HOW DO PSYCHODYNAMICALLY ORIENTED THERAPISTS UNDERSTAND, RESPOND TO, AND WORK WITH NEGATIVE RACIAL SENTIMENTS AMONGST TRAUMATIZED CLIENTS?

By

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DECLARATION OF ORIGINALITY

I declare that this research report is my own unaided work, and that I have given full acknowledgement to the sources that I have used. It is being submitted for the Degree of Masters of Arts (Clinical Psychology) at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.

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Tracy Sharon Fletcher

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ABSTRACT

This study explored how psychodynamically oriented therapists understand and work with negative racial sentiments arising in traumatized clients. One of the aims of the study was to highlight and examine the technical, countertransferencial and ethical dilemmas faced when a patient brings 'politically difficult' material infused with negative racial sentiment to therapy. It was hoped that information gleaned would contribute to theoretical and technical understanding of this phenomenon and assist in working with such negative racial sentiments. In order to investigate the research questions eight therapists who identified themselves as 'psychodynamically-oriented' participated in semi-structured interviews on the topic of negative racial sentiment (NRS) in therapy. The study was located in the qualitative research tradition, and interview transcripts were subject to a critical thematic content analysis. The main themes were identified and presented under three sections, namely: how therapists *understand*, *work with* and *respond to* the phenomenon of NRS in traumatized clients. Understandings included the formation of NRS as inter alia reflecting the use of defenses such as splitting, projection, projective identification, the triumph of the bad object and a breakdown in the capacity to symbolize. Tensions in understanding the phenomenon of NRS post-trauma and related latent themes were also identified. Therapists' approaches to working with NRS included the use of a range of implicit assessment criteria such as, whether, for example, the patient's response was experienced as ego-dystonic or ego-syntonic. Technical strategies for intervention included adherence to a working model, interpretive interventions and cognitive strategies. The participating therapists' countertransferential responses to negative racial sentiment were categorized, taking the form of: negative feeling towards or disidentification from the patient; negative feeling towards the perpetrator or identification with the patient and therapeutic impasse. Some guidelines proposed by the participating therapists for managing NRS, as it occurs in psychotherapy with traumatized clients, are presented.

In world history, those who have helped to build the same culture are not necessarily of one race, and those of the same race have not all participated in one culture.

Ruth Fulton Benedict

TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTORY CHAPTER

He has got intense feelings of hatred and racial sentiment that include everybody, even Nelson Mandela. It was a two-hour ordeal. Throughout the attack comments were made about how all white men deserve this. He was essentially a sacrificial lamb for white men. There is absolutely no ambiguity for him around black people. His overriding experience was of not being held and of feeling unbearably alone, wishing there was somebody out there to put their arms around him. [T4]

She is a black woman and her son was killed. She was very racist for a while. She herself is a sangoma (traditional healer) and was held up in her family home. [T5]

It was a Xhosa guy with Zulu perpetrators and it became a Zulu thing. [T6]

1.1 RATIONALE FOR THE STUDY

Sexual, domestic and interpersonal violence such as hijackings, armed robbery and assaults continue to occur in South Africa (Leggett, 2005)(See Appendix B for statistics). In Johannesburg the need for trauma counseling has grown considerably as evidenced by both the increasing number of debriefing centers and the number of therapists in practice finding themselves having to address trauma issues in the context of long and short term therapy (Eagle, 1998b). There is a considerable body of work on trauma in the psychodynamic literature and psychodynamic theory informs the intervention style of a number of trauma practitioners in South Africa and in Johannesburg. However, little or none of this theory deals with negative racial sentiments in the aftermath of trauma, despite the fact that this phenomenon is frequently observed in practice (Benn, 2006). The concern has arisen that ignoring post-trauma client prejudice is unhelpful to clients, impairs their psychological healing or psychological functioning (Frosh, 1997; Rustin, 2001; Schlachter, 1995), and may well inhibit the integration of the traumatic experience into their lives.

Regardless of any conceived positive social or psychological gain for the individual harbouring negative racial sentiments, several detrimental psychological effects accompany discrimination as presented in the psychodynamic literature on racism, where it is suggested that racism is a 'primitive' response or defense (Frosh, 1997; Lane, 1998; Rustin, 2001). In the psychodynamic literature on racism it is argued that racism is psychically toxic for the individual who harbours such sentiments and that racism represents a regressive form of functioning. Thus, in and of itself, racism may be

understood as pathological, whether it follows trauma or not.

During trauma work, the therapist is dealing with serious trauma related symptoms such as flashbacks and intrusive thoughts (Herman, 1992; Janoff-Bulman, 1990; McCann & Pearlman, 1990). These symptoms often form the focus of trauma debriefing, as opposed, for example, to confronting virulent, racialized post trauma content. A potential dilemma has been identified in which therapists risk causing 'secondary victimization' to the client (McCann & Pearlman, 1990) by engaging with such sentiments (particularly given that working with client racism has the potential to be shaming and challenging in the post-apartheid South African context) but where ignoring prejudice has potentially negative consequences for the patient at a psychic and social level. The study was thus intended to investigate and document aspects of this issue from a practitioner perspective.

1.2. KEY AIMS

The research aimed to explore how negative racial sentiments arising in trauma clients are understood, responded to and worked with in therapy by psychodynamically oriented therapists. The study also hoped to explore the possible ethical dilemmas that might arise for the therapist in this context as well as possible countertransference responses.

1.3. THEORETICAL ORIENTATION

A psychodynamic perspective informs the study and so views of psychotherapy, trauma and racism presented are psychodynamic in orientation. The term 'psychodynamic' refers to the study of dynamic or conflictual elements of the psyche, or mental processes (Lemma, 2003; Rycroft, 1995). The term 'psychodynamic theory' may be used to refer to both the approach of classical psychoanalysis, which grew out of the clinical work of Freud, as well as to contemporary theory that grew out of the work of Freud and others, such as Kleinian theory, object relations theory, ego psychology, attachment theory and self-psychology. For the purposes of structuring the literature review a distinction was made between traditional Freudian contributions and object relations theory. Freud's instinct theory focuses on the individual's need to reduce instinctual tension whereas object relations theory focuses on a person's relationships to their internal and external objects (Fonagy & Target, 2003; Lemma, 2003). Psychodynamic understanding allows idiosyncratic meanings of trauma symptoms and responses to be considered (Eagle &

Watts, 2004a). Both ‘responses to trauma’ and ‘racism’ are deemed by psychodynamic theory to be areas in which strong unconscious elements as well as conscious forces and social discourses operate.

The research does, however, acknowledge that many other interpretations and methods of explaining trauma and racism exist and may add alternative understanding to the research topic.

1.4 THE FIELD OF TRAUMA, RACISM AND NEGATIVE RACIAL SENTIMENT POST-TRAUMA

Given that there was an absence of prior study in this specific field, the range of theoretical and research material drawn upon in the research report straddles several bodies of literature. This includes literature on the psychodynamic therapeutic stance, on traumatic stress impact and on some psychological understandings of how racism develops.

It was only as recently as 1980 that posttraumatic stress disorder was formally recognized as an anxiety disorder (Friedman, 2003). Subsequently, several, researchers have written about the challenges faced by therapists working with trauma. Trauma evokes responses to events outside of the range of usual life experience (Janoff-Bulman, 1992) and the therapist’s task is to contain these responses that have the potential to overwhelm a person’s coping mechanisms or, in the context of this study, to moderate the development of malignant internal object relationships (Garland, 1998). Brief term trauma psychotherapy, from a psychodynamic perspective, aims to contain the overwhelming effects of the trauma on the patient, preventing regression and the use of primitive defenses (Garland, 1998; Horowitz, 1992). In order to integrate traumatic experiences, a survivor needs to make sense of their particular response (Lemma & Levy, 2004) and the therapy aims to facilitate this.

Up until fairly recently psychoanalysis has been criticized by authors such as Suchet (2004) for the relative absence of attention to racism and serious analysis of the construct of ‘race’, except for the work of Franz Fanon in the late 1950s. However writers such as Frosh (1997), Lane (1998), and Rustin (2001) have applied concepts originally used to refer to internal processes more discursively to broader social interactions. In this way

racism has been understood either as a manifestation of man's primitive aggression (Lane, 1998), a form of 'societal splitting', or as the projection of undesirable aspects of the self into the 'other' (Frosh, 1997; Rustin, 2001). The focus of this paper is limited to psychoanalytic understandings of racism and prejudice as they occur in the clinical setting after a patient has been through trauma. However, given the limited material on this topic, a broader overview of psychodynamic theorization on racism is provided.

Psychotherapy aims to be a helpful endeavour. Racism in the clinical setting and other 'politically difficult' material has the potential to induce complex psychotherapeutic dynamics for the therapist, patient and their interactions (Straker, 2006). This seems especially relevant in the South African context where issues of race are foregrounded and the social impetus is towards racial integration.

1.5 STRUCTURE OF THE RESEARCH REPORT

Following the introductory chapter, a review of the theory deemed pertinent to the study is presented in chapter two. Literature pertaining to psychodynamic psychotherapy, psychodynamic understandings of trauma, and psychodynamic understandings of racism is presented in three sections. The first section of the literature review outlines the therapeutic guidelines and principles that define a psychodynamic stance. Metatherapeutic issues such as ethical considerations are also presented in this sub-section. Psychodynamic understandings of trauma form the focus of the second section of the literature review. Classical Freudian theory and object relational ideas are presented. The third section of the review focuses on racism. The phenomenon is briefly located within the South African context and then psychodynamic understandings of racism are presented.

Chapter three provides a discussion of the method the study employed, its central design and implementation features.

The fourth chapter, in keeping with much qualitative research, presents the research findings and the discussion of emergent themes concurrently. The chapter first looks at understandings of NRS, then at intervention, and finally at countertransference responses and the therapists' more personal responses to this area of work. Finally the discussion concludes with guidelines therapists endorsed when thinking about post-trauma NRS in

therapy.

The report is completed with chapter six, the conclusion, which offers a critical evaluation of this research, highlighting the central implications to emerge as well as identifying limitations, possible directions for future research and reflexive considerations.

CHAPTER TWO
LITERATURE REVIEW

INTRODUCTION

In approaching this research study it became apparent that the originality of the topic meant that there was no clear body of literature or directly related research to draw upon. For instance, even the literature on multicultural therapy, while dealing with aspects relating to the 'politics' of psychotherapy, generally focuses on these in terms of dynamics between client and therapist rather than on 'politically difficult' material that a client might bring to therapy. Given this background, the literature review straddles several distinct bodies of material with the aim of providing a kind of conceptual net within which to understand the research findings. This literature review draws on three distinct bodies of literature; in brief literature relating to: psychotherapy; trauma and racism. Although theoretical material relating to these three areas is presented in separate sections, the review attempts to integrate and weave the information in each section into a coherent theoretical framework for understanding therapists' views on NRS expressed by patients in therapy and therapists' approaches or options for dealing with this subject matter.

The review covers material relating to definitions and principles of what psychotherapy is, what constitutes a psychodynamic approach to therapy and what responsibilities a therapist assumes both to their individual patient and to society at large. The guiding principles and the ethical considerations that form the frame within which all therapeutic interventions and processes take place are fore grounded. The second section of this literature review is focused on traumatic stress. The usefulness of psychodynamic concepts for trauma intervention is argued. Classical Freudian theories as well as object relational ideas are presented. Implications for therapeutic practice derived from psychodynamic understandings of trauma are presented. Specific therapeutic tasks include *containment* and *validation* (Levy, 2004). The third section of this review considers racism and NRS. The phenomenon is briefly located in post-apartheid South Africa and an argument is made that trauma responses are not immune from contextual factors such as politics and social dynamics. Secondly, psychodynamic understandings are used to make sense of racial attitudes. Racial or prejudicial phenomena of particular salience in South Africa are also discussed, such as xenophobia towards refuges, tribalism

and within group discrimination between different social classes.

The literature review concludes by bringing together the three bodies of theory presented and linking them to the research questions.

2.1 PSYCHODYNAMIC PSYCHOTHERAPY: THERAPEUTIC GUIDELINES AND THE PSYCHODYNAMIC STANCE

2.1.1 Principles of psychodynamic psychotherapy

Gabbard (2004) outlines a set of fundamental theories and principles that constitute the foundation of psychodynamic therapy. These include: the unconscious; a developmental perspective; the use of transference and countertransference; understanding the function of defences and working with resistance; and the goal of achieving authenticity and uniqueness in therapy. A brief overview of some of these essential concepts is provided here.

The psychodynamic approach originated in psychoanalysis. Freud elaborated on a theory and technique that gave central importance to the unconscious (Gabbard, 2004). Psychoanalysis aimed to bring repressed contents that created conflict into consciousness (Freud, 1917a). The emphasis on unconscious mental life remains a core principle of psychodynamic therapy. Freud's structural model of the mind is comprised of the ego, id and superego (Freud 1923/1961). The conscious aspects of the ego include the mind's executive functions, such as decision-making and the integration of perceptual data. The unconscious aspects of the ego involve defense mechanisms designed to counteract the instinctual aggressive and sexual drives of the id. The ego is required to make defensive efforts to prevent the powerful sexual and aggressive drives from disrupting a person's functioning as well as to manage anxiety stemming from both intrapsychic conflict and external demands or threats.

A second core principle of psychodynamic therapy is the need for a developmental perspective. Childhood experience in concert with genetic characteristics shapes the person (Gabbard, 2004). The complex interactions that take place between parent and child and the fit between them shape later life (Gabbard, 2000). Early experiences of self and other are internalized and influence interpersonal interactions (Fonagy & Target,

2003). Trauma could be argued to be one such occurrence, producing the kinds of moments of which Straker (2006) speaks when she argues that intimacy and attachment are threatened. At times of great threat unconscious relational models are drawn on and embodied. Self-other perceptions, such as those to do with race, are derived both from the interaction between mother and child and from early models of how we learn to be in a particular culture and in society more generally (Straker, 2006). Thus the developmental perspectives drawn on in this study incorporate ideas about both attachment with the primary caregiver and attachment with multiple others at a macrolevel.

The therapeutic relationship is of upmost importance (Casement, 1985; Weiner, 1998). When childhood patterns of relatedness are repeated in the therapeutic relationship, the core concept of transference can be observed (Gabbard, 2004; Lemma 2003; Weiner, 1998). Object relations theory expands on the notion of transference to include the idea of what is known as 'projective identification' (Ogden, 1979). In phantasy the patient projects a self or object representation into the therapist and by exerting subtle interpersonal pressure nudges the therapist into taking on characteristics of the projected representation (Gabbard, 2004; Hinshelwood, 1989). This will be discussed in detail under object relational contributions. Countertransference is the phenomenon that accounts for the therapist's emotional reactions to the patient (Lemma, 2003). Countertransference is a technical and diagnostic tool that can be used by the therapist in large part to understand a patient's internal world through the use of the emotional reactions roused by the patient in the therapist (Kahn, 1991; Lemma, 2003; Lindy & Wilson, 1994). Newberry, (1985) cautions how the core assumption that therapists working with posttraumatic stress are not part of the traumatized system or can refrain from identifying with the patient in particular political or societal contexts, can at times create difficulties. When the therapist is operating within a political and social context where the patient's intrapsychic conflict is reflective of problems in reality, such as those of the post-apartheid South African setting in which this study is located, countertransferential reactions (Haley, 1974) or 'antitherapeutic defenses' (Kirshner, 1973) need to be monitored closely.

Psychodynamic therapy anchors itself in the principle that patients are ambivalent about change (Gabbard, 2004; Lemma, 2003). Therapy threatens a patient's psychic equilibrium resulting in possible resistance to the process. The patient uses characteristic defenses to deal with unpleasant emotions, which are then activated in the therapy and

present resistance to the process of change. The therapist sees resistance not simply as an obstacle but as an important part of the therapeutic process that needs to be worked through revealing something of the patient's object relationships (Greenson, 1967; Phillips, 2001). Some of the kind of primitive defenses utilized by clients in and outside of therapy will be discussed when Kleinian theory is presented in the next section.

The core principles of psychodynamic therapy are what inform any intervention made within this modality and what distinguish a psychodynamic approach to working with trauma. These principles inform the thinking of the eight therapists interviewed in this study in the sense that they self identify with this way of working. The following section looks at the three preconditions for therapy that constitute the psychodynamic stance. The three major preconditions for psychotherapy to occur are the nurturance of the *therapeutic or working alliance*, the holding to a fixed therapeutic setting or *therapeutic frame* and the adoption of the *analytic attitude* (Jacobs, 1988; Lemma, 2003).

2.1.2 The therapeutic alliance

This aspect of the therapeutic relationship is based on the mutual commitment of both patient and therapist to pursuing the goals of therapy despite ambivalence or resistance experienced by the patient (Clarkson, 1990; Ivey, 2004; Weiner, 1998). This alliance depends primarily on empathic connection (Gabbard, 2004). There needs to be some shared agreement between patient and therapist on the tasks and goals of therapy, encouraging the responsibility of the patient for the success of the partnership (Egan, 1986). Caution needs to be observed when the therapist has an agenda that is perhaps outside of this shared agreement with the patient, such as working with an ego-dystonic aspect of functioning in the patient. Fawcett, (2004, p. 80) comments on the complex phenomenon for the therapist of deciding what is 'best for your patient' and whose decision this is, as will be discussed further under ethical considerations. Pedersen (1997) recommends sensitivity to the alliance through altering when interpretation and confrontation are used according to the patient's changing needs. Given that the experience of trauma is one of force, coercion and authoritarian control, the therapist needs to painstakingly build a collaborative relationship (or working alliance) that rebuilds the capacity of the patient to enter into a trusting relationship.

2.1.3 The therapeutic frame

The contractual fixing of the therapeutic space is what distinguishes the therapeutic encounter from any other relationship and allows unconscious and transferential material to emerge (Lemma, 2003; Malan, 1995). It also creates the safety for patients to express their most difficult thoughts and feelings.

Part of the frame is the therapist's maintenance of relative anonymity (Lemma, 2003; Malan, 1995). The non-disclosure of personal details extends to religious, political and ideological attitudes. Therapeutic neutrality is a central principle of dynamic therapy although many contemporary therapists recognize that it may be impossible to keep subjectivity out of the therapeutic space (Gabbard, 2004; Lemma, 2003; Phillips, 2001).

In writing about working with victims Herman (1992) differentiates between technical and moral solidarity. When working with trauma, she states, the therapist must affirm a position of solidarity with the victim. This solidarity involves understanding the fundamental injustice of the traumatic experience for the victim, but entails conveying this without transgressing therapeutic boundaries. The 'frame' may at times be powerfully influenced by the context within which the therapy is taking place. For example, Straker's (2006) conceptualization of particular noxious social discourses as representing a potential 'anti-analytic third' that can hinder the analysis can be used as a way of trying to understand what makes topics such as racism so sensitive in therapy for both patient and therapist. It is argued that social discourses generated by a particular set of circumstances or by social history can go as far as opposing analysis. It seems that dealing with socially or politically value laden material in therapy has the potential to undermine or break the frame, particularly in respect of therapist anonymity or neutrality and this leads on to the discussion of the analytic attitude.

2.1.4 The analytic attitude

The analytic attitude is the specific professional way in which the therapist relates and behaves towards the patient that distinguishes the therapeutic relationship from other relationships (Lemma, 2003; Malan, 1995). Fundamental to this is the therapist's respect for the patient's autonomy and the patient's freedom to express whatever he or she thinks about anything and everything. Ivey (2004) explains how the therapist facilitates the

patient's insightful resolution of his or her difficulties by:

> i) Avoiding moral judgment of the patient's thoughts or actions
> ii) Not attempting to change the patient or direct his or her actions and/or decisions
> iii) Modeling an attitude of unscrupulous interpersonal honesty and sustained willingness to confront difficult feelings and interpersonal experiences
> iv) Being aware of how unconscious patterns originating in the patient's past play themselves out in the current relationship with the therapist
>
> (Ivey, 2004, p.2)

The inhibition of the therapist's so-called 'normal' personality, (Lemma, 2003) allows the patient's projections to be received, contained and transformed. This inhibition also facilitates the development of the transference. This specific attitude that the therapist adopts to the patient's communications creates a relationship that is qualitatively different to relationships outside of the therapeutic space (Lemma, 2003). The therapist listens and interprets the unconscious meaning of the patient's communications rather than giving advice. According to Lemma (2003) there are no neutral interventions since interventions persuade, steer and encourage patients with implicit therapeutic intent.

In summary, originating in the work of Freud, a number of different schools of thought have developed within psychoanalysis along the way. A shared assumption of these schools of thought is concern with the dynamic unconscious, although its exact structure is debated. In addition, psychoanalytic schools generally agree that the human personality and increasing psychic complexity develop during certain stages in early life (Frosh, 1987). For most psychoanalysts, the therapeutic space is where the dynamics of mental life can be unearthed most clearly (Frosh, 1987). An attempt has been made to describe the therapeutic space and to present the means through which psychodynamic therapy attempts to bring about possibilities for personal change. Some of the ideological constraints of psychoanalysis have also been suggested.

2.1.5 The politics of psychoanalysis

In the past, a common criticism of psychoanalysis was that "it is by nature a bourgeois discipline, opposed to radical activity" (Frosh, 1987, p.10). The argument is derived from the perceived dismissiveness with which psychoanalysis has greeted political action and the way in which it has been criticized for an historical misuse of analytic theory to

explain away oppressive practices, such as father-daughter rape, or the treatment of homosexuality as pathology (Ward, 1984 in Frosh, 1987). Psychoanalysis has been accused further of obscuring the social basis for human life. It is argued that the relationship between social structures and the individual has been largely neglected. Frosh (1987) however, while acknowledging that some psychoanalytic theories are wholly in the mode of revealing individualistic and retrograde tendencies, argues that psychoanalytic theory also contains the possibility for analyzing the mechanisms by which the social world enters into the experience of each individual.

Psychoanalysis takes place within society and is not immune from the social and ideological forces of the context in which it occurs. It is apparent that politics may intrude into the therapy space at times (Brom & Witztum, 1995; Frosh, 1987; Rustin, 2001; Staker, 2006) and may well lead to some testing of aspects of the alliance, frame and analytic attitude.

Having discussed psychodynamic approaches to psychotherapy and how this informs therapeutic practice and introduces possible constraints and biases, the discussion now moves to looking at ethical principles informing the practice of psychotherapy in general.

2.1.6 Ethical Considerations in Psychotherapy

The word 'ethics' is derived from the Greek word *ethos* meaning 'character' and reflects "beliefs… about what constitute right conduct" (Corey, Corey & Callanan, 1998, p.3). Ethics can be further defined as a set of formal and informal standards of conduct used to guide behaviour (Wood, 2002). Often developed by a professional body (such as the Health Professions Council of South Africa), an ethical code outlines a set of rules, which have to be adhered to (Burke, Harper, Rudnick & Kruger, 2007). In reality, however, questions of moral obligation and the application of ethical codes to practice are often complicated. Burke et al. (2007) argue that current professional codes of conduct are often too simplistic to capture the complexity of real-life ethical dilemmas.

> In the past we did our best for our patients- that was our ethic. Today… it becomes more complicated. If you want the best for your patients, you have to realize that you are working in a system much bigger than you… The system is going to decide what treatment your patient can get, regardless of your opinion. (Fawcett, 2004, p. 80)

The first of such dilemmas faced by the mental health practitioner is to decide what is

best for the client (Fawcett, 2004), if indeed this decision is in part up to the practitioner. The client is also involved in the deciding what is best for him or herself. Tjelveit (1999) points out that 'what is best' or represents a positive therapeutic contribution is far easier to establish when there is some serious dysfunction in a patient's life. Where dysfunction is less severe or where there is some debate about what constitutes pathology, however, the practitioner finds him or herself in a problematic area where no real consensus about what defines abnormality exists (Tjelveit, 1999). Being able to distinguish, or come to some reconciliation between one's personal moral code and one's professional commitment to ethical conduct is required in many therapeutic situations (Cottone & Tarvydas, 1998).

Brems (2001) identifies two sets of ethics: mandatory and aspirational ethics. Mandatory ethics are clear in their application and have little room for grayness or ambiguity. An example of a mandatory ethic would be that no sexual relationships with current clients are permitted and any such behaviour will result in serious consequences for the offending therapist. Aspirational ethics, however, represent ideal professional behaviour (Brems, 2001). The implementation of aspirational ethics is often left up to the practitioner. The practitioner is thus responsible for determining and rectifying when an aspirational ethic has been violated or neglected. The example of aspirational ethics that Brems, (2001) provides is the fact that mental health providers are encouraged to provide some pro bono services. However, in most countries this aspirational ethic is neither enforced nor monitored in any formal way.

In South Africa the question as to whether to address racism in therapy may be viewed as an aspect of aspirational ethics. Ridley (1995) says that therapists will encounter numerous opportunities to confront racism in the course of their work and cautions that both fears and unwarranted confidence around confronting racism can prevent the therapist from doing the right thing. He emphasizes that engaging with racism in therapy involves behaviours that one does not display (omissions) as well as behaviours one does (commissions). In the context of human right's violations Simpson (1995, p. 209) accuses workers in the field of trauma who operate under 'the fallacy of neutrality' of a variety of denial:

> Within secure and established democracies there are many issues and debates from which a professional caregiver can remain aloof. But with regard to torture and repression, doing nothing, or behaving as if nothing is happening, is not neutral; it is pathological denial and is usually effective assistance to the perpetrators.

Such views seem to demand therapist responsibility for implementing socially responsive policies. However, it seems that determining what constitutes social responsibility in specific contexts as well as what is in the best interests of the individual patient are gray areas. Six moral or ethical principles become useful for therapists in evaluating gray areas or dilemmas in respect of ethical conduct, those of: autonomy, beneficence, nonmaleficence, justice, fidelity and veracity (Brems, 2001). The three principles seemingly most relevant to the dilemma of interest in this study are those of autonomy, beneficence and nonmaleficence as will be elaborated.

In order to adhere to the principle of *autonomy*, the therapist honors the rights of an individual to make their own decisions, to exercise independence, individualism and self-determination (Brems, 2001; Corey, Corey & Callanan, 1998). Therapists are required to exercise cultural sensitivity and not to determine the direction of the treatment or the nature of solutions. It is generally anticipated that client's value systems, and spiritual and 'cultural' beliefs should be respected by the therapist (as in Eagle, 2004). The principle of autonomy suggests that the client is entitled to determine what he or she chooses or is willing to engage with in therapy. Who then, for example decides to make racism a focus of interest in the therapy, and does the therapist take the initiative if the client does not?

In upholding *beneficence*, the therapist seeks to do good unto others and strives to promote the client's welfare, dignity and respect. Brems, (2001) cautions that beneficence may not always be the same for all clients and that it is individually determined and context specific. Whereas a community-psychologist or feminist-psychologist may have an overt political agenda (Frosh, 1987), a clinical psychologist is often seen as an individual healer. In psychotherapeutic terms, the overarching intention of the principle of beneficience is for the therapist to promote the welfare of the client. As touched on above, determining what is to the benefit of the client is not always self-evident and two apparently beneficial courses of action may appear to be in conflict.

As well as seeking to do good, the principle of *nonmaleficence* posits that the therapist is ethically obligated to do no harm (Brems, 2001). A trauma therapist aims not to judge a client but also might seek to promote the well being of trauma clients whose recovery may be impaired by an inability to restore and reinstate previously held assumptions (Benn, 2006; Janoff-Bulman, 1992). Intervening in response to beliefs and sentiments

concerning race, particularly if these have become overtly racist in kind may, however, be disconcerting for the client, or be seen as representing censure of their behaviour or misunderstanding on the part of the therapist, in turn evoking distress or guilt. Such outcomes would be understood as potentially harmful to the client. Shame and guilt that often occur after trauma (Herman, 1992) would very possibly be exacerbated by perceived judgment. The patient may be deprived of the opportunity to express their anger. It is even possible to speculate that a patient who feels subtly pressured by the therapist to suppress negative sentiments, thus deprived of the expressive experience, may develop more costly symptoms in the long term (Fonagy & Target, 2003). However, given that clients live in this racially diverse society, it may be harmful for a therapist not to examine with them what the implications of holding such beliefs might mean for their daily lives. As discussed previously, there may be tensions both within the confines of a single ethical principle, such as what constitutes non-maleficience, or between sets of ethical principles such as between subscribing to both autonomy and beneficience.

At times it seems the therapist is faced with confusing choices in therapy. The analytic attitude requires that the therapist make no judgments and impose no political ideology in their therapeutic role, however, ethical guidelines require that the reflective practitioner perpetuate no individual or societal harm. It is not the aim of this research to resolve the kinds of moral dilemmas that might emerge in this aspect of trauma work but to create a language for thinking through them. It may even be argued that defined solutions would ignore individual and contextual differences. Ross (2005) suggests that clear-cut solutions to ethical problems inevitably leave out important aspects to moral life. Indeed, Scarturo and McPeak (1998) regard the therapeutic process as a constant series of ethical and clinical choices. It seems that ethical codes assist in ethical decision making processes but may not fit individual situations. How and when the therapist prioritizes client autonomy over societal malevolence, or other such considerations, are of particular interest in this study. Therapists were asked how they reconcile these seeming contradictions and their thoughts are presented in the analysis section of this report.

2.1.7 Some Ethical Principles in Trauma Work

Brom and Witztum (1995) emphasize the significance of ethical considerations when working with trauma. The trauma patient presents because their boundaries, norms or values have been violated (McCann & Pearlman, 1990). This patient's values are at stake

and the fundamental breach in confidence leaves the patient wary to trust (Brom & Witztum, 1995). This is identified as an area in which technical and ethical considerations are necessary to prevent further distress to the traumatized client, thereby upholding the principle of *nonmaleficience*. (Brems, 2001; McCann & Pearlman, 1990).

