle/upper class groups and academic research and teaching. It was suggested that they were positioned to confirm or/and add to the obtained data. They mostly confirmed what the researcher had already obtained. At the same time they did provide new data to be followed up. Although there were certain categories that did reach saturation, it was not possible to continue theoretical sampling to reach total saturation due to time constraints. Moreover, due to the nature of the South African society it has been challenging to find mental health workers of varied racial background and the male gender. However, despite these challenges the participants worked within varied settings and with a wide range of clients in terms of, race, culture, income, gender and age. This has in turn enriched the data to give a fuller understanding of trauma therapy in South Africa.

Ethics

Ethics was obtained by the University’s Faculty of Arts and Human Sciences Ethics Committee (see approval - appendix 2 and consent form – appendix 3). The study also adhered to the BPS Code of Ethics and Conduct (BPS, 2006). Due to the sensitive nature of the topic it was decided to interview key informants instead of getting first-hand accounts. The decision not to interview victims of trauma was based on the limited support and referral services that were available to the researcher. Moreover, as the interviews were conducted over the phone, it would have been difficult to assess how the interview would affect participants. Thus, with participants who were victims of trauma, interviews could have caused re-traumatisation. However, many of the participants mentioned that they themselves had suffered from traumatic events and could interlace their professional opinion with personal experiences. Prior to the interview, the participants were deemed appropriate for participation only if they considered themselves to have a strong support network (see background sheet – appendix 4). Additionally, the participants were all trained mental health workers and it was felt they had a greater self-awareness to stop their interview should they feel
overwhelmed. This did not happen. Although some participants did find it distressing to talk about their work. They were then de-briefed and the researcher made herself available to respond to any queries or concerns they may have had.

The interviews were recorded and the tapes were kept in a secure location until they were transcribed. The tapes were then erased. At all stages of the research all names were changed, as were any other identifying material in order to protect confidentiality.

Data Collection
The interview process was conceptualized as a directed conversation (Lofland & Lofland, 1984). The interview was semi-structured (see appendix 5) and adapted as the interview process developed. The interview was designed to allow for an in-depth exploration of the understanding of trauma in the South African context. The participants were interviewed over the phone and they lasted an average of 58.2 minutes. Although the interviews were conducted without difficulty, there were some issues that emerged. Firstly, it may have been easier to facilitate the participants during a face to face meeting as cues other than voice could not be picked up over the phone. Secondly, at times there were some interruptions on the line and the call had to be re-dialled. At times this disrupted the flow of the interview. However, the participants were able to pick up the where they left off. The interviews took place from the researcher's home and the participants were generally located at their work place or at home. The interviews were recorded with a digital recorder and then transcribed.

Following the transcription, grounded theory advocates line-by-line analysis (Charmaz, 2006). As the line-by-line analysis developed, categories would start to emerge (Pidgeon, Martin & Turner, 1991). In this study the line-by-line analysis entailed the researcher coding each line of the interviews and then entering them into an excel spreadsheet in flexible categories. The analysis is generally done after each interview to focus the theoretical sampling. Due to time restraints the researcher transcribed the interviews in batches. The first three, then another four and lastly the three remaining interviews. Although the interviews were not done one-by-one, it was
possible to focus the selection on the next participants to enrich the data. An essential part of grounded theory is memo-writing of ideas, elaborate processes, assumptions and actions that emerge from the data (Pidgeon, Martin & Turner, 1991). Memo-writing took place during the entire process of analysis, but specifically during the line-by-line analysis. When all the interviews were coded line-by-line and put into categories, the assembling of the first draft began. It started with defining and linking the categories that were saturated and stood out to the researcher.

**Data Analysis**

Analysis was conducted according to grounded theory to generate a conceptual theory from the data. Grounded theory suggests that the emerging theory is a result of the researcher’s interaction with the data (Charmaz, 2003, 2006). The assumption is that the researcher’s own background, personal, philosophical, theoretical and methodological beliefs shape the research process. Thus, the discovered theory is a version of interpretation of the data and to some degree another researcher is likely to construct another reading (Willig, 2001). Grounded theory was considered suitable for this research question because it is aiming to take initial steps towards the development of a localised theory of the contextualized understanding of trauma by mental health workers in South Africa. Moreover, grounded theory is concerned with identifying and explaining contextualized social processes that account for a phenomenon (Willig, 2001). Grounded theory was deemed especially useful for the research question as it will allow the researcher to carefully integrate variations and complexities of the participant’s world to gain deeper insight into the topic within its context. Additionally, Grounded theory strives to include participants that offer potentially different perspectives as opposed to, IPA, that focuses on homogeneous sampling. Although as mentioned above it has not been possible to exhaust the possible participants, the study has made attempts towards focused theoretical sampling.

Finally, the theory emerging from the data is evaluated on how grounded the theory is in relation to the raw data (Pidgeon, 1996). Moreover, Yardley (2000) suggested four elements in evaluating qualitative research results. Firstly she wrote that results should be assessed by their sensitivity to context including, socio-cultural
setting, participants’ perspectives, and positioning of theory. Secondly, results should be considered in the light of commitment and rigour in terms of in-depth analysis, methodological skill and thorough data collection. Some researchers suggested that the term ‘rigour’ is juxtaposed to qualitative research methods as it evokes harshness, strictness and severity (Forshaw, 2007; Willig; 2007). However, this study translated ‘rigour’ into commitment to systematic progression in the attempt to elicit understanding and interpretation. Thirdly, the research process has to adhere to transparency and coherence such as; clarity of argument, transparent methods, fit between theory and method and reflexivity. Lastly, the results need to be assessed in terms of impact and importance to socio-cultural context, theory and practical implementation.
Figure 1. Demonstrating the flow and links between categories.

The meaning of trauma.

Trauma as a dividing factor.

Similar symptoms

Dissociation

Focus of therapy

Resilience

Therapist helplessness and frustration

Soldiers of the past.

Ongoing exclusions.

Shattered communities

Crime

Trauma as a landscape of suffering.
Figure demonstrating the flow and links between categories.
The figure above shows the flow of the findings presented below. ‘Trauma as a landscape of suffering’ and the four aspects of trauma is demonstrating the multidimensional nature of trauma in South Africa. In the data the many dimensions of trauma generated two other categories, that of: ‘The meaning of trauma’ and ‘Dissociation.’ ‘Dissociation’ has a contour around it as it stands out in the data. The arrows between ‘Resilience’ and ‘Therapist helplessness and frustration’ demonstrate how they seem to feed-back into ‘dissociation’ creating a loop. The two-way arrow between ‘Trauma as a dividing factor’ and ‘Dissociation’ shows how these two concepts feed in to each other. The jagged line at the bottom is indicating that developments in trauma therapy seems blocked.

ANALYSIS OF FINDINGS
Trauma as a landscape of suffering in South Africa.
This category, trauma as a landscape of suffering in South Africa, is made up from four sub-categories; shattered communities, trauma of the past soldiers and freedom, fighters, trauma as ongoing exclusion and poverty and trauma as a consequence of crime. As seen in figure 1, these sub-categories are what makes trauma into a multidimensional issue and a landscape of suffering.

As the figure above indicates South African trauma is not a discrete event that happens out of the ordinary. “[Trauma] is almost like a landscape of suffering where people have to negotiate their lives...” (Marie). It is an experience that is becoming so embedded in the social that it is a common experience. Susan explained that: “It [trauma] is a common experience...It is extremely common in all types and forms.” This is interesting to counselling psychology in that it questions the ‘out of the ordinary’ meaning of trauma. Although trauma may be a common occurrence, it is unclear if it is experienced as normal or abnormal. Monica said that: “Almost as if what we are facing here is normal. Although it is abnormal.” Furthermore, some took the idea even further. Susan exclaimed that: “I think in South Africa it [trauma] is virtually an endemic thing.” Perhaps, it is not surprising that trauma is a common occurrence in South Africa, considering the recent past the country carries. Next this report explores the traumatic impact of shattered communities.
Trauma as shattered communities.

“...[I]n South Africa whole communities were traumatized and affected in a variety of ways by violence and oppression” (Marie). When trauma was spoken about was often referred to on a social level. There is no getting away from the idea that South Africa is “a traumatized nation” (Lisa). A real concern was the idea of shattered community and family bonds. Caroline explained that: “...[w]e have the trauma, of the way the system treated the black people...What happened then was pretty much a disintegration of the family unit and disintegration of the holding effect of the family unit.” The community is shattered because its parts are broken and disconnected. “I mean starting with being treated as an object and a non-human being through to being neck-laced. Having the army in your neighbourhood and having your friends shot” (Caroline). In a sense it is not just the shattered community bonds that is a trauma, but also that each person within in that community is carrying a trauma. The next sub-category discusses the next dimension of trauma in a landscape of suffering, the trauma suffered by soldiers and freedom fighters.

Trauma of the past soldiers and freedom fighters.

Another trauma that was mentioned was that of the soldier or the freedom fighter of the Apartheid past. “...I saw military trauma like, landmine explosions, seeing friends shot or killing the enemy and very often being the perpetrator of dreadful things like scalping, trophies or counting how many ears you got. So they were already traumatized” (Caroline). Some have argued that ‘perpetrators’ do not have the right to claim trauma Phillip sarcastically expressed that: “...[I]t is perfectly acceptable that you go around murdering people and then you say you have poor mental health.” Nonetheless, those who come back from the front lines now have to come to terms with actions classed as evil. “So in a way you kid yourself in that what you were doing was for the greater good, but in 1994 all of that fell away. Suddenly, everything you had done in the interest of your people and your country became null and void...So suddenly you had to deal with what you had done” (Caroline).

Trauma as ongoing exclusion and poverty.

Those working with people living in poverty and excluded from society felt that this was a type of trauma. “Do you call living in extreme poverty trauma? Do you call
having your dignity stripped everyday of your life traumatic? I mean, yes, yes it is” (Phillip). Phillip explained that: “[black South Africans] were far more concerned about the ongoing exclusion, economic problems and not having a job.” It is also suggested that these factors are not only traumatic in themselves, but that poverty and exclusion also makes people much more vulnerable to other traumas. “I also see trauma as mediated through other factors such as, poverty and the person’s ability to protect themselves...Thus, they become much more likely to suffer from traumatic experiences than those that have access to protection and services” (Phillip). The fourth dimension of the landscape of suffering is trauma experienced as a consequence of crime. This is discussed in the next section.

*Trauma as a consequence of crime.*

Currently, it seems crime-related trauma is the most serious concern for therapists. Those who never really suffered from violence during Apartheid are increasingly experiencing crime now. Moreover, those who suffered from trauma in the past are now just as vulnerable to crime-related trauma. Martha explains that: “I think trauma is highly related to crime. Ja, it is pretty harsh, the violence is pretty harsh. It is not just about taking your radio out of your house. It is like ‘I’ll take the radio out of your house, but I’ll rape your wife before I go.’ ” Phillip expressed that: “The nature of the crime in South Africa is very brutal. People will torture and hurt people...” Even though an individual may not have been a direct victim of crime, it is likely they will have been indirectly involved. “Even if you haven’t been involved in trauma directly, you know someone who has been a victim of crime” (Lisa). It is not just the actual suffering from trauma, but also the expectation of trauma that is a real issue. Lisa suggested that “I mean I think we are all really on edge...we all suffer from low levels of PTSD.” Thus, it seems most people, if not everyone, is somehow impacted by crime.

This category has presented four sub-categories; shattered communities, trauma of the past soldiers and freedom, fighters, trauma as ongoing exclusion and poverty and trauma as a consequence of crime. Evidently, the traumas described are interwoven and not distinct, but how they are linked was not the focus of this study. Marie explained that: “My understanding of it is that there is huge amounts of
unresolved trauma in the community. Unprocessed trauma and as a collective we are responding like an individual in the first phase after trauma....And this is only going to bring on more violence.” However, how the country is responding as a whole did not emerge as a category from the data and needs further sampling. The next category explored is the meaning of the experienced trauma.

The meaning of trauma.

Within this category, the meaning of trauma, there is one sub-category; trauma as a dividing factor of the people of South Africa. It was mentioned that a contextualized understanding has developed over the last few decades. “[W]e have sort of developed an understanding which was much more contextual and much less based on thinking about the individual events” (Phillip). However, it is not clear to psychologists or mental health workers what that contextual understanding is: “That is something we debate quite a lot in our department because there is a range of views from a more narrow DSM version to using the word much more generally” (Phillip).

What does seem clear is that trauma carries a different meaning depending on where in society the person is positioned. Figure 1 also shows that the meaning of trauma seems to be affected by the type of trauma the person has suffered. Marie expressed that: “The collective experience of trauma in this society is different at different levels.” Although it is not clear from the data what this means, it can be theorized that coming from a shattered community could, among other things, mean a loss of belonging. Sarah suggests that: “Young black men had a purpose during the struggle, but have now lost meaning and have to come to terms with horrific acts, that was done for the greater good.” However, it is clear that this would need further exploration. It should also be noted that the participants found it difficult to formulate their thoughts around this idea. The current crime-related trauma seems to unite people in that it is experienced as a sense of injustice. “I think it is a lot to do with injustice, it feels like it is an injustice that is being inflicted on us and that makes us very angry” (Lisa). However, this sense injustice and anger seems directed differently depending on race. This will be explored in the sub-category below.
Trauma as a dividing factor of the people of South Africa

The meaning of trauma, as indicated by the figure, seems to entail a sense of division of population along racial lines. Where the trauma is attributed depends on who is exposed to the trauma and by whom it was inflicted. "[I]f it was a white person that was attacked by a black man it enhances that fear of all black men. Or even if it was a black woman that was attacked by a Nigerian man then it enhanced Xenophobia" (Lisa). Marie said that: "If you work with white clients they want to hate the blacks that robbed them. And if you worked with refugees they hate black South Africans. Black South Africans hate refugees and so on." It is almost as if trauma splits the population and there is a disconnection between groups where one group has to protect themselves from another group. This is interesting to counselling psychology as the social is entering into the consulting room.

"No one wants to look at ongoing race and violence... It's like we now have democracy, can't we all just get along. It's like people don't want to look at the badness within" (Marie). Phillip argues that: "I think here in South Africa it is very easy for English speakers in particular to say 'here are the baddies and here are the goodies.'" This sense of splitting good and bad is also linked to a lack of wanting to take responsibility for one's own impact in society. "People don't make the link between past injustices and current experiences. People don't want to make the link. There is also an unwillingness to take responsibility" (Monica). It would seem the split between good and bad is also related to a split between the past and the present. Although Marie urges that: "We have to realize that these criminals come from us, from our society. If we think like that, then we can respond with love, care and nurturance. Not with anger, hate and violence. Executions." Trauma seems to act as a division between the people in South Africa. Although the meaning of trauma differs among the people, it seems the symptoms of trauma are shared across the population. This is discussed in the category below.

Shared symptoms across the population.

This category, shared symptoms across the population, contains one sub-category, dissociating from traumas, reality and society. Although the trauma is attributed differently it seems it is the consensus that people suffer from the similar symptoms
Dissociating from traumas, reality and society.

Counselling psychology would suggest that dissociation is a defence mechanism that is used when emotions are too overwhelming to deal with. Lisa explained that: "I think we dissociate from it, I think it is a protection mechanism. We don't want to take it on because it gets to scary, we shut it out because we can't let it in, it is too overwhelming." It is suggested that on a social scale people are dissociating from the past and the present circumstances. What is happening on a social scale is then impacting on what enters into the consulting room. "A lot has to do with the past political violence. People believe that because Apartheid is over the past is the past and I think that is unhelpful" (Marie). Susan exclaimed that: "If you look at post-traumatic stress you get this loss of the ability to feel and I think that is what we feel. I think that is what the vast majority is feeling. And the minute you become blunted then you don't really care anymore do you?" It seems that participants felt it is impossible for people to connect with the subjective or social past.

Of course therapists are also a part of the South African society and many have suffered their own trauma. Thus, a strong theme in this study is the psychologist's own sense of dissociation. Susan described a supervision meeting she had with her colleagues: "They all said that they shut down emotionally, that they could not allow themselves to feel...I found that frightening because if you do that...Then you can't feel their pain." Martha sadly said that: "Eventually you get a bit blunted and at times I am providing a mechanical service. I'm not saying that every experience isn't unique, but when you are dealing with this kind of trauma it is a certain, there is a certain pattern that I will follow." "Even this interview is scary because most of the
time I try to deny these things. I try not to feel what I feel, I try not to put together what I am feeling in my practice, because if I do it will become too much. Then I will start running” (Caroline).

