TOWARDS AN ESSENTIAL DESCRIPTION OF THE EXPERIENCE OF PSYCHOTHERAPY WITH EX-DETAINEES

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To an exceptional woman who has lived out and shown me courage, faith, determination, growth and compassion. I am truly privileged to know you and will be eternally grateful for your guidance, teachings and love.

Thanks Mum

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ABSTRACT

The aim of this thesis is to explore and clarify what the experience of psychotherapy with ex-detainees entails. This investigation and analysis is conducted within the framework of a phenomenological method. The researcher elicits both the ex-detainees' and the therapist's experiences of psychotherapy.

Initially the problematic nature of research in psychotherapy is layed out. This is followed by an overview of literature and theory on trauma and its conceptualizations from various psychotherapeutic perspectives. The treatment implications in each case are mentioned. Trauma occurs in the detention experience so detention is then briefly looked at in terms of torture basically and the detention syndrome, post traumatic stress disorder. Core personality processes in relation to this diagnosis are given and the stress recovery process is summarized.

Literature on the treatment of torture victims and persecution victims overseas and treatment attempts with political ex-detainees in South Africa is reviewed. The

factors affecting treatment in the overseas situation and the South African situation are presented too.

The themes that emerge from the protocols of both ex-detainees and therapists show some similarities with issues mentioned in the literature but generally show that environmental constraints and conditions specific to the South African socio-political context are strong, influential determinants in psychotherapy. It becomes apparent that these cannot be ignored and that therapists must respond to them in order to be of some therapeutic effect.

It is observed that the detention experience and trauma is idiosyncratic and dependent on a whole variety of things, at different levels and a multi-disciplinary approach to treatment is implicated. The limitations of individual psychotherapy are brought to light and the marginal role played by therapists emerges clearly. It can be used to its maximum benefit however by encouraging and promoting the full use of innate potentials and external agents that are regularly available to the ex-detainee and can be exploited in the healing process.

It is shown also that no one classical approach to psychotherapy is adhered to. An eclectic therapeutic style is more appropriate. In addition therapists confronted

with this very specific population need essential background knowledge as a prerequisite to attempting effective psychotherapy with ex-detainees.

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INTRODUCTION

Politics touches all our lives to varying degrees. The political and social changes in South Africa are picking up momentum. The situation in certain parts of the country such as Soweto, Cape Town, Port Elizabeth and yes, even Grahamstown, is volatile. These are by no means the only areas. People are being detained without trail. In recent times legislation has made provisions for the state, like indefinite detention with regard to terrorism and 180 days detention without trial. Since the declaration of the state of emergency lasting seven months and ending on 7 March 1986 over 7 500 people were reported to have been detained.

On 12 June 1986 another state of emergency was declared. Political and civil unrest continues. Recently on 12 February 1987, the Minister of Law and Order tabled names in parliament making the official total number of people detained 13 194.

The latest Detainees' Parents Support Committee (DPSC) estimate published on 28 February 1987 (Fifth Special

Report on State of Emergency) was that since the start of the second emergency a total of 25 000 people have been detained. DPSC points out the fact that the official total released fails to include detainees who were imprisoned for under thirty days and five mass detentions in various parts of the country (Nel's Dairy workers in Johannesburg, a church congregation in Cape Town, another group in Graaf-Reinet and OK workers nationwide).

Swartz & Swartz (1986) in their paper delivered at the OASSSA conference raise a very pertinent issue. They discuss the negotiation of the mental health professionals' role in Cape Town and write of "Feeling increasingly marginalized in a city experiencing unprecedented repression and violence..." and their need as professionals to "... feel potent in a political situation where we, like many others, were in reality almost completely powerless". (p10)

Surely the above applies to many mental health professionals throughout South Africa and not only in Cape Town. There is a need for us as professionals to review the situation and discover how we can responsibly respond to victims of the troubled society in which we live. Many

questions are as yet unsatisfactorily answered. How can we be more effective in our work? Furthermore in this turbulent period are we only playing marginal roles in the healing process? If so, is that good or bad, workable or immobilizing?

Aims and Rationale

Although detention occurs in several countries in the world, it is of no comfort to know that we are also on that list. Many people who are detained are mentally and physically healthy when they are imprisoned. They are arrested because of their political involvement or suspected participation. The psychological effects they manifest when they come out and for a long time thereafter, are directly attributable to their detention.

These casualties in affected groups of the population are increasingly exhibiting stress related psychiatric problems such as posttraumatic stress disorder. The effects thereof have to be better understood and attended to. The implications for treatment of stress related disorders such as the detention syndrome have to be investigated,

elucidated and responded to in an appropriate, well thought out fashion by professionals.

Therapists are left with the task of assisting such people to somehow readjust, once they have been released. Not enough work on psychotherapy with ex-detainees has been done. This may give us some pointers on how to best intervene, in an effort to be facilitative in the healing process. The aim of this thesis will be to arrive at a description of the essence of psychotherapy with ex-detainees.

There is much to be gained from the concept of clinical psychological research when investigating psychotherapy in general. When asking a more specific question, such as "What is revealed about the nature of psychotherapy with ex-detainees?", a clinical method of research is extremely useful and by far the best.

The therapists' lived experience of psychotherapy with former detainees is not enough however. In order to get a full picture of the whole and all the factors at play when in a healing process with an ex-detainee, the affected person's experience of the encounter has to be considered as well.

CHAPTER 1

METHOD OF DATA COLLECTION AND EXPLICATION

Psychology has long been recognized as the science of experience. Phenomenology is an approach to psychology that explicates experience systematically in order to delineate the nature of human existence. Phenomenological psychologists are well aware of the folly of psychologys' adoption of the perspective and methods of natural science without sensitivity to the proper character of the phenomena under study (Husserl (cited by Giorgi, 1970); Giorgi 1970). Contributions from men such as Giorgi have provided an alternative approach to psychological research that does not lack vigour yet is faithful to the qualitative dimensions of human phenomena.

Justification for using the descriptive psychological research method need not be attempted here. Firstly its been used so often that its use has already become fully acceptable. Secondly let it suffice to say the qualitative method is seen by the researcher as better able to allow the phenomenon under scrutiny to emerge for what it is. As

Giorgi (1985) states: "The guiding theme of phenomenology is to go back to the 'things themselves'" (Husserl, 1979/1900, p252). From the investigation outlined below, we hope to learn from the experience of therapy of a specific group of people who had been in detention.

1.1 Research Method

Subjects: The two groups from which subjects were chosen are very specific. The only subjects who formed part of the investigation were

(i) mental health professionals who had done psychotherapy with two or more ex-detainees, and

(ii) ex-detainees who had had the experience of psychotherapy.

So the principal criterion for choosing subjects was that they be able to provide full descriptions of their lived experience of psychotherapy.

Three therapists who satisfied the above requirement were located and asked the following question:

a) Describe as fully as possible your experience of psychotherapy with X and Y, indicating its possible differences from and similarities to psychotherapy with non-detainees.

Three ex-detainees who fulfilled the above mentioned criterion were interviewed and asked the following question.

b) Relate as descriptively and fully as possible your post detention experience of psychotherapy, how it affected you at the time (mentally, physically, emotionally, spiritually, professionally, socially) and if, how/or to what extent it helped you.

The subjects in the mental health professional group were between 25 and 35 years of age, two psychiatric registrars and one clinical psychologist. They were all white.

The subjects in the ex-detainees group were between 20 and 40 years of age, two working professionals and one std 10 pupil. All three were people of colour. "Psychotherapy" ranged from two sessions only to regular sessions once a

week for a period of 2 years. Some subjects had negative feelings about their experience whilst others had positive feelings.

A written copy of the question was given to each subject for them to refer to whenever they felt a need. In this adapted phenomenological perspective the interview is the central and sole research instrument. The interviewer probed and clarified where necessary. The interview was not pre-structured but followed and went along with each subject's response. The interview was rigorous in that it was subject orientated and not experimenter defined. It was felt that the spoken interview enabled the subject to remain as close as possible to their lived experience.

Hagen (1986) writes of the valid use of the interview as "a main means of access to the respondent's life world." (p338) and how it captures "..the respondent's own concerns, opinions and actions in her own words, rather than eliciting bits of behavioural responses to pre-categorized stimuli." (p338) as other forms of collecting data, such as questionnaires, tend to do.

1.2 Method of Analysis

The method of analysis of data contains four essential stages:

1) The researcher reads the whole protocol in order to obtain a general sense of the whole description.

2) Once that has been accomplished the researcher goes back and re-reads the text. The objective is to discriminate "meaning units" or essential themes with the emphasis being placed on the phenomenon being investigated.

3) These "meaning units" are then looked at and the psychological meaning derived from them is then expressed, ie the central themes are specified. The meaning units which better reveal the nature of the phenomenon under consideration are focused on.

4) Repetitive statements are then eliminated. The relevant translated components are given

equal value, their frequency not withstanding. Eventually all the transformed meaning units or essential themes are worked into an insightful Gestalt embodying the subjects experience of psychotherapy.

The above mentioned procedure is aimed at "letting the data speak for itself" (Kruger, 1981, p132).

1.3 Research in Psychotherapy

Gottschalk and Anerbach (1966) view research in psychotherapy as a "risky undertaking" because of so many factors - unreliability of observations, general predictive capacity of the theoretical framework, the lack of precision in assessing change, the difficulty in controlling potentially relevant variables ... but to name a few. What method of research in psychotherapy is used depends largely on what aspect of psychotherapy is being looked at. Outcome research for example is approached differently from process research.

There are three general categories of research in psychotherapy namely i) research in the process of psychotherapy ii) research in the effects of psychotherapy and iii) research in personality theory.

Although this dissertation falls mainly in the first category, it infringes slightly on the second. The author is interested principally with the course of psychotherapy yet cannot see how that fails to somehow include to some degree the ultimate changes (effects) in patients, consequent to psychotherapy. Indeed as Sargent (1961) states "...understanding of process without reference to its outcomes is hardly conceivable; likewise, outcome studies which contribute nothing to knowledge of determinants would consist only in statistical summaries of judgements on gross change..." This is as true as it is messy so for the sake of clarity in my thesis, the two will mostly remain separate and distinguishable, emphasis will be placed on process. Sargent puts it clearly when she says "...More broadly, process research may be conceived of as concerned with the how of change, while outcome research attempts to identify what changes (p.97).

Process research can take various forms, for example moment to moment accounts in one session. In this research however it will be summarizing generalizations about sequences of psychotherapy ranging from just 2 sessions to regular sessions over a period of two years. We aim to involve studies of the behaviour and responses of both therapists and ex-detainees to determine what aspects have "therapeutic" effects.

Kiesler (as listed by Kruger, 1983) writes about how the measurement approach to psychotherapeutic research is dominated by the myths of uniformity of patients or clients and therapists which we all know to be impossible. Kiesler (1977) concluded that it is not even possible to reliably quantify research for example the theoretical models of Freud, Rogers and the behaviourists because the problem of specifying operationalized variables remains. The process of psychotherapy cannot be specified in terms of independent, dependent and confounding variable interactions.

The scientific status of psychological research has been defended and upheld by psychologists at great cost. The question of the validity of qualitative research is well argued by Kvale (1986) who sees psychoanalytic therapy as the most prominent and influential qualitative research method which has contributed enormously to psychological knowledge. Phenomena such as dreams, neuroses, therapy, sexuality and child development have all been investigated through psychoanalytic method. Psychoanalytic therapy has served as a qualitative investigation and inquiry.

Kruger (1983) gives an exposition of phenomonological research praxis in psychotherapy. He states that "Being retrospectively present to psychotherapy means ... a nondefensive, open, vulnerable presence to what really happened and how one acted in psychotherapy, in fact, re-experiencing what had happened during the process" (p.28). He suggests the correct response to the question of how an existence is transformed in psychotherapy, may be discovered in a systematic survey of the "... lived structures of being client and of being a therapist" (p.30).

Robert Fessler (1983) writes a critique of traditional methodologies, as used in research on psychotherapy. In most studies, only the therapist's account is reported and considered. The therapists in their attempts to explain and describe, invariably fell back on their traditional conceptual understanding presented to them (and perhaps even indoctrinated into them) during their training.

CHAPTER 2

A VIEW AT THE RELATEDNESS OF THEORIES, TRAUMA DETENTION AND POST TRAUMATIC STRESS DISORDER

Introduction

The aim of this chapter is to introduce trauma, the conceptualization of it by various theories in therapy and its relatedness to detention. Firstly different theories and their conceptualization of trauma plus how it can be tackled in therapy is looked into very briefly. The cause of trauma or traumatization in ex-detainees is contained in the detention experience. It is for this reason that the various concepts and psychological approaches to trauma used, are seen as important. This is done within the framework of various psychotherapies.

Some aspects of detention are touched on. The conditions in detention are not gone into in any great detail, except for torture. Most of the research literature comes from overseas (predominantly Canada, Denmark and the Netherlands)

Psychological research done on detainees in South Africa is reviewed. The relatedness of posttraumatic stress disorder to a detention syndrome is highlighted. Conditions making possible the emergence of this disorder are given. Core personality issues and the stress recovery process of post traumatic stress disorder are discussed.

2.1 CONCEPTS OF TRAUMA

As Krystal (1978) states, it is imperative to define trauma because this exercise provides a framework for therapeutic considerations. Therapeutic considerations being the focus of the thesis, it seems a logical first step.

The word trauma originates from the Greek word "wound". Breuer and Freud (1893-95) in their Studies on Hysteria offer the following definition:

> "In traumatic neuroses the operative cause of illness is not the trifling psychical injury but the effect of fright - the psychical trauma. In an analogous manner, our investigations reveal, for many, if not for most, hysterical symptoms, precipitating causes ..... Any experience which calls up distressing affects such as those of fright, anxiety, shame or physical pain - may operate as a trauma of this kind" (p.5).

As Decker (1979) stresses it is important to separate and distinguish a bad experience from a traumatic one. In the former discomfort is experienced but the subject always feels in control of the situation and recovery is favourable. A trauma however is "... a period of severe unpleasantness that exhausts coping resources ...." and it leaves "... psychic wounds which are slow to heal." (p.288) He goes on to say that the afflicted person probes the psychic wound in various ways especially a fantasised rehappening of the traumatic experience (either in the sleeping or waking state) with repetitive experiencing of the original horror.

In attempting to define trauma we need to appreciate the context in which it will be referred to in this dissertation. Figley (1985) in explaining the setting, sites catastrophe as a situational prerequisite for the occurrence of trauma. He describes catastrophe as an extraordinary episode or series of events which suddenly, overwhelmingly endanger the individual or significant others. This condition then makes fertile ground for the occurrence of trauma. He then goes on to define trauma as

"...an emotional state of discomfort and stress resulting from memories of an extraordinary catastrophic experience which shattered the survivors' sense of invulnerability to harm..." (XVIII).

2.2 THEORIES AND THERAPY APPLICATIONS TO TRAUMA

2.2.1 Psychoanalytic Therapy

Freud's contribution about trauma is still the cornerstone of the psychoanalytic understanding of it. Briefly Balint (1969) reviews Breuer and Freud's (1893-5) conceptualization of trauma as an external event causing a severe psychical upheaval with enduring consequences which requires sustained therapeutic efforts to understand and correct.

Following World War I Freud wrote:

> "In traumatic and war neuroses the human ego is defending itself from a danger which threatens it from without or which is embodied in a shape assumed by the ego itself. In the transference neuroses of

> peace the enemy, from which the ego is defending itself, is actually the libido whose demands seem to it to be menacing. In both cases the ego is afraid of being damaged - in the latter case by the libido and in the former by external violence". (1919)

An experience that brought about disturbing emotion was a trauma, which resulted from the addition of excitation in the nervous system with no discharge. The curative process was seen to entail discharge of excitation, and the therapeutic modality of this period was abreaction. The pathological condition was an excess of excitation causing a break in the protective wall (defences) against stimuli. In order to cope with the excess excitation, a compulsion to repeat is sparked off, the clinical expression of which is some neurotic symptom.

Krystal (1978) identifies "helplessness" as the key word in Freud's conception of trauma. Basically the essence of the traumatic situation means the subject's evaluation of his own strength and most important his acknowledgement of

helplessness in the face of it. If the danger is real, physical helplessness is experienced and if it is instinctual danger, psychical helplessness is felt. This helpless submission or surrender is what changes anxiety (a retrievable situation) to an effective state of "cataleptic passivity" that manifests in numerous ways such as blocking of emotion, progressive inhibition and depression etc.

So, in short, according to psychoanalytic theory trauma occurs when the ego is overwhelmed. The person's normal adaptive capacities are disrupted. The individual reverts to a primitive form of defence namely the repetition compulsion. This mechanism used extensively in early childhood consists of actively recreating the event rather than passively experiencing it as in the original situation. The victim can gradually master the experience. Freud identified 2 broad effects of trauma firstly fixation to the trauma as is described above and the second is defensive reactions that see to it that the trauma will be neither remembered nor allowed to be repeated in any form be it symbolically or otherwise.

Implications for treatment:-

> Breuer and Freud (1893-95) found that the symptoms disappeared when the meanings where retrieved from repression and brought into consciousness and stated that recollection without affect almost invariably produces no result. Their findings were that "... each individual hysterical symptom immediately and permanently disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked and in arousing its accompanying affect, and when the patient had described that event in the greatest possible detail and had put the affect into words." (p17)

2.2.2 Behaviour therapy

The basic principles of behaviour therapy are to change what the patient does as opposed to what he thinks or feels. Relatively little emphasis is placed on exploring psychological life and the history of the problem. In behaviour therapy it

is sufficient to substitute new adaptive behaviour patterns for older, maladaptive ones. Appropriate rewards are administered in a way which reinforces the desired behaviour.

Indications for behaviour therapy: Authors such as Johnson, Snibbe and Evans (1980) have admitted that behaviour therapy is a less effective treatment method for patients who have numerous or ill-defined behavioural disturbances and who are overwhelmed by intense feelings as is the case with traumatized people. It is better applied to circumscribed problem areas.

Basic assumptions of behaviour therapy are as follows:

1. Behaviour therapy tends to concentrate on behavioural processes and those closer to overt behaviour.
2. Behaviour therapy concentrates on the here and now.
3. Behaviour therapy assumes that maladaptive behaviours to a considerable degree are acquired through learning, the same way any

behaviour is learned. Three basic learning models are typically invoked: the operant paradigm, the classical conditioning paradigm and modelling.

4. Behaviour therapy maintains that learning can be very effective in changing maladaptive behaviours.
5. It involves setting specific, well-defined therapy goals.
6. It rejects the traditional trait approach.
7. It stresses the value of getting empirical or scientific support for its various techniques and methods.

Behaviour therapy consists of applications of experimentally established principles of learning to the purpose of overcoming unadaptive habits or traumatic symptoms. So trauma is looked at in its behavioural manifestations and is then dealt with by designing a programme using various behavioural techniques.

2.2.3 Cognitive therapy:-

Cognitive therapy attributes misconceptions, unrealistic expectations and maladaptive attributes to pathology. Popular proverbs such as "As you think, so shall you feel", and "If you are not feeling well, you are probably not thinking right" capture the spirit of this approach. Traumatized states are maintained by cognitive misconceptions. Treatment implications are very straight forward. In order to alleviate symptoms these incorrect thoughts have to be identified and tackled in various ways using reasoning and appropriate cognitive techniques such as thought blocking practices.

2.2.4 Cognitive - Behaviour Therapy

Cognitive behavioural therapists highlight the interdependence of multiple processes involving the individual's thoughts, feelings, behaviours and environmental consequences. So cognitions are viewed as only one of several contributing factors to the etiology and maintenance of behaviour. Cognitive behavioural therapy integrates the

concerns of both schools and combines the clinical insight with the technology of behaviour therapists. Cognitive behavioural therapy has an integrative explanatory thrust and has a multicausal, multidetermined view of psychopathology. This also includes pathology caused by trauma. In keeping with this perspective, therapy deals with both emotional and physical aspects of the effect of the trauma.

2.2.5 Integrative Psychodynamic Therapy

This is not a new school of psychotherapy but rather as the name suggests an integrative approach. This rapidly developing trend moves toward the integration of psychodynamic and behavioural approaches. It does not view insight alone as sufficient in most cases to produce the full range of changes the patient is seeking or needing. This evolving point of view is still assimilating ideas and methods from other approaches. The approach is well spelled out by Wachtel (1982).

This approach includes working through and conflict resolution (both central concepts in psychodynamic theory) plus behavioural consequences attained by various strategies and techniques. Trauma is conceptualized in both dynamic and behavioural terms so all of the above approach is used in the treatment of traumatic symptoms.

2.2.6 Crisis Intervention

Crisis theory has borrowed substantially from ego-psychological principles. Firstly, a person in a noncrisis state manages a level of emotional homeostasis in which stress is successfully handled by habitual problem-solving abilities. A crisis reaction is experienced when the individuals coping resources are inadequate. The definition of a crisis therefore can be said to be a lack of equilibrium between the perceived difficulty of a threatening situation and the coping resources available to the individual. Once emergency coping strategies fail, anxiety is progressive until the individual reaches breaking point and this is followed by personality disorganization and a traumatized state.

It is important to note that Caplan (1964) did not see a crisis reaction as a form of pathology but rather as a normal response produced by a dangerous external event. The crisis can lead to impairment in adjustment or growth in personality through the acquisition of new coping responses. The variables that determine an individuals adjustment to a crisis are their perception of the menacing event, the repertoire of available defences and the existence of social support.