A technical dilemma can be understood as the process of clinical reasoning to establish minute to minute clinical decisions that can cause some consternation in the reflective practitioner, but that do not have the magnitude of ethical overtones or implications of an ethical dilemma (Scaturo, 2002). If therapy is conducted soon after trauma, for example, it might be suggested that 'technically' immediate support is more appropriate than confrontation of problematic aspects of functioning (McCann & Pearlman, 1990). However, therapist considerations move from the merely technical to the ethically loaded if sentiments expressed by the patient are construed to be causing harm to themselves or others. When the patient expresses sentiment that may well be harmful to other people in the patient's life, the reflexive practitioner is faced with a choice (Tjelveit, 1999). Although no literature was identified that dealt with ethical considerations around post-trauma racism or NRS specifically, one article referred to 'general racism' expressed in therapy. Burke et al. (2007, p. 109) raise the concern that a therapist who 'respects a client's value system' while the client goes on a 'racist tirade' about a colleague at work could in fact be condoning racism which has consequences for the patient and for society.

Herman (1992) reminds the therapist at all times not to take power away from the survivor of a trauma. The therapist is cautioned to allow the survivor to author and arbitrate their own recovery. Herman (1992, p.134) states:

> The therapy relationship is unique in several aspects. First, its sole purpose is to promote the recovery of the patient. In the furtherance of this goal, the therapist becomes the patient's ally, placing all resources of her knowledge, skill and experience at the patient's disposal. Second, the therapy relationship is unique because of the contract between patient and therapist regarding the use of power. The patient enters therapy in need of help and care.

Thus Herman (1992) points to the need for strong client autonomy in trauma work, a countertransferential stance that she argues is particularly important given the client's experiences of prior subjugation and loss of control. This kind of perspective clearly informs trauma intervention and the debates about how best to exercise ethical imperatives.

Having raised some of the meta-therapeutic issues involved in conducting therapy in this field, the discussion now turns to understanding trauma and its effects on the human psyche.

2.2 TRAUMATIC STRESS

2.2.1 Locating psychological trauma

The original Greek word, from which the word "trauma" originates, means 'to wound or penetrate' (Herman, 1992). In a psychological trauma this 'wounding' constitutes a kind of psychic disturbance or disruption.

> Traumatic events are extraordinary not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life. Unlike commonplace misfortunes, traumatic events generally involve threats to life or bodily integrity, or a close personal encounter with violence or death. They confront human beings with the extremities of helplessness and terror, and evoke the response of catastrophe. According to the *Comprehensive Textbook of Psychiatry*, the common denominator of psychological trauma is a feeling of "intense fear, helplessness, loss of control, and threat of annihilation".
>
> (Herman, 1992, p. 33)

The focus of this study is on trauma of intentional human design. The DSM-IV (APA, 2000; Kaplan & Saddock, 2003) correlates trauma inflicted on one human being by another with increased symptomology and vulnerability to post traumatic stress in comparison with traumatic events of 'natural' origin. The intentionality of trauma of human design transgresses a social boundary (Benn, 2006). This forces the survivor to confront the potential for aggression and destructiveness in human interactions (Eagle & Watts, 2002b). Eagle and Watts (2002b) attribute some of the most profound effects trauma has on survivors to the gratuitous violence and deliberate degradation that can occur in interpersonal trauma.

2.2.2 Theories and models of post-trauma reactions

Before moving on to psychodynamic understandings of trauma some seminal trauma literature from various theoretical perspectives will be summarized. Although this study is conceived within the psychodynamic field of psychotherapy, there is considerable overlap at times between methods, frameworks and techniques for understanding trauma. Some of the models used to formulate the impact of trauma have gained considerable

credibility in the field. These models form the backdrop against which many therapists formulate their interventions (Eagle, 2000) and are briefly covered in this sub-section since it was anticipated that the therapists interviewed might draw on some of these formulations.

Psychiatric Diagnosis

The essential feature of post traumatic stress disorder, based on the American Psychiatric Association's (2000), DSM-IV-TR clinical criteria, is the development of characteristic symptoms including intense fear, helplessness or horror following exposure to a traumatic stressor (Criterion A). The traumatic stressor must involve direct personal experience of threat to one's physical integrity, or witnessing of an event that involves death, injury, serious harm or unexpected violence (APA, 2000). The characteristic symptoms arising from the exposure to a traumatic stressor include persistent re-experiencing of aspects of the event (Criterion B), persistent avoidance of stimuli associated with the traumatic event (Criterion C) and persistent symptoms of hyperarousal (Criterion D). For a clinical diagnosis of PTSD, these symptoms must be present for more than a month after the event and must cause significant distress to the person or disruption to their general functioning (APA, 2000). Within most diagnostic systems trauma symptoms are understood to fall into three broad categories (Herman, 1992; Kaplan & Saddock, 2003). *Hyperarousal* or *arousal* refers to the constant expectation of danger. *Intrusion* reflects the impact of the traumatic event in the sense of constant revisiting of aspects of the trauma. Lastly constriction or *avoidance* reflects the response of surrender, denial or withdrawal.

Horowitz's Information Processing Model

Horowitz (1999) pioneered a cognitive theory of information processing to explain traumatic stress syndromes. Trauma impacts cognitive schemas and thinking processes. Until a traumatic event can be integrated into existing cognitive schemas, representations of the experience remain in active memory. Intrusive thoughts and uncomfortable emotions are the result of repeated representations of the event bombarding the mind. To prevent becoming emotionally overwhelmed, emotional numbing or denial may be used to defend against this onslaught (McCann & Pearlman, 1990). Oscillation between arousal and numbing may occur. This model could be seen as an elaboration of Freud's

(1920/55) ‘repetition compulsion model’, a model that will be discussed more fully later.

Foa’s conditioning model

Presenting a behaviourally oriented model to explain aspects of trauma impact, Foa views the avoidance of anxiety-provoking stimuli as problematic after trauma (Foa & Davidson, 1993; Foa, Rothbaum, Riggs & Murdock, 1991). This may have a consequent cascade effect where anxiety is also generalized to other stimuli and may result in the development of phobic responses. The process of psychotherapy attempts to deactivate *fear networks* that have arisen in response to the trauma (Dagliesh, 1999; Yule, 1999; Joseph, Yule & Williams, 1993a; 1993b).

Shattered assumptions

Janoff Bulman (1985; 1989; 1992; 1995) writes about how ‘basic assumptions’ are shattered by trauma. The emphasis in this model is that adjustment to trauma requires the healthy management of alterations in beliefs about the self, about other people and the world. Janoff Bulman (1985; 1989) focused on three major assumptions that are disrupted by trauma. These three assumptions are: a person’s belief in their invincibility or personal invulnerability, a view of the world as meaningful and a perception of the self as worthy. The shattering of an illusion of safety or invulnerability can leave a survivor in a state of anxiety. The world may be construed as malevolent resulting in anxious, avoidant and maladaptive behaviours (McCann & Pearlman, 1990). The ways in which traumatization affects people can be so extreme as to bring about a completely altered personal identity, the restructuring of an individual’s life, increased suspicion of strangers, the taking of greater precaution against future harm, and/or decreased feelings of personal autonomy and control (Miethe, 1995). These disruptions can have a destabilizing effect on the personality if the traumatic experience is not assimilated to re-establish equilibrium (Janoff-Bulman, 1992; McCann & Pearlman, 1990). Janoff-Bulman (1995) proposes that some form of restoration of the basic assumptions is essential to mental health, and the ability to operate in the world.

McCann and Pearlman’s core schemas

Adopting a cognitive framework, McCann and Pearlman (1990) list common psychological consequences that may occur as a result of trauma. Trauma may cause common reactions, such as, fear and anxiety, depression, decreased self-esteem, identity problems, anger, guilt and/ or shame. Interpersonal response patterns are also impacted by trauma and reactions may take the form of sexual problems, problems in intimate relationships, or the victim may start to display victimizer behaviour. Building on Janoff-Bulman's framework, McCann and Pearlman, (1990) developed a theory for informing traumatic stress intervention namely "Constructivist Self-Development Theory". Seven core schematic representations are disrupted by trauma they argue, those for *safety*, *trust*, *independence*, *power, self-esteem*, *intimacy* and *frame of reference* (McCann & Pearlman, 1990). The central dimensions of psychotherapy entail examining how these central schemas have been affected by trauma and assisting clients to reconstruct schemas in a way which enables them to live meaningfully in the world, similar to Janoff-Bulman's restoration of basic assumptions (Eagle, 2004).

A biopsychosocial approach to trauma

A biopsychosocial approach to trauma understands the impact of trauma as mediated by an interaction of components (Green, Wilson & Lindy, 1985). Three components are mentioned here. Firstly, individual characteristics of the patient determine vulnerability to symptomology. Secondly, the characteristics of the traumatic event itself play a role in determining outcomes for the survivor (also emphasized by McFarlane, 1995). Lastly, the recovery environment and social support mediate the impact of trauma. Cross-cultural theories of trauma also emphasize that trauma needs to be mapped against broader social issues (Kleber, Figley & Gersons, 1995). Bracken, Giller and Summerfield (1995) caution against separating the individual from their cultural or social context. The appreciation of diverse meanings of a particular person's response to trauma is suggested and the possible social, cultural and contextual influences on beliefs, and outcomes are acknowledged.

Having covered some of the more general literature on the experience and impact of trauma the discussion now provides a more narrowly focused psychodynamic understanding of trauma impact, given that the orientation of the participants approached to take part in the study was explicitly psychodynamic.

2.2.3 Psychodynamic understandings of trauma

There are many psychoanalytic theories that deal with trauma. The theories presented in this chapter were selected for their usefulness in conceptualizing and formulating aspects of interest in this study and cannot do justice to all the psychodynamic theory on trauma. This section of the literature review examines the contributions of both classical and object relational theories. Theorists whose work is selected for attention, include Freud (1920); Klein (1935, 1940); Bion (1962); Fonagy and Target (2003); and Lemma and Levy (2004).

2.2.3.1 Freudian contributions to understanding trauma

Because this study focuses on trauma of intentional human design, Freud's early theories on the more developmental traumatic anxiety of aspects of infantile development (such as castration or Oedipal anxiety) (as in Eagle & Watts, 2002a) are excluded from this discussion. However, the idea that early trauma is reactivated by later trauma (Freud, 1917b) still strongly influences analytic thinking and will be born in mind when considering the effect of trauma experienced in later life, such as intentional violent crime. Brett (1993) refers to this aspect of Freud's theorization on trauma as 'the symptom-formation model'. Original infantile conflict is the focus when attempting to understand the traumatic response, with less attention paid to the nature of the stressor (Campbell-Arthur, 2002). More contemporary analytic thinking, such as that of Garland, (1998) and Herman (1992) emphasizes that the nature of the stressor may indeed warrant attention, as even the most robust psyche can decompensate in the face of a particularly overwhelming harmful stimulus.

A real external stressor and the mental capacity to cope with such a stressor is discussed by Freud for the first time in what has become a seminal paper in the trauma literature, *Beyond the pleasure principle* (1920). An overview of some of the central concepts in this paper is useful to provide a base from which to appreciate dynamic understandings of trauma.

Theorization linked to *Beyond the pleasure principle*, (1920)

Freud (1920, p. 12) observed a condition of ‘traumatic neurosis’ in patients after a risk to life had occurred. More general disturbance of the mental capacities was noted than had previously been described within the category of ‘hysteria’. Freud identified the repetitive nature of traumatic thoughts and their origin as a core aspect of the trauma response and emphasized that a psychic breach had taken place. The way in which trauma is conceptualized as a rupture to the ego also provides some explanation for arousal symptoms and how ‘primitive defenses’ may be used to cope with such a breach.

Freud recognized the intrusive nature of trauma and the fact that the traumatic situation constantly forces itself upon the person after it has occurred, even in their sleep. This he called ‘fixation’ at the point of the trauma and took as evidence of the strong impact of such an experience on the psyche. He understood the repetition of the unpleasant experience in the person’s mind as an attempt to gain mastery over what had been an experience of passivity for the person and as an attempt to gain an active hold over what had been so disagreeable through repeatedly reprocessing it. This ‘repetition compulsion’ he noticed in children’s play in which things that have made a strong impression on the child are reenacted to release the emotions stirred up through the repetitive experience. Repressed material seeks discharge through either breaking into consciousness or through some real action (Freud, 1920). However, such discharge or liberation of traumatic material may cause the person ‘unpleasure’. The ego operates under the sway of the reality principle endeavoring to keep excitation or arousal levels in the mind constant. Horowitz (1992) understood the cycle of intrusion and denial of trauma as the psyche’s way of attempting to gradually integrate and work through the experience without being overwhelmed.

Intense outside excitations or stimuli impinging on the mind from the external world are modulated by what Freud envisaged as a protective shield that diminishes the impact of such stimuli. Overwhelming external excitation, such as that experienced during trauma, also increases internal excitation. For example, the nature of traumatic stress involving, for instance, the threat of death or bodily harm (external excitations), has the ability to evoke primitive responses linked to unconscious fears and phantasies (internal excitations). However, the mind has little protection from excitations coming from within (such as unconscious associations and anxieties in response to trauma), which Freud saw extending directly into the system. The mind adopts a technique for dealing with these internal excitations. These internal excitations are treated as if they were coming from

outside so that the mind can shield itself against them. Treating internal excitation as if originating from outside is thus a defense against the unbearableness of these stimuli. This is the origin of projection. Trauma can potentially arouse unbearable excitation in the mind that can only be managed by projecting it outside into others. (Although the immediate discussion is concerned with trauma of external origin, these mechanisms are mentioned in detail as in a later section of this review many authors explain racism psychodynamically as a form of projection.)

Trauma implies that excitation from outside has occurred that was powerful enough to break through the protective barrier. Such a breach sets in motion every possible defensive measure of the mind. The mind cannot prevent large amounts of stimuli from flooding the mental apparatus. The mind then starts attempting to master the stimuli that have penetrated it through "binding them in the psychical sense so that they can be disposed of" (Freud, 1920, p.30). The mind reacts to the invasion of outside excitation by summoning up cathectic energy from other systems. If the mind's "quiescent cathexis" (Freud, 1920, p. 30) or baseline arousal level is low it has less capacity for binding the inflowing energy and the consequences to the system are more violent. The traumatic neurosis is thus the consequence of a violent breach in the protective shield in which the mind battles to control the freely flowing stimulation. The arousal and hyperarousal symptoms following a trauma could be explained by Freud's assertion that the system has been shocked by its lack of preparedness for the invasion. He argues that the system's preparedness for anxiety can determine the outcome. However, he also acknowledges that certain traumas, by virtue of their severity, exceed any mental preparedness. The individual is rendered incapable of distinguishing between actual threat and potential threat, or automatic and signal anxiety (Garland, 1998). Such a rupture within the ego not only weakens the ability to distinguish inner from outer reality but also lowers overall psychic functioning (Eagle & Watts, 2002a). A regression to more primitive modes of thinking can occur. One such regression is the loss of the capacity to symbolize the experience and to draw upon reality based mental models (Eagle & Watts, 2002a).

When the defenses employed fail to decrease the intensity of the anxiety, they transform into symptoms (Lindy, Moss & Spitz, 1995; Solomons, 1988). Traumatic symptoms involve an increased state of autonomic arousal in anticipation of the intrusive symptoms (Solomon, 1988). Denial may then come in to play as a way of dealing with the anxiety

generated by the re-experiencing or repetitive intrusive symptoms. The denial of the trauma may manifest as behavioural or ideational avoidance of any aspects associated with the trauma (Campbell-Arthur, 2002; Horowitz, 1992). Aspects of the trauma (including people that evoke traumatic memories) may be avoided. This may have significant effects on a person's interactions and emotional engagement with others.

What stands out as important from the stimulus barrier model of trauma (Brett, 1993) is that the patient presents for therapy because they have been wounded. The ego has been ruptured. Any intervention the therapist makes needs to be mindful of the psychic vulnerability of the trauma patient. Klein's (1935) further development of some of Freud's ideas informed her interpersonal, object relational model of development that also emphasizes the central importance of an ego that is able to feel and tolerate anxiety.

Object relations theory concerning trauma impact developed from Freudian understandings of trauma to include an understanding and possible model of the survivor's internal world. The external world was identified as largely being used in the service of internal, defensive systems of relationships (Fonagy & Target, 2003; Klein, 1935; 1948).

2.2.3.2 Object relational theory and trauma

In summarizing a range of psychoanalytic ideas Eagle and Watts (2002a) identify the fundamental importance of the internalization of a secure matrix of object relations in order for psychic stability in the world to be maintained. The experience of trauma threatens, or more devastatingly, can destroy 'good internal objects'. The discussion presents selective developmental theory that explains the internalization and preservation of the good object as well as its vulnerability in situations of trauma. These ideas are separated into two broad sections, firstly involving discussion of paranoid schizoid modes of functioning; and secondly an elaboration of the failure in containment and symbolic thought evidenced in the traumatised response. The first section draws predominantly from Kleinian theory and the second from Bion's.

Three components of Klein's theory seem particularly relevant to understanding trauma (and also possibly negative racial sentiment post-trauma): 'split object' relations; the use of 'projection' and 'projective identification'; and the failure to mourn or employ

'depressive' modes of functioning.

Splitting, projection and projective identification- and the 'paranoid-schizoid' mode of functioning

Klein observed that the internal images children developed from their interactions with their primary caregivers were shaped and distorted by internal phantasy (Fonagy & Target, 2003; Grosskurth, 1985; Hinshelwood, 1989; Klein, 1932; 1959). Klein developed the concept of an 'internal world', built up through the processes of 'introjection' and 'projection'. The fragile ego strives to introject positive nurturing experiences that progressively form the core around which a healthy ego or personality is structured. However the young ego is also beset with negative experiences of frustration and deprivation, generating anxiety. This anxiety presents the infant with the threat of disintegration. The anxiety is caused both by external experiences and from the death drive within. The infant tries to get rid of these negative experiences or feelings by externalizing them, mobilizing the first primitive defense of splitting. In an effort to get rid of bad experiences and preserve good experiences, badness is ejected outwards or disowned and the good is felt to be uncontaminated.

When bad experiences or feelings are split off they do not evaporate but rather come to be perceived as threats from outside, through the process of projection onto an external object. External threat is perceived to be more manageable than internal threat. The recipient of the bad projections is typically perceived to have hostile or persecutory intent towards the self. Klein called this basic position in the human psyche the 'paranoid schizoid position' (Klein, 1935; 1946 in Mitchell, 1952). In the paranoid-schizoid position the leading anxiety is that persecutory objects will get inside the ego and overwhelm and annihilate both the 'ideal object' and the self (Klein, 1930 in Mitchell 1986). In trauma, actual annihilation is confronted. This can cause a regression to the primitive defenses that operate in this mode of functioning, including the mechanism of splitting of internal and external objects and the ego, as well as projective identification in which parts of the self are projected onto and attributed to another person. These mechanisms and defenses are part of normal development and at the same time form the basis for later illnesses (Klein, 1940 in Mitchell, 1986; Steiner, 1992). Traumatic anxiety is linked to fears of annihilation (Freud, 1920). External forces threaten the self and thus early persecutory anxiety and paranoid schizoid processes are re-evoked.

After a person experiences a traumatic event it is common for them to feel intense anger about what happened to them (Young & Gibb, 1998). However, some patients, for varying reasons, may defend against this anger. Perhaps unmanageable anxiety is evoked, which might be related to the survivor's own capacity for destructiveness as suggested by Young and Gibb (1998). People left crippled by trauma may employ defenses such as denial and projection to get rid of feelings in phantasy that are then located in other people and in the outside world (Klein, 1946; Young & Gibb, 1998). The consequence of splitting off threat from destructive internal feelings is that the outside world is then experienced as dangerous, hostile and attacking. The individual develops faulty perceptions of others and themselves in the world. This prevents the traumatic experience from being dealt with in a realistic and manageable way. Another feeling that may replace anger is grievance (Steiner, 1996). Grievance involves the feeling of being a victim of some injustice (Young & Gibb, 1998). Where this inhibits integration of trauma is when the sense of injustice experienced by the survivor, fuels a need for revenge whether in phantasy or in reality. This could justify a sentiment such as hate in the victim and perpetuate further violence. In line with the desire for revenge, a 'projective imperative' can occur (Lemma & Levy, 2004). The humiliation of trauma can inflict a narcissistic wound leaving the survivor feeling helpless (Caper, 1999). In an attempt to feel powerful again, the feelings of humiliation are projected back into the perceived agent of the wound (Lemma & Levy, 2004). This is a type of 'paranoid schizoid identification' otherwise referred to as a 'narcissistic identification' (Caper, 1999).

Rigid splitting may become unhelpful as a defense for an adult trauma survivor. Unlike regression, in which distressing content is simply pushed from conscious awareness into unconsciousness, splitting distorts one's perceptions of the external world, and involves an alteration of the psyche itself, removing and transferring toxic elements of the self onto others. Emotions in general may become inhibited, or hatred may increase (Hinshelwood, 1989). The ego may project all the hatred evoked by the trauma out into the external world. It is suggested that people who do not mourn may only escape manic-depressive illness by severely restricting their emotional life (Klein, 1940 in Mitchell, 1986). Trauma intervention seeks to allow the integration of the traumatic experience, bringing together into consciousness the previously split off aspects of oneself and others. Eagle and Watts (2002a) advocate the restoration and reinforcement of ego boundaries as part of trauma intervention. A person's sense of self, violated by trauma, can re-cohere

only when realistically perceived boundaries between self and other are reconstituted (Fonagy & Target, 2003). This allows greater emotional reflexivity and restores self-esteem.

Containment and symbolization

Garland (1998) presents trauma as a failure of containment, by virtue of the fact that the trauma was allowed to happen at all. This leads to difficulties in *symbolisation*. The capacity to symbolise, defined as "the ability to use aspects of the actual world to represent internal objects and object relationships for the purposes of thinking and understanding", depends on the healthy functioning of an *internal container* (Garland, 1998, p. 109; 2004). In trauma the container is lost and the function of treatment is to restore its functioning.

Bion, (1967) wrote about the interaction between mother and child that allows unbearable experience to be transformed into something that can eventually be thought about and metabolized. Raw sensory data, coined 'beta elements,' representing the baby's unprocessed anxieties and fears, are projected into the mother who acts as a container for these elements (Bion, 1962). Through the process of *reverie*, the receptive maternal mind gives meaning to these elements making them manageable (Bion, 1962). The beta elements are altered in some way (Greenberg & Mitchell, 1983) to render them more digestible to the infant's mind. Through this process mental contents that can be used for thinking, known as 'alpha elements', are generated (Bion, 1962).

Overwhelming experience, like that of trauma, causes a breakdown in the ability to think (Garland, 1998; 2004). When in trauma, the capacity for alpha functioning is compromised by the destruction of, or damage to, one's internal maternal container, it is possible that "pseudo thinking is employed" (Bion, 1961, p. 6). Bion (1961) linked this inability to properly process thought to the dominance of projective identification, in which confusion between self and external object results, referred to as "bizarre object experiencing" (Eagle and Watts, 2002a, p. 16). In this state the ego cannot distinguish between automatic and signal anxiety, resulting in the characteristic hypervigilance experienced after trauma (Garland, 1998). Stimuli that would not normally be construed as threatening are not filtered through the system and automatic anxiety is triggered indiscriminately. The result is that benign stimuli are construed as potentially dangerous.

In psychotherapy, the therapist aims to provide a 'container' and to be capable of reverie (Bion, 1962). Unmetabolised elements of the survivor's trauma can thus be metabolized in the interaction between patient and therapist. It is cautioned that no container should inhibit or block possible projections as only through therapeutic openness to bizarre experiences can the anxiety related to such experiences be uncovered and consequently bound.

2.2.4 Some principles of psychotherapeutic intervention based on psychodynamic understandings of trauma

Some brief mention of 'therapy issues' including treatment and intervention considerations arising from psychodynamic understandings of trauma, will be made in this section.

Broadly, psychodynamic treatment for trauma aims to prevent the over-use of repression as a defense and to protect the person from further regression or impaired ego functioning. (Eagle, 1998). McCann and Pearlman (1990) provide an overview of intervention strategies, which include stabilizing the client, strengthening self capacities and restoring ego-functioning, restoration of disrupted schemas, and integrating the trauma. Treatment has to allow integration of the conflicting information that trauma presents the survivor with. Unconscious conflict has to be allowed into consciousness and out of a combination of old and new information meaning has to be constructed (McCann & Pearlman, 1990). Treatment aims to allow the individual to explore personal meanings of the traumatic event and to experience the emotions associated with the event without being overwhelmed. The individual should ideally be able to maintain a stable sense of self-esteem whilst gradually tolerating the emotions, thoughts, recollections, primitive phantasies and images connected to or aroused by the trauma (McCann & Pearlman, 1990). Therapy aims to enable the individual to assimilate the experience without clinging to overgeneralized negative schemas about the self or the world.

Lemma and Levy (2004) offer an integrated psychodynamic model for working therapeutically with trauma survivors. The model brings together four of the central themes in psychodynamic understandings of trauma: Trauma is an *attack on attachment*; there is a breakdown or *perversion in the capacity to mourn*, *destructive identifications* may form and there may be a *breakdown in the capacity for symbolic thinking*. The

process of healing from trauma is equated with the process of mourning. Through mourning, the traumatic event becomes a part of the survivor's emotional world in a way that is bearable, allowing flexible thinking rather than spilt off realities (Garland, 1998).

In Levy's (2004, p.51) experience of working with torture survivors the greatest difficulty for the psychotherapist is managing and containing "their powerful feelings of hatred and death". It is stated further that the only hope of survival for a traumatized individual is to have their experience validated. This includes their intense communications and feelings of vengeful rage (Levy, 2004). Levy (2004) affirms that it is the task of the psychotherapist to attempt to both contain and validate the multi-layered conflicts and problems of the survivor. These two therapeutic tasks will be outlined in the discussion that follows.

2.2.4.1 Containment

The concept of 'containment' was introduced briefly in the previous section as a way of formulating the impact of trauma. It was stated that trauma disrupts a sense of containment. It will now be considered as a necessary analytic task required of the therapist. Containment can be understood as the therapist's attempt to manage and process the patient's internal states of mind and affects (Levy, 2004). Containment is provided both in a real sense in the provision of a safe and consistent physical environment and also at a symbolic level (Levy, 2004). At the symbolic level, in phantasy, the therapist provides mental holding for the patient's expression of what is occurring unconsciously in their mind (Winnicott, 1965). Bion (1962) emphasizes the importance of the therapist's capacity to manage his or her own feeling states in response to the patient. In managing his or her own responses, the therapist is able to offer his or her own mind as a container for the patient. Given the kind of psychic disruption and intense affects evoked by trauma the provision of containment is vital in such psychotherapy.

2.2.4.2 Validation

'Validation' refers to the psychotherapist's acknowledgement of the traumatized client's experience. According to Winnicott (1965) and later Fonagy, Gergely, Jurist and Target (2002), the infant is able to feel his or her existence because his or her mental state is represented, made meaningful and validated through the mother. This experience forms the basis for the child's sense of self and psychic resilience (Fonagy et al., 2002; Levy, 2004). Trauma destroys resilience and undermines attachment relationships (Lemma & Levy, 2004). The therapeutic process needs to provide an experience in the therapy similar to that of 'maternal reverie' (Bion, 1962; 1967) in which the therapist's mind is acutely sensitive to the needs of the traumatized patient. Levy (2004) emphasizes that it is not only the internal state of the patient that needs validation but the actual encounter they have endured. According to Levy (2004) validating a survivor's experience is the most containing gesture a therapist can make. The ability to represent the traumatic experience and to provide an emotionally authentic account of their experience is disrupted by a possible breakdown in the capacity for symbolic thought (Garland, 2004). In the initial phases after a trauma, experiences are often represented in a fragmented, or overly rigid way in the mind of the survivor. It is part of the therapeutic task to try and assist the patient to construct a narrative around the trauma. The process of therapy aims to replace the horror for which there are no words with the act of thinking and talking (Levy, 2004).

Another consequence of a breakdown in the capacity for symbolic thinking is that destructive 'identifications' may form. Previously held symbolic identifications are potentially made concrete by a traumatic event (Lemma & Levy, 2004). Identifications are crucial to survival and represent the infant's internalized version of his or her caregivers (Freud, 1923 in Lemma & Levy, 2004). Some identifications are sustaining to the self, while others are destructive. These latter identifications often take the form of aggressive or "sadistically toned" identifications (Levy, 2004, p. 19) inside the ego. Anna Freud (1936 in Levy, 2004) referred to this process as 'identification with the aggressor'. In a process of 'introjective identification' the victim takes the perpetrator into him or herself and actively becomes the aggressor or perpetrator, targeting a victim outside the self. In 'projective identification', the aggressive parts of the self are not taken in but split off and projected onto an object outside the self. An external agent is thus associated with the individual's aggression and is felt to be persecuting the self. In these kinds of paranoid schizoid identifications (Caper, 1999), the individual's sense of separateness from the object is lost and boundaries between self and other fuse. Defensive

identifications are a psychic attempt to control an excruciatingly painful internal situation. These identifications serve to assist the traumatized individual to avoid psychic pain associated both with loss and with destructive impulses in the self. Levy (2004) describes the therapeutic process as painstaking work, with only minimal gains. She acknowledges that there are limits to the amount of pain a person can endure. She declares, "for some patients, as indeed for some groups and societies, hatred (in all its forms) frequently offers a retreat, an exciting analgesic to suffering" (Levy, 2004, p. 20). The work of therapy is, however, to think about the painful predicament of the individual who has retreated into an identification with the aggressor. A sense of separateness, of boundaries between self and other and the capacity to bear the reality are undermined by trauma. The cost of these identifications for the individual is that the survivor is rendered more vulnerable to cycles of internal and external violence if this retreat is not engaged with. In the therapeutic relationship there is a possibility to reconstruct narrative (Levy, 2004). In this way destructive impulses can become known and thus "loosen their grip" (Levy, 2004, p.20). Through this process a sustaining object can find a place in the survivor's internal world (Levy, 2004).

