Narratives of hope:
Trauma and resilience in a low-income South African community

ILSE APPELT

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Declaration

I, the undersigned, hereby declare that the work contained in this dissertation is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

…… ……
Signature Date

Abstract

South Africans are often subjected to violence and trauma. However, many can tell stories that speak of resilience in the face of trauma. Against this background, this social constructionist study aims 1) to contribute to the growing body of knowledge of the consequences of trauma, as well as of resilience, in a low-income community in South Africa; and 2) to describe a narrative therapy approach to trauma - an approach that is thought to emphasise context, resilience, empowerment and ecological well-being.

The study was set in the high-violence community of Lavender Hill, with participants being individuals or families exposed to violence. Interviews guided by ideas and practices of narrative therapy were used to gather data about trauma and resilience in this community. In an effort to establish how trauma and resilience were constructed by participants themselves, first and last interviews were analysed, using constructivist grounded theory. The areas of concern were: i) the daily impact of trauma on thoughts, emotions and behaviour; ii) the conflict between speaking out and staying silent; and iii) the impact of trauma on relationships with self, others and God. These became the main categories for the discussion of the consequences of trauma. Findings supported the notion that persons working with trauma survivors in South Africa should be aware of how complex, multi-layered and context-bound the consequences of trauma are when they design interventions.

To reach the second aim of the study, the application of narrative therapy ideas and practices were described by focusing on five case studies. The case studies were discussed in relation to different notions of recovery and therapeutic change. Emphasis was placed on double-storied accounts of trauma that included attending to alternative, hope-inspiring stories of participants' lives. It was shown that a narrative approach to therapy offers contextual and resilience-focused practices that are geared toward empowerment of individuals, families and communities. As such, the argument that narrative therapy is particularly relevant and appropriate in the context of a low-income South African community, was supported.

Opsomming

Suid-Afrika is ’n land waarin baie mense aan gewelddadige trauma blootgestel word. Tog kan baie Suid-Afrikaners stories vertel wat spreek van veerkragtigheid. Dit is in dié konteks dat hierdie sosiaal konstruktivistiese studie ten doel stel 1) om’n bydrae te lewer tot die groeiende kennis oor die gevolge van trauma en oor geesteskrag (*resilience*) in ’n lae-inkomste gemeenskap in Suid-Afrika; en 2) om ’n narratiewe terapeutiese benadering te beskryf - ’n benadering wat beskou kan word as een wat klem plaas op konteks, geesteskrag, bemagtiging en ekologiese welstand.

Die studie is onderneem in die geweld-geteisterde gemeenskap van Lavender Hill. Deelnemers was individue en families in die gemeenskap wat aan geweld blootgestel is. Data oor trauma en geesteskrag is ingesamel deur narratiewe terapie-onderhoude. In ’n poging om vas te stel hoe trauma en geesteskrag deur die deelnemers self gekonstrueer is, is die eerste en laaste onderhoude geanaliseer deur die toepassing van gegronde teorie (*constructivist grounded theory*). Die kategorieë wat gegenereer is het ooreengestem met die literatuur. Die areas van belang was i) ’n komplekse kombinasie van gevolge vir denke, emosies en gedrag, ii) die botsende tendense wat saamgehang het met konteks: die wens om die stilswye oor trauma te verbreek en die wens om die stilte in stand te hou, en iii) die impak van trauma op verhoudings - met self, ander en God. Hierdie bevindinge ondersteun die idee dat persone wat met trauma-intervensie in Suid-Afrika gemoeid is, bewus moet bly van hoe kompleks, veelvlakkig en konteks-spesifiek die gevolge van trauma is.

Om die tweede doel van die studie te bereik, is die toepassing van die idees en praktyke van narratiewe terapie beskryf deur op vyf gevallestudies te fokus. Die gevallestudies is bespreek aan die hand van verskillende idees oor herstel en terapeutiese verandering. Klem is geplaas op dubbel-storie weergawes van trauma wat ook aandag geskenk het aan alternatiewe, hoopvolle stories van deelnemers se lewens. Daar is gewys dat ’n narratiewe benadering terapeutiese praktyke bied wat gerig is op bemagtiging van individue, families en gemeenskappe, terwyl die fokus geplaas word op die konteks en op die geesteskrag van persone wat trauma ervaar. As sulks is die argument dat narratiewe terapie ’n relevante en toepaslike benadering tot terapie binne die konteks van ’n lae-inkomste gemeenskap in Suid-Afrika is, ondersteun.

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Dr. L. Kruger, my promoter, for her guidance and encouragement.

My family and friends, for their support and patience.

My brothers and sisters in Christ, for their prayers.

My Creator, for life and a passion for justice.

Dedication

This study is dedicated to the participants from Lavender Hill.

Their stories of bear testimony of their

love for children - their own and others'

belief in justice and fairness

hope for a safer future

commitment to community

Their "doing hope" in the midst of pain is a proclamation of their

care and concern for **others**

belief in **God**

hope of **eternal life**

commitment to leave a **legacy**

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CHAPTER 1: CONTEXT, GOALS AND OUTLINE

The more we talk the more I get a different picture. The more I see – who of us is perfect? In spite of whatever, we can take the good out of it. We went through a lot and we got a lot of knocks and bumps, despite our hard work. But, there are still sparks…There is hope still. There is lots of hope still.
(Bella, a participant in this study)

Prologue

This story begins not so long ago, when, inspired by the notion of "doing hope" (Weingarten, 2000, p.399), I embarked on this research journey. This study is an attempt to put the journey into words. Words cannot, however, do justice to its multi-layered reality, both for me, and the participants who co-researched with me. However, I hope that the voices of the women and children who participated in this study will attain the prominent position that they deserve. I am grateful for the opportunities this journey gave me to be a witness to the lives of others - lives that bore testimony of love for children, commitment to community, belief in justice and fairness, and hope for a safer future. I trust that the way in which participants' stories are told in this study will reflect what I witnessed: those proclamations of care and concern for others, belief in God, and commitment to leave a legacy.

1.1 Introduction

My interest in working collaboratively with survivors of violence is informed by an array of factors, not least of which is the context in which we live. Since context is pivotal in this study, the problem of violence in South Africa is highlighted in this chapter, with specific reference to the situation in the Western Cape and in low-income communities. The focus then shifts to the role of psychology in addressing some of the consequences of these contextual problems in South Africa. Since violence contributes to experiences that many people deem traumatic, this study responds to the need for research into appropriate ways of attending to trauma and co-creating resilience. In the final sections of this chapter the goals and research questions are stated, and an outline of the chapters in this study is presented.

1.2 Violence in South Africa

South Africans can tell many stories that speak of resilience and hope in the face of trauma. Unfortunately, however, trauma in South Africa is often linked to violence - "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (Krug, Dahlberg, Mercy, Zwi, & Lozano quoted in Higson-Smith, 2004, p.303). Under the apartheid regime white domination was maintained by violent suppression. Through imposing physical and psychological control over activists and by using torture to demoralize them as individuals, as well as their families and communities, political control could more easily be maintained (Kagee, 2003). In post-apartheid South Africa the legacy of violence remains, although the pattern has changed. Eagle (1998b) highlights that "exposure to violent crime is more commonplace than in many other countries and in this respect South African society offers a distressing natural laboratory setting in which to study the impact of trauma" (p.6). Crime statistics of the last decade

(SAPS, 1997; CIAS & SAPS, 2005) illustrate this violent context. Every third crime recorded in South Africa is said to be violent in nature (Schönteich, 2002). Reportedly, in 1997 South Africa had the highest incidence of rape in the world and occupied fourth place regard to murder cases (SAPS, 1997). More than 80 people out of 100 000 were murdered, compared with 9 in the United States of America and 1 in the United Kingdom (Hamber & Lewis, 1997). In 2001 it was reported that "the homicide rate in South Africa is some eighty times higher than in Switzerland, England, and France, and ten times that of the United States" (Nell, 2001, p.266). The everyday occurrence of visible violence has arguably desensitized South Africans to tolerate violence as a "normal and legitimate solution to conflict" (McKendrick & Hoffmann, 1990, p.5). This may have contributed to increased use of interpersonal violence and to descriptions of South Africa as being caught in a "cycle of violence" (McKendrick & Hoffmann, 1990, p. 5).