Those who are unable to dissociate either come to therapy or leave the country if this is an option. Monica said that: “Those who come to therapy are the ones that are not dissociated. They don’t have strong defences. ”It is also suggested that clients come to therapy when there is no other way out. “People come to us when they have hit rock bottom” (Marie). The one emotion that people found hard to dissociate from was anger. “The lingering feeling is always anger. That is the difficult one to dissociate from” (Lisa). As mentioned above, anger often appears directed against the government or a racial group in terms of injustice. Now to the crux of the matter. How do the different dimensions of trauma, the meaning of trauma and the shared symptoms of trauma influence the focus of therapy.

**Focus of therapy influenced by the social.**

This category, is made up of three sub-categories: To connect or not to connect?: that is the question, focus on resilience to be able to cope in a landscape of suffering and therapists’ challenges with practicing trauma therapy in a landscape of suffering. In essence, this category explores the struggle to work therapeutically with trauma when traumatic suffering is so widespread. It seems as though the collective and subjective response to trauma is often dissociation. It is something affecting both clients and therapists. This is presenting a problem for the therapist, because they struggle with traditional models that assume that healing means connecting with difficult emotions and making sure that the client is able to cope out in the real world. Lisa discussed: “I struggle with, do I push for them to feel their feeling because I know that to recover from trauma you have to feel all those feelings. In a way the question that sits in my mind is how healthy it is to make them feel those feeling when they still have to go out in the world and the world hasn’t changed and there is a real fact that it might happen again?” It then looks as if dissociation is such an important way for people to cope in South Africa that therapists may have to find ways to help people dissociate. “I see that those who are able to dissociate are more resilient and don’t take on or feel
all the feelings all the time" (Lisa). This is not without its problems and it will be discussed below.

*To connect or not to connect?: that is the question.*

So how do you engage in therapy in terms of connecting or not connecting with emotions? Most therapists say that they are able to connect with the client in therapy and that this is not affected by dissociation. Susan explained that: “I don’t think that I am cut off at all when I am with people. I am very aware of what they are experiencing.” Additionally, Lisa said that: “I think it is about balancing and finding that space within yourself where you can access those feelings and then disconnect them.” Perhaps this is the case for most counselling psychologists, however, the balancing act in the South African context may be a more difficult task. For clients it is a challenge to connect with difficult emotions. Marie who works with disadvantaged and marginalized people explained that: “You can’t really address people’s past because their current trauma was so consuming. Like addressing the loss of the family or genocide or whatever, is impossible because on their way to their therapy appointment they were mugged. So that trauma was so present.” Perhaps like in trauma therapy anywhere connecting with emotion can be utterly overwhelming. Lisa said that: “I think sometimes accessing those feelings are too scary or dangerous to them and they don’t want to come back. That might mean they have flown into dissociation but that is difficult to say.” Additionally, in the South African context the likelihood is high that another trauma will occur. Caroline describes some of her frustration with trauma therapy: “I can try now and we can take one particular event and we can try to integrate that particular event, but next week you might be back with another event.” Thus, the interviews show that many therapists have to work with the immediate trauma and rarely have the time to focus on past trauma.” So I found that the work is more about how they are traumatized in between sessions” (Marie). Similarly, “I cannot be optimistic anymore, because I can only deal with that trauma. And if tonight you are traumatized again we’ll try to deal with that in the next session. Dealing with trauma in South Africa is futile“ (Caroline). Thus, healing past trauma is a difficult task. It seems this leads therapists to focus on resilience.
Focus on resilience to be able to cope in a landscape of suffering.

Therapy is heavily focused on resilience. Martha described that: “I find something that they did fantastic. I think there is a focus of resilience.” Therapy tends to be aimed at being able to cope with the oncoming trauma and manage without falling apart. “It is essential that they feel some control maybe, that they have survived the trauma, that they are coping. Maybe that they experience less flashbacks and dreams about the trauma. Ja. So that they can stand-up in the current onslaught of trauma” (Marie). Some said that connecting with difficult emotions was useful, yet most said that wallowing was unhelpful. Lisa explained that: “I try to stay away from wallowing in the negative, I think there needs to be a space for this as well...but I think with trauma I find myself being more directive to give them some direction and structure. Otherwise, I find that they wallow in the negative. I think they get stuck, but what I found in narrative and CBT is that it gives you a way of being more proactive.” For those working with people living in poverty, it is a necessity to focus on resilience as the client group is even more vulnerable to further traumas. Phillip suggested that: “Since they can’t really avoid trauma. It is essential to build their inner sense of confidence instead of helplessness and hopelessness.” It was about finding a way to move forward. Martha ironically described what often happens in therapy: “What are we going to do? How are we going to overcome this thing? So it is very practical. Then well sum it up and say ok. Perhaps you think you could have done x, y and z. Let’s see, if you did x, y and z would you have been here to tell the story? No, possibly not. Then you must have made the right decisions at the time.” Following on from that Lisa explained: “[Y]ou can’t be resilient without dissociating.” It then seems resilience is about re-discovering a sense of dissociation. Focussing on resilience in therapy may also make it more possible for clients to choose when and how to engage with difficult emotions and when not to.

A focus on resilience also gives therapists a sense of control and containment. Marie explained that: “I think that is why looking at resilience is so important. That they don’t lie down and die after experiencing so many traumas. That helps me to cope to think about it in terms of that.” Along that line of reasoning Susan suggested that: “Containment is very important because of where South African society is at the moment. We are using more cognitive interventions.” Living with high crime rate
where people are vulnerable to crime "the counselling session becomes a containing space. The one space in their lives that where they can come and feel safe" (Marie). The flip side of the focus on resilience seems to be an overarching sense of helplessness on the therapist’s side.

Therapists’ challenges with practicing trauma therapy in a landscape of suffering.

“Well I think that we are drawn to the idea of processing the trauma. So there is not a great sense of success with therapy. Never even winked at the past traumas, never even got to work through those. I think the levels of frustrations is quite high (Marie).” What has stood out was a strong sense of helplessness felt by therapists in that they are not able to actually change anything for the client. Lisa explained that: “There is a helplessness in that there is nothing that we can do to make that person feel safer. I think for myself and therapists it is difficult to help people overcome that sense of helplessness because we feel it too. They cannot change the practical situation. As someone working with trauma I feel as though it is a tsunami. You really don’t know where to stop it or where to catch it. It is incredibly overwhelming” (Caroline). Many felt that they were only ‘fire fighting’ as the clients are likely to suffer trauma upon trauma. “For example if you have planned for a termination and they get attacked then you are down to square one” (Anne).

This is coupled with the therapist’s own trauma that most of them mentioned during the interview. “My neighbour, last Christmas was strangled and stuffed under her bed. So you see what I mean. You cannot get away from it” (Caroline). “[T]hree years ago...I was held up and gun point” (Lisa). Additionally, therapists are dealing with vicarious traumatisation. “You burn out and I think I am seriously burnt out and there is no recovery for me either. I can go away, but I cannot go on the beach because I will probably be assaulted there. The only way I can get away from it is to leave the country. I am moving to [another country] as soon as I possibly can.” As a result of the overwhelming helplessness therapists find themselves cutting off or distancing themselves. The figure indicates how helplessness and frustration seem to feed-back into dissociation. “When you feel so helpless, you have to try to block it out. Ja. I forget about my sessions as soon as I can, otherwise, I couldn’t do this work” (Anne). Reflecting on this category it seems that the continuous trauma impacts the therapeutic
work in that there is a conflict between connecting with difficult emotions or not to do so. Moreover, the therapy focuses on resilience, rather, than healing. However, this is leaving therapists feeling helpless and frustrated. This in turn seems to propel them to dissociate to enable them to continue their work.

**Other emerging data.**

There were several other categories that emerged, however, there is no space to discuss these at length. One important category was that of money. It was said that money determines vulnerability to trauma, access to services and investigation of the trauma. “You can’t see people for monetary reasons and then there are not enough provisions in the governmental services. That is almost traumatizing” (Caroline). Josie said that: “People with a lot of money have choices, to relocate within the countries, to living in closed of housing estates with tight security.”

Another emerging theme is the wish for more community work that addresses the actual issues of the past/present traumas and the link between groups. Marie explained that: “Community work...is necessary because in South Africa whole communities were traumatized and affected in a variety of ways by violence and oppression...Focusing...on building up social bonds that have been broken down by violence. Building bonds between groups...I think that way community based interventions have an important place, for the well-being of that community and society. You can’t reach all those people through individual work.” However, it seems that professional burnouts hinder the development of another model. Monica sighed and said that: “I know we need another model that addresses the community, but I can’t, I don’t have any more energy.”

**DISCUSSION**

A localized theory based on the above data suggests that symptoms are shared across the population. Many suffer from anxiety, flashbacks, sense of insecurity, loss of control, depression and numbing, much like the PTSD model suggests. However, PTSD does not explain the strong sense of dissociation felt among clients and therapists. Dissociation is of course not a novel concept in relation to trauma as can be seen in Herman (1992), Kalched (1996), Straker at al. (2002) and van der Kolk...
(1996). Moreover, the DSM-IV-TR speaks of 'numbing.' Nevertheless, these writings do not seem to mirror the strength or the social aspect of dissociation in the South African context. Moreover, trauma is not considered out of the ordinary in the South African context. Rather, trauma is perceived as multidimensional, as seen in the category 'trauma as a landscape of suffering in South Africa.' There is the trauma of living in a shattered community, the trauma of the past soldiers and freedom fighters, trauma as ongoing exclusion and poverty and trauma as a consequence of crime. That trauma is a continuous experience is something that has been explored previously by Straker and Moose (1994). Trauma is so frequent that it has become a common experience. Yet, as expressed by Monica, there is a tension between trauma being normal and abnormal at the same time.

It is this 'tsunami' of trauma that seems to impact the focus of therapy. Connecting with the trauma and difficult emotions becomes challenging when it is likely that the client will be traumatized again or live with the threat of being traumatized. The focus of therapy then becomes resilience. In essence, how the client can cope with having endured a past trauma and how she/he will manage the next trauma and/or the threat of trauma. It seems that therapists are struggling with how to focus trauma therapy. Do they encourage clients to feel difficult emotions or help them keep these emotions at bay? Nevertheless, it seems to be about being able to access a sense of strength and at the same time being able to feel some difficult emotions. It was suggested that resilience is about re-discovering dissociation. However, it seems this heavy emphasis on resilience leaves therapists feeling helpless and hopeless. There is a feeling that therapists are unable to facilitate healing. Perhaps by focussing so heavily on resilience and not wallowing in difficult emotions leaves the therapist with all those difficult emotions. It seems it is the therapist that is left feeling those feelings that the client is resilient against. Moreover, it is also easy for the therapist to access those emotions because they have often experienced trauma themselves and are also positioned in this landscape of suffering. However, this was not an emerging theme in this study but, perhaps it is something that needs further exploration.
Another aspect of this localised theory of the focus of therapy is the meaning of trauma. The meaning of trauma depends on where in society the person is positioned. More pertinently, the meaning is suggested to split along racial lines as seen in the category, the meaning of trauma. The socio-political is, thus, embedded in trauma and comes with the client into the consulting room. Although therapists connect with clients and difficult emotions in therapy, there is a sense that the meaning of trauma is dissociated. In light of these findings we are left wondering what it might mean to go beyond dissociation and connect with the traumatic experience. Does it mean to connect with one’s own position in relation to past trauma? Will it bring up emotions such as: hate, anger, revenge, fear, guilt, shame and helplessness that threaten the person’s very identity? What would happen to such emotions in a traumatized country like South Africa? Would it mean to have to come to terms with one’s own connectedness with the country’s history, other groups and shake the foundations of one’s identity? Is dissociation crucial to maintain a coherent sense of self in today’s South Africa? In essence, all of these questions are present in the consulting room and perhaps it would be too overwhelming to connect with these issues. The focus of therapy then has to remain with resilience. Of course there is a risk in using the word ‘dissociation’ because it can bring to the fore the psychoanalytical meaning of it, because, as useful as this concept is, it may misguide us in what it really means in South Africa. In the West dissociation is problematic, in that it is assumes that processing the past is necessary for healing. Then again we do not know if it holds the same problematic meaning in South Africa. However, the Centre for the Study of Violence and Reconciliation (South African organization) expressed, in relation to the recent Xenophobic attacks in South Africa, that: “[W]e have not done enough to address this history and the subsequent unresolved trauma. This culture of violence is evidenced in the high levels of crime and violence in SA (CSVR, 2008).” This begs the question: How should trauma be approached? Perhaps this is a question all counselling psychologists struggle with their trauma work. However, in South Africa this is a particularly pertinent question.

The complexities of the study
As a method, grounded theory allowed for the development of new insights into trauma in the South African context. It allowed for new categories to emerge and for
new casual links to be made. Due to time constrains it has been difficult to reach saturation of theoretical sampling as suggested by Glaser & Strauss (1967) and Charmaz (2006). Without saturation it is difficult to put forward a theory that confidently explains all aspects of the research question. This can lead to questioning the use of grounded theory within this particular context. However, it is argued that theory construction is an ongoing process and not a close ended project (Glaser & Strauss, 1967). Furthermore, the major categories presented in this study were saturated. Thus, within the time limitation faced by this study, it is possible to add to the existing body of knowledge and develop a spring board for future research.

Due to the sensitive issues studied it would not have been appropriate to interview victims of trauma. However, as mentioned before most of the participants revealed that they themselves had suffered from trauma. Thus, many had first-hand knowledge from their own experiences and their clients. An additional issue concerning the participants is that of race, class and gender. All participants were white, middle class and there was only one male. It would strengthen the study to interview people from other backgrounds. Thus, further theoretical sampling would be beneficial.

This study has highlighted the implications that social forces can have on trauma therapy, not only in South Africa, but also for counselling psychologists in the UK. It has brought to the fore how therapy is dictated by social forces and how the counselling psychologist is very much embedded in society. This may sound obvious, however, it brings the attention to mental health problems worked with on an everyday basis in the UK such as depression and/or trauma. How is the focus of therapy impacted by social forces in the UK? What are we not seeing?

Finally, the findings in this study have raised many questions in relation to trauma in South Africa. As a result the finding can be used as a spring board for a variety of new projects.
REFLECTIONS

What has been most important to me researching and writing this paper as been to find my ‘inner academic.’ I suppose what that means is that I have found something inside of me that is able enough to do and write research. Getting here has been a bit of journey, one that continues. I think it all started with failing my literature review last year, then re-writing it. My supervisor has trusted that I can write well and that has allowed me to trust myself. It has made it possible for me to be totally open and ask many endless questions, something I hadn’t done before. In the past I would have showed fragments of work and only asked a few questions in fear of being told ‘I’m just not clever enough’. Ah! The scars of childhood get in everywhere.

Starting to trust myself a bit more has resulted in my work become more solid and coherent. It is work that comes from me. It is no longer something I have to invent as it is already inside of me. I say this not knowing what the outcome will be of this paper. However, I think that no matter what the mark is, it has been a valuable experience for me. I can even say that I have had fun with, wait for it, fun with Grounded Theory. These are not the words that I expected to write, but it has been fun. When I started thinking about Grounded Theory it felt like a complex, organized, confusing and laboursome journey. Taking it all step by step and allowing my supervisor to guide me through, has made it much more manageable. Don’t get me wrong, it has not been easy, but it has not been a self-critical exercise that so many things become for me.

One of the most challenging aspects of this study was to attempt to be free of assumptions and judgements of what ‘good therapy’ is in the South African context. I struggled with not inferring from the data. For example it was hard to not infer that dissociation is a form a denial, something problematic. I am still not convinced that the report is free from Western values on what should and shouldn’t be, although I have tried my best. I suppose, how could it be? I’m Western. I have to admit a part of me is unclear on how to be and think of things free from judgement. It has been hard to understand concepts as they were presented and not filter them through my own value system. Perhaps this is in part why I choose to do a study like this. To clarify to
myself what it means, when it is said that social forces impact or even construct our world and therapy.