Another assumption of Caplan's (1964) was the time-limit nature of crises. In addition during such a traumatic event the individual is more receptive to help from others and is more open to interpersonal intervention than during the phase of emotional equilibrium.

There are various types of crises that will not be reviewed here. Basically this approach is a brief form of intervention (no more than 12 sessions) that should be provided immediately after the trauma or as soon a possible to capitalise on the persons heightened, emotionally aroused state.

This type of intervention is basically a hybrid approach of behavioural and humanistic principles whereby the main objective is symptom relief. There is no effort made to reconstruct, simply reattaining the individual's precrisis level of functioning is the goal. The work is very focused because of the time constraints and emphasis is placed on the "here and now" plus the client's attempts (past and future) to manage with the threatening situation.

Concreteness is promoted and the therapist is often called upon to be active, flexible and directive in dealing with the family, significant others and informing or connecting the client with support such as institutional resources in the community.

2.2.7 A Sociological Conceptualization of Trauma

Mestrovic (1985) looks at a sociological conceptualization of trauma. This view sees trauma as more than merely an event. The concept of trauma is attached to the ideas of arrangements

and derangements of collective representations in a context of society conceived of as a system whose parts influence each other.

Although the implications of treatment here with respect to therapists are likely to be largely out of our scope, it is important to be able to conceptualize trauma for the better understanding of our clients. The danger as far as the writer is concerned is to see those who go to therapists traumatized with their symptoms in isolation.

Flemming and Cannon (cited in Mestrovic, 1985) see the individual's homeostasis as significantly dependent on that of social homeostasis. They maintain that in order to lead a healthy life, society has to provide essential minimal conditions. So, as therapists with such a perspective there is more awareness and sensitivity to what minimal conditions the individual can still survive in adequately. By questioning what type of conditions work towards complete immobilisation and which ones towards health, more knowledge about the affected individual and his environment is acquired. Such knowledge can be therapeutically beneficial and utilised in their treatment.

2.2.8 Existential Psychotherapy

The underlying principle of existential psychology is that the true sense of meaning for human beings is that which they discover for themselves. Thus meaning is highly individualistic. Van den Berg (1980) in his phenomenological concept of psychotrauma sees the bare event of a trauma as insufficient. He places emphasis on the meaning or value that the trauma holds for the individual who experienced it. Admittedly there are tangible things and happenings out there but they're only given substance by the human being's experience and interpretation of them.

Existential psychology does not deny the unchangeable facticity or "givens" of experience. Two categories are biological and personal givens. An example of the former is gender and of the latter is choices made by the individual in the past.

This theory considers the debilitating effects of trauma or stressful events. It views trauma as those events in life that are unexpected and disconfirming of explicit or implicit beliefs.

Implications for psychotherapy:

Phenomenology begins with the assumption that all we term subjective happens out there in the world. It goes on to make clear that we discover our subjectivity in the objects around us because it is amongst those things that human enactments are actualised. So, the patient's neurosis develops in his world and it is in that same world that he regains health. Psychotherapy aims at change, bettering the relations an individual has with others and with the world.

2.3 Detention

Each individual detention situation involves its own peculiar combination of some of the following variables - solitary confinement, physical and psychological methods of interrogation, uncertainty, low predictability and controlability, plus torture.

Detention can consist therefore of a whole range of abuses some of which receive the recognition, of organisations such as Amnesty International and the United Nations, as being "torture" and others that are merely seen as "ill treatment".

In Stover and Nightingale's (1985) attempts to answer the question of what torture is, they give the definitions of the two above mentioned organisations. There would seem to be disagreement as to whether solitary confinement or other isolation by itself can be considered as torture or ill-treatment at all. Amnesty International argues this point and contests the view held by international law, that solitary confinement is not torture.

The United Nations (cited in Stover and Nightingale, 1985) defines torture in the widest possible way. It is seen as "... confinement that includes the systematic application of severe physical pain or mental suffering" (p.6).

The processes of torture include the physical, psychological and psychiatric-pharmacological realms. A few examples are electric shocks or sensory deprivation, threats and overdoses of psychotropic drugs or toxic agents respectively. The consequences of torture are destabilisation of the victims physical and/or mental well-being. The individual is disorientated and undermined.

Forms of mental torture include isolation, sleep deprivation, mock executions, sexual attack (including injury to the genitals). Light torture, such as threats that members of the prisoner's family will be harmed, enforced hearing or watching of others being tortured also fall under this category.

Accounts of psychological and physical torture experienced in detention are given in Stover and Nightingale (1985). In their study Kolff and Doan (cited in Stover and Nightingale, 1985) suggest that the psychological effects of torture generally persist long after most of the physical effects have ceased to be troublesome. This was the finding with South American victims who had become refugees in North America. Since World War II numerous studies have been published

which illustrate lasting psychological sequelae after extreme stress. Rasmussen ard Marcussen (1982); Allodi and Rojas (1983).

Rasmussen and Marcussen (1982) found physical sequelae in torture victims seven years after some of them had been tortured. Allodi and Rojas (1983) also found psychosomatic impairments in victims up to ten years following the traumatic experience. In their assessment of 135 torture victims, Rasmussen and Marcussen elicited a wide variety of mental torture that has already been mentioned above.

2.3.1 Psychological Effects of Detention

An insufficient amount of psychological research on the psychological effects of detention has been done and documented internationally. Researchers, such as Inge Lunde (1982), who is one of the pioneers in the field, emphasise this.

Inge Lunde (1982) from the Danish Medical Group describes the psychological sequelae resulting from torture in detention. In her study (1982)

the psychological sequelae included hallucinations and delusions, depressive symptoms, fear, anxiety, symptoms of phobia, irritability, change of contact pattern (tendency to isolate oneself and difficulty in relating to others), asthenia and being easily tired, memory and concentration difficulties, headaches and sleep disturbances. Different combinations of some of these symptoms appeared to varying degrees in her population of subjects. The same neuropsychological complaints are referred to in the work done by Somnier and Genefke (1986). Their psychotherapeutic intervention for victims of torture will be dealt with later under treatment.

In South Africa, little if any published research on the psychological effects of detention or torture on detainees has been done. Some work with detainees that has been reported was by Foster and Sandler (1985). These two psychologists from the University of Cape Town did a study on 176 ex-detainees throughout South Africa.

Amongst other things they reported encountering problems with irritability, depression, fear of being re-detained or killed, or family being harmed because of threats, passivity or an inability to mix socially, impaired memory and concentration and psychosomatic complaints.

Hugh Bloch (1986) in his work on South African political detainees found that various things affected the extent to which detention affected the former detainee. Their tolerance levels, ability to cope and symptomatology were different and marked. The individual's social context and the conditions of detention were varied and were influential. Post-traumatic stress disorder (PTSD) was shown to be indicated. In his work, as well as that of others mentioned below, we see post-traumatic stress disorder's relatedness to a detention syndrome.

There is strong evidence to show that people who have been in detention display, after release, symptoms seen in the criterion for the post-traumatic stress disorder syndrome. This is the case despite the fact that they may not have

enough criteria to obtain the diagnosis. A paper delivered at the 1985 NAMDA Conference by Dr Paul Davis reviewed 21 ex-detainees seen in Johannesburg. His results of the psychological assessment was that classical symptoms indicated varying degrees of post traumatic stress disorder. The treatment conducted for ex-detainees will be dealt with later. Robin Friedlander (1986) a member of NAMDA and D.C.S (the Detainees Counselling Service) interviewed a sample of 28 ex-detainees and found 14% fulfilled the DSM III criteria for PTSD and 18% for major depression and 29% had both, the 2 major diagnoses being PTSD and major depressions.

The major work done in South Africa by Foster and Sandler (1985) has shown that although ex-detainees have not managed to fulfil the criteria for this diagnosis, they do manifest some of the symptoms. Papers delivered at the American Psychiatric Association at various times have however shown that many ex-detainees who were tortured, met all the criteria for the DSM III diagnosis of post

traumatic stress disorder (Brett and Ostroff, 1985).

2.4 Post Traumatic Stress Disorder (PTSD)

Jack R. Ewalt (1979) points out that traumatic neurosis or posttraumatic disorders differ from the other neuroses by virtue of the external situation being real rather than symbolic.

According to the DSM III this disorder is seen in response to external stressors of unusual intensity. Survivors of natural or man-made disasters such as World War I and II, the Vietnam and Arab - Israeli Wars, Nuclear War and the holocaust have been studied. More recently survivor refugees from South American countries have been looked at and worked with and on a much smaller scale this phenomenon is being examined in South African detainees as mentioned above.

Stressors that are man-made like bombing, death camps, torture, and detention make for longer lasting, more severe forms of PTSD. This is thought to be because they are of human design.

Impairment and complications vary from mild to noticeably affecting all aspects of living. Occupational and recreational activities may be affected resulting in phobic avoidance if for some reason they resemble or symbolise in any way, the original trauma. Interpersonal relationships (marriage, family, friends) may be affected because of "psychic numbing". Self defeating behaviour may manifest as a result of depression and guilt. Other consequences such as substance abuse may develop into a full blown substance use disorder.

2.4.1 CORE PERSONALITY PROCESSES

The whole area of premorbid personality structure and it's relation to people who develop posttraumatic stress disorder is complex. For purposes of this dissertation it will not be dealt with in any great depth.

Allodi and Rojas' (1983) comment on the use of personality to anticipate the likely reactions and behaviours of people who are exposed to stress is

that it's important but elusive. They say that "Studies of personality as a factor of predicting responses on an individual under severe stress have been disappointing ...." (p.2)

Most authors on the subject of posttraumatic stress disorder are in agreement about the importance of an individual's psychological makeup in the outcome of the reaction to a traumatic event. Different people respond to stressor events differently. It is for this reason that there's a need to investigate how this influences post trauma adaptation. There is a need for therapists to understand what part personality variables play in the development of post traumatic disorder.

Figley (1985) presents a broad theoretical overview that is summarised in table form (see table 1). Figley (1985) cites contributions by Erikson, Lifton, Seligman, Garber and Horowitz which explain the effect of trauma in terms of psychosocial development, psychoformative process, learned helplessness and cognitive processing of trauma respectively.

The first is an application of Eriksonion theory and his perspective on ego development. So timing here is seen as very important and the predominant stage of ego development. The effect produced in terms of PTSD varies and is a function of the stage-specific characteristics of ego development. In this model there are several possible consequences.

Trauma can lead to retrogression in ego development by straining ego defences beyond their limits according to the individual's developmental stage. Examples of this could be profound mistrust, feelings of abandonment, heightened sense of vulnerability. This happens to some degree in all cases of PTSD but is pronounced if premorbid weaknesses that we acquired from childhood development compound the problem.

Another consequence is accelerated ego development whereby the ego is strengthened through the premature coming up of qualities of awareness resulting in an increase in ones sense of integrity and self-actualization. This does not happen often.

Only two consequences have been given but there are numerous depending on a combination of several factors. The individual's stage of ego development in the life cycle, the level of personality integration and ego strength and needless to add the severity of the trauma itself all help determine the outcome.

Psychoformative theory is about the manner in which individuals conceptualise and symbolise their experiences in life. Lifton (cited in Figley, 1985) within this framework, cites the main focus of experience into paradigms of connection versus separation, movement versus stasis and integrity versus disintegration.

Immersion in a death experience or exposure to destruction then makes for a loss of social order or continuity and connectedness in psychoformative processes and leads to a survivor syndrome. The survivor may firstly become physically numb and emotionally dulled because of the incoherence and meaninglessness of their fragmented self.

The healing task lies in reformation of the experience and development of a new sense of self as living, creative and growing again.

Learned helplessness is as a result of the victim who, faced with an uncontrollable, unpredictable situation, decides to give up. They feel and view themselves as pawns who have no control and lose the ability to imitate adaptive reactions. The end result of learned helplessness is depression, withdrawal, isolation and if prolonged can evolve into a somatoform disorder.

Horowitz (1976, 1979) has used a cognitive model of information processing to explain PTSD. According to him, psychological elements of the event (cognitions) remain in memory as determinants of intrusive imagery or other symptoms of the syndrome until the integration of the event into the existing self-structure.

Horowitz (1979) also has a well-defined sequence of stages of trauma assimilation. It is outcry, avoidance, intrusive imagery and re-experience of the event, followed by transition and integration.

Emery and Emery (1985) in their effort to look into the influences of premorbid personality in the development of PTSD apply their knowledge of ego psychology, developmental lines of growth and the narcissistic phenomenon. They look at the defence processes prior to exposure to trauma in conjunction with an examination of the process resulting from trauma.

According to them, the defence process starts before exposure and the act of surrender. In the early stages there is an increase in narcissistic libido due to the increase in aggressive strivings. It is the mounting degree of anxiety that activates ego-mechanisms. When things deteriorate to the level of splitting and usage of "archaic" defence mechanisms (eg. projective identification) a traumatic syndrome comes about.

A distinct premorbid factor incorporated into the psychic apparatus of their patients (who had the diagnosis of PSTD) was that external reality was a hostile, demanding environment. This predisposition towards misperceptions of reality is because of the

presence of archaic defence mechanisms such as projective identification, denial and splitting.

2.4.2 The Stress Recovery Process

In Trauma and its Wake, Figley (1985) reviews several models of the posttraumatic stress recovery prccess (Burgess and Holmstrom, Figley, Horowitz, Smith, in press). He then identifies 4 essential characteristics common to all. These are:

1) the traumatic episode and the initial emergency coping mechanism, eg. denial or numbing, flight or fight;

2) the reliving or intrusive imagery into consciousness of negative facets of the trauma;

3) endeavours to deal with the intrusions or re-living of parts of the trauma (by taking charge, minimising or obliterating the perturbing impositions), most often through a combination of denial and intrusion;

4) the combination, into an understandable whole, of the good and bad effects of the trauma on the self and relatedness with others, family and friends, and even one's society.

This basic four part route to health can take the form of many different treatment approaches to individual psychotherapy, some of which have been discussed above (psychoanalytic, cognitive behavioural, phenomenological, crisis intervention, behavioural). Various types of therapeutic treatment can be used, namely individual, group or family therapy, the last two of which are important but outside the scope of this thesis.

CHAPTER 3

TREATMENT

Introduction

A literature review on the treatment of torture victims overseas is presented. Although treatment is the focus of our research not much research has been done in this area as previously mentioned. What little investigation has been reported is gone into but unfortunately the characteristic common to all is a tendency to be vague. After that the local scene is viewed and what has been done here in South Africa is summarised.

Here an assumption is made. The author is taking it for granted that the reader has sufficient basic knowledge about what psychotherapy is. Briefly, in simple terms, it is a treatment process involving the talking and listening (interaction) of two individuals whereby one attempts to influence another.

3.1 Treatment attempts overseas

International research on detained victims of torture has been conducted with a view to treatment. Treatment implications, based on the Canadian study by Allodi (1982) on subjects from three Latin American countries, for health professionals to be aware of, have been suggested. The four issues were trust, catharsis and regression, the feeling of guilt and the new self's contribution of a dialogue with society. Allodi used a dynamic psychotherapy designed to enable the patient to realise the emotional and psychological bases of their feelings and actions.

Lunge Lunde (1982) in her study raised many issues in her thinking about treatment. Indeed the kind of treatment available depends on several factors. The effectiveness of assisting torture victims living in exile as opposed to in their own country was questioned. Linguistic barriers plus cultural differences were also problem areas. These issues are pertinent to how we view treatment in South Africa for various reasons and will be further discussed in the final chapter.

The most important points that come out of this study are that as far as Lunde is concerned, individual treatment is inadequate. Involvement of the victim's family and circle of friends is required. In addition the active consideration of the victim's economic, physical, legal and social situation is necessary. A need for interdisciplinary expertise is emphasised.

What Lunde saw as imperative was to encourage the person to talk so as to allow the victim to begin to gain a perspective of the experience. Secondly, the issue of personal identity is fundamental to all such victims and needs to be tackled and restored. The emotional and psychical relationship the individual has with him or herself is crucial.

Somnier and Genefke (1986) saw 3 separate groups of torture victims with the objective of arriving at the basis of a concept of psychotherapy for torture victims. They outline the course of psychotherapy in 3 parts. The initial phase is mostly cognitive, the second emotive and the last serves to re-establish reality, using in-depth interviews.

The aim of the first phase involves going straight into a detailed reconstruction of the experience and the victim's behaviour is evaluated as a cause - and - effect situation. The goal here is to assist the victim to realise how torture distorted normality and that the torture was systematically designed to immobilise normal psychological mechanisms and manipulate them. When the former detainee is able to correctly attribute what happened and understand it as only predictable instead of blaming themselves as innately lacking in strength, the second stage is then ready to be dealt with.

This phase is going over the same material but in a more emotional context. Trust is of the utmost importance and the therapist must at no stage be associated with the torturer and empathy not sympathy is required of the professional. Although emotionality is in a sense encouraged any issue that precipitates uncontrollable pain and memories is steered away from.

If strong repressive forces are at play the victim is encouraged to relate the story in chronological sequence, in other words exactly

what was experienced during isolation, time spent waiting to be tortured, everything - all thoughts and feelings and perceptions, even the seemingly insignificant, as well as the actual torture.

In this stage issues such as guilt feelings about decisions made or conduct should be inspected so that the victim realises that in all probability the outcome would have been the same, or of no greater or lesser consequence. Emphasis is placed on the victim not taking responsibility for his own actions or lack thereof under such strenuous conditions.

If these two phases have been accomplished and done thoroughly, the third (re-establishment of reality) is not difficult.

The aim of this whole exercise is to give the victim an opportunity to work with the past painful event within a new context. It would seem that inwardly directed aggression is a common characteristic. This misguided aggression should be rechanneled. Their aggression should be pointed at the torturer.

The memories are worked with so as to no longer cause the victim fear, humiliation, guilt, etc. and the distortion of their normal psychological mechanisms is realised as systematically designed by the torture and thereby making their conduct predictable and excusable.

Other interesting work, using a novel approach to integrate the experience positively into one's life, was done by Chilean psychologists in 1983. The relationship between emotional functioning and political commitment was conceptualised as a special internalised (made part of the self) type of object relation. The use of testimony as a psychotherapeutic instrument led to the alleviation of anxiety and other acute symptoms. Psychoanalytic therapy in the object relations variant was the theory on which treatment was based.

Different treatment proposals based on different studies, have been suggested in the American Journal of Psychiatry, at various times. The increased use of imagery in analysis is one example. The justification for this clinical approach is based on Freud's view of the

repetition compulsion. As explained previously, he understood it as a primitive form of defence the overwhelmed ego reverts to when the usual adaptive capabilities (defence mechanisms) fail, resulting in regression. The effect of the encouragement of dreams and imagery in the patient's waking state during therapy, in an effort to master actively what was previously experienced passively, is underestimated in Brett and Ostoff's opinion (1985).

Contrary to the above, Boehntein, Kinzie, Ben and Fleck (1985) fear that re-evoking the traumatic situation may be counterproductive in therapy. A follow-up study was done after one year and they found that medication (such as antidepressants and anxiolytics) when necessary and a supportive (non-confronting) psychotherapy were the preferred method of treatment. By supportive psychotherapy they meant that the traumatic event of victimisation was not dealt with or worked through directly or in any great detail. Psychotherapy consisted then of focusing on the present and the future.

3.2 Treatment attempts in South Africa

In South Africa, Dr Robin Friedlander (1986) maintained that "... support, reassurance and education remain the mainstay of treatment." (p10) Gaining insight, in his opinion, can be secondary to the above.

K Solomons (1986) also a psychiatric registrar and DCS member, in his offering to the treatment of South African political ex-detainees, expands on a theory of the dynamic mechanisms in posttraumatic stress disorder.

He mentions vital realities such as the lack of available time. The psychological intervention is brief (usually one session) unlike the work done overseas, and he sees this as incentive to pursue new channels and ways of making better sense of psychotherapy with South African detainees.

His work deals with the 2 defence mechanisms that come to the fore in the face of trauma or destruction (the repetition compulsion and denial) but goes on to add that peculiar to the local setting is the emergence of a third defence mechanism namely the conversion somatization mechanism. The failure of these coping strategies

result in symptomatology (symptoms being yet another endeavour to integrate the trauma) which leads to the posttraumatic stress disorder diagnosis.

His treatment approach based on the above model is the only truly detailed step by step account of psychotherapy with former detainees in South Africa and it is for this reason that the author sees it as essential to recount his treatment method.

Basic to the model (and most other psychodynamic approaches) are 4 imperative points which are as follows:

1) Sensitivity to the therapeutic situation, making it conducive to the development of rapport and establishment of trust.

2) Eliciting symptoms which are then connected directly with the detention experiences. Here the therapist encourages verbalisation of the detention experience.

3) Assist the ex-detainee to relate the emotional effect of the traumatic impact so as to "externalise" the painful feelings.

4) "Normalise" the detainee's experiential responses by way of assuring him or her that all people exposed to such trauma react predictably and in a similar fashion.

Specific to the Solomons' model is a need to help the former detainee to understand the dynamic beginnings of their symptoms in a simple didactic way.

This is followed by a pointing out of the adaptive nature of the symptom so as to diffuse its powerful hold and influence on the detainee. Lastly comes the promotion of the use of restitutive and reparative phantasies to re-do, un-do or actively redesign what happened in the detention experience.

The South African situation is not identical to the overseas situation. Bloch (1986) discusses the factors that are different and influence the treatment of political ex-detainees in both areas.

These factors are presented here in tabulated form.