1.3 Violence in the Western Cape

A report by Skinner (1998) on violence in the Western Cape indicates that isolated political violence and widespread discrimination continue in post-apartheid South Africa. However, the dominant culture of violence is said to have changed to gangster and taxi violence, internal community conflicts, and high levels of crime and sexual violence. Unfortunately, crime statistics in the Western Cape indicate an increase in most categories over the last ten years when comparing 1994/1995 figures to those of 2003/2004 (CIAS & SAPS, 2005). Reported cases of murder increased from 2 732 to 2 830; rape cases rose from 5 678 to 6 315; almost 1 000 more attempted murder cases were reported – 2 678 compared to 3 633; assault cases with the intent to inflict grievous bodily harm went up from 33 816 to 39 912; almost 18 000 more people were victims of common assault, with cases increasing from 34 262 to 52 339; robbery cases with aggravating circumstances increased from 6 474 to 13 855; reported cases of neglect and ill-treatment of children increased from 960 to 1 762; and car hi-jacking, which was for the first time entered as a separate category in 1996/1997 with 273 cases increased to 1015 cases in 2003/2004. The only categories of crime that showed a decrease from 1994/1995 in comparison to 2003/2004 were less violent crimes such as burglary at business premises, commercial crime and stock theft (CIAS & SAPS, 2005). In the light of these figures it is not surprising that 1998 statistics indicate that "almost half of Cape Town's residents (49,6%) were victims of crime over a five-year period (1993-1997)" (Business Against Crime, 1998, p.7). In a survey in the Western Cape in 1999, 46% of people reported feeling personally unsafe and 22% had been victims of crime during the year (Crime index, 2000). Half of these had been violated more than once and 2% more than 5 times in the year. The crime statistics of 2004/2005 suggest that an even larger percentage of all sectors of society in the Western Cape have been affected by crime in recent times. The poor are particularly vulnerable (Vetten, 2000).

1.4 Violence in low-income communities in South Africa

Although South Africa is classified as a middle-income country, most South Africans are poor (Terre Blanche, 2004). This is due to extreme inequality in South Africa: "the richest 10% of households have a 46% share in all income and consumption in the country, and the poorest 40% of households have amongst them only an 8.4% share" (Tomlinson, Swartz, Cooper, & Molteno, 2004, p.410). South Africa is indeed one of the most "unequal"

(Tomlinson et al., 2004, p.411) countries in the world. Like other unequal countries, South Africa has "a high rate of social instability and upheaval, criminal violence and family discord" (Tomlinson et al., 2004, p.411). Public health surveys in the United States found that "residential segregation of poverty and the extent of income inequality are primary factors explaining rates of crime and violence" (Bloom & Reichert, 1998, p.38). These factors, both present in South Africa, could partly explain why violent crime is so high. Another explanation offered by Simpson (1993) is that unemployment, poverty, racism and the inability to protect families from trauma have resulted in the perceived emasculation of men. As a result, women and children are more vulnerable to falling victim to violence since some men symbolically reassert their power by imposing it on those physically weaker than themselves (Simpson, 1993).

Crime statistics confirm that levels of violence and substance abuse in the Western Cape, as indeed in the rest of South Africa, are at their highest in low-income communities (CIAS & SAPS, 2005). One such community (Mitchell's Plain) on the Cape Flats serves as an example. In 1999/2000 more than 1 000 drug-related crimes were reported. In 2003/2004 cases of driving under the influence of alcohol or drugs added up to 6 442 and the figure for common assault was 2 934. These figures correspond with research findings that established a relationship between children's exposure to single violent incidents and internalising behaviour such as anxiety, depression and somatization; and between chronic community violence and externalising behaviours such as alcohol and drug use, carrying of knives and guns, and fighting (Seedat, Kaminer, Lockhat, & Stein, 2000). The fact that the number of deaths and injuries caused by gangsterism on the Cape Flats in the first half of 2002 paralleled that in the West Bank and Gaza Strip, illustrate the extent of violence (Evans in Reckson, 2002).

A newspaper headline, "Crime rockets in the Far South" (False Bay Echo Community Newspaper, October 27 2005) highlights the escalating problem of crime. A general increase in drug-related crimes and a "sharp rise in some serious crime categories" (King, 2005, p.1) such as rape and attempted murder on the Cape Flats, were reported. It is also important to bear in mind that many low-income communities do not have a police station in close proximity. This makes the reporting of crime less likely. The reporter comments: "It would be interesting to find out what percentage of the perpetrators of reported crimes were brought to book and what percentage of those arrested successfully prosecuted" (King, 2005, p.1). Although such figures are not readily available, it has been reported that the state's legislative and operational initiatives have unfortunately had little impact on the effectiveness of the criminal justice system. In fact, most criminal justice performance indicators are said to show a worsening of the system's effectiveness (Schönteich, 2002).

The vast number of people affected by violence in South Africa highlights the need to find ways of addressing this situation through social action, political action, appropriate preventative and therapeutic approaches, and continued research. Within this context, the need for relevance has been highlighted within the discourse of critical psychology, specifically within community psychology and liberation psychology. Community psychology in South Africa, and critical psychology within which it can be positioned, are discussed next. Liberation psychology is discussed later in this chapter.

1.5 Discourses of psychology in South Africa

Critiques of modern psychology have recently been drawn together in the discourse of "critical psychology" (Hook, 2004; Prilleltensky & Nelson, 2002). The term "discourse" as used here and throughout this study refers to a "system of statements, practices, and institutional structures that share common values" (Hare-Mustin, 1994, p.19). Critical psychology is no single theory or practice, but a diverse field encompassing a variety of discourses. This study can be situated within the discourse of critical psychology, with which it shares "points of departure" (Prilleltensky & Nelson, 2002, p.5) such as poststructuralist concerns about power, an ecological view of well-being, and a focus on liberation through a process of resistance to oppression. These points are reflected on throughout this study.

This study can also be positioned within the field of community psychology in South Africa (Seedat, MacKenzie, & Stevens, 2004), since it is aligned with "practical concerns of redress, of community involvement and assistance in areas which may traditionally be seen as lying outside of what Eurocentric psychology should concern itself with" (Hook, 2004, p.21). Within the discourse of community psychology, Naidoo, van Wyk and Carolissen (2004) note that health intervention in South Africa has "traditionally been predicated on the biomedical model" (p.520) and that "mental health service delivery was marginalised within the health system and subservient to the discourse of disease, pathology and treatment" (p.520). Naidoo et al. (2004) also point out that in the past mental health provision in South Africa had been "marked by racial segregation, fragmentation and duplication" (p.519), with the mental health needs of Black South African and disadvantaged communities largely neglected. These factors, amongst others, are said to have rendered mental health services in South Africa "largely inaccessible and inappropriate to the majority of South Africans, catering mainly for a privileged minority" (Naidoo et al., p.520). The Truth and Reconciliation Commission (1998) confirmed the need for identification and development of appropriate models for counselling in the South African context. They proposed community-based models that promote community involvement and raise public consciousness of the moral responsibility to participate in healing the wounded (TRC, 1998). The current restructuring of mental health intervention in South Africa is therefore attempting to address the inaccessibility and inappropriateness of services. As a result, a primary mental health care approach has been adopted in post-apartheid South Africa. It is focussed on prevention and promotion of well-being of individuals and families in the community context through public health services. The implementation of such a multifaceted community mental health approach extends traditional intervention strategies (Naidoo et al., 2004).