The model for intervention presented by Lemma and Levy (2004) could be considered a purist psychodynamic model. Psychodynamic ideas can however, also be integrated into more short-term or eclectic models (Eagle, 1998b; 2000). Although not a pure or classic psychodynamic model, an additional model for trauma intervention is mentioned here as one of the key training models that many Johannesburg based therapists have been exposed to. It was anticipated that the therapists interviewed might make mention of this treatment model or integrate it within their psychodynamic ways of working with trauma. The 'Wits trauma model' addresses both the 'internal' psychodynamic effects of trauma as well as integrating 'external' cognitive-behavioural elements into the treatment plan (Eagle, 1998). The model encompasses psychodynamic aims such as preventing the use of repression as a defense (Freud, 1915 in Eagle, 1998), and protecting the client from further regression or ongoing impairment in ego functioning. From a cognitive behavioural perspective, maladaptive cognitions are repaired and anxiety is moderated. The model incorporates five components that facilitate the creation of a coherent and meaningful narrative of the traumatic experience, whilst processing exceptional or distressing symptoms or experiences. The Wits trauma model also aims to provide some containment and validation to the trauma survivor in the context of short-term therapy but employs more eclectic methods in the service of these aims.

Having discussed psychodynamic understandings of trauma impact and some aspects of treatment, the third section of the discussion deals with psychoanalytic understandings of the mechanisms at play in the holding of prejudice in the form of racism.

2.3 RACISM: PSYCHODYNAMIC UNDERSTANDINGS OF RACISM, AND NEGATIVE RACIAL SENTIMENT IN SOUTH AFRICA

This research aims to investigate racist sentiment within a particular paradigm. As in the previous section on trauma a psychodynamic framework is used to throw light on various conscious and unconscious aspects of client racism expressed post trauma. However this task is taken up with the cognizance that racism is a highly complex field of study (Frosh, 1997). To neglect the social, political and historical aspects of racism altogether, is impossible. Thus, before the analytic argument is presented, this chapter looks at some aspects of the South African social context, the operation of stereotypes in South Africa, the legacy of Apartheid and the more subtle forms of racism that have developed since overt forms were relegated to the extreme right (Van Dijk, 1990). Once this contextualization has been offered, psychodynamic ideas are applied to two particularly problematic components of racism, the irrationality and intractability of racism (Foster, 1991). The work of a range of theorists including Freud (1930); Klein (1935, 1940); Lane (1998); Rustin (1991; 2001); Frosh (1997, 2002); Fanon (1967) and Davids (2004) will be discussed.

2.3.1 Post Apartheid and Contemporary Racism in South Africa

Racism as a response to trauma is examined here in a very particular and peculiar social and political context. South Africa is a society, which has suffered the chronic trauma of Apartheid. The effects of this hateful system will long outlive the regime itself and continue to reverberate within its direct survivors and subsequent inhabitants (Simpson, 1995; Kornegay, 2005).

> Much trauma has political causes, and almost all trauma has politically relevant effects and dimensions…Not only does politics cause trauma, but in a relevant sense, trauma causes politics. Individual, group and societal responses to earlier trauma form a substantial substrate for the violence, pain, and conflict that pervade the world.
>
> (Simpson, 1995, pp. 208-209)

The legacy of apartheid is one of chronic discrimination, poverty, homelessness, denial of human rights, social unrest, political harassment, and torture. Secondary dimensions of the trauma left behind by such a system include a uniquely high degree of social pathology (Simpson, 1995), such as high rates of rape, familial abuse, violent crime and murder. Sociocultural factors cannot be neglected when seeking to understand the effects of trauma in South Africa.

Racial stereotypes have been a strong part of South African society since colonialism and continue to operate today in post-apartheid South Africa:

> Despite the unprecedented political and social changes that South Africa has undergone since its first democratic elections in 1994, racist ideology and practices have persisted in all sectors of South African society, including academia. Indeed, not a day passes without us being reminded that racism is not a phenomenon of South Africa's past that was buried along with the apartheid laws of the old order. Regrettably, its remnants continue to feature as an integral aspect of contemporary South African society.
>
> (Duncan, Van Niekerk, De la Ray & Seedat, 2001, 1).

Duncan (1996) identified six major themes concerning racial stereotyping of black people produced by the media, which, when internalized by people, become part of their mental schemas: "black people are violent, black people's version of events cannot be trusted, black people are non- or sub human beings, black people are racist, black people are child-like beings", and "black people are unreasonable" (Duncan, 1996, p. 72). These stereotypes may be apparent in the thinking of victims of crime. It is apparent that some ten years ago, post the 1994 elections, pervasive negative stereotypes about black people were still evident in the media. However, there has also been interest in more covert and indirect expressions of racism in the last two decades.

By analyzing discourses in newspapers, Van Dijk (1988; 1990) points out a movement away from ideological racism, whereby ethnic or racial groups are overtly perceived to be inferior, to more modern, indirect and subtle manifestations of racism that operate when overt racism is condemned. Such indirect forms of racism include constructions of cultural difference and incompatibility, or the legitimization of xenophobia as a cultural defense (Van Dijk, 1990). A trend has been observed whereby people internalize a social norm of non-discrimination but this then appears to clash with their negative personal experiences and is then reflected often in people's speech forms, (Van Dijk, 1989) "I'm not racist, but…" (Van Dijk, 1989, p.116) or "I have nothing against blacks, but…" (Van Dijk, 1990, 1). Van Dijk (1990) sees these strategies as forms of denial. Downtoning,

mitigating, minimizing, or using euphemisms are seen to be part of a defensive strategy in which self-esteem is preserved. The speaker attempts to present their racism as isolated to the immediate situation and to block any inferences from being made about their racial attitudes in general. A specific racist opinion may be held as justified in a given circumstance by the person expressing it, whereas a more general negative opinion about a race group might be construed as racist per se. How pervasive does an attitude have to be in order for the individual to be construed as racist? Is racism something one can adopt in response to a particular situation but not harbour during 'times of containment'? Van Dijk, (1990) cautions that the treatment of racism as an individual incident or as a deviation from liberalism or as something that should be analyzed at the individual level is a way of denying systematized racism.

Another common discourse seen in the media is the identification of the young black male as the most prominent perpetrator of violent crime in South Africa (Benn, 2006). Could such a discourse in the media contribute towards the reproduction of racism (Duncan, 1996) or is there a legitimate justification for such representations based on the demographics of crime committed in South Africa? Do socio-economic explanations and justifications for perpetrator involvement in crime ameliorate overt racial stereotyping or are they disguised forms of racism, such as those suggested by Van Dijk? A further stereotype that occurs in South Africa, in line with Van Dijk's (1990) definition of more subtle forms of racism, is the perception of non-South African black Africans as the cause of unemployment, disease, crime and inequality in the country (Landau, 2006). Vale (2002) identifies xenophobia as the new racism. It is suggested that African foreigners are seen as a burden to Johannesburg (Grootenhuis, 2007; Landau, 2006; Palmary, 2003) and that xenophobia around refugees has become a national discourse, often associated with the assumption that refugees are the perpetrators of violent acts. Racism and xenophobia have become closely associated in South Africa.

In South Africa, trauma that results from crime seems to carry political implications for many South African people (Gibson and Gouws, 2003). Gibson and Gouws (2003) suggest that concerns around the state of the country and its development, arising out of violent crime, are often tied up with perceptions about race. Trauma victims thus often introduce political and racist content into their therapy and this content has to be engaged with in the room.

2.3.2 The understanding of racism and negative racial sentiments informing this study

Duncan et al (2001; Duncan & Franchi, 2003) define racism as an ideology that justifies and organizes racial domination. In this study the term 'negative racial sentiments' was selected to explore racialized content in therapy because it allows for the possibility of including responses that might not necessarily fit narrow definitions of 'racism', such as in this defined sense. What is an overgeneralization and what is outright racism, for example? Duncan et al (2001) also point out that racism defies easy definition because of its changing manifestations. Often definitions of racism contain the assumption that one race is marginalized by another race, (Foster, 1991 in Duncan et al, 2001), however, in this study the possibility of within group 'racism' will not be excluded. Van Dijk (1987) cautions against underplaying racism by using words such as 'prejudice', however, it is hoped that 'negative racial sentiments' will provide a category for discussion in this research in which generalized racialized content, subtle forms of racism (Van Dijk, 1987), and xenophobia, tribalism, and Afro-pessimism can be reflected upon. The category is intended as inclusive without necessarily throwing therapists into a debate as to what constitutes 'racism' in a client's expression.

At this juncture it is important to point out too that this study is not looking at fear of crime, which is often closely linked to racism. Fear is often a rational response to experiences that can guide purposeful action and future safety (Skogan, 1995). Fear reflects people's perceptions of their individual vulnerability to trauma and its harmful consequences, as well as real statistical risks, experience of personal victimization and experiences reported by friends, colleagues, family and the media (Skogan, 1995). This study is concerned with the way in which these fears about crime might be translated into unease about race relations by clients, or conversely how negative racial sentiments might be irrationally confirmed by trauma.

What is of interest is why fear and hostility post-trauma should be embodied as racist expressions and not take other forms. Rustin (1991) provides what seems to be the most useful explanation as to why race and not some other attribute is emphasized in contexts of stress and anxiety. Race in and of itself is meaningless, although categories such as ethnicity or culture are often mixed up with race. However, when race is not conflated with other connotations or association, such as those of class, it holds no particular

identifiers of it own (Rustin, 1991). In its emptiness lies its power. Almost like the blank slate or therapeutic neutrality required from the therapist on which a patient can project their unconscious material, race becomes an open category for people to invest with meanings, phantasies and projections. It has even been argued that 'race' is an easily available container into which negative feelings can be released (Davids, 2004; Frosh, 1997; Rustin, 1991). This introduces the discussion of psychodynamic understandings of racism.

2.3.3 Psychodynamic understandings of racism

Christopher Lane (1998) argues that the inclusion of unconscious dimensions is essential in attempting to understand the dynamics of racism. He argues that phantasy organizes the meaning of racial and ethnic identity. Traditional approaches to racism have focused on false consciousness or faulty cognitions. However, if racism were a purely conscious phenomenon it would respond to counter argument. Knowledge should by implication enhance cultural understanding and diminish hostility (Lane, 1998). Studies such as Benn's (2006) enquiry into the alterations of racial perceptions of victims following trauma, confirm that in practice racism can indeed coexist alongside equally valued ideals of cultural and ethnic diversity. Racial sentiment seems to defy rational thought in is tenacity and begs for more psychoanalytic explanation as to why it endures when experience disconfirms negative stereotypes outright (Frosh, 1997; Lane, 1998; Rustin, 2001).

A common strategy to promote integration is the use of anti-bias workshops or exposure to people outside one's conventional social circle to appreciate their fellow humanness. Such strategies are based on the fundamental hope that freed from struggle and conflict human beings will place others' needs on a par with their own (Lane, 1998) and that people are essentially communitarian. Certain psychoanalytic theories present an alternative view of human nature and the psychic factors that fuel acrimony and hatred. A less optimistic view of human nature can be found in Freud's understanding of civilization where man's constitutional inclination to be aggressive to other human beings is argued. Although this theory does not engage directly with race, it presents a cogent, if dated, account of human enmity, and has influenced later psychoanalytic formulations (for example, Lane, 1998; Rustin, 2001).

2.3.3.1 *Civilization and its discontents* (Freud, 1930)

Freud (1930) declares that civilization is built up out of renunciation of instinct or is founded on instinctual non-satisfaction. Social relationships between human beings are consequently dominated by 'cultural frustration' and it is the cause of hostility and conflict against which all civilizations have to fight. Freud questions how it is possible to deprive an instinct of satisfaction and cautions that doing so is not without danger. If the loss or non-satisfaction of instincts is not compensated for economically, he predicts that serious disorders (both personal and social) will ensue. Although Freud's reference is to psychic disorder, it is possible that one could think of violent crime against others and the holding of racial prejudice as forms of 'disorder' stemming from the 'discontents' related to the necessary bounds of civilization.

One of the ideals demanded by civilization in order for it to survive runs: 'Thou shalt love thy neighbour as thyself.' Freud (1930) argues that this is a preposterous command. The recipient of love must be deserving of that love in some way. For example, he or she might deserve it on the basis of being so similar to oneself that one can love oneself in the other. It is argued that it is hard to love a stranger who attracts no worth in terms of his or her own significance. To do so, Freud argues, would be an injustice to one's own people for whom love signals that they are preferred to others and whose significance would be undermined were one to put others on a par with them. Freud argues that a stranger is not only unworthy of love but conversely has claim to one's hostility. Human beings have differences. These differences are classed as either good or bad on the basis of socially generated criteria. Freud (1930, p. 111) emphasized human beings' primitive aggression:

> …men are not gentle creatures who want to be loved, and who at the most can defend if they are attacked; they are, on the contrary, creatures among whose instinctual endowments is to be reckoned a powerful share of aggressiveness. As a result, their neighbour is for them not only a potential helper or sexual object, but also someone who tempts to satisfy their aggressiveness on him, to exploit his capacity for work without compensation, to use him sexually without his consent, to seize possessions, to humiliate him, to cause him pain, to torture and kill him. Homo homini lupus (man is wolf to man).

When the forces, which ordinarily inhibit aggression, are removed, the instinctual aggression of human beings is revealed. The human inclination to aggression complicates relationships to one's 'neighbours'. Freud explains how small cultural groups allow themselves the advantage of having an outlet for their aggression by forming hostility towards intruders or people outside of their 'own' group. One of the ways people bind together is to identify other people left outside of the grouping onto which all of the negative manifestations of their aggressiveness can be projected. Although critical of his

own phrase, Freud (1930, p.305) refers to this as “the narcissism of small defenses”. It is the mechanism by which group cohesion is made easier and aggressiveness is given some convenient satisfaction by finding an outlet in directing antagonism towards those outside of one’s own grouping.

Freud sees civilization as the work of Eros with the purpose of combining individuals into families, races and nations, and into a unity of humankind. However, humankind is not cohesively held together in this way because of the conflicting aggressive instinct, which is the main derivative and representative of the death instinct, in conflict with Eros the life instinct, that brings hostility ‘against all and of all against each’ (Freud, 1930, p.313).

In summary, a person’s neighbour is both the cause and the object of his or her distress (Lane, 1998). Lane (1998) elaborates in arguing that other people elicit the hatred that a person experiences internally, given the superego’s ‘tyrannical’ relation to the ego (Lane, 1998, p. 6). Such explanations may be useful in thinking about why racism continues to occur in liberal times. If one accepts aspects of the instinct theory it could be speculated that the more society restricts aggression, the more human beings unconsciously seek a vehicle on which to project their unacceptable parts or to vent internal aggression.

The displacement hypothesis also proposes that if energy or libido cannot be released in the direction in which it was intended, a displacement of the energy onto a substitute will occur (Freud, 1915; 1923). In a trauma the guilty perpetrator is not generally available to the survivor as an object on which the discharge of emotion can take place. A substitute has to be found on whom to redirect one’s anger and the easiest substitute may be someone who looks similar to the perpetrator.

2.3.3.2 Projection and post-Freudian developments

Building on Freud’s theory, the construct most commonly used to explain racism is the unconscious process or defense mechanism of projection (Dalal, 2001). The basis of projection is that an inner conflict between the id and the superego seeks resolution by ascribing the unacceptable id impulse to someone else (Freud, 1930). Racism may be conceived of as a group mediated form of projection, in which disowned aspects of one’s own identity are attributed to members of another group. Racism operates when impulses construed to be unacceptable are split off and identified in another race group to preserve

the self. Complementing this notion of projection at work, racism can also be construed in the Kleinian sense as an attempt to ward off anxiety (Frosh, 1997; Rustin, 1991; 2001). Various theorists have presented versions of this understanding of the mechanism of racism. For example, at an individual level, Adorno, Frenkel-Brunswik, Levinson, and Sanford (1950) identified how people who repressed personal conflicts projected these onto others and how their hostility found its easiest receptacle in minority groups.

Fanon (1967) wrote of the struggle for identity faced by the oppressed when projective identifications bombard one's racial group. He argued that the person who finds themselves at the receiving end of these projections has no control over the meanings ascribed to or forced upon his or her race group. He understood the experience to be one of projective identification; the expulsion or disavowal of unconscious needs and qualities of the racist by depositing them in an unwilling other who subsequently is forced to be identified with and to identify with these projections (Fanon, 1967).

Rustin (1991, 2001) examines the usefulness of Kleinian ideas for understanding racism and other social phenomena. His argument provides some insight into the irrationality of racism. Racism, he explains, is rooted in primary process thinking, akin to psychotic or primitive mental processing. What is unconscious does not subscribe to reason.

> …the psychotic attributes of the mind that are universal, original and latent components of human mentality; never wholly banished from the self; liable to become salient in conditions of fear and anxiety rather than in more benign settings; and of course more central and pathogenic in some individuals than in others, sometimes for explicit reasons in an individual's psychic history.
>
> (Rustin, 1991, p. 62)

Rustin (2001) makes an argument that Kleinian concepts can be used to formulate the structure of societies. He suggests that this thinking is characteristic of paranoid-schizoid forms of functioning. South Africa is used in his argument as an example of a nation emerging from a 'paranoid-schizoid structure' (Rustin, 2004). He suggests that societies emerging from this paranoid schizoid structure seem to enter a 'borderline' state, which involves a characteristic state of paralysis. He says that in this borderline state there is an inability to recover from the original structure and paranoid-schizoid outbreaks such as violent crime and racism continue to occur. He suggests that in these conditions violent ethnic conflict takes place, akin to a psychic collapse. In this state he says that all weakness and evil is expelled into stigmatized objects. The self narcissistically identifies

with an omnipotent, idealized object. The processes of idealization and denigration (or what he calls demonization) are a form of regression to paranoid-schizoid functioning. This regression he suggests, destroys the capacity to apprehend reality. At a societal level he uses this mechanism to explain racism. Objects are perceived only as sources of potential danger and are not recognized as having separate existence or as capable of suffering their own pain (Rustin, 2001).

Frosh (1987, 1997) argues that it is through irrationality that social and political levels of oppression are upheld. Frosh argues that the racist cannot tolerate reality as it is and thus resorts to irrational primitive processing. "Racism is a lie that is experienced as a truth, if the racist could tolerate the world as it was, or the self as it has become, then they would not need to find denigrated objects onto which to dump all their internal mess" (Frosh, 1997, p.220). Frosh (1997) and Rustin (1991; 2001) both draw on Bionic concepts of the breakdown in symbolic thinking to explain the irrationality of racism. Bringing together contradictory feelings and perceptions or reality is the precondition for symbolic capacity (Rustin, 2001). The psychic cost of investing in the lie that is racism, is that an unhealthy dependence results. The racist cannot survive without the denigrated object. The racist needs the hated other in order to feel alive (Frosh, 2002; Kovel, 1995). For these reasons, racism is regressive and psychically toxic. Hinshelwood (1989) outlines the ways in which projective identification has negative consequences for the individual who employs it. The dislocation of the self and underlying splitting leaves the individual with the sense of being in pieces or of being fragmented, the ego is left feeling weak and depleted with the client commonly complaining of having no feelings. Severe anxieties may be generated by fear that the object will retaliate, to name but one cost of the use of this defense.

Thus within psychoanalysis, racism has largely been understood as a manifestation of a primitive defensive strategy whereby unacceptable impulse and feelings are attributed to external objects and the self is preserved in particular ways. Different theorists place different weight on a variety of aspects of this kind of 'pathological' process.

David's (2004) conceptualization of a 'pathological racist organization' suggests that this kind of internal psychic formation may be endemic to human functioning. He suggests that the psyche may have an almost inherent "pathological racist organization", which is continuously present, but only operative at times of stress (Davids, 2004, p.12). He

understands the particular direction of the defense towards a racialised target as pre-empted by a host of pre-established conditions, thus strongly emphasizing the importance of social conditions for the racial manifestation of the projection to occur. He argues that individuals develop intrapsychic templates of relationships during their formative years based on their experiences with close others, who in turn are inserted into a social milieu. These 'templates' built up in the psyche to regulate expectations of the world, are common. When an expectation is violated by someone who deviates from the script, a racist attack takes place (Davids, 2004). The 'normality' of this organization lies in the fact that it is common, not that it is necessarily healthy or acceptable. His conception allows for an explanation of why racism would result after a trauma. Violence produces high levels of stress and the circumstances of the trauma deviate from an expectation for safety and of non-antagonistic behaviour, that is, deviate from templates. The groundwork laid by political and social history and circumstances prepare the category of race as an ideal target for hate-feelings. Then in moments of stress, racism is unleashed. Thus, although David's theorization was not intended as a theorization of negative racial sentiment in the aftermath of trauma it provides a further potential model for understanding the mechanisms that may be at play.

This discussion of how various psychoanalytic theorists have understood the possible dynamics involved in racism has highlighted some of the central themes in the literature. Beginning with Freud's argument concerning instinctual aggression and the hypothesized human need to direct this aggression at an acceptable target, that is, those outside one's immediate group, the discussion then looked at more contemporary formulations. The idea that disowned aspects of the self are projected into the other, who then attracts censure was elaborated, together with the notion of projective identification, that is, that the one projected into is forced to identify with the projection. The primitive nature of racism in terms of the kinds of thinking involved was also theorized to be related to regression, paranoid schizoid and pre-symbolic functioning. The idea of an internal 'pathological racist formation' was also presented as a formulation that attempts to draw together some of these ideas with an awareness of the significant role played by pre-existing social discourses or templates. Rather than attempting to thoroughly theorize racism in psychodynamic terms, the section was presented to provide some background to the kinds of ideas that it was anticipated that the therapists might draw upon in their conversations about working with this phenomenon in psychotherapy.

This review of a range of bodies of literature has attempted to provide an overview of core concepts used to understand trauma and racism from a psychodynamic framework. As few sources that straddle these topics were located in the literature, attempts were made wherever possible to draw inferences and to make theoretical links. When an individual is faced with a violent trauma in the external world, it is understood to confirm early phantasies. If working psychodynamically with traumatized clients, rather than focusing primarily on symptoms, the psychotherapist aims to modify and shift problematic object relations and to engage with the person's internal world. Psychodynamically oriented psychotherapy also aims to assist the patient to incorporate traumatic events into their thinking and functioning without overlooking any split-off, encapsulated or avoided sentiments that might inadvertently be aroused by future circumstances (Garland, 1998). How negative racial sentiment post-trauma is engaged with from this perspective was the primary focus of the research. The following chapter describes the method used to conduct the study.

CHAPTER 3
RESEARCH METHOD

3.1 INTRODUCTION: QUALITATIVE METHODS IN PSYCHOLOGY

The study was located within a qualitative research methodology. Qualitative research involves the detailed analysis of material enabling the researcher to capture depth, detail and nuance (Paton, 2002). Qualitative methodology was chosen for this study as it allowed the complexity of a particular therapeutic occurrence to be explored. The choice to use a qualitative research method arose from the nature of the research questions posed which involved enquiry about therapist's opinions, experiences, understandings, dilemmas and responses to patient negativity in relation to race following a traumatic event. Qualitative research is committed to an emic ideographic position valuing rich descriptions of the social world and privileging the search for meaning and understanding (Denzin & Lincoln, 1994; Elliott, Fisher & Rennie, 1999; Stevenson & Cooper, 1997).

The research paradigms employed in this study were broadly descriptive and interpretive. Interpretive research takes as its primary point of departure the value of individual subjective experience (Terre Blanche & Kelly, 1999). The experiences of participants are then placed within some kind of perspective rather than simply represented (Terre Blanche & Kelly, 1999), the aim of the interpretive part of analysis being to create a balance between neither imposing theoretical understandings on material, nor simply reproducing information without some critical consideration of the phenomena.

3.2 RESEARCH AIMS

This research aimed to explore how negative racial sentiments amongst trauma clients are understood, worked with and responded to in therapy by psychodynamically oriented therapists. It was hoped that information gleaned from experienced psychodynamically oriented therapists would contribute to theoretical and technical understanding of this phenomenon and how to work with such negative racial sentiments sensitively and appropriately for the good of the client and society at large. This study also hoped to explore the possible ethical dilemmas this raises and countertransference responses.

3.3 RESEARCH QUESTIONS

In order to support the research aim, three broad questions were posed:

- How do psychodynamically oriented therapists *understand* negative racial sentiments amongst trauma clients?
- How do psychodynamically oriented therapists *work with* negative racial sentiments amongst trauma clients and what thinking informs their approach?
- How and why do psychodynamically oriented therapists *respond to* negative racial sentiments amongst trauma clients?

3.4 METHODOLOGICAL APPROACH/ FRAMEWORK

3.4.1 Interpretive inquiry/ hermeneutics

A layering of two main theoretical approaches is present in the study: The participants gave data about psychotherapeutic practice of an interpretive or psychodynamic nature, which the researcher then presents from a more descriptive or interpretive hermeneutic. Strous (2001) describes two traditions in psychological research and in psychotherapeutic practice: a hermeneutic of faith in the subjective accounts of patients or participants and a hermeneutic of suspicion (Straker, 1987). If operating from a more client-centered and phenomenological perspective, then client or participant verbalizations are accepted in their essence without interrogating them for hidden meanings, such as unconscious processes (Strous, 2001). However psychodynamic therapies or more discursive methods operate from 'a hermeneutic of suspicion,'(Straker, 1987) looking as much at what the data conceals or defends against as what it reveals. In the present study the researcher adopted more of the former approach, seeing the participants predominantly as experts in their field and using their experience to generate theory on a particular topic in a descriptive and interpretive way from a hermeneutic of faith. The participants themselves often employed critical reflection upon material in the interviews. Thus the participants interpreted and presented ideas about the hidden meanings and defenses of their patients. Their interpretations are largely taken at face value by the researcher and presented as findings. However, because this study employed an interpretive methodology some interpretation of and critical commentary on the data on the part of the researcher is also made. This allowed the researcher to present less transparent findings, points of debate or

apparent contradictions in the interview data.

To explain the process of interpretation of research data, *the hermeneutic circle* or *circulus fructosis* is referred to in many interpretive studies (Kelly, 1999; Kvale, 1996; Patton, 2002). Separate parts of the text are understood and interpreted within the context of the global meaning of the text as well as the context within which the research took place (Kvale, 1996). The spiraling process entails a back and forth movement between parts of the text and the whole allowing for a continuous deepening of understanding and meaning. The aim of this is to establish sensible patterns or coherent units that will function as themes, what Kvale, (1996, 46) refers to as '*a good gestalt'*. These themes are then tested against other texts as well as against their own frame or global text. This is both a deductive and inductive process. In addition, this process requires the researcher to remain aware of his or her presuppositions throughout this process. The researcher combines a first and third person perspective. The accounts are in a sense constructed between the researcher and the participants. Interpretation then takes places by distancing oneself from the research material and reengaging with it as a separate text (Kvale, 1996; Schwandt, 1998). This circularity of the process also allows for both inductive and deductive elements as the data is interpreted both in terms of existing theory and in terms of what fresh dimensions it might point to.

In phenomenological inquiry the essential experience of others who experience a particular phenomenon is studied intensely (Paton, 2002). The third research question, concerning therapist responses, amongst other possible aspects, enquired about therapists' personal experience in the form of countertransference when particular negative sentiments are expressed to them. It is thus noted that the exploration on some more descriptive aspects of data may be phenomenologically informed in the sense that an attempt was made to understand experiential aspects of the phenomenon being researched However, given that the study was quite strongly theoretically driven, drawing explicitly on psychodynamic ideas, it was clearly not predominantly phenomenological in orientation.

In summary this study is ontologically relativist, epistemologically subjectivist and methodologically hermeneutic and interpretive.

3.5 PARTICIPANTS

Purposive sampling allows research participants to be selected according to criteria relevant to the specific research project (Willig, 2001). Because this study focused on a particular context namely, therapists' perceptions of working with negative racial sentiments amongst trauma clients, a purposive rather than a random selection method was used. The participants approached were selected with a view to eliciting useful manifestations of the phenomenon of interest (Miles & Huberman, 1994; Paton, 2002; Terre Blanche & Durrheim, 1999). Purposive sampling allowed for a sample of participants who shared particular characteristics, interest and expertise in a particular area of therapeutic work.

All participants were practicing clinical psychologists registered with the Health Professions Council of South Africa. Criteria for inclusion as a participant in the sample included that therapists self-identified themselves as psychodynamic in orientation or leaning. Participants were approached due to some identified specialist experience in working with trauma in South Africa.

Between October 2006 and July 2007 8 research participants were interviewed. The information sheet was extended to 14 therapists in total. Reasons given for declining the invitation included lack of availability (3 therapists), lack of interest in the topic (1 therapist) or lack of sufficient experience of the phenomenon (1 therapist). Creswell, (1998) identifies the minimum sample size for qualitative research as being between 6 and 9 participants. This point is supported by Eagle, (1998) who reports that qualitative methodologies attempt to access rich, diverse information from fewer participants and sample sizes of less than 10 are frequently used and sufficient for this aim. It was felt that 8 participants would be sufficient to generate information in the area of interest as well as to lend credibility to this information (Paton, 2002). Although a larger sample may have generated even richer data, resources and time constraints were limiting factors as well as the fact that this was a study of limited scope. In defense of smaller samples sizes, Coyle, (1995) argues that larger sample sizes often add to the analytic task without adding much to the analytic outcome.