Along those lines I also found it difficult to remain curious about everything that was said in the interviews with participants. There were certain things that spurred my attention more than other things. I had to remain aware and sensitive to what I wanted and what was actually being said. This also applies to the choice of categories. There were so many that emerged, yet there was only room for a few. Although I chose the ones that stood out, at the end of the day it was my choice to include some and exclude others. I am then immediately aware of how research is so dependent on the positioning of the researcher.

A pleasant surprise was to be met with a very positive attitude by the South African participants. They were open, curious and willing to share their experiences. I had thought that it was going to be a struggle to find participants, but I was met with eagerness and enthusiasm. I have learnt from these participants what it means to be truly open about your practice.

I have also struggled with justifying why I'm concentrating on South Africa. What is it to me? Perhaps it has to do with being Swedish. Perhaps coming from a country where peace and tranquillity is taken for granted, I am intrigued by South Africa where there is so much tension between people. I also have personal links to South Africa and have spent much time there. I think I have a crush on the country. Although I did not experience any trauma when I was there, it feels like it is everywhere. I feel I have experienced most of what these participants have shared with me and that makes this study even more meaningful to me. I think this has enhanced the study in that I have a sense of their experiences. I guess, I can imagine myself walking in their boots.
REFERENCES


James, E. The political economy of 'Trauma' in Haiti in the democratic era of insecurity. Culture, Medicine and Psychiatry 28(2), 127-149.


APPENDICES
Participant Information sheet
I'm a doctorate trainee in Counselling Psychology at the University of Surrey in the UK. For my doctoral research I am interested in exploring trauma as embedded in the social and in its time. Some research suggests that trauma can be explained as PTSD. However, we know little about how the meaning of trauma changes with the socio-political. This is why I have turned to South Africa. South Africa interests me, as trauma has occurred on such a massive scale and I am curious how that affects its meaning. The objective of this study is to explore South African mental health professionals' understandings and insights of trauma in South Africa following massive social changes.

To gain an in depth understanding of trauma in South Africa you must have at least a year therapeutic experience with trauma survivors. It is important to note that this study is not exploring any personal traumatic experiences. The interviews are semi-structured and will take place over the phone, at a time convenient for you. The interviews are expected to last for about one hour but, can last longer if so required and will take place between February and April 2008.

The interview will be recorded on audio tape. This will allow for some of your responses to be reproduced in the final research report. The tapes will be kept in a secure location until they are transcribed by myself. The tapes will then be erased. At all stages of the research your name and names of any other people mentioned, will be changed, as will any other identifying material in order to protect confidentiality. You have the right to withdraw from the research at any point without providing a reason.

On completion I would be happy to send you a copy of the study.

If you are interested in participating in this study, please contact me by leaving a message with the department secretary at the university on +44(0)1483-689-176 or you can email me, Louise Brorstrom, at l.brorstrom@surrey.ac.uk.

Sincerely yours,
Louise Brorstrom
Counselling psychologist in training.
University of Surrey.

Supervised by:
Dr. Martin Milton
Department of Psychology
School of Human Sciences
University of Surrey, Guildford
GU2 7XH, UK
Appendix 2

Dr Mark Cropley
Committee
Chair: Faculty of Arts and Human Sciences Ethics Committee
University of Surrey

Louise Brorstrom
Department of Psychology - PsychD Trainee
University of Surrey

14th February 2008
Dear Louise
Reference: 204- PSY- 08
Title of Project: ‘South African mental health professionals’ Insights and understandings of trauma in post-apartheid South Africa’
Thank you for your submission of the above proposal.
The Faculty of Arts and Human Sciences Ethics Committee has given favourable ethical opinion.
If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Yours sincerely
Dr Mark Cropley
Appendix 3

Research Consent Form

Title: South African mental health professionals’ insights and understanding of trauma in South Africa.

Author: Louise Brorstrom, Counselling Psychologist in training, PsychD Psychotherapeutic and Counselling Psychology, University of Surrey.

Supervised by: Dr. Martin Milton.

- I the undersigned voluntarily agree to take part in the study on South African mental health professionals’ insights and understanding of trauma in South Africa.

- I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised about any discomfort and possible ill-effects on my health and well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

- I agree to the interview being audio taped for the purpose of transcription.

- I agree to co-operate with the interviewer during the interview. I shall inform the interviewer if I feel distressed during the interview and the interview will be terminated if I request.

- I understand that all personal data relating to participant is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).

- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

- I acknowledge that I will not receive payment for any participation in this study.

I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of participant (BLOCK CAPITALS)
Signed
Date

Name of researcher taking consent (BLOCK CAPITALS)
Signed
Date

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Appendix 4

Background Questionnaire

1. How old are you?

2. Please indicate if you are female or male by circling.

3. How would you describe your ethnicity?

4. What is your highest qualification?
   None
   Std 8
   Matric
   Diploma
   Degree
   Postgraduate

5. Where do you hold a professional registration?

6. How long have you been registered?

7. Which of the following describes you best?
   Psychotherapist
   Counsellor
   Psychologist
   Psychiatrist
   Social worker
   Community support worker
   Mental health support worker
   Other (please specify)

8. How long have you worked with trauma survivors?

9. In what capacity have you worked with trauma survivors?
10. When feeling distressed about clinical material, how do you support yourself?

11. Do you consider yourself having a support network you could approach if you found the interview distressing?
Appendix 5

Interview schedule
South African mental health workers’ insights and understandings of trauma in South Africa.

Introduction
• Introduction of the researcher and the nature and aims of the research project.

"Thank you for taking your time today and agreeing to take part in this interview. My name is Louise Brorstrom and I’m currently doing some research as a part of my doctorate in counselling psychology at the University of Surrey in the UK. I would like to use this time to talk to you about your insights and understanding of trauma in South Africa.

• Discussion of confidentiality.

"Confidentiality of audiotapes will be assured and following the transcription the tapes will be erased. During the transcription names will be given a pseudonym and any other identifying material will be omitted to ensure you remain anonymous. All parts of this recording is only for the purpose of this research study."

• Explain right to withdraw without explanation and their right to not answer questions if they do not wish to.

• Acknowledge that both of us have signed the consent form at a previous time.

• Acknowledge the previous completion of the background questionnaire.

• Address any potential questions the interviewee has at this time.

• Turn on the audio tape recorder.

The interview is semi-structured which means I will be following your lead as to what you think is important for us to talk about in terms of your insights and understandings of trauma in South Africa. Before we start, do you have any questions?

1. As a South Africa mental health professional, what does trauma mean to you?
   - What makes you say that?
   - Can you say more about that?
   - Has that changed over time or been the same since you begun your work?
   - How do you feel about that?
   - What has prompted this understanding about trauma?
   - A definition/experience?
   - Social/psychological?
   - Black/white?
   - Past/present?

2. Having described what trauma means for you, how does this appear in your work with your clients?
   - What makes you say that?
   - Can you say more about that?
   - How does that effect your work?
   - What effects might that have on you?
   - It what sense?
   - What are the effects of that?
- In the narrative?
- In the relationship?
- Why do you think that is?
- In what ways?

3. How does your understanding of trauma inform your decision making about focus and therapeutic task?
   - Can you say more about that?
   - Why do you think that is?
   - How do you think that comes about?
   - What makes you say that?

4. Taking into consideration what you have said about your insights into trauma what are your thoughts about its effects on success of therapy and/or problems with it?
   - How do you think that comes about?
   - Can you say more about that?
   - Why do you think that is?
   - What makes you say that?
   - How do you feel about that?

5. Reflecting on trauma here in South Africa, what are your thoughts on the type of interventions for traumatic suffering?
   - Community/individual interventions?
   - Limitations/benefits?
   - Can you say more about that?
   - Why makes you say that?
   - What are your feelings about that?
   - How do you think that comes/came about?

General Prompts:
Can you tell me more about that?
What makes you say that?
How do/did you feel about that?
How/why do you think that as happened?
What effects do you think that has?
How do you think that effects...?
How do you make sense of that?
Can you give me an example about that?
Are there any other aspects/factors?

Ending the interview.
- Before we come to an end is there anything you would like to add to the topic that we have not had the chance to chat about?
- It would be helpful for me to reflect on the interview for a minute. What has it been like for you?
- How are you doing/feeling now?
- How did you feel about the questions asked? Do you feel they were relevant to the subject? Are there any questions that you would asked?
- Thank you for participating.
- Explain how they can obtain a copy of the research report.
Appendix 6
Transcription (interview 3)

I: As a South African psychologist what does trauma mean for you?

P: Like in the type of problems that we see. Ja. I think that is SA. I think we are a traumatized nation. I think that crime is one thing, even if you haven’t been involved in trauma directly you know someone who has. I think the pervasive element of trauma is crime, ja, I think that the other element is rape and domestic violence and child abuse. So I think in terms of understanding trauma it is kind of around experiencing something other than our normal experience, taking us right out of our comfort zone. A sense of insecurity in the world, ja, I think a huge sense of insecurity. I think that is how trauma is experienced in this country. I think there is a lack of trust in the powers that should protect us, that isn’t there at the moment. Also something, it creates a lot of anger because it shouldn’t be happening, because it shouldn’t be happening. It think trauma around a natural disaster, those things happen, trauma around an earthquake or a fire, those things happen all the time, everywhere, but I think trauma around the crime, think people are very angry about it because it shouldn’t happen. There is a feeling that something should be done, but nothing is done about it. It is a feeling of helplessness and I think that is what we feel around the trauma, but also around the crime. I think that prolongs the experience of trauma that people have in this country. I think the helplessness is everywhere in people that have directly experienced the trauma, I think they feel helpless because let’s say I was hijacked. I mean it would help me to recover from my trauma if I could be assured that I would never be hijacked again so. I think there is helplessness in that it is actually likely to happen again. Whereas in a plane crash or an earthquake you can probably make sense of it in that it was an out of the ordinary experience so unlikely
to happen to again. But here the likelihood is that it will happen again. And I think the way that affects us around family member, colleagues; there is helplessness in that there is nothing that we can do to make that person feel safer. I think for myself and therapists it is difficult to help people overcome that sense of helplessness because we feel it too. It is almost like you align yourself with them in the anger against the government saying that something should be done about it. There is helplessness and it is difficult to move forward from it.

I: Could you say a bit more about the alignment with the client.

P: I think I don’t do it overtly, but when they say you know the anger towards the government or the frustration against the country. I can feel myself agreeing to that. I can feel myself thinking yeah you are right, it is not like a dysfunctional belief that they have. It is not something that can be changed it is a true concept they have, we do have to take action. I don’t say it with them most of them time. I think from a countr0transference kind of view I can feel myself getting drawn into that. Because it ties in with my own views that I have at the moment.

I: I was wondering as well about the sense of trauma being out of the ordinary in the SA context, where trauma is more frequent, has the ordinary changed?

P: Ja it has. I think what we were used to has changed and...My aunt was out here form the UK and she was commenting on or conversation around the dinner table. “So and so was hijacked yesterday” you know. And it is just a by the way. For her she was shocked by it. I think that those things become ordinary. A lot of people don’t even come to counselling when it happens to them they say “ach that is just a part of our lives here, I don’t need counselling I’m fine.” In the suburbs where I live there is a community action programme where they have security guards with AK47 and we don’t even see it. And when someone from overseas come to visit it is bizarre
because we don’t even see it. We don’t see these guys with guns and arms, big vehicles with stuff on it and we just take it for granted. So I think the conversations, it has been normalized. I think we dissociate from it, I think it is a protection mechanism. We don’t want to take it on because it gets to scary, we shut it out because we can’t let it in, it is too overwhelming. Or people share their stories like you would share you travel experiences. We say I was mugged and hijacked and it is like a commonality. But the element of shock and horror is just not there. I think it is a coping mechanism, I have seen that in myself and in my clients. I think it is the way to cope. If we would have to see what is happening it is too unliveable. I think there are people that are like that and those are people that have to leave they can’t live like that anymore. I see the ones that come to therapy and say it happened and they processes it and then say I can’t move on and they have to leave. They have realized the enormity of what it actually is. Whereas I think that a lot of us are able to say, I don’t know if it is healthy or not, but are able to say it happened and it is a part of this country and I am just going to have to leave with it. I have to be vigilant and not take stupid risks, but I choose not to buy into the panic of it. So I think for me I think it is a coping mechanism you have to dissociate from it. I can give you a here and now example. I just spoke to a colleague of mine and her husband’s office they were all held up and tied up and tonight I am going to peer-supervision in the same area and she called me up to say that she doesn’t want to go. She doesn’t want us to leave late because it is dark. I just said to her that it is terrible, but it happens and we have to carry going because this happened around the corner. I made a choice not to live in that panic. So I’m just cut off, because I have to be. Otherwise, you won’t go anywhere or do anything.
I: I'm curious as to how dissociation and the common experience of trauma enter the therapy room, if it does?

P: Ja. I think it does. It is difficult to say because it is really individual. But I typically find that those who come for therapy are those who can't dissociate. The trauma is so close or the fear is so close and that is why they are coming to therapy because they can't cope. Whereas those who cut off don't come for therapy, because they think they are fine or they are afraid of coming because they fear that they will have to confront their experiences and feeling that they just don't want to feel. There is still an element where they just can't access those feeling. I struggle with do I push for them to feel their feeling because I know that to recover from trauma you have to feel all those feelings. In a way the question that sits in my mind it how healthy it is to make them feel those feeling when the still have to go out in the world and the world hasn't changed and there is a real fact that it might happen again. They have to build their resources to be able to cope. Other than constantly being able to feel those feelings. So I think there is a struggle between feeling those emotions and then giving them the space to cope with the world.

I: Does it then get a bit complicated in how to focus therapy?

P: Ahm, I haven't really thought about it in this way. But I think I very much go with what the client brings. It is client-centred. Where they come from, their family and background. I mean the therapy mostly takes it own course. I just have to keep in check what my stuff is and not put that onto them. Because I think it is so close to us. Like in other countries therapists may not have experienced it themselves but the crime thing we have all experienced. So I think it is very close to home experience. And I think it is harder for therapists to stand back and not let it affect you. I mean I think it was three years ago that I was held up and gun point. It was fine and not
violent but I remember that the next week I saw a client that was held up a gun point and it was a very real raw experience to go and counsel someone after that. It was a real healing experience for me. Thos kind of things does make therapy a complicated process, the crime trauma. I remember I went to a talk about it a while ago and I remember them saying that it breeds more racism so if it was a white person that was attacked by a black man it enhances that fear of all black men. Or even if it was a black woman that was attacked by a Nigerian man then in enhanced Xenophobia. It is always, it is very difficult in the therapy because that comes up a lot. And I think that is something that I choose to work around a lot, saying “but is it all black men or haven’t you had a good experience of a good other” I think that when that comes up in therapy I focus on that and how functional is it going to be for you thinking that all black men are dangerous, or all Nigerian men are dangerous or all men are dangerous. Trying to establish a level of functionality so that that person can go out and cope in the world.

I: So there is a socio-political issue that enters into therapy.

P: Ja, ja. And that is what they were saying when I went to this workshop on it. They said it is very difficult to exclude the political from it or social realm. I think in other types of therapy it is not necessary or it doesn’t come up into the therapy as much. Whereas you often end up having to or the client often bring up political thoughts and issues of what is happening in the country. Which is a different kind of therapy. In other types of therapies I don’t know what their political views are where in this type of therapy in is evident. This directly brings it out. They are traumatized by the crime and that bring up all this micro issues of what is happening in the country and their thoughts around it. So it is a totally different kind of therapy and one that I wasn’t
trained for. I don’t think that traditional training gives you enough assistance in these kinds of issues.

I: I was struck by the contradiction between working to connect emotions and then going out to a society that is largely disconnected. What are your thoughts on that?

P: (laughs). Ja. I think it is about balancing and finding that space within yourself where you can access those feeling and then disconnect them. I think it fits in with therapy generally when I do therapy I am differently from when I leave. I think when I leave I put on a different hat. I put on my therapy and hat and my everyday hat. So when I am in a normal, everyday I don’t usually think therapeutically. It is not that different or uncomfortable. I just think that the difficulty working with trauma is the types of emotions that are being stirred up. For me the lingering feeling is always anger. That is the difficult one to dissociate from. It is anger or a sense of injustice that this woman had to be raped or whatever. I think that is the feeling I struggle with and with helplessness. Other than helping them dealing with their feelings, I can’t do anything about the practical situation and I find that hard to deal with.