In community psychology, prevention of violence is seen as an important way psychologists can be of service to society, especially in South Africa (Higson-Smith, 2004). Primary, secondary and tertiary levels of prevention are envisaged. The principles of prevention recommended by Naidoo et al. (2004) are, at a primary level, "confronting the entrenched cultural forces such as patriarchy and gender inequality that perpetuates male dominance over women and children" (p.515). National policies aimed at deconstructing culturally dominant forms of masculinity that promote violence against women should be developed and implemented as one way of preventing violence. This argument is supported by a study by Wood and Jewkes (in Boonzaier & De la Ray, 2004b) who found connections between young men's talk about violence and the predominant forms of

masculinity available in a township community in the Eastern Cape (and in South Africa at large). That study indicated that adolescent sexual relationships within that community were characterised by violence, coercive sex and threats towards female partners. Boonzaier and De la Rey (2004a) found the construction of gender to be a significant discourse in South African narratives of violence.

Naidoo et al. (2004) argue that at secondary and tertiary levels prevention should render services to both the victims of violence, as well as rehabilitation programmes for perpetrators, with the wider community involved at various levels and across disciplines. Higson-Smith (2004) also proposes that violence prevention interventions should occur at different levels - at individual-level (for example conflict resolution programmes and identifying protective resources), small group-level (for example family counselling), community-level (for example, public awareness and information campaigns), and societal-level (for example, changes in the criminal justice system). Higson-Smith (2004) recommends the implementation of "empowering and linking" (p.307) interventions both to prevent violence, and to assist individuals, families and communities to overcome traumatic experiences resulting from violence. Although this study focuses more on attending to the consequences of violence, violence prevention is seen as crucial in South Africa.

1.6 Trauma as a consequence of violence

The Truth and Reconciliation Commission (TRC) emphasised the importance of more research into the consequences of trauma related to the experience of violence (TRC, 1998). According to Van der Merwe and Dawes (2005) research literature that addresses the effects of exposure to violence can be divided into two broad conceptual trends. The first is informed by the medical discourse of diagnosis, and it is "principally focussed on post-traumatic stress reactions within the individual" (Van der Merwe & Dawes, 2005, p.4). The second tradition, within which this study falls, has a more social constructionist, ecological perspective and "tends to focus on the combined effects of community/neighbourhood, family and individual characteristics and processes" (Van der Merwe & Dawes, 2005, p.4). Within this perspective, Bloom and Reichert (1998) describe the stressful impact of a continuous threat of violence as follows:

> As a child, a spouse, an innocent pedestrian, or community resident, violence seeps into most all relationships, creating an insidious presence that influences behaviour, development and progress. Where individuals, families, and whole communities organize to cope with problems of safety and violence, there is a stress level that pervades all relationships. (p.xii)

Research has demonstrated that, although many people will present with a reaction after a traumatic incident, only a minority will develop Post-Traumatic Stress Disorder (hereafter PTSD) (Allan, La Grange, Niehaus, Scheurkogel & Stein, 1998). In one study a general population prevalence of up to 12% (Sherman, in Taylor, 2004) was reported. Variables in the development of PTSD may be due to a variety of personal and contextual factors (Stewart, 2001). A review by Gelman (1999) indicates that the rate of PTSD is higher amongst crime than non-crime victims; amongst women rather than men; and amongst victims of sexual assault. A South African literature review of specific ways in which girls are affected by violence (domestic and community violence, sexual abuse and war trauma) indicate that violent trauma, particularly sexual victimisation, is highly prevalent among girls, and that girls seem to be more vulnerable to post-traumatic reactions than boys (Kaminer,

Seedat, Lockhart & Stein, 2000). One study of crime victims (predominantly female) in South Africa found that 25,8% experienced PTSD (Peltzer, 2000).

Dinan, McCall and Gibson's (2004) investigation of non-political violence outside the home, and its psychological impact on women is particularly relevant to this study, since this study is set in the same community as that one, namely Lavender Hill - "an established subeconomic area in the south peninsula district of greater Cape Town" (p.729). Dinan et al.'s (2004) study included both a help-seeking sample of women as well as a community sample, with nearly half of the help-seeking women meeting all the criteria for PTSD, and the mean number of traumatic experiences per year being 26. The community sample of women displayed a median of 8.8 PTSD symptoms (Dinan et al., 2004). It emerged that two-thirds of the woman had experienced several traumatic events outside the home in the past year. Dinan et al. (2004) expressed surprise at the "sheer magnitude of the 12-month reported rates of exposure to traumatic stressors" (p.737) in Lavender Hill, since these were found to closely resemble lifetime rates among women in the United States.

The well-documented link between violent victimisation and post-traumatic stress therefore seems particularly relevant to the community of Lavender Hill, where exposure to chronic interpersonal violence seems to be the norm (Resick, 2001). However, as Eagle (2002) points out, "the implications of subscription to the conceptualisation of violent victimisation under the rubric of traumatic stress are complex, and …warrant some scrutiny if interventionists are not to run the risk of divorcing their practice from contextual and activist concerns" (p.77). The risk in studies that employ symptoms checklists is that the entire community of Lavender Hill may be pathologised. Estimating the prevalence of psychiatric disturbance through checklists is problematic because it ignores resilience, meaning, beliefs and complexity (Kagee, 2004b; Kagee & Naidoo, 2004). I therefore support Kagee's (2004b) critique of a "unidimensional psychiatric approach" (p.55), favouring instead a "broader, more contextual, and more indigenous paradigm" (p.55). Within such a paradigm psychological distress is acknowledged and explored without pathologising it. This study heeds the caution to "people from outside" (Perera in Arulampalam, 2005) to avoid medicalising responses to trauma:

> Every individual reacts differently: many people will show amazing strengths and resilience to different degrees in different phases of recovery. At other moments they will display responses that include confusion, fear, hopelessness, sleeplessness, crying and difficulty in eating, headaches, body aches, anxiety, and anger. They may be feeling nothing at all or helpless; some may be in a state of shock; others may be aggressive, mistrustful, feeling betrayed, despairing, feeling relieved or guilty that they are alive, sad that many others have died, and ashamed of how they might have reacted or behaved during critical incidents. There may be some experiencing a sense of outrage, shaken religious faith, loss of confidence in themselves or others, or sense of having betrayed or been betrayed by others they trusted. These are normal reactions to extremely dangerous and stressful situations, or where people have felt helpless or overwhelmed. They do not mean that these people are mentally disturbed or mentally ill. We have tried to encourage international organisations who are working in Sri Lanka not to interpret or diagnose people's immediate reactions to the tsunami as indicating some medical condition. These are simply normal reactions to a terrible situation. (p.5)

Although the Sri Lankan context after the Tsunami in 2004 was vastly different from that of Lavender Hill, the above caution and focus on resilience is relevant in South African contexts where violence and poverty may be prevalent. It can be argued that the community of Lavender Hill experiences a "terrible situation" of a different kind. Construction of trauma specifically for the South African context, as well as priorities in finding

appropriate ways of attending to the psychological consequences of violence and trauma in South Africa, follow in this chapter. Dominant discourses in the area of the psychological trauma are discussed in Chapter 3.

1.7 Constructions of trauma in South Africa

It is clear that South Africa faces the very real challenge of both past and present trauma (Peeke, Moletsane, Tshivhula & Keel, 1998). Despite South Africa's "almost miraculous transition to democracy" (Skinner, 1998, p.2) with the election in 1994, the long-term effects of historical trauma due to the structural violence of apartheid remain severe. In apartheid South Africa, violent events such as political detention and torture occurred in a context of ongoing violence, deprivation, lack of safety and poverty. For many South Africans, these contextual factors have not changed in post-apartheid South Africa. Many low-income communities in South Africa could therefore be described as having been violated by their past, traumatised by their present, and frightened of the future (Crawford-Browne & Benjamin, 2002).