THE SOUTH AFRICAN SITUATION	THE OVERSEAS SITUATION
(i) Outpatient service	Inpatient units
(ii) No safety	Safe environment for refugee guaranteed
(iii) Single disciplines with disjoint services	Interdisciplinary approach includes psychological, social, legal and medical services
(iv) No control over environment	Controllable environment
* Caution not to recreate interrogation situation in any way	* Caution not to recreate interrogation situation in any way
* re-experience the traumatic event - goal of therapy	* re-experience the traumatic event - goal of therapy
* Therapist needs to be calm and holding	* Therapist needs to be calm and holding
(v) No time to unwind gradually It must be immediate treatment	Gradual unwinding to get victim to talk

(vi)	Time available for therapy is unpredictable	There is time for therapy to include the following: - Catharsis, regression, new perspective - Guilt feelings - explored - Broader assistance (eg helping patient get in touch with social, legal and welfare, organisations)
(vii)	Specific demands of the environment - going into hiding, being on the run - being member of an organisation - mounting political tensions in the country	Specific demands of the environment are different to those mentioned in the South African situation

(viii)	Exacerbating symptoms - no available support systems - ever present danger and vulnerability	Exacerbating symptoms - no available support systems
(ix)	Insufficient response by mental health professionals	There is sufficient response from the mental health professionals
(x)	Advantage which needs to be made use of = Ex-detainee goes back into already existing support structures and familiar community setting	Disadvantage = Ex-detainee needs to form or become part of a new community
(xi)	The government here is oppressive and would hardly encourage the existence of an inpatient service since political detainees are against the present political system.	No political opposition from the government

* common to both South African and overseas situation.

As the author sees it, basically the general principles of treatment still apply in both situations. The exceptions are when methods of administration have to be adapted because of specific demands and factors which were included in the above table.

3.3 Treatment Teams in South Africa

There are several treatment teams in Johannesburg, Cape Town and Natal. They are the detainees treatment team (DTT) and the Organisation for Appropriate Social Services in South Africa (OASSSA) that has a branch in Cape Town and Johannesburg, the Detainee's Counselling Service (DCS) in Johannesburg, the Natal Health Group in Durban and most recently the Sanctuaries Team based at the University of the Witwatersrand, Johannesburg.

DTT in Cape Town seems to have done the most in the field of primary prevention. This process involves preparing individuals for detention by imparting coping skills before detention for them to use during the detention. DTT has worked with organisations and people at risk by way of teaching and having experiential groups.

Secondary and tertiary prevention entails the management of life after the detention experience. All the groups listed above intervene at this level. The distinction between secondary and tertiary forms is that the former deals with the sequelae at the soonest possible time after the trauma and the latter deals with the damage and injury caused by the sequelae.

Due to conditions peculiar to the South African situation these treatment teams are extremely mobile and go to where they are needed. The luxury of having an institute or permanent service based in one place whereby an inpatient setting would be offered is not yet possible. At the moment the use of makeshift rooms and offices is the real life situation.

The use of lay people to counsel ex-detainees has been slow in coming about. OASSSA is in the process of workshopping with people in the mental health profession and responsible recognized figures in the various communities to supplement the shortage of professionals who can and are willing to assist ex-detainees. The use of video

tapes, literature and role playing are the means used to train these lay people.

Although the wisdom of training lay people will not be discussed and debated here, DCS in Johannesburg has so far made a decision against that. They saw the need as having to train professionals in this very specific type of work. They organised a workshop in the latter part of 1986 stretching over 4 weekends and invited psychologists, social workers and doctors in private practice and different work settings to learn how to assist this very specific population.

At present all these organisations offer a very limited service for obvious reasons. They offer brief short term interventions not only because of the distances and the ex-detainees transport problems but also because of the small numbers of available professionals.

Those former detainees who are identified as needing longer term therapy are referred out to people who can assist them. The limited number of professionals and the ever increasing number of detainees therefore dictate the nature of the

service as well. The largest number of people have to be seen for at least some psychological intervention rather than a chosen few for a longer more in-depth and thorough therapy.

CHAPTER 4

RESULTS

Introduction

A copy of one verbatim protocol divided up into natural meaning units with accompanying essential themes of both an ex-detainee and one therapist will be included at the beginning of this chapter. The rest can be found in the appendices. An integrated general situated structure of the ex-detainee's experience of psychotherapy will be derived from three situated structures of the ex-detainee's experiences of psychotherapy. The same will then be done for the psychotherapist's group. Three therapist's situated structures will be presented then an integrated general situated structure of the therapist's experience of psychotherapy with ex-detainees will be developed from them.

Essential themes	Natural meaning units (NMU's)

4.1 PROTOCOL OF EX-DETAINEE NUMBER 1

1.	Hesitancy and doubts about how to relate to people. Existence of an altered feeling which was not there prior to case before detention. Relationship with others is altered.	The immediate thing coming back home was some kind of hesitancy in relating to people. One didn't know how they were feeling. And there's a sense in which one had some kind of anticlimax feeling.
2.	The ex-detainee feels unable to respond enthusiastically to people's enquiries about his detention experience.	One of the first feelings one had was a feeling of uselessness. You get back home, everybody's excited that you're there, people want to talk about your experience. People want to hear something.
3.	Reluctant to communicate. Feelings of emptiness are strong	There's a sense in which you feel why, I really don't want to talk about this thing, it's behind me. But at the same time you're feeling empty that's the right word. Totally empty; its an anticlimax.
4.	Experience uncertainty in relation to everyday living and the future. Reluctance to approach or tackle the issue of	In your mind you're not sure what you should be doing. You're not sure what the future's like, you don't want to think about it. You've gone through something you're wanting to forget.

Essential themes	Natural meaning units (NMU's)
detention. Feelings of restriction and aloneness which brings partial relief in the form of safety.	You have some sense of deep inner isolation. You feel you're in some kind of a world of your own in which you feel you somehow cannot remain forever but which you wish you could stay and live in because it's taking you away from so much.
5. Reluctance to rejoin and become a member of the community again and all that what doing so entails.	You know you can't stay in it because you've come back into the flow of things. You know that sooner or later you're going to have to grapple with the problems that most probably lead to your detention in the first place.
6. Despite feelings of emptiness the knowledge that there was support all around in immediate surroundings filled person with comfort.	But it's some kind of, I can't say its emptiness. Then in terms of support I had a congregation and family plus the satisfaction of knowing that my family is being taken care of. I never had problems of wondering if my kids were starving. There was a great deal of rallying, that, I knew was happening. I attribute that to being a minister because as a minister you are part of the community.
7. Knowledge of outside concern brings relief when in detention.	Maybe the other thing was during detention one of the people I knew very well, joined us and they came in with news from outside and we knew that there was a lot of caring

Essential themes	Natural meaning units (NMU's)
	taking place.
8. Torture was mostly of the mental kind. Verbal threats were used. Fear that they're capable of anything. Felt that their minds were at war with the jailors.	I did not have a great deal of nightmares arising directly from the experience inside. I was not severely tortured. If there was any torture it was not so much physical as mental. Those fellows were throwing verbal threats but you know deep down that they're capable of doing anything and you have to still your mind for that type of thing. You live through battle of minds.
9. Lasting impressions that affected ex-detainee were recollections of the arrest and forced entry. As a result ex-detainee became hyper-vigilant and had a startle response to noises. The fear of being re-detained persisted.	We were assaulted briefly, but some of the things that had a lasting impression on me or I think left scars were the way they broke in when they came to pick up one. There's a sense in which one was deeply upset by the forceable entry - for days after that I'd get up at the bark of a dog and run and look out the window. A passing car, I'd jump up from bed in the direction from which they had came. In a sense you felt they had forced their way into your life - What can stop them from doing it again?
10. Still experiences distress at not being able to identify the exact reason for his	Maybe one of the most upsetting things about my detention was I've never known why I was detained exactly. That's why I say if I had been taken to court, if

Essential themes	Natural meaning units (NMU's)
detention. Conventional procedure was totally absent no charge, no trial etc. which leaves former detainee insecure (lack of an explanation for detention distressing and robs individuals of ability to control and determine to some degree his own destiny).	a charge had been laid then, it would have left me with a sense of reasonable security, knowing that its that sort of thing that creates trouble for me. I can avoid that, that and that. But you don't know what you've actually done and that says for you "What can stop them from doing it again? What do you need to do?"
11. Ex-detainee experienced feelings of forced apathy and helplessness because of his adverseries	I'm still convinced myself that I was very positive and have always been positive with trying to find a way forward with the problems in this country. I'm not a big one for protests and things like that but I'm always very eager to find points of engagement where you can engage people and try and find solutions. I believe that's the most moderate thing you can do in our South African situation. If for doing that, these are sheer projections I cannot say if that was the reason but if that was it, the frightening thing is that you're being forced into a situation of apathy. You're being forced into some kind of paralysis.
12. Need to be satisfied with	Those are some of the things I struggled

Essential themes	Natural meaning units (NMU's)
ones conduct and behaviour. Tried to see what fault could be found with his conduct prior to detention.	with. What is it exactly that I did which I shouldn't have done? I'm convinced however that everything I did before detention was right. Detention didn't prove for me that I'd been doing anything wrong. The first thing you say when you get out of there is "How do I regain my balance? How do I find the way forward for myself in the future?"
13. First healing experience occurred outside therapy in the community. Support of others and the ability to be witnessed as not guilty of any crime in public was self-affirming.	Now the first healing experience I had was a service held in our community for the ex-detainees and in that service I had to speak. That was the most healing thing for me, to stand up in front of all those people and say "There's not one thing in what I had been doing that was wrong," which is a self affirming thing. I was able to stand up and say what I was about.
14. Being able to make sense of self and direction in which to proceed was essential and therapeutic in addition to the support and approval of others.	I could define for myself how I was going to handle my life. I would imagine the worst thing that can happen is to be so paralyzed that you're not able to define where you're wanting to go. I found that that was highly therapeutic to me. We had the service itself the rallying of the people, the affirmation. I found that a contributory factor to healing.

Essential themes	Natural meaning units (NMU's)
15. The continued responses to things which started after release from detention, lead to the realization that more help is needed. Sort help from old trusted friend, who'd helped and been concerned throughout former detainee's detention.	Thereafter I found I still went to the windows. I knew I had to talk to someone a little more in detail so I went to a friend of mine who's doing the same job as me, who'd also been actively involved in trying to secure our release, who had been standing with my family and trying to find ways of sending us clothes and so on.
16. Sharing with another who had similar hardships or different aspects of a common experience helped. Made for an appreciation that fear and certain responses are universal and not specific to individual, which was encouraging. But reactionary behaviour to noises and movement persisted.	I listened to him sharing some of his fears during the encounter with the police and so on. I listened to him try to turn over the intimidation tactics directed at him, that kind of battle. It was quite something to listen to a guy sharing something of his own fears. For me it suddenly made me feel that the fear and tension I'd gone through is kind of universal and other people have it too. They fight against it. That helped me in my psychological build up to struggle further but it still did not in the final analysis, help me with the way I was behaving, this reactionary type of behaviour.
17. Repeated verbalization of experience was forced	I was made to go over and over my experience by many people, being

Essential themes	Natural meaning units (NMU's)
by interested and concerned people. Felt feelings of helplessness in connection with his experiences and the legal system. Was empowered to take action by and with others who had gone through a similar experience and this helped to heal his feelings of helplessness	forced to talk about it. Some people would suggest that I pick it up with the law because I was assaulted, but there's a sense in which you give up. I felt I'd given up on the justice of the legal system. I'd say why go through that just to come out a loøser again. Until a group of us found ourselves in a position where we were strengthened to take legal steps. That happened when one doctor took it up and others too laid charges. That was a healing thing for me especially in the way of meeting with my sense of helplessness.
18. Close friend advised and referred former detainee to a psychologist. Related this story fully to psychologist.	Now my friend with whom I shared experiences then advised me to go and see a psychologist and gave me the name of the guy. I related the story fully We had lengthly conversations, 2 sessions of about an hour each.
19. Therapy entailed a detailed step by step account of the experience. Extremely painful point was brought into consciousness. It was something that had happened but which ex-detainee avoided and as a result	He made me go through my experience bit by bit in detail. During that interview I suddenly discovered that the event that I had been avoiding to face I had never been aware of it; was the moment we were made to stand naked directly after detention.

Essential themes	Natural meaning units (NMU's)
had not been able to confront and deal with.	
20. Ex-detainee was pained by the disregard and humiliation of a person who he held in high esteem and symbolized leadership for him.	I discovered that I had been particularly pained because one senior guy, a respected man in the community with whom we had been detained was made to stand naked in front of us all, the youngsters and I actually found that that was what disturbed the detainees the most. I was able to withstand everything else but even in detention we talked a great deal about this man being made to walk naked in front of us. I think it had been a deeply hurting factor. I found that I'd never been able to go over that.
21. Therapist explained the objective of therapy, namely the interpretation of experiences. Therapist listened a great deal, intervening at points he felt important. Identified the single event which encapsulated the meaning of the most terrible things about detention for the individual. Then stayed with that event	During the conversation with the psychologist he actually said to me we were trying to interpret my experiences, he listened a great deal and now and again threw in something that helped me to interpret. Anyway he said "Don't you think that's how you are seeing your whole detention factor? Don't you think it is encapsulated around that event?" And that suddenly made a lot of sense for me. I now understood the things I'd been fearing. You were forced to walk naked. Everything you've believed in was stripped

Essential themes	Natural meaning units (NUM's)
and explored it's meaning and impact on individual and his political view of life; associated pain.	from your hands. "You've always believed that besides protests and things what is important is to engage in dialogue meaningfully and detention for you has meant taking that from your hands forcibly and it has left you suddenly naked".
22. Then suddenly this made sense and made lucid many hurts experienced during and after detention - a revelation.	That made a lot of sense for me and suddenly I could begin to make meanful sense to my hurts.
23. Ex-detainee shared with therapist things that humiliated, confused and and hurt the subject; things that made subject doubt his own credibility	The other meaningful thing for me was that I shared with this guy one of the things that I couldn't face about my detention. The security police made an offer after the detention, for me to inform. Immediately the question for me was "What is it that I have done, that could suggest to these guys that I could be an informer? Is there something in my strategy that could suggest it?".
24. Therapist related his experiences and feelings of guilt to those of a raped women who was trying to take the blame or responsibility for what	When I shared that this guy said don't I think, in fact he told me the experiences of being raped and the reaction of the woman - what is it that I did, that attracted this person to come and rape me? Is there something that I

Essential themes	Natural meaning units (NMU's)
happened.	did?
25. Confronting a frightening question changed ex-detainee's perspective. Working through the issue traced it back to the systems, motives and designs of the oppressor. Reconciling actions with ex-detainee's expectations of himself.	Immediately that I could face that question I was then able to see things from a different perspective. Working through it we actually got to a point where we said, couldn't this have been the intention of the whole thing, to make you feel guilty right through, that there is something that you've done. You are the one who has done something wrong. And with all my Christian conviction I was battling to find the point at which I had let down somebody.
26. Relinquishing of misplaced guilt, self-blame and feelings of responsibility was achieved by examining the oppressors manipulations and subject's response to them. This reacceptance of self was of extreme significance to ex-detainee's fuller recovery.	When I suddenly discovered that this is part of the trap that I had fallen into I was better able to handle my situation and begin to interpret and accept that look, it's not me. I'd been touched in the depths of my inner being. I think that was the point at which I was able to recover fairly fully.
27. Individual experience of psychotherapy was positive and relieving such that he referred	Immediately after that I met a young boy who had been detained with us at that time. We had a chat and he said he had a problem, that he's been want-

Essential themes	Natural meaning units (NMU's)
others who had been detained and had experienced problems since release. Individual sees it as necessary for therapist to reach those who, like him, need help.	ing to talk to someone and each time he tries to think he comes back to my name. He couldn't sleep. Each time he heard a noise he'd jump to the window. It was ironic. I recognised the signs he described so well. I spoke with him for a while and after that I turned back to the psychologists office and said "Look right on your doorstep there are people who have gone and are going through the same experiences I've done, so maybe you could start finding a way to reach those people and help them too."
28. More than 2 sessions would have been superfluous in the individuals estimation. Saw psychotherapy as having created a base, on which subject builds in dealing with coming to terms with the experience.	I didn't see a need for more than 2 sessions although I could have gone to see this man anytime, he was not charging me anything, he was just helping. I felt I had with psychotherapy created enough base on which I could continue my own inner struggle. So I stopped going.
29. Feeling of gratitude and appreciation for therapist but sees the limits of therapist's scope. An acceptance of the rest of the problem as his own to contend with.	He did all he could have done for me the rest was up to me and I'd accepted it as my inner fight. I don't know what else he could have done that would equip me more. I was satisfied with what he had been able to do for me.

Essential themes	Natural meaning units (NMU's)
30. Recommendation of therapist by trusted friend enabled ex-detainee to be open, and feel at ease when talking with the psychologist.	I didn't have problems of opening up in therapy purely because the psychologist had been recommended by someone I trusted so it wasn't an issue. In fact I did know this man before in that I knew he was a psychologist but I never really thought that he could render any services to me at any stage. He wasn't even an acquaintance really but on the strength of my friend's recommendation, who I have come to trust very much over the years, it was made easy.
31. Some things are reconcilable, others not. Re-detention is a possibility that ex-detainee is resigned about ~~Therapy didn't help in that area.~~ will meet it in terms of a recommitment to the truth as he sees it	I have resigned myself to the fear that one can be re-detained. Therapy couldn't help me there. Now I think if it comes, let it come, what more can I do. For me I want to be sure that if anything happens to me it must be because I was trying to be true to what I primarily believe in as a Christian. So I constantly weigh my actions against my faith and that's the only source of strength. All programmes I engage in have reconciliation of our people in mind. I do realize that some people will feel hurt by being moved from the strong positions they are in but I take comfort in the

Essential themes	Natural meaning units (NMU's)
	knowledge that when you challenge people to move from their fixed positions it is not because you're wanting to hurt, you-'re committed to helping and seeing a new society coming up. For me that's the only thing that helps me be able to face the possibility of detention in the future and say look if I must be detained again - then okay. I just want to be sure that it's not because I have sold out on my principles.

Essential themes	Natural meaning units (NMU's)

4.2 PROTOCOL OF THERAPIST NUMBER 1

1.	Tendency to be more supportive for post-traumatic work with ex-detainees.	I'd tend to be more supportive. If someone came to me in crisis and for post-traumatic work I'd be more supportive. Often with people who come out of detention either it's a withdrawal thing or total flamboyance, it's either one. With one I feel they need to be contained somewhat and the other I hope to draw them out.
2.	Amount of available time for therapy determines how therapist experiences the client. When one session is all that therapist can depend on, the tendency is to work differenctly. Therapist is more upfront, more affirming of the ex-detainee and is more structured in the session. Therapist rounds session off more cleanly.	I think in some way how long you're going to see the patient determines how you experience them and it's differently according to the time. I think when I see someone where all I can depend upon is one session I feel very different to when I know I have a long time ahead of me, that's irrespective of whether I'm working with an ex-detainee or a normal patient and am doing a consultation. When I go in and I know I've got as long as I need it feels differently to when I've got one hour only. I'd work differently. I'd be more affirming of the person, be more structured and try and round off the session more clearly.
3.	Therapist more active in joining with ex-	I'd also probably be more active in joining. I think that with detainees

Essential themes	Natural meaning units (NMU's)
detainees than any other patient. With detainees there's an issue of credibility which one must establish with caution and awareness when joining.	there's an issue of credibility and I think that to some extent one has to be careful and join and establish credibility in a way that I would not do with any other patient.
4. When ex-detainee has been referred specifically to a therapist by someone they trust, the referral establishes the therapist's credibility for them. Sometimes with an ex-detainee, the detention is not seen as the problem.	But it's not often that different because people will come to me or who have come to me for long-term therapy and are ex-detainees have already established my credibility for me. They won't just go to anyone. There are, however, some who are just referred to me. They'll have other hassles, a crisis and have been detained at some stage. They don't often see the detention as the problem. They'll come and experience the kind of problem that we see in ex-detainees like a lack of concentration and an inability to settle.
5. An inability to settle is often a very important component and underlies the complaints they come with. They find it hard to put down roots.	I think an inability to settle is often a very important component. Although with some of the detainees like at Wilgespruit and subsequently others that I've seen, one of the problems is that they don't have reading matter and they can't concentrate - but one of the problems is that what they don't see is that that lack of concentration is that

Essential themes	Natural meaning units (NMU's)
	inability to settle and that many ex-detainees find it hard to just somewhere put down roots when they come out of detention.
6. Therapist more containing Encourages ex-detainee's self application. Recognizing and distinguishing what is directly attributable to the detention as opposed to the ex-detainee as a person.	So often I try to be more containing, to help them stick to what they're doing more and I think that may be directly related to the effect of the detention and not to them as a person.
7. The longer the therapy the less differences there are between therapy with ex-detainees and other patients. With the ex-detainees validation of the person is necessary in the South African context. Analytic mode of interpretations is inappropriate. Validation stands, until the ex-detainee shows irresponsibility or otherwise. Political	Then when it comes to the more longer term ex-detainees I feel then that it's not that different from my other patients except for the need to validate their experience. Validate them as a person and that's more true of the South African context. One can't get into the analytic mode where one sees a political idealism as them acting-out or as them never having resolved their problems with their fathers. I would validate the actual political action and accept that as a valid form of protest or an active choice within them and I'd often affirm that. With some people it can be irresponsible but by and large that is where I come from unless it's