Candidates suitable for participation were largely selected on the advice of trauma experts in the Johannesburg therapeutic community, thus this was also a *convenience sample*. At the end of one of the interviews, one participant recommended another two therapists and

this led to some *snowball sampling*. All eight interviewees were obtained by third party referral. Thus, this was not strictly speaking, a volunteer sample, the participation of the therapists who agreed to be interviewed could be viewed as cooperative. Initial telephone contact was made and the nature of the study was explained, specifically, the interest in NRS and the fact that data collection would involve recoding the interviews, which would then be transcribed.

3.5.1 A brief overview of the orientations and experience of the therapists interviewed

The numbering introduced here will be used in the analysis and findings chapter. "T" denotes therapist and the numerals assigned were selected for confidentiality purposes. The sex of particular participants has at times been altered to further protect participants from possible identification based on the contexts in which they work described below. Six of the participants were female and two male. The participants came from a range of cultural backgrounds. The racial composition of the sample consisted of 7 white therapists and 1 black therapist. This may be reflective of the demographic of practitioners in which there are still more white psychodynamic therapists in practice than psychodynamic therapists from other racial groupings in Johannesburg. Not immediately pertinent to the research but of interest is the varying length of time the therapists had been practicing in the trauma field. Three of these participants had been qualified and working as therapists in both the pre and post 1994 context, working in the field of trauma through apartheid and the transition to democracy, and 5 therapists had started working in the field only after the 1994 elections. The 8 therapists interviewed identified their orientations as follows:

Participant one identified herself as working primarily with middle to upper class patients.

> *"I have been trained psychodynamically but I am quite eclectic within the psychodynamic model. I am particularly interested in object relations, and I have a particular fondness for Winnicott " [T1]*

The second participating therapist works in Johannesburg in private practice, in an academic setting and at a trauma clinic in a supervisory capacity.

"My orientation is primarily psychodynamic, primarily object relations within that and a lot of my focus in long term therapy would be around relational dynamics" [T2]

Participant three works in private practice with both adults and children.

"I certainly do come from a psychoanalytic background and that is where my mind automatically goes but I don't necessarily always act on that or work in that way. I have had a lot of experience with trauma in adults as well as with children."[T3]

Therapist four works in private practice with long-term patients and trauma patients specifically. This therapist also works in clinic settings as well as in a supervisory capacity.

"I am psychodynamically trained but I work mostly integratively, but I certainly think mostly psychodynamically" [T4]

The fifth participant differentiated between her short-term work in trauma settings and her longer-term therapy work. She has worked in contexts such as employee assistance programs, community and trauma clinics in Johannesburg (in a supervisory capacity) as well as practicing longer-term therapy in private practice. This therapist worked with trauma in community contexts through the years of apartheid.

"I am psychodynamically oriented. A lot of my work is short-term work, which means that I am not always purely psychodynamic in my therapy stance but my understanding of clients' history is completely psychodynamic. I have a fondness for the self psychologists and for Winnicott." [T5]

Participant six works in a community clinic context with a diverse population of clients as well as at two trauma clinics in Gauteng. This therapist has also completed academic research in the area of trauma.

"I am psychodynamic. I think a lot in terms of Kleinian stuff in terms of how I formulate. My trauma work is different. I still try and formulate using object relations stuff but not as in depth, more in terms of restoration in functioning." [T6]

Participant seven works in the community and clinical context as well as in private practice.

"My prejudices are psychodynamic but I was trained systemically. I have a

> *constructivist prejudice as well. I make use of psychodynamic understandings more than anything else. I think that my therapy is informed by attachment theory and I have always found Klein very compelling. I will not necessarily always make use of them, whatever connects to the client best." [T7]*

Participant eight has completed in depth academic work in the area of interest in this study. This therapist works in private practice as well as in academia and in a supervisory capacity at a Johannesburg trauma clinic. Participant eight pointed out that he or she has only seen black patients in private practice.

> *"I am psychodynamic in approach. I feel my persuasion would be insight oriented. Within the psychodynamic realm I am more comfortable with self-psychology but also comfortable with object relations. I have studied beyond a Masters professional training, which has broadened the way clinical training enables you to see things and think about things. The broader exposure to the social sciences has helped me to have a deeper understanding of certain issues" [T8]*

The choice to interview psychodynamic therapists was made explicitly as part of the design in order to refine the focus of the research. It seemed evident however from the therapists' biographies and accounts that psychodynamic theory was often used as a way of thinking about and informing their work but was not necessarily what always shaped their interventions in the trauma context. This distinction will be considered further in the discussion section of the report.

3.6 DATA COLLECTION

After seven months of immersion in the literature, interviews with eight therapists were conducted. The interviews were held at locations convenient for the participants, negotiated with the participants. This included, for instance, the practice rooms of six therapists, the researcher's own office and the home of one participant. These locations allowed for confidentiality to remain intact as well as to increase interviewee comfort. The interviewees chose a time convenient for them for the interview. In the majority of cases the interview lasted approximately fifty minutes, the time of a therapeutic session that the therapist had vacant. Two of the interviews were slightly longer as they took place after hours. After the first two interviews had taken place they were transcribed and discussed with the research supervisor. Themes that seemed to be evident in these interviews were highlighted and kept in mind for the following interviews. It was decided that the interview schedule was appropriate and no alterations were made.

3.6.1 Interviews

Semi-structured interviews were chosen as the method of data collection for several reasons. Interpretive research requires rich descriptive text or interview narrative for analysis. The purpose of the study was to develop ideas and research hypotheses rather than to gather facts and statistics. An exploratory interview fits these heuristic purposes (Oppenheim, 2004). The face-to-face interactional exchange of dialogue allows 'loaded', sensitive or complex topics to be spoken about freely (Mason, 2002; Oppenheim, 2004). The interview occurs over a period of time, approximately fifty minutes in this study, allowing feelings and thoughts on a topic to develop. During the interview the researcher is also able to listen with a 'third ear' paying attention to what is being said as well as what is not being said, which cannot be achieved with questionnaires (Oppenheim, 2004). The semi-structured interview allowed the researcher to obtain not just the answer but also the reason for the answer. Interviews also allow for reflexivity on the part of the researcher (Banister, Burman, Parker, Taylor & Tindall, 1994). The use of open-ended, directive and non-directive questions in this study allowed for the participating therapist's experiences and understandings of the phenomenon to emerge in as much detail as possible. The directive questions tapped into specific areas identified in the literature as possibly more contentious, for example, ethical dilemmas and how the therapist negotiates these. The more open-ended questions allowed unexpected themes to arise. In the initial conceptualization phase of the research it was debated whether to use individual interviews or focus groups to elicit the most useful data. It was decided that this study would be more exploratory and aim to capture how therapists are finding their own way of working before setting up possible forums for debate.

The interview schedule was derived from the literature and from practice concerns discussed with various trauma experts and the research supervisor (See Appendix C). It was used to create a guiding structure to answer the research questions, with identified areas of interest and probing questions. The questions were designed to elicit both descriptive and applied answers, asking for examples of cases therapists had encountered, as well as more technical or theoretical answers. Clarification was sought and reflections allowed meanings to be constructed in the dialogue, however, the researcher's role was primarily to facilitate the participant's narrative.

All interviews were audio recorded to allow for transcription and analysis. Because

audiotaping can potentially lead to some initial self-consciousness, the interviewer attempted to 'break the ice' before starting to audiotape by engaging generally with the therapists about their well-being or their clinical practice. However, being therapists, the interviewees were so accustomed to building rapport it felt at times as if it was the interviewer who was put at ease. Any queries the participants had about the interview or its purpose were also addressed prior to audiotaping. (As discussed later, ethical principles were observed in obtaining consent to interview and audiotape).

3.7 DATA ANALYSIS

This study was concerned with the themes that emerged from the interviews and therefore employed thematic analysis. Thematic content analysis is a more interpretive form of content analysis in which emergent themes are identified, put into categories (Berg, 2007; Krippendorff, 2004; Neuman, 1997) and elaborated "on the basis of systematic scrutiny" (Eagle, 1998a, p.214). Thematic content analysis was chosen over quantitatively oriented content analysis because the exploratory nature of this study meant that the intention was to understand therapist's responses and to draw inferences from the interview texts rather than to know the frequency of particular responses found in the data (Patton, 2002). The procedures of thematic content analysis are essentially designed to reduce and categorize large texts into meaningful units from which interpretations can be made or theory can be deduced (Banister et al., 1994; Berg, 2007; Krippendorff, 2004). Although thematic content analysis was the primary means of analysis, because the nature of the data lent itself to such discussion, relevant discursive elements were touched on where it seemed useful to do so. Thus the study employed a more critical thematic analysis in respect of some elements as discussed previously.

3.7.1 Steps in the Analysis:

The process of reduction and extraction was influenced by a number of commonly accepted procedural steps (Wimmer & Dominick, 1987). Lieblich, Tuval-Mashiach and Zilber, (1998) outline four steps for using thematic content analysis to analyze interview data. Terre Blanche and Kelly, (1999) identify five steps to guide analysis but caution that analysis rarely proceeds in a stepwise manner and may rather be less linear in reality. A combination of these two approaches to thematic content analysis was used in this study.

The transcripts were analyzed by using the following steps:

Step 1: Familiarization and immersion (Terre Blanche & Kelly, 1999)
Before data was even collected the researcher had studied considerable literature on the phenomenon of interest. In discussions with the research supervisor, peers and other therapists, ideas and theories about the phenomenon being studied were already starting to form. For example, the researcher met with a previous master's student whose research had involved investigating a similar topic of interest, i.e. how racial schemas are altered following a trauma. The initial familiarization with the topic allowed for nuances to be clarified during the interviews when they arose. Terre Blanche and Kelly's, (1999) suggestion of using diagrams and brainstorming when conceptualizing a study was followed.

Step 2: Inducing themes
Once the interviews had been transcribed each transcript was read several times. Any interesting or significant responses were noted. Themes were listed and connections between themes were considered. The defining of content categories was both a deductive and inductive process. The interview questions served as the original content categories for comparing interview content, which is a more deductive process, the interview schedule having been formulated from themes in the literature and identified practice concerns (Neuman, 1997). Out of these original categories more implicit themes or subtexts (Lieblich Tuval-Mashiach and Zilber, 1998) were identified by both researcher and supervisor and used as organizing categories, which is a bottom up or inductive process (Terre Blanche & Kelly, 1999). Joffe and Yardley (2004) suggest that latent themes drawn from scrutinizing the manifest data require deeper interpretation of the text. One such example in this study was the identification of therapists' use of implicit assessment criteria before making an interpretation in trauma work. Tensions and contradictions within the information in these organizing categories were noted.

Step 3: Coding (Terre Blanche & Kelly, 1999)/ Sorting into categories (Lieblich Tuval-Mashiach and Zilber, 1998)
During the process of coding the themes identified were given labels. Direct quotes were allocated to the appropriate categories at this stage of the analysis. Data was marked in different ways, such as coding and highlighting in different colours. A spreadsheet was drawn up (See Appendix A). In this way the body of text was broken down into what

Terre Blanche and Kelly (1999, p.143) call 'bits' of coded material, and reconstructed based on relations to other clusters of material. At times however it was noted that units could not be separated out into discrete themes (as noted by Eagle, 1998) and bits or sections of material appeared under more than one topic. Neuman, (1997) outlines the process of analyzing qualitative data in general as usually involving three stages of coding, namely, *open coding*, *axial coding* and *selective coding*. The first stage of open coding corresponds with step two, 'inducing themes' discussed above, in which themes are at a low level of abstraction arising form the research questions or concepts in the literature (Neuman, 1997). During the second phase of axial coding the researcher attempts to find causes and conceptual links, processes, strategies or concepts that cluster together. In this study an example of such clustering would be the identification of interpretive strategies versus cognitive strategies for working with NRS. The final stage of 'selective coding' corresponds to the stage of 'elaboration', discussed below, in which the researcher once again returns to the research questions and identifies the most important aspects identified in the themes and concepts (Neuman, 1997).

Step 4: Elaboration

As in step two the information initially grouped together was once again examined more closely to establish finer nuances and meanings potentially overlooked or misunderstood in the initial coding systems (Terrre Blanche & Kelly, 1999). This step of the analysis ensured a more cyclical examination of the data, going back and reinterpreting information that was grouped together and evaluating whether such grouping was indeed appropriate.

Step 5: Interpretation and checking

The final step in the analysis involved putting together the final interpretations of data (Terre Blanche & Kelly, 1999). Interpretations were used to formulate possible answers to the research questions and to draw conclusions from the results (Lieblich Tuval-Mashiach & Zilber, 1998). The last step of this process, whereby a written account of findings was assembled, forms chapter four of this report aiming at what Paton (2002) terms the creative synthesis of the inductive analysis. The researcher's own role in the data collection and formation of interpretations was again considered at this point including how subjective opinions or subtle social positioning may have coloured the data or influenced participants (See Chapter 5- reflexive considerations).

3.7.2 Validation

Creswell, (1998) suggests eight procedures to validate qualitative research findings: prolonged engagement and persistent observation, triangulation, peer reviewing or debriefing, negative case analysis, clarifying researcher bias, member checks, rich thick description and external audits. It is recommended to use at least two of the procedures.

Peer review was used as an external check on the research process. Research supervision also allowed for debate and clarification of understandings of the data that emerged out of the interview data. In addition, the semi-structured interviews and verbal skill and reflective capacity of the participants allowed for thick description. The reflexivity commentary includes possible observations of researcher bias. Thus it was hoped that sufficient validity checks were implemented to establish the strength or coherence of the findings.

To satisfy dependability criteria, the data analysis aimed to show a clear audit trail rich with examples of the subjects' responses in the text (Flick, 2003). Therapists' responses were directly quoted to substantiate findings.

3.8 REFLEXIVE CONSIDERATIONS

Within qualitative research it is often argued that subjectivity cannot be circumvented and should in fact be accepted. The role of the researcher needs to be considered, particularly when human experience is being studied. In this study the researcher was both the primary instrument for collecting and analyzing the data (Terre Blanche & Durrheim, 1999). Taking the role of hermeneutist, the researcher was aware of her role in constructing the 'reality' presented in this study (Eichelberger, 1989). The researcher's (and research supervisor's) interpretations of the data construct the reality presented with the help of the participants who provided the data (Eichelberger, 1989).

In the concluding chapter of this research, an attempt is made to look back on the study and to critically evaluate the possible impact of the researcher on the outcome. Important considerations in the context of this research were the ethnicity of the researcher, as 'white' in terms of racial categorization, and the fact that the researcher was 'junior' in experience to the therapists interviewed. The researcher's cultural and ideological

positioning and how this may have influenced the interpretation and selection of 'findings' is presented.

Given the researcher's interest in negative racial sentiment post-trauma, and the particular questions or reflections made, participants may have responded in particular ways (consciously or unconsciously), influenced by the researcher's stance (possibly assumed to be liberal).

3.9 ETHICAL CONSIDERATIONS

Ethical guidelines enunciated in the code of conduct for psychological research by the Professional Board of Psychology (PBP, 2004) were followed.

The therapists interviewed for the study volunteered themselves and were not offered compensation of any kind for their participation. An invitation to withdraw from the study at any time was extended at the start of each interview as well as the assurance that should any participant not wish to answer any particular interview question this was acceptable. The information letter received by participants prior to agreeing to participate assured potential respondents that no negative consequences would ensue should any person chose not to participate in the study (See Appendix D).

Confidentiality was ensured through disguising and removal of most of the participant therapists' particulars as well as any potential identifying details of patients referred to in the interview material. They were also assured that as far as possible no identifying information would be incorporated in the research report or into any publication arising from the research. Participants were, however, made aware that the researcher intended to use direct quotations from the interviews in the research report for purposes of illustration, validation of argument and analysis. The quotes used in this final report were selected in such a way as to attempt to ensure that no participant or patient could be individually identified. Consent was obtained for participation in the study as well as explicitly for the interview to be recorded. No therapist objected to the recording of his or her interview. The recordings will be destroyed after examination of the research report. They will be kept in a safe place by the researcher until such time (See Appendix D & F).

It was decided to include a basic interview schedule in the information sheet sent to all

participants in the study prior to the interview due to the potential sensitivity of the topic. Participants were thus recruited with full knowledge of the scope and content of the project as well as what the interview would generally entail. This allowed them to give 'informed consent'.

CHAPTER FOUR

ANALYSIS AND DISCUSSION

In keeping with much qualitative research, the presentation of research findings and the discussion of emergent themes take place concurrently in this chapter. The themes identified during the data analysis process are categorized in this chapter under the headings provided by the three research questions:

1) How do psychodynamically oriented therapists *understand* negative racial sentiments amongst trauma clients?

2) How do psychodynamically oriented therapists *work with* negative racial sentiments amongst trauma clients and what thinking informs their approach?

3) How and why do psychodynamically oriented therapists *respond to* negative racial sentiments amongst trauma clients?

The interview transcripts produced clear evidence that negative racial sentiment is a phenomenon encountered by the eight therapists who participated in this study in their work with traumatized patients. It is also clear from the transcripts that this is an area in which therapists are finding their own way of working. After presenting the participants' affirmations that this is indeed a phenomenon they are witnessing in their work with traumatic stress, the second section of the analysis focuses on how therapists understand this response psychodynamically. The material presented draws on theory and on case material. The third section of the analysis is then informed by the research question, "how do psychodynamic therapists work with negative racial sentiments amongst traumatized clients?" The themes discussed in this section include whether NRS is indeed something therapists would work with, whether directly or symbolically; implicit assessment criteria therapists consider when making an intervention; and the technical dimensions of interventions therapists considered. The fourth and final section reports on the various countertransference reactions experienced by therapists, ethical issues and the therapists' imperatives when working with NRS. Therapeutic guidelines suggested by participants conclude the chapter.

4.1 THE OCCURRENCE OF NEGATIVE RACIAL SENTIMENT (NRS) POST-TRAUMA

The first question posed to therapists was designed to establish whether or not they had indeed encountered negative racial sentiment post trauma. Their responses confirmed that the practice concerns identified in the research rationale were indeed real and prevalent. The following responses illustrate not only that post-trauma NRS occurs, but also the frequency of its occurrence.

> *I think I have never not encountered it. It has been an absolutely consistent theme with traumatized clients that there will definitely be a sense of this now becomes the identified threat and people who look like this, people who remind me of this… I have people who… it completely shatters them because they see themselves as non-racial, that they are liberal, open, they believe in the new South Africa and suddenly now a black man will walk into the lift with them and because this has been the figure of the assailant they will get such a fright they will have feelings towards this person. So to be really honest with you, when I got your questionnaires I sat and I thought have I ever not encountered it and my sense is that it has always been present to a lesser or greater extent.* [T1]

> *I would say negative racial feeling is the rule rather than the exception. I will never raise it or introduce it, but if it doesn't come up, I am quite surprised.* [T3]

T5, T6, T7 and T8 said they too encountered NRS often, giving examples of how this occurred in both black and white traumatized patients. It was noted that rather than arising purely in response to a traumatic event, these sentiments might also be something that gets '*woven*' into the way people integrate their trauma experiences [T8]. For some of the therapists, trauma was understood to expose an underlying feeling rather than as producing a new feeling, as discussed later.

T2 also found NRS to be pervasive, but only amongst patients with particular defensive structures.

> *I don't think that occurs in all people who have been through traumatic experiences. I think that is a function of preexisting tendency and predilection towards racist sentiment and also personality style that allows for that level of regression. Some people might regress or dissociate for an hour or two or three days but people who manage to do that in style I would say either have a very severe or extreme trauma or are themselves, their personality style lends itself to that sort of primitive defense strategy.* [T2]

Thus it appeared that some therapists considered the phenomenon commonplace and in this sense a 'normal' response to trauma, whereas others did not necessarily encounter such sentiments routinely and thus viewed such presentations as perhaps somewhat more

pathological.

T4 suggested that the length of the therapy was an important factor in whether negative racial sentiments emerged or not.

> *I have most definitely (encountered post-trauma racism), but also just to say that quite often in short-term work even though people are traumatised, they still come in with defenses and most conscientised people will have some sense that in this country it may not be okay to make racist comments so it might only be down the line in longer term therapy that the racism will come out. I think that is something to bear in mind. So somebody who hasn't worked in trauma might make the assumption that everyone who comes in or that many people come in and make racist comments when in fact that is not my experience. People are quite self-censoring and can take a little while to get to that. I think obviously there is no rule but I think there is an incredible sensitivity to making racist non-PC remarks over the last thirteen years and maybe it is the more liberal, clientele that I see, sort of liberal, broad-minded, educated, I think it is enormously hard for them to make those comments. I don't think it is rare, I just think it is rare that it will come out in blatant or extreme ways. Like I was saying I think people will preface it by saying something like 'I know it is not all black people…'* [T4]

This response suggests that therapists' experiences of expressed post-trauma NRS may not be a valid indicator of how frequently the phenomenon occurs. The sentiments may exist but remain unexpressed in therapy. Thus the argument that NRS occurs only amongst patients with a particular defensive structure might be challenged by this notion. Overt expressions of racism may in certain cases correlate with more primitive personality functioning, however, patients with other personality structures may experience racial responses but feel too ashamed or be too self-censoring to express them in therapy.

Little literature was found on whether or not post-trauma NRS occurs. The literature certainly suggests that racism continues to occur in post-apartheid South Africa (Benn, 2006; Davids, 2004; Duncan, 2004; Simpson, 1996). The literature also suggests that there are high levels of trauma in South Africa for various reasons (Eagle & Watts, 2002a, Leggett, 2005). A study by Benn, (2006) found that alterations in people's racial perceptions might certainly be an observed consequence of trauma. The findings in this study supported the observation that alterations in racial attitudes are a common response in South African trauma survivors.

All of the therapists who participated in this study recognized negative racial sentiments as a familiar response amongst trauma patients. This provides support for the research rationale and suggests that this is a valid practice concern. The implication of suggesting

that NRS occurs commonly in trauma survivors could be that such a response is seen as normal. David's, (2004) notion that racial sentiment can be both common and pathological could be relevant in this instance. The fact that NRS occurs suggests neither that it is necessarily a pathological response nor necessarily that it is a trauma symptom that warrants no concern. Such ideas and debates will be explored further in subsequent sections.

The participating psychodynamically oriented trauma psychotherapists were able to reflect on how negative racial sentiment (NRS) in traumatized clients can be understood, given their adherence to identifying of unconscious or latent content in therapy and defensive processes in their patients.

4.2 HOW DO PSYCHODYNAMICALLY ORIENTED THERAPISTS *UNDERSTAND* NEGATIVE RACIAL SENTIMENTS AMONGST TRAUMA CLIENTS?

Psychoanalytic thinking encompasses a variety of different psychoanalytic frameworks, for example classical, object relational and attachment-oriented thinking, each of which generates is own conceptualization of human emotional and mental functioning (Dalal, 2001). In this section of the analysis it becomes clear that the therapist making use of psychoanalytic thinking brought different interests and preoccupations to their interpretations. Rather than presenting a single account of the internal workings contributing to the manifestation of a negative racial response to a traumatic event in the clinical setting, the data obtained in this study presents a range of understandings of the phenomenon. These are at times antithetical to each other as Greenberg and Mitchell, (1983) caution that analytic theorization can be. The danger of selecting data that reinforced a particular thesis was considered and an attempt has been made to do justice to the many accounts of NRS that arose in the interviews.

4.2.1 Psychodynamic formulations of negative racial sentiment (NRS): Theory and Practice

In analyzing the data, it soon became apparent that therapists strongly endorse a way of working that is case specific rather than technique driven. For this reason some of the examples therapists spoke about will be presented along with how they understood their

individual patient's racial sentiments. Various examples of the operation of NRS have been selected to illustrate individual patient's dynamics. From these examples common themes are deduced. Therapists understood NRS as inter alia reflecting the use of defenses such as splitting, projection and projective identification; as representing the loss of the good object and the triumph of a bad object; as a consequence of a failure to symbolize; and as a displacement of anger. Each of these kinds of theorization will be elaborated further.

4.2.1.1 Splitting, projection, projective identification and the paranoid schizoid position

The majority, if not all of the therapists made use of Kleinian theory in formulating the origin of NRS. Thus they used the language of primitive defenses associated with paranoid-schizoid functioning in describing client/ patient responses. The therapists drew on notions of splitting, projection and projective identification, often in combination. While each of these defensive styles is discussed in turn below, it will be apparent that there was considerable overlap between categories in therapists' theorization.

The first case example illustrates how NRS is understood as reflecting the operation of the primitive defense of splitting.

Splitting: Case 1- The articulate man

T1 described a patient who came for therapy after having experienced two traumas. In the first incident she was attacked by black, male, teenage youths living on the streets who were loitering at a traffic light. The attack was opportunistic and although a horrible experience, it *"fitted into her fantasy of what a threat would look like"* [T1], and was not experienced as personally directed. However, her second experience of trauma *"completely threw her perceptions of people because she works in an environment with black empowerment and a lot of the people she works with are highly educated black men"* [T1]. The perpetrator was a *"highly educated and well spoken black man and this shocked her. Her expectation, or her fantasy before this attack happened, was that robbers are poor people, uneducated who can't speak the language properly. So it threw her that now any black man was a trigger."* [T1].

T1 went on to explain this type of thinking as clear splitting in the Kleinian sense.

"There is this clear splitting that happens between their good black people and their bad black people" [T1]. Before the second trauma occurred this split proved to be an unproblematic one for this patient, however, her views had to shift following the second trauma. According to the therapist, the patient preserved a sense of safety in the world after the first trauma by identifying threat for herself as represented by poor and uneducated people. However, rather than accommodating the fact that all people, and not just poor people, are capable of great destruction, after the second attack, the signifier of having a black skin became the common denominator shared by both perpetrators across her two experiences, replacing the now shattered causal attribution of *poor* and *uneducated* with race. It was initially too difficult for this patient to tolerate the ambiguity and pain of recognizing all human beings as both potentially good and potentially bad, so they were split into good and bad objects, first on the basis of poverty and level of education and then, subsequent to the second trauma, on the basis of race. In line with the literature, T1 went on to say that in the initial stages of working with someone after trauma, higher order functioning is often compromised resulting in primitive all or nothing thinking (Lemma & Levy, 2004).

All eight therapists referred to splitting at some point when explaining how they understand NRS. A detailed explanation of its operation was supplied by T4.

> *I think it is about the need to put things into boxes in order to feel safe. If you can locate somebody or an entire group of people as all bad, you don't have to sit with the discomfort of ambiguity, or the discomfort of having to discriminate. Then it is much easier to locate yourself in the good camp. It is about safety. It is about splitting. I think it can form part of a worldview or a belief system that helps you to make sense of the world. Once again I am thinking about splitting, a strong need in more primitive ways of thinking is to identify what is good and what is evil and I think it is very convenient to have an entire group of people that you can identify as being evil.*
>
> [T4]

T4 explained that splitting is the mechanism that operates in all *"othering"*. Speaking of more subtle forms of racism she states *"It becomes class based or tribally based. I have had racism from Xhosas against Zulus, or South Africans against Mozambiqueans or Zimbabweans. Within race groups there will be 'schisms' or sorts"*.

In the examples below from two other therapists it can be seen how splitting not only classes groups of people as good and bad but can be an attempt to separate the self from a particular group of people or from one's own racial group.

What has been interesting is that in the clients I have seen, they have separated self from the attacker, so they will use words like this is really just a tsotsi (derogatory township slang for trouble maker/criminal), a word to create a distance so that even they don't identify with the attacker. The attacker being of the same race doesn't mean that everyone of my race… they will have the same prejudice. [T2]

And certainly in my working with black victims, they will experience equal fear around a specific kind of black man who looks in a specific way, a big or a young black man or a group. [T6]

One therapist wondered whether the notion of splitting was in fact too primitive a process to be applied to NRS.

The resentment that goes along with all of that has to go somewhere and in some ways the race is an easy target. I don't know if that goes as deep as that primitive splitting. [T5]

For this therapist race is seen as a receptacle for the resentment generated by trauma rather than quite as extreme a defense as splitting might imply and she suggested that some circumstantial qualification of understanding might be useful. Overall, however, there seemed to be consensus that one way of understanding NRS post-trauma psychoanalytically was to draw upon Klein's notion of the defensive process of 'splitting'. Within this general understanding of NRS as a process of 'splitting' it was seen to have various functions for the patient. It was seen to serve as a defense separating self from attacker, of preserving an imagined sense of safety in the world between good and bad people and as a means of identifying threat on the basis of race to prevent imagined or feared future trauma.

The second case example illustrates how NRS is understood as the operation of the primitive defense of projection.

<u>Projection: Case 2- Incompetent Cop, incompetent government</u>

T2 gave the following description of a recent manifestation of NRS post-trauma:

The most recent example I can think of is a client I saw recently who had been with his sexual partner, it was really a sexual liaison relationship that he was having with this girl and he had come for a sexual liaison to her house in the middle of the night, at which point this group of armed men came into the house and attempted to attack them or whatever. With him, he certainly had very strong racist descriptions of the people who had been the attackers and in fact what was worse, where the racism came out even more strongly was in the response to the police, in the response of government officials post the trauma. There

> *was a lot of stuff about their incompetence, that they can't speak a language properly, that the police person he called couldn't even spell the name of the street, but with a lot of racist undertone to it. So it was not so much about the attacker who was black, that did not seem to be where the issue lay, the racist stuff came out more in when he was trying to report the crime. While he was trying to report the crime, he had locked himself off and he was trying to phone them to report the crime and that experience was very much overtoned for him with racist language, projections and stereotypes* [T2]

In this example the processing of a traumatic event does not only involve the moment of attack, but also the perceived lack of support after the trauma, which seems to have evoked equally powerful feelings. T2 understands negative racial sentiment as:

> *…the projection and splitting off of your own hostility, your own sense of violation, violence, or darkness onto something external to you. People in traumatic situations are extremely disempowered. They are infantilized in a sense. You are placed in situation of extreme vulnerability where other people have power over you. And I think that within that process people shift back into primitive defensive strategies.* [T2]

It seems that from T2's understanding of post-trauma NRS as projection, the client she described above could be understood to be projecting incompetence into the policemen or government officials. The therapist seemed to suggest that the policemen who were perceived to have failed to help the patient, although possibly guilty of some reality based errors, may also have become containers for the patient's own feeling of incompetence and his experience of being infantilized during the trauma. This latter aspect appeared to be what was unbearable for this patient and had to be ejected onto something external to himself. The policemen were infantilized and despised for being powerless, incompetent and even unable speak properly, like infants. T2 emphasizes that it is important to reflect on what the NRS is expressing, *"a sense of being disappointed by people in authority, a sense of being let down when they needed support of help"*. T2 suggested that the perceived failure of the policemen to respond effectively and thus contain the man's anxiety, created a further climate for projection. Being left only with the overwhelming persecutory anxiety of a bad internal object is what necessitates the use of projection.

