Psychotherapy for post-traumatic stress disorder in a young rape survivor: A case study

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This paper describes the psychodynamic psychotherapy of a 20-year-old African woman with post-traumatic stress disorder (PTSD). ‘Mphumi’ entered therapy a year after her father’s friend had repeatedly raped her. The paper documents the process of therapy and uses the case material to examine theoretical issues relevant to the treatment of PTSD. First, Horowitz’s (2001) theory is used as a basis for arguing that a histrionic personality style predisposed her to an extreme degree of denial and dissociation, which prevented her from processing the trauma at a cognitive or emotional level and contributed to the entrenched PTSD. It was only after she had suffered a breakdown, which necessitated hospitalisation, that her resistance to processing the trauma was overcome. Second, the case material is used to show how other significantly disturbing events earlier in her life shaped her response to the rape and to examine the extent to which effective processing of the current trauma calls for the acknowledgement and working through of earlier traumas and losses. Finally, the case narrative shows how the treatment of PTSD is of necessity a slow, complex process which takes into account the individual’s unique history, idiosyncratic vulnerabilities and socio-cultural context.

Keywords: post-traumatic stress disorder, psychodynamic psychotherapy, rape, South Africa

Introduction

This paper reviews a case of post-traumatic stress disorder in a 20-year-old rape survivor whom I call Mphumi. She was referred for treatment when she manifested severe post-traumatic stress symptoms a year after she had been raped by her father’s friend. Her case demonstrates the devastating impact of trauma on the psyche, and the complexity of traumatic symptoms, which are extremely difficult to undo. It is argued that a complex interplay of external and internal factors structured Mphumi’s response to the trauma and that her response to the impact of the rape cannot be understood or treated theoretically, independently of an understanding of her unique history, idiosyncratic vulnerabilities, and socio-cultural context.

Review of theoretical understandings of trauma relevant to Mphumi’s case

Garland (1998, p.11) defines a traumatic event as:
one which, for a particular individual, breaks through or overrides the discriminatory, filtering process, and overrides any temporary denial or patch-up of the damage. The mind is flooded with a kind and degree of stimulation that is far more than it can make sense of or manage. Something very violent feels as though it has happened internally, and this mirrors the violence that is felt to have happened, or indeed has actually happened in the external world.

In other words, a traumatic event such as a rape ruptures the psychic skin of the traumatised individual and evokes a sense of inner fragmentation and disorganisation (Garland 1998; Herman 1992; Janoff-Bulman 1992). Though there may be marked differences between individuals as to what experiences constitute a ‘traumatic event’, when a trauma has occurred the type and degree of stimulation that the mind must accommodate is unbearable and unthinkable. Janoff-Bulman (1992) speaks of trauma as rupturing our basic assumptions about the benevolence and meaningfulness of the world. Our sense that the world is relatively safe, predictable and controllable is shattered. A shattering of the assumptions of the self-worth, integrity and relative invulnerability of the individual is often associated with the loss of safety and predictability. The resultant anxiety, confusion, helplessness and despair are intense, and are the subject of a vast literature on post-traumatic stress.

Herman (1992, p. 35) describes how the many symptoms of post-traumatic stress disorder can be grouped under three main categories: hyperarousal, intrusion and constriction. She argues that:

hyperarousal reflects the persistent expectation of danger; intrusion reflects the indelible imprint of the traumatic moment; constriction reflects the numbing response of surrender.

Traumatic memory is lived in the present as a frozen moment that cannot be put behind one. For the most part memory is malleable and subject to constant reworking and recategorisation (Van der Kolk and Van der Hart 1995, p. 170). New information is organised and processed in relation to prior cognitive schemata. However, trauma overrides the mechanisms that exist for filtering and organising.
information. The intense anxiety, fear, rage and horror cannot be accommodated in terms of existing assumptions or beliefs about the world (Janoff-Bulman 1992).

It is hypothesised that severe and prolonged stress has implications for neurological functioning. Myelination of the hippocampus allows memories to be localised in time and place. Stress can suppress hippocampal functioning, meaning that memories of the trauma are not localised in space and time. Instead trauma is remembered at a somatosensory level, where the emotional and bodily sensations remain etched in memory. The mechanism for accommodating these memories into symbolic, linguistic representations is disrupted (Van der Kolk and Van der Hart, 1995).