Straker (1987) and the Sanctuaries Counselling Team propose that "continuous traumatic stress syndrome" (p.1) may develop when a person or community remains in a context of community violence with a real threat to safety on a daily basis. Their construction may be considered applicable in low-income South African communities such as Lavender Hill. Van der Merwe and Dawes (2005) found that violence in low-income South African communities contributes to "multiple traumatizing events" (p.3) on an almost daily basis. Crawford-Browne and Benjamin (2002) reflect that endemic violence in many neighbourhoods in Cape Town means that people never experience a sense of safety and move quickly from a specific traumatic incident to contextualise the event within their general experience of violence. Swartz's (1998) concern that the model of a discrete event causing emotional distress as set out in the early versions of PTSD (APA, 1994) is generally seriously de-contextualised in South Africa, clearly still warrants attention.

In South Africa, traumatic experiences are often not unanticipated or isolated events, and experiences of "secondary (vicarious) trauma" (Reckson, 2002, p.9), when witnessing the trauma of others in the community, are common. According to DSM-IV-TR (APA, 2000), traumatic events can be experienced directly; witnessed; or learned about. Based on this, Mitchell and Everly (in Stewart, 2001) highlight three categories of trauma victims: 1) primary victims, i.e. those directly affected by trauma; 2) secondary victims, i.e. individuals who are in some way observers of the traumatic affects on primary victims; and 3) tertiary victims, i.e. those who are indirectly affected by later exposure to primary and/or secondary trauma. Mental health professionals may become tertiary victims. Kilpatrick and Resnick (in Stewart, 2001) argue that PTSD rates of individuals indirectly affected by trauma (i.e. secondary victims) are comparable to those associated with direct trauma (i.e. primary victims). According to Friedman (2000), secondary traumatisation is evident when family or community members become anxious and hyper-vigilant.

Levett (1988) highlights that in apartheid South Africa, crimes took place "against a semi-invisible background of violence: sexism and racism" (p.6) and that "the structural violence of male domination is pervasive and rarely commented on in South Africa" (p.6). Despite efforts to stem racism and sexism in post-apartheid South

Africa, racist and sexist discourses still wield power. These discourses are important to bear in mind in this study, since participants were victims of institutional racism in the past, and most are women. Sinclair (1993) stresses that trauma inflicted on a person with minority status, or on a woman, can have increased effect due to "the inherent trauma of racism or gender prejudice" (p.15). Sinclair's (1993) argument that "acknowledgement that institutional racism could create generational trauma" (p.15) should also be kept in mind when working in these communities. I therefore argue that attending to the consequences of trauma and violence is particularly urgent in low-income South African communities of colour, where generational trauma and the trauma of racism and gender prejudice could aggravate the consequences.

Van Niekerk (2002) poses the question as to whether there could be a "South African personality disorder" (p.46), in view of the fact that "in many ways sections of our people dissociate from the horrors of daily reality by remaining sheltered in their own worlds" (p.46). She argues that "the impulsivity of violent crime, the sadness of poverty, and the suicidal quality of hopelessness could be seen as a national version of affect dysregulation" (Van Niekerk, 2002, p.46). She notes that in many South African communities not only poverty, but also gangsterism, child abuse, divorce, homelessness, HIV/AIDS and substance abuse make trauma more complex. Her contention is that "family murders, rape, gang shootings, muti killings and child abuse are symptoms of a highly traumatised society that has lost its sense of safety" (Van Niekerk, 2002, p.2). Finally, she proposes that depression, PTSD and suicide within the Police Force can be seen as symptoms that draw attention to the effects of secondary traumatization. These factors, in combination with the HIV/AIDS pandemic support her conclusion that "sadly, there seems to be ample opportunities for future research on complex adaptations to trauma" (Van Niekerk, 2002, p.2) in South Africa. This conclusion is confirmed by Corrigal (2003) with the construction "cumulative trauma" to refer to trauma in South Africa. She conducted a study with 8 women diagnosed with complex PTSD in a low-income South African community. The stories of the women in that group confirmed that trauma in communities on the Cape Flats can be constructed as cumulative. Trauma was said to comprise the general context of their lives. Corrigal (2003) found that social stressors such as poverty, unemployment and housing crises are prevalent in low-income communities on the Cape Flats and these stressors are both mediators of the traumatic response and traumatic in themselves.

1.8 South African priorities in attending to trauma

Contextual knowledge of how trauma affects individuals, their families and their communities is particularly important in South Africa (Kagee & Naidoo, 2004; Kagee, 2004b). This knowledge could assist in optimising psychological intervention to meet the needs of the huge number of people traumatised by violence (Skinner, 1998). Eagle (2002) proposes that "the discourse of human rights appears to embody the most viable set of moral principles to inform trauma intervention in South Africa in the twenty-first century" (p.88). According to Crawford-Browne and Benjamin (2002) and Straker et al. (1992), priorities for therapeutic models that seek to be appropriate in high-violence South African communities include:

- brief interventions, with each interview a complete, containing process
- facilitating mastery and agency by strengthening coping strategies, not pathologising symptoms
- not attempting catharsis, but exploring the meaning of ongoing experiences of violence

- emphasising practical problem-solving, skills development and practical issues of safety
- counsellors' sensitivity to the implications of their outsider status

Swartz (1998) confirms that people living in a context of an ongoing struggle to survive, may be sceptical of interventions that are trauma-focused and he recommends approaches that assist with "building constructive identities" (p.180) by exploring the nature of oppression and responses and resistance to it:

> These responses are not always, or even primarily, in the area of symptoms, but rather in the ways people feel about themselves as they grow up - what they feel they can aspire to, what they deserve in life. Ways of intervening in the psychology of oppression, similarly, have to do with building constructive identities through work and social action, and not with the curing of symptoms and illnesses. (Swartz, 1998, p.180)

Hajiyiannis and Robertson (1999) agree that the high levels of violence and trauma in South Africa necessitate using a short-term, flexible approach which is applicable cross-culturally and which is not the exclusive domain of professionals. I argue that South African priorities in attending to trauma include a focus on resilience, context and empowerment, a shift in working with groups and communities rather than focusing on individuals, and adopting an ecological view of well-being. As such, these are discussed in the ensuing sections.

1.8.1 A focus on resilience

In recent years international authors (Chesler & Ungerleider, 2005; Gold, 2000; Hawley & DeHaan, 1996; Liddle, 1994; Walsh, 1998) and local authors (Appelt, 1999; 2000; Appelt & Roux, 2002; Eagle, 1998a; 1998b; 2002; Kagee & Naidoo, 2004) have focused on a re-conceptualisation of trauma and resilience in more phenomenological and contextual terms. Resilience models that "avoid pathologising and facilitate an examination of competencies that foster positive family functioning and adjustment" (Stoiber, Ribar & Waas, 2004, p.436) are becoming more common. This study continues the trend, as highlighted in the section on constructions of resilience in Chapter 3. The expanding knowledge of "the new focus on resilience" (Van Niekerk, 2002, p.21) and the paucity of research on trauma and resilience in Africa and South Africa make related research particularly important. Smith (2003), who worked in the United States with exiled torture survivors from Africa, asked a relevant question:

> …the question often becomes a stigmatizing, 'What is wrong with Africa?' as opposed to clinically assessing the following question: 'What sort of resilience and coping mechanisms must a people use to survive such harsh life conditions?' (p.297)

As Repper and Perkins (2003) point out, "the traditional focus of mental health service on deficits and dysfunctions means that it is very easy for both client and those helping them to lose sight of that person's abilities and resources" (p.82). Seedat et al. (2004) note that while "promoting the virtues of prevention, empowerment and positive mental health, champions of community psychology advocated for a focus on resilience and competencies, and the rendering of accessible community-orientated services" (p.597). This study supports the move within the field of community mental health to "draw on local resources and strengths to facilitate capacity-building and empowerment within communities by working with those communities themselves to address needs" (Naidoo et al., 2004, p.522). As such, this study fits within the movement away

from deficit-based toward strengths-based models in postmodern approaches to trauma intervention (Hawley & DeHaan, 1996).