> *It is like there is this explosion. This projection of aggression outwards in order to protect one's own vulnerability and one's own sense of violation, sadness or aloneness as this particular point in your life.* [T2]

Although not mentioned directly by T2 it seems that this case might be a good example of the formation of a 'projective imperative' discussed in the literature review. Lemma and Levy (2004) explain that the humiliation of trauma inflicts a narcissistic wound of sorts and in an attempt to feel powerful again, feelings of humiliation are projected back into

the perceived agent of the wound, in this case the policemen.

Six of the therapists mentioned projection as one of the key mechanisms in operation in the formation of NRS. In the following excerpt it can be seen how T4 gives an explanation that strongly supports T2's view.

> *I think it is a projection of anything inside of oneself that is persecutory or unpalatable and of course what then begins to happen in the projection and in the consequent projective identification is that groups of people begin to behave in ways that confirm the original hypothesis. So I think it becomes this terrible self perpetuating… if you hold racist views I think you treat black people in a particular level of disdain, withdrawal or whatever and then you evoke potential acting out behaviour that confirms the original hypothesis so I think that there are all sorts of splitting mechanisms at work, both projection and projective identification.* [T4]

Fanon (1967) wrote about how projective identification operates to confirm projections as described here by T2. He argued that the person who finds themselves at the receiving end of these projections has no control over the meanings ascribed to or forced upon his or her race group. He understood this process as the expulsion or disavowal of unconscious needs and qualities of the racist that are deposited in an unwilling other (Fanon, 1967). The other then responds to confirm the projection, resulting in a vicious cycle. Therapists seemed to suggest that this kind of expulsion of unbearable feelings is particularly characteristic of traumatized clients and that the projection of aggression (or other unbearable qualities evoked by trauma) onto groups of people categorized by race can in turn create interpersonal tension and conflict.

One therapist drew more directly on the Freudian notion of displacement in elaborating on the use of projection.

> *Thanatos tends towards a wish to kill the self and that is in conflict with the wish to live and preserve life, the eros. It becomes displaced so to speak. This comes back to the human tendency to be destructive. Because one defends from destroying oneself by displacing the anger towards something else, the less the resemblance between the self and that onto which the aggression is displaced the better, the less anxiety one would experience in depleting the freedom of, and destroying the other.* [T8]

While this explanation was not linked to NRS specifically, it appeared that T8 saw some link between traumatic events and the entertainment of self-directed aggression. It might also have been interesting to ask this therapist to elaborate on whether he perceives there to be a qualitative difference between the mechanism of displacement and the mechanism

of projection. In many respects his comment seemed to resonate with other therapists' descriptions of projection at work. Generally, therapists understood a racist or racially–toned response to trauma as the projection outwards of the patient's own aggression, hatred or violence. However, as in the case described by T2, the projections can also be more idiosyncratic, for example the experience of being infantilized, helpless and incompetent during a traumatic encounter that is then disavowed.

In addition to highlighting the role of projection in understanding NRS post-trauma, T3 and T4, amongst others, also referred to the operation of projective identification.

Projective identification

T3 presents the idea that NRS is not only about projection but may also be a projective identification. She considers what the perpetrator has expelled into the victim of a trauma that is then left with the victim and responded to by the victim after the trauma. She says ego-dystonic responses can at times be the result of feelings the victim is unwillingly containing for the perpetrator.

> *One mustn't forget what is going on in the perpetrator in order for him to do such a thing. There is quite a lot of projective identification on the part of the perpetrator, and the victim or the survivor sits holding all of these things. Where there is intense fear or intense rage, some of the purpose of the perpetrator's act is to expel all of this or ejaculate all of that stuff. This is often what happens with rape. The survivor feels all this badness but isn't able to understand it or to give it back. In a sense it is about the container and the contained. In that moment you were purely the container for the perpetrator's sense of rage, of disappointment, sense of injustice, of unfairness, and you contain all of that, which I would imagine fuels ego-dystonic feelings even further. You sit with your own distress and you sit with the confusion and distress of that other person. That feels like a primitive communication from the perpetrator into the victim.* [T3]

T3 suggests that the hatred felt by the trauma survivor may not in fact be all his or her own hatred but might also be some of the perpetrator's hatred for the victim (or for him or herself) that has been ejected, deposited and taken in, in the form of projective identification.

Psychodynamic theory on projective identification and racism generally considers the mechanisms through which projections into a particular race group by someone holding a racist ideology are then responded to by the people 'othered', to confirm the racist beliefs (Duncan et al, 2001; Fanon, 1967). The description made here by T3 seems to be the other way around (resembling introjective identification). Here T3 is suggesting that in an

act of interpersonal trauma, the perpetrator is forcing the victim to become container for his or her unwanted unconscious material (In the example above the perpetrator ejects rage, disappointment, unfairness and injustice). The link between this action and the formation of NRS is not explicit. However, what seems to be implied by T3 is that the victim cannot easily become container for this rage or hatred and is unable to process this. The resultant hate response (manifesting as racism) is thus, in fact, the perpetrator's hate, which the victim then acts out in the formation of NRS. Although the term was not mentioned explicitly by T2 the formation of NRS seems to be understood here not only as a possible manifestation of projective identification, but might also be representative of a process of 'introjective identification' in which the victim takes the perpetrator into him or herself and actively becomes the aggressor or perpetrator, targeting a victim outside the self (Caper, 1999; Levy, 2004).

Six participating therapists [T1, T2, T3, T4, T6 & T8] mentioned the process of projective identification as an explanation for NRS. It was seen as both a possible cause of NRS (as in this example), as well as a possible consequence of NRS. That is, therapists suggested that NRS might occur in response to carrying the projections of assailants (as in the case example) or that NRS directed to people in general after a trauma might be a consequence of victims projecting disowned aspects into people they can 'other' who are then seen as 'owning these disowned attributes. Projections left unattended to, were seen to lead to projective identifications. However, few illustrations of this process were described and there appeared to be considerable overlap in the use of ideas of projection and projective identification.

Loss of the good object, Triumph of the bad object: Case 3- No one to hold me

Four therapists felt that NRS could be formulated by understanding the experience of a traumatic event for the patient as an internal experience of the triumph of their bad internal object [T1, T2, T6 & T7]. It was felt that NRS was then an attempt to locate the triumphant bad object in the external world, as represented by people of the same race as the perpetrator.

T4 described a case in which the patient's core experience of the trauma was that he felt unbearably alone with no one to comfort, defend or protect him. This was an intensely personal and highly racist attack in which five black men sexually assaulted a white man.

> *He has got intense feelings of hatred and racial sentiment that include everybody, even Nelson Mandela. It was a two-hour ordeal. Throughout the attack comments were made about how all white men deserve this. He was essentially a sacrificial lamb for white men. There is absolutely no ambiguity for him around black people. His overriding experience was of not being held and of feeling unbearably alone, wishing there was somebody out there to put their arms around him.* [T4]

What T4 suggests here is that the extremity of the trauma evoked a very infantile need in the client; a need for tactile comfort. This need was evoked by an attack, by highly persecutory objects/ people. T4 suggests that the patient essentially felt abandoned as his good object failed to protect him.

T1 and T3 also strongly supported the idea that trauma is experienced as a failure of the good internal object to protect the person and this is experienced internally as the triumph of a bad or persecuting internal object.

> *The defense structure is very primal. It is not high order. It is not an advanced defense where I can rationalize, where I have a good facilitative mother who has interpreted the world for me so that now I have got a good internal object that can make sense of and hold my fear through this experience. At this moment, I am just raw. I am that infant again, exposed in this very hostile and frightening world and the only way I can defend is through very primal defenses, good breast and bad breast. You almost get a regression to that primal level of functioning in extreme trauma. In that primal level of functioning your defenses are going to be very primal as in extreme racial sentiment.* [T1]

> *If one talks object relations wise, your objects have been relatively securely positioned and you have been relatively securely positioned. You view yourself in a certain way; and you view other people in a certain way. When things go contrary to what you believed, it throws your internal world into complete disarray. Who you previously thought was perhaps quite an unsafe object might not be the unsafe object at all, or it might be confirmed that they were the unsafe object. For a lot of people there is an intense response. This is the rearranging of their object world. Who am I? Who are they?* [T3]

It was suggested that trauma requires a shift in a person's object relations. The good internal object failed to protect the trauma survivor from the suffering experienced during the trauma and in an attempt to preserve any sense of future security in the world or any sense of internal safety some alteration in object relationships has to occur. It seems that one consequence of this re-arrangement may be increased splitting. Thus while the failure of the good object may not be directly linked to NRS, the triumph of the bad object/s may lead to intense anxiety and aggression which is then directed towards the external representation of this badness- the race group with which the perpetrator is associated. It may also be that the rage and disappointment at the 'spoiling' of one's existing object relations constellation has to be directed somewhere and the 'spoilers' become the target

of this hostility. These understandings are in line with those of Garland (1998, p. 11):

> The external event is perceived as confirming the worst of internal fears and phantasies- in particular the reality and imminence of death, or personal annihilation, through the failure of those good objects (internal and external) to provide protection from the worst.

Discussion

In the illustrations presented above, therapists use traditionally Kleinian concepts to make sense of NRS's expressed by their patients after trauma. Although the concepts were originally intended to describe very particular primitive defenses and early developmental processes in which the infant struggles to bear the tension of positive and negative emotions (Rustin, 2001), the participating therapists used the concepts more discursively in the above examples to make sense of other human relationships, such as social and inter-racial relationships. The implied premise is that a violent traumatic event in adult life can be understood as similar to the trauma of early infancy. In both instances core fears of annihilation or persecution are evoked (Garland, 1998; Lemma & Levy, 2004). In trauma, the persecution may often be actual rather than imagined or unconscious (Eagle & Watts, 2002a). Participating therapists argue here that the persecutory anxiety evoked by trauma may regress a patient to employ more primitive defenses such as splitting, projection or projective identification to tolerate the experience of being confronted with these core anxieties. These anxieties are projected out onto a 'bad object', which is then feared because of the possibility of its retaliation. The participating therapist's explanations support Benn's (2006) hypothesis that these primitive defenses may translate into racist thinking. The above examples provide an argument to the effect that NRS serves a defensive function for regressed, traumatized clients.

Rustin (2001) and Frosh (2002) argue for the relevance of psychoanalytic concepts, (traditionally intended to make sense of internal processes), to understanding broader social interactions. Rustin (2001) goes so far as to suggest that all social, group or family relationships depend on the containment and limitation of persecutory anxiety. The therapists' explanations for NRS suggest that trauma can indeed destroy any sense of containment thus regressing the patient to more primitive or potentially paranoid-schizoid modes of functioning.

However, participants made mention of the mediating influence of a patients' premorbid

defensive structures [T1, T2, T3, T4, T5, T6, T8] and the quality of their object relations [T1, T3, T5, T6] on the kind of defenses employed post-trauma. Some also saw the severity of the trauma itself [T1, T4] as playing a role in determining how primitive the level of defensive response might be, rather than attributing this only to a client's premorbid functioning. Having looked at one 'set' of explanations employed by the participants a second register is now described and explored.

4.2.1.2 A breakdown in the capacity to symbolize

An attack on thinking: Case 4 - I'm black, he's black

Seemingly drawing on Bion's concepts, one of the ways T6 understands the racist response in the following case is that the experience of trauma gravely impairs the patient's capacity for rational thought.

> *I had a black client who had the same thing about black people. They would be at a robot (a traffic light) and they would get anxious. I started thinking about it as some sort of response to the trauma. The trauma is almost like an attack on their thinking apparatus… he has got his bad object out there, 'black people are violent'.* [T6]

T6 goes on to say:

> *Let's say someone is saying, "all black people are dangerous and I can't trust any of them'. If someone was out of touch with reality in some other way and was saying things apart from racial generalizations, one might say this person has a delusional or a psychotic process and we have to deal with it. Should race be dealt with differently? I think the reason it is sometimes left is because we are all colluding with it. Because of social racism one says it is fine, the person can think all black people are bad, all Indian people are this, all white people are like this. Should racism be treated as pathology?* [T6]

T6 explains how a context of social racism makes the irrational thought processes that emerge after trauma more difficult to distinguish and identify. The historical context of social racism makes it easier to collude with the irrational thinking of a patient who expresses negative racial views. Using elements of Bion's theory, T6 argues that NRS may be the result of a breakdown in the capacity for rational thought following trauma. In trauma, there is an experience of the loss of the container; "the internalized place, or vessel, or space, intimately connected with early care in which thinking-about-something can occur" (Garland, 1998, p. 110). Containment is necessary for the capacity to symbolize. Trauma may cause damage to this capacity. T6 equates NRS with delusional

or psychotic thinking. There is a symbolic equation between blacks and violence for his patient. According to this therapist the fact that the patient is of the same race as his feared persecutors further emphasizes the irrationality of these beliefs. This is in line with Garland's (1998, p.112) description of the "striking literal mindedness" of trauma survivors who display apparently concrete thinking when faced with certain evocative stimuli, which take the form of black people at traffic lights for T6's patient.

T3 refers directly to the breakdown in the capacity for symbolic thinking that may follow trauma and links this to NRS. The type of thinking following a trauma is not rational and by implication, negative racial thinking is irrational.

> *It is so concrete. A bang that before was just a bang, someone shutting a door, was just what it is. Everything is so heightened and so actual. Even dreams lack the symbolism of an adult dream. It is very concrete. We dream about the event, even in that sense, very concrete, your fear of all black men is not reasonable, it is not rational, your fear of red robots is not reasonable, it is not rational. That for me is the one thing, the regression.* [T3]

Discussion

Theories that attempt to understand the unconscious mechanisms of racism, such as those presented by Frosh, (1997), Lane, (1998), and Rustin, (2001) all draw on Bion's (1961) theory to argue that racism is not based primarily in conscious thought and is an irrational unconscious sentiment based on primary process thinking. Racist thinking is equated in the literature on racism to Bion's (1961) concept of "pseudo thinking", the kind of thinking which replaces symbolisation after a trauma (Davids, 2004; Frosh, 1997; Lane, 1998; Rustin, 2001). Racism defies rational thought and can be harboured despite logical evidence that disproves it, as in the case above where the patient's shared race with the perpetrator provides no mediation for their anxiety in relation to black people. In the last mentioned quote T3 links the irrationality of negative racial thinking itself to the loss of symbolization that occurs after a trauma, as suggested by Garland, (1998). These two participating therapists make links between the effect of trauma on thinking and the nature of negative racial thought, combining ideas from the two bodies of theory on trauma and racism (as presented in the literature review). Although the other participating therapists did not make mention of the process of 'a breakdown in symbolic thinking' overtly, similar descriptions of negative racial thinking were made. All eight therapists used words such as 'irrational', 'faulty', 'delusional' or 'primitive' to describe the unconscious thought processes through which NRS is formed, which seem to resonate

with formulations around impaired capacity for symbolic thought as mentioned explicitly by T3 and T6.

4.2.1.3 Other Psychodynamic Themes and Formulations

Two further themes that therapists grappled with in their understandings of NRS were identified. These have been titled the regressive nature of trauma and induced or unearthed racism. Also, what could be referred to as a tension in psychodynamic formulation was identified in therapists' understandings of the phenomenon. This tension is the apparent risk of either minimizing or over-pathologizing NRS expressed by a traumatized client.

Regression and impaired reality testing

The ways therapists understood NRS support the conclusion that the state of stress imposed by a trauma might lead to a psychological regression in which "developmentally primitive adaptive patterns" are resorted to (Horowitz, 1999, p.337). The following illustrative material shows how therapists referred directly to the regressive nature of trauma.

As in the 'incompetent cop' example described by T2, T3 provides a detailed understanding of how trauma responses such as racism or NRS illustrate the regressive effect of trauma on the psyche. In trauma, irrational childhood fears return and previous coping skills are no longer effective:

> *If one thinks psychoanalytically, you find yourself in a place where all those stereotypes that you have been trying to fight for so long come flooding back. Suddenly you are afraid of all men, of all black men, you are thinking that they are just all you know, thugs and criminals and bad and scary. All these unconscious fears and feelings we have, as grown ups we put to bed. There are no monsters under the bed. We are safe. We are o.k, and we can keep those awful things from happening to us because we are rational, thinking people and we have all the necessary coping skills to deal with the things the world throws at us. But in trauma, those monsters come back and it freezes us. Frozen in a regressed state, people are afraid of the dark, scared to be alone again, dreams scare us, nightmares, childlike responses. Where we were previously capable in our work, now scatterbrained and forgetful. One sees people in a regressed state where they feel overwhelmed and previous coping styles don't work anymore.* [T3]

T1 suggests further that the quality of the trauma itself makes a difference to the type of responses patients have towards it or the level of regression that might ensue. It is

suggested that violent and sadistic trauma increases the likelihood of decompensation. In addition, if a person already has a vulnerable personality structure with poor internal resources, regression is likely to be more pronounced and processing the trauma more difficult.

> *Something like a rape will be more difficult to process and will shake people to the core versus something that is more anonymous and over in thirty seconds. A violent trauma, a beating, or when people are hi-jacked and taken away and tortured for hours fundamentally shakes their internal world. They then decompensate and that level of decompensation can be quite extreme in those situations. I think we are all vulnerable to that level of decompensation if the trauma is severe enough. You have no script for it. You have no place to make sense of this experience in your life. If you are already in a state where your object relating is quite flawed, where there is narcissistic, borderline or pathological relating you already have an internal world that is chaotic and fractured and your relationship style in the world is already quite aggressive, you use very primitive defenses, projective identifications, projection, and splitting and your recovery is going to be very difficult.* [T1]

In both these quotations, although the therapists do not make direct reference to NRS, their responses are made in the context of formulating why NRS might be apparent in psychotherapy with traumatized clients. These responses seem to suggest that racist or racially-toned fears, feelings or stereotypes are linked with regressed modes of operating, that are more likely after trauma.

T1 suggests that a person has no 'script' for processing violent trauma. Horowitz (1999) suggests that people have a repertoire of multiple schemas of self and other. Different schema might be relevant in different states of mind. The likelihood of a shift of mind into transference distortions after trauma is suggested. For example, Horowitz, (1999) suggests that in this regressed state, latent conflicts are activated and more apparent and a person may feel an increased need for a parental object. The regression of a patient into role relationship models that represent schemas of an earlier time (Horowitz, 1999) might account for the regressive way a traumatized mind makes sense of self and other. This might include the return of fantasized persecutory objects, the 'monsters' referred to earlier, which in a sense have come to life in reality and now haunt one in a way that makes it difficult to distinguish between the fantasized and the real. This is both a consequence of regression and an obstacle to becoming less regressed in functioning. It was argued by all the participating therapists that trauma may cause psychic decompensation and that this in turn makes the patient more vulnerable to expressing primitive or latent material.

Unearthed or induced? Negative racial sentiment as a trauma symptom versus as an underlying pathology

In the data it was apparent that therapists debated as to whether NRS was a response resulting directly from trauma or whether trauma simply unearths underlying racism or negative racial sentiment. Given that psychodynamic theories tend to understand the individual response to trauma as influenced by object relations (Garland, 1998, Lemma & Levy 2004; Horowitz, 1999), it was interesting that half of the participating therapists suggested that this response could be viewed as purely a trauma symptom in certain cases. In contrast two therapists were emphatic that a racial sentiment is never exclusively attributable to trauma alone.

The symbolic versus the real

All eight participants made reference to what was happening for patients unconsciously or internally that resulted in NRS.

> *I am not so much interested in the racist assumptions so much as what they reflect about the person's internal world. I would reflect on what it says about how they feel, their pain at that particular point, their anger, or the extent of their anger and how they feel so let down by people who should have been there for them.* [T2]

The view of NRS as largely symbolic was shared by T3 as can be seen in the following excerpt. T3 states that NRS in a concrete sense is inconsequential:

> *This is how we need to perceive the other in order to feel safe. This is where the psychodynamic and the object relations stuff becomes really useful. It is not about race. It is about what we need to do to split our world when we feel scared or when we feel anxious or when we feel we are being over-taxed. That is what we need to do whether it is a black person, a white person, a same sex, it is of no consequence.* [T3]

In the first quote T2 is clear that her interest as a therapist is less in the content of what a patient is saying and more in what the racism or NRS says about the person's internal world and the underlying feeling communicated by the patient's sentiment. However, T2 also emphasized that it is hard to separate out such a response from contextual issues, which will be discussed under a later heading. T2 uses more contextual understandings of racism when she proposes that the patient is expressing negative racial sentiment that would have been expressed regardless of the whether the trauma had occurred or not. T2 understands this form of NRS, less directly linked to a trauma, as *"broader, contextual learnt ways of perceiving groups of people in society"*.

Thus it was apparent that at least some of the therapists took a strongly intrapsychic perspective, emphasizing what is mapped from the internal world onto the external, rather than vice versa. There is considerable debate in the psychodynamic literature concerning whether trauma impact is understood as more intrapsychically or externally mediated (Eagle & Watts, 2002a; 2002b) and what this might suggest in terms of judgment and understanding of response. At least at the points in the interviews reflected in the two previously cited quotations, therapists appear to be understanding trauma as a catalyst which brings to the foreground pre-existing constellations as opposed to understanding post-trauma racism as essentially evoked by the trauma and then in a sense used as a defensive tool or mechanism. While this may seem a subtle distinction, it does inform their engagement with such material, and will be debated further in the analysis.

These interpretations of patient NRS are strongly linked to how therapists would then work with such content during the therapeutic process, which will be discussed when interventions are considered later in the chapter.

Having established that the participants tended to make intrapsychic interpretations of NRS, some of their contrasting thinking on whether NRS could be seen as a 'simple' symptom of post-traumatic stress is presented.

NRS as trauma symptom

The following material illustrates therapists' considerations of how NRS might be a manifestation of anger, fear, avoidance or associations arising from the traumatic event. The links between NRS and symptoms of post-traumatic stress suggest that at times NRS might be regarded as a result of the traumatic experience and possibly less internally motivated.

-Anger

Three therapists [T2. T4 & T5] suggested that NRS could be a manifestation of anger resulting from trauma and not an underlying pathology.

> *It is appropriate to experience a sense of indignation, a sense of violation and sometimes it is expressed in racist language. In some ways I have found the client who didn't express any racist sentiment, who didn't feel violated, taken advantage of, who sort of understood her aggressor, her attacker as in some ways more disturbing than the client who comes and raves and is aggressive and angry about their exposure to the traumatic experience.* [T2]

T2 suggests that it may in fact be more pathological for the patient if he or she expresses no anger towards the perpetrator of their attack. Some of the literature suggests that a patient who fails to mourn a trauma may have a seriously inhibited emotional life and that a lack of anger or other emotions might be a problematic trauma reaction (Garland, 1998). If indeed NRS is accepted as an expression of anger, it might then, by implication, facilitate mourning of the trauma in some cases. Thus it seems from this perspective, that racist language might ironically be a presentation of a sheep disguised in wolf's clothing.

In the following quotes a distinction seems to be made between having negative racial sentiments after trauma that are in fact a manifestation of displaced anger and 'being a racist', with all the negative connotations that go along with that identification.

> *It is much easier to intervene with a simple response of displaced anger. You are not suddenly a blatant racist.* [T5]

> *The rage is also about the loss of control in the situation. There is so little people can do to protect themselves. The resentment that goes along with all of that has to go somewhere and in some ways race is an easy target.* [T4]

These quotes clearly separate NRS post-trauma from systematized definitions of racism. However, in contrast to T2 and T5, when asked whether the NRS might be a way of expressing anger following the unjust experience of trauma, T1 emphasizes that this is a far more regressed or primitive reaction. She differentiates *"this rage"* as being more than just anger, but a *"primal rage, a primitive rage that gets triggered"*. In this way T1 understood NRS to be separate from healthy and appropriate expressions of anger after trauma. However, it seems that it is possible to sometimes understand NRS as a 'simple' symptom of post-traumatic stress.

-Intrusive and avoidant symptoms: Cues from the event

T8 explored how NRS may be understood as a manifestation of avoidance symptoms or how stimuli associated with the trauma can trigger a 're-experiencing' of the event. In the

extract below T8 compares the avoidance of a perpetrator with long hair with the avoidance of a perpetrator who is black suggesting that the response can be more of a direct protective mechanism of identifying cues that may signal threat rather than reflective of an intrapsychic difficulty.

> *In experiencing trauma related symptoms, race becomes integrated into those symptoms as far as it is or isn't relevant. So if one is talking about particular re-experiencing symptoms of the trauma, nightmares for instance, I don't believe the nightmare will change the race of the person, the perpetrator as they are raced and similarly if there is an avoidance after trauma. That particular symptom will be most intense in relationship to men raced as black if the perpetrators were black or men with long hair if that is who violated you. The closer the association between the perpetrators and the people you see subsequently, the more avoidance. The closer the association the more intense.* [T8]

Here, race is seen to be no more exceptional than any other signifier characteristic of the perpetrator or traumatic event.

T5 supports the idea that racism can be a symptom of trauma that abates along with other trauma symptoms. In the following case she argues that the racism occurs across all races after trauma, which for her suggests it is possible that it may be a direct reaction to trauma. Avoidance symptoms are normalized in many trauma-working models (Eagle, 1998b; Janoff-Bulman, 1992; McCann & Pearlman, 1990).

> *I have a black client who has been traumatized and the racism is there as well. It is not as though it is limited to one particular race group, which makes me think it is a reaction to the trauma. She is a black woman and her son was killed. She was very racist for a while. She herself is a sangoma (traditional healer) and was held up in her family home.* [T5]

The fact that T5 emphasized that this patient was a *sangoma*, or traditional healer, implies that she felt this patient was somebody whose role in the black community strongly suggests that she supports African tradition and culture. The NRS she experienced post-trauma appeared all the more ego-dystonic and irrational because she was someone who identified herself as a socially committed member of the black community.

T4 provides some guidelines as to how to differentiate when a racial sentiment is a manifestation of the typical trauma responses, such as overgeneralization or avoidance, versus when it is a more noxious or primitive response. She attributes this difference to the patient's comfort with the sentiment.

> *When people make racist comments or racist remarks if it is coming from a paranoid-schizoid place and a place of splitting they will usually say it without any self referencing*

> *or self observation, whereas if it feels like a generalization that has been prompted by the trauma they will say 'I can't believe that I am saying this', or 'I never used to feel this', or' I never used to be racist', they preface it in some way, they are aware that it may come across as racist in some way whereas for other people you can tell that it is part of their makeup or their structure.* [T4]

T3 supports this differentiation. If the response is ego-dystonic she suggests it is more likely that it is in reaction to the trauma.

> *The ego-dystonic nature of it is quite a sign that it is specific to the trauma…. Suddenly to have fear when you are still traumatized. That is quite normal and when you put it to people like that it is quite relieving. It doesn't mean they are bad and narrow-minded. It contextualizes it for them and normalizes.* [T3]

T3 refers to fear as the underlying feeling in this response. It seemed in the interviews that when NRS was understood as fear of a particular group of people it was generally regarded to be less noxious than when it was understood as an expression of hate, hostility or aggression. From a psychodynamic perspective fear is so often the result of aggression directed outwards, or anger that is defended against (Young & Gibb, 1998, for example) that it could be argued that this separation of two forms of NRS is spurious. However, in trauma there is often an acute experience of reality based fear. It seemed in the responses that it becomes hard to separate out what is an effect of the experience of fear in reality and what is initiated by internal persecutory anxiety.

The consideration of whether a patient's NRS is ego-syntonic or ego-dystonic is discussed in more depth under a later section, as it was an important assessment consideration for therapists.

<u>NRS is never a reaction to trauma exclusively</u>

T6 and T8 disagreed with the above viewpoints. They emphasized that NRS is never exclusively a response to trauma.

> *Even if it is a way of responding to trauma, it has got something to do with the way the person was operating before. It is not something that comes out of the blue, it has been there before.* [T6]

> *The history of out country renders that kind of a situation where there are racial attributions quite complex. It can never be so straight forward that it is a normal response to trauma and that it is simply because this person resembles the stimulus of my trauma. It will never be that. It becomes quite complicated.* [T8]

T8's refusal to differentiate between NRS as a trauma response and ingrained racism was substantiated by the assertion that trauma responses are mediated and informed by the way a person has been brought up. He suggests that:

> *Race and racism are part of us. Trauma attacks the total person and whether we choose to admit it or to avoid it or to subscribe, we are raced subjects in many ways, not only raced subjects, but racist subjects.* [T8]

Five participants made links between NRS and more commonly described trauma symptoms. It was suggested that NRS could be understood as an avoidance or intrusion symptom, that it might be a form of displaced anger, that it was associated with the expression of underlying fear, or that it was being used as an attempt at regaining some sense of control in a helplessness inducing situation. Three therapists argued, however, that NRS could never be attributed purely to the experience of a trauma. They argued that as a response, it is inseparable from contextual factors and the patient's history and object relational constellations. Ongoing contentiousness around over-zealously labeling expressions as 'racist', versus denying and thus perpetuating racism is reflected in the tentativeness of therapists in labeling a reaction as 'racism' or as a trauma symptom and in the inter-participant discrepancies.