It follows then that recovery from trauma always entails a process of remembering and mourning (Garland 1998; Herman 1992; Horowitz 2001). The frozen, dissociated memories of the trauma must be reworked in symbolic, linguistic form into a narratised account of what happened. Horowitz (2001) draws on psychodynamically informed theories of bereavement, as well as contemporary cognitive-behavioural theories of PTSD to explain the complex trajectory of recovery from trauma. He argues that when individuals are first faced with trauma the initial apprehension that something traumatic has occurred produces a phase of outcry. During this initial phase there is heightened experience and expression of raw emotion, as well as a number of physiological changes in the sympathetic, parasympathetic, histaminic and immunological systems. This may result in stunned shock or hyperarousal. Importantly too, in the phase of outcry, initial appraisals of the trauma emerge. These are often unconscious, and are overdetermined by heightened emotionality and physiological arousal associated with trauma or loss.

Trauma can only be processed and accommodated slowly. Horowitz (2001) suggests that for a period lasting anything from a few days to several months following the trauma, people mobilise a range of conscious and unconscious defences to avoid or reduce the emotional suffering associated with the trauma. If it is not unduly prolonged this phase of denial is adaptive and functional, in that it allows time to restore a rudimentary sense of safety. However there is an in-built psychological need to process and accommodate the trauma. Eventually, traumatic memories actively break into consciousness in the form of flashbacks, intrusive thoughts or nightmares. There is often a conflict between the impulse to suppress the traumatic memory and the need to complete the processing of the trauma. Thus the individual oscillates between avoidance and intrusion. If all goes well, the individual relies less on repression as an unconscious defence against pain. The intrusive memories can be worked through and accommodated. However, failure to process trauma leads to persistent post-traumatic disorder, characterised by a continued oscillation between denial and intrusion. This pattern will be evident in the discussion of Mphumi’s case. Mphumi’s use of defences was extreme and maladaptive in the sense that they compounded her suffering and prevented her from processing the trauma.

Horowitz (2001) argues that the defensive manoeuvres which are used to counter intrusion and painful emotions will differ according to personality style. Characteristic defensive strategies can be mapped onto DSM IV categories of personality disorder. Thus individuals with strong obsessive traits will deploy strategies of switching to alternative themes to avoid the intrusion of painful emotion. Those with narcissistic tendencies will slide meanings to maintain grandiose self-concepts. And those, like Mphumi, with strong histrionic traits rely primarily on inhibition to defend against unwanted thoughts and feelings. Histrionic individuals commonly use five cognitive manoeuvres to counter intrusion: they provide a global, impressionistic account of the traumatic event which lacks factual detail; they avoid translation from sensory-motor apprehension of the trauma to symbolic, linguistic representation of the event; they try to avoid triggers associated with the trauma; they avoid conscious, active problem solving; finally they may alter states of consciousness, or blur fantasy and reality, or dissociate in order to avoid pain or conflict, and in order to alter their sense of self as initiator of thought or action. Thus, as will become clear in the case discussion, Mphumi, because of her specific personality style, was particularly at risk for prolonged and entrenched PTSD.

Contemporary psychoanalytic accounts of trauma emphasise that trauma activates, with renewed vigour, the individual’s own mental representations of cruelty, sadism, and rejection. Garland (1998, p.11) argues that:

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

This leaves the person vulnerable to attacks from within, and to a resurgence of earlier unresolved traumas. In the course of therapy, early traumata were uncovered which impacted profoundly on Mphumi’s response to the current rape. It is argued that only by understanding the fusion of past and present traumas was it possible to comprehend and resolve Mphumi’s post-traumatic stress responses.

Research method

Mphumi, a 20-year-old student, was referred to the author for psychotherapy following a series of rapes. She met the criteria for post-traumatic stress disorder and was seen for 24 psychotherapy sessions between March and November in a single year. The therapy was prematurely terminated when her year of study in Grahamstown came to an end and she returned home again. She gave permission for the case material to be used for this case study, but certain features of the identifying data (including her name) have been changed in order to protect her identity. A case-based methodology was employed in which the chronological sequence of the case material was summarised in the form of process notes and reflected on by the author. Out of this, and in interaction with the literature reviewed above, several important themes emerged that provided a basis for understanding the case material in psychodynamic terms. These themes have been used to structure the presentation below in the form of a narrative and interpretative commentary.
Clinical method

Garland (1998, p.29) points out that a theoretical framework provides containment for the therapist working with trauma in that it helps to organise and make sense of the flood of information offered by the patient. This in turn enables the therapist to provide a safe, containing environment in which the patient can (re)construct her own meaningful accounts of the trauma she has suffered. This author works within a psychodynamic framework, which heightens awareness of how current pain and stress resonates with earlier unresolved trauma. Thus rather than focussing on symptom alleviation, the therapy concentrated on providing a safe, containing relationship in which the meanings and unconscious resonances of the symptoms could be explored, interpreted and worked through.