I: What are your thoughts on the success and/or limitations with therapy?

P: It is difficult to say because I think a lot of people who have suffered trauma don’t stay in therapy. I mean that is a generalization. I think sometimes accessing those feeling is too scary or dangerous to them and they don’t want to come back. I also have had the experience of “flight into health” in that they have had the first session and are so grateful that they could off load and then say oh no I’m fine. If that means that they have flown into dissociation that is difficult to say. I would say to that person that lets leave for a couple of weeks and then check. But they rarely come back for a follow up session. It is difficult to say that blanketly that it is effective or not. I think these are people that seek out therapy because they want to. They wan to resolve a
particular personal problem and it is almost as if they have to in order to cope. The aspect of motivation, generally it is not long-term therapy and it generally short-term. It depends on their support structure or their previous way of coping. It is very different when I have someone that is living alone or that is isolated or who have negative family set up or they come from a family that has a negative outlook on the country or that has had a lot of trauma. I find those people take a lot longer to recover or overcome it in comparison to someone that has a very good support system. It depends on if they have a hard time talking about it. Often the only space that they have to talk about it is in therapy and that is difficult. If they are in a situation where, as they have a flash back or a memory they can actually talk to somebody about it. I think trauma therapy in this country is very effective in terms of being the experts of knowing what works and doesn’t work. Not much id grounded in theory but I think it is in practice and experience to work with this kind of trauma. I think that the work that is being made at the South African institute for traumatic stress in ground breaking. They are definitely dispelling the older ideas of trauma de-briefing and that trauma should be dealt with. I think that if you think about a normal therapist’s practice maybe not in SA. Maybe one out ten would be trauma cases whereas in SA it is more maybe 3-4 would be a trauma case. I think that the SA institute of traumatic stress are writing it up. Because I think lot therapists are busy or are not writing up our experiences and that is a shame, because I think there are so many valuable experiences in here that could be useful for the world to know. Although I think the kind of trauma that we deal with is different in terms of the crime, but I think it gives us an edge in being able to see what works and doesn’t. I think it is more about the older theories that say that as soon as someone has become traumatized they have to go and speak to someone right away. We have definitely found that that doesn’t work,
because it has not hit them yet and they don’t know how they are going to be affected by it. There are people who do quite a lot of group trauma de-briefing and I just don’t think it works when we go in straight after the trauma has happened. I mean there is a time when the practicality dictates what we need to deal with like, food, water and other medical things that needs to be dealt with first. I think the literature says that it takes at least 48 hours when they realise what has happened and it sets in. And I think that is the best time for interventions. And what has come out of my work as well is that group de-briefing is not useful at all and it actually can be quite dangerous, because you don’t think that you are giving everybody a chance. Those who are quite are quite and don’t get a chance. It isn’t the right environment for it, sitting in a group with your colleagues talking about your feelings. It is not serving the purpose that we think it is and these people should all be seen individually even if it is just for one session, but at least then the therapist can assess their levels of stress and trauma and make recommendations. I think the group thing is just a quick, easy cost effective way of dealing with this. But I don’t think that is clinically accurate.

I: Could you say a bit more about that.

P: I think that if we do it too soon then I don’t think we can access the feelings. I think it only becomes a repeat of what facts. I think from my experience the emotions only come a few days later when the mind has clicked in. So I think that it is about finding the right timing when the can access the feelings. And I think there is an element of re-traumatisation in the group because not everyone experiences the event in the same way. I could have been tied up and someone locked in a room and for me to now hear your experience might add to my trauma. Whereas I am dealing with my own one and I don’t need to hear what happened to you. Or what you were feeling and thinking. I think what the idea is behind group work is that it will help people to deal with the
commonalities in trauma. It is normal to feel these kinds of feelings, but what I have seen is that it can have an adverse effect where it adds to the trauma. I have seen this before where some people who worry about everyone else then I hear about your trauma I am now going to be worry about you and not my own trauma. Ja.

I: What models are you finding useful?

P: I don’t have a model. I prefer the CBT route and works with those dysfunctional thoughts that can come after trauma but I don’t only work in that model, I’m quite eclectic. I use a lot of narrative work as well because I think that the narrative work helps with restructuring and. I remember my trainer telling me about a severe trauma that a family went through and the mother was feeling very guilt because she couldn’t protect her kids. The therapist was able to sat, "but see what you did do" see what you were able to do. In that terribly awful experience let’s look at what you actually were able to do. I think the narrative and the CBT works nicely in that and doesn’t get too involved in the negative stuff. I try to find some way of empowering them because they are so disempowered. They need to regain the sense of control. Even though at this instance I wasn’t I am in control of my life. To give them something to hold on to. Like a life jacket. I think I try to stay away from wallowing in the negative because I think it can be, I think there needs to be a space for this as well and I am usually not directive in my work, but I think with trauma I find myself being more directive to give them some direction and structure. Otherwise, I find that they wallow in the negative. I think they get stuck but what I found in narrative and CBT is that it gives you a way of being more proactive.

I: I was wondering if the focus on resilience is related to the high frequency of trauma or not, what are your thoughts about that?
P: Ja. I think we are a resilient population. I think that dealing with the current situation. What struck me over the last few years is the focus not just on resilience, but also on adaptability. How we are just able to adapt to different circumstances. I don’t know if they are the same, but I think it is definitely about getting on with it. We deal with it. I think as a nation I think we are very resilience. I think we are able to rise above the negativity. You always find those who are very positive about the country and not get sucked in to the negativity. I think that it is a way of being. I mean I think we are all really on edge and at one stage I thought that we all suffered from low levels of PTSD in some degree. I think that it is a, it isn’t a negative thing we are able to cope with it and rise above it. We don’t just sit back. There are various action groups that are trying to do something about it.

I: Would you say that resilience and dissociation are linked?

P: Ja. I think we can only be resilient by dissociating. I think we are able to be resilient and to cope because we dissociate from the absolute level of panic that there should be perhaps given the nature of the crime there is. You could be worried about being violated all the time or you can choose to live your life vigilantly and not buy into the panic. There is a difference. I think both in my personal life and therapy life I see that those who are able to dissociate are more resilient and don’t take on or feel all the feelings all the time. It is difficult for them to lead a normal life when they have to be home before dark and lock themselves in behind electric fences and security guards. They don’t want to go out. If you don’t dissociate then you don’t have a life. I think that in way I think there is a war here going on against criminal and I think that it is like living in a warzone. You do have to cut off a certain element and connecting with what is going on. And I think when I think about it too much it just gets overwhelming
and if you don’t such a strong ego then it can totally take over. To the point of break
down and it can totally engulf you. Dissociation is the way we cope.

I: Has your perception of trauma changed over time?
P: I have only been practicing for 3-4 years. So I haven’t...ah, I think the types of
trauma has changed but I don’t think the perception has changed. I think what people
are presenting with. Ja, I think before there wasn’t so much crime. I think about rape
women weren’t speaking about a lot so maybe that is why it feels like there is more
rape. But I don’t think there is more. I just think that women are being more
empowered to speak out more. There is more assistance. I think trauma has always
been trauma. It has also been experienced as n injustice that we shouldn’t have to
experience, but we do because of the politics of the country. That is the majority of
trauma. There is obviously ‘normal’ trauma like sexual abuse that happen but not as
much. I think it is a lot to do with injustice. I think that it always has I don’t think
because of this government there is more trauma I think under the other government
there was also trauma. Also politically related trauma to the whole Apartheid issue. I
think it is very politically orientated.

I: What are your thoughts on race and therapy?
P: I think that the way we experience trauma is the same. I think where the trauma
gets directed is different. I think the white middle class it is around the black
government and by into the apartheid racist thinking. Whereas people of other races
don’t necessarily go into the lack in the government. I think it is more around the
other nationalities or ethnicities. Like at the moment there is a lot around foreigners,
because a lot of the crime is done by foreigners and it becomes more of a Xenophobic
slant. I think that is the different. But the way the feel and approach it seems to be the
same. Ja.
I: I am coming to an end to my questions and I was wondering if there is anything that you would like to add?

P: No I don’t think so. I think your questions have helped me think about me ideas about trauma.

I: Ok. I would also help me to know what the interview has been like for you?

P: It was interesting because I haven’t verbalized and put my thoughts into words. To think about my work and what is happening in the country. We dissociate so much that we don’t even think about it. We come across so many trauma cases, but we don’t think about it in these terms.

I: So here I come asking you to connect with your experience.

P: Yes that I am trying so hard to cut off (laughs). I think I am fine and will be able to put down the phone and dissociate again. Ah, I really think that it is important to reflect on our work so I am fine.

I: What was the questions like for you and are there any questions that you might have asked that would have been helpful?

P: The questions were all very relevant in guiding the thinking and it was also kind of opening up areas that I just mentioned briefly. So you explored that. I don’t think I have any other questions. Maybe accessing what it is like being a therapist working with trauma, because I think a lot of therapist don’t want to be therapists in this country, because. I mean it is a growing feeling that “if I have to see another trauma case...” I think that the actual experience of being a therapist in traumatized country would be helpful as well.

I: Thanks that is really helpful for me. We have already chatted about how to get a hold of a report is there anything else that you would like to add or ask?
P: No I think that’s fine. I mean I am on my way to supervision so I think that will be useful. I know how to get a hold of you if there is anything else.

I: Ok. Well, thank you very much for your time.

P: No worries. Thank you and good luck. Bye.

I: Bye.
Appendix 7

South African Journal of Psychology

Instructions to authors

Submitting a manuscript

SAJP is a peer-reviewed journal publishing empirical, theoretical and review articles on all aspects of psychology. Articles may focus on South African, African or international issues. Manuscripts to be considered for publication should be e-mailed to sajp@up.ac.za. Include a covering letter with your postal address, email address, and phone number. The covering letter should indicate that the manuscript has not been published elsewhere and is not under consideration for publication in another journal. An acknowledgement of receipt will be e-mailed to the author (within seven days, if possible) and the manuscript will be sent for review by three independent reviewers. Incorrectly structured or formatted manuscripts, or manuscripts not edited for language, will not be accepted into the review process. Only one article per author will be published per calendar year. Exceptions to this rule will be at the sole discretion of the editor (with his or her associate editors) in the case of an exceptional article that needs to be published, a special issue where the specific article will make a significant contribution, in writing or responding to a riposte, etc.

Authors must please quote the manuscript number in ALL correspondence to the editor.

Revised articles

Where authors are invited to revise their manuscripts for resubmission, it is crucial that the editor be notified (by e-mail) within three weeks of the author’s intention to resubmit. Author(s) must then submit the revised manuscript within six weeks from the date of their expressed intention to do so and resubmit within three months. All articles where this procedure was not followed will automatically be disqualified and removed from the process. Should an author wish to resubmit this article after a longer period, it will be treated as a completely new submission and a new article number will be allocated.

Manuscript structure

- The manuscript should be no longer than 20 pages (5 000 words).
- First page: The full title of the manuscript, the name(s) of the author(s) together with their affiliations, and the name, address, and e-mail address of the author to whom correspondence should be sent.
- Second page: The abstract, formatted as a single paragraph, and no longer than 300 words. A list of at least six keywords should be provided alphabetically below the abstract, with semi-colons between words.
- Subsequent pages: The text of the article should be started on a new page. The introduction to the article does not require a heading.
- Concluding pages: A reference list, followed by tables and figures (if any). Each table or figure should be on a separate page. Tables and figures should be numbered consecutively and their appropriate positions in the text indicated. Each table or figure should be provided with a title (e.g. Figure 1: Frequency distribution of critical incidents). The title should be placed at the top for tables and at the bottom for figures. The appropriate positions in the text should be indicated.
- Authors are requested to pay attention to the proportions of illustrations, tables, and figures, so that they can be accommodated in a single (135mm) column after reduction, without wasting space.
Manuscript format

- The manuscript should be an MS Word document in 12-point Times Roman font with 1.5 line spacing. There should be no font changes, margin changes, hanging indents, or other unnecessarily complex formatting codes.
- The SAJP referencing style should be adhered to. The referencing style of the SAJP is similar to those used by the British Psychological Society and the American Psychological Association. The American Psychological Association (APA, ver. 5) style guidelines and referencing format should be adhered to.
- Headings should start at the left margin, and should not be numbered. All headings should be in bold. Main headings should be in CAPITAL LETTERS.
- The beginning of paragraphs is indicated by indenting the paragraph's first line using the tab key on your keyboard, except when the paragraph follows a main or secondary heading.
- Indents are only used for block quotes.
- In the reference list, the first line of each reference starts at the margin; and subsequent lines for each reference are indented.

Language

Manuscripts should be written in English. As the SAJP does not employ a full-time or dedicated language editor, it is compulsory that manuscripts should be accompanied by a declaration that the language has been properly edited, together with a letter by a certified language specialist, stating the name and address of the person who undertook the language editing. Failure to do so will result in the manuscript being returned to the author. Should the editor not be satisfied with the quality of language usage, in spite of the evidence that the language has been edited, she or he reserves the right to send the article to the a language editor of the Journal’s choice and invoice the author(-s).

Ethics

Authors should take great care to spell out the steps taken to facilitate ethical clearance, i.e. how they went about complying with all the ethical issues alluded to in their study (or studies), either directly or indirectly, including informed consent and permission to report the findings. If, for example, permission was not obtained from all respondents or participants, the authors should carefully explain why this was not done.

Following on the instructions.

E-mail from the journal.

RE: article

Dear Ms Brorstrom

Thank you for the enquiry. The “language Specialist” section applies mainly to our South African and other non English-speaking colleagues. Where English is a second and sometimes even third language, we require a certificate form a practitioner. In your case, however, it will NOT be necessary, although we do request that you have your article peer reviewed by a colleague, to make sure that there are no typo’s etc. May I also remind you of the 5 000 word limit. We are flexible regarding the length, but the article should be kept as close to 5000 words as possible.
We look forward to receiving your article.

Kind regards

Renette Keet
Editorial Secretary: SAJP & PiE

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Sent: 13 July 2008 03:07 PM
To: sajp@up.ac.za
Subject: article

Dear Sir or Madame,

I'm interested in submitting a research report to your journal as it is highly relevant to mental health in South Africa. However, I was looking at the language section in your 'instructions for authors' and I am unclear on what a 'language specialist' is and if I have to have that type of certificate. I live in the UK.

I look forward hearing from you.

Kind Regards,

Louise Brorstrom
Understanding Disconnection: An IPA study.

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Understanding Disconnection: An IPA study.
Abstract

This study explored six participants’ accounts of their experienced disconnection. It asks the question: How do people make sense of their disconnected experiences? It addresses the research question through Interpretative Phenomenological Analysis (IPA). Through semi-structured interviews it explores the participants’ accounts of their experienced disconnection. The developed themes are, triggers of disconnection, the disconnected experience, function of disconnection, reactions to disconnection and emerging connection. Each theme and sub-theme is explored in this report.

Key words: disconnection; dissociation; IPA
INTRODUCTION

Disconnection is a prevalent way of people protecting themselves against unbearable pain and suffering. Disconnection is a necessary defence mechanism we all need to cope in the world. However, it can also become an unhelpful way of dealing with difficulties. As such it is frequently encountered and worked through in therapy to facilitate well-being. Dissociation or disconnection (see below for use of words) was described by Freud (1920/1955) as a defence against stimuli overwhelming the psychic barriers. Following Freud’s definition, many theorists have elaborated and researched the phenomenon. Psychoanalytical theory suggests that disconnection is a means to store away unbearable pain in the unconscious where it can be kept safe from overwhelming the self (Auerhahn & Laub, 1998). In essence, disconnection is a trick the psyche plays on itself in order to allow life to carry on. This is achieved by splitting the overwhelming experiences into separate compartments of the body and the mind, thus making the experience discontinuous (Kalsched, 1996). Cognitive theory reformulates dissociation or disconnection as discontinuity between a past and a present schema. The information generated by the overwhelming experience cannot be integrated into the existing schema, thus, the overwhelming material is disconnected from reality and the existing schema (Straker, Watson & Robinson, 2002). Interestingly, eco psychologists are suggesting that disconnection (at a personal and social level) of overwhelming and painful emotions is protecting us (humans) from knowing about our destruction of the planet, to enable us to cope with everyday life (Higley & Milton, 2008). Additionally, researchers have found biological changes in the brain during and following trauma recall, such as decreased activation in Broca’s area (which has been well documented as vital in language production) and increased activation in the limbic system located in the right hemisphere (Rauch et al.,
These findings suggest that the person may be physiologically disconnected from the overwhelming experience by being unable to access language or analyze emotions. Less dramatically, but no less important, is the understanding of disconnection in modern psychotherapy. Here it is not referred to as only a formal defence mechanism, but as a way to symbolise any fragmentation of the self (Yalom, 1980). This fragmentation refers to when a person feels unable to trust their own experiences, feelings and desires.