<u>Is it racism? Over-pathologising versus minimizing</u>

> *Racism is a strong word; as soon as you call it that it becomes heated…I am using an extreme word because it is an extreme thing.* [T6]

A tension identified during the analysis of the research material that seemed to be continuously present was whether NRS post-trauma can be normalized or whether the expression of NRS should be understood as always a primitive form of pathology. The debate is outlined in the question raised by T6:

> *Is racism a negative thing in terms of being able to operate in the world, or is it a defense that plays an important role in terms of survival?* [T6]

Two therapists, T4 and T5, argue that a distinction between what is racist and what is non-racist is not possible.

> *It is so complex, it is not as simple as saying well are you racist or aren't you, there are so many factors.* [T4]

> *I don't think one can always decide: racist/non-racist. It is gradual. It is not a definite thing.* [T6]

Another two therapists, T6 and T7 suggested that racism is pathological. T6 equated racism with a kind of delusional thinking that is acutely problematic.

> *Someone is saying that there is a problem in some way with an entire group of people. That is not a problem we should collude with, the social racism. If you feel racism is pathology, even if it is a social pathology, would it be okay for a patient you are working with for five years to be saying that they are racist and psychologically healthy.* [T6]

T7 suggests that racism is a split, supporting T6's sentiment that it is pathology.

> *I think that being racist is by its very nature a split and so it exacerbates trauma.* [T7]

The patient is unable to experience a renewed sense of safety in the world until there has been some resolution of racist feelings according to T1.

> *Inevitably it does block recovery. That kind of extreme prejudice keeps you in a state of hate.* [T1]

The therapists seem to wrestle with this area of conceptualization of NRS, particularly in understanding it in the context of real attack and traumatization, sometimes preferring different perspectives across the course of an interview. T6 who had argued earlier that racism was delusional, here questions whether, rather than exacerbating the difficulties of processing trauma, NRS can actually be protective against helplessness and threats to meaning systems in certain cases.

> *I think the fact that we have got racism in South Africa can make it easier for people to deal with trauma. They have got a definite label. Let's say there was no race and no gender, if we were all exactly the same, I think the response would be that we would still try to find something. I think the implication of sitting with the fact that you, or some part of you, could rape you, could kill you… leaves you helpless.* [T6]

T3 proposed not only that NRS can be protective but also that for certain patients negative racial feelings can be beneficial. She did say immediately afterwards, however, that for most people, racist feelings inhibit healing.

> *If they are quite happy to be a broederbond (Group historically associated with right wing politics) member that is how it is. If they did all sorts of criminal stuff then of course one finds oneself in an ethical dilemma, but other than that, no. It can actually promote healing and be protective.* [T3]

'Racism' was defined in the literature as the marginalization of one 'race' group by another (Foster, 1991 in Duncan et al, 2001). In four of the interviews, therapists expressed concern as to whether fear that translates into unease in racial relations (Skogan, 1995) is different from a more hostile racism in which there is a clear feeling of being 'better than' or attempting to humiliate or dominate people on the basis of their race. NRS was described in the interviews as both a feeling and as a judgment. There seemed to be some spectrum of how pathological the NRS observed in clients' talk was considered to be. For those therapists who supported such a differentiation, a feeling of fear toward a race-group, such as, 'I'm scared of Nigerian men' would be regarded as less pathological on an implicit spectrum than an attribution assigned to a particular race group such as 'all Nigerian men are dangerous'. T2, T3, and T4 and T5 felt that some separation between fear and hostility is warranted.

> *For her there wasn't a strong overture of racism, it was much more a fear of black men*. [T2]

For T6, however, this was an unacceptable way of defending NRS that happens at a societal level. He cited Davids (2004) and suggested that NRS is a defense that has been put in place by society:

> *We have this template of how the world is, and in trauma people fall back on that*. [T6]

Thus it seemed there was considerable debate both within and across therapists as to how to understand the pathological nature or severity of expressions of racial generalization and associated affects and how to take account of both pre-existing psychic and contextual factors.

4.2.2 South African contextual influences

Therapists were asked how working in the South African context influences this aspect of therapy. All eight therapists stated that the phenomenon is made more complex by contextual factors as outlined here by T1 and T2. It was stated that a person cannot be neutral around race and racism in the South African context. The context might make

people more aware of racism and its destructive potential or it might reinforce racist sentiment given the historical prevalence of these feelings.

> *Living in this country, you cannot be neutral around racism, you have had to confront it on some level, what are your thoughts, what are your feelings, where do you come from, where does your family come from, what is your work environment?* [T1]

> *There are subtleties here and what it means for people to own up to something like that, I think it is incredibly complex*. [T2]

4.2.2.1 Increased vulnerability to racism

T8 uses the notion of 'psychohistorical vulnerability' to explain how people can be more vulnerable to making negative racial attributions in South Africa. T2 and T3 also perceive this propensity and then link this directly to trauma and experiencing racist feelings.

> *A psychiatric condition cannot be devoid of the general social fabric and the experiences of the person in general. My view goes back to psychohistorical vulnerability, even for a liberal person who has been exposed or grown up in whatever way, in our context here it is full of historical meanings that are tied to race and racism. Getting into racist or racial explanations of things is just below the surface. You are rendered vulnerable by this very context. It will be quite an easy jump to make from the fact that people can be unpredictable, sometimes even people that you perceived as harmless can harm you. It is quite a jump to say that black people are vicious and violent and similarly the other way around, to say that white people tend to be volatile, and they can harm you. People that have certain political inclinations that are anti-racist in nature in a context like this it is quite easy, the vulnerability of those people to making racist attributions is heightened.* [T8]

> *Trauma reflects the realities of the economic discrimination in this country. It all feeds the racist response and almost normalizes a racist response*. [T2]

> *Our society is so divided, or has been so divided, between 'us and them' that any kind of trauma will widen that. Where there has been such a violent breech, racism is a way to protect us in the future. We have to keep that gap very wide.* [T3]

T8 stated further that this vulnerability also extends to xenophobia as can be seen in the following quote:

> *It is quite common next time you meet Nigerian guys for it to evoke particular feelings. It feels like our context provides a particular vulnerability for people to switch to that quite quickly.* [T8]

T5 suggested that perceptions of the state of the nation at the time of the study were very negative and that this contributes to more racist feelings in South Africa.

> *I think we are getting to a phase now where we are gatvol (slang Afrikaans for 'having had enough') and nobody is happy with the way things are going and it is beginning to be easier to lash out and make global statements.* [T5]

These quotes illustrate how four therapists suggested that NRS post-trauma might be more common in the South African context and that assessing and engaging with such content in another country might be different. Their argument is that the prevalence of schismatic and racist thinking in South Africa means that the social discourse of difference in terms of race is readily available as a schematic trope through which to interpret and make sense of traumatic events. This is resonant of Davids (2004) hypothesis of the existence of a 'pathological racist organization' that is resorted to at times of stress. It seems that in these quotes therapists are conceptualizing the operation of such racist templates at a broader societal level.

4.2.2.2 The South African context as an inhibiting/liberating factor in therapy

Participants considered whether the context inhibits or encourages the expression of racial sentiment in therapy. T5 felt that race and racism are more likely to be talked about freely given the exposure to these issues in SA.

> *I think we are probably streets ahead of other countries in terms of trauma work and in terms of racial dynamics. I think we have far more permission to talk about racist dynamics than other places like America and the UK. We are probably used to that level of complexity. I have a sense that we work with very complex dynamics. A trauma that takes place in a township is different to somebody that lives and works in Sandton (generally up market area) or in Roodepoort. It is all those contextual things that you have to be aware of. I was talking to somebody yesterday whose stepfather was white, her mother was black, and her stepfather was racist and he had three stepchildren and this black wife whom he adored, yet his racism was extreme.* [T5]

It was felt by T5 that the context allows these issues to be expressed and therefore rendered more benign rather than leading to potential repression. However, T2, T3 and T4 felt the opposite to be true. They referred to the shame and guilt perpetuated by the context, which inhibits dialogue about race and racism. Patients were seen to be at risk for feeling ashamed about their politically inappropriate responses to trauma. It seems to be implied in the material that censoring of information perceived to be incorrect is unhelpful for the resolution of these conflicts.

> *I think there is something for a lot of people that is shaming about owning racist feeling, whereas somewhere like the states I think it is pretty blatant.* [T4]

> *As a function of the racist context in South Africa, often the victim of the trauma is made to*

> *feel guilty, if I can think of it like that. Or often the victim of the trauma might engage with the trauma from a perspective of guilt. When I see a client engaging with a trauma like that, I often hope they will express racial sentiments, or aggression, or anger because actually that is appropriate.* [T2]

> *It is quite disturbing for people who come from a background where effort is put into trying to overcome racial prejudices and stereotypes. There is a lot of shame around that. I try to reassure people that they need to get it off their chests.* [T3]

Other ways in which South Africa was also described in the interviews were as "*a traumatized nation*" [T5] and as "*quite a paranoid-schizoid society*" [T6]. It was suggested that in South African society splitting and primitive defenses operate at a social level, which is reminiscent of theory on the psychological effect of major political trauma on society spoken of by Rustin (2004). T6 was asked what he meant when he referred to South Africa as paranoid-schizoid and he used the example of how race is adopted as a way of contextualizing, or categorizing how one behaves in the world.

> *At one point it was completely spilt up, physically even. Black people live here… and I think that was part of people's thinking. That was how they viewed the world. We are still trying to get to more of a depressive position in terms of seeing ourselves as one thing. Not that I think any society has such a strong identity that they see themselves as one thing like, "we are all Italian". There are still splits.* [T6]

These responses suggest that NRS was seen by participants to be a complex issue given the post-apartheid context in South Africa. How therapists think this complexity influences this aspect of therapy seemed to be varied. Contextual factors were seen to have the potential to inhibit the patient's ability to express the most difficult aspects of their experience of trauma or to have the potential to make people more conscious of race and race issues in a way that may be helpful to them.

4.3 HOW PSYCHODYNAMICALLY ORIENTED THERAPISTS *WORK WITH* NEGATIVE RACIAL SENTIMENTS AMONGST TRAUMA CLIENTS

4.3.1 Whether to intervene or not

According to Horowitz (1999) the aim of dynamic trauma interventions is the resolution of stress rather than character modification. This kind of thinking seemed to inform respondents

reflections upon their decision as to whether necessarily to intervene in relation to NRS or not. The participating therapists reported that they explicitly take into account the goal of therapy when considering whether or not to intervene with post trauma racialized responses. When asked whether or not they would intervene in some way if a traumatized patient were expressing strong racial sentiment, three therapists said outright that they would tend to intervene for the patient's well being; three therapists pointed out that they would evaluate whether intervention was necessary on a case by case basis; and one therapist said that they would not intervene.

Of those therapists who asserted that it was important to intervene, slightly different motivations for this were advanced.

> *Definitely, it inhibits healing. In terms of recovery it is not a good predictor if there is extreme racial sentiment and you have got to work with that. How can I use this in the therapy to help this person rather than just ignore it or just not go there? It is part of recovery; you have to look at it.* [T1]

> *I do work with it. I think it is something you can't ignore. I certainly don't introduce it but I will do a bit of fishing if it doesn't come up*. [T3]

> *You must understand that the victim is as raced as the perpetrators. My problem would be that there would be a deliberate elimination of the racial aspect when it comes to trauma work. One again I need to emphasize, that it should mainly be about the fact that that person has suffered the trauma and first and foremost you want to help that person but you have to remember that they are raced people and you are sending them out into a raced world. Race has now become prominent for them in certain ways. If I say that I have been violated by people that are raced in a particular way it needs to be explored and that has been released into the therapy. You might find it doesn't go anywhere and you will leave it and pursue other pertinent issues that the client is presenting.* [T8]

While still emphasizing strongly that the survivor's experience needs to be validated first and foremost, quotes such as these suggest that integrating racialized responses are part and parcel of the processing work after trauma.

For T4 (one of the therapists who argued for case specific decision making), although this is recognized as an area that could potentially be worked with, considerations include not only the nature of the case and the quality of the therapeutic relationship but also the characteristics and values of the therapists. The implication is that this cannot be an area in which therapists are 'told' to intervene. If this does not suit the particular therapist, this will create inauthenticity in a process that aims to be congruent.

> *I think it is something that can potentially be worked with but it does depend on the nature*

> *of the work. It also depends on the therapist. If you are just paying lip service to something you don't really believe in then it is not enduring. I do think there needs to be an established relationship.* [T4]

T2 was the only therapist who stated explicitly that she would tend not to intervene. She feels racial sentiments abate in their own time and of their own accord after trauma without some therapeutic involvement.

> *I generally don't address racist material in therapy with a client who has been through a trauma, often in the first week or two or three that will come with a lot of racist, a lot of the anger is expressed in racism, the injustice of the trauma is expressed in racism but often that abates as part of the process of working through the trauma. I don't find that one necessarily has to address it directly.* [T2]

Seven therapists thus felt that some thought, discussion or intervention was warranted in this area. However, these therapists said that they would make a decision as to whether or not some intervention was necessary by making reference to various implicit assessment criteria. Thus one of the 'findings' that emerged from the study was that therapists appear to employ a number of implicit assessment criteria in deciding how and when to intervene in relation to NRS's. Based on the material derived from the interviews these implicit assessment criteria or aspects can be categorized as follows:

1. Length of therapy and therapeutic contract;
2. Patient's ego strength, level of regression and support structures;
3. Premorbid sentiments;
4. Whether NRS appeared ego-syntonic or ego-dystonic;
5. Centrality of the racism for the patient;

All of these factors played a role in therapists' considerations of whether they would intervene.

4.3.2 Implicit assessment criteria

4.3.2.1 Length of therapy/ therapeutic contract

A distinction was made between the goals of trauma debriefing and the goals of longer-term psychotherapy. Therapists made the argument that short-term trauma work generally involves assisting the person to restore premorbid ego-functioning in order to integrate

the trauma experience, whereas long term therapy generally involves some necessary dismantling of defenses or even regression, in the interest of deeper level psychic change and integration. Depending on how they perceived their brief in this regard, therapists might intervene differently, recognizing that long-term clients can be traumatized in the course of an ongoing therapy.

> *What is your brief? How much time do you have available?* [T5]

> *In trauma it is more about helping the person to be contained, to become whole again. In long-term therapy you will have some level of regression*. [T1]

> *Certainly I see trauma debriefing as different to therapy because therapy often you will have that kind of deconstruction process and you will have some level of regression in long-term therapy but in trauma it is more about helping the person be contained, become whole again. That is why I say I work differently. I am far more directive in trauma working with the racial sentiments.* [T1]

> *I think that that to interpret something like that if it is more core, you have to be working more long-term, otherwise, what you then do is you alienate, and the sense of 'not being understood' which is so core to trauma is then aggravated… With some short-term patients we don't even think about it.* [T4]

For T2 the therapeutic contract provides a guiding structure for what her role is in the therapy. If this is a crisis intervention she is clear that this would not be an area in which she would intervene. However if in longer-term therapy, NRS was a reflection of the patient's internal dynamics, she would then engage with it.

> *It depends on what I am contracting with the client for. If I am working around a particular crisis in their life, then no I wouldn't. If I am trying to understand their internal world and their racism is a reflection of their own sort of projection of hostility or inadequacy or whatever it is inside of themselves they can't tolerate, then I would engage with that with the client. That is not the brief of trauma work. I am not there to shift their personality structure or help them engage with their split off parts.* [T2]

T4 described a case in which she had contracted with a traumatized patient for longer-term therapy. She shows how the NRS is then an important indication of his relational dynamics that could potentially be worked with.

> *If you were working more long-term it is about trying to understand where it fits in with that person's matrix. So for this particular guy I think that he does have an external locus of control and he attributes blame externally and projects a lot of the badness outside anyway and I see that happening. Initially I saw it happening only with the trauma and along racist lines, but now I see it happening in his family, for example.* [T4]

In contrast, T1 felt that the more directive nature of trauma debriefing lends itself to a "head on" handling of problematic symptoms. Even in short-term therapy, she would discuss NRS in a direct way.

> *I do work slightly more directively when I am in a trauma debriefing in that I do see it as more goal oriented, there are specific symptoms that need to be addressed. It is a specific event that has happened in somebody's life. I will often tackle it head on.* [T1]

The way she would work with it would be different in short term versus long term therapy but she would incorporate it in both processes. In the following fairly extended quote she explains how in longer-term therapy she would use interpretive strategies to help the patient identify what function the NRS is serving for them. In short term therapy she would adopt more cognitive strategies such as pointing out incongruencies and the disjuncture in premorbid and post-trauma sentiments.

> *If I am working with a client long-term and we are working psychodynamically, and it is all about the internal world. 'How do I relate?' It is absolutely vital if there are prejudices (not just racial) if there are prejudices such as gender, if there are age prejudices, any kind of prejudice will be a comment on that person's internal world and how they have been raised and what their object relations are like, whether they have had very punitive objects, because often those prejudices and those sentiments come as a way of making myself feel better in the world. So inevitably if you take them away, there is a very helpless, powerless, insecure child that you are dealing with. They were raised in a world where someone had to be the baddy. That was their understanding and 'if I don't look like that', 'if I am not like that' at least I have some good, at least I have some value. In long term therapy when working with clients over a long term period, if I come across any kind of prejudice it is absolutely vital to work with it but it will be done in a completely different way and I will work with it far more in terms of internal world dynamics than I would in a short term, focused, this is trauma debriefing because the client hasn't presented for that stuff. So I work more around how it is inhibiting your recovery, it is not what you believed beforehand, there are good people, that reality checking, that reality testing that not all people who look like this are bad and that is part of reclaiming your safety in the world. In long term therapy that is why it is challenging when someone who is in long term therapy goes through a trauma and you shift modalities because you might have started dealing with some of that and then you can use it as a tool or you can hold it depending on how fragmented that person is as a result of the trauma.* [T1]

All eight participating therapists drew a distinction between trauma debriefing and long-term psychotherapy. In short-term therapy, therapists were generally less likely to discuss NRS although the possibility was not eliminated. The goals of short-term trauma work were identified as containment [T1, T2, T3]; the restoration of premorbid functioning [T1, T2, T3, T6] and the alleviation of trauma symptoms [T5, T6]. If a patient was contracting for trauma debriefing, therapists emphasized that they (the clients) are not

asking for character modification and should not have this imposed upon them. The work of trauma counseling was seen to be focused on restoring a patient's functioning to the level at which they operated before the trauma took place. If premorbid sentiments were not negative and post-trauma sentiments were negative then therapists tended to see some need to intervene. This is discussed specifically below. In longer-term therapy in which there was a well-established therapeutic relationship, the potential to work with more core dynamics was recognized.

4.3.2.2 Patient factors: ego strength, level of insight, level of regression and support structures

Psychodynamic understandings of trauma suggest that ego resources and self-capacities contribute to the unique experience of trauma for any survivor and to the resolution of the trauma (McCann & Pearlman, 1990). Therapists considered what have been referred to as 'patient factors 'in their weighing up of whether or not they would intervene. These capacities include level of insight or intelligence [T1, T2, T3, T4, T5, T8], potential for fragmentation of personality structure [T1, T2, T4, T5, T6], internal resources [T1, T2, T3, T4], and social support [T1].

To work symbolically with prejudice, T1 points out that a patient requires the capacity for insight.

> *Depending on the client and their level of insight and their level of mental health we can work with it symbolically, we can work with it in terms of kind of symbol formation Can I challenge their pre-existing constructs or will I fragment the person? It can be quite frightening and overwhelming*. [T1]

T6 states explicitly that the phenomenon can only be worked with on a case-by-case basis. He says that intervention is dependent on an individual's particular internal world or matrix of object relations.

> *In trauma work, it does depend on where the person is at. It is sort of a case-by-case thing in the way one deals with it. It can't be a blanket thing. If there is racism manifesting from trauma it will be different depending on the individual's inner world.* [T6]

Others emphasized that they would assess the client's level of current functioning and the role they believed trauma played in this.

> *If somebody were very shattered or very primitive, I probably wouldn't work with it*. [T5]

In the initial phases you are just looking at their extreme emotions. [T6]

Sensitivity to the patient's vulnerability was mentioned throughout all the interviews. Thus one of the assessment considerations for therapists was what might be termed the client's level of ego functioning or psychic intactness, not only in respect of general functioning but also in response to the traumatic event. If they felt that the client was too fragile, or ego functioning too compromised, they would generally not work with NRS as this was generally perceived as challenging for the client.

Bearing in mind the understandings of NRS presented previously, a possible implication of therapists' reluctance to engage with NRS where the patient has impaired capacity for symbolic thinking, poor ego-strength or little insight, might be that the most rigid or vehement racial beliefs (correlated previously with the most 'primitive' psychological levels of functioning), are the least likely to be worked with in shorter term therapy. This was identified as a potential ethical dilemma by participants and is discussed as such in a later section.

4.3.2.3 Premorbid sentiments

Six therapists felt that they would be more likely to discuss negative racial sentiments if there was some disruption of the patient's previous views of a particular race group following trauma.

> *I will work historically. So to say, what was your sentiment if I had met you three months ago before the incident happened? What would you have told me about black men? What were you before the incident? What was your belief system? What is your belief system now? Point out the incongruity of that.* [T1]

> *Your role as counselor or therapist is to get them to their premorbid level of functioning. It is not my job to convert them but it is about trying to explore what their premorbid level of functioning was.* [T3]

T1 works to point out the incongruity between premorbid and post-trauma sentiments. T3 states that for her this is an essential assessment criteria. If premorbid sentiments are not disrupted then this is not an area in which she has contracted to work. Related to this consideration was some assessment as to whether NRS was experienced as ego-syntonic or ego-dystonic.

4.3.2.4 Whether NRS appeared ego-dystonic or syntonic

Seven therapists felt that this would be an area in which they would be more likely to intervene if patients were themselves distressed by their NRS, i.e., if they experienced their feelings and attitudes as ego-dystonic.

T2 and T3 insist that the response has to be ego-dystonic in order to warrant intervention.

> *If they are completely happy with the fact that they hate all blacks, it is not my job to say that is not right, or that is not healthy. It is my job to say I am pleased that you feel happy. My job is done whether I think you are a terrible person or not.* [T3]

> *I wont challenge a client generally with that sort of language unless it feels ego-dystonic for them, unless they feel uncomfortable with it.* [T2]

T1, T4 and T6 indicated that if the response was ego-syntonic this makes intervention much more complicated as compared to when the response produces clear distress and discomfort for the patient.

> *When clients have an exiting racial prejudice it is much more difficult because this will fuel it. I have dealt with clients who have said this is proof. 'I have got to get out of this country'… and just these horrible stereotypes around racism and the language they use is hostile and aggressive. I certainly work with this as if it is a destructive process, 'I can understand that you are angry and upset but your expression of it is actually interfering with your healing process'.* [T1]

> *If they were very uncomfortable with it, it would be a thing that would be worked with in therapy. If they are comfortable with it and this is reinforcing their racial beliefs it becomes a lot more complicated.* [T6]

> *I think it is very distressing for someone who sees themself in a particular way. As a liberal, broad minded, non-prejudice person to feel overwhelmed by feelings of hatred.* [T4]

Thus a further element that these therapists weigh up in deciding whether and how to intervene with NRS (or not) was the degree of subjective discomfort clients appeared to feel in holding such views. However, this criterion had to be weighed in relation to awareness of defensive process and the therapist's intrinsic position as to whether 'racism' is necessarily viewed as unhealthy or not.

4.3.2.5 Centrality of the NRS for the patient

A final consideration was how central the NRS was for the patient. Respondents generally indicated that negative racial sentiments should not be prioritized or worked with if there are more pressing or more distressing aspects of the trauma experience for the patient. T1 assessed this particular criteria by how "*present the racism is in the room*" [T1].

> *It is something that the patient is releasing into the therapeutic space. It is there already and didn't have to be excavated. It is problematic that it wasn't followed up.* [T8]
>
> *It became a thing of hating white people and that she was unfairly treated. That became the major theme of sessions. It was central enough. It called for some attention. You need to check it out if it is presented.* [T8]
>
> *If we think of it as being indicative of something at a deeper level, something about a core dynamic then it does need to be looked at in therapy.* [T4]

Thus centrality seemed to be defined both in terms of how prevalent and intense such content was in the room and in terms of whether the material seemed to relate to what the therapist viewed as 'core dynamics'.

Discussion

In this section of the analysis the fact that therapists employ an implicit process of assessment in deciding when and how to interpret in respect of NRS was identified. This section attempted to explore when and if a therapist felt they would intervene and what some of the factors were that determined the appropriateness of intervention. What was not referred to in these considerations was the severity of the trauma, which was mentioned in the literature (for instance, Garland, 1998). It might have been interesting to ask participants whether they thought the severity of the trauma influences the sentiments or justification for the sentiments in any way. The therapeutic contract was considered by all participants to be an important consideration. According to participants, the timing of interpretations in respect of this dimension needs to be very carefully considered against the backdrop of an assessment of this range of considerations. The risk of secondary traumatization and therapeutic rupture was raised in therapists' considerations but is presented later in the analysis as an ethical consideration. Therapists all considered patient factors in their assessment criteria and case-by-case assessment was advocated. While it could be argued that all therapy involves some ongoing assessment of the patient's pathology, capacities and relational dynamics, it was interesting to elucidate the particular thought processes and criteria employed in this instance. While therapists did

not explicitly refer to an 'assessment' component of such work they were clearly employing this kind of approach.

4.3.3 Technical dimensions

Therapists advocated for flexible case formulation and intervention in different contexts and with different patients. Therapists warned of the dangers of technique driven practice, but nevertheless gave some examples of potential intervention strategies. Although participating therapists were psychodynamic in their orientation, all eight of them suggested that an integrative approach to trauma could be most beneficial for the patient. Therapists drew on both interpretive and cognitive approaches when discussing possible interventions. It was suggested that therapists should work non-judgmentally to open up the space to talk about NRS. Therapists recommended that it be thought about clinically and not personally, if such a distinction was possible.

4.3.3.1 Adherence to a working model

Three therapists referred to drawing upon a framework for working with trauma responses.

> *I start with the trauma model as my framework and modify my approach accordingly depending on the client's disposition. I may move or shift or look at underlying themes*. [T2]

> *I will try and formulate using object relations stuff but the model I use would be the Wits trauma model.* [T6]

The interventions would then fall broadly into the structure of the Wits five-component model (see Eagle, 1998b). However, the therapists did not state how they would work specifically with NRS using this model. No other specific working models were suggested, although as will have been evident in prior discussion therapists drew on Kleinian, Winnicottian and Bion- related formulations in their work in a manner that echoed some of Garland's (1998) formulations of trauma therapy.

4.3.3.2 Interpretive strategies

Having understood NRS as a regression to more primitive modes of functioning, interpretive strategies were then employed by therapists to facilitate the restoration to

more depressive states of being. In addition, interpretation was employed to help clients to understand the defensive functions NRS was performing and the operation of projection, displacement and other mechanisms.

> *Look at what it means for this person. What has their relationship been with white people? What has their relationship been with black people? Has this changed?* [T5]

If working in a longer-term interpretive way with a patient, therapists might interpret at a deeper level, linking NRS to internal dynamics and sometimes to prior material.

> *If I am working with a client long term, it is all about the internal world, how do I relate? What their object relations are like, whether they have punitive objects because then often those prejudices are a way of making the self feel better in the world. Inevitably if you take them there, there is a very helpless, powerless, insecure, child that you are dealing with. They were raised in a world where someone had to be the baddy. If I don't look like that then at least I have some good, at least I have some value.* [T1]

> *You are taking it back to them. You are taking something they are essentially projecting out in terms of violation and hostility and reflecting on what that says about what the experience was like for them. So perhaps an interpretation might be that part of why people are racist or why racial sentiments are exaggerated post-trauma is that it is easier to experience aggression and hostility that it is to experience vulnerability. To project it outwards is what a person is doing. As a therapist I then turn it inwards to reflect the vulnerability, the pain or the loneliness, which that aggression and hostility reflects. The way I interpret the racism is like there is this explosion of aggression in order to interpret one's own vulnerability and one's sense of aloneness, sadness or violation at this particular point in your life.* [T2]

> *…it is about reaching a place of ambivalence which is what the depressive position is about.* [T4]

T7 described a case in which the patient she was seeing for trauma debriefing felt rage towards white people following a trauma. Her core experience of the trauma was that she was rendered vulnerable to the experience because she was black and disadvantaged. The interpretations thus focused on what her experience of the trauma tapped into for her in terms of her early difficulties around her own value.

> *…The sense of racism (against you) of you not being good enough could dovetail with parental messages and there could be a connection between this sort of feedback. It could exacerbate early childhood trauma. I also wondered whether with this woman in particular what she had picked up, what sense she had made of the world as such an unfair place, what were here experiences of oppression, what tales did she get from her parents of oppression. Trauma does get transmitted from generation to generation to some extent.* [T7]

T2 looked at interpreting a patients' NRS as a historical defense adopted due to underlying feelings of inadequacy and extrapolated the implications of this for trauma

work.