Interpretive psychodynamic therapy, which is rooted in a Western tradition, poses specific challenges in cross-cultural therapy. Mphumi comes from a traditional, rural, African family. In the course of therapy she made several references to bewitchment. Like many other Western acculturated African people, Mphumi holds ‘hybridised explanatory systems which allow for the incorporation of both Western and traditional African premises’ (Eagle 2004, p.2). Thus it is unsurprising that her attempts to make sense of her painful experiences of trauma drew to some extent on traditional African understandings of the origins of misfortune. In traditional African cosmology there is little credence given to the notion that bad things happen by chance. There is always a search for causality. The idea that some malevolent person wishes ill on another person, and seeks, by means of witchcraft, to injure or exterminate that person is a commonly held explanation for the occurrence of misfortune (Eagle 2004).

Mphumi vacillated between espousing these beliefs herself, and attributing them to her family. Eagle (2004) points out that is not uncommon in the aftermath of trauma to draw on religious or spiritual belief systems which have been abandoned to make sense of the traumatic event. Moreover, in the wake of trauma the victim frequently frames events in more reductionist, literal terms than she might do in a non-traumatised state. Thus, whilst recognising the complexity and integrity of metaphysical belief systems, it is important that the psychotherapist treats the patient’s references to religious, spiritual or cultural beliefs as a communication about the patient’s own psychic life. There is a long tradition within psychoanalytic thought of understanding religion as ‘an outgrowth into adult life of the child’s relations to his parents’ (Brenner 1982, p.240).

Kinzie (2001, p.265) points out that the therapist working in the cross-cultural setting needs to be flexible and sensitive to the patient’s culture. He suggests that the patient’s expectations and goals need to be openly negotiated. In her work with Mphumi this author found it helpful to ‘negotiate’ meanings attributed to the trauma. Thus the cultural explanations of witchcraft were acknowledged, but Mphumi was encouraged to think about how her use of the word ‘witch’ was associated with strong feelings of powerlessness, helplessness and rage. In this paper Mphumi’s references to witches and witchcraft are treated as a symptomatic, metaphoric expression of a particular type of mental representation of her relationship with her mother and maternal figures. A fuller examination of the intersection of psychoanalytic thought and specific cultural beliefs is beyond the scope of this article.

The crime in question, like many rapes in South Africa, was not reported to the police. It did not seem likely that it would have been productive to encourage Mphumi to do so. It was over a year since she had been raped and there would have been no forensic evidence to support a charge. This would have weakened the chances of a successful prosecution. It would have taken a high level of commitment on Mphumi’s part to follow through on the lengthy process of laying charges and bringing the perpetrator to court. The practical difficulties of distance were one barrier which would have had to be negotiated, since she was studying in a province over 1 000km from where the rapes took place, and her family home was in yet another province which was also far from where the abuse occurred. More importantly Mphumi expressed no interest in pursuing criminal charges. Given the fact that the South African Police Services and Criminal Justice System provide at best patchy support for rape survivors, and Mphumi’s extreme vulnerability and tendency to avoid speaking of the rape, the idea of pressing criminal charges was not pursued in therapy.

Mphumi’s story: Narrative and commentary

The rape and its aftermath

When she was 19 years old, Mphumi travelled to Gauteng to seek work. Her parents had arranged for her to board with a man, whom her father had known in his youth. Things went awfully wrong. Instead of providing a safe base from which she could venture out to seek work, her father’s friend abused her physically, emotionally and sexually over a period of three months. He locked her into the flat, and withheld food from her. He would wake her up at night for no reason. He demanded that she do his laundry, no matter what time of the day or night. When she washed his clothes, he screamed that his clothes weren’t properly clean and demanded that she wash them again. He also raped her three times.

The rapes were forceful and humiliating. She was scared that she had contracted HIV, and was worried about the risk of pregnancy. She felt as though she had been damaged inside. The final rape was particularly terrifying. She had locked herself into her room to avoid his advances. He kicked the door down, pinned her to the bed, and raped her violently. She was left bruised and aching and unable to urinate. Soon after this she borrowed money from an acquaintance and travelled home to Limpopo. She never told anyone that she had been raped. For the next five months she sat at home feeling angry and hopeless. She felt that her future was ruined and that nothing mattered anymore. She fought with her parents and siblings and began drinking heavily. She was finally persuaded by a friend to join a very patriarchal, conservative church and managed, through church connections, to procure funding to study in Grahamstown the year after she had been raped.

A year after she had been raped, when she was settling into her studies in Grahamstown she began to experience severe symptoms:
• agitation and lack of concentration
• somatic symptoms: a bad headache, an aching back and a sore stomach, feeling that her whole body was aching and sore
• anger and irritability
• anxiety and panic when she was alone, particularly at night
• terrifying flashbacks during which she relived the experience of her rapist trying to get into her room, or felt his weight on top of her
• inability to sleep
• frightening dreams that people were laughing at her and ridiculing her
• distressing feelings of alienation which she expressed in the words: ‘this is not me, I am not myself’

She disclosed to a woman tutor and a close female friend that she had been raped the previous year and was referred for therapy.