Essential themes	Natural meaning units (NMU's)
idealism not to be seen in a reductionistic manner.	proved otherwise to me. I'd acknowledge that experience.
8. An inroad for why therapy is important and to help the ex-detainees make sense of therapy for themselves is to acknowledge their political choice and way of living as the most difficult - against the odds. Therefore they need to withdraw into therapy to make themselves strong again and to heal.	What I'd acknowledge also is that going with that kind of experience, action and that kind of choice is a need to be a stronger than usual person, to cope with the kind of life that they're choosing to live - outside the average way of living. I feel you have to be stronger to cope rather than weaker. I think that is important. And that, in a way, is an inroad for why therapy is important. That it is actually normal and natural and it is pitting oneself against greater odds to actually have to withdraw, to make yourself strong again, to heal yourself in some way.
9. The difficulties in language mitigate against forming a really strong bond. Battle to find a common language, drawing on anything. When the situation is bad an interpretor is used.	Another issue at a very practical level is that some of the people I saw were articulate in English, but a lot of the people I saw at Wilgespruit for example were not, and I do think that mitigates against really forming a strong bond. At the same time I've formed a very strong bond at Bara and with the people I've subsequently worked with. We've just kind of battled together to find a common language often drawing on everything and anything possible and sometimes using an

Essential Themes	Natural meaning units (NMU's)
	interpreter.
	To get back to the longer term psychotherapy is that different people have come with different agendas. For example, at a certain point at Wits, I looked at my case load and over 50% were seeing me because of some direct political intervention in their lives that didn't mean they'd necessarily been in detention but I do think there were similarities across them. The most important thing is validating their experience in the South African context.
10. Therapist has to respond to what the ex-detainee brings. The detention experience can bring about a need in the ex-detainee's life to change things unrelated to the detention experience and associated areas.	Outside of that it depended on what the person brought me. CASE A: With the one, being in detention evoked a lot of reflection on early experiences and they felt a need to resolve. They'd faced the possibility of a long long-term incarceration and that felt for them like the end of their life. That evoked for this person a need for their life to be different, that they had almost gone this far. The issue in fact of their political conviction had nothing to do with it, it was other things in their lives. It was their relationship with father, that if they'd been detained for a long long time they expressed that they'd be

Essential themes	Natural meaning units (NMU's)
	persecuted by the last contact with the father and that if they were going to go on with that life situation they had to somewhere clear up things that had emerged in their lives. They didn't want to carry baggage around and wanted to come to a resolution and this person actually came to a reconciliation.
11. With some ex-detainees the detention experience, its humiliation, anger, pain and sense of betrayal is worked with.	CASE B: With another person we worked on the detention and the humiliation that it brought and the anger and the pain and the sense of their own betrayal because at times they had been friendly with the jailors, they felt they shouldn't, that they'd been good whereas others had not been good and well behaved for the police.
12. The distant past is not drawn upon with ex-detainees unless it becomes an issue and is brought into the therapy. Often a guilt theme has to do with their families.	When working with ex-detainees I don't draw on past unless it becomes an issue and it is brought into the therapy. What is also interesting is that a lot of ex-detainees do talk about the past. I think part of the guilt has to do with the families they've left back home and they talk about it and the pain of that.
13. Sometimes there are different personality variables that emerge in therapy aside from	With others I think there were personality variables that emerged in the therapy that were difficult to deal with aside from the detention. I think it was

Essential themes	Natural meaning units (NMU's)
the detention experience. Sometimes an ex-detainee's way of being-in-the-world has always been problematic.	part of the person's problem and way of being-in-the-world and that one should relate that back to other symptomotology outside the actual detention. One tries to contain that as much as one can. In the end other issues were not resolved.
14. When ex-detainees indicate a need to stop therapy the decision is not challenged. Having reached the first plateau ex-detainees may then need time, out of therapy, to construct themselves in the world, to consolidate what has happened in therapy.	In my work with ex-detainees if we've worked together and they think they've had enough it's fine. I don't think there's any harm in going to the first plateau and then giving them a time out of therapy to construct themselves to be-in-the-world. And many people I've seen have been out of therapy a year after the initial period and come back.
15. Duration of therapy also dictated to by the contraints of one's work situation. Mostly organizations are doing a very focused job with ex-detainees because of their numbers (too few therapists, too may ex-detainees).	Continuing to see an ex-detainee long-term is dictated by the constraints of where you are working. In some jobs one has license to do more, but for example, with the Santuaries movement where I supervise, we've got X number of people (therapists) working on detention and our number of detainees far outstrips it. I think we are doing a different job. So I often try to focus therapists in supervision or else it'll mean that others who have experienced the trauma or the crisis cannot be seen. I would

Essential themes	Natural meaning units (NMU's)
	try and refer out and use other avenues where they can be seen for a longer time. If I've got someone on the run or a traumatized child and I know I've got them for the next 6 months I would engage them in in-depth therapy.
16. With ex-detainees who have no time therapists must not cut across defenses, rather give the ex-detainee licence to be defended.	This one case I supervised was an intelligent, responsible, mature, engaging, healthy personality. He was about twenty but he kept talking on about how these other kids were immature and not taking responsibility. I felt very much that that was defense against looking at the vulnerable parts of himself. Now you have two options, either you can say to him "perhaps there's a part of you that's quite vulnerable". But he was too defended to accepted that or you can go with his defense and give him licence to be defended and I think when you can't depend on someone coming back to you, I would not cut across their defenses.
17. Do not cut across an ex-detainee's defenses. Therapists must make efforts to join quite hard in the real relationship. Do not evoke major transferance	So, with ex-detainees, I will tend by and large not to cut across defenses. I will tend to join quite hard in the relationship. I will tend not to evoke major transference neuroses unless it is so obvious in the relationship. In other words, that they actually

Essential themes	Natural meaning units (NMU's)
neuroses.	attack me in the relationship and I think our ability to bond would be affected. That is a big difference, if I saw someone once I'd never cut across their defenses.

4.3 Ex-detainee number one's situated structure of the experience of psychotherapy

Themes that emerged from the protocol are underlined and expanded upon below.

The ex-detainee's relationships after release is an important theme of his life after release from detention. The former detainee experiences hesitancy and doubt in relation to others. This affects the ex-detainee, causing their reluctance to become a member of the community again. The existence of these less than positive feelings does not negate the importance of the support of others however. Interpersonal support brings the ex-detainee comfort.

Communication is another affected area of the ex-detainee's lived experience. The ex-detainee initially experiences a reluctance to communicate. There is a feeling of being forced when asked to talk about the detention experience. The communication of one's legal innocence to others, however, can be experienced positively as self-affirming. Communication takes many forms such as sharing humiliating and confusing things with the therapist and the shared

communication of having undergone a similar experience with another, plus referring other ex-detainees to a therapist.

The reaffirmation of self is a theme that emerged as central to the recovery of the ex-detainee as the subject, after release, tended to doubt their credibility. There would seem to be a need for the ex-detainee to be satisfied with their own conduct. The ex-detainee goes about this by way of self-examination and a thorough evaluation of the situation along with its various components.

The ability to be witnessed as not guilty of any crime in public is positive and contributes to the ex-detainee being able to make sense of self and the direction in which to proceed. Achieving the reaffirmation of self can result in the acceptance of the rest of the problem as one's own to contend with, after therapy.

The ex-detainee's traumatic experiences are a distinct feature. Some events more than others have heightened meaning for the individual and are of significance. An incident like the arrest and forced entry of police

into one's home can cause hypervigilance in an ex-detainee's manner of responding. Another example is an ex-detainee experiencing pain due to the humiliation of an esteemed individual and fellow detainee.

Another theme is guilt feelings and manipulations thereof. Guilt is experienced by the ex-detainee and can lead to any number of consequences and/or symptomatology. This misplaced guilt is traced back to the detention experience. Reappropriation or relinquishment of guilt is able to take place after guilt is understood in terms of the oppressors manipulations and designs.

Feelings of enforced apathy and helplessness also emerged. Support from and joint action with fellow ex-detainees empowered the individual thereby helping to heal feelings of helplessness.

The relief brought about by psychotherapy can happen in various ways. It is attainable through specific things such as an ex-detainee understanding the meaning of their experiences and hurts in and surrounding detention or confronting a frightening question and relinquishing one's feelings of responsibility. More

generally the positive experience of psychotherapy brings relief and can result in encouraging the individual to promote it to fellow ex-detainees.

4.4 Situated structure of ex-detainee number two's experience of psychotherapy

Incidents repeatedly emerged that reflected problems in therapy as a theme. It basically entailed several non-beneficial activities. Placing the emphasis of therapy on current problems with no reference to the past detention experience being made, was not viable for example. Another factor that contributed to therapy being experienced as a problematic process was the ex-detainee's verbal inhibitions due to their feelings of unworthiness. The ex-detainee experiencing the actual therapy situation as too remote from their lived world also added to problems in therapy.

The therapist's attributes or lack thereof in terms of training is very important and was an essential feature. The therapist not being aware of conditions in detention and not eliciting the ex-detainee's relevant past experiences that are related to the detention affects the progress made in therapy. The therapist

must have knowledge of possible symptoms caused by detention and be aware of the political forces at play so as to be ready to fully contextualize the presenting problem thereby linking the ex-detainee's present with their recent past. The therapist should also be aware of and willing to deal with issues specifically related to women. Armed with background knowledge the therapist will be able to ask questions and say whatever is necessary to give enough permission to free the ex-detainee and enable open disclosure.

The area of relationships is crucial in the former detainee's life. Psychotherapy can have a negative influence on an ex-detainee's outside relationships. Equally true is the fact that a relationship with a close friend can be more therapeutic than the relationship with the mental health professional. This is possible when the ex-detainee finds the therapist incompatible and problematic to relate to. Very specific issues such as acknowledgment and reaffirmation of ones body is only really possible in the confines of an intimate relationship. Another aspect in relationships can be the ex-detainee's need for the same acceptance after release by people who matter, as was present before detention.

Communication is an important sphere in the ex-detainee's experience that can be positive and negative, therapeutic as well as nonexistent. Examples of communication in its positive sense is the ex-detainee expressing their feeling about their detention experiences to people who are close, sharing by speaking and listening to other ex-detainees in group encounters and revealing common characteristics. The use of poetry as a therapeutic instrument or springboard to talk is also useful. The lack of communication can be experienced by an ex-detainee in their inability to talk about taboo subjects such as women related vulnerabilities.

Support systems are also very important and can be found by the ex-detainee in various structures and people. Family and social involvement are essential supports. Support can be found in people who are in the ex-detainee's immediate environment and with whom they interact regularly. The ex-detainee experiences the need for a circle of support and feels that that in conjunction with love and caring forms an essential background for spontaneous recovery and self healing.

The ex-detainee experiences fear in relation to various things. The ex-detainee fears the expectations of others for example. Alternatively they may fear that what is experienced as terrible by them is seen as insignificant by their therapist. They can also fear the disapproval of high profile politicos or just that their complaints and problems are not valid and are less than well known established "respectable" traumas.

The theme of guilt and a sense of responsibility permeates the ex-detainee's experience. The ex-detainee can have such emotions due to a whole range of things. The ex-detainee can experience feelings of guilt about the legitimacy to express their problems amongst other things. When the ex-detainee takes responsibility for their own problems and symptoms and feels responsible for the working through of their own problems singularly, trying to engage in psychotherapy can produce feelings of guilt.

4.5 Ex-detainee number three's situated structure of the experience of psychotherapy

Emotional symptoms such as fear, depression and guilt are experienced by the ex-detainee. This is mostly in

relation to the safety of their family and the consequences brought about because of the detention. Ex-detainee then devised mental activities to keep intrusive memories at bay.

Communication has emerged as positive and healthy. The ex-detainee has experienced talking to different people who help, like legal advisors, beneficial. Communication is not problematic at all especially because the ex-detainee is a person who likes verbalising and communicates with ease. Talking freely is so characteristic of the ex-detainee that he voluntarily counsels fellow ex-detainees to whom psychotherapy is not accessible.

Psychotherapy can be experienced positively, resulting in the ex-detainee's promotion of it to other former detainees. Understanding the concept of psychotherapy brought comfort to the ex-detainee and encouraged him to participate enthusiastically in his own healing process. Be that as it may the limitations of psychotherapy are recognised and accepted by the ex-detainee who appreciates what it is designed for and able to do.

Psychotherapy's main function as experienced by the ex-detainee was to establish the re-identification of self. This encouraged the ex-detainee to pursue and persist with their objectives and goals in life. Ex-detainee has implicit belief in the individual's spontaneous recovery potential.

Trust which amongst other things can be affected by racial barriers took some time but was not difficult. There was no doubt about the therapist's professional ability and living in the therapist's house helped establish trust.

4.5.1 General Integrated Situated Structure of the Ex-detainees' Experience of Psychotherapy

By and large the realm of relationships is a most important aspect of the ex-detainee's experience. There can be an initial hesitancy in relation to others after release which hinders the ex-detainee's reintegration into their community. There are various factors which lead to difficulties in relating. Psychotherapy itself, for instance, can have a negative influence on an ex-detainee's outside relationships. The support of others is of

importance to the ex-detainee however, despite their doubts about how to relate.

A good interpersonal relationship with a close friend can be far more therapeutic than the relationship with the therapist. Cases of incompatibility between therapist and ex-detainee can occur.

Specific to intimate one-to-one type relationships are issues such as the reaffirmation of ones body image or physicality. One-to-many type relationships are important also. The ex-detainee needs to experience the same acceptance after release by significant others as they were accorded before their detention.

Communication is another affected and influential area of the ex-detainee's lived experience. Communicating with others may feel laboured and difficult at times to the ex-detainee. Sometimes the ex-detainee finds it impossible to communicate. Equally true are its positive therapeutic aspects. In a positive sense communication with others, fellow ex-detainees, close friends and family can be therapeutic and work towards the ex-detainee's healing process and recovery. On the other hand the lack of communication or an ex-detainee's inability to talk does

not alleviate symptoms or contribute towards an ex-detainee's sense of well being.

The reaffirmation of self by various means including re-identification is a theme that runs throughout the ex-detainee's experience be it in the therapy situation or in the community (in-the-world) or in a relationship. Very obviously the detention experience results in the ex-detainee's tendency to doubt him or herself, be it their credibility, body image or ability to persist with intended objectives. The ex-detainee's reaffirmation of self is achieved in therapy by way of self examination and a rigorous evaluation of the detention experience along with all its components. The opportunity to be publicly witnessed as not guilty helps enable the ex-detainee distinguish their direction in the future.

Feelings of guilt can be experienced by the ex-detainee due to a whole host of possible reasons that lead to any number of consequences and/or symptoms. Taking on too great a sense of responsibility for ones problems can lead to the experience of guilt when trying to express them in therapy or guilt can be in connection with the ex-detainee's family. The ex-detainee's guilt, which is often misplaced, is first traced back to the detention experience,

understood in terms of the oppressors manipulations; then it is either reappropriated or relinquished.

There are various reasons for the ex-detainee's experience of fear. The expectations of the therapist and other people or their disapproval fills the ex-detainee with fear. Fear is also often experienced in relation to the safety of family members.

Some incidents more than others are of significance to the ex-detainee and encapsulate their traumatic experiences. Which events mean enough to be termed traumatic is unique to the ex-detainee and very idiosyncratic.

Forms of support and support systems are embodied in various structures and people for the ex-detainee - family, friends and community activities or social services. Support is important and the ex-detainee experiences the need for it as essential to the recovery process.

On a positive note psychotherapy can be experienced by the ex-detainee as bringing relief. An ex-detainee getting to understand the meanings of their hurts and experiences surrounding detention, dealing with an issue that had previously been too awesome to tackle or coming to terms

with ones feelings of guilt and responsibility are all examples of how the ex-detainee might experience release from problems that affect him or her psychologically. Experiencing therapy in such a beneficial way can and often does encourage the ex-detainee to promote the "talking cure" to other former detainees.

An alternative to the above are situations when the ex-detainee experiences therapy as a problematic process. Various strategies or activities fail to promote or facilitate progress in therapy. Total emphasis being placed on current problems with no link to the recent, past detention experience can be what is wrong in therapy for example, or being verbally inhibited and unable to communicate what one's real problems are to the therapist or not being able to relate the experience of therapy to the rest of ones lived world are all possible problems with psychotherapy as a process.

The therapist's knowledge and/ or training to deal with this very specific population is essential at a content level. The ex-detainee experiences his/her therapist as inaccessible and distant if the therapist is not aware of the range of possibilities open to an ex-detainee. To somehow accommodate the ex-detainee's range of possible

experiences the therapist must be aware of the conditions in detention, have knowledge about the psychological effects of detention and have some measure of political awareness. This background information enables the therapist to contextualize the presenting problem and be able to link the problems the ex-detainee is presently experiencing with their origins in their recent past (detention).

Trust is an issue in therapy that can be affected by many factors such as racial barriers and become problematic in therapy. On the other hand, it can be so easy to establish that it is not really experienced as much of an issue.

4.6 Therapist number one's situated structure of the experience of psychotherapy

The therapist's manner of approach is an important theme because it is so different to that of the non-detainee. The therapist tends to be more structured in the session and rounds the session off more cleanly at the end. The therapist makes an effort to be more supportive and containing of the ex-detainee. Not only is the therapist more active in joining with an ex-detainee but the therapist is also active in

affirmation and validation of the ex-detainee in the South African context.

The therapist experienced definite differences in therapy with ex-detainees as opposed to non-detainees. The therapist is very aware of three things when dealing with the ex-detainee (i) not to draw on the distant past (unless the ex-detainee brings it up); (ii) not to cut across defences, if anything the therapist bolsters the ex-detainee's defences or gives the ex-detainee licence to be defended; (iii) to work in the real relationship in the here and now, plus not to evoke major transference neuroses.

Time is another issue experienced as vital by the therapist. More often than not one session is all the therapist can depend on and the amount of available time determines how the therapist experiences the ex-detainee. The longer the therapy the less differently the therapist experiences both the ex-detainee and the non-detainee. The duration of therapy is also dependent on the constraints of the therapist's work situation.

Determining the presenting problem emerged as an important theme and is crucial because it dictates what should be tackled in therapy. First and foremost the therapist has to respond to what the ex-detainee brings to therapy. Sometimes the ex-detainee does not experience detention as the essential problem. At times aside from the problems brought about as a direct result of detention, the ex-detainee's way of being-in-the-world has always been problematic. Long-standing personality variables must be distinguished from problems that have been brought about by the trauma of detention.

Potential threats: Factors experienced as potentially threatening and able to affect communication in a negative sense are language and credibility. Language difficulties are experienced as mitigating against the establishment of a strong therapeutic bond. When communication is near impossible, an interpreter is used. The therapist's credibility is also experienced as an issue that needs to be tackled with caution. Referral from someone the ex-detainee trusts can help substantially in establishing credibility.

The therapist experiences the need to be aware of certain therapeutic themes that seem quite common and likely to emerge in therapy with ex-detainees. Guilt is a theme that often appears and it often has to do with the ex-detainee's family. The inability to settle is another important component that underlies the complaints expressed by most ex-detainees.

4.7 Therapist number two's situated structure of the experience of psychotherapy

The therapist experiences their role in several ways, namely as providing the ex-detainee with a space in which to think through and sort out problems and helping the ex-detainee to integrate his or her detention experience. The therapist also feels that their role is sometimes didactic. They can teach and suggest relaxation exercises that can be done at home, discourage over activity explaining the reasons why and normalise the ex-detainee's symptoms by telling the ex-detainee something about the predictable, common symptoms and effects of detention that all traumatised people have. Encouraging the ex-detainee's use of available support systems is also experienced as vital to the therapist's role, by the therapist.

Differences in therapy with ex-detainees and non-detainees emerged as a theme. The therapist states her credentials and discloses much more about herself than is the case with non-detainees. The therapist does not experience therapy with ex-detainees as an on going process. In the case of ex-detainees, therapeutic settings are unpredictable and constantly changing.

The therapist experiences potential threats as factors which are capable of hampering the progress of therapy. Language and racial barriers are experienced as the most hazardous potential threats and are issues that the therapist feels should be confronted immediately if they appear to be problematic. Credibility is also experienced as essential and potentially harmful to therapy. Seeing ex-detainees in offices of a politically accepted organisation lends the therapist credibility.

The differentiation of problems by the therapist is experienced as important. The ex-detainee comes with their history which might have long-standing problem areas. A distinction should be made between those and problems attributable to the detention experience.

4.8 Therapist number three's situated structure of the experience of psychotherapy

The major theme that emerged is the potential threats to the therapeutic process that were experienced by the therapist. The basis of most of these difficulties experienced in therapy stem from the fundamental differences between therapist and ex-detainee. The dissimilarities between them include race, social class and professional status. The therapist experiences the ex-detainee as a member of an unfamiliar population and very different from himself. This is problematic because establishing rapport with people whose backgrounds, orientations and lived experience is different needs time; time which the therapist is aware that they do not have. Political and racial issues in the South African context cannot be ignored. Sometimes the therapist fears that resistance may be because of the race differences between him and the ex-detainee.

Another closely related theme is the differences in population experienced by the therapist between ex-detainees as a group and other people he sees. All other blacks seen by the therapist are psychiatric

cases. The ex-detainees the therapist sees are high functioning black people. Secondly as a group ex-detainees often lead a life that is full of a series of stressors, not just one traumatic event preceded and followed by stable, safe surroundings. Ordinary patients are experienced as having to recover in a safe environment.

Normalisation emerged as another theme. This phenomenon entails helping the ex-detainee understand why he or she is displaying the type of symptoms they have. The therapist provides reassurance by informing the ex-detainee about the commonness of such symptoms to all people who have been through a similar experience. Normalisation in the therapist's experience has provided ex-detainees with comfort and hope of recovery.