1.8.2 A focus on context

From within the poststructuralist perspective that informs this study, it is crucial to contextualise individual experience within specific socio-political and ideological discourses that give meaning to social events (Levett, 1988). Trauma intervention that emphasises contextual contributions to post-traumatic responses "acknowledges the possibility of recovery in the absence of clinical intervention, highlights the construct of resilience, the role of the larger environment, the contributions of natural support, and the relevance of community interventions" (Harvey, 1996, p.21). As such, it fits within the discourse of trauma as multi-faceted, bio-psychosocial process (to be discussed in Chapter 3) and stresses that post-trauma interventions should take social environmental factors, recovery needs over time, and person-community relationships into account (Harvey, 1996). The helpfulness of greater social support and opportunities to talk with others about traumatic experiences is thus acknowledged (Stephens, 1997).

The need for a greater awareness of context and a focus on resilience that became evident in the discussion on community mental health in South Africa, has been confirmed by many national as well as international authors (Ahmed, Seedat, Van Niekerk & Bulbulia, 2004; Burman, 1994; Fay, 2000; Gold, 2000; Harvey, 1996; Levett, 1988; Straker, Moosa, Becker & Madiyoyo, 1992; Swartz, 1998; TRC, 1998; Werner, Ronald, Schindler-Zimmermann, & Whalen, 2000). Despite efforts to restructure mental health provision in South Africa, Corrigal (2003) observes that the role of social stressors is still downplayed by some mental health professionals, as is evident in her criticism of interventions at a local community psychiatric hospital: "The standard medication and 15 minute consultation is not appropriate in helping clients whose psychiatric illnesses are either caused or aggravated by constant exposure to trauma." She argues that this position should be reconsidered since it undermines contextual relevance and underlies the tendency to locate problems primarily in people. Chantler's (2005) review of international mental health literature also indicates that therapy fails to attend to marginalised groups, and "marginalised groups are more likely to be offered bio-medical or coercive interventions rather than talking therapies" (p.240).

I have already noted that within community psychology, the medicalisation and individualisation of trauma is questioned since it runs the risk of rendering traumatic experiences apolitical and de-contextual. Rather, traumatic stress is viewed as a psychosocial phenomenon (Eagle, 2002). Westernised conceptualisations of trauma that tend to dominate assessment, intervention and research in the area are therefore questioned since they marginalise other understandings and inhibit acknowledging the culturally specific nature of these conceptualisations (Eagle, 2002).

Given the importance of a focus on context, I agree with Terre Blanche (2004) that consideration of "the question of poverty" (p.263) is essential for psychologists in South Africa. Terre Blanche (2004) notes, "of the 44 million South Africans, 8 million survive on less than a dollar a day (the internationally recognised poverty

line) and 18 million on less than US$ 2 a day" (p.262). Some participants in this study formed part of the almost 40% of South African households that survive on less than a R1 000 per month. Terre Blanche (2004) notes that being poor not only has an impact on physical and mental well-being, but that people's experience of the world and the social structures they are involved in is related to their income. In fact, poverty is an important part of how the world is currently organised and "for many people, poverty is a state of uncertainty about the future" (Terre Blanche, 2004, p.265). In this study it is important to bear in mind that poverty contributed to participants being particularly vulnerable to economic 'shocks' such as becoming a victim of crime.

Therapeutic approaches that address issues of fairness and poverty by taking the gender, culture, social and economic contexts of people into account are needed to help in addressing challenges faced by the poor. However, whilst acknowledging the risks to physical and mental health associated with poverty (Barbarin & Richeter in Terre Blanche, 2004), this study also places an emphasis on the extensive networks of mutual support that often speak of community resilience (Osher et al. in Terre Blanche, 2004). I propose that an appropriate therapeutic model for trauma in South Africa would actively acknowledge that therapeutic reflection always begins in a social context and that it "cannot begin from an ahistorical point of departure" (Gerkin, 1986, p.37). As such, relational and collective values need to be attended to by situating problems in their socio-political context (Prilleltensky & Nelson, 2002).

1.8.3 A focus on liberation and empowerment

On all levels of intervention within the field of psychology the importance of addressing issues of power is confirmed by the negative impact of violence and oppression. The discourse of liberation psychology is therefore also relevant to this study. Wallace (2003) highlights that understanding and dealing with violence means acknowledging the social context, as well as historical and / or contemporary forms of oppression:

> The legacy of institutionalised violence, oppression, and historical disadvantaging has direct links with persisting contemporary forms of oppression, including white privilege. Considering the factors means fully appreciating the social context for violence. The approach to violence that is taken, therefore, allows us to draw links between historical factors, prevailing practices that are rooted in history, and contemporary manifestations of violence (p.5).

Wallace (2003) defines a "psychology of liberation" (p.10) as a psychology that seeks to create "reciprocal recognition" (p.10) through a new dialectic in which therapist and client enter the worldviews of each other and "discover the other" (p.10) with an attitude of genuine respect and acceptance. Wallace (2003) also describes "a psychology of oppression" (p.9) where invisible covert violence can be perpetrated through "the projection of negative and low expectations, the practice of domination and exercise of hierarchical authority, and verbal communication wherein a dominant superior talks down to a subordinate inferior" (p.9). According to Wallace (2003), a psychology of liberation strives towards the creation of a "non-hierarchical state of equality" (p.10) within therapeutic relationships that allows for "free-flowing dialogue among equals" or "two-way mutual exchange" (p.10). However, Wallace (2003) points out that support for a "non-hierarchical state of equality" is not a denial of real power:

> It cannot be denied that the counsellor who possesses professional training and degrees, the researcher who pays a fee or provides access to a service, or the teacher who ultimately gives out a final grade, each has real power. However, it is important for those with power to avoid engaging in the unacknowledged practice of domination and exercise of hierarchical authority, which serve to oppress clients, research participants, and students. (pp.12-13)

I agree with Wallace (2003) that a call for social justice and advocacy work on behalf of the oppressed follows logically "once one appreciates how the manifestations of violence and solutions to violence have everything to do with a social context rampant with the realities of oppression" (p.5). This study is therefore aligned with calls for a "liberation psychology" (Martin-Baro in Bloom & Reichert, 1998, p.278; Foster, 2004). It should be acknowledged that psychology has served to strengthen oppressive political structures by drawing attention away from them towards individual and subjective forces. According to Martin-Baro (in Bloom & Reichert, 1998) liberation psychology proposes that the task of psychology is, firstly, recovery of historical memory (of "elements of the past which have proved useful in defence of the interests of exploited classes and which may be applied to the present struggles") (p.279); secondly, to acknowledge and situate people's everyday experience by deconstructing prevailing discourse that denies, ignores or disguises lived realities of the lives of poor people; and thirdly, to utilize people's virtues by acknowledging their "solidarity with the suffering", "faith in the human capacity to change the world", and "hope for a tomorrow" (p.279). I argue that approaches giving assistance to trauma survivors in South Africa should incorporate these tasks.