> *I am thinking of an actual client, an Indian client and she makes distinctions between Malay people. This person is Malay. The person she married is Indian. She feels discriminated against because she is Malay, she feels second-class, she feels like a servant in the family. So in that instance I would reflect on her sense of inadequacy, her sense of not feeling good enough in the world. But again, I am using her racist assumptions to try and understand her internal world. Similarly in trauma work, if the person has a lot of racism that persists, I would reflect on what it says about how they feel, their pain at that particular point, their anger, how they feel so let down by people who should be there for them.* [T2]

When considering interpretive strategies employed by participants it became apparent how strongly therapists suggest staying close to the patient's personal dynamics. Although much of therapists' understandings were theory driven, interpretations were less theory driven and focused very much on the individual patient, their underlying feelings, their unique history and the possible meanings of NRS in light of these factors. It can be seen in the last two examples from T2 and T7 that NRS expressed towards other groups after trauma occurred in patients who themselves were victims of racial discrimination or perceived discrimination. Such subtleties suggest the important of case-by-case interpretation. A common theme, however, was that therapists all suggest in their interpretations that NRS often comes from some painful or unresolved underlying feeling or experience, whether this be, for example, a feeling of inadequacy, vulnerability or aggression. In addition, to the kinds of interpretive interventions discussed thus far, in situations in which it was meaningful, interpretations also extended into possible transference dynamics.

> *You might say, 'I am noticing that there is a lot of reference to black men, if there was a lot of reference to black men, this black man came up to me, and he did this and that black man did that… you might say I am noticing that you are referring a lot to the fact that these men were black and I am wondering what it is like for you to speak to me given that I am a black woman'. So you engage openly with that issue.* [T2]

> *If the racism starts to play out in the transference relationship then that is a different story and that has to be engaged with directly.* [T2]

It is apparent that one of the mechanisms therapists described using to work with this occurrence in therapy was interpretation. Interpretive strategies included reflecting the underlying feeling, working historically to understand what the meaning of the NRS was for the individual and working in the transference. However, in keeping with reports that they were inclined to use more integrative approaches in trauma psychotherapy, therapists also described using interventions of a less clearly psychodynamic orientation.

4.3.3.3 Instrumental interventions, cognitive and behavioural strategies

Therapists mentioned some cognitive and behavioural strategies that they used such as reducing overgeneralization, looking for exceptional or discomfirming experiences, challenging irrational thinking, reframing and psychoeducation.

NRS's were tackled as oversimplifications that could be opened up for examination to prevent a rigidifying of beliefs and as reflecting distortion in thinking. Patients exposed to trauma were seen to place an overemphasis on the negative and to make 'faulty' generalizations like; 'No one is trustworthy'. Therapists then worked to reframe such assumptions as can be seen in the following example from T2 (although not stated explicitly, bringing to mind McCann and Pearlman's core schemas (1990)).

> *What I would then do is to reframe that to the client and probably develop behavioural strategies. As in for instance, cognitive strategies, are there black men that you do trust? Who are those black men? So it seems not all black men are bad. It seems that only when you see black men on the street that you feel uncomfortable and perhaps something about that is that you have been exposed to a very frightening situation and perhaps that at the moment it is o.k. to feel unsafe, to feel like you can't trust black men. So I might normalize it, reframe it, and try to limit the generalization of it. If it persisted we would explore it more and see if the client wanted to work with it.* [T2]

Five therapists suggested that they would point out incongruities in the patient's experience of a particular race group by inviting them to think of good relationships with people of the negatively perceived race group.

> *And then with everybody, they will have come across somebody they have liked, whether it was a nanny, a domestic worker, or the policeman. Often you will be able to identify somebody in their life, a colleague, or a manager that was understanding and supportive and gave them time off for therapy. Point out the incongruence, even if you have got a preexisting racial sentiment, inevitably you will have come across somebody in your life you have formed a bond with.* [T1]

This strategy could be seen as using experience of reparative relationships to mediate generalizations and as bolstering 'good object' introjection. It could also be seen as counteracting splitting and as encouraging whole object relating at a social level. The bringing together of experiences of both good and bad, could be a way of mending the splits that have been set up or exacerbated by trauma exposure.

Therapists also suggested that some reality testing, desensitization or confrontation

techniques could be helpful. Where NRS was seen to be a cognitive distortion, it was felt that clarification and discussion of the conscious aspects of NRS could be useful.

> *This is not what you believed beforehand. There are good people. That reality testing, that reality checking that not all people who look like this are bad and that is part of your reclaiming your safety in the world.* [T1]
>
> *On a level it is part of the desensitization process. Not everybody is a criminal. Not everyone of that race is worse than someone of another race.* [T5]
>
> *I would sometimes say to people, "Shoh, that is a blatant generalization and then I would leave it.* [T5]
>
> *It was a Xhosa guy with Zulu perpetrators and it became a Zulu thing. But then there was this confusion for him. His wife is Zulu and he thought 'her family is actually nicer than mine' and so it wasn't sustainable because the reality impacts on the phantasy and it changes it. It is when people don't have that reality check that this thing can just continue and then maybe the therapist needs to be a bit of a reality check.* [T6]

Thus therapists appeared to employ a range of techniques and approaches for working with NRS, largely based on the kinds of explanatory models and assessment criteria presented earlier. What was apparent was that many of the respondents would depart from a more strictly psychodynamic stance in doing trauma work in general and in tackling this aspect in particular. While the participating therapists seemed comfortable to acknowledge using more instrumental interventions, there was still some evidence of tension in the stance they should take, in some measure related to the earlier debate or tension presented concerning whether NRS is understood as a primarily symbolic as opposed to reality based phenomenon. They seemed to straddle this tension by using both interpretive and more straightforward cognitive therapy techniques depending on the client and context. In was also apparent that therapist's attempted to work with both conscious and unconscious aspects of NRS.

4.4 HOW AND WHY DO PSYCHODYNAMICALLY ORIENTED THERAPISTS *RESPOND TO* NEGATIVE RACIAL SENTIMENTS AMONGST TRAUMA CLIENTS?

This research question was broken down in the interviews into two areas. Firstly, participants were asked about their countertransference towards patients expressing NRS. Secondly, therapists were asked about how they perceived their imperative to intervene as clinical psychologists and the ethical dilemmas that arise given the traditional focus on the individual in psychodynamic therapy.

4.4.1 Countertransference evoked by post-trauma racism

> *Of course racism evokes incredibly strong reactions.* [T4]

Therapists are not impervious to social discourses. All eight therapists endorsed the importance of monitoring their countertransference around what has historically been such a sensitive topic in South Africa:

> *It is always a challenge as a therapist when a client comes in and expresses very strong racial attitudes one-way or the other. It puts your own racial beliefs under the spotlight. What are my underlying thoughts and feelings? It is certainly something I have to be very aware of when I am with anyone who is expressing racial attitudes in a trauma debriefing or just in therapy in general. It highlights your own belief. You can't sit complacently. You have to think about what are my thoughts and feelings. It is about being very self aware and making sure my own stuff doesn't cross over and making sure my own stuff doesn't come into the therapeutic space, so lots of attention to my countertransference feelings around that.* [T1]

> *One has to take a stand as to where you position yourself as a therapist. Depending on what decision you take will determine how you work with it as a therapist. If you feel racism is a pathology even if it is a social pathology would it then be okay for a patient you have been working with for years to be saying they are racist and psychologically healthy?* [T6]

In South Africa, where racial segregation and racial tensions have characterized interpersonal relations, it was argued in some of the literature that it is especially important to investigate the attitudes of therapists when dealing with racially salient material (Haley, 1974; Straker, 2006; Strouss, 2001). It is important for therapists and trauma counselors to understand the impact of their racially informed attitudes and assumptions made about patients or other people in racially charged situations and the therapists' comments reflect awareness of this.

Three broad themes were identified in the discussions with therapists about their countertransference towards patient's expressing post-trauma racism. These are grouped as follows:

1. negative feeling towards or disidentification from the patient
2. negative feeling towards the perpetrator or identification with the patient
3. a freezing or impasse

For heuristic reason interview material is presented under these discrete categories of

countertransference. However, therapists described not merely oscillating between discrete categories of countertransference but feeling varying sentiments at the same time and at different moments in the therapeutic encounter.

4.4.1.1 Negative feeling towards or disidentification from the patient

T8 pointed out that "*therapists are total human beings*" with their own feelings, assumptions and racial attitudes. T1, T2, T6 and T8 recognized that strong racial sentiment expressed by a patient has the potential to evoke discomfort in them.

> *Sometimes it is very difficult because when you are sitting with a client who is expressing extreme hatred or extreme prejudice, not to have a reaction and not to want to say to them that is not my viewpoint or my philosophy and not to say I am uncomfortable with you. It is really very difficult to hold onto my own stuff and to remember that this is part of the process…I have to work with them as trauma victims and to constantly hold onto that understanding in my mind it allows me to look beyond what I am hearing and think what is this about, this is their way of coping in the world, this is their way of making sense of the world but they are still traumatized, these are still frightened individuals even though they are coming across as these horrid people they are really traumatized and this is their response*. [T1]

For T2, NRS is not only uncomfortable but also offensive.

> *If people use racist language I find it offensive. For instance I have this one struggling client who is offensive at a whole lot of levels. I need to manage my countertransference. I have to think whether I can work with this particular person. I think it is about a simple process of being aware… Sometimes things a client says impact with my authenticity or rub up against my genuineness and I need to recognize that I feel uncomfortable. This client comes from a different frame of reference to me and have been through a highly traumatizing experience where they felt abandoned or neglected.* [T2]

It seems that T1 and T2 manage personal offense to their own belief systems caused by patient NRS by remembering or calling to mind the fact that the patient has been traumatized. It seems that awareness of the horror experienced by the patient serves to mediate personal reactions to the patient's hostility. It is as if allowance for primitive responses is made due to the actual assault that has occurred. The hostility is linked back to a source and framed as a trauma reaction to manage uncomfortable feelings it evokes in the therapists. Many therapeutic interventions aim at assisting a patient to reach a place of ambivalence where love and hate, or good and bad, are both recognized by the patient (Gabbard, 2004; Lemma, 2003). It is worth considering whether more tolerance of 'black and white thinking' is made in trauma work where the patient has less capacity for depressive modes of operating. The question remains as to whether all hate responses would be 'tolerated' equally or whether NRS or racism is a particularly gray area. It

seems that if a traumatized patient hated all men following a rape, for example, healing this kind of split would be an important part of the therapy (for example, Lebowitz & Roth, 1994).

T2 explicitly states that she reminds herself that her patient comes from a different frame of reference to her. This may be construed as sensitive awareness of difference between the therapist's own views and the patient's views (in line with multicultural sensitivity, such as in Eagle, 2004). However, it may also be hypothesized to be some attempt at separating the self of the therapist from the self of the patient. In the same way a separation of the self of the victim from the self of the perpetrator may preserve for the survivor a sense of his or her own goodness, perhaps a separation of the therapist's self from the 'racist' patient can serve to protect the therapist from having to confront uncomfortable feelings or thinking that enter the therapy and the therapeutic relationship following a racist attack. In the literature a common countertransference response to trauma is over-distancing oneself from the patient (Fishman & Ross, 1990 in Levy, 2004). It does seem however, that in the above example the therapist is trying to remain aware of the patient's frame of reference, which is coloured by traumatic experience rather than distance herself.

Another interpretation might be that in managing her own feeling states, T2 offers her mind to the patient to perform a containing function. In line with the literature (Bion, 1962) it seems this therapist could be engaging with and thinking about the patient's distressing experience and is thus able to convey to the patient a modified version of their internal experience through managing her own responses.

T8 had experienced similar negative feelings towards patients for whom a negative racial response had been ego-syntonic.

> *I conceive of the therapist, the supervisor and the patient as total persons and as total persons bring into these relationships their strengths, weaknesses and their vulnerabilities and indeed if there was something racist that was evoked in the session, it does evoke certain feelings. I think naturally it would be particularly evocative in the South African context. I would be more likely to identify with a victim of racial discrimination. It is likely to affect me in certain way. There is a discomfort.* [T8]

T8 is aware that this is an area that creates personal discomfort for him and that he may even be more inclined to identify with a victim of racial discrimination at the expense of empathy for or solidarity with the patient expressing negative racial views. He recognizes

that he responds to patient NRS not just as a therapist, but as a human being. As a human being he admits his own vulnerabilities and discomfort in this area are heightened.

Therapists recognize that there is potential that the discomfort they feel might inhibit the therapy process. A particular set of circumstances including the therapist's personal and social history can generate a mindless state or compromise analytic reverie in the manner referred to by Straker (2006) in her paper on the anti-analytic third. What therapists acknowledge is that the expression of NRS's can lead to feelings of dislike for and disidentification from the client. The introduction of a prurient social discourse in the room can potentially lead to disconnection if the therapist is not able to manage associated countertransference. Therapists suggest that awareness can mediate the effects of these feelings on the process. This is in line with Straker's (2006) suggestion that understanding promotes some escape from 'mindlessness', or the noxious effects of the anti-analytic third. Levy (2004) also emphasizes the fundamental importance of the preservation of the therapist's capacity to think that is threatened in the face of the horrors expressed by a traumatized patient. It is evident from participant responses that the therapists make a conscious effort to reflect on their own personal feelings about NRS expressed by their patients to guard against compromised reverie.

4.4.1.2 Negative feeling towards the perpetrator or identification with patient

Five therapists described feeling outrage, anger or other negative feelings at the injustices their patients had endured that may at times take on a racial component. As in the case of negative feelings towards the patient, these feelings can facilitate empathy and understanding on the part of the therapist if properly attended to, or inhibit the process if the therapist is not mindful of them.

> *I am quite aware that I have quite a strong countertransference. Initially I was quite uncomfortable with it. The woman was beaten to death with a bat and I could feel it afterwards. The emotion was really intense. I left there and I could feel it. I stopped at a traffic light and I could feel a racial component to it. I could feel the negative racial stuff. It is there for myself. I shouldn't talk for the rest of South Africa but I think it is part of what our society has been.* [T6]

> *I feel enormously angry on his behalf. I think it was unnecessary. Look all crime is unnecessary but there was something gratuitous about the way he was treated so violently.*

> *I do feel vengeful on his behalf. It is important to be able to sit with and to use our knowledge of theory to defend us against whatever onslaught. So much of trauma work is about trying to connect with the person so that they don't feel so unbearably alone in the experience.* [T4]

These quotes illustrate how therapists find themselves immersed in their own strong feelings around violence and their own vengeful [T4] or racially toned responses [T6]. In many quotes it was highlighted by therapists how theory assists them during these times of strong personal or countertransferential feelings. Participants use theory to stay anchored in the experience of the patient, and not to get swept away by their own strong feelings or responses.

In attempting to validate the survivor's experience, Levy (2004) normalized some acknowledgement from the therapist of the impact of the traumatized client's experience on the listener. Knowledge that the testimony moves the listener can be validating. Therapists [4] and [6] suggest that this is an area, which evokes strong feelings but that these feelings should not overwhelm the therapist. It is emphasized in these quotes that the therapists validate the survivor's experience (of unbearable aloneness, for example) and not their NRS's or racism. T6 admits there is a very real danger of the horror of the trauma overriding the therapist's capacity to think. He describes a case in which a patient went to a therapist who reinforced negative racial sentiments. This therapist's response was described by T6 as disturbing for this patient and untherapeutic.

> *My concern was that one person I saw had gone to a therapist who had reinforced the whole thing. When they had brought up the racist thing, the therapist had said they must emigrate. This therapist obviously had their own racial stuff, which disturbed the patient even more. It was against where the person was at.* [T6]

Thus therapists were clear that a strong identification with the client's feelings and perspective, while apparently contributing to empathy, could compromise their capacity to keep reflecting and thinking and in this respect could become potentially destructive to clients and cause major disruption to the therapeutic frame.

Only one other therapist referred directly to racism in the transference. T7 described her countertransference when working with a black patient who developed a negative racial response to white people following a trauma in which she perceived white people in authority at the time to be responsible.

> *I was acutely aware of the fact that she black and I was white. It made me so angry as a*

> *white person because one carries the blame to some extent for apartheid and one works very hard to be decent and bring up one's children not to be racist and one hopes that one is building a South Africa where everyone can be happy and then there are still these people who sabotage things. I don't know if was the right intervention but I engaged with her around it and I validated her feelings of injury and indignation.* [T7]

T7 suggests that the social oppression by white people in South Africa of black people requires an active effort from white therapists working with patients from other race groups to communicate understanding:

> *As white therapists, we can't forget that we are part of a group that was viewed as the oppressor and from the moment someone walks into the therapy room and sits down we have got to do a lot of work in terms of ensuring that they don't see you as some kind of umlungu (derogatory slang for white person) who doesn't understand and can't connect to them. I think you have got more work to do in a sense.* [T7]

This view was not evident in any of the other interviews with white therapists, which is interesting in light of Strous' (2001) contention that it is possible that where there is over-sympathetic treatment of patients who have suffered injustices, therapy may be hindered. Even socially commendable agendas may interfere in the therapy process by detracting from a need for client change (Strous, 2001). However, this therapist seemed to be attempting to engage proactively with possible group or context transferential phenomena in this instance.

4.4.1.3 Frozen therapist or therapeutic impasse

T1, T4, T5, T6, T7 and T8 all mentioned the potential for some freezing, a lack of spontaneity or the experience of a personal challenge for the therapist that can occur in response to patient NRS.

> *I often have a moment of freezing inside when the racism comes out unmitigated in intellectual conversation. I have a sense of freezing inside and then try to remember the context and go back to soothing the person into understanding what happened to them rather than railing at the terrible world.* [T5]

T8 supervised a case in which the therapist's discomfort resulted in a therapeutic process that became stuck. Sessions became focused on the patient's hatred for white people. The therapist crippled by his own whiteness, ignored the racial aspect of his patient's sentiments.

> *It felt uncomfortable and a difficult subject to broach in this context. My student was*

> *clearly aware of his whiteness and aware of the race of the coloured woman. He was aware of the whiteness of the person carrying the gun. The coloured woman was making racist attributions saying she hated white people but being quite careful to say to the therapist, 'I am not referring to you'. It is almost a relief to be disassociated, to be distinguished away from the perpetrator.* [T8]

It seems that the expression of negative racial content in sessions evokes personal aspects of identity in the therapist, be it their own values, their own racial attitudes or aspects of their own racial identity. While clearly there are always potential personal hooks for therapists in client material, material about race (perhaps particularly in South Africa) seems to have powerful potential to do this for the majority of therapists. One of the consequences of this is a breaking of a relational connection and compromised capacity to think, leading to some 'stuckness' or disjuncture in the therapy process.

Where a hiatus in knowledge exists and there is insufficient knowledge and limited technique to "bridge this hiatus", an impasse can emerge in the therapy (Strouss, 2001, p. 312). To make matters worse racial attitudes are not only conscious but frequently unconscious (Frosh, 1997; Lane, 1998; Rustin, 1991; 2004), so that the role they play in therapy may be difficult to detect. These investigations suggest the importance of racial sensitivity and some understanding of the impact of racial attitudes for all involved, including therapist and patient. T1 supported T8's concern that ignoring strong racial sentiment in the room is potentially anti-therapeutic. She suggests that the challenge is to find a way of working with the sentiments that are not destructive for the patient.

> *That is certainly the challenge, being able to hold empathy for the patient when they are being so brutal towards people when you might not feel the same. I suppose the challenge is to work with it in a way that is not destructive. How can I use this in the therapy to help this person rather than just ignore it or just not go there. It is part of the recovery. You have to look at it.* [T1]

The solution to these kinds of impasses then, providing they are in conscious awareness, is to bring the material into the room in some form, to engage with rather than ignore toxic content.

All eight therapists acknowledged the need to use countertransference without becoming overwhelmed by political difficulties. Various means of managing the complexity of countertransference evoked by NRS included self-awareness, self-care, non-defensiveness, and a non-pejorative approach.

> *Countertransference can be a very useful thing if you are dealing with trauma work. You have got to look after yourself. The patient has been the container and has been projected into and now it is your job.* [T3]

Management of countertransference seemed to be strongly linked to fulfilling a containing function (Bion, 1962). Through thinking through the patient's fears and anxieties and managing their own responses, the therapist's mind is able to process the hatred expressed. Participants' acknowledgement of their difficulties in managing strong countertransference is in line with Levy's (2004) experiences of working with torture survivors in which the most challenging task for the therapist is often to manage the patient's powerful feelings of hatred.

4.4.2 Ethical issues and dilemmas

As well as having the potential to generate strong countertransference responses for the participating therapists, NRS was also seen to present therapists with possible ethical dilemmas in certain cases. Therapists considered their ethical obligations in light of the possible consequences of NRS for the individual patient in terms of their own psychological health and functioning in society as well as NRS as having possible broader social implications if left unprocessed.

4.4.2.1 Beneficience versus non-maleficience

Therapists identified the potential for confronting or discussing NRS in therapy to be 'wounding' [T1], 'shaming' [T2], 'alienating' [T1], 'attacking' [T4] or overwhelming for trauma survivors.

> They have come to you saying I have been wounded, the world has wounded me. For you to start saying there are a few things you need to fix about yourself can cause a secondary wound. [T4]

> I think it can only be looked at when there is a strongly established therapeutic relationship, when safety and reconnection has been reestablished in terms of the trauma… It feels a bit like a medical pathologist, you have got to go through every level of tissue with a fine tooth comb and do it with and incredibly intricate sensitivity and I don't think it is helpful to get angry or defensive or attacking because all you are doing is then replicating the behaviour. [T4]

McCann and Pearlman (1990) point out that there can be severe disillusionment suffered

by a trauma survivor when there is an experience of feeling unsupported or blamed after their ordeal. Four therapists in this study identified this as a very real danger. T4 even suggested that the therapist risks perpetuating the behaviour of the attacker with inappropriate interventions. T1 and T3 suggested that patients might leave therapy further regressed than upon initial presentation if appropriate sensitivity and care was not exercised and that inappropriate handling of NRS might constitute such insensitivity.

The literature describes the experience of trauma, particularly of interpersonal origin, as one of force, coercion and authoritarian control. The fundamental breach in confidence compromises the patient's capacity to trust (Brom & Witztum, 1995). After trauma the therapist needs to painstakingly build a collaborative relationship that strengthens the capacity to enter into a trusting relationship. T4 warns that interpreting patient negativity presents the danger of severing the empathic connection and leaving a patient in a state of crisis and in further distress, supporting cautions from the literature concerning the delicacy of trauma work and the risk of 'secondary traumatization' (Egan, 1986; McCann & Pearlman, 1990). Three therapists considered the potential for a "*secondary wound*" [T1, T4, T3] should the patient feel misunderstood in therapy in an already vulnerable psychological state.

Three therapists were concerned however, about the ethics of non-intervention, feeling that NRS may not be psychologically healthy for their patients both internally, as suggested by authors such as Lane (1998), and also due to the difficulties patients are likely to encounter as they attempt to function again in multiracial society with these intensely fearful or hateful feelings. It was also acknowledged that these sentiments might not only be destructive for the patient themselves but for society at large, as suggested by authors such as Davids (2004), Duncan (1996), Frosh (1997; 2002) and Simpson (1995). T6 questioned whether a failure to discuss these sentiments might represent some 'collusion' in prejudice on the part of the therapist.

T8 feels that neglect of this aspect of therapy might be detrimental to the therapeutic process.

> *If you choose to ignore certain things, you are doing that, I believe, to the detriment of the process. I am not saying go out there and look for racist sentiment and take it out. But if it is something that is presented by the patient and it is there and you are ignoring it because of your own discomfort, how do you explain ignoring it? I can't think of a reason why one would ignore race related sentiments when they are brought up. Those people who are*

> *saying they are not activists in being therapists, I think to some extent are right. You always have to work with certain issues based on your understanding of the patient and where they are at. It should never be about your discomfort. It should not be foregrounded unless there are indicators that you need to deal with that. I do not believe in eliminating the person or the therapist in therapy. You are there as a total person as well.* [T8]

T6 points out that the sentiments might not only have negative consequences for the person who carries them but also for those around him or her.

> *In what sense is one colluding with the person if one doesn't draw attention to the fact that someone is saying 'all black people are dangerous and I can't trust any of them'?* [T6]

> *A person who is using primitive defenses can actually be horrible to other people whether it is racist or whether it is just that they have got these bad objects and they hate them. If you look at a whole society doing that, the cost of it is huge, there is war.* [T6]

The participating therapists advocated that they wished to do no harm, adhering to the ethical principle of *nonmaleficence* (Brems, 2001). However, doing no harm in light of both the vulnerable state of the traumatized patient and the cost of primitive defenses for the patient (and society) created an ethical dilemma identified by three of the participating therapists. It seemed that this was a tension that required negotiation over time and that there were differences in respondents' sense of therapeutic imperatives. This does point to some need for these issues to be more widely debated.

4.4.2.2 Autonomy versus beneficience/ nonmaleficience

For T3 there was no ethical dilemma. The principle of autonomy, the rights of an individual to make their own decisions, to exercise independence, individualism and self-determination (Brems, 2001; Corey, Corey & Callanan, 1998), was the most important ethical consideration that a therapist should honor when working with this aspect of therapy.

> *If they are completely happy with the fact that they hate all blacks, it is not my job to say that is not right, or that is not healthy. It is my job to say I am pleased that you feel happy. My job is done whether I think you are a terrible person or not.* [T3]

However, T6 and T4 suggest that there are times when confrontation is appropriate in therapy even when this that may override the patient's autonomy. T4 suggests that the dilemma may be solved by sensitively ensuring that the patient has worked through much of the trauma and has a reinstated sense of safety before challenging any splits that might have been serving a defensive function.

> *There are also difficulties in the philosophy where you totally accept the person and their world and their belief systems. So you come there and make a judgment on it? What if it has a function, or is a defense? It is a strong judgment to see it like that and yet there is a consequence not to.* [T6]

> *I think it puts you as a therapist into a moral dilemma. You have to choose what cap you are wearing, do you meet the patient where they are at or do you have an agenda of where you think they should be? I suppose, for me, if we think about racism as being legitimate in some way, that is one way, but if we think of it as being indicative of something at a deeper level, something about a core dynamic, then I think that it does need to be looked at in the therapy. But I think it should only be looked at once the trauma is partly resolved or when there is a strongly established therapeutic relationship and secondly when safety and reconnection has been reestablished in terms of the trauma. And then to slowly start to think about why it is that there is such strong black and white, such split thinking and the patient's need to blame somebody, which, of course, is a core theme in trauma. We have to find a reason for it, so when you say why me, why now and why them you can find some reason for it.* [T4]

T1 presented an argument in disagreement with T4's recommendation to wait until the patient's sense of safety has been restored. T1 suggests that NRS or racism is what prevents a patient from regaining a sense of safety and that until it is worked with in therapy the patient remains in a traumatized or paranoid state.

> *Inevitably it does block recovery, that kind of extreme prejudice, it keeps you in that state of hate. Kept in a state of hate, you are constantly needing to identify the threat so you can't get to that place of renewed safety, back to your previous construct.* [T1]

Although six therapists in one way or another identified such ethical dilemmas in their work with traumatized clients, no easy solutions were identified. T4 suggests that these are not easily resolvable dilemmas.

> *I think there are so many ways of thinking about it and as a therapist I think you need to have thought about it for yourself, I'm not sure you need to have resolved it, because I don't think it is resolvable.* [T4]

This supports the view presented by Ross (2005) that ethical dilemmas need to be thought about rather than solved and Scarturo and McPeak's (1998) observation that the therapeutic process requires a constant series of ethical and clinical choices.

4.2.2.3 Individual versus social responsibility

The psychodynamic stance is often associated with a focus on the individual (Gabbard, 2004). Seven of the eight therapists felt that working as clinical psychologist implied a primary focus on the internal dynamics of the individual and thus that their responsibility

was to the individual patient. However, one therapist felt that to think of a distinction between the individual and the social might be artificial and it is apparent in the excerpts below that therapists struggled with this issue.

> *The whole point or one of the points of a clinical focus is to think about what this means for this person and not to say well this is the way one should be. Clinical psychology is an individually based psychology. It does depend on what your orientation is. If you do come from a particular multicultural frame you do have an agenda* [T4]

> *I don't think one can be a social activist when dealing with that sort of a situation. I think you can be an activist in other settings. If you are working with abused women you are going to present a feminist viewpoint, a sense of herself being a victim of social factors or whatever.* [T7]

> *As a person, I would love to say yes, but as a therapist I don't know that it should be for me to decide what my client should be like when they are presenting for a specific reason. As a person I would love to get onto my soapbox and start preaching but as a therapist I keep myself in check. With some people you will encounter resistance so then the therapy is becoming counter-productive and I have to be very sensitive in working with the racial stereotyping that is happening in the room and the prejudice, is this actually productive or is this now counterproductive? I am not a preacher; I am not here to convert these people.* [T1]

Attempting to distinguish between clinical, psychodynamic, feminist, multicultural and community-oriented psychological orientations may have the consequence that a split between the individual and the society in which they are embedded is perpetuated. The discipline of clinical psychology was strongly endorsed as individually focused by seven of the participating clinical psychologists. T8 was the only therapist who felt that this might be problematic.

> *I think one of the limitations that I have found is that there is a need to think about the formation of racism, from both an individual and a societal perspective. A lot of the formulations are that they are separate, when they are not. I think a lot of the difficulty is thinking that the social part is separate.* [T8]

Although the responses indicate that this was apparently not a problematic area for participants with seven of the eight therapists identifying strongly with an imperative to place the needs of the individual first, it could be argued that much of the rest of the material discussed and the strength with which this position was asserted, suggests that in fact therapists did feel somewhat ethically compromised with regard to this stance in dealing with NRS. However, the majority position seemed to be that if engaging with perceived prejudice and antagonism could be understood as in the interest of the patient (in terms of psychic health and/ or everyday adaptation) then this was justified. However,

as a therapist one's own sense of political imperatives or what was required for the social good did not have a place in the consulting room and to bring this in would be an imposition on the client. The subtle variations in respondents considerations of these issues, together with their debates about race categorization, prejudice and pathology suggested that although they generally came down on prioritizing the individual, answering the research questions had been challenging and introduced difficult considerations. It should also be noted that allegiance to a psychodynamic manner of working may have meant that these therapists took a particularly strong position on therapist neutrality, patient autonomy and therapeutic boundaries, which is not to suggest that psychodynamic psychotherapy is necessarily asocial practice.