The initial stage of therapy

By the time Mphumi came for therapy she was in the grip of a massive breakdown. The trauma of the rape had completely overwhelmed her (fragile) coping mechanisms. For the first two weeks of therapy, Mphumi slumped in the chair and pressed her hands to her eyes. It looked as if she was trying not to cry, but also as if she could not bear to look at what had happened to her. She provided scanty details of her stay in Gauteng. She could not talk about the rape or abuse. When she was questioned gently about the rape, she would gasp, as if someone had hit her in the stomach, cry out in pain, slump even further in her chair, and roll her eyes back. The author found herself thinking that it looked as if she was dead. As her therapist, the author felt helpless, perplexed and irritated. It was difficult to know how to respond: would it be helpful to be ‘strict’ with her, to pin her down to facts? It was very difficult to understand what had happened, as she couldn’t provide even the barest outline of her story.

Nothing made sense, nothing fitted. Everything was a jumble of vague bodily symptoms. She spoke of an aching back, of pains in her stomach, of feeling as though she was dying. The sessions consisted of fragments of stories. Sometimes she spoke vaguely about being the ‘one who always suffered in her family’. She often mentioned that she felt ‘worthless and isolated’. When the author tried to clarify what she meant, she would provide a stream of associations and memories: of being sick as a child and nearly dying, of not being allowed to go on school trips, of having all the responsibility at home. But she could not be held to any details or dates. There was no narrative or context in which to anchor an understanding of what had happened to her.

It was striking how contradictory and fickle her sense of self seemed. She would describe herself as: ‘a good Christian… a holy person… a helpful daughter… a role model to her younger siblings’. In the next breath she would slip into some flight of fantasy: wishing that she could be an actress or a singer, or a character from one of the local soapies. She didn’t feel real. It seemed as if there was no inner core that could contain her or process what had happened to her. Two friends, who walked on either side of her literally propping her up as she walked, usually brought her to the sessions. She could not make use of therapy. Nor was she helped by the medication prescribed by the general practitioner.

The only time Mphumi spoke clearly during the early sessions was when she said that she wanted to leave the church. She would sit up in her chair, her face would come alive and she would say very angrily: ‘I don’t want to be in this church, I can’t be myself in this church. But she could not engage in any exploration of how she might leave, or why she had joined in the first place. She spoke as though something outside her control was keeping her in the church against her will. She had no sense that she had any choice as to whether to stay or leave. It seemed as though the power and responsibility to make such choices lay completely beyond her reach.

In the third week of treatment, Mphumi had to be hospitalised. She had come to her session on her own and had been able to speak fairly coherently about wanting to leave the rigid, conservative church to which she belonged. Instead of slumping in her chair as she had done the previous weeks she moved around agitatedly. She spoke angrily about how she found the church restricting and stifling. For the first time she allowed some exploration of how she could leave the church. She seemed to acknowledge that she had choices and the power to make decisions. It seemed as though the numbing and constriction, which had characterised the first two weeks of the therapeutic process was abating and some real work might be possible. However, after the session Mphumi went home and locked herself in her room. She was found by a friend several hours later cowering in the corner saying, ‘close the door, he’s trying to get in.’ She had no memory of having come for her session that morning. She was disoriented and incoherent. She was sedated by a doctor and admitted to hospital.

Mphumi remained in hospital for two weeks during which time she received a lot of support and nurturance from the staff and from friends. For the first time her mother was informed that she had been raped. She relied a lot on the nurses and social worker to talk to others and to intercede on her behalf. The nurses informed her church about her hospitalisation, and made the fact that she had been raped known to the church authorities. She left the church, and her tutor organised alternative funding for her studies. It was only after her discharge from hospital that she was able to begin to engage in the therapy process, and to slowly piece together the basic narrative of the rape, which is described above.

Overcoming avoidance

Mphumi recalled how she had been overcome by shock and disbelief when the rapes occurred. Her body was bruised and sore. From her descriptions it is clear that she experienced profound dissociative symptoms in the course of the three months during which the rape occurred. Brewin and Holmes (2003, p. 234) define dissociation as ‘any kind of temporary breakdown in what we think of as the relatively continuous, interrelated processes of perceiving the world around us, remembering the past, or having a single identity that links our past with the future.’ Mphumi felt intensely helpless, frightened and ashamed. She coped by numbing herself. She manifested symptoms of derealisation and
depersonalisation. She remembers thinking: 'This isn't happening to me... I cannot believe that I am a rape victim.' This discontinuity in identity made it difficult for her to process the fact of the trauma, or to take action to prevent further injury or damage. It was only after the third rape and three months of severe abuse, that she was able to mobilise the resources to escape from the situation. Peri-traumatic dissociation of this kind is a strong predictor of later PTSD (Brewin and Holmes 2003, p. 234).