1.8.4 A shift in focus from the individual to groups and communities of people

Within the discourses of community and liberation psychology, groups and communities – rather than individuals – are the preferred sites of intervention (Gibson & Swartz, 2004). Working in ways that include, rather than exclude, others from the therapeutic process allows possibilities for peer support and the development of connections with resources outside the therapeutic relationship. Within more traditional, mainstream psychology, a variety of approaches to group therapy for those who have all survived the same type of trauma (e.g. war, rape, torture, terrorist bombing, etc.) is said to be effective and popular (Friedman, 2000). Group therapy may involve normalisation after trauma, development of coping strategies, and creating meaning from the traumatic experience. According to Friedman (2000), the goal of supportive group therapy is not to revisit, reframe, or analyse traumatic material, but to focus on members' current life issues by discussing the here-and-now. Traumatic consequences are only relevant if they affect current functioning. Smith (2003) describes "creative adaptations to the 'traditional' group psychotherapy model that have been used to create a more culturally syntonic therapeutic experience for survivors from Africa" (p.292) at the Bellevue/New York University Program for Survivors of Torture. He found that traditional psychotherapy was often perceived as an "alien or stigmatised notion" (Smith, 2003, p.301) by the African people they worked with. Their African clients reported that a more collaborative stance helped to give them an increased sense of personal control. Smith (2003) argues that pan-African norms should inform therapy with trauma survivors:

> Examples of these pan-African norms are the importance placed on social and collateral ties and the central role that the extended family plays in an individual's sense of belonging. In fact, in times of emotional distress, it is far more likely that an individual from Africa will seek guidance from members of the extended family, particularly elders, rather than seek outside assistance from a mental health professional. (p.304)

Aspects highlighted as important by Smith's (2003) African group, namely a focus on adaptation and empowerment and on taking care to avoid re-traumatisation, inform this study:

> Group members spoke about the need for continued courage and mutual support to surmount the challenges they face. They also expressed appreciation for all the blessings they have received, despite their troubled situations. As previously mentioned, the group often focuses more on adaptation than emotional exploration. Adaptive defences are supported, not dismantled. As always, special care is taken that group members are not re-traumatised by the therapeutic work. We have found it important to end sessions, particularly those that have been emotionally charged, in a way that leaves clients feeling empowered and supported. It is helpful for the clinician to be able to sum up what has transpired in the group in a way that focuses on the wisdom that was shared and the courage that was displayed and, most importantly, engenders continued hope for the future. (pp.312-313)

This study supports shifts to working in ways that move beyond traditional one-on-one models in attending to trauma. Furthermore, even in cases where conversations are one-on-one, the focus is not on the individual, but is shifted towards including others and acknowledging that others are involved in the process of making meaning.

1.8.5 An ecological view of well-being

The themes of context, resilience and empowerment discussed above fit with an ecological view of health that integrates physical and mental health across three domains of well-being: "individual well-being, relational well-being, and collective well-being" (Prilleltensky & Nelson, 2002, p.517). Within this view individual well-being is aimed at "empowerment, giving individuals mastery, control, a voice, and choice" (Naidoo et al., 2004, p.517). Relational well-being is focused on "the promotion of respect and appreciation for human diversity and for collaboration and democratic participation" (Naidoo et al., 2004, p.517). Finally, collective well-being is said to be "fostered through the establishment of community structures that facilitate the pursuit of personal and communal goals" (Naidoo et al., 2004, p.517) as well as through the attainment of social justice. These three domains should be attended to in contextual approaches to trauma intervention. The goals of the current study are informed by these themes and trends in the search for finding appropriate ways to attend to the consequences of trauma in a low-income community in South Africa.

1.9 Goals of this study

There have been South African studies on how trauma and resilience are experienced by people situated in specific communities (Ahmed et al., 2004; Appelt, 1999, 2000; Appelt & Roux, 2002; Boshoff, 2000; Levett et al., 1997; Macliam, 2000; Martin, 2003; Nomoyi, 2000; Reckson, 2002; Wilkinson, 2002). However, the need for further research, both about the specific experience of trauma in low-income communities and about the appropriateness of different psychotherapeutic modalities for such communities, has been expressed (Deacon & Piercy, 2000; Dinan et al., 2004; Druiff, 2001; Goulding, 1995; Hook, 2004; Kagee, Suh, & Naidoo, 2004; Long, 1999; Luthar & Goldstein, 2004; Van Niekerk, 2002). Bearing this in mind, the goals of this study are:

1. To contribute to the growing body of context-specific knowledge of the consequences of trauma, on the one hand, and resilience and "doing hope", on the other, in a low-income community in South Africa.

2. To describe a therapeutic approach that emphasises context, resilience, empowerment and ecological well-being.

These goals are informed by the Skinner's (1998) conviction that survivors "deserve appropriate, accessible and affordable mental health care" (p.1) and need opportunities to tell the stories "that need to be told" (p.1). This study is designed to create opportunities for participants to give voice to resilience in everyday living and to explore the notion of "doing hope." The therapeutic approach that is described attends to the social construction of people's realities and is based on the idea that people and communities of people use stories as "frames of intelligibility in their interpretive acts" (White, 2001, p.12). The "importance of hope in overcoming adversity, pain, suffering, and various forms of evil, cruelty, and unfairness" (Wilson & Raphael, 1993, p.xxii) informs these goals. On the broadest level, it is hoped that a contribution could be made to the development of non-violent, just and considerate human relationships in South Africa, as envisioned by Wilson and Raphael (1993):

> If compassion for those who are wounded and hurt can override the aggressive and destructive themes so prevalent in many of our cultures, then we may become ready for peaceful, non-violent, just and considerate human relationships amongst those who inhabit the small planet. (p.xxii)

1.10 Research questions

To meet the above-mentioned goals the research questions explored in this study are:

1. What are the consequences of trauma for participants from one low-income South African community?
2. Could narrative therapy (White & Epston, 1990; White, 1995, 1997; Epston, 1998; Freedman & Combs, 1996; Freedman, Epston & Lobovits, 1997; Morgan, 1999, 2000; Parry & Doan, 1994) offer an appropriate, context-specific and resilience-focused approach for trauma counselling with individuals, families and communities in the context of a low-income South African community?

1.11 Chapter outline

This study consists of eight chapters. Chapter 2 focuses on epistemological discourses that inform this study. The postmodern discourse of poststructuralism and its application in social constructionism are discussed. Chapter 3 centres on a conceptual clarification of trauma and resilience. Chapter 4 offers a comprehensive discussion of the ideas and practices of narrative therapy, the therapeutic approach used in this study. Specific attention is given to narrative therapy as a form of poststructuralist inquiry. Methodological issues are addressed in Chapter 5. The study is placed within a qualitative research framework. The research setting and procedures, as well as data analysis are described. Issues of validation and ethical considerations are also reflected on. In Chapter 6 the results of a constructivist grounded theory analysis of the data pertaining to consequences of trauma are reported. These areas of concern (which become the main categories for the discussion of the consequences of trauma) were the daily impact of trauma on thoughts, emotions and behaviour; the conflict about speaking out and staying silent; and the impact of trauma on relationships with self, others and God. Chapter 7 consists of five descriptive case studies of narrative therapy with sixteen participants from the low-income community of Lavender Hill. Experiences that participants deemed traumatic included torture, woman abuse, sexual abuse, murder of a child, gang violence and rape. In the final chapter, Chapter 8, the study is discussed and recommendations for future intervention and research are made.

CHAPTER 2: EPISTEMOLOGICAL POSITIONING

All knowledge is situated knowledge, reflecting the position of the knowledge producer at a certain historical moment in a given material and cultural context.
(Lennon, 1997, p.37)

2.1 Introduction

This study is informed by the postmodern epistemological discourse of poststructuralism. Epistemology points to the basic assumptions and discourses that inform a person's way of knowing. In this chapter the implications of the discourse of poststructuralism for views on reality, language, self, power and truth are highlighted.

2.2. Poststructuralist discourse

Poststructuralism represents a major postmodern epistemological influence which has had "profound effects not only on academic discourse but on broader social and political processes" (Long, 1999, p.20). Poststructuralism is informative of the academic discourse of social constructionism (Burr in Long, 1999; Lupton, 1995). According to Lupton (1995), "the application of a poststructuralist perspective in sociology and history is generally termed 'social constructionism'" (p.11). This is arguably also the case in the field of psychology. Macleod (2004a) notes, "social constructionism allows for new questions to be asked about old topics, questions that connect supposedly individual issues to social power relations" (p.626). It is not possible to provide a comprehensive review of poststructuralism and social constructionism due to the complexity and volume of work in both these fields. However, the basic concepts and assumptions that have particular application to this study (such as the view of reality, language, self, power and truth) are explicated.