Disconnection is without a doubt essential for survival. If we were to connect with all pain and suffering in us and the world, we would most likely be paralysed, if not annihilated. However, disconnection can also become dysfunctional or unhelpful for the person and it is at this point that one tends to meet the person in the consulting room. Disconnection can be considered dysfunctional when it results in a re-enactment of trauma or a pre-occupation with anxiety and/or depression (Chazan, 1992). Many who have suffered trauma often continue to suffer at the hands of others or they themselves torment others, they struggle to know other ways of relating (Prior, 1996; Ralph, 2001; Russell, 2006; van der Kolk, 1989). This refers to the Karpman (1968) triangle where the abused person is stuck in a triangle, acting either as a victim, persecutor or rescuer. This person may be unable to step out of this triangle drama which in turn limits ways of relating. Ogden (1979) talks about this as transposing unwanted parts of the self into another in terms of projective identification. The traumatized person unconsciously projects overwhelming and painful emotions into the other to avoid recognizing it in the self. Moreover, Green (2008) and Farber (2008) have both found that disconnection is present and at times a predictor of self-harming behaviour. Herman (1992) writes that among several aspects of healing
trauma, reconnection with the self, others and the world is vital. Moreover, research has found that what clients most valued about therapy was to regain lost parts of themselves (Yalom, 1975). It seems that processing disconnection may be an immensely important aspect of therapy. Thus, exploring disconnection is relevant to practicing counselling psychologists as most of us will work with it in the consulting room. Additionally, it may enable us as practitioners to become more aware of our own disconnection. It may allow us to engage more fully with the client’s material.

There is much research and writing on disconnection, however, phenomenological research is lacking. Perhaps this is because of the inherent difficulty to study and know something about a phenomenon that is designed to protect against knowing. This study aimed to overcome this difficulty and better understand disconnection as a phenomenon by asking a group of people who have become aware of their own disconnection and their accounts of it. Specifically, this study asks the question: How do people make sense of their disconnected experiences? It addresses the research question through Interpretative Phenomenological Analysis (IPA). IPA allows for a detailed exploration of the participants personal and social world and close examination of meaning-making (Smith & Osborn, 2008). Of course it was not the aim to uncover the ‘true’ meaning of disconnection (if there is one). Rather, this study looked to explore people’s experience of it. It was the intention of this study to use the word dissociation to describe the defence against knowing something unbearable. However, after having asked a random sample of people what the term dissociation meant for them, it was found that very few people could relate to it. Rather, they tended to ask the researcher what it meant. With that in mind dissociation it was substituted for the word disconnection. Upon reflection of the meaning of dissociation
and disconnection there is a sense that dissociation may be a deeper state than disconnection. Disconnection is perhaps more conscious than dissociation. Thus, it may be helpful to view disconnection and dissociation on a continuum where disconnection is less severe and dissociation is on the severe end of the continuum. Perhaps in line with what Krakuer (2001) who suggested that day-dreaming and pathological dissociation are on a continuum, daydreaming being less severe than pathological dissociation. It is important to keep this in mind while reading this study.

It would have been counter-intuitive to use an abstract word such as dissociation that needed explanation in a study that aimed at getting to know the participants' experiences and their meaning making. Rather, it would have imposed a meaning on the participants. Moreover, Straker et al., (2002) suggest, in their extensive literature review covering disconnection, that dissociation and disconnection can be used intermittently. In their review disconnection is used as a layman's term for dissociation. Consequently, the word, disconnection, was used in e-mails and leaflets to recruit participants. Of course this is problematic as it may be argued it changes the topic under investigation. Perhaps the data obtained would have differed of the word dissociation was used. Below is an outline of method including participants, ethics, analytical process, data collection and evaluation criteria. The themes and sub-themes are then explored, followed by a discussion.

METHOD

Participants

In accordance with IPA, there is no set number of participants, rather, it is the richness of the material obtained that determines the number of participants needed, however,
IPA is generally conducted with small sample sizes (Smith, Jarman, & Osborn, 1999). After six interviews it was felt that the data was rich enough to stop interviewing and that it was ethically responsible to stop recruiting more participants considering the sensitive nature of the topic studied. Moreover, the IPA researcher tries to find a fairly homogenous sample so that the research question is significant for the participants (Smith & Osborn, 2004). The inclusion criteria were that the participants had become aware of having had a disconnected experience, whatever that might mean for them. The exclusion criteria was if they self-reported adverse reactions to talking about difficult experiences, such as re-traumatisation, panic attacks and/or aggression, because the participant’s and the researcher’s well-being would have been compromised.

The participants approached the researcher after having seen global university e-mails being sent out at the University of Surrey and leaflets being handed out in yoga, mindfulness and meditation classes (see appendix 1 for the e-mail/leaflet). These groups were targeted because it was thought they were more likely to be aware of having disconnected and processed it. Perhaps this is also one of the limitations of the recruiting process, because in some way it excludes those people who are not aware of disconnection and who struggle with verbalizing it. However, if someone is unaware of their disconnection or find it difficult to speak about it they would probably be unlikely to show interest in the study in the first place. Perhaps, that people have to be fairly psychological minded and articulate to grasp this concept is also limitation of the topic under investigation. Nevertheless, as mentioned above it is typical of IPA to find a fairly homogenous sample to whom the research question is relevant.
After the participants made contact with the researcher via e-mail, they were given an information sheet about the study (see appendix 2). They were asked to read the information sheet and then contact the researcher again if they felt they wanted to continue with the process. All of the participants chose to continue to the screening stage (see appendix 3). During the screening process they were asked about any adverse reactions to connecting with difficult material such as, re-traumatisation, panic attacks and/or aggression. None of the participants self-reported having any current difficulties and were considered appropriate for the study. However, some reported past experiences of eating-disorders, depression, panic attacks and anxiety. Nevertheless, they all considered themselves safe and having the support network required if they would feel distressed. Moreover, they did leave contact details of a close friend or family member to contact would there have been any difficulties. It was never necessary to use these contact details. Rather, the participants tended to regard the research interview as a learning process and as a forum to speak about experiences they had not spoken much about.

A group of six adults (age 18 and above) were selected for this study. There were four women and two men. Four were aged between 25 – 29, one was aged between 45 – 49 and one was aged between 55-59. Four of them were white British, one white Swedish and one white Greek. Four participants were in the field of mental health and the other two work in surveying and administration. Four participants reported having a degree as highest level of qualification, one had a professional qualification and one had a post-graduate degree and they all live in the South-East.
Although it was not an inclusion criteria that the participants should have attended therapy, all of them had at some point been engaged in therapy or counselling. It may be that people who have attended therapy are more likely to be aware of their disconnection and have processed it during therapy. Perhaps those who have not been in therapy are less likely to be conscious of disconnected experiences or less able to verbalize their disconnection. This raises questions around the language used by the participants. For example, have they themselves symbolized their experiences or is it learnt from the therapist who is immersed in dominant psychotherapeutic discourse? Thus, have therapists transmitted this discourse to their clients by labelling their experiences with existing concepts? Of course a participant’s ‘real’ experience would always be a construction from interactions with people and society, so it would not be possible to find a ‘pure’ reality of disconnection. However, it is important to keep in mind that the participant’s meaning-making of disconnection may be impacted by their therapeutic encounters and the language used by the therapist. Nevertheless, it was important for this study to interview people who were aware of their disconnected experiences. It was therefore considered appropriate that the participants would have been in therapy.

**Ethics**

The study gained favourable ethical approval by the University’s Faculty of Arts and Human Sciences ethics committee (see appendix 4). The study also adhered to the BPS Code of Ethics and Conduct (BPS, 2006). Participants were made aware that they were able to stop or withdraw from the study without any explanation. They were then asked to read and sign the consent form (see appendix 5). Due to the sensitive nature of the phenomenon studied, it was possible that distress and anxiety could arise in
participants. Participants were therefore asked how they would cope with their distress and anxiety prior to the interview, as a measure of risk and an assessment of their ability to look after themselves. The interviewer also monitored the participants' responses during the interview to assess how to proceed with the interview; hence to either proceed sensitively or to discontinue the interview. However, this never happened. They were also given information about local psychological services should they want further support after the interview. They also had access to the researchers e-mail and could have made contact had they felt it was necessary.

The interviews were recorded and the files were kept in a secure location until they were transcribed. The files were then erased. At all stages of the research the name and names of any other people mentioned, were changed, as were any other identifying material in order to protect confidentiality.

Data Collection

The first part of the interview schedule consisted of a demographic questionnaire (see appendix 6). From then on, the interview process was conceptualized as a directed conversation (Lofland & Lofland, 1984). It was a semi-structured interview (see appendix 7) and was adapted as the interview process developed. This is based on Smith & Osborn (2003) who suggest that the interview process should remain flexible and it is the researcher that decides how much to shift away from the interview schedule to explore new data (Smith & Osborn, 2003). The interview questions aimed to capture and explore the participants' accounts of dissociation. It aimed to ask questions about how their experiences related to the idea of disconnection, and then from there explored their accounts without leading or inferring using prior knowledge.
This first question was framed as "You contacted me because there was something about disconnection (in the e-mail/add) that captured your attention, can you say a bit more about that?" Ultimately, forming an understanding of the participants' accounts of their disconnected experiences. The interviews took place at the university premises and lasted between 50 and 80 minutes.

There were some difficulties during the interviews in terms of the sensitive nature of the topic. There were times the researcher could have gone deeper into the participant's meaning making, however, the researcher chose not to do so for ethical reasons. It was felt that it would have been unhelpful for the participant and irresponsible of the researcher to go deeper, as it could perhaps have done more harm than good, considering the researcher was unable to offer continuous support. After all, this was not a therapeutic dialogue, it was a research interview. Moreover, one participant clearly stated she did not want to share her account in too much detail. It transpired that even though most of them were aware of the disconnection and had processed it, there was always more material that had not been processed. Moreover, the participants had often spent time processing what they had disconnected from, but not the disconnection. It was often a powerful experience for the participants and the researcher. There were also some participants that seemed disconnected and/or defensive during the interview process and it was a challenge to negotiate around this. Other than that the participants were open and trusting in the research process.

Analytical Process

The data was analyzed using IPA (Smith, Flowers, & Osborn, 1997; Smith et al, 1999; Willig, 2001). Qualitative research methods, as opposed to quantitative methods,
stood out in relation to this study as it concerns itself with meaning-making rather than disproving a hypothesis or finding one definitive account of a phenomenon. IPA facilitates the exploration of how a phenomenon is experienced. In this case it allowed us to explore in depth the participant's accounts of disconnection. Its inductive nature allowed the researcher to hold no prior assumption about the topic. Rather, the researcher is able to be open to capturing the experiences and meaning-making of the participants (Reid, Flowers & Larking, 2005). However, it was difficult to hold no prior knowledge on a phenomenon such as disconnection, where there is a large amount of pre-existing literature. Nevertheless, being able to bracket prior knowledge or understanding of disconnection was particularly important for this study as it concerned itself with the experiences and meaning-making of the participants and not pushing existing theory onto their experiences. Reid et al. (2005) suggest that this openness allows the researcher to form "insider's perspective" by keeping interpretations close to the verbatim material obtained through the interviews. What IPA offers is not just the insider perspective, but also the researcher's interpretations of the participants' experiences. This double-hermeneutic approach takes into account that the interpretation made is a dynamic one between the researcher and the participants. Thus, a different researcher may form a different interpretation of the data. However, the interpretations aim to highlight certain aspects of the experiences that stand-out in the interview (Reid et al. 2005). It is a strength of IPA, in relation to some other qualitative methods, that it remains close to the data, but at the same time is willing to make cautious interpretations. This final interpretation of the data is preceded by a thorough analysis of the data.
Following each interview the recording was transcribed. Due to time constraints the researcher analysed the interviews in two batches. The first three, then the three remaining interviews. The transcripts were read several times and the left hand margin was used to put down what was interesting or significant about what the participants had said. After using the left-hand margin, the right-hand margin was used to note down emerging themes (Smith & Eatough, 2007). The researcher used an excel spreadsheet to note down emerging flexible themes along with relevant extracts from the interviews. Flexible themes implies that the themes are emerging, but are not set and could change, split and/or be collapsed into other themes. As suggested by Smith & Osborn, (2004) this stage also involved the responses beginning to move into a more abstract level, thus it evoked more psychological terminology. The researcher also kept simple notes on thoughts, ideas and links that arose during the interviews and transcriptions, but specifically during the analytical process. When all the interviews were analyzed and put into themes and sub-themes, the assembling of the first draft began by defining and linking the themes.

Evaluation Criteria

Yardley (2000) writes there are four elements in evaluating qualitative research results. Firstly, she suggests that results should be assessed by its sensitivity to context including, socio-cultural setting, participants’ perspectives, and positioning of theory. Secondly, results should be considered in the light of commitment and rigour in terms of in-depth analysis, methodological skill and thorough data collection. Some researchers suggest that the term ‘rigour’ is in contrast to qualitative research methods as it evokes harshness, strictness and severity (Forshaw, 2007; Willig; 2007). However, in this study, ‘rigour’, means commitment to systematic progression in the
attempt to elicit understanding and interpretation. Thirdly, the research process has to
adhere to transparency and coherence such as; clarity of argument, transparent
methods, fit between theory and method and reflexivity. Lastly, the results need to be
assessed in terms of impact and importance to socio-cultural context, theory and in
practical implementation.

RESULTS
The interviews generated rich data. The data clustered around five main themes:
Triggers of Disconnection, Function of Disconnection, The Disconnected Experience,
Reactions to the Disconnection and Emerging Connection. Each main theme contains
sub-themes which will be outlined below. The themes are a result of ample data,
however, The Disconnected Experience, Reactions to Disconnection, and Emerging
Connection seemed to provoke stronger and more powerful responses in the
participants and the researcher. It is important to do justice to each theme by delving
deeper into the complexities of the participants’ accounts. However, due to the time
and word limitations of this report it was not always possible to do so.
C. The disconnected experience.
2. Numbness.
3. Disconnection: A safe place
4. A pervasive feeling of not belonging.
5. The unspeakable

A. Triggers of Disconnection
1. In the name of the unlovable self.
2. Terrifying Helplessness.
3. An overloaded system.

B. Function of disconnection.
1. Disconnection: A way of coping.
2. Disconnection: In the name of love and survival

D. Reactions to disconnection.
1. Disconnection: The lost emotion.
2. Disconnection: A double edged sword.

E. Emerging Connection.
1. Connection: Loving all of the self,
2. Finding the language.

Figure 1 - Demonstrating the flow of themes.
Figure demonstrating the flow of themes.

Figure 1 suggests a flow of the findings presented below. The figure is likened to an electrical system as suggested by one of the participants: “If the system is overloaded then the system shuts down...So the disconnection saved me by managing to shut the system down before it was too much (Joey).” Of course disconnection is neither definitive, nor linear. However, this figure may serve as a visual aid to presenting the themes in a comprehensible manner. Firstly, the orange individual arrow represents stimuli that the individual is able to cope with. The bound together orange arrows are the path this information travels and it reaches awareness (represented by the light bulb). Secondly, the large free standing blue arrow represents the theme known as Triggers of Disconnection (A). These are stimuli that the individual feels she/he cannot cope with (also represented by the repeated blue arrows). The Function of the Disconnection, (B), has been described as a coping strategy and also a way to ensure love and survival. The larger orange switch is demonstrating the function of disconnection in that it stops the stimuli from reaching awareness. The disconnected experience, (C), is represented by the narrower arrows that create a feed-back loop where disconnection is maintained or it filters into awareness in some shape or form.