The emotional numbing continued once Mphumi returned home and the immediate danger had passed. She elected not to tell anyone that she had been raped. She had been concerned that she was perhaps to blame for the sexual assault, and even suggested in therapy that perhaps she had been raped because she had dressed in revealing mini-skirts. She was certain that she would be reproached and reviled by her family and community. She felt that her only option was to try to forget about the rape and get on with life. Unable to manage the myriad of intense emotions evoked by the rape: rage, loss, and hopelessness, she pretended to be fine, and to be having a good time. She went out a lot with friends at night, and turned to alcohol to numb herself. Ultimately, these strategies provided no relief. Her description of the months that followed the abuse indicates that she was oscillating between avoidance and intrusion of the trauma (Horowitz 2001). Whilst she tried to suppress the trauma in order to protect herself from psychic pain, the intense unresolved feelings associated with the rape kept intruding. Her attempts at suppression thus became more and more extreme.

Her decision to join the church after five months of sitting at home was the most symptomatic enactment of her defensive avoidance of mourning and working through. She joined the church after attending an all night meeting during which time she felt herself to have been saved. Mphumi's belief that she could be saved from her traumatic past without the immense psychological work of remembering, mourning and working through, reflects her wish for a magical resolution of her difficulties. It also demonstrates her tendency to avoid active problem solving. Having side-stepped the real work of recovery, she assumed a pious, sober persona. She began to dress modestly and conservatively, and adopted an altogether abstemious lifestyle. In so doing she could defend against her (distorted) belief that she was to blame for the rape. She felt and behaved as though her entire sexual history, including the fact that she had been raped, was erased. She perceived herself to be virginal and sexually naïve. She even went so far in one of the early therapy conversations as to disavow knowledge of female anatomy and reproductive functioning. At a later point during therapy it was suggested to her that she had not really wanted to be religiously saved as much as she had wanted to be a virgin again.

When she came to study in Grahamstown the intrusive memories of the rape broke through her defensive armature. In Grahamstown she found herself back in a situation in which she had been happiest and most confident in her life – at school with friends. She is an attractive, bubbly, fun-loving person, who is particularly popular with male peers. The pious, abstemious, virginal persona she had constructed when she joined the church felt unbearably restrictive. To put it bluntly, it got in the way of her enjoying herself. Moreover in the course of her studies she was faced with several cues that threatened her defence system – there was a lot of publicity about rape and violence against women on campus. It is unsurprising therefore that she began to experience flashbacks and nightmares when the defensive persona was not as useful and desirable as it had been before, and when there were several triggers for the traumatic memory.

When Mphumi began to acknowledge the fact that she had been raped, her coping mechanisms were overwhelmed. She was unable to fall asleep at night for fear that terrifying nightmares would plague her. She was agitated and hyper-vigilant. Her constrictive symptoms made it impossible for her to use therapy productively. She could not look at what had happened to her, she didn’t want to think about it or talk about it. Paradoxically her symptomatic behaviour in the therapy room revealed more than it concealed. It spoke of her sense of hopelessness and ruin. The past was unbearable, the present intolerable and the future felt as if it was spoiled.

There is evidence that Mphumi has strong Histrionic Personality traits. Although it is arguable that certain dimensions of her behaviour, such as her tendency to somatise, may be strongly culturally influenced, her ways of dealing with traumatic stress were consonant with the descriptions of a histrionic style provided by Horowitz (2001). Typically, people who have histrionic traits are attention seeking. They may demand that others look after them or they may use charm, vivacity, sex appeal or childlike behaviour to draw attention to themselves. They experience very fluid and intense emotions, and there may be an inconsistency of apparent attitudes. Their interpersonal relationships are often repetitive, stereotypical and impulsive and are characterised by aggressor-victim themes, and dramatic ‘card-board’ fantasies of self and other (Horowitz, 2001, p.215). They typically use inhibition to avoid the processing of trauma. Mphumi’s account of the trauma was impressionistic and lacked factual detail. She avoided talking about the rape in words, relying instead on bodily symptoms and postures to communicate her intense distress. There were strong elements of attention seeking in her behaviour. All her friends on campus knew something was wrong, but few had any clear idea of what it was. Similarly, her behaviour at home before she came to Grahamstown was impulsive and attention seeking. Her decision to join the church was also impulsive; and the fervour with which she threw herself into the role of devoted Christian, was, to say the least, dramatic.