4.5 SOME GUIDING PRINCIPLES FOR ENGAGING WITH POST-TRAUMA RACISM AND THE IDENTIFIED THERAPEUTIC DILEMMAS AND DIFFICULTIES

Findings from the previous three sections have outlined some of the difficulties in conceptualizing and working with NRS, and possible ethical dilemmas therapists face in their therapeutic work with clients expressing NRS. Given the large number of support services that offer trauma interventions in South Africa (as documented by Eagle, 1990), therapists were asked whether there were any recommendations they could offer to lay-counselors or beginning therapists working with trauma in South Africa. This section presents an overview of therapists' suggestions concerning possible solutions or guiding principles to better inform such work. Three dominant themes were identified in their responses:

1. Self-awareness;
2. The provision of a therapeutic space in which the unspeakable can be spoken about;
3. The importance of thinking about this phenomenon.

4.5.1 Self-awareness

> *Whatever your orientation, be aware if you have any underlying sentiments, what are your beliefs* [T1].

Therapists endorsed the importance of self-awareness to enable this aspect of therapy to be thought about it a meaningful way. Because this theme has been covered during the

discussion of therapist countertransference, it is mentioned only briefly again here. It was recommended by the participants that therapists think about where they stand on this issue, personally and theoretically.

4.5.2 Allow the unspeakable to be spoken about: We are all susceptible to being racist

All participants suggest that this is an area in which therapists should work to avoid censure. In line with the literature on psychodynamic therapy, the findings suggest that central to the therapeutic process is the provision of a space in which the patient can speak about absolutely everything and anything no matter how difficult it might be (Ivey, 2006; Lemma, 2003; Malan, 1995).

Racism is a '*relational pathology*' [T8]. One of the principles of therapy is that healing happens in relationship (Gabbard, 2004; Lemma, 2003). T8 suggests that problems of relating should be engaged with through relationship. The therapeutic relationship is central to allow open communication to occur around problematic issues for the patient and is the cornerstone to all therapeutic work (Lemma, 2003; Weiner, 1998).

> *Racism is relational. It implies a relationship of some sort with the other and I think that if it can be dealt with within an interpersonal relationship and if we are accepting, I think we can think openly and engage with it on both sides. That would help with the usual defensiveness and blaming that happens on both sides.* [T8]

The therapist needs to communicate a willingness to engage with NRS without indication of blaming or discomfort [T8, T1].

> *Let the client feel your comfort as a therapist in being able to talk about racial stuff.* [T1]

> *…say we need to talk about this in the room and it is difficult because we have become such a PC society so people are frightened to admit, 'I hate black people, I hate white people', you know, to allow the unspeakable to be spoken in the therapy and you as a therapist to be comfortable to go there, to be able to say we are not here to comment politically on the situation and to be able to say I know your political belief system before the incident was not this but right now you are feeling hate, you are feeling x, y, z emotion and let's talk about it.* [T1]

> *I think one of the things that would go a long way in terms of helping us with avoiding racism when it is coming from us is to get out of the victim/ perpetrator mentality and to somehow try and gain a different and alternative way of understanding racism and one of those ways is potentially to say that we are all racist and just by saying that it is likely to remove the defensiveness around racism when it is raised as something to deal with. So if a black therapist raises it they are not necessarily raising it as the people who carry the*

> *exclusive rights to being victims of racism, which automatically places a white person in a defensive position of being seen as the perpetrator. So we need to be aware of psychohistorical vulnerability and the need to be aware of it when it emerges.* [T8]

T8 suggests that only through some normalizing of this 'deviance' can human beings escape the victim/perpetrator mentality and render the phenomenon more manageable. Thus therapists need to be non-defensive and 'courageous' in a sense in engaging with a social pathology that takes on personal form.

4.5.3 The importance of thinking

Therapists need to be able to manage the distress and disturbances brought to them by their patients. Toxic feelings need to be digested into more manageable forms (Bion, 1962; Levy, 2004). In order for therapists to be able to take on this containing function, T4 and T6 advocate that thinking needs to happen.

> *There needs to be thinking about it. I am not sure that there are answers. There is not a five-step model, but I think it needs to be thought about and talked about. I think it would be enormously useful to get a group together or multi-cultural group of therapists together to talk about it and think about it.* [T4]

> *If you start going on your own tangent of looking at racism it is not going to be therapeutic. You have to stay with where the person is at. One has to mark in one's head what is going on so that you can be aware that there is a racial issue that has come up, make a little note in your head and ask around it. You still won't jump on it.* [T6]

Therapists presented thinking as an essential process to ameliorate against potentially anti-therapeutic responses and defensiveness that could potentially be generated by NRS. Straker (2006) suggests that thinking by the reflexive practitioner guards against the intrusion into the therapy of anti-analytic thirds arising from malignant political or personal discourses.

It is hoped that this study has itself generated thought about understanding and working with this aspect of therapy.

4.6 IN CONCLUSION

Some of the themes identified are briefly summarized here to conclude the findings presented in this chapter.

<u>Trauma intervention versus therapy: The therapeutic contract</u>

A distinction was draw by therapists between contracting with patients for therapy specifically to process a trauma and working with trauma in long-term psychodynamic psychotherapy. This distinction informs intervention strategies. In this study it was found that therapists were more likely to engage with NRS in longer-term therapies although it was possible to engage with it as a trauma symptom in short term therapies if it was regarded as such in light of other assessment criteria.

NRS: The symbolic versus the real

A debate was identified in relation to whether therapists understood NRS primarily as ' symbolic or real'. Symbolically, NRS was considered as representing aspects of the patient's internal world or as serving a defensive function in response to the trauma. Concretely, NRS was understood as a manifestation of the particular social and political climate in which the trauma took place. Therapists raised the issue of whether "racism" is a term that quickly creates a judgment. It was debated whether NRS is in fact the same as "racism". The question was raised as to whether systematized racism can be differentiated from racism or NRS arising as a defense. NRS was understood as a regression to a more primitive mode of functioning, inducing the use of splitting, projection, projective identification or representing the triumph of the bad object. It was also linked to various trauma symptoms or core experiences of trauma such as the expression of anger (a hyper arousal symptom), as well as to avoidance and intrusion symptoms.

Intervention considerations and criteria

A consistent caution from therapists was that therapy is not technique-driven practice and any understandings and interventions tend to be case specific. When considering whether or not NRS is something that therapists would consider necessary to address in therapy, implicit assessment criteria and guiding principles emerged as was outlined in the discussion.

Therapists also grappled with the contentious issue of whether NRS is necessarily pathological and inhibits patient functioning in the world, or whether the racial response is context-shaped or represents the expression of intense feelings of anger post-trauma that abates along with other trauma symptoms. A constant tension was identified between

either minimizing or over pathologising NRS.

Therapists' imperative to the individual patient

Countertransferential responses to client NRS and therapist ideology concerning whether and how to intervene varied significantly. Therapists interviewed leant strongly towards prioritizing the well being of the individual patient over perceived responsibility to society, however, careful consideration of this distinction was presented. The argument was raised that a distinction between the 'individual' and the 'social' may be an artificial one.

Overall it was apparent that the respondents found this an interesting and complex aspect of therapy to discuss and that their responses to questions reflected considerable personal questioning and consideration of a multiplicity of factors that made intervention in the area complicated and sometimes anxiety provoking. Increased thought and discussion of these issues was thought to be productive.

CHAPTER FIVE
CONCLUSION

The final chapter of this research report is comprised of four sections: a summary of the central findings; limitations of the study; implications for future research, and a reflexive comment.

Recent research in the area of racism has attempted to apply psychodynamic concepts, originally formulated to understand internal dynamics within the mind, to social and inter-racial relationships in the external world. From a psychodynamic perspective, racism has largely been understood as the operation of primitive defense processes involving projection and consequent projective identification. Related theory has been generated using concepts derived from Freudian, Kleinian and Bionic thinking.

Research into psychodynamic understandings of trauma highlights the importance of understanding an individual's response to trauma in relation to their idiosyncratic object relational constellation. Research indicates that personal responses to trauma are mediated by the severity of the traumatic event, the person's internal psychic resilience and the support they receive post-trauma. The regressive nature of trauma responses has been extensively documented. Although sensitive to the personal meaning of traumatic events for each individual patient, certain common response patterns have been identified.

This study has sought to link these two bodies of theory to contribute to technical and theoretical understandings of negative racial sentiment amongst traumatized clients as it presents in the context of psychotherapy. To this end, the study explored psychodynamically oriented therapists' understandings, interventions, technical considerations and responses regarding negative racial sentiments arising in the context of psychotherapy with traumatized clients.

5.1 CENTRAL FINDINGS

Therapists endorsed post-trauma NRS's as a phenomenon they have not only encountered, but have observed and engaged with frequently in practice. Therapists described negative racial sentiments in traumatized clients from a range of race groups,

including white, black, coloured, and Chinese clients. The race of the identified perpetrator was in the majority of cases, 'black'. However, NRS towards white perpetrators, non South-African African's and other cultural or class groups was also reported, and included xenophobia towards Nigerians and Zimbabwean's, tribalism, and the description of perpetrators as "tsotsi's". The more precise manifestations of NRS, although of interest, were not a focus in this study.

In accordance with the literature on psychodynamic understandings of racism, therapists understood NRS as *inter alia* reflecting the use of defenses such as splitting, projection and projective identification; as representing the loss or failure of the good object and the triumph of a bad object; as a consequence of a failure to symbolize; and as a displacement of anger. It was interesting that, although all of the therapists felt it important to consider what internal dynamics the NRS represented, over half of the therapists also felt the NRS could, in certain cases, be understood purely as a trauma symptom, reflective of fear, overgeneralization (with 'race' as signifier), avoidance, intrusive symptoms or anger. In the case where NRS was understood as a trauma symptom, it was felt that the response was not as severe or regressed as when it represented a form of 'splitting', 'projection', 'persecutory anxiety' or primitive rage'. However, a tension was identified in the participant's responses in not wanting to minimize NRS but also not wanting to over-pathologize it. All the participating therapists recommended considering each expression of NRS on a case-by-case basis.

The South African context was seen to make the phenomenon of NRS more complex. It was felt that the South African context had the potential both to inhibit the expression of these sentiments in some cases, and in other cases to make people more comfortable in talking about issues of race and racism. Therapists felt that there may be more of a tendency to self-censor given the social impetus towards integration and strong political censure of racism. Therapists found feelings of shame and/ or guilt around negative racial feelings to be common amongst patients for whom the response was ego-dystonic.

When asked whether or not NRS is something therapists would 'work with' in therapy, seven therapists felt they would consider it. One therapist felt she would avoid this generally. Five implicit assessment criteria that were considered by participants in whether and how they would work with NRS were identified during the analysis process. Salient considerations included the length of therapy and the therapeutic contract. The

aim of therapy was perceived as different for trauma intervention and longer-term psychodynamic therapy, with the aim of trauma intervention to restore premorbid functioning rather than effecting personality change. In longer-term therapy, therapists felt that NRS would in most cases be an important reflection of what is happening in the patient's internal world and would warrant analysis in this light. Other considerations included patient factors such as ego strength, level of regression, whether the racist NRS's were ego-syntonic or ego-dystonic and whether they confirmed the individual's premorbid beliefs or were beliefs that appeared to have arisen in response to the traumatic event.

Actual intervention strategies arising out of the accounts and case material described by therapists seemed to be generally integrative and eclectic in nature. Therapists adhered to trauma working models, and used interpretive and cognitive strategies in their work with NRS, such as pointing out incongruities in the patient's racial perceptions or interpreting the underlying feeling behind the NRS, such as inadequacy, helplessness or powerlessness. However, therapists cautioned strongly against seeing psychotherapy as technique driven practice and advocated a case-by-case approach to NRS.

In considering therapist's 'responses' to NRS it was found that all eight therapists endorsed the importance of monitoring their countertransference around what has historically been a sensitive topic in South Africa. In accordance with the literature, participants recognized that therapists are not impervious to the social discourses or political climate within which psychotherapy takes place. Therapists identified NRS as potentially evocative of strong personal feelings within themselves. Three salient countertransference themes were identified. Firstly, therapists recognized negative feelings towards or disidentification from their patient expressing NRS, although they also understood the awareness and acknowledgement of countertransference as helpful. Secondly, therapists had experienced negative feelings or 'racially-toned' sentiment towards the perpetrators of their patients' traumatic experience that were out of synch with their own personal views and advocated the importance of reflection on such experiences. Thirdly, therapist identified the potential for a therapeutic impasse or freezing of the therapeutic process in response to NRS. Continuous self-reflection, self-awareness and 'thoughtfulness' on the part of the therapist were recommended to manage strong countertransference feelings in response to NRS.

Therapists identified the occurrence of NRS in the context of psychotherapy as presenting them with potential ethical dilemmas. Therapists considered a possible conflict between their duty to assume a position of solidarity with the traumatized client, against the perpetuation of psychological harm to the patient and/or to society if NRS is left unaddressed. Therapists also considered working with NRS to evoke possible ethical conflict between respecting the autonomy of the patient and deciding, as a psychotherapist, what is in the patient's best interests in upholding the principle of beneficence.

When asked about what they understood to be their imperative to intervene, seven of the eight therapists felt working as a clinical psychologist implied a primary focus on the internal dynamics of the individual and that their primary duty was thus to the individual patient. Participant thinking is in line with more traditional conceptions of clinical psychology presented by the literature, with the emphasis on social relationships considered to be more appropriate in the realm of community, cultural or feminist applications of clinical psychology. Historically, a focus on the influence of inter-racial and other social relationships on the development of the individual has been downplayed in psychoanalytic theory and therapists appeared to appreciate this as a potential problem but to continue to work within this frame or paradigm. One therapist felt that the distinction between the individual and the social might be an artificial one and that therapists may have some political responsibility to ensure that the values of society and the implications of NRS for the individual in his or her social world are considered in the therapeutic space. Some current research considers the application of psychodynamic theory to social phenomena (for example, Frosh, 1987) and suggests that individual dynamics are inextricably linked to social context. However, it was apparent that therapists needed to perceive working with NRS as in the interest of the client in order to intervene in this area.

Three guidelines were suggested for working with NRS in therapy. Firstly, participants suggested that therapist self-awareness was essential and secondly, that psychotherapy should be preserved as a space in which even the most difficult responses can be spoken about without censure. Lastly, therapists felt that this was an area that needs to be actively thought about and in which theory needs to be generated. This is in accordance with the literature that suggests that theory or a language to speak about potentially difficult therapeutic material can be helpful in overcoming a therapeutic impasse such as NRS

might generate (Straker, 2007).

5.2 LIMITATIONS OF THE STUDY

The descriptive and critical interpretation of texts derived from interviews conducted with a small number of participants (common in qualitative studies) permitted access to rich and diverse information. However, the small number of therapists interviewed from a specific geographical area (Johannesburg) does compromise the generalisability of the findings. The breadth of responses also suggests that saturation was not reached and that more possible interpretations of this phenomenon might be elicited with extended research. However the aim of the study was not to generate generalizable information but to explore a particular practice concern and to generate theory and descriptions towards other future investigations of the phenomenon. The study used a purposive sample with the hope that identifying therapists with experience in the trauma field would generate richer data. Indeed the familiarity of the therapists with both theoretical and technical concerns when working with trauma enriched the data.

The racial categorization of the participating therapists is predominantly white. As suggested in the method chapter, this may be reflective of the current demographic of practitioners in which there are still more white psychodynamic therapists in practice than from other racial groupings in South Africa. The results may or may not have been influenced by the racial composition of the sample. As the number of black and other racial categorizations of therapists increases and this imbalance continues to correct itself, it might be interesting to conduct a similar study with a more diverse sample in the future.

Although the results suggest that therapists had not only encountered NRS, but had observed it frequently, it was noted in the method chapter that one therapist declined participation due to the fact that he had not encountered the phenomenon. Thus the prevalence of NRS cannot be deduced from such a small sample of participants who agreed to participate having encountered NRS.

The topic of the study proved to be conceptually dense and the bodies of theory drawn upon covered a broad range. This meant that some of the depth of the theory presented was lost. The links between trauma theory and psychodynamic understandings of racism were based largely on therapists' clinical experience. Little literature was available to

contest or support the links created between these two bodies of theory.

In considering the design and approach to the analysis there was some debate as to what ontological approach to adopt, for example, whether to adopt a more realist or discursive approach. Some thought was put into whether to present the study in accordance with grounded theory approach, which aims at generating conceptually dense theory and descriptions from a strongly data driven position. It was decided, however, to use critical thematic content analysis as this method of analysis allowed for descriptive and interpretive analysis of the data. What is apparent nevertheless is some tension between the theory and data driven aspects of the analysis, or between deductive and inductive approaches. Given that much of the respondents' accounts was theory driven in and of itself, this aspect was more difficult to negotiate and it is hoped that a reasonable balance was struck. It will also be apparent that bar one or two observations the researcher generally approached the material from a hermeneutic of faith and represented these therapists' responses as of heuristic value rather than adopting a strongly critical or discursive approach. The data could probably be quite differently interpreted from a discourse analytic perspective. However, the study was undertaken in a spirit of explicit collaboration.

Although the study argued for the usefulness of psychodynamic understandings when working with post-trauma racism, another limitation of the study may be the exclusion of other equally useful ways of understanding the phenomenon. Research with other groups of practitioners, varying in theoretical orientation and approach would thus be interesting. However, an exclusively psychodynamic focus for this study allowed rich and in depth accounts of NRS to be presented

The study relied on an understanding of NRS that included more subtle and covert forms of discrimination. It may be argued that xenophobia, classism and tribalism are not in fact manifestations of NRS and warrant separate investigation rather than being included under this rubric. Notions of race and racism also change over time. However, the therapists seemed to find it useful to talk about working with client prejudice more generally and the theorization seemed to fit this broad approach. The use of the term 'negative racial sentiment' (NRS) used in the study to include these more subtle forms of racial sentiment may have resulted in a distinction between what is considered "racism" and what presents as racism but is in fact not considered to be racism. These distinctions

may generate considerable debate.

5.3 IMPLICATIONS FOR FUTURE RESEARCH AND PRACTICE

As there appears to be no formal literature concerning psychotherapeutic work with NRS in South Africa, this study attempted to contribute to opening up a space where knowledge and research-based ideas on working with NRS can be produced. In general, further research concerning this specific occurrence in psychotherapeutic work will be useful.

Because both inter-participant discrepancies (for example, whether or not to intervene in relation to NRS) and discrepancies between what the literature suggests and respondents' understanding were identified (for example, in respect of relations between the individual and society) it might be worthwhile to conduct a study that allows for debate of these issues in a forum such as that provided by focus group interviews. A focus group based type of study or set of discussions might allow for some of the debates that emerged in the interviews to be interrogated more intensively. This was even suggested by one of the participants in discussing the importance of actively thinking about issues of contention raised by this topic.

The study also presents some ideas for working with trauma that may be useful to therapists and counselors in general. Thus some thought about training or workshops on this aspect of trauma therapy seems warranted.

This study was exploratory in nature and aimed to generate a broad understanding of the phenomenon. In depth research into any three of the research questions, namely how therapists understand, respond to, or work with NRS would generate more focused data.

5.4 REFLEXIVE COMMENT

One of the limitations of qualitative research is the subjectivity of the researcher in the process of deriving 'findings'. Despite attempting to reflect upon and contain the impact of the role of the researcher's own ideological and therapeutic assumptions, the organization of results and the analysis of the interviews cannot be regarded as objective or definitive. These are one set of a multitude of possible interpretations of the data. The way data was structured also emphasized certain nuances of the material whilst giving

less attention to other aspects. As discussed in the method chapter the supervisor's input was also viewed as important in confirming much of what was highlighted in the analysis.

The researcher was aware that her own personal, ideological and cultural assumptions and knowledge could potentially influence her arrival at certain interpretations or constructions of the data. An attempt was made to restrain this subjectivity by illustrating consistent support for interpretations and using many direct quotes from the interviews (Stevenson & Cooper, 1997).

The demographics of the interviewer may have influenced the contributions of the participants. Participants were informed that the interviewer was registered for the degree of Master of Arts in Clinical Psychology at the University of the Witwatersrand. This may have prompted certain assumptions about the orientation of the researcher and the level of familiarity with theoretical and technical phenomena as student psychologist. This may have limited the depth of data that interviewees shared or conversely participants may have assumed a common therapeutic language and understanding as is illustrated in some of the material. It may also have been advantageous that the researcher was 'junior' in experience to the interviewees as there were times in the interviews when participants were conscientious in explaining fully what they meant when they used psychodynamic or therapeutic ideas in the context of the study, possibly sensitive to the learning process of the interviewer.

The fact that the researcher is 'white' in terms of racial categorization may have influenced the examples selected by participants, a possible example of this being the identification of more white victims and less white perpetrators in the examples described. However, participants were conscious of referring to demographics and statistics to explain the choices they made in terms of examples. Participants may have assumed that the researcher held a liberal orientation based on the choice of research topic and this may have inhibited discussion of more controversial countertransference responses. However, there were certainly times when this did not seem to be the case and therapists engaged with difficult feelings, such as their own wishes for vengeance in response to the suffering experienced by their traumatized patient.

All participants interviewed were made aware of who was supervising the research

project in the information sheet. Given the familiarity with this supervisor's work amongst trauma practitioners in the Johannesburg therapeutic community, the supervisor's reputation may have encouraged trust and rapport between interviewer and interviewee, potentially facilitating self-disclosure on the contentious and sensitive topic of racism. However the reverse may also have been true with some participants having professional relationships with the research supervisor and thus feeling more self-conscious about their responses despite the undertaking to protect confidentiality. However, overall the exchanges seemed to be reasonably relaxed, therapists were thoughtful and rather candid in their responses and there was no obvious indication of strong researcher influence.

In the way of a concluding note, the researcher offers some comment on the context in which this research took place. At the time this data was collected, a number of racial issues were playing out in South Africa. Alleged hate crimes were reported at the time of the study including the shooting of black victims (including an infant) by a young white perpetrator, a video illustrating the humiliation of black staff by white students on a university campus, and xenophobic attacks on non-South Africans by some South Africans in many provinces, and the reported rape of many geriatric white women by black perpetrators. For some the category of 'race' seems to form an integral and important part of identity and social formations while for others it is seen to be a time to stop drawing attention to race.

With many confusing and contrasting views in operation what seems certain is that society is in need of containment. This study focused on the phenomenon of NRS post-trauma and illustrated the usefulness of psychoanalytic concepts for thinking about this phenomenon that has personal and social implications. In the same way that participants advocated a need to think about and engage with NRS in order to render it more accessible, it is hoped that research into this area will facilitate further debate into this particular trauma response and will assist patients, therapists and society that seem in need of ongoing healing of rifts.

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APPENDIX A: SUMMARY OF FINDINGS

APPENDIX B: CRIME STATISTICS

CRIME INFORMATION ANALYSIS CENTRE – SOUTH AFRICAN POLICE SERVICE

Crime in the RSA per Police Area for April to March 2001/2002 to 2004/2005

Province :RSA Total
Area :RSA Total

Crime Category	April to March			
	2001/2002	2002/2003	2003/2004	2004/2005
Murder	21,405	21,553	19,824	18,793
Rape	54,293	52,425	52,733	55,114
Attempted murder	31,293	35,861	30,076	24,516
Assault with the intent to inflict grievous bodily harm	264,012	266,321	260,082	249,369
Common assault	261,886	282,526	280,942	267,857
Robbery with aggravating circumstances	116,736	126,905	133,658	126,789
Common robbery	90,205	101,537	95,551	90,825
Indecent assault	7,683	8,815	9,302	10,123
Kidnapping	4,433	3,071	3,004	2,618
Abduction	3,132	4,210	4,044	3,880
Neglect and ill-treatment of children	2,648	4,798	6,504	5,568
Culpable homicide	10,944	11,202	11,096	11,995
Public violence	907	1,049	979	974
Carjacking (Sub Category of Robbery Aggravating)	15,846	14,691	13,793	12,434
Truck hijacking (Sub Category of Robbery Aggravating)	3,333	986	901	930
Bank robbery (Sub Category of Robbery Aggravating)	356	127	54	58
Robbery of cash in transit (Sub Category of Robbery Aggravating)	238	374	192	220
House robbery (Sub Category of Robbery Aggravating)	-	9,063	9,351	9,391
Business robbery (Sub Category of Robbery Aggravating)	-	5,498	3,677	3,320
Arson	8,739	9,186	8,806	8,184
Malicious damage to property	145,451	157,070	158,247	150,785
Crimen Injuria	60,919	63,717	59,908	55,929
Burglary at residential premises	302,657	319,984	299,290	276,164
Burglary at business premises	87,114	73,975	64,629	56,048
Theft of motor vehicle and motorcycle	96,859	93,133	88,144	83,857
Theft out of or from motor vehicle	199,282	195,896	171,982	148,512
Stock theft	41,635	46,680	41,273	32,675
Illegal possession of firearms and ammunition	15,494	15,839	16,839	15,497
Drug related crime	52,900	53,810	62,689	84,001
Driving under the influence of alcohol or drugs	24,553	22,144	24,886	29,927
All theft not mentioned elsewhere	576,676	620,240	606,460	536,281
Commercial Crime	58,462	56,232	55,869	53,931
Shoplifting	68,404	69,005	71,888	66,525

APPENDIX C: BASIC INTERVIEW SCHEDULE

Demographic Information:
Pseudonym:
Sex:
Race group:
Brief description of psychodynamic orientation and trauma work:

Interview Questions:

Have you encountered negative racial sentiments or racism in psychotherapy with traumatized clients? Please give examples wherever you can throughout.

Would you describe a specific case you worked with in the last year or so in which a client brought negative racial sentiments in response to a trauma into the therapy session?

How did you feel about the client's negative racial schemas?

Do you think this is something that should be dealt with in therapy? If not, why not? If so, how?

What are some of the ways negative racial sentiments in response to trauma can be understood psychodynamically?

How do you work with negative racial sentiments amongst trauma clients?

What are some of the key difficulties in working with negative racial sentiments in psychotherapy?

Do you think this is particular to psychodynamic approaches and why or why not?

How does working in the South African context influence this aspect of therapy?

If you encountered such sentiments in a non-traumatized client would you respond any differently? Why?

Were you working with the client you describe above in brief or long-term therapy? Did this impact on the way you worked with these issues?

Do you have any training guidelines that would help lay trauma counselors to deal with client racism?

APPENDIX D: INVITATION TO PARTICIPATE/ INFORMATION SHEET

UNIVERSITY
OF THE
WITWATERSRAND,
JOHANNESBURG

School of Human and Community Development
Private Bag 3, Wits 2050, Johannesburg, South Africa
Tel: 072 376 4253
Email: tracyfletcher@gmail.com

Dear Potential Respondent

MA CLIN Research Report: How do psychodynamically oriented therapists understand, respond to, and work with negative racial sentiments amongst trauma clients?

My name is Tracy Fletcher. I am a Clinical Psychology Master's student at the University of the Witwatersrand conducting research for the purposes of obtaining my degree. My focus is on how psychodynamically oriented therapists understand, respond to and work with negative racial sentiments that arise amongst trauma clients. This research will hopefully contribute to technical and theoretical understandings of this phenomenon. The ultimate aim of this study is to provide better therapy to survivors of crime whilst considering relationships in society at large.

Participation in this research will entail being interviewed by myself at a time and place that is convenient for you. I would be very willing for example to come to your practice rooms. The interview will last for approximately forty-five minutes. With your permission, the interview will be recorded in order to ensure the accuracy of the information. Participation is voluntary and no therapist will be advantaged or disadvantaged in any way for choosing to participate or not participate in this study. All of the responses will be kept confidential, and no information that could identify you or any patients you may speak about will be used in the research report. However, some direct quotes from the interviews may be cited in the research report in order to illustrate points without any identification of the source of the comment. The interview material (transcripts and tapes) will be kept in a safe place. Only my research supervisor and myself will process them. These tapes will be destroyed on completion of the research after the themes that arise in the interviews have been identified and analyzed. You may refuse to answer any question you would prefer not to and you may choose to withdraw from this study at any point.

A summary of the themes that arise during the interviews will be made available by e-mail to the participants who wish to see the results of the study. Please also consider whether you would be interested in participating in a focus group with other therapists to discuss the results of this study. If so, a separate consent will be negotiated.

Your participation in this study would be greatly appreciated.

Kind Regards

Tracy Fletcher
072 376 4253

APPENDIX E: INFORMED CONSENT FORM

UNIVERSITY
OF THE
WITWATERSRAND,
JOHANNESBURG

School of Human and Community Development
Private Bag 3, Wits 2050, Johannesburg, South Africa
Tel: 072 376 4253
Email: tracyfletcher@gmail.com

I_____ consent to being interviewed by Tracy Fletcher for her study on how psychodynamically oriented therapists understand, respond to and work with client's negative racial sentiments in response to trauma.

I understand that:

- Participation in this interview is voluntary
- I may refuse to answer any questions I would prefer not to
- I may withdraw from the study at any time
- No information that may identify me, or my clients will be included in the research report, and my responses will remain confidential.

Signed_____

Date_____

APPENDIX F: INFORMED CONSENT FOR TAPE-RECORDING

UNIVERSITY
OF THE
WITWATERSRAND,
JOHANNESBURG

School of Human and Community Development
Private Bag 3, Wits 2050, Johannesburg, South Africa
Tel: 072 376 4253
Email: tracyfletcher@gmaill.com

I_____ consent for my interview with Tracy Fletcher for her study on how psychodynamically oriented therapists understand, respond to and work with client's negative racial sentiments in response to trauma to be tape-recorded.

I understand that:

- The tapes will only be processed by the researcher.

- All tape recordings will be kept in a safe place and will be destroyed after the research is complete.

- No identifying information will be included in the final research report.

Signed_____

Date_____