The therapist has often observed the ex-detainee's feeling of guilt. Examples of the reasons for these feelings of guilt can be connected with family members or the individual's past.

Another theme that emerged was the eclectic nature of the therapist's interaction with ex-detainees. His

style and approach changes during the course of the session from didactic to psychodynamic or supportive as the need arises.

4.8.1 General Integrated Situated Structure of the Psychotherapists' Experience of Psychotherapy with Ex-detainees

Therapists experience the differentiation of problems and determining the presenting problem as primary to psychotherapy with ex-detainees. The therapist has to deal with what the ex-detainee brings but must be able to make a distinction between which problems are due to long-standing personality variables and which are directly attributable to the detention experience. The former need more long-term therapy.

Several specific issues have been identified by therapists as potential threats to the progress of the therapeutic process, namely language differences, racial barriers, social class, professional status, lived experience and the therapists credibility. Language difficulties are experienced as affecting communication in a negative sense and mitigating against a strong therapeutic bond. Political and racial issues, especially in the South African context,

cannot be ignored. The need to establish credibility with the ex-detainee is also experienced as important. Referral from a trusted source lends the therapist credibility, also having therapy in the offices of a politically accepted organisation helps the therapist establish political credibility.

Differences in therapy with ex-detainees and non-detainees are experienced as very distinct. The therapists state their credentials to a greater degree and are more disclosing about themselves with ex-detainees. The therapist is careful not to do the following with ex-detainees:

(i) draw on the distant past
(ii) cut across the individual's defences
(iii) evoke transference neuroses but rather only works in the real relationship, in the here and now.

In addition, with ex-detainees the therapeutic setting is unpredictable and often constantly changing and the therapist does not experience psychotherapy as an ongoing process.

The therapist's manner of approach is also experienced as different with the ex-detainee in comparison with the non-detainee. The therapist tends to be more structured in the session, rounding off at the end of each session. There is also an attempt on the part of the therapist to be more supportive, more containing and more active in joining with the ex-detainee. The therapist is generally more affirming of the ex-detainee and feels the need to validate the ex-detainee's experience, especially with reference to the South African political context.

Some therapists experience a definite sense of their role in the psychotherapeutic situation and process. They see their function as providing a space for the ex-detainee's convenience in terms of problem solving, helping the ex-detainee to integrate the detention experience and they feel the need for them to be didactic at times.

Time is another theme experienced as vital by the therapist. All three therapists work on the assumption that one session is all the time they can depend on even if time is insufficiently mentioned in their protocol to emerge as a theme. Each session is seen as a discrete entity, complete with a beginning, middle and an end because the available time for therapy is unpredictable. Reasons for

this unpredictability are because of environmental demands and pressures experienced by the ex-detainee as well as the constraints of the therapist's work situation. The longer the time available for therapy however, the less differently the therapist experiences both ex-detainees and non-detainees.

There are certain therapeutic themes that seem common to most ex-detainee's therapy that therapists have become aware of. Guilt is a theme that often emerges in psychotherapy and usually in relation to the ex-detainee's family. Another theme that underlies many of the ex-detainee's complaints in therapy is the inability to settle.

A third theme that featured in the therapists' protocols is normalisation. The therapist experiences this phenomenon, of explaining the ex-detainee's symptoms as reasonable, common and predictable in the light of their having been detained, as relieving to the ex-detainee. The therapist feels that kind, informative support and reassurance of a positive prognosis brings the ex-detainee comfort and helps in the healing process.

Eclecticism also emerged as a theme that ran throughout the protocols. The therapists experience differences in their therapeutic approach during the course of a therapy session. Didactic, psychodynamic and supportive styles are used at various points, depending on what seems appropriate.

CHAPTER 5

GENERAL DISCUSSION AND CONCLUSION

Introduction

In this final chapter the results will be discussed and some conclusions will be arrived at. Firstly a comment about the data, then themes common to both ex-detainee and therapist groups will be looked at. Evaluation of the situated structures in terms of the literature reviewed in chapters 2 and 3 will be focused on next. Mention will be made of what was common to both, what was specific to our research and what came up in the literature but did not emerge in our study.

Next issues that appeared in all protocols from each group but not sufficiently to emerge as themes in each will be given. These points are important to the author because they seem typical of the experience of ex-detainees or therapists.

Lastly, a few important features about our results will be discussed. A proposed working model for therapists who wish to or are doing therapy with ex-detainees has been developed from the protocols in the research.

GENERAL DISCUSSION AND CONCLUSION

An important comment about the results of the ex-detainee group is that their themes did not only emerge in psychotherapy. The themes that emerged from the ex-detainees' protocols describe to a large extent the detention experience as reflected in the psychotherapy of ex-detainees. In the author's view, these themes are essential and informative as they have very important implications for therapists and how to conduct therapy with such individuals. Although the interpretation and meaning of detention is unique to the individual concerned, this information helps broaden the range of a therapist's awareness of the possibilities open to being an ex-detainee.

The themes that emerged in the results as common to both groups (ex-detainees and therapists) were guilt and support systems. The fact that these two themes were experienced as important by both ex-detainees and therapists should be noted as significant in terms of therapy.

We have established that most of the healing takes place outside the therapy situation. Outside healing agents seem to be:

(i) people (family, friends, significant others);

(ii) activities (mental and physical involvement)

People have the potential, in their social and intimate capacities, to provide nurturance, affirmation, approval and support for the ex-detainee.

It can therefore be concluded that one of the therapists' major tasks is to promote the use of those healing agents accessible to the individual in his immediate environment. So at some stage in the therapy the investigation of existing support systems in the ex-detainee's life is essential. When the therapist is aware of the ex-detainee's circle of support, or the lack thereof, he is in a position to encourage either its full use or its creation and establishment if it does not yet exist.

When evaluating the findings in our study with those in the literature reviewed in chapters 2 and 3 we find that Figely (1985) mentions the final recovery stage as evaluating the effect of the trauma on the self and the victims relatedness with family, friends and society. This has also been shown by the results of our data. For the ex-detainees in our research re-identification also emerged as an important theme. The recognition that an

ex-detainee's reaffirmation of self matters is shown in the therapists' experience that validating the ex-detainee in psychotherapy is important.

Apart from the restoration of personal identity, relationships with others (family, friends and society) is also an important theme that is common to both the literature and our research results.

Another similar feature in the literature and our results, is the evaluation of the detention experience in the treatment. This entails inspecting the victims self conduct to clear up, understand and/or excuse misconceptions, self blame, feelings of responsibility and guilt (Somnier and Genefke 1986).

Normalisation of symptoms and reassurance in psychotherapy is also common to both our study and the literature. Although a more supportive form of therapy is present in both, the type described in the literature entailed no reference in therapy to the traumatic event - detention (Brett & Ostoff, 1985). This is not the case in our results. More often than not the detention experience is dealt with. In other treatments reviewed (eg. Somnier & Genefke, 1986; Boehntein et al., 1985 and Solomons, 1986) as well as in our results, connecting elicited symptoms

with the detention experience and where possible dealing with the accompanying affect is aimed for and achieved in therapy.

Lastly, the inadequacy of individual treatment and need to involve others, plus have interdisciplinary assistance, is mentioned in the literature (Lunde, 1982). This was also typical of the ex-detainees' experience in the present study. They all reported an acute awareness of the limitations of individual psychotherapy, even though it was not mentioned frequently enough to be identified as a theme in any one protocol.

Let me take this opportunity to refer back to the introduction to this thesis. A response to the questions posed right at the beginning in the introduction is now possible. One of the questions was "... are we (mental health professionals) only playing marginal roles in the healing process?" The results show that yes, our role is marginal. The next question that followed was "... is that good or bad, workable or immobilising?" The author does not think it helps to or indeed can be judged as good or bad. The data just tells us that it is a fact. Individual psychotherapy and our role is marginal in the ex-detainees' lived experience of their healing process. As for the second part of the question, our results showed that

despite that the situation is workable, mental health professionals, in our case therapists, can be effective and have a constructive hand in the healing process.

So, although judging from the protocols by the ex-detainees it seems evident that psychotherapy very definitely has its limitations, the author does not see this as a shortcoming. It is good to know ones limitations in terms of scope, so as to concentrate, emphasise and be most effective within one's sphere of influence.

The data has shown us what can be done by psychotherapy, for an improvement in the quality of life for the ex-detainee outside therapy as well as our primary focus namely what can be done for the ex-detainee whilst in therapy. That effective treatment requires much more than only psychotherapy is true and an established fact now. A multidisciplinary approach is implicated but has not thus far been successfully co-ordinated or indeed attempted in South Africa. The treatment implication for therapists now is to encourage the use of outside healing agents as suggested above.

The one most important factor common to our research findings and the South African report (Solomons, 1986) but not an issue in the overseas literature reviewed is time.

The unpredictability of available time for therapy has had a very unique consequence. A one off session therapy whereby each session is a complete entity with a beginning, middle and an end is as a direct consequence of this time factor.

Now several factors specific to our research results and not found in the literature reviewed will be mentioned. Firstly, the therapists' manner of approach in therapy with ex-detainees is different and distinct.

Let me make a point of saying that although here the differences between psychotherapy with ex-detainees and psychotherapy with other client populations are being focused on, there are similarities, especially in principle and these should not be forgotten or belittled. In all cases the therapist is available to help the individual return to the pre-traumatic level of functioning or a more adaptive level. It is interesting to note that what emerged from the therapists' general situated structure is that a therapist experiences the similarities between the two increase, with an increase in time. So the longer the duration of therapy with an ex-detainee, the less different from any other long-term therapy case it becomes.

To get back to our topic however, therapy with ex-detainees is experienced by therapists as having to be more of a realistic encounter in the here and now, with another human being. The only area to work in is the real relationship, no "transference" is involved. The nature of the alliance is such that the therapist must be willing to do the following:

(i) join actively
(ii) be more supportive
(iii) disclose more about him or herself
(iv) validate the ex-detainee in his/her detention experience
(v) not draw on the distant past
(vi) not cut across the ex-detainee's defences.

Although therapists might do all of the above in ordinary therapy with non-detainees, with ex-detainees it is done to a greater degree and overtly.

Secondly the potential threats to the progress of therapy mentioned in the therapists' general situated structure are specific to the research done here. It would seem that a lot of the potential threats to psychotherapy experienced by the therapists stemmed from the differences in population of the ex-detainees from their therapists. For

the mental health professional potential problems were experienced as arising from the dissimilarities between therapist and ex-detainee in several categories, namely:

(i) race and language
(ii) life experience, eg social class
(iii) credibility (political credibility)

When looking at what influence differences in race, life experience and political standing (in which credibility is an issue) have on the effectiveness of therapy, we have to view our South African context.

The socio-political forces at play presently make it possible to understand these three potential threats to the therapeutic relationship. In our research language differences are a function of the difference in race. Language strongly influences to what depths therapy can go. It slows down the process because the therapist has to keep checking that the ex-detainee is being heard correctly and that they too are being clear. When an ex-detainee's level of English (their second or third language) is low, and the therapist's command of a Black language is virtually nonexistent, there can be no real concern with nuance and something is lost. It definitely does make therapy more laboured than it already is by its very nature.

The difference in social class results in different orientations and most important different values. Most of the therapists doing this sort of work in South Africa come from a privileged class by virtue of their profession and race. Most ex-detainees are working class and all Black ex-detainees are members of an oppressed population.

The difference in life experience is very unfortunate but unavoidable under the present government's official policy in South Africa. Although both ex-detainee and therapist are victims of the social order, apartheid, in that their life experience has been largely designed for them by an external force, there is no denying the fact that their life experiences are worlds apart yet directly connected in a way that can make "therapy" between the two difficult or meaningless and not effective.

We cannot begin to go into the life experience of Black and White people living in South Africa today, that is a whole dissertation on its own, but we need as therapists to be aware that there is that difference if at all white therapists especially are to work despite it. Although race and class structure are problematic issues the whole world over and in any one country, they are however exacerbated here in the South African context by the political

sanctioning of discrimination purely on racial grounds, by a minority government. They especially make the white mental health professionals' work so much more difficult and complex. Such problems do not arise in Canada, Denmark or the Netherlands. Our situation is probably as difficult as countries in South America but the issues are still somewhat different there and shall not be gone into here.

The author views it as necessary to bring to the readers attention issues that were not expressed often enough in the protocols of ex-detainees or therapists to emerge as a theme, but which repeatedly appeared at least once in each protocol of either of the two groups. These issues should be raised because they seem typical of the ex-detainees' or therapists' experience of psychotherapy and are relevant to our study.

One such typically experienced issue is the concept of psychotherapy or lack thereof. Ex-detainees tended not to know or fully appreciate the culture of psychotherapy as the West sees it and this was experienced as problematic by the therapists. If the ex-detainee is sufficiently "sophisticated" to already appreciate the concept of psychotherapy as was the case with some, there was no problem. It would seem, however, that the majority of ex-detainees that the therapists had seen were Black and

found to be unfamiliar with the concept, in which case there would be a need for some explanation and introduction to the concept before psychotherapy could begin.

Another issue typical, this time, of the ex-detainees' experience, was a belief in spontaneous recovery and self healing. All ex-detainees experienced the self as a resource with health potential and healing abilities. The implication for therapy here is that the therapist emphasise the body's innate psychological ability to recover spontaneously with time and given some assistance in the form of a background of support and caring from others.

A few things were mentioned in the literature and did not emerge in the results of the present research. The rechanneling of misguided anger and aggression (Somnier & Genefke, 1986) was specific to treatment overseas. Secondly the use of testimony as a therapeutic instrument to discuss emotional aspects of issues in therapy and political commitment in an object relations variant of analytic therapy was unique and done by Chilean psychologists Cienfuegos and Monelli (1983). Treatment in the object relation framework has not been recorded in South Africa. The use of a therapeutic instrument is not altogether foreign though. One ex-detainee reported using poetry as a springboard for

exploration and healing (see appendix number one, ex-detainee number two).

Thirdly the encouragement of dreams and imagery is mentioned in the literature (Brett & Ostoff, 1985). This procedure could lead to the victim's exposure of vulnerabilities and often there is no time in the South African situation to repair any initial damage.

Fourthly, a didactic approach to explain the dynamic beginnings of symptoms as suggested by Solomons (1986) was not shown in our data. Lastly, his pointing out of the adaptive nature of symptoms to decrease their powerful hold on the victim and the use of fantasy in the healing process did not emerge from our therapists' situated structures.

In addition to all of the above, the data has revealed certain important factors that have not yet been mentioned. What has emerged very clearly from the protocols of the ex-detainee group is that trauma is relative and idiosyncratic. What seems inconsequential to one individual might be experienced as extremely significant to another. The ex-detainee's idiosyncratic meaning of the trauma must be brought out in therapy, dealt with and interpreted.

Something else that can be gathered from our research is that the therapist must have background knowledge and certain essential prerequisites before they can effectively deal with the ex-detainee's (psychotherapeutic) situation adequately.

Background knowledge entails an awareness of the following:

a) conditions in detention (torture, solitary confinement, etc)
b) the effects of detention
c) subtle potential forms of torture and vulnerabilities specific to women (threat of rape, damage to body image) and effects thereof after release
d) politics at large and therapist's own personal stand.

This enables the therapist to anticipate the kind of possibilities that will emerge in therapy. It can also enable the therapist to give permission or lead very hesitant, less verbal ex-detainees into a disclosure of their detention experience.

Generally it would seem that therapists, when dealing with this very specific group of people, have to professionally shift their perspective a little in order to attain as much as possible in the way of recovery. The reality is that

there is, most often, insufficient time. By accepting the above and that therapy and healing often comes by way of the living out of things in-the-world (community or society) with others (friends or family), therapists when given their small amount of time in therapy can help the ex-detainee more effectively. Locating the trauma or pathology and its resolution out there in the lived world is a phenomenological conceptualisation therapists will have to adopt if they want to help the ex-detainee back to health despite the time constraints.

Clearly from the therapists' protocols we saw that therapy entails approaches from various psychological schools and is quite eclectic. This eclectic nature of intervention is flexible and varies from therapist to therapist. Where appropriate interpretations associated with painful affect are made, psychodynamic linking of present with past detention experience is advised where possible, misconceptions are dealt with cognitively and at times there is need for a didactic response from the therapist.

The research has shown that our (South African) efforts at dealing with politically traumatized individuals is made different from the efforts overseas in Toronto and Copenhagen by the uniqueness of our South African situation. Our whole line of work as therapists and the way

in which we use our training is thrown into question. Given for example that what Dr Federico Allodi says is true, namely that "Safety is the primary need for a persecution victim" (1984, p.64), is what therapists are offering (psychotherapy) worthwhile?

Are support and care only secondary to the security of safety? Unlike the political refugees from South America that Allodi was treating in Toronto, the people therapists are faced with here are not taken out of the context that houses the potential danger. Our clinical situation is that ex-detainees are often still being actively persecuted or can become so in the future. To what extent exactly safety affects the success of psychological intervention is important but unknown. It has implications for the work of therapists doing psychotherapy, so we should be aware of such variables. Therapists cannot however allow the lack of a guarantee of safety to stop them. The therapist's task remains, to do the best he or she can, given our conditions.

As for problems raised by race and lived experience as a result of the present social structure, they too remain. Needless to say the issue of race especially could be diffused greatly by a change in government policy. Other less grand structural changes or adaptations to our concern would be to increase the number of black therapists (there are about 20 clinical psychologists in the

whole country). Training more black therapists would cut right across the problem of language but is no immediate solution. A quicker one would be for white therapists to learn at least one Black language. The question of which Black language would not be a problem seeing as any Black person can make sense of one of the three predominant groups of Black languages, Nquni, Sotho or Tsonga, depending on which language is most widely spoken in a particular area.

As part of the conclusion a proposed working model will be given below. This model has been developed from the data.

A Working Model for Ex-detainees : The Single Session

This model entails six broad steps some with specific phases in them. It must be stressed that this model is to be used flexibly by mental health professionals. At all times during the session the therapist uses his or her discretion and may see the wisdom of "juggling" a few things around in the model or adding and improvising as he or she sees fit "in the moment".

The first part in step 1 is introductions. This consists of biographical disclosures, active joining and establishing credibility. Once this has taken place the second part of

this step entails explaining the concept of psychotherapy if the ex-detainee is not psychologically sophisticated. The therapist describes therapy as a process whereby healing through talking about ones thoughts, feelings and fears, etc. take place. The last part of this step is explaining the reality of our (South African) situation. Here the therapist briefly discusses how, for example, in terms of our context available time for therapy is short, psychotherapy as a continuous process is unpredictable and unlikely. Each session therefore is a discrete entity complete with a beginning, middle and end.

The second step consists of two phases, namely milling around and zoning in. In the first phase the therapist invites the ex-detainee to talk, briefly state whatever they would like to look at. At this point symptoms will most probably be elicited. The therapist then normalises the ex-detainee's symptoms, by putting them into perspective. Relief and reassurance is provided. Next, recounting occurs. This basically means the therapist encourages and extracts a detailed step by step retelling of the detention experience. Immediately after recounting, the therapist is in a position, if it is appropriate, to link present symptoms to the ex-detainee's detention experience in the recent past.

The second phase, zoning in, entails targeting areas. Here the therapist asks the ex-detainee to do the following:

a) identify the areas they feel they need help in and want to talk about;
b) choose the most essential or pressing for him/ her given the time constraints.

The main objective here is to locate the traumatic experiences or the single symbolic event that encapsulates the detention experience and what it meant to the individual. At this point the traumatic moment should be apparent to the therapist and ex-detainee, even if it is difficult for the ex-detainee to talk about. The emphasis here is to focus on a specific area or the traumatic event.

In step three all energies in therapy are directed at the traumatic experience. First the ex-detainee is required to concretely retell the event. Next the therapist helps the ex-detainee bring into awareness associations and accompanying affects of the traumatic moment. This is followed by joint looking at and evaluation of the ex-detainee's coping mechanisms including their failures to cope. Lastly the therapist interprets the meaning of the experience and that is discussed.

If in the initial two steps no single traumatic event is identified then the therapist will just invite the ex-detainee to demarcate a specific area that they want to deal with. In this alternative step four, the therapist and ex-detainee must talk about the specific area in real terms. This means a disclosure of the ex-detainee's feelings surrounding the area and exploring them together. Here also the therapist must look at the ex-detainee's ways of coping or failure to cope in this area. In the last part of this step, the therapist elicits alternative new ways of coping or helps the ex-detainee change his or her perspective or uses didactic input if it is appropriate. They both look at more adaptive ways of dealing with the ex-detainee's problem.

Step five investigates the ex-detainee's support systems. The therapist finds out available support systems (domestic, social, etc). When detecting what outside healing agents there are, the therapist enquires about people in the ex-detainee's life and what activities they enjoy (both individual and social). By this point the therapist should be able to assess the ex-detainee's personal resources too. Once all the above has been established the therapist is then in a position to promote the use of the outside healing agents available to the individual. This includes for example encouraging the

ex-detainee to talk to close friends and family about their feelings and their experiences. One can also suggest involvement in mental and physical activities that the ex-detainee is interested in. Lastly the therapist can stress the innate resilience and recovery potential that the ex-detainee and/or all human beings have.

The final stage, step six, consists of two phases, namely rounding off and feedback. In the first phase there should be an arrival at a clearer and better understanding of the problem and the ex-detainees own reactions to it and feelings about it, by both therapist and ex-detainee. In phase two there is definite closure. Here the therapist finds out how the ex-detainee feels about the session they have just had. The therapist can also ask the ex-detainee that retrospectively given another chance how would they have rather spent the time in therapy, what does the ex-detainee imagine would have helped more.