The superficiality of her relationships with others meant that she was deprived of the kind of emotional support that would enable her to recover from the trauma. Her impressionistic/associative style of thought made her particularly sensitive to reminders that triggered the intrusive memory of the rape. Crucially, however, it was the conflict about whether to stay in the church or leave which precipitated the onset of severe symptoms. This crisis evoked trapped, angry feelings, which were reminiscent of her feelings during and after the rape. The desire to leave the church also challenged her typical cognitive and behavioural manoeuvres that kept her denial in place. She could no longer avoid problem solving thought, or remove herself as an initiator of
action. She had reached an impasse. Either she could drop her defences in order to work through the trauma, or she could (unconsciously) redouble her efforts to avoid processing the trauma.

In the third therapy session she began to think in a coherent, problem solving fashion about how to resolve her dilemma about leaving the church. It seemed as though she may have been ready to engage in therapeutic work. In reality she was not ready. She was so overwhelmed and incapacitated by the trauma that she retreated into massive dissociation, and had to be hospitalised. Mphumi resolved the church crisis in the only way that she knew how at the time: by getting sick and by getting others to do the work for her. However, once she had left the church, and the secret of the rape had been revealed, she was able to build a therapeutic alliance with the author. She began to take small steps that indicated that she accepted some responsibility for her healing. For example, after she was challenged on the fact that she had not taken an interest in what medication had been prescribed for her, she brought the packet and insert to therapy and we spoke about anti-depressants and how they work. She slowly began to take more responsibility for sharing information in therapy. She became more actively involved in the process of what she termed ‘getting over the rape’.

It took five sessions for Mphumi to piece together the basic narrative of the abuse she suffered in Gauteng. She had to overcome her avoidance in order to provide clear factual details of what had happened. In session eight she managed to tell the whole story coherently, without undue emotion, and without a retreat into bodily symptoms. She was able to say: ‘I can think about the rape because I am still alive… I can go on with my life.’ She felt more able to face the unbearable past, and she believed that the future held some hope. After this, some of the presenting PTSD symptoms abated. She was less hyper-vigilant and slept better. However for several months she remained vulnerable to intrusive memories and flashbacks.

**Linking the present and past**
The mere recounting of the story, though significant in the overall therapy process, was not sufficient to enable Mphumi to overcome the trauma. The treatment of traumatic conditions is a slow process of careful reconstruction of what the particular traumatic event, or aspects of thereof, mean for the particular individual. In the latter half of the year the focus of therapy shifted away from overcoming the avoidance of intrusive memory, towards piecing together a fuller story of the rape and its meaning. Slowly, a rudimentary understanding of how this rape fused with past trauma and unresolved developmental conflicts emerged.

The rape evoked strong anxieties about the extent to which Mphumi felt loved and valued by her parents, and about their capacity to protect her from harm. One of the hardest things she had to do in being able to reconstruct the story of her rape was to acknowledge how angry she was with her parents, who had gravely misjudged the character of her rapist. They had trusted him, and had arranged for her to stay with him. In reality their grave misjudgement of his character had a part to play in the fact that she was raped. As she struggled to tell her story of how she had travelled to Gauteng from Limpopo to earn money to help her mother support her five younger siblings, an image formed in the author’s mind that in effect her parents had sent her into sex slavery.

Lindy, Wilson and Friedman (2001) point out that the task of monitoring the counter-transference is central to a psychodynamic treatment approach. The author’s image of the cruel, exploitative parents who sent Mphumi into sex slavery was a response to her unconscious communication of her mental representation of harsh rejecting parental objects. Bion reminds us that the baby experiences the absence of the breast not as an absence, but rather as a malevolent presence of ‘no breast’, a tormenting, bad object which is invested with the baby’s own frustration and rage (Symington and Symington 1996, p. 82). The failure of Mphumi’s parents, particularly her mother, to protect her from trauma, was unconsciously experienced not as a limitation or omission, but rather as the presence of a harsh, rejecting maternal object, a ‘witch’, to use Mphumi’s own word.

Of course Mphumi didn’t only travel to Gauteng to help her mother. She had her own hopes of a bright future away from the constraints of her family who in her words ‘prevent me from doing what I want’. Her struggles around self-assertion and separation were implicated in the relationship with the ‘witch’ mother. She believed that she could only please her mother, and earn her love and respect by being a good, dutiful daughter who was a role model to her younger siblings. But equally, she resented this injunction to be a ‘good girl’, and she envied her siblings. She often complained that they were allowed to do what they wanted and only she amongst them was constrained. She felt that she was the only sibling condemned to suffering. This was a frequent theme in therapy sessions. She felt burdened and subjugated. She was sure that every expression of who she was and what she wanted would be met with harsh disapproval and rejection. She frequently used the expression ‘my mother would kill me’ when she spoke about her idea of having fun with her peers. This was balanced by a story, which was often repeated in the course of therapy, about a time when she was planning to go on a school trip and her father stopped her from going at the last moment because he was afraid she would be killed. The anxiety about separating from her parents was infused with anxiety about her own death.