Reactions to disconnection, (D), is not represented in the figure, because meaning does not seem to be attributed to disconnection until after it has reached awareness. Moreover, emerging connection, (E), is also separate to the figure as this theme
explores how disconnection decreases as aspects of the self changes. The themes are presented below.

**Themes**

**Triggers of Disconnection**

The sub-themes are: disconnection: in the name of the unlovable self, terrifying helplessness and an overloaded system (blue arrow in figure 1). The arrow signals that there is something that activates the system. Of course these three sub-themes are not distinct, but for the purpose of this study they have been divided into separate sub-themes.

*Disconnection: In the name of the unlovable self*

Disconnection seem to protect the self when there is something that is unacceptable about it. “It is how acceptable they [emotions] are to me or how acceptable I am...When I feel weak or weak emotions, feeling inferior, I disconnect (Julie).” Some experience anxiety, guilt and regret as unacceptable. “Anxiety I do struggle with. It is a difficult emotion. Like regret and guilt, it is like the helplessness” (Julie). However, there are other emotions that are unacceptable and, therefore, disconnected from.

“The disconnection kicks in when feelings are risky and might have a negative impact on how people see me. For example when I broke up with my ex I felt confused and sad and destroyed. But my first thought is that I don’t want to tell people, because I have to be cheerful, because I am the most unlovable when being sad, angry and a mess. It is just not acceptable” (Joey).
It seems as though disconnection is triggered by threatening subjective experiences against the self.

**Terrifying helplessness**

It seems that the feeling of helplessness is immensely threatening to the self. “With the bereavement there was nothing I could do about it. There was nothing I could do to take those feelings away. I was totally helpless” (Sofie). There is something powerful and desperate in these words. It seems helplessness cuts through to the very core of existence.

“Terrifying. I feel out of control, helpless...I am a failure I think. I think I have that need to be on top of things and when I can’t do that. Then, it is unbearable. I am totally helpless...I mean there is a link between how helpless I feel and how much I disconnect” (Julie).

Helplessness was often uncovered after considerable exploration. When helplessness was connected with in the interviews there was often a loaded silence and a sense of being overwhelmed by it. “I didn’t know what to say anymore, I couldn’t do anything, I was helpless in the interview” (excerpt from researcher’s notes).

**An overloaded system**

“I guess if you are totally powerless, then why stay present, if there is nothing you can do about it. Just so unbearable and overwhelming” (Marie). Disconnection seems to
protect the self when there is no other way out. In essence, when the self is overwhelmed and can’t cope with unbearable experiences.

“As a child I have witnessed emotions that were too much for me. I got overwhelmed. I shouldn’t have seen the emotions that my parents exhibited, nor should I have had to deal with an assault. I couldn’t make sense of it. If the system is overloaded then the system shuts down and I wouldn’t be able to function. So the disconnection saved me by managing to shut the system down before it was too much” (Joey).

There is a sense that what is happening is incomprehensible and there is an incapacity to process information, thus, disconnection served as a way of surviving. “For me it was all too much, to the point that I used substances to disconnect. I guess that way I could survive these, kind of, unbearable feelings” (Pippa).

As mentioned above these sub-themes are not isolated triggers. Rather, they seem to act in conjunction with each other. For example, helplessness seems to trigger something unacceptable in the self and is also overwhelming. The next theme explores the disconnected experience.

The Disconnected Experience

In figure 1 the disconnected experience is what makes up the feed-back loop. In essence, it is how this loop is experienced. The accounts of disconnection are discussed in the sub-themes of body and mind: a separation, numbness,
nothingness/neutrality, disconnection: a safe place, a pervasive feeling of not belonging and the unspeakable.

**Body and Mind: A Separation**

"I’ve had an eating-disorder in the past, um, which I absolutely experienced as a real kind of separation between mind and body, that body doing one thing and mind doing something else" (Marie). There is a sense that the disconnection shuts down the link between the body and the mind.

"I was flying away and leaving body behind...I guess if, if, if, those feelings in my body was just so overwhelming that I just couldn’t process that. Trying to make sense of that would have been mind destroying, so preserve mind and get away from it" (Marie).

It seems the mind was protecting against knowing. There is also the sense that the mind is more suggestible, but at the same time it can control the body or control the pathway between body and mind.

"I think your mind can be conditioned to follow norms. But the body is more trustworthy, but the brain down plays it. I think that when the assault happened I was thinking get out of here, run, I felt trapped and I was being herded into this alleyway. But then my mind said, oh, don’t be rude. You don’t know what is happening. So the mind down played my body. I think that is what plays into the disconnection a lot" (Joey).
Although the mind down plays the body by disconnecting it seems the body remembers and continues to speak.

“I think that that the body wins. I mean with the assault my body knew that there was something not right... I was frighten of going to sleep because the dreams were too much, and heavy. The flashbacks would give me uncontrollable butterflies and I didn’t know where it was coming from. I felt so much more alive compared to the numbness, but I was confused... It was like a civil war between body and mind“ (Joey).

The body remembers and the mind tries to not to know. Thus, there seems to be a conflict between the two. “I didn’t want to own my body as part of myself... that is where the split comes... anything kind of bodily... became the enemy... My mind didn’t want to know it” (Marie). Disconnection is experienced as a split between body and mind. It also seems as this disconnection can be experienced as numbness.

*Numbness.*

“So that is what is going on in mind and in body... numbness or it feels like... I can pinch and scratch and not being able to feel anything” (Marie). Moreover, “... there’s the physical aspect as well, like I’m just numb about things that I should feel a bit excited about or anxious about or frightened about or angry about, but I don’t” (Julie). It is this experience of disconnection that was remembered clearly. Moreover, when talking about his experience at boarding school Pete said that: “I remember it strongly, I could see the roof tops of my house from the school, but I didn’t miss them, I felt
numb.” It also seems that numbness is a signal that disconnection is happening. “I do wonder when I feel empty or numb that I think there is something going on” (Joey).

This sub-theme has been separated (perhaps artificially) from the nothingness/neutrality sub-theme, because it is suggested that feeling numb is feeling something, rather than nothing. Moreover, the participants were more able to express this idea of numbness, whereas, they found it much harder to symbolize nothingness/neutrality.

Nothingness/Neutrality.

How do you express something that is not there?

“Sometimes I think it’s hard to put your finger on what’s going on, it’d be easier if it was something like an added feeling but when it’s something like a feeling that should be there but that’s not there, I find it kind of hard to put my finger on what’s missing” (Julie).

After some reflection Julie said: “...I didn’t really feel any of it at all, it was literally like hearing on the news about something quite irrelevant – just nothing had touched me at all inside.” There was also a sense of stillness. “There’s nothing going in and nothing really coming out, just like nothing” (Sofie). However, it was also spoken about as something missing and a concern about not feeling anything. “It is like an emptiness or a void. A neutrality in the body when there shouldn’t be” (Julie). It also seems that feeling nothing or neutral, similar to helplessness, cuts of the very heart of existence. “I was so disconnected from my body, I felt nothing, absolutely nothing, to
the point that I felt I didn’t exist” (Pippa). As well as being experienced as an uncomfortable void, it also seems this is a fairly safe place.

*Disconnection: A Safe Place.*

Disconnection is also experienced as a separate place where it is comfortable, safe and non-judgemental. “It feels...like being above everything. I can be just a witness to what is going on. I am completely, non-judgemental...it’s like being in a white room...me it’s quite a comfortable situation to be in” (Julie). It is, as if, when there is something internal or external that is unacceptable, overwhelming and/or unbearable this safe space protects the individual. “It was like a separate place, without judgement from me or anyone else” (Julie). There is a sense of serenity in this disconnected place.

“From that point from when I am flying away and literally feeling it...whatever it was, it allowed me to not process that bit in the middle. So yes, it is my mind that needed that safe place” (Marie).

It seems disconnection can create a space that is safe from whatever is unknowable at that point. However, being distant in that safe place also seems create a sense of non-belonging.

*A pervasive feeling of not belonging*

Although disconnection can be safe and protective it seems that it also excludes the person. “I could see things going on but, I don’t feel I’m a part of it...” (Julie). When disconnection is at play it seems to create a sense of not feeling part of what is going
on. Marie has had to disconnect for many years and she said that: "because of that [long-term disconnection] I have a very pervasive feeling of not belonging..." Although not a major theme in this study, it seemed significant to both Julie and Marie. However, this may need further exploration in future studies. There was also something about this sense of not belonging that was difficult to verbalize or express.

*The unspeakable*

The difficulty of symbolizing the disconnected experience is something the participants found whilst disconnected, but also in the interview when they were explaining their experiences. Some were able to verbalize this difficulty, whereas others went quiet or stuttered while searching for words. "I have never really thought about this like this before, but I think you are right, it is hard to talk about it [disconnection] because it is something I never had the language for..." (Pippa). It seems putting words to the disconnected experience was difficult. "I’m not sure, I don’t know how to explain it [disconnection]" (Marie). There is also the sense that disconnection shuts down language and communication.

"I feel it is really hard to process at those points in times. I find it really hard to process what people, ahm, are saying and hard to formulate my own thinking. Speech becomes pretty much impossible, um, so therefore communication becomes impossible...I can’t access thoughts to do that. I can’t process anything (pause) and if I am trying to talk in those moments then, ahm, ahm, you’ll have a word there, um, and a word seconds later and it’s really slow, ahm...she [a friend] asked me a question about something that got a bit close to home, and I started answering and then lost it mid sentence, and I couldn’t find the end of the
sentence, it just wasn’t there, um, to be said that, (pause) I couldn’t connect up my thoughts...” (Marie).

If one reflects on Marie’s statement it seems as though she was finding it difficult to communicate during the interview as well. Although she explained very well what she meant there were many ums and ahms, perhaps reflecting a difficulty in connecting thought and speech.

The Function of Disconnection

This theme is represented by the orange switch. The sub-themes are, disconnection: a way of coping and disconnection: in the name of love and survival.

Disconnection: A way of coping

Not surprisingly disconnection is a way of coping with the triggers. “I had to disconnect. It was a coping strategy. I wouldn’t have lasted there if I didn’t disconnect” (Pete). It also seems it is a way to stay in control. “It is a coping strategy really. Just to be able to feel in control and not feel overwhelmed” (Julie). It seems clear that this is the main function of disconnection. When explored deeper it seems the coping strategy is experienced as a way of ensuring survival, acceptability and lovability of the self.

Disconnection: In the name of love and survival.

It seems the function of the disconnection is to ensure feeling loved and being accepted. “Disconnection tries to ensure that I am more lovable. Being lovable is being protected by the disconnection. Certain emotions are allowed out and in. It
allows me to monitor to make sure I am lovable and acceptable” (Joey). When explored in-depth it emerged that disconnection is also about survival. For example, survival in a difficult environment. “Disconnection was about survival for me. I had to hide my emotions to be accepted” (Pete). Disconnection is also about physical survival.

“...I think it is about survival. It about emotional and physical survival...The whole being. Physically if I wasn’t loved, then as a child then I wouldn’t get any food. So it is about survival and if I disconnected...I could ensure that I am ok and lovable” (Joey).

This sub-theme is strongly linked with the above sub-theme, disconnection: In the name of the unlovable self as it seems the function is to protect lovability and acceptability of the self in relation to others and the world around. Additional to the disconnected experience and the function of disconnection, reactions to disconnection emerged as a theme.

Reactions to Disconnection

This theme encompasses two sub-themes disconnection: the lost emotion and disconnection: a double-edged sword.

Disconnection: The lost emotion.

There was a sense that the there should be a certain emotion that is not present. “I felt like, oh my God I should feel something, so I had to force out an emotion” (Julie). The mind seems to assume that there should be a certain emotion. “Intellectually I am
aware that I should feel certain way but I am not...” (Joey). Disconnection also causes worry about not being able to feel love again. “I worry what part disconnection will play... I don’t want my disconnection because I want to feel love again” (Joey). Disconnection even seemed to cause considerable distress. “...I feel actually quite ashamed of saying it, that I had to force out the tears so that I could tell them I was upset” (Julie). There is a sense that shame replaced disconnection. Feeling disconnected can also be experienced as cyclical.

“It is a real cycle. I mean from my two destructive behaviours I know that bulimia was a way off switching of and not feeling and the self-harm was a way of bringing it back...I kind of blank out by using the bulimia to get to the switch ‘offness’, but then it would be really scary when I was there” (Marie).

Moreover, when disconnection is so effective that actions are not accounted for it creates fear and anxiety.

“Something happened in the time I didn’t remember, I stole petrol. What else could happen then? I was thinking. Does that mean, was there a part of me that chose to do that that I wasn’t aware of at the time? A separate part of me...” (Marie).

Although distress was felt in relation to disconnection it seems the meaning attributed to the distress varies. Moreover, on the one hand disconnection is useful and on the other hand it seems unhelpful.
Disconnection: A double edged sword

Disconnection seems necessary and vital in some situations. “Of course, disconnecting from my feelings was an absolute necessity. If the other boys would have sensed any weakness they would have used it against me” (Pete). During this interview it was interesting to observe that Pete sat with his arms crossed and answered questions forcefully. Perhaps a way of disconnecting from feeling vulnerable in the interview. Disconnection is also useful on a day-to-day basis to manage in distressing environments “I disconnected from emotions around shame, embarrassment and being alone. And it wasn’t until afterwards where I realized that actually that was quite brave to join this group to do these odd things. So disconnection was useful at the time” (Joey).

Although disconnection is considered helpful at times, participants did not seem convinced of how helpful it really is. There is a concern that there are parts of the self that might get lost during disconnection. “…I worry I’m going to lose that part of myself again. If I disconnect I would lose a part of me” (Joey). There also seems to be a drive to be connected. “Being in therapy I have found the motivation, ahm, that connection is entirely preferable in most situations, it is a new discovery really” (Marie). It is this emergence of connection that is explored in the next theme.

Emerging Connection

This theme involved two sub-categories: connection: loving all of the self and finding the language.

Connection: Loving all of the self
The need to disconnect becomes less when the sense of self including thoughts, emotions and body sensations, becomes increasingly lovable and acceptable.

"Through therapy and my home environment and friends, I can be more immediate and learn that I am ok. So feeling that I am ok and lovable. If I can trust that I am lovable then disconnection does not have to play a central role..." (Joey).

Moreover, therapy seems helpful to learn to accept one’s emotions and then, consequently, the self. "If, they [emotions] are more acceptable then, I am more acceptable...The more I'm connecting with myself, the more I’m connecting with others..." (Marie). Moreover, "I have realized that I don’t need to disconnect so much anymore. Ahm. I guess because I am ok the way I am" (Pippa). This seems linked to the function of disconnection. The function is to protect the sense of self from threats, however, when they realize that all parts of them are acceptable then there is little need to protect the sense of self against threats, thus, less of a need to disconnect.

Finding the Language

Another important aspect of decreasing disconnection is finding the language to talk about experiences.

"Connection for me is about language and being able to connect with other people and so that they can fully hear me. Not hearing me in the sense of sound, but meaning. So I suppose it is about connecting with me first" (Pippa).

Perhaps this is linked to the above sub-theme in that it is about connecting with emotions and also about connecting with language. "Having a language...I didn’t have
that before. I couldn't, because I was, I had cut it off and I didn't have anyone to manage it when I was young meant that I didn't have a language for it" (Marie).

There is also a sense that the participants have benefited from finding language to talk about their experiences because they have all been in talking therapy and reported that that is what has helped them connect. "I have been to counselling and it did help me to talk through what was going on for me at the time" (Pete).