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APPENDIX 1

PROTOCOL OF EX-DETAINEE NUMBER 2

Essential themes	Natural meaning units (NMU's)
1. Duration of therapy was just over 2 years at one session a week except for holidays.	I was in psychotherapy for just over 2 years and I saw a women who was in fact from the Wits counselling centre for an hour every week. I came out in March and saw her all of that year for an hour except holidays if it was difficult.
2. Continued therapy despite the change of location by both therapist and individual.	The following year I worked on campus and continued to see her. July the following year I started teaching and actually even then I kept on seeing her. She then resigned and worked from home and I saw her there.
3. Emphasis and focus of therapy was on current problems. The problem was that no detailed account of the detention experience was successfully managed, due to ex-detainee's reluctance.	I found the problems was that what she was looking at were the problems that I was having, or trying to focus on some problem. We touched on so many things, spoke of all sorts of things but we never actually looked at detention. I suppose in a way it was partly because I was reluctant to do it. Every time we started I found I could not talk about issues that had to do with my detention.
4. Parents recommended that she see a therapist	I'd come out of 8 months of solitary confinement. The reason I went to

Essential themes	Natural meaning units (NMU's)
because of her inappropriate behaviour. Her interactional style with people had changed and had been hampered, other symptoms were hallucinations and memory impairment.	see her in the first place was because my parents wanted me to see a psychologist. They thought I really needed one. One of the things for example was that I could not look at people when I spoke to them I'd always avert my eyes, I could not face people. There were times when I'd have hallucinations which I had a lot in detention. My memory was practically nonexistent and I had practical problems that had to be dealt with immediately.
5. Indecision, impaired concentration and inappropriate behaviour made ex-detainee realise there was cause for concern.	I could not decide what to do in terms of study, I could not concentrate when trying to study. There were a whole load of other problems. I found that I was losing conscious awareness of what I was doing at times. I remember the first few days my parents were shocked. It was hot and without thinking I got up and I took my skirt off and there were other people there.
6. Need for a politically aware and conscientized therapist was expressed by referring person but ignored. Subsequent contact with the organisations specifically offering treatment to	So I started seeing this woman mainly because my parents wanted me to see her. My dad had wanted me to see someone who was politically involved or some person who had some knowledge of the political system and what was going on. But at the time; I realised now that, having gone to the OASSSA

Essential themes	Natural meaning units (NMU's)
ex-detainees has made ex-detainee realise that problems were normal and to be expected, the universality of her problems in that specific population. Guilt and feelings of inadequacy and the lack of legitimacy to express her problems because she felt they were not valid.	thing, that what I felt was actually common to a whole load of detainees. The guilt. I felt I'd come out relatively unscathed, that the problems I had were not real.
7. Felt inhibited to talk because she felt the degree of her suffering did not warrant, deserve expression and a hearing. (Felt too unworthy to verbalise her problems.) Took responsibility and blamed self for the problems and symptoms she was displaying.	I always felt I'd talk to someone and they would think what did she come here for she does not have real problems, he has not been through the kind of things that I have been through. So I did not see the thing that I was going through as real problems. I saw them as issues of my own making and perhaps it was a fault on my part.
8. Felt that the responsibility of working through her problems fell squarely and completely on her own shoulders. Refused to go to a psychologist who was au fait with the	I should go and work it out on my own. So I did not go to the psychologist that my father wanted me to see. She was a woman who's father had been detained for a very long time and she had a good knowledge of the political system and things that detainees had been through. I suppose

Essential themes	Natural meaning units (NMU's)
political system and had knowledge about ex-detainees and their problems.	somewhere I felt that I'd fall short of someone's expectations.
9. Feared the expectations that would be placed on her by others. Felt more fortunate than others had been in detention experience therefore undeserving to receive help or of the indulgence of complaining.	People have incredible expectations. I think that I would be seen as making an issue out of this. People would want to know why I'm making an issue out of this, why come for psychotherapy when you have not had the kind of problems that other people have had. You have not landed up in hospital being anorexic or bleeding internally or deaf like others. Some have really come to very serious harm. I felt that I coped for most parts.
10. Realises a missed opportunity to speak about distressing events that occurred in detention. Psychotherapy was not helpful.	I see and realise <u>now</u> that I did not come out of it unscathed I realise now that there are a lot of things that I'd probably have been better off having spoken about. There are some things that I still have not spoken about and do not know if I ever will. But psychotherapy wasn't ....
11. Retrospectively think if the therapist had known about what the conditions in detention can be like and what to expect of people who've	In retrospect I think that if I'd gone to someone who perhaps knew about the sort of problems that detainees faced and what happens in detention, she might have been able to lead me into talking about those things and

Essential themes	Natural meaning units (NMU's)
experienced that, being led into discussion would have been possible. As it was, felt her complaints and problems were not valid. Feared that what was terrible for her would be seen as insignificant.	know how I'd been able to cope with things. There were things that I almost thought were invalid. Some of my worst experiences might not even touch other people. I felt terribly degraded and almost raw because of some of the experiences that happened with the doctor I saw. I knew that other people that might not see that as a heavy thing.
12. Therapist's knowledge of symptoms to be expected is essential so as to give permission to ex-detainee to talk and and say things.	How can you say to someone "In many ways I feel as though I've been raped." You can't say that unless she allows you to, or she's been through that, or she has knowledge.
13. Even "political psychologists" who know all about detention should not look at it in isolation. They must get in touch with how it affected you as an individual in your context.	So I don't know if it wasn't the fact that she wasn't a political psychologist or if it was just in terms of psychology. I think now that for psychologists in many ways, a psychologist, if she's going to look at detention in isolation, at your experiences of detention, she's not really going to help you.
14. Therapist focused only on the present symptoms failing to link them to the detention context.	But what happened with my psychologist is that there was only focusing on me as a person. So she was looking at my relationships with people then which, of course, were affected by my experience by

Essential themes	Natural meaning units (NMU's)
	detention. But she was looking at them outside the context of detention and what I'd been through and why I was behaving that way. So it didn't help.
15. Psychotherapy made her negative in her outside relationships and lowered her self-esteem.	I found that in many ways, the guy I was seeing at the time he felt that my psychotherapy sessions were not very good for me. I often came out of there feeling very negative. Possibly because I looked at things very closely in there and when I came out I carried on at them. I became quite negative about relationships and myself.
16. Expression of experiences of detention to people who were close to her problems. Listening and not forcing ex-detainee to talk freed her to speak.	I found that when I started talking to people who were close to me about the experiences I had been through and people not forcing things out of me but just listening, I found that I was able to let go of some of the things that I'd had. Actually look at them and not forgot them but put them aside so they do not bother me any more.
17. Family and social support by way of involvement with the community are most essential. Participating and being shown that you belong and are cared about are more	I think that for a detainee you need to be involved with your society and things happening in your community and with friends, and those are things that help. Being shown that you're part of a circle of people who care about you and want you to be there and

Essential themes	Natural meaning units NMU's)
important. Psychotherapy in isolation is meaningless yet things that really help are outside the bounds of individual psychotherapy. One private hour a week is too remote.	I don't believe that psychotherapy can actually do that. I don't believe that an hour a week is going to help you to know how to deal with life again.
18. Many symptoms are better known and picked up by the people who interact with the ex-detainee in everyday living. People around one make one more aware of oneself.	There are so many things that you can't really put your finger on, that you don't realise are happening. Things that you're not aware of that have changed in your relationships and the way you behave, unless other people point them out to you. A practical example is that business about not looking at people. I hadn't realised that I actually turned away from people when I started talking to them, that if I spoke to my father I'd look down and he became aware of it and pointed it out. Then I could begin to wonder why I do that.
19. Realise selectivity about which experiences to talk about and varying degrees of freedom with therapist they've spoken about depending on how ready the ex-detainee feels to deal with it.	Now I realise that when I start talking about things that happened in detention, there are things that I've learnt to talk about and there are other things that I've learnt not to talk about and others that I talk a bit about so that I find that when I start talking about something painful or that I'm not ready to talk about, I find it very difficult

Essential themes	Natural meaning units (NMU's)
	to look at people. Psychotherapy couldn't deal with that. So that's why I'm very negative about it.
20. Immediate present problems and objectives for the future were dealt with. Some symptoms are long standing and have deterred professional advancement and further studies.	The things she helped me with were things like what I'm going to go with my studies, very immediate things and working out what was happening in my career and to get back into my studying as quickly as possible. As it worked out I decided I couldn't go on studying because the grades that I'm getting are far below what I was expecting to get. I went on after my basic degree to work and thought I'd do honours and such later. My memory and concentration were so bad I thought it would be hopeless. Now I'm wary of studying.
21. There are some psychologists who one finds problematic and incompatible.	You don't know later, to what extent those things would have been solved because I've just left everything. It might also have been a problem with that particular therapist. It might not have been something, maybe other detainees might have felt helped.
22. Psychotherapy was not personally helpful. What was more therapeutic was a close friend with who ex-detainee felt she could communicate. The use of poetry as an	It just certainly didn't help me. The things that helped me were a particular friend who I could talk to about detention. He was the first person I was able to talk to. He was very aware of writing and poetry and I wrote a lot of poetry about my detention experiences.

Essential themes	Natural meaning units (NMU's)
instrument and spring-board to talk about detention experiences. Two aspects were dealt with simultaneously what detention is and how it was in her context. He was in touch with her as a person and the detention.	In talking about them and reading it with him I found that I could come through a lot of experiences. And that was very good. There were two things you see. He was in touch with me as an individual, as a person and my experience of it and he was also listening to the whole experience of detention. He was just a fellow student.
23. Speaking to other ex-detainees revealed that they also felt their problems were invalid and feared the severity of the detention experiences did not warrant complaint. There are many forms of torture and it is a relative term that begins at different points for different people	I found though that speaking to other detainees they always sort of feel that so and so had it much worse than me. I should be grateful I shouldn't complain about this or that. That's something that I too have always felt. People don't understand they ask you "were you tortured?" By tortured they mean were you given electric shocks or made to stand on bricks for hours. How do I say to them ....
24. Made up excuses, feigned amnesia when people pressured her to talk. Experienced an inability to express the subtle potential forms of torture and vulnerabilities specific to women ex-	I started making excuses. I'd say, look there's a week of my detention that I don't remember at all. How do I say to them that the whole idea of being sexually abused and things that happened with the doctor and with the policewomen - those were things that for me were far worse for me than being smacked. Being

Essential themes	Natural meaning units (NMU's)
detainees. Things which men might not view as terrible were crushing and meant so much more as a woman.	stripped and made to jump up and down were worse experiences. Those experiences were not considered as bad as being hit with a sack over your head, but for me they were really destroying.
25.	I think a lot of women, I spoke very briefly to Barbra Horgan in fact I didn't even speak to her. We'd passed each other at the district surgeon's and greeted each other. She's in prison now. She was the first white woman to be imprisoned ten years for political reasons. We just waved to each other.
26. Women are faced with different vulnerabilities that fellow women detainees can sympathise with.	You do find a sympathetic policeman here and there who'll take food from one detainee to the other, and that kind of thing happened. With Barbra on one of the days of her trail, I was out by then and went to her trial and she recognized me. She went over to me and held my hand. We just stood there and wanted to cry. She said she remembered me from the doctor's office. Then she said "He was a bastard, wasn't he? It was one of the most terrifying experiences of one's life."
27. Therapists should be aware of and be willing to deal with issues like the threat of rape in detention. Rape crisis	I said yes and knew that she'd been through the same thing I had gone through. I think that the kind of experiences and threats that women have all the time - the way women are treated

Essential themes	Natural meaning units (NMU's)
centres don't normally think of helping women ex-detainees. Rape crisis may not be willing to deal with the threat of rape. One's body image as a woman was calculatingly destroyed. This "therapy" took time and could not happen in psychotherapy. It had to be lived out with friends and in the safety of an intimate relationship. That sort of reassurance and acknowledgement about one's own body can only be done by the person herself and people who love and care about you.	in detention and that constant threat of rape in detention is not what a lot of therapists would deal with. I don't know if you'd have to go to some place like Rape Crisis. But in real terms or in most men's terms I wasn't raped but how do you go to Rape Crisis and talk to them. I think a lot of the way women are treated and damaged, and their bodies being exposed are things you recover from by talking to friends. I know for myself it took a very long time and I needed people all the time to tell me that my body was O.K., that my breasts are O.K. It came from being undressed and them flicking your breasts and asking why this or nasty remarks. That sort of acknowledgement you can't get from a psychologist. That sort of acknowledgment that you are okay. You partly have to do it yourself in the end like with most things, but part of it you get from people who love you and care about you.
28. Going to a psychologist has its advantages. The anonymity for example. The disadvantage for me is the inability to talk openly until I've had meaningful interaction with a person. It gets complex because	Although sometimes I think the anonymity of a therapist especially in the beginning might be easier to deal with. It's so complex. I find that I can only talk to people about those experiences when I've had some sort of interaction with them. But then there are other things that, for example when I asked to talk about in court, I

Essential themes	Natural meaning units (NMU's)
then there's a need to protect those very close to one from the horrors of the detention experiences. It seems different areas of the experience are approachable with different people.	wouldn't do it because I know that my parents wouldn't be able to cope with it, could not handle it if they had to be told about some of the things that happened to me. I know that my father would just about go out of his mind. So there are things that I'd rather my family didn't know because it would hurt them too much. So there were areas always that I kept closed.
29. Emphasis on self healing and recovery against a background of support, love and caring. It all goes in degrees - family, friends, fellow detainees and fellow women detainees. Fears that her terrible experiences were not wellknown, established, "respectable traumas".	I felt that with political people, I've found that in so many ways an ex-detainee has to recover on her own because although you need a background support of love and care I remember so many things that I couldn't say to another person who had been detained, well possibly another woman yes, and more and more women are being detained nowadays. How do you say to another detainee somebody whose perhaps had a sack over his head and dipped under water all the time. Most of us perceive that as being a more respectable trauma than .... Well for me that was not worse than people bringing in my sanitary towels feeling them, then watching these things decomposing and the rats coming to eat them. It was like something was gnawing at me, inside me. Those experiences were awful.
30.	Then there was the doctor, because I

Essential themes	Natural meaning units (NMU's)
	trusted him and you always have this allegiance with other women. You don't expect them .... This sounds racist but I always feel very bitter about black policemen because I feel they should understand. I always feel with women policemen - how can they treat another woman like that? It's because you expect, you know that they're one of our kind, they shouldn't behave like that and maybe that's not quite right.
31. Feared that high profile politicos would disapprove, criticise and judge her as silly (that her complaints are not real issues).	I was never able to talk about those things in therapy. I suppose now with distance and having spoken about a lot of other things with people, it's become a lot easier. But there was always this fear, with political people especially, that it would be silly. Now having spoken to many detainees I realise that so many other detainees feel that their complaints, the things they think are not as bad as someone else are going to sound silly and people will say why are you complaining, that's not an issue.
32. Sharing and listening in group encounters organised by treatment teams was therapeutic.	Going to DPSC listening to others made me realise that we have similar experiences and we react in the same way. Some of us will react more intensely to different things because we're different people, different things affect us.

Essential themes	Natural meaning units (NMU's)
33. Recently more is known about detention and its effects. Now therapists are more sensitised (and can be more facilitative). Personal stress is in healing placed on social everyday support (eg friends visiting, participating in circle of people who are as accepting of one after as before the detention.	The other thing is perhaps now so much more is known about detention and there's been this whole move to know more on the effects of detention and the effects of solitary and so on, so there's more understanding. All things being considered I'm never going to say to somebody "You shouldn't see a psychologist but what I'd like to see for the detainee is people visiting and an awareness for the detainee that you've come back into a circle of people for whom you are as acceptable as when you went in, who care about you as much.
34. A whole circle of support is needed - Psychologist failed to link up present problems with their origins in the detention experience.	A whole circle of support is needed and not actually. The problem is the psychologist in order to get in touch with you as a person will look at other things. I felt that we were looking at just what happened to me every week and how I was reacting but it wasn't linked with my detention experience.
35. Dropped out of therapy without terminating.	In the end I just stopped going and didn't terminate properly. I felt guilty about wanting to go and stop. Since then I've spoken to other women who were detained about their experience and it's a lot easier.
36. Much more would have been achieved in psychotherapy if	Maybe I would have come through a lot of things that I haven't come through if I'd had someone who had actually asked

Essential themes	Natural meaning units (NMU's)
psychologist had asked questions that freed ex-detainee to talk, communicated faith and belief in what ex-detainee is saying without suspicion of exaggeration.	questions that would have freed me to talk and believe me without thinking I'm exaggerating.

APPENDIX 2

PROTOCOL OF EX-DETAINEE NUMBER 3

Essential themes	Natural meaning units (NMU's)
1.	When I came out I was physically damaged. I had bruises, face swollen round and had no shape. I was very bitter about detention and felt vengeful. I wanted military training. The pain took time and returned even after the wounds had healed. It took a month but even now for example when exercising some scars still hurt especially the one on my spinal cord.
2.	I was depressed afterwards at home. Immediately after release I spent only 1 day at home and moved to Johannesburg, because I knew about SACC. Leaving the location was hard because they'd persecute my girlfriend. I was afraid that she would suffer for what I had done. I felt responsible for her, so we both came to Johannesburg for a few months. This action was to protect her but made the police more suspicious.

Essential themes	Natural meaning units (NMU's)
3.	I wanted her to be politically aware and not just follow a mob. I felt knowledge would give her protection and if she was detained she would also know what to say and be less scared.
4. The fear of being alone persists even after psychotherapy. Remain worried about consequences of things that came about as a result of the detention. Depression and guilt about effect of detention on family and their persecution as a result of detention.	Now after therapy, I still have a fear of being alone. I start thinking and regret 1984 when things stared happening politically and I feel responsible but I found myself back again as an activist. I still think about my family who have tried for me, also my future which looks dismal and loss of freedom. I'm on the run. I feel depressed and guilty about my family which is still persecuted because of me. They've raided my home several times. I miss my family.
5. Innate belief in spontaneous recovery even if over an extended duration. Talking to different people who help like legal advisors assists. (Keeping busy with mathematic exercise book kept the ex-detainee's mind active.) Mental activities set by the ex-detainee for himself	Inside I knew that eventually I'll be well again. I'd talked to legal advisors and different people which helped. I kept busy with maths exercise books and practised in order to erase all that had happened in detention. My ambition to be a physician helped in that I had read about diseases and damage and its consequences. I was aware of the danger as they beat me; hoped they would not

Essential themes	Natural meaning units (NMU's)
stimulates and maintains alertness. This designed occupation keeps intrusive memories at bay.	damage my brain.
6. Psychotherapy was offered and understanding the concept of therapy encouraged ex-detainee, who knew that talking does help. Comfort found in the knowledge that ex-detainee is participating in something that will eventually help him get better.	Feelings about psychotherapy. Understanding the meaning of the word therapy helped and encouraged me. I knew that talking would help. I had some knowledge of therapy and what its about and supposed to do. Found comfort in knowledge that this would eventually help me get better.
7. Did not doubt the therapists ability to listen, hear and understand.	I didn't feel they'd (therapists) fail to understand because they had brains and could reason and that was enough for the therapist to hear from me.
8. Racial barriers were not an issue because of ex-detainees concept of being non-racist. Trusting took time with both therapists of different races. Trust with white therapist facilitated by living close proximately with her for a while.	Therapy was not very difficult because I'm not a racist so the white therapist was okay. Trusting took time with both therapists. I stayed for just over a week in the white therapist's house which thing facilitated trust because I feel I'm a good judge of character.

Essential themes	Natural meaning units (NMU's)
9. Therapy helped to a large extent in helping me re-identify myself. It helped encourage the ex-detainee to initiate and pursue goals and persist with his objectives.	Therapy helped me to feel that I'm myself now. It helped encourage me to do things and follow thing up or stay with what I want to achieve in life for myself.
10. The experience of psychotherapy has enabled ex-detainees to counsel those less fortunate, to whom professional psychotherapy is not accessible.	Now I have the knowledge of therapy and help others who cannot have therapy by talking to them.
11. Other practical needs fall outside the parameters of psychotherapy but that is appreciated and accepted.	Therapy couldn't reach the practical needs I have, like wanting to go overseas and study but I understand that's outside a therapists scope.
12. Talking as a part of living characteristic of ex-detainee, a person who verbalises and communicates with ease.	Talking has always helped. Even before detention I'd digest what people say and analyse it after. It broadens my knowledge.
13. Psychotherapy was beneficial in so far as it is designed and able to help.	There were no real failures in so far as therapy is designed to help. I believe my experience of it was successful and I benefited.