There is an element of truth in Mphumi’s perception that she was valued for being ‘a good girl’, and that her freedom to do what she wanted to do was curtailed. She is the second born of six siblings from a working class rural family. She has an older brother who is the much-prized first-born son, whom the family welcomed with a name that means ‘The Prince is here.’ Her next sibling, a sister, was born when she was three years old. The next three siblings, a girl and two boys were born within the following six years. The marriage between her parents was not stable. It is not difficult to imagine that her mother was often overburdened and unavailable. One can surmise that Mphumi must have felt angry and jealous at the arrival of the younger siblings, and that her own opportunity for getting infantile needs met, was curtailed early on. One can imagine too that her family would not have condoned her expression of jealous rage.
It is worth noting that modesty and hard work are highly prized virtues in women within traditional rural families. Mphumi may well have been valued for being helpful around the house from a very young age. There is evidence from her adolescence that as the oldest girl she had a lot of responsibilities around the house. Mphumi’s mother relied on her to take care of her younger siblings at the height of the marital conflict between the parents. Moreover her mother leant heavily on her for emotional support in relation to her marital difficulties.

Thus a basic structural vulnerability in the self, caused in part by maternal unavailability and struggles around self-assertion, was suggested by Mphumi’s history. The deep tragedy of her life is that this basic vulnerability was overdetermined by profound trauma before the age of five. In those chaotic first weeks of therapy, before she had been hospitalised, Mphumi spoke of having been sent together with a cousin to visit an aunt in Gauteng. Shortly after she returned from her stay she became desperately ill and had to be hospitalised. She described the incident as follows: ‘I wanted my mother… I wanted a glass of water… the nurses pulled me away… I nearly died.’ The first time she told the story she said with absolute conviction that the aunt who ‘was cruel and had even killed another cousin’ had bewitched her. She retold the story of her illness some months later. There was a different quality in this retelling. She spoke more objectively, with less somatic enactment. She acknowledged that her family had not known what had been wrong with her. They believed that she had been bewitched. In the grip of trauma internal and external realities coincided. It must have felt as though the mental representation of the hateful, rejecting object had found a counterpart in real life: a malevolent, cruel witch who had snatched the young Mphumi from her loving parents and nearly killed her.

About a month before therapy ended Mphumi recovered a memory, or perhaps more correctly, acknowledged a memory of having been sexually abused by a family member when she was very young. She knew that this man had also abused a cousin. She remembered having told her mother about the abuse. She knew that the matter had been discussed by the extended family and that the relative had been banished from the house. However, the incident was not discussed further. Her family encouraged her to ‘forget about it.’ As we pieced the story together it became clear that the sexual abuse happened when she was about four years old, and the visit to Gauteng must have taken place within months of the assault. It is the author’s belief that the two traumatic events, the early sexual abuse and the frightening illness, have become deeply associated with each other, and indeed have become inseparable in her memory.

The similarities between the current rape and earlier traumas are striking. Both are associated in Mphumi’s mind with being ‘sent away’ by her parents to Gauteng. Her descriptions of her physical symptoms at the time of the illness echo her descriptions of the physical effects of the rape: ‘my stomach was swollen…I couldn’t go to the toilet…my body was aching.’ When Mphumi sat in the therapy chair rolling her eyes, I think that she was communicating to me in very concrete terms her sense of what Robert Jay Lifton refers to as the ‘death imprint’ (Lifton 1983 p.169). Mphumi really felt as though she was dying. The later rape and the earlier traumata activated very powerful anxieties about annihilation and death.

Given her poor capacity for symbolisation, and the fluidity and intensity of her emotions, it is little wonder that Mphumi was terrified to face the memories. Her over-reliance on avoidance and denial can be explained by the fact that she was trying to keep the memories of both the later rape and the earlier trauma at bay. Mphumi learnt to deny psychic pain early on in her life. Her family’s injunction to forget about the sexual abuse, and the mystifying explanation of witchcraft meant that neither the sexual abuse nor the illness had been processed. She believed that problems could only be managed by denial. She expressed her distress by way of somatisation and by impulsive acting out behaviour. These defences in themselves smothered something vital inside her. Her defensive armoury thwarted her true self (Winnicott 1971 p.7).