2.2.1 Knowledge, reality and truth

The status of knowledge is a central concern of poststructuralism. A critical and anti-essentialist stance is generally adopted toward taken-for-granted knowledge (Long, 1999). Knowledge is viewed as "context-dependent, socially constructed, and constituted primarily through language" (Kogan & Gale, 1997, p.102). Knowledge is therefore seen as a contextual and historically specific social process that develops and circulates amongst people (Shaw & Gould, 2001). A poststructuralist view of knowledge prompts us to "question the borders between science and non-science, expert and lay-knowledge, universal and local knowledge" (Backstrand in Kostkowska, 2004, p.188). Within the discourse of poststructuralism, the term 'local knowledge' refers to the situated knowledge of ordinary people – "the common-sense wisdom that comes from everyday life rather than formal book learning" (Van Vlaenderen & Neves, 2004, p.452). Local knowledge is relevant and valued in poststructuralist inquiry.

From a poststructuralist perspective it is assumed that realities are multiple and are "constituted through language and are organised and maintained through narrative" (Freedman & Combs, 1996, p.22). Reality is seen as "negotiated and constructed through societal lenses such as beliefs, values and customs" (Hoffman, 1990, p.1). An anti-essentialist stance is therefore also implicit in a poststructuralist view of reality. Truth is no longer regarded as unchanging, objective and absolute, but as relative to social context. Since there are no essential truths the accommodation of a plurality and a variety of views of reality are possible (Gergen, 1991).

2.2.2 Language and discourse

Poststructuralists draw attention to the constitutive role played by language in creating notions of reality and truth. Language is seen as "pre-dating rather than merely representing thought and is understood to be the mechanism through which everything is constructed" (Long, 1999, p.20). This notion of language is said to be one of the major characteristics of the poststructuralist "linguistic turn" (Lupton & Barclay, 1997, p.8). Language is seen as "both carrier and creator of a culture's epistemological codes" (Kvale, 1992, p.95). Meaning is viewed as created through language (linguistic and non-linguistic). Language is thus used to create meaning, not to mirror nature, and the language we use "constitute our world and beliefs" (Freedman & Combs, 1996, p.28).

For the purposes of this study, the term 'discourse' will reflect that described by Hare-Mustin (1994), whereby discourse is "a system of statements, practices, and institutional structures that share common values" (p.19). Hare-Mustin (1994) points out that "the ways most people hold, talk about, and act on a common, shared viewpoint are part of and sustain the prevailing discourses" (p.20). Discourse therefore refers to "any related system of thoughts or ideas as manifested in language, be it written or oral, and the associated social practices that accompany that system of meaning" (Kogan & Gale, 1997, p.102). Discourse is, however, "not a narrow function of the social structure, but is created, maintained, remanufactured, and reshaped by social interaction at all levels of context" (Kogan & Gale, 1997, p.103). Each language system has its own particular ways of distorting, filtering and constructing experience (Kvale, 1992). Language is therefore understood as "performative of meaning" (Long, 1999, p.20) rather than simply a vehicle for description of meaning. It is not language as such, but the way in which it is used within discourse that constitutes reality. Discourses have a powerful influence on how they allow for and shape people's life stories, and they typically reflect established structures of social and power relationships (Hilker, 2005). Examples of discourse include those about normative standards (body image, success, self worth, manhood, etc.), professionals' role as experts, and discourses about pathology (Freedman & Combs, 1996).

2.2.3 Self, subjectivity and identity

A concept central to poststructuralist theorising is that of subjectivity, with the focus on the intertwining of textual representation and the construction of personal identities (Lupton & Barclay, 1997). Foucault argues that we cannot accept the notion of selfhood as a pre-existing social and cultural process, since it is a product of these processes. He shows how notions of the human subject are historically bound and that these notions are "constantly created and recreated through discourse" (Lupton & Barclay, 1997, p.8). Individual experience therefore cannot be separated from the contexts and conversations that give it meaning. McNamee and Gergen (1992) agree that "what can be said about the world - including self and others - is an outgrowth of shared conventions of discourse" (p.4). As such, there is more emphasis on the social roots of what is taken to be true and the notion of "the self" as a fixed identity is questioned. The self is not viewed "as core, essential, and stable

from context to context; rather selves emerge from discourse" (Kogan & Gale, 1997, p. 103). Subjectivity is therefore seen as dynamic.

If discourse is assumed to be at the centre of the production and maintenance of subjectivity, dominant discourses can become so powerful so as to "constitute and shape self-narrative and personal discourse" (Neal, 1996, p.74). However, poststructuralist perspectives create spaces for people "to oppose, reject or transform what they perceive to be constraining or reductive subject positions" (Lupton & Barclay, 1997, p.11). Weedon (1992) argues that "knowledge of more than one discourse and the recognition that meaning is plural allows for a measure of choice on the part of the individual and, even where choice is not available, resistance is still possible" (p.106). Exploring the range of competing discourses and meanings upon which people can draw in understanding the social and material world, as well as themselves, would form part of therapy informed by a poststructuralist perspective.

2.2.4 Power relations

Foucault's work has been "invaluable in drawing attention to the way language is organised around different systems of meaning (or discourses) which offer positions of power to certain people and disempower others" (Parker, Georgraca, Harper, McLaughlin & Stowell-Smith, 1995, p.10). For Foucault, "power is part of every social relation and representation" (Lupton & Barclay, 1997, p.11). Foucault does not see power as a negative force, something which denies, represses, negates; for Foucault, power is a productive force that "produces reality and rituals of truth" (Storey, 1994, p.105). Power and discourse are seen as interrelated and working together to constitute subjectivity and social relations. As ways of framing, speaking about and giving meaning to phenomena, discourses become sites of struggle, open to challenge from other discourses. If discourses issue forth from privileged and authoritative social institutions such as the government, the mass media, religious institutions and medicine, they can take charge over the definition of what is considered 'truth'. Hierarchies of discourse can then be identified. At times some discourses could be identified as hegemonic, carrying most credibility and weight. However, "the hegemony of any discourse is tenuous, continually subject to contestation" (Lupton & Barclay, 1997, p.8). Discourses reflect and reproduce power relations, while power produces discourses:

> The Foucauldian understanding of power relations is that central discourses invite and persuade individuals to conform to norms and expectations rather than directly coercing them, appealing to individuals' desires and wants at both the conscious and unconscious levels. Individuals are neither passively enmeshed in power relations nor are purely free agents, for subjectivity is always produced through power relations which themselves involve resistances. Power cannot simply be removed or stripped away, allowing individuals to be "free", for power in some form or another is a condition of subjectivity. We are always the subjects of power. (Lupton & Barclay, 1997, p.11)

Within the field of psychology, poststructuralist and social constructionist perspectives have challenged claims to versions of reality and truth by deconstructing the role of language and discursive frameworks in formulations of experience (Eagle, 2002). Ways in which poststructuralist thought has informed the development of ideas in narrative therapy, the therapeutic position adopted in this study, are discussed in Chapter 4.

2.3 Concluding remarks

In this chapter the postmodern epistemological discourses of poststructuralism and social constructionism were discussed. Since epistemological reflexivity encourages not only reflection on the researcher's assumptions, but also on the implications of these for the research, constructions of trauma and resilience that fit within poststructuralist discourse are highlighted in Chapter 3. In Chapter 4 the impact of poststructuralist theory on narrative therapy is highlighted. Ways in which methodological choices made in this study are informed by poststructuralist thinking will be discussed in Chapter 5.

CHAPTER 3: DISCOURSES OF TRAUMA AND RESILIENCE

Promoting resilience is something everyone can do, in every interaction with another human being.
(Bloom & Reichert, 1998, p.251)

3.1 Introduction

In this chapter different constructions of trauma and resilience are discussed. It is shown that, to understand these concepts from within a poststructuralist framework, attention must be paid to the interplay between what occurs in the different contexts within which people operate: the familial, the political, the economic, the social, the community and the racial contexts (Walsh, 1998). Ideas relevant to trauma treatment are then briefly introduced, with special reference to treatment priorities in a low-income community context in South Africa. In the final section of the chapter, different conceptualisations of resilience are considered. Emphasis is placed on poststructuralist constructions of resilience that inform this study.