APPENDIX 3

PROTOCOL OF THERAPIST NUMBER 2

Essential themes	Natural meaning units (NMU's)
1. Similar issues are dealt with differently in ex-detainees' context. Trust important in both but with ex-detainees therapists state credentials and disclose much more of themselves than in ordinary therapeutic situation, where therapist's personality shouldn't interfere with the transference.	Some of the issues are very similar. I think though they're dealt with differently. For example trust - in both situations they're very important. I think that when I try to establish some trust with an ex-detainee, I would explain where I fit in, where I come from and that has to be quite clear otherwise it becomes an issue; whereas with someone who's not a detainee it's quite important to not interfere with the transference, to keep yourself quite out of the situation. That's a major difference. That happens right at the beginning of the session.
2. Time factor another difference. Deal with ex-detainee on the assumption that it is a one-off session. Important to have a beginning and actually terminate at the end of each session even if ex-detainee will come back.	Another difference we've reached by now is we realise that we don't have that much time with ex-detainees. I deal with most of them on the assumption that it's going to be a one-off session. So it's important to have a beginning, go through the process and actually terminate at the end of each session, even if the people end up coming back. It's sort of seen as a whole entity in

Essential themes	Natural meaning units (NMU's)
Each session seen as a whole entity in itself. In following session go deeper but that should also be closed off. Ordinary therapy seen more as an ongoing process.	itself. And you might in the next session go deeper but that should also close off each time. Where as with an ordinary client, although there might be closure, it's seen as part of an ongoing process.
3. The concept of psychotherapy is unfamiliar to most ex-detainees. Up to 90% are sent to see a psychologist as opposed to taking the initiative to do so.	The other difference is that I have often seen ex-detainees who have no idea why they've come to see you. They've been referred by a doctor. There's no idea of what's going on or what they're doing with a psychologist. They usually come to see a doctor. They're not too sure why they're seeing a psychologist but it's quite normal standard to see a doctor after detention. I suppose that when people come for therapy they're also not sure about what process is going to go on either. But they realise that it's a talking thing, they're not going to be physically examined. That is the problem. So although both don't know about the process it's in a different kind of way. One group chooses to go the other doesn't as such. In fact I think with ex-detainees approximately 90% have been sent to see a psychologist as opposed to have taken the initiative.

Essential themes	Natural meaning units (NMU's)
4. Ordinary clients have an idea about what's expected of them. Ex-detainees do not.	Also the idea of psychotherapy, in the population of ex-detainees we've seen, is relatively new. People haven't thought about talking therapy whereas someone who comes to a psychologist has that idea, that that is what it's about whether they know how it works or not.
5. Environmentally therapeutic settings are unpredictable and constantly changing in the case of ex-detainees, which is not ideal. With ex-detainees therapy conducted in whatever space is available. See ex-detainee in offices of a politically accepted organization lends therapist credibility.	The other difference is that it's not usually conducted in a kind of a quite room. It would be ideal but it's really not done like that at the moment. You see people in a different place each time, you might have to run around looking for a place, there's often background noise. The environment is often not stable or ideal. Ideal for an ex-detainee is a bit difficult because you don't want to recreate the experience of the detention, you don't want it to be too dark or too small. I suppose that by trying to if client isn't an ex-detainee the same office and keep the plants and the pictures. Try not to bring too much of myself out in the appearance of the office. With an ex-detainee you often work in whatever space is available. Sometimes that might be in DPSC office and it is helpful because it gives you credibility which would be sometimes difficult to establish elsewhere.

Essential themes	Natural meaning units (NMU's)
6. Working alongside medical doctors helps ex-detainee associate therapist with health and healing. Therapist emphasis that ex-detainee may have trouble now, but can become whole again.	Working at the doctor's room helps because they get a sense of that they're actually getting something from the doctor and we're associated with that which helps. What they get from the doctor is reassurance that they're not permanently damaged and we are trying to associate that they're not permanently damaged and might have trouble but can become whole again.
7. Language difficulties can be an issue. In cases where ex-detainee can hardly speak English at all groups are used with a participant fellow ex-detainee interpreter.	Other differences are also that language can also be a problem, well is a factor shall we say. Initially I was much more nervous about the fact that I didn't speak whoever's language it was, that that would be quite a barrier. I've seen we've improvised as we've gone along. I've never had one-on-one therapy with someone who cannot speak English. In such cases we've used groups with an (participant) interpreter in the group which has worked quite well especially if the interpreter has been through the same experience too.
8. Ex-detainee who's had successful individual therapy usually best person for the role of interpreter and mediator.	I had seen one person on an individual basis and he'd thought he's really benefited from it, and he came back and we did the therapy group session with him as the interpreter. He had improved

Essential themes	Natural meaning units (NUM's)
	and felt better and acted as mediator. So in a group you can reach other people who you would not have been able to reach on a one-to-one basis.
9. Group therapy sometimes the preferred mode of therapy when reassurance from therapist is insufficient, sharing of experiences with other ex-detainees can be. Language and race barriers potential threats which must be picked up, confronted if they become issues, if therapy as a process is to progress.	I think the sharing of experiences is very important and sometimes it's not enough for me to be reassuring. Staying with the issue of language, my most difficult case was one where he didn't in fact speak English, he was in fact already quite switched off and distracted. I was talking and he was just completely somewhere else and there was no way I could catch him in any way. He really wasn't participating in the group and couldn't relate even to the others in the group besides me. That was quite difficult. The other difficulty apart from the language is the fact that you're white. I'm quite aware of the issue and I realise that it's an important one. I must admit that in my code of introduction when trying to establish some trust I don't say anything about being white. I talk about what organisation I come from or who I work with but I don't say "...I'm white and you aren't..." During a session it might come up, that it might be difficult for you to trust me because I am white but I wouldn't start off like

Essential themes	Natural meaning units (NMU's)
	that.
10. Abuse and aggression directed straight at therapist can be expected when therapist and ex-detainee are of different races.	In fact I had one session with a client who worked for a union who was picked up by the murder & robbery squad and beaten up. He in fact spend about three hours screaming at me about whites this and whites that. I then said it must be very hard for him, but why carry on abusing me. Eventually I think he got something out of voicing all this aggression but I actually thought it wasn't doing us any good to carry on. We kind of ended on a reasonable note. I said if he wanted to come back to see me it's okay. You seem to be more accommodative of rage and anger when it's coming from a detainee than an ordinary patient.
11. The most difficult bigotted idea to confront in therapy is an ex-detainee's racism.	Because of the context, it's difficult to confront a person on his racism if you're seeing an ex-detainee than to confront someone else on the bigoted ideas they might have. It seemed obvious in that context why this person hated white people, he'd had bad experiences. He also had what I'd consider antisocial traits, so I really wasn't going to get into it. Outside the struggle he's stolen cars and things like that so ....

Essential themes	Natural meaning units (NMU's)
12. Ex-detainees are people who are coming along with their whole history and the detention experience compounds it. Sometimes they had long standing problems prior to the traumatic incident. When this is identified, they may benefit from long-term ordinary therapy.	Yes, definitely, that case was the most striking but other people, for example, might have had some difficulty in relationships before, other's school difficulties before and are now having difficulties at school after. I felt that this man might benefit from long-term ordinary therapy but I wasn't in a position to offer that.
13. First and foremost where there are other problems alongside the detention experience, therapist would deal with the detention experience forst and then refer out to a service that caters for such.	You see the point is the person has come along because of the detention experience, so I'd deal with that first. If that person came back and we together felt that there were other issues to be dealt with, then I'd if they wanted to see someone outside the detainee's counselling service because we don't actually do that kind of thing. I'd refer out. Elements of distrust are common but that was one case where there was blatant aggression that was directed straight at me.
CASE NO. 1	
14.	The first experience was with a guy in his late 30's who'd been detained about 6 months. He'd been questioned quite

Essential themes	Natural meaning units (NMU's)
	early in his detention and he was a member of an organisation and he'd been left for about 4 months totally on his own and at various times in a cell.
15. Ex-detainee showing some symptoms after detention (impaired memory and concentration) and felt he wasn't readjusting well to his old job.	And he'd come out. He's signed a statement and gone straight back to work and he felt that he wasn't functioning as well as he could have. He felt that there was a difference between how he'd been before and now. He had been detained once before, prior to the time after which he sought help. He want back and felt that his memory was poor and that he couldn't concentrate and he just wasn't doing as well as he could. He was a secretary in the union, more in the office.
16. Self-referred. Introductory phase with names and presenting problem.	He came, hadn't seen a doctor and wanted to see a psychologist. I asked him why he had come, what was bothering now. We'd started with the introductory stuff. I told him my name, what I do and that he'd come to see. He told me, yes, his ....
17. Dealt with ex-detainee's expectations. Therapist explained who she works for and explained a bit about the service and	We rushed up and down with keys looking for an office. When we'd found one we sat and had coffee. I asked him about why he'd come and what he sort of expected from the situation. He said

Essential themes	Natural meaning units (NMU's)
its function. Unconventionally beverages are shared by therapist and ex-detainee if there are available facilities. Then started with the present.	he'd come to see a psychologist because he wasn't happy at work. So I said I work for a particular counselling service and what we do is see people who've come out from detention because what we've noted is that people coming out suffer from certain things and we've also found out that there are certain things that help and we work closely with DPSC and that's what we do. I asked how he felt about that and he said no that was fine, it's what he expected. Then I asked what's happening now.
18. Ex-detainee usually start with their symptoms. Verbal ex-detainee easily recount their detention experience from beginning to end. Control during detention is an important issue. Ex-detainee's fear of going crazy is met with re-assurance from therapist. Most of one's energies in detention are spent trying to maintain some control and on release one lets go and re-adjusting is difficult and slow and filled with	He went through his symptoms. They usually start by talking about symptoms. Symptoms can be like sleep complications, etc. Then I asked when it started. Then I explained ... It doesn't always go this way but this guy was nice and verbal. Like what had happened from the moment he was detained, he went from there right through from start to finish. I suppose what is interesting is one can actually see; he was expressive. Like when he told the security police he doesn't want them coming into his cell anymore, they must bugger off and he got quite animated about it. You could feel that he's somehow regained some sort of control over the situation and then he related the whole thing

Essential themes	Natural meaning units (NMU's)
symptoms. The arrival at ways in which ex-detainee can regain control are investigated together.	about how things were when he's got out; he'd also said that things had improved; he'd actually spoken about things that had happened to him and he felt it had helped to a certain extent but there was still something wrong. He went on in detail, when he'd felt worst, whether there were times when he felt that he'd go mad and I think that I did a lot of reassuring at those points, that people do feel like they're going to go mad because there's no control. We discussed the issue of control a lot. That when you have no control it's very hard to keep sane. That in fact what happens when in detention all your energies are spent on trying to keep things under control. Then when you get out what happens is that you let go and what people do I explained about symptoms that they're how your body get used to that sort of experience and your body only lets it in a little bit at a time, and then you work through it slowly. But that one has to go through that experience so that one can actually hold onto it and it doesn't destroy you. And that there are other ways in which you can control.
19. Another tactic used in therapy by some therapists	What people have done that I haven't done that much of is kind of get people

Essential themes	Natural meaning units (NMU's)
is the use of fantasy to reverse the situation such that the ex-detainee has control and power he didn't have in the original situation.	to reverse the situation. Like say if they were picked up at 4 o'clock in the morning and pushed around, you get them to go through their head what they would have liked to have done in their head.
20.	People find that kind of difficult because they don't feel they can do that and those things work well for other therapists and their clients, I find it a little more difficult.
21. Normalization of ex-detainee's symptoms. The use of relaxation exercises, suggestion that a close person massage the ex-detainee if there is complaint of tension. Some ex-detainees expect too much of themselves too soon after detention. Encouragement for ex-detainee to talk to others about their experience, if there are concerned others.	So I suppose that I tried to normalise this experience and I said maybe his headache was because he was trying so hard to forget about it that the body gets tense. And that I showed him a little bit some kind of relaxation exercises and that maybe someone could massage his back and that maybe he shouldn't be so hard on himself and let things in a little bit at a time, and he'd maybe be able to integrate them a bit better. And that a lot of the time what helps is talking to others about the experience. He did have people that were kind of sympathetic and wanted to know and kind of wanted to help which was quite nice for him. There are people who don't have that and people who have been though similar experiences.

Essential themes	Natural meaning units (NMU's)
22. Offer the option of returning.	I suppose we kind of ended off - I didn't know if I offered him the option of coming back again, he seemed to me that he was quite an integrated person anyway and that maybe it wasn't necessary but that I'd leave him with the option of coming back and we actually made a time - he came back.
23. Ex-detainees who have had a positive therapeutic experience can help facilitate the recovery of other ex-detainees.	He came back saying he was remarkably well and was quite keen to maybe speak to other people and kind of help. He felt that things were going at work much better and his memory was better and he was able to relate to people. I mean I think that the changes that he noted had been going on all the time. I don't think that it made that much difference. He was already doing part of the process.
24. Aim of therapy is to help integration of the detention experience.	Therapy might have spurred it on a little bit and he got some reassurance that it was going to go away also. And that it was ok to feel that way. But he seemed to have integrated the best part for himself.
25.	We ended that session by me asking if he wanted to come back. In fact he wanted to and next time we just

Essential themes	Natural meaning units (NMU's)
	discussed how things were going. After that he just phoned once and said look things are fine, he wouldn't mind helping if we were running groups and needed more help and in fact I didn't contact him again. But that was quite a pleasant experience.
CASE NO. 2	
26.	The other case was a young man, about 17, and he came referred by the doctor. He'd arrived, gone to Tembisa in a group to stop people from going to work or something. They'd got involved in a very strange incident. They were caught throwing stones at a car but this had nothing to do with what they'd gone there for. He denied throwing stones. He said they just picked him and his friend up and beat him after that, quite badly and kept him for about two days. This was in Tembisa. He had been charged with public violence and he came along and was extremely districted.
27.	He was very quiet, he was. He did speak some English, but not that much. He sat right back with a group member on either side of him. What struck me was that while other members of the group were listening to each other whilst relating

Essential themes	Natural meaning units (NMU's)
	their experiences, he was totally distracted. He was slightly out of it. I don't think he was too sure about why he came. He'd been sent with a doctor's letter saying they thought he was depressed and they'd put him on antidepressants.
28.	So we went through the same process of everybody relating their story. He didn't relate his story with much interest. It was in a very detached way and he was picking at his scab the whole time. It was a long session - 3 hours. At the end I asked them what they wanted to so. This guy, I felt that he needed to be seen again and asked him if he'd like to come in. I made a time at the DPSC offices - I was working at Hilbrow at the time and I made a time to see him at Hilbrow.
29.	The interesting thing was that he arrived a week early. I gave him a time for Friday two weeks later. What I had done is I'd written Ward 27B, the time and the date, and he came with the letter and said it says here the 17th and it's the 10th, is there some reason in particular why you came today. He said yes, he wanted to get back to school and could I write him a letter to

Essential themes	Natural meaning units (NMU's)
	say that he'd been detained. He was still quite distracted and I asked him if there were any kind of problems and he said no, everything was fine except he wanted to get back to school.
30.	I tried pushing a bit. I asked how things were going with his colleagues. He said, no fine. So I gave him the letter, addressed to the principal, saying that he'd been ill. I asked him if he minded my mentioning that he'd been detained. I added that part of his rehabilitation would be to get back to school. I showed him the letter and he felt that was fine, and he left and I never saw him again. So - I don't know. I don't know if getting back to school is what he really wanted or ....
31.	What interested me though was that he had arrived a second time, and a week early, to the right place.
32. For some ex-detainees psychotherapy is of no use. Their needs are more practical.	In fact I asked him to contact me to say whether he'd got back into school. He didn't. I think we made an appointment for a week later. But he'd got there and it wasn't like he didn't know the date - I mean it was written on the paper. Maybe he was desperately trying to get back to school. He was

Essential themes	Natural meaning units (NMU's)
	saying I'm fine and I want this, this is what you can do for me.
33. Investigation of ex-detainee's family or family supports, and any other supports is carried out by therapist.	I would have liked to know what happened in the end. I also had no idea about what he was like before. He might have been a very quiet person. Although when I meet an ex-detainee I do go into the family and family supports. I ask do you have people that you talk to and who's at home with you? One does go into family and work. I suppose that if family is an issue like they don't support one's participation in the struggle, then one would go into that and see when it started. I always do that. I'll ask "is there someone you can talk to or is there someone that you've spoken to about this?"
34.	If they say no, then I'll ask "well, do you have any family and how are things going with the family?" And by the end of the session you usually have an idea of whether they're married and have children and what the family is like.
35. A lack of organization of different disciplines and services does not make for smooth therapy. Usually ex-detainee has	I suppose that what has come up with some ex-detainees - by no means all - is they feel they must be strong to participate in the struggle. What often happens is that you end up seeing

Essential themes	Natural meaning units (NMU's)
seen various professionals for different things.	someone who's seen 10 other people. They've gone for their feet somewhere and another's gone for their eyes and a doctor, and you're not too sure what's going on.
36. Ex-detainee's pains and organic illnesses are a temptation and distraction as a doctor, apart from one's role as a therapist.	He'd decided to come and I was not too sure why. He had quite a responsible position in an organization and he was just like working furiously. He didn't have a minute for anything and he was complaining of gastric pain. He'd been detained for quite a while. Being a doctor you're also in a difficult position because when people have pains and things you have the possibility of finding out what's going on and it's quite hard to stay out of that and get into therapy. I find that it's quite difficult for me, especially if it hasn't been sorted out somewhere else.
37. Discouraging overactivity is sometimes also necessary.	So he was working furiously and we kind of pointed out that maybe he needed to slow down a bit. He said that he was find and working hard and there was a lot of stuff to do. I went on to say that he worked so hard and maybe he needed to slow down a bit and maybe working so hard is part of his not coping - although I don't think it was put that bluntly. He said look there's

Essential themes	Natural meaning units (NMU's)
	this struggle going on and I'm not going to be beaten by it and whether I'm working hard or not it's got nothing to do with that. That doesn't quite answer your question.
38. Sometimes ex-detainees need to be contained if they are caught or stuck and have to make decisions and therapy can be the place for that. Providing ex-detainee with the space in which to tackle their problems.	The other thing is you get people who are in the most incredible position. And like young people. I think older people have like more of an option of getting out of the struggle for a while, whereas school kids will come and say they've been detained and they really feel quite anxious and bad, and they really don't want to or are scared of going back into their organization straight away, and they're scared that if they don't, how that will be interpreted. I think those people are really caught and all one can do is just sit with them in what their decision is. I think the choice is the persons and one has to respect that. It's also their responsibility and makes them see that they have some control over their life. You might suggest that there are other ways of dealing with things but that's all, not giving them an answer.
39. Some ex-detainees are at certain developmental life stages which are	I think it's such a traumatic experience being 17 years old and being detained and when the police are forever

Essential themes	Natural meaning units (NMU's)
extremely vulnerable such as adolescents.	saying once you're out we know where you are and we're going to catch you again.

APPENDIX 4

PROTOCOL OF THERAPIST NUMBER 3

Essential themes	Natural meaning units (NMU's)
1. Ex-detainees not particularly referred for counseling but rather a routine medical examination, got enormous amount of relief from a thorough history in which many symptoms were elicited. Reassurance and explanation that their complaints were normal in the light of their stressful experience and a prognosis of improvement with time really helps.	Well the first thing is that I've got more patients who I feel I'm not sure exactly about than patients where I felt I really knew what was going on. The one I felt happier about .... There were a couple of people who came in for a routine medical examination, they weren't referred particularly for counselling. They got an enormous amount of relief from a thorough history in which many symptoms were elicited. A thorough medical examination that was generally noncontributory, that is not much really came out of significance and then reassurance and explanation that their particular set of complaints like headaches, poor concentration and feeling withdrawn from people and the general feeling of fear and often a sleep disturbance were very normal to people who had been under some degree of stress and that they were in an adjustment period very often and there were many stresses in their lives, besides the detention. And that is with time hopefully these would improve.

Essential themes	Natural meaning units (NMU's)
2. A feeling of relief partly attributable to the explanation and partly that they'd been somehow looked after.	I thought that an incredible amount of relief was given. I'm not sure if it was the explanation or just feeling that they'd been somehow looked after, someone had examined them. But certainly somewhere along the line there seemed to be a feeling of relief.
3. Reassurance and kind informative support are essential parts of a therapeutic experience. experience.	Support and reassurance, kind informative support should not be neglected. I think it's an essential part of any kind of therapeutic
4. In one case an ex-detainee displayed some of the kind of symptoms found in people who have been in detention. He had a misconception that resulted in continued distress. Therapy consisted of explaining away his misinformed belief, reassuring and de-mystifying the notion.	One interesting example was a guy who had these kind of symptoms that you find in people who have been in distress, particularly people who have been in detention. The headaches and the can't sleep and the problems relating to people and just feeling different. And he had a story where he thought he was being poisoned. He wasn't psychotic, he was just misinformed. He thought the food had been poisoned. Some explanation and reassurance that this was a very common problem. He wasn't being poisoned and it was a common problem that happens to people who we see. He responded to that. So besides explanation and reassurance

Essential themes	Natural meaning units (NMU's)
	there's, I suppose that's an example of a myth or rumour that got out, - de-mystifying.
5. Often ex-detainees think they're the only ones experiencing such feelings. They don't know its a common response and need to be reassured. The therapist encourages ex-detainee to talk to their friends or family about their feelings. Although ex-detainee runs the risk of not receiving empathic responses there's a great chance that someone will respond positively.	Often people feel very, have all sorts of strange feelings and think "... you're the only one like that..." and to know that you're not, it's a common thing I think is reassuring. It also enables people to communicate to their friends and family their feelings because they're not encouraged and used to doing so. Whether its useful or not would be interesting for you to find out and follow up. My experience has taught me, we think it sounds so obvious, "... talk to your friends or family ..." Firstly I think it's extremely difficult for people to talk about their feelings openly. I don't know if people ever did. I'd be interested to know if they ever have done. I mean people who previously had not talked then started to talk and if that was useful, I don't know. I imagine it might not be if the family didn't respond in an empathic way or friends.
6. General advice includes prescription of rubbing	But I must admit that's part of my general advice. I suppose on the

Essential themes	Natural meaning units (NMU's)
medicine for tension headaches. Getting some friend or family member to rub them facilitates touch and enhances physical contact.	medical line another thing I used to prescribe was rubbing medicine for tension headaches and suggest that people get their friends or family to rub their necks and shoulders, which is an effective way of getting rid of them and also I thought would be a nice way of getting people to touch and enhance physical contact.
7. So far all of the above variations of medical support, not psychotherapy.	Those are all variation of medical support and not psychotherapy as such.
8. In a one off session, one ex-detainee relayed horrifying experiences of torture etc. He was made to feel responsible for the torture of others. As a result he was having nightmares about the incident. This particular incident symbolised his experience in detention.	With this case I think something was done but I felt left hanging. Let me first tell you about one that I was unhappy about. The one was a one off session. A man who relayed a really horrifying experience to me. He was detained, tortured too but most important was while he was there he was forced to watch young kids being beaten up in front of him. He said that he was having nightmares, in which he saw these kids all the time, every night in his sleep. It was a very typical nightmare recreating the experience. The man was about 30. He'd been detained 4 months This particular incident for him symbolised his experience inside.