In the light of this discussion it is perhaps unsurprising that two particular images constitute the main flashbacks that Mphumi experienced at the height of her symptomatic presentation. The first flashback was the feeling of being pinned down by the weight of the rapist’s body. Although she could recall very little of her childhood sexual abuse, Mphumi did remember being crushed on the bed under her abuser. The traumatic moment of terror and helplessness, which was common to both the current rape and the early abuse, was replayed again and again as an intrusive flashback. However, I think that this flashback also had a metaphorical resonance which goes beyond memories of the traumas themselves. It is possible that the weight of the body on top of her symbolises her feelings of being pinned down and thwarted, and the image of herself screaming and flailing underneath resonates with her own flailing attempts at self-assertion.

Similarly, the second flashback of the rapist trying to get in at the door reflects real memories and is also replete with metaphorical associations. As described above, Mphumi’s rapist kicked down a locked door when he raped her the third time. Similarly the early childhood abuse took place behind a closed door while the rest of the family were outside. But the need to keep the door shut suggests her attempts to keep the door firmly closed on terrifying memories and feelings which were threatening to spill out and destroy her. Mphumi divulged that when she was angry with her parents, she usually locked herself in her room. Her diffuse sense of identity and fluid emotionality meant that she struggled to distinguish who was angry with whom. Thus when she felt angry it felt to her as though her parents were angry with her. She could only protect herself from the destructive power of rage by locking the door. It is not coincidental that after the third therapy session when she had asserted herself and expressed her wishes to be free of the stifling compliance demanded by the church, she was attacked, from within, so to speak, by the hugely punishing flashback of the rapist trying to get into her room.

Mphumi’s retreat into madness was not only an avoidant manoeuvre. It was also a spontaneous gesture towards healing. It was only when she became ill, when her defences
crumbled, that she was able to begin reconnecting with her vulnerability. The care and support she received from other people enabled her to reconnect with good internal objects. Only then was she sufficiently contained to engage in therapy and to begin to think about the horror of the rape without feeling that it would destroy her. As Mphumi prepared to go home for the mid-year break, she commented ‘the wounds are still there, but I’m looking forward to seeing my mother.’ In the following session after a fight with a friend which left her angry and humiliated she reported that she had been able to calm herself by writing down: ‘my mother loves me… my mother is proud of me’. The containing internal mother who had been banished by the cruel ‘witch’ object could be more easily accessed. Some solace and healing was possible.

Conclusion

Judith Herman (1992, p. 155) proposes that recovery from trauma unfolds in a series of interlocking stages. The first stage is the establishment of safety, the second is the stage of remembrance and mourning, and the final stage involves reconnection. Herman warns that:

like any abstract concept, these stages of recovery are a convenient fiction, not to be taken too literally. They are an attempt to impose simplicity and order upon a process that is inherently turbulent and complex.

In Mphumi’s case it was vital that sufficient safety and containment was established before the hard work of remembering and mourning could be done. This was partly achieved through hospitalisation and appropriate medication. But, in large part, it was the ongoing support that she received from her tutor and friends throughout the year which made it possible for her to engage in the therapeutic work. Before she could address the rape trauma, she had to resolve the current crisis about leaving the church. Again the practical support provided by her tutor, who procured alternative funding cannot be underestimated.

Therapy enabled Mphumi to tell the story of her recent rape as coherently as possible without retreat into somatisation. Her experience of the brutality and injustice of the rape was validated, and her perceptions that she was to blame for the abuse were challenged. Mphumi’s unproductive patterns of dependency and passivity were identified and confronted in the therapy process. Her attempts at self-assertion and self-exploration were encouraged. The containment provided by therapy slowly allowed her to begin to manage previously unmanageable thoughts, memories and feelings.

Significant progress was made in terms of processing the current trauma. By the end of the year the intrusive symptoms and hyper-vigilance had abated, and Mphumi was able to speak freely and openly about the rape. She was sufficiently contained to apply herself to her academic work and managed to pass the year. She re-established regular contact with her mother and apologised for behaving badly after the rape. In all, she complained less of feeling isolated and unhappy. Some progress was made in uncovering the earlier traumata. The stories were (partially) told, and some sadness and pain was acknowledged. However, the effects of the early trauma were profoundly shattering. The characterological scars remain. When she left therapy Mphumi was still prone to impulsivity and dissociation. She remained fundamentally fragile and poorly integrated.

It is hoped that this lengthy discussion of Mphumi’s case shows that the treatment of trauma is no simple matter. Much as it is important to recognise and accurately diagnose trauma syndromes, it is prudent to remember that we are always treating traumatised individuals. Our work is with complex human beings, who have individual histories, idiosyncratic vulnerabilities and areas of resilience. As Herman (1992, p.156) puts it ‘there is no single, efficacious “magic bullet” for traumatic syndromes.’

References