**DISCUSSION**

This study has explored six participants' accounts of disconnection. In the study we have seen that disconnection is triggered when there is a perceived threat against the self. There is an emotion or a part of the self that is unacceptable to self and/or to the other. For example, sadness, guilt and/or anxiety are emotions that have been experienced as unacceptable and even making the person unlovable. Moreover, helplessness seems to render the person almost paralyzed, thus, disconnection plays a role in maintaining functionality. This was expressed by the participants and also by the researcher. There is a sense that helplessness strikes at the core of existence. Marie asked: "Why stay present?" That raises the question, what is the fear of what might happen if we do stay present? That is not clear from this study, but it is indicated that it might be about destruction. Destruction of the mind, annihilation and perhaps ultimately death. Thus, in horrific situations such as, sexual abuse, disconnection allows us to survive. In less dramatic situations, though just as important, it protects us from feelings of failure, abandonment and rejection. Perhaps that is about survival as well. After all, if we are unacceptable to others we are marginalized and ostracized. When a human being is an outcast, physical and psychological survival becomes a
struggle. This study has shown that disconnection is necessary at times. We often see clients disconnect in the consulting room when faced with difficult and/or overwhelming emotions. It may be important for counselling psychologists to acknowledge its protective function and explore how and when it has been used in the past to gain a sense of what the perceived threat is. This brings us to the theme, reactions to disconnection.

It seems disconnection brings secondary distress. We have seen that distress is expressed in terms of, shame, worry about not being able to love again and fear of lost memories. The concern is that disconnection is bad, that there should be a certain emotion that is not there. Therapeutically, it might be helpful to uncover lost memories and understanding how, when and what triggers the disconnection so that the person can stay present and perhaps as a result make choices for themselves. That may mean protecting themselves by getting out of a situation, feeling self-compassion and/or finding another way of keeping themselves safe that does not sacrifice parts of themselves. It was seen in emerging connection that staying connected is said to be preferable in most situation. There is a strive to connect to all parts of the self and to others. For counselling psychologists, it seems that the therapeutic relationship becomes immensely important to convey that the person is fully accepted and that we as human being have a range of emotions. There are not just a set of emotions that are acceptable. The consulting room may be a positive space to begin naming those unacceptable parts/emotions because, we saw that finding the language is important for connection to emerge. This may entail accepting disconnection, in a sense, connecting with disconnection.
Moreover, it seems that disconnection can be experienced as a body and mind split where the body knows what is happening, but the mind does not. Thus, there may be room for working with the body in the therapeutic space. Perhaps learning to listen and be compassionate with the body. This may be through mindfulness, yoga and/or other movements that fit for the client. This could provide an alternative way of working with disconnection. For example, Marie explained that the more she connects with herself and accepts her body, the more she is able to connect with others. It is important to note that this is not just to do with disconnection, but also about mental health. In essence, her experience is about being able to connect and accept her body as a part of herself and, thus, her well-being. There is a sense that when the self to self relationship is more accepting the participants feel more able to be present in the world. Of course this is highly relevant to counselling psychology. If we can accept a client we are in essence modelling acceptance. Moreover, it supports Yalom’s (1975) research that well-being is related to regaining lost parts of the self. This is a part of most models of therapeutic practice including, psychoanalytical, humanistic and newer cognitive models such as, schema therapy. Perhaps it is not such a part of manualised therapeutic interventions.

This study adds a phenomenological perspective to the large amount of theoretical work written about disconnection. The theme triggers of disconnection talks about overwhelming stimuli and supports Freud’s (1920/1955) idea of dissociation as a way of defending the psychic barrier against overwhelming stimuli. The theme around the disconnected experience has in some way enriched the understanding of what happens for some people when disconnection is at play. This fits with Auerhans & Laub (1998) when they write about disconnection as a way of storing away pain in the unconscious.
where it is kept safe from harming the self. It also links to when Kalsched (1996) writes about disconnection as compartmentalizing body and mind, discontinuing the experience. That was certainly highlighted by Marie’s, Pippa’s and Joey’s experiences where they explain how the mind and the body were either in conflict or unaware of each other. As mentioned above it also seems as though the body remembers, even though the mind protects itself from knowing. This is also highlighted by van der Kolk (1994) when he writes that the body keeps the score. It also fits with the cognitive theory which suggests that disconnection is a discontinuity between past and a present schema. Which reads that the overwhelming information cannot be processed into the existing schema and is, therefore, disconnected from knowing (Straker, Watson & Robinson, 2002). The participants’ accounts of their disconnected experiences have in some sense made the theory come to life, making it more real. Perhaps this is one of the contributions of the study. This study highlights that disconnection is not just an issue for people on the severe end of mental health, but also an everyday issue that can impact well-being. It seems there is a need for connection to facilitate well-being. However, this report has also shown that disconnection is necessary sometimes. The report highlights how important it is for us as counselling psychologists to meet the client on a relational level, allowing them to be who they are. Moreover, as mentioned above there might be room for working with the client’s relationship with their body in the consulting room.

Complexities of the Study

Due to the phenomenological stance of this study the findings cannot be considered representative of the general population. It is not typically the aim of qualitative research to establish generalizations. Rather, the aim is to gain in-depth understanding
of meaning-making for a particular group and any generalizations should be considered with care. As mentioned above this study makes original contribution to counselling psychology because it is addressing the meaning attributed to disconnection and also highlighting the link between feeling accepted/lovable and decreased disconnection.

In conclusion, this study has explored six participants' experiences of their disconnection. They have shared accounts that have resulted in five themes, triggers of disconnection, the disconnected experience, function of disconnection, reaction to disconnection and emerging connection. Some implications for practice were discussed, alongside some new questions raised around disconnection and discourse. Disconnection seems to have implication for well-being, not just for people who have suffered trauma. Rather, it is a coping strategy used to maintain acceptability, but has a cost in that parts of the self are lost or hidden.
REFLECTIONS

I tend to have trouble with ending researcher reports. Perhaps it is a reflection of my difficulty with endings in general. I want to end it fast and without having to feel sadness, loss and pain. I tend to disconnect from those unacceptable emotions. I think my interest in disconnection is a personal interest. I grew up in a household where there were many rules and it was clear what was unacceptable and what wasn’t. I felt that there were parts of me that were unacceptable and I have re-gained some of those parts through my own therapy. I also strive to connect. Connect with myself, others and the world around me. However, I continue to be curious about what disconnection is and how it works. Why do we need it? That is why I conducted this study. Perhaps this is also reflected in the use of IPA. It is a method that requires the researcher to connect and relate to the participant on a deeper level. My strive to connect is also evident in the researcher question as a whole. Moreover, it is likely this has guided my reading about the topic. I tend to connect well with existential and psychodynamic literature around the subject. Perhaps this is something for me to bear in mind in the future, to allow me to broaden my literature base.

It has been interesting, frustrating, overwhelming and difficult to write. The interesting part has been hearing others.’ I was amazed by how open they were about their experiences and how connected they seemed during the interview. The frustration is around this being the last piece of work I am writing for this Doctorate course and I am exhausted. I keep saying I have gone so far over the edge that I am just hanging on to the cliff face hoping the harness will hold me. It has also been overwhelming due to the nature of disconnection. There was so much information and I had the feeling that when the participants begun speaking of their disconnection the
flood gates opened. Often it was difficult material that was shared such as, sexual abuse, rape, eating disorders, suicidal behaviour (past behaviour), self-harm and deep depression. In essence, I asked these people to connect with material that has been so overwhelming, that they have disconnected from it in the past. However, the interview that was the most difficult for me was not one of these where trauma had been experienced. Rather, it was with a woman who was very similar to me and who disconnected in similar ways. Together we got to the triggers of her disconnection which was that she was concerned about being unloved if she was to fail. Her processes resonated for me.

This report has been difficult to write. Not because I’m not interested in the topic, but because sometimes it was so abstract that it was too hard to put into words. Perhaps I have been overwhelmed by it all and I have ended up frustrated. It has felt as if there have been flares of connections to words and then total emptiness. I then ended up trying to force out the words and it was just crass. I think this is similar to disconnection in that it was not ok for me to not be connecting with words and language, but I pushed myself so hard that I ended up being self-destructive. However, you cannot force data analysis and I learnt to trust the research process by stepping away from it. In a sense, letting the interviews form their own themes instead of me pulling them out. When I begun to do that I realized the themes are there and I will let them emerge. That way I had fun with the data and could be more playful and listen to the participants’ accounts. I think I was able to listen to the participants and their stories without pushing theory on to them. However, there was a sense that they already embodied a psychotherapeutic discourse, because they spoke of something unbearable, overwhelming and a body and mind split. For me this was about trying to
unravel what those concepts meant to get to their experience. It was interesting how quickly we could get to the deeper meaning when the reflection was about disconnection, not about what they were disconnected from. It was helplessness that has puzzled me the most. I actually struggle to put words to that experience. To connect with helplessness leaves me with a sense of desperation and I am unable to express what it is. I would like to explore this in further research, but also what it means to me. I finish this reflection on the use of self in this research endeavour relieved and slightly fragmented. Perhaps it will take time for this to all fall in to place.
References


Appendices
Appendix 1

A Study on Disconnection
Have you ever felt numb, overwhelmed or ever wondered how you didn’t know how you were feeling or what was going on for you? Would you explain that as feeling disconnected or cut off from experiences, feelings, events or your body (there may many other things) or external things like other people, the environment, events or anything else? If, so would you like to take part in a study exploring people's experience of feeling disconnected from parts of themselves, others or from the world? If you are interested in participating in this study, please contact me on email Louise Brorstrom, at l.brorstrom@surrey.ac.uk.

Sincerely yours,
Louise Brorstrom
Counselling psychologist in training.
University of Surrey.

Supervised by:
Dr. Martin Milton
Department of Psychology
School of Human Sciences
University of Surrey, Guildford
GU2 7XH
UK
Appendix 2

A Study on Disconnection

I'm a doctoral trainee in Counselling Psychology at the University of Surrey. For my doctoral research I am interested in exploring people's experience of feeling disconnected. You might have experienced disconnection from, experiences, feelings, events or body (there may many other things) or external things like other people, the environment, events or anything else. Disconnection from something internal and external is something we all experience. I would like to find out more about how you made sense of this and how you experienced it.

To take part in this study you will need to be aware of having felt disconnected from yourself, others and/or the world at some point in your life. Participation will take the form of an interview and will take place at the University of Surrey, at a time convenient for you. The interviews are expected to last for about one hour but, can last longer if so required and will take place between February 2009 and May 2009. If, you suffer from adverse reactions to connecting with difficult material such as, re-traumatisation, panic attacks and/or aggression it would not be appropriate for you to take part in this study.

The interview will be recorded on audio tape. This will allow for some of your responses to be reproduced in the final research report. The tapes will be kept in a secure location until they are transcribed by me. The tapes will then be erased. At all stages of the research your name and names of any other people mentioned, will be changed, as will any other identifying material in order to protect confidentiality. You have the right to withdraw from the research at any point without providing a reason.

On completion I would be happy to send you a copy of the study.

If you are interested in participating in this study, please contact me by leaving a message with the department secretary at the university on 01483-689-176 or you can email me, Louise Brorstrom, at l.brorstrom@surrey.ac.uk.

Sincerely yours,

Louise Brorstrom
Counselling psychologist in training.
University of Surrey.

Supervised by:
Dr. Martin Milton
Department of Psychology
School of Human Sciences
University of Surrey, Guildford
GU2 7XH
UK

Appendix 3

Screening
1. Do you suffer from any mental health problems such as, panic attacks, high anxiety or current depression (or anything else that is relevant)? If yes, how does it manifest?

2. When feeling distressed, how do you support yourself?

3. Do you consider yourself having a support network you could approach if you found the interview distressing?

4. In the unlikely event that this interview would cause you distress, would you be happy for the researcher to contact someone to ensure you are supported such as, a friend or relative? If yes, please include contact details.

Name: .............................................................
Home number: .............................................
Mobile number: .............................................

The above information above is accurate to the best of my knowledge.

Please sign and date.
Appendix 4

Dr Adrian Coyle
Chair: Faculty of Arts and Human Sciences Ethics Committee
University of Surrey

Louise Brorstrom
Psychotherapeutic and Counselling Trainee
Department of Psychology
University of Surrey

3rd March 2009

Dear Louise

Reference: 297-PSY-09 RS
Title of Project: Understanding dissociation: A phenomenological analysis

Thank you for your resubmission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has given favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Yours sincerely

Dr Adrian Coyle
Appendix 5

Research Consent Form

Title: "Understanding dissociation: A phenomenological analysis."
Author: Louise Brorstrom, Counselling Psychologist in training, PsychD
Psychotherapeutic and Counselling Psychology, University of Surrey.
Supervised by: Dr. Martin Milton.

- I the undersigned voluntarily agree to take part in the study on "Understanding dissociation: A phenomenological analysis."

- I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised about any discomfort and possible ill-effects on my health and well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

- I agree to the interview being audio taped for the purpose of transcription.

- I agree to co-operate with the interviewer during the interview. I shall inform the interviewer if I feel distressed during the interview and the interview will be terminated if I request.

- I understand that all personal data relating to participant is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).

- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

- I acknowledge that I will not receive payment for any participation in this study.

- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of participant (BLOCK CAPITALS)
Signed
Date
Appendix 6

Demographic Questionnaire

1. With which of the following groups do you most identify?

White
British
Irish
European
Other

Black
British
Caribbean
African
Other

Asian
Indian
Pakistani
Bangladeshi
Chinese
Japanese
Other

Middle Eastern
Iraqi
Iranian
Lebanese
Other

Mixed
White and Black Caribbean
White and Black African
White and Asian
Other

Other

2. What is your gender?

Female
Male
Transgender

3. How old are you?

Under 20 years
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
Over 70

4. What is your highest qualification?

None
O-levels
A-levels
Diploma
Degree
Postgraduate
Appendix 7

Interview schedule

“Understanding dissociation: A phenomenological analysis.”

Introduction

Introduction of the researcher and the nature and aims of the research project.

“Thank you for taking your time today and agreeing to take part in this interview. My name is Louise Brorstrom and I'm currently doing some research as a part of my doctorate in counselling psychology at the University of Surrey. I would like to use this time to talk to you about your experiences of disconnection.

Discussion of confidentiality.

“Confidentiality of audiotapes will be assured and following the transcription the tapes will be erased. During the transcription names will be given a pseudonym and any other identifying material will be omitted to ensure you remain anonymous. All parts of this recording is only for the purpose of this research study.”

Explain right to withdraw without explanation and their right to not answer questions if they do not wish to.

Acknowledge that both of us have signed the consent form at a previous time.

Acknowledge the previous completion of the background questionnaire.

Address any potential questions the interviewee has at this time.

Turn on the audio tape recorder.

The interview is semi-structured which means I will be following your lead as to what you think is important for us to talk about in terms of your experiences of disconnection. Before we start, do you have any questions?

6. You have said that you have experienced feeling disconnected. Can you tell me more about that?

- What makes you say that?
- What does that mean for you?
- That’s curious?
- How do you make sense of that?
- What shape or form did it take?
- Where did you feel it?
- Can you explain that for me?
- How did you become aware of it?

7. You have told me there is a sense of feeling disconnected. How does that come up in your life?
   - What makes you say that?
   - Can you say more about that?
   - How does that affect you?
   - It what sense?
   - Why do you think that is?
   - In what ways?
   - What does that mean for you?
   - That's curious?
   - How do you make sense of that?

8. Could you tell me about a time when you felt disconnected?
   - What makes you say that?
   - Can you say more about that?
   - How does that affect you?
   - It what sense?
   - Why do you think that is?
   - In what ways?
   - What does that mean for you?
   - That's curious?
   - How do you make sense of that?

General Prompts:
Can you tell me more about that?
What makes you say that?
How do/did you feel about that?
How/why do you think that as happened?
What effects do you think that has?
How do you think that affects...?
How do you make sense of that?
Can you give me an example about that?
Are there any other aspects/factors?

Ending the interview.
- Before we come to an end is there anything you would like to add to the topic that we have not had the chance to chat about?
- It would be helpful for me to reflect on the interview for a minute. What has it been like for you?
- How are you doing/feeling now?
- How did you feel about the questions asked? Do you feel they were relevant to the subject? Are there any questions that you would asked?
- Thank you for participating.
- Explain how they can obtain a copy of the research report.
Appendix 8

Interview with Marie.

L: Could you tell me a bit more about your experience of disconnection.