Essential themes	Natural meaning units (NMU's)
9. Ex-detainee's feelings of guilt were great. Difficulty experienced in talking of symbolic event. Therapist encourages continued verbalisation, despite a break down and tears, which was cathartic.	The problem was apparently the authorities wanted information. He didn't want to tell them, or didn't have anything to tell them, so they then brought these young men in from the village, beat them up and said its your fault, you won't talk now look what we're forced to do. He felt terribly guilty, unbelievably guilty and he said "... I can't talk about it ..." I encouraged him to do so and he broke down and cried as he was trying. I encouraged him to carry on telling me. I then felt that he became quite cathartic and it became clear that he felt guilty and responsible that this had happened.
10. Therapist enquired about ex-detainee ever having felt in a similar way in his past. Ex-detainee responded positively and therapist was able to make a link with ex-detainee's past, drawing parallels with his detention experience. Brought into the open ex-detainee's feelings of self-denegration, guilt and anger the latter of which he was	I then asked him how if he'd ever had this kind of problem before. In a way this was partially successful in that I was able to make a link with the past. I asked him then about his anger straight after. I think I was trying to do too much because I was pushing him. I asked how angry he must have felt, to try and get him out of this self-denegration and guilt, and try and get him to express some of the aggressive feelings that he must have had. How angry for example he must have been to be put in such a position which he found difficult. I wasn't

Essential themes	Natural meaning units (NMU's)
not able to accept. Ex-detainee not able to recognise and acknowledge certain emotions. Therapy was going too fast and ex-detainee was not ready. There could be several reasons as to why there was resistance 1) Therapist is a different race 2) not enough time to have established trust or 3) there may have been long-standing repressed psychodynamic reasons.	sure why but he found it difficult to be angry. Whether it was because I was a stranger or because I was white or because there was no real trust established he'd just met me; or whether he was scared for psychodynamic reasons, I'm not sure.
11. Discovery of clear psychodynamic obstacles in ex-detainee past experience explained his resistance in the present. Past brought too much pain and left ex-detainee inhibited. Reasons buried in the ex-detainee's past influenced his present behaviour in therapy. Therapist also made this link for ex-detainee but ex-detainee was not able	I certainly however found one clear psychodynamic reason. I then asked him why, I wondered if he was scared of his anger and he said yes. I asked him if he'd ever had an experience where he'd lost his temper before. He described a case when he was a young man and he'd beaten up a guy. He said he lost control and didn't realise what he was doing and he nearly, well the guy was really badly hurt. And he remembers feeling absolutely devastated and terrible and going to speak to this guys parents and apologising - which I felt quite good about, being able to make a

Essential themes	Natural meaning units (NMU's)
to take in anymore and integrate this discovery. Therapist feels he pushed too hard. Ex-detainee was emotionally exhausted. Therapy had consisted of catharsis and a linking with the past but complete resolution was not achieved. There was no follow up.	link with the past like that. He didn't come back. At that stage he'd had enough and he'd said like "... look that's enough". We left if there and he didn't get back to me. So maybe he did get something out of it - catharsis and there was more than that. There was actually a link with the past and maybe he felt held, I don't know if he felt contained. I said "It sounds like it's difficult for you to talk and you'd like to stop", and he said yes. I felt bad that I'd opened it up and hadn't helped resolve it for him. This stuff was very on the surface. I would have loved some follow-up on that.
12. Ex-detainee showed signs symptomatic of depression. Ex-detainee recounted her experiences in detention but had come for a medical examination and not therapy really.	Okay a bad one next. This is one where I felt there were different feelings coming across. I saw a young lady who had been detained, she was about 23 and had been in for about 6 months. Ultimately she was released with no charge being laid. I think it was largely a preventative thing to do with the state of emergency. She'd lost a lot of weight in detention, she'd lost about nearly 10 kilos. I actually wondered if she'd gone through a biological depression. I don't think she did but she's one of these people who, - she told me about

Essential themes	Natural meaning units (NMU's)
	her experiences and I felt at the time; Well she came to me at the time for a medical examination. She did not come for therapy. I picked up that this woman was depressed and asked her about it. Physically I couldn't find much. I thought her physical symptom like the loss of weight and headaches and feeling different and her general feeling that she didn't want to be with people I thought were related to her depression.
13. Ex-detainee expressed feelings of guilt associated with her not being able to maintain her responsibilities as sole breadwinner at home whilst in detention and after. Ex-detainee was reluctant to talk and remained distant merely allowing therapist to elicit symptoms.	Also she said she felt guilty. I think she was the sole bread winner and she felt guilty that she'd been locked up and unable to support her parents. She'd gone back to her job but said she wasn't right. Like she just sat, didn't work and she was depressed. I tried to open her up by trying to get her to talk about it and I felt the distance from her. I felt she was far away. She wasn't in the room with me and so really what happened was that I basically saw her and elicited a whole load of physical symptoms like headaches, concentration, sleeping difficulties ... I think she also had very minor medical problems which were non-significant and which I gave her medication for and I suggested to her that I see her again.

Essential themes	Natural meaning units (NMU's)
	She seemed to be depressed. She agreed.
14. Some ex-detainees may seem to be coping but are often just covering up feelings. No substantial progress can be made in therapy whilst ex-detainee is still mistrustful and if there is a lack of rapport. Being a doctor and a therapist is helpful if the symptomatology has a biological aspect to it and needs medication.	She came back. The very first time I met her she came across as being - the initial few minutes I met her I thought gee look at this woman, how she's coped well really strong. She was a bright intelligent and articulate person. I was misled: clearly she was covering up a lot of I don't know what, underneath that all. I felt that although she came back to see me 3 times after that first interview, I felt that she was mistrustful of me and there wasn't a rapport. Eventually I decided right maybe she is biologically depressed and to try and treat her with medication which I did.
15. Therapy, sporadic and unplanned, is made available when ex-detainee indicates the need.	She didn't come back for 5 months. Then I bumped into her unexpectedly in town and she said "I want to see you." I said "fine give me a ring". So she phoned and came to my office and sat down.
16. Displays of helplessness even to the point of not being able to communicate verbally.	I asked her what's the problem and she didn't cry she just put her head on her hands and just wouldn't look at me. She might have been crying but didn't want to look at me because she felt it was too intimate or revealing. Then I was called out for some reason. I went out

Essential themes	Natural meaning units (NMU's)
	and came back and she was still like that.
17. An unpreparedness for therapy is a request for medication and total lack of response when encouraged to talk.	I tried to encourage her to talk and said that it's difficult for me to talk if I don't know what the problem is. She said "I just want pills". Well then I said "I can give you some help but I'm not sure if they're going to help because I'm not sure exactly where you're at and I need to find out." She wouldn't open up at all.
18. Therapist experiences hostile, silent, non-verbal messages emanating from ex-detainee. Therapist aware of own counter-transference feelings.	I felt there was a big "layoff" sign on her saying don't come near. I felt there was a lot of aggression coming out of her. Inside myself I was feeling quite anxious. I wondered if she was putting that in me.
19. Therapist can find therapy confusing when ex-detainee comes for therapy but refuses to participate once there - this makes for an impasse in the therapy.	I'm actually not sure what was happening. I never really got a feel of it. But I must say I remember thinking, "...gee, what's going on?" Why did she come and see me and then she acts like this. She must be frightened but what does she want. She just says she wants pills but she wouldn't open up or anything, she says she just wants pills. She wouldn't open up or give me a history on what's been happening in the

Essential themes	Natural meaning units (NMU's)
	past five months.
20. Presenting problem had organic components to it and only medication was able to be administered.	So I simply did give her medication. She never came back and I feel very unsatisfied, I still do, I don't know what happened.
21. The role of medicine in healing process was used. Difficulty experienced by therapist with the type of person ex-detainee is and their origins. Dissimilarity between therapist and patient include 1) race, social class, and professional differences. The ex-detainee usually comes from a population the therapist is not used to doing therapy with and that is very different to him. Therapist often feels unsure: experiences their backgrounds and orientations as so different from that of the ex-detainee. Psychiatrist experiences	I have no doubt that I use medication when I don't know what else to do. One of the difficulties I find in this line of work is that I see people who are very different to me for therapy. They're black and very often aren't middle class and very often aren't professional. They're not the kind of people I normally or am used to doing therapy with and they definitely aren't the kind of people I socialise with. So I'm sure a lot of it is my own uneasiness at not quite knowing, I'm wondering what's happening. At a medical level when I'm the doctor, I feel quite comfortable that I'm accepted as the doctor. On that level I can give a lot, as a doctor. The minute I step in the role as the therapist a whole load of issues about trust, white, black issues and intimacy generally especially when you haven't established rapport and establishing rapport of people whose life experience is different from yours

Essential themes	Natural meaning units (NMU's)
his role as a doctor and as a therapist as very different. As a doctor very confident and has a a lot to give: his role as doctor he feels is accepted. In doctor's role as therapist issues of trust, race (black/ white issues) acceptance and intimacy are raised. Difficulty for therapist is felt in terms of establishing rapport with people whose life experience is different from ones own. Resolution is difficult especially given the short amount of time available for therapy with ex-detainee's.	come in and I don't think I tackle them successfully. I think they're enormous issues, I think they take months to resolve. I'm not sure how one does it quicker but possibly - I was pushing too much. Trying to get too much done, too soon.
22. Therapy need sometimes only contain the ex-detainee as opposed to induce catharsis.	I might have pushed someone like this lady into feeling mistrustful and anxious. I might have induced or, maybe all I needed to do was be a container rather than a catharsis - thinking about it.
23. There is a danger in therapist trying to push and do too much, too	It's very difficult to talk in generalities: these 2 specific cases which both neither cases people who

Essential themes	Natural meaning units (NMU's)
soon.	came and were bubbling over with things to talk about. They certainly weren't people in crisis. They were people under stress but it had been happening for a long time and they'd developed defences to deal with it. They weren't wanting to talk - It wasn't my role to encourage them or to push. Looking back perhaps I was doing too much, or tried to do too much.
24. Similarities and Differences	
There is a difference in population. Therapist used to seeing blacks with different pathologies which usually go with a low level of functioning. The ex-detainee group consists of blacks who are high functioning and probably good candidates for psychotherapy.	Oh now for the similarities and differences. Well first of all the population is different. It was a very different experience for me: in psychiatry the majority of black patients tend to be for various reasons tend to be psychotic, alcoholic, toxic psychoses, drug addict type people, manic, not the patients who come to therapy. And here I see really high functioning population of people who were verbal and probably are good candidates for talk therapy.
25. Detention is not the only stressor in the lives of ex-detainees. Often their lives prior to and	One thing I didn't realise at the beginning of this work is that detention isn't the only stressor in the lives of people who have been detained. Very

Essential themes	Natural meaning units (NMU's)
after detention is full of real life stressors. Therapist must be viewed from this different perspective. Therapy with other groups of people is because of one particular distinguishable traumatic event but their lives prior and after that were lived out in a safe, supportive environment.	often there's been severe stressors preceding the detention and very often their life after coming out, has got a number of stressors very real life stressors. I think when you've got that perspective, you won't try and there's a different kind of therapy from when someone has had a particular traumatic event en you try and help them deal with that but then they're now living in a safe, supportive environment. I don't think it's like that for ex-detainees and it took me a while to realise that perspective.
26.	There are however some people, although you don't know what's going to happen 3 months down the line, who seem to be on the surface have coped remarkably well of a severe stress and disruption in their lives.
27. Orthodox fashioned crisis intervention is not an appropriate model. It may be applicable in an ordinary population who need to be seen pass a crisis. Ex-detainees lives are a series of crises. Their lives are full of personal, social	Especially old fashioned crisis intervention, which I thought was the model, I don't believe is the model anymore. We've not seen people past a crisis. We've seen people whose lives are a series of crisis. The people who aren't coping and seem to be suffering severe effects following their detention are often people whose lives are full of stresses personal and social or

Essential themes	Natural meaning units (NMU's)
and interpersonal stressors.	interpersonal. I think its naive to try and think that you can do old fashioned crisis intervention. It's not the model.
28. Political aspects are an issue: most ex-detainees are politicised. Therapist has to be prepared to be disclosing of their political position. This issue varies according to ex-detainees age group. Older ex-detainees more amenable to old fashioned therapeutic approach which require mostly empathy, listening and no real personal disclosure from therapist. Adolescent grip concerned mostly only with politics. The older ones with dual responsibilities also have families to be concerned about.	I think that there are political aspects. A lot of these people are politicised and when you get into an intimate relationship like therapy they kind of want to know where you are at, which is ... although I must say it depended how old they were. The adolescents were like that but the patients over 25, in their 30's who had families, work and other responsibilities outside the politics were much more amenable to the therapeutic approach I felt than - the old fashioned one of being empathic and just listening. They were much less they had real now political issues to deal with, like conflict with their and guilt concerning their families and dual responsibilities. Much more concerned about the future of the country on a real level. I feel much more aware of how, that things aren't going to change overnight.
29. Some younger people have an unrealistic view of	Some of the younger people perhaps they're still going to get depressed

Essential themes	Natural meaning units (NMU's)
the political situation. Political aspect in terms of therapy cannot be ignored but it's stratified in terms of age.	because some of the young people I saw who really believed that everything would have changed and apartheid would be gone by this year; which is really frightening. That was their basis for not going to school. They thought oh well why go to school, we'll go to school when things have changed and next year its all over and that's such an incredibly naive thought. Maybe that kind will get depressed later. So - you can't ignore the political aspect in terms of the work but that was stratified in terms of age.
30. Racial issues especially in the South African context cannot be ignored. Geographical locations are a problem affecting continuity and follow-ups.	Secondly - I don't think you can ignore the racial issues in South Africa, that would be naive to act as if it didn't exist and we're all chommies. The geographical problems where people live far away they don't come regularly and one can't get follow-up.
31. Ex-detainees real life problems are different to anything therapist has had or is likely to face, leaving therapist with feelings of discomfort. Ex-detainees lived conditions are different from another	The whole notion of therapy is, I felt uncomfortable doing therapy with people who had such real life problems and I wondered what I was doing, I think that's why I reverted to a medical model, to provide some structure. Ideally someone who comes for insight real psychodynamic therapy, should not have real life crises at that moment in

Essential themes	Natural meaning units (NMU's)
person seeking insight in in-depth psychodynamic therapy. Ordinary persons in a stable environment and is usually employed and has recourse to ego strength. Ex-detainees ego strength is being continually taxed: in-depth work is going to be less possible.	time. They should be employed and have some ego strength. If your ego strength is spent trying to hold yourself together: of all these onslaughts from outside, obviously you're not going to be able to look inside yourself which I suppose says something about the type of therapy that you do with an ex-detainee as oppose to the other type of person.
32. New repetitive one-off therapy model which is being talked about and in process sounds more appropriate than the often used crisis intervention model. When cantextualizing therapy in our situation a lot of the first session should consist of a medical examination, information and normalisation. These initial things can be very reassuring.	I think although crisis intervention is the model often used, I must say I like Jill Strakers model. It's repetitive one-off therapy. I am not sure, I think one has to recognize that there has been, put it into context and a lot of the first session should consist of information, normalisation and a medical physical examination. It can in that context be very reassuring.
33. A preparatory stage before therapy proper is needed. There should	And then once that's been done, I don't think there should be any opening up in that first session, unless person's

Essential themes	Natural meaning units (NMU's)
not be any opening up in first session, unless the ex-detainee is eager to talk. Catheresis in the first encounter should not be forced. Things should be left, kept open in the first session with the therapist only stating what the issues are and summing up the situation as therapist sees it for ex-detainee and invite ex-detainee to come a second time to discuss them. Ex-detainee who are specifically referred for counselling are more receptive than those who've not been readied for it.	bubbling over to talk. Otherwise it should be left there and should be kept open with stating the issues and they should be summed up, that these are the issues that have come up so now would you like to come and see us some more. So you're beginning to feel that people are needing to be prepared for therapy, some preparatory. Yes some preparatory stage is needed. Someone who's specifically referred for counseling is better to deal with than some who just come to be helped for the first time.
34. Ex-detainees vary, some are sophisticated and immediately suited to therapy. Those who aren't need context, method and basic framework explained to them first.	Of course people are very different. Some can be very sophisticated they're at different levels, some an fait with psychotherapy. But there are also people who need to have the context and the method explained and the basic framework explained. It's important to say "...This can take a while it's a talking kind of therapy".

Essential themes	Natural meaning units (NMU's)
35. Therapy with an ex-detainee is not predictable. Explain this to ex-detainee and agree to try and finish. It's a one off session and its repetitive if possible at a deeper level each time. You have a beginning, middle and an ending, you say good-bye at the end of each session.	With an ordinary person I know I'll see them again unlike with an ex-detainee. Perhaps it would be useful to say although it would be best to see them again and try to get done in this particular session. I think Jill Straker put it very well. It's a one off session and its repetitive if possible at a deeper level each time. You have a beginning, middle and an ending you say good-bye at the end of each session.
36. Procedure is eliciting symptoms common to detainees and inform ex-detainee that their responses are typical which may be considered intrusive but I do it. Must first understand the context from which ex-detainee comes from, which a reasonable history before therapist can start treatment. Without a proper assessment therapist may not get the presenting problem clearly or the	My session is that one session is to elicit symptoms that are common and seen. I actually say these are typical responses to people who have been through similar experiences. That's what I've done I might be intrusive and wrong and off beam. That might be making people feeling, like that woman, that it's too much. I must say my training which any therapy patient is that if I don't understand the context from which they come with a reasonable history. I don't believe that I start treatment. But I must say it's my personal belief: of my training. You don't start therapy until you've done a proper assessment

Essential themes	Natural meaning units (NMU's)
issues which affect the ex-detainee most. Associated problems secondary problems to the detention may be experienced as more distressful than the detention itself.	which I think is valid; when you think about it, you might think the problem is the detention mean while the problem is that the patient's sister died before she was detained and she's never mourned, you'll miss the boat or that the guy's lost his job and that's his predominant worry.
37. Support, reassurance, eliciting symptoms and normalisation are heavily relied on. This provides relief giving information and putting symptoms into context (perspective). This forthright approach may be experienced as intrusive to some ex-detainees and can be anti-rapport building.	I tend to rely heavily on support, reassurance eliciting, symptoms and normalisation. The advantage of that is it gives information, reassures and puts their symptoms and problems into context. The disadvantage is that it can be intrusive and seem like too much. It can open too many things and not deal with any of them. It also might be anti rapport building.
38. Above approach was adopted 2 years ago: not enough was known about the symptom picture and background ex-detainee came from.	The objective to do the above is ... When we started working with detainees 2 years ago we did not know enough about what happens to them. My brief was to find out what the symptom picture and background that detainees came from.
39. Therapists now context	Now the focus is how best can we help

Essential themes	Natural meaning units (NMU's)
better and focus on how best to help.	people like this. About 50% of them were beaten but not all. I mostly saw people who'd been released after the first state of emergency was called off.

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TABLE 1

The Effect of Stressor Events on Core Personality Processes : Personological Variables in PTSD

Core Personality Processes: Dimension and Theorist	Dimension of Personality Affected by Stressor Event	PTSD Symptom Related to Personality Process	DSM-III Criteria
Stages of Psych-social Development (Erikson, 1982)	1) Stage-specific impact on psychosocial development 2) Age-related influences on emergent ego strengths and integrative capacities	Mistrust, isolation, time confusion, identity diffusion, loss of intimacy, decreased autonomy, loss of industry, death anxiety, despair, loss of meaning, ideological changes	Numbing, changes in adaptive behaviour
Psychoformative Processes (Lifton, 1983)	1) Decentering and ungrounding of self-structure in modes of psychological experience	Psychic numbing, survivor guilt, rage, depression, loss of continuity in self-structure, symbolic death, search for meaning, denial, loss of intimacy, death guilt	Re-experience, numbing, changes in adaptive behaviour
Learned Helplessness (Seligman & Garber, 1980)	1) Cognitive: External focus of attribution for causality 2) Motivational: Loss of response initiative; loss of goal-directed behaviour	Depression, helplessness, intense anxiety, somatic processes, withdrawal, isolation, despair, negative view of world, fear of repetition	Re-experience, numbing, changes in adaptive behaviour
Cognitive Processing of Trauma (Horowitz, 1979)	1) Entire self-structure; cognitive process of assimiliating trauma into self	Avoidance, denial, dissociation, anxiety, nightmares, intrusive imagery, cognitive constriction, somatic complaints, fear of repetition, rage at source	Re-experience, numbing, changes in adaptive behaviour