M: I guess because I think the word disconnection itself um, was probably the bit that I tuned into, um, my own experiences are because I’ve had an eating disorder in the past, um, which I absolutely experienced as a real kind of separation between mind and body, that body doing one thing and mind doing something else and not um feeling like I was taking ownership of my body in what I was doing. Day to day nowadays I don’t think I experience it so much but I know that if I’m feeling stressed or anxious then kind of my first cue to recognising that is feeling quite spaced out and, kind of, I don’t know the (pause), yeah I don’t know, things look different at that point I’m not sure I could say how, that I guess things look further away and I have a numbing in my body at that time as well, that if I where to pinch my skin, touch my skin I wouldn’t feel it

L: Really so it’s actually you’re body’s actually kind of manifesting it as well?

M: I don’t know if it is or not I think that way I choose to see it is that I’m just not connecting within myself at that point in time so I’m sure that my body is registering that sensation but I’m not connecting to my body at that point in time so I can’t, that’s how I make sense of it in my head that um things could be happening to my body I’m not going to be feeling it but that doesn’t mean that (pause) that pain can’t be registered it’s just that my mind at that point in time just isn’t registering it, does that make sense.

L: OK, I think so. It sounds really interesting. I’m just trying to get a little more, if you could say more about it or what comes to mind for you, cause it seems like you’ve had experience of an eating disorder that seems really interesting and if you want to tell me about it that would be really helpful, if not that’s alright as well, but also the day to day experience that you don’t have that much, but a bit, so it happens with being (interruption)

M: yeah I’d say I don’t have it so much now because I think I feel that things in my life are a lot more manageable now, but I do recognise that, as I say, it’s my cue to knowing, then there’s something up here that I need to be dealing with um my experience of an eating disorder in the past was bulimia um which was over 12 years before I sought help for that um and I think certainly in the beginning phase of that I would be in a completely separate state of consciousness that (pause) to the extent that sometimes I need the cue the next day of seeing,(pause) of seeing kind of rapids or whatever to know that I’ve been there, that it feels like it’s a different zone.
L: I guess complete split or something, like it’s not you or

M: Yeah, no it is, I’m not disowning it and I don’t but I think the experience is at that
point that I don’t know that it’s banished your body or that (pause). I don’t know.

L: You seem to have really emphasised the split between mind and body, so is that
kind of where the disconnection takes place for you in this as well, the kind of mind
and body disconnection.

M: Yeah, my past experiences were abusive, um so I think, and if someone had said
ever to me at any point in time that I blame myself for what happened I would have
absolutely denied it but then I realised a lot more recently that I was blaming my body
but not seeing that as part of myself.

L: Okay

M: So that’s how I made sense of the split for me that I wasn’t, (pause) that I haven’t
blamed myself for my passed experiences because I haven’t owned my body as part of
myself, so for me that is where the split comes in that I’ve kind of owned, mind and
thinking and, and anything kind of bodily and feeling then that’s (stutter) almost
became the enemy I guess, um so if, yeah I guess times of high anxiety or whatever
the you revert, don’t you, to the familiar and to the known and for me the familiar and
the know is, is, to create that split again and in a way use that as a resource to then
manage how I’m feeling.

L: So in your early experience it’s been a really necessary way for you to kind of
survive or function in some ways, and now at times you might fall back on it because
you know how that works, the disconnection, would you say that?

M: How do you mean?

L: You say in terms of high anxiety, and then you might fall back on it

M: Yeah but at those points it doesn’t feel like its something I’m in control of, it’s not
something I’m choosing to fall back on. I think it’s just an autom, (pause) it feels at
this point in time it feels like an automatic, kind of, (pause) way of protecting myself
I guess, which means that, (pause) it, it means that I really do have to consciously
think what’s up because, I guess those normal cues, those normal bodily cues and
emotional cues that was telling me what was up, have become the problem in
themselves because they have become the bit that becomes split out so it’s, um I then
don’t have those as a resource to know where I’m at and how I’m feeling which I
think is why then I can feel quite confused at that point in time because it’s, (pause)
um yeah, (pause).

L: It’s difficult. I’ve noticed that quite a few people find it quite difficult to talk about
the disconnection because I think it’s kind of the absence of something; it’s quite
abstract to talk about it.
M: It doesn’t feel hard to talk about in the sense of I’m quite happy to talk, but, yeah to kind of know what I’m describing, when, at those points in time I don’t feel that present. I was at a friend’s house on Friday and that this is the most recent time that over quite a while that I’ve been aware of it outside of therapy, um, that I was at a friend’s house on Friday um and she asked me a question about something that got a bit closer to home, and I started answering and then lost it mid sentence, and I couldn’t find the end of the sentence, it just wasn’t there, um to be said that, (pause) I couldn’t connect up my thoughts, um, and then after that I was aware that I was getting quite jumpy, so I was like I’m feeling quite vulnerable now, um, but it is a real forward step of needing to take each thing and actually process and think about it and rather than having that flare of experience, I guess.

L: But you seem to have done a lot of work on knowing when it happens and you seem very aware that, ok, something is going on.

M: Yeah, because I also know that is has the potential to be unsafe. Aham, that, aham. I think that because (muddled) some of the self-destructive behaviours that I have had in the past, aham, if I haven’t been able to feel my body then I want to be able to do that again. It’s not a nice feeling. So times in the past when I have self-harmed I have been trying to get sensation back into the body and, aham, it doesn’t work because that is not how to, that is not how to do it I have realized. It is a real cycle. I mean from my two destructive behaviours I know that bulimia was a way of switching off and not feeling and the self-harm was a way of bringing it back. Aham, so it was using those two things that helped me keep equilibrium, that’s how I see it. I kind of blank out by using the bulimia to get to the switch offness, but then I would be really scary when I was there.

L: I’m curious about how the disconnection works for you...

M: Ok, in mind, it feels like numbness, there is nothing there and I feel it is really hard to process at those points in times. I find it really hard to process what people are saying and hard to formulate my own thinking. Speech becomes pretty much impossible so therefore communication becomes impossible. Being able to find a thought, find words, I am working on it. In that moment I am in an empty void in my head, there is nothing. Even though I know I am being distressed and it would be helpful for me to put words to it, I can’t access thoughts to do that. I can’t process anything and if I am trying to talk in those moments then you will have a word there and a word second later and it is really slow, aham. Yeah absolutely cut off and I can hear what people are saying so it isn’t so much hearing what people are saying, it is being able to process it and respond to it. It is really hard.

L: So you know what is going on?

M: Yes, but it is far away. I am connected to that, but numb at the same time. I know that someone is there. It is just very distanced. It is hard to, eh, eh. The most intense times I have been feeling this lately is in therapy so I am trying to recall and say what it is like. So I know that if my therapist is speaking in those moment I know that she is there and that she is speaking, but I don’t know. But I would need like a minute to respond to that. So that is what is going on in mind and in body it is either, numbness
or it feels like, ahm, I can pinch and scratch and not being able to feel anything. Or else it feels like my body just takes over and kind of, and I find that hard to regulate then because I can't talk myself down at those points. Behaviour, self-harm, was a way of taking control over the situation.

L: You said your body takes over so is the behaviour related to that?

M: No, it is me trying to take control over what my body is doing. With my bulimia in the past it felt absolutely that whatever my body was doing I could get some control over that. Because physiological the changes that you make to your body in binging and then in purging are quite phenomenal, the change in your heart rate, in your breathing and the pressures at different parts of your body. Which was absolutely the drive for me in the past. Ahm, ok because feeling a high state of anxiety I was not in a place in my head where I could do something about it, but I could physiologically do something about it by that behaviour. Sounding quite crazy isn't it?

L: It is interesting cause there is something there are the disconnection that is necessary, but also the connection is necessary?

M: The disconnection is an attempt to escape, I have some idea in my head that I am powerless to do anything about it, but I can escape in other ways. And the way I made sense of it is that the attempt to connect is just very human. The things, that, that, the disconnection from others and the self goes against everything, every developmental drive that we have. Yeah so I find it quite reassuring that I still have that drive so that I do come back even at those times. It feels like such as swinging at that time, it is a push-pull and I end up not knowing where I am. I am glad that those drives are still there and I think that must be instinct. That is how I make sense of it.

L: Could you say a bit more about the escaping?

M: Escape from body, escape from body that I have positioned as enemy. Ahm, my, I guess in the past when, if, my body was out of my control and I guess in the ancient past my body was outside of my control. The sometimes now I feel like I am reacting to something, feeling angry, fear and it is a real fear that. What then will happen then if I lose control of my body again? So my head wants to switch of and does not want to process that and wants to keep control over it.

L: So it is about safety?

Yes, but, it a very defunct way. In mind it is. Ahm, kind of, yeah, it feels like it is about safety and survival. I I I, I guess, ahm, I don't, I. I don't know how much kind of, you want me to talk about the past, which is where I kind of remember and experiencing it?

M: As long as you are comfortable with it.

I feel very processed so it is good. Ahm, so yes. I have a fragment of a memory or an abusive situation feeling, where it wasn't, I couldn't escape. Trying to escape to one place, trying to escape to another. Essentially being held into place, into my body,
ahm, so therefore not being able to get away from that. Feeling like right I just have to fly away from this, my memory was like I was flying away and leaving body behind...So I don’t know if that was, if that comes down to...I guess if, if, if, those feelings in my body was just so overwhelming that I just couldn’t process that. Trying to make sense of that would have been mind destroying, so preserve mind and get away from it. I guess. I guess. From that point from when I am flying away and literally feeling it, then that fragment of that memory ends, ahm, until it is finished. Ahm, whatever it was it has allowed me to not process that bit in the middle. So yes, it is my mind that needed to go to that safe place.

L: So it is too much to process.

M: Yes, the point as to which is something feels overwhelming. Ahm, don’t know. Why stay present? I guess in a situation where you are powerless, really, why stay present. As far as adaptation goes and keeping on using that is not useful or helpful, but I guess if you are totally powerless, then why stay present, if there is nothing you can do about it. Just so unbearable and overwhelming. Yeah. Yeah. I don’t know how to explain it.

L: It is hard to put words to it.
M: Yes because if there is a nothingness and a numbness, then what is there? And I can’t say what is there. I had an experience in 2006, which was the last episode when I was unwell. I went to a petrol station I was aware that I needed petrol, I was looking at that petrol tank and I knew I needed petrol. Also, I had other things in my head that were stressing me out and the next thing that I was aware of was being a lot further down the A3 with petrol in the tank and a card in my hand and I was not aware of if I had paid for the petrol or not. I panicked, came off at the next exit and kept looking the mirror the whole time thinking that they were going to send the police after me. Got there and I hadn’t paid, I apologized and said I’m pretty sure that I have filled up here, I don’t know how much or what tank. No you haven’t. They were absolutely fine about it. Where ever I was in my head at that point I got out of my car, filled up with petrol an kept on driving. But there was nothing within that bit that kind of, I guess, a lot of people that drive, but if there is a change there is a cue there and you kind of wake up, but there was not cue for me to come back in.

L: So there was a cue for you to disconnect?

M: Yes, I won’t go into the context but I remember what that was now. I have talked about this a lot and I have processed it. And there was a thought that told me to leave. And the things I was thinking about at that time I couldn't deal with it. I don’t know how I came back at the time. I just remember being in my car and looking at the car didn’t have any petrol in it and coming back. But that bit in the middle I don’t know. That was the most pronounced time I had such a loss and I really panicked. I was working somewhere else then, ahm, so I drove to work and grabbed a friend and cried in the staff room. I didn’t know what that means, and what else could happen then or what was going on with me. Ahm.

L: So something about loss of control?
M: Absolutely! Totally about the loss of control. Something happened in the time I didn’t remember, I stole petrol. What else could happen then? I was thinking. Does that mean, was there a part of me that choose to do that that I wasn’t aware of at the time? A separate part of me. What could have been the consequences if I didn’t realize...I mean in the past the disconnection has been necessary, but in this context it is totally maladaptive. So I think it is totally context dependent if it helpful or not.

M: It seems it takes a lot of energy to be aware of the disconnection.

L: It does. Most of the time it does not feel in my head like it matters. But there are times when I think there is times where I have to think and work through things in my mind and that’s fine. Other times I am glad that I am not as connected to things like other people because it feels like things are much more manageable. Now they don’t come around as often. I mean before I did not have the motivation to do anything differently. It is only in the past years that that had become an issue or something I am motivated to do. Being in therapy I have found that motivation that connection is entirely preferable in most situations, it is a new discovery really. In my head petrol station was a problem and most other things weren’t.

L: Does this affect your connection to other people?

M: Yes, in the past more than now. I had to think very hard...ahm, I mean, I wasn’t intuitively empathic, Although people thought that I was. I had to think so hard about what I was seeing and hearing, but I had to logic through in my head and I would then present it in a way that seemed empathic. Because I wasn’t connecting enough to my own emotions to I didn’t use them to inform me to be empathic. But I could use logic to infer what people might be thinking or feeling. I looked very connected, I was growing up I was very popular, but it didn’t feel natural to me. So I have a very pervasive feeling of not belonging, fitting in, it is not a part of me. It does not feel like a natural connection process. It feels like something that I have to work it out. The more I am connecting with myself the more I am connecting with other. But in the past I used to get very worried about it. And I used to think what is wrong with me that I just don’t get it. I was just very lucky to have the skills to do that. It looked natural and like it was working. But it didn’t work for me. I think there are easier ways of being in the world.

L: As you connect with your emotions...

M: Yeah it is that it is ok to feel. Specifically that it is ok to feel x, y and z without attaching another meaning to it the way I used to do it in the past. Ahm, I think because I was pathologizing myself so much that if I was anxious that meant I couldn’t hold it together the way others could, if I was sad then that meant I was dwelling on the past and I just needed to get other it. So you know, injunction against feeling sad. So an injunction against everything and just accepting feelings as feelings and not attaching another meaning to it has increasingly made it possible for me to feel. It is more acceptable I guess. But having a language for them as well, I didn’t have that before. I couldn’t, because I was, I had cut it off and I didn’t have anyone to manage it when I was young meant that I didn’t have a language for it. That meant that no one, my parents would have, I grew up next to with a sibling that is out there
with how he feels about everything and my parents thought that he needs to be
managed and I was someone that was contained and just got on with things. I think the
idea was that I was self-contained, but actually I wasn’t in touch with my emotions.

L: You said that when your emotions become more acceptable you disconnect less is
that right?

M: Yeah, because I guess, if, they are more acceptable then, then I am more
acceptable then it is not so much about all or nothing. I still do it, but that is only when
I feel something more intensely and I get let in lower levels of stuff without having to
switch off. It is less intolerable. I mean the I know that emotions are not incontrollable
anymore. I also know that I won’t lose control over what I will do or of my body
functions. That it is pretty useful to know what I am feeling.

L: So with your friend this weekend, you said that you know what was happening, you
felt a bit spaced out and that was a cue.

M: Yes, now I know that, but not before. I cut off midsentence and I feel spaced. I am
also being much more vocal about it like this interview and my friend then knew what
is up and she can say what’s going on? So my close friends then know, that maybe we
need to have a chat right now.

L: Are there other things that helps you connect?

M: ...I don’t know. Instinctively in the past I wanted to shut people out so now I feel
much more open. I am much more likely to give someone a ring which I wouldn’t in
the past. I don’t know. Day to day I don’t know. Life is pretty good now, three years
ago I was in such a bad state. I am enjoying my work and it feels good. I enjoy my
social life so, I don’t know. It is hard to know. I have an infinity with being outside,
but I don’t think it is related to connection. I like the sensory stuff, hearing twig snap,
but I don’t think that is a strategy. Starbucks! I think Starbucks!

L: Well, I think we have covered my questions, is there anything that you think we
could have covered but we haven’t?

M: No, not really. I am surprised how much you got out of me really.

L: How do you feel now at the end of the interview?

M: Good, it feels like a vindication to have been able to talk about it.

L: Are there any questions that you think I could have asked, but I didn’t.

M: Ahm, no. Not really. I am sure I will have so much more to tell you in a while. But
I will take it to therapy. I go three times a week.

L: Ok, well, if there is anything please feel free to contact me. Are you ok if we turn
finished there.
M: Yes that is fine.

L: Ok. (turns the recorder).
Appendix 9

Journal of Contemporary Psychotherapy
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