3.2 Trauma

3.2.1 What is trauma?

The word 'trauma' originates from the Greek for 'wound' and can be defined as a term used freely either for physical injury caused by some direct external force or for psychological injury caused by some extreme emotional assault (Reber, 1985). In this study the word 'trauma' is used to refer to lived experience that participants themselves identify as traumatic, shocking or distressing. Trauma is considered as "arising in a social context, and shaped by local and contextual meanings and understandings" (Kagee, 2004b, p.325). Trauma is therefore defined in relation to participants' meaning construction, since meaning affects coping and understanding (Wilson, Friedman, & Lindy, 2004). Furthermore, each participant is viewed a "complex and dynamic aggregate of political, social, cultural, and personal factors, who continually creates meaning of his or her experiences" (Kagee & Naidoo, 2004, p.48). Within the narrative therapy approach that informs this study, a person's attribution of an event as traumatic could be due to: a) irreconcilable with what they accord value to; b) an assault on what they hold precious; c) irreconcilable with their culture's cherished notions of life; and/or d) associated with disqualification or punishment of their responses, and of the foundations of these responses (White, 2004). Inquiry into these aspects can facilitate the co-construction of context-specific, experience-near conceptualisations of trauma in "double-storied accounts" (White, 2004, p.49) - accounts that also focus on resilient responses to trauma.

3.2.2 Constructions of trauma

The field of trauma studies is expanding and has moved into the mainstream of modern psychiatry, psychology, the neuro-sciences, as well as the social and behavioural sciences. There are many theoretical approaches to understanding the concept 'psychological trauma' (APA, 2000; Foa, Keane & Friedman, 2004; Horowitz, 1992; Janoff-Bulman, 1992; Wilson & Raphael, 1993; Wilson et al., 2004). Within each of these approaches, different discourses inform definitions of trauma. Wirtz (2003) highlights four distinct discourses: 1) within a medical discourse, trauma can be described as a psychiatric or a medical condition with physiological symptoms as manifested in Post-Traumatic Stress Disorder (PTSD); 2) within psychodynamic discourse trauma can be seen

as an intra-psychic process that necessitates psychoanalysis; 3) trauma can be viewed as a bio-psychosocial process in which the socio-political context gains importance; and 4) in the discourse of post-traumatic growth the potentially transformative spiritual processes and issues around values, faith and hope related to trauma are acknowledged. Each of these discourses covers a complex and broad field of research and practice where overlaps between discourses frequently occur. Due to the particular focus of this study, these discourses are very briefly considered next. Critiques of the construction of PTSD are included in the discussion.

3.2.2.1 Constructions of trauma informed by biomedical discourse

3.2.2.1.1 Post-Traumatic Stress Disorder (PTSD)

Within biomedical discourse trauma is conceptualised as a syndrome, i.e. a cluster of symptoms that fits the diagnostic criteria for Post-Traumatic Stress Disorder (PTSD). The diagnosis of PTSD was first described in the third Diagnostic and Statistical Manual (DSM III) (APA, 1980). By 2004, more than 22 000 academic articles on PTSD had been published, according to the "PsychInfo" database, attesting to the considerable interest in PTSD as a diagnostic category (Taylor, 2004). The revised fourth Diagnostic and Statistical Manual (DSM-IV-TR) includes six criteria in the diagnosis of PTSD (Sadock & Sadock, 2003, p.626) summarised as follows by Taylor (2004):

> *Firstly*, there must be exposure to an extreme traumatic stressor involving direct personal experience, witnessing, or learning about an event that involves actual or threatened death or serious injury. *Secondly*, the person's response to this event must involve intense fear, helplessness, or horror. The characteristic symptoms resulting from the exposure to the trauma include, in the *third* place, persistent re-experiencing of the traumatic event; *fourthly*, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness; and *fifthly*, persistent symptoms of increased arousal. *Finally*, the full symptom picture must be present for more than one month, and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. (p.4)

3.2.2.1.2 Critique of PTSD

Critiques of biomedical, diagnostic constructions of trauma fit within a broader critique of psychiatry that claims psychiatric practice obscures social and political problems and inequalities:

> Critiques of psychiatry have traced and analysed the history of this institution, emphasising its role as a powerful mechanism of social control with a system of surveillance and regulation as well as examining the 'medical gaze' and the appropriation of 'madness' by the medical professions. (Wilson & Strebel, 2004, p.422)

As mentioned in Chapter 1, critics note that medical diagnostic frameworks risk being de-contextualised, masking political intention and that the construction of PTSD is based on a Western, individualistic frame of mind (Eagle, 2002). Hook (2002) refers to the term "psychological reductionism" (Pilgrim quoted in Hook, 2002) to describe the way in which inner events of individual psychology is given primacy over political or cultural contexts. The placement of psychological trauma within medical discourse may contribute to trauma survivors viewing themselves as "sick", "labelled" or "damaged" (Wirtz, 2003). Levett (1988) also suggests that discourses of psychopathology as contained in the diagnosis of PTSD tend to imply an experience of abuse will be followed by a series of inevitable psychological processes that are damaging to the individual's mental state.

The notion of damage could contribute to constructions of others and oneself as fragile or vulnerable (White, 2004). Critics therefore note that diagnosis can be stigmatising, pathologising and disempowering (Hook, 2002; Kagee, & Naidoo, 2004; Summerfield, 2001; Young; 1995). It can be argued that discourses of traumatic memory, psychological damage and the accompanying stigma are part of "broader discourses of control of women and girls" (Wilson & Strebel, 2004, p.424). Wilson and Strebel (2004) argue that "psychiatric labels – often associated with 'madness' – have the problematic effect of stigmatising the woman who is distressed and obscuring the causes of that distress" (p.423). Young (1995) highlights additional ways in which trauma discourses can become disempowering:

> The discovery of traumatic memory revised the scope of two core attributes of the Western self, namely free will and self-knowledge – the capacity to reflect upon and to attempt to put into action one's desires, preferences, and intentions. At the same time, it created a new language of self-deception and justified the emergence of a new class of authorities, the medical experts who would now claim access to memory content that owners (patients) were hiding from themselves. (pp.4-5)

In descriptive narratives, traumatic experiences are placed into a story – one of many stories of a person's life. In psychiatric practice, however, symptoms are separated from these narratives. According to Wilson and Strebel (2004), this separation can be understood as part of "a discourse strategy of appropriation and objectification" (p.429) and it points to "a disjuncture within psychiatry, between a medical discourse and a narrative discourse" (p.430). The underlying assumptions about where the 'problem' lies are very different in each of these discourses. When working within medical discourse, diagnostic activity of symptom finding and disorder management substitutes detailed exploration of experience and locates the problem as internal to the patient rather than lying within living in a context of violence. The distancing effect of psychiatric language has also been critiqued, although Wilson and Strebel (2004) acknowledge that this may serve as protective measure:

> This distancing effect of psychiatric language might well be a necessary protective measure for South African clinicians working in violent areas and who are faced with listening to an unusual number of traumatic life experiences. However, it also has an alienating affect, creating a dichotomy between the expert who has the power to prescribe the language of understanding and treatment and the patient who becomes a conglomeration of symptoms to be managed. In this way, the patient has been stripped of her full experience, which would contain a variety of discourses, some of which might be at odds with the psychiatric discourse. (p.42)

According to Swartz (1998), issues of responsibility for trauma and its effects, as well as issues of treatment should be the focus in South Africa. Exploring an alternative discourse of responsibility is, however, made difficult by the practice of diagnosis (Wilson & Strebel, 2004). As narrative therapists, working in ways that are informed by narrative discourse as opposed to medical discourse, I support critiques of psychiatry that challenge "psychiatry's implicit 'blaming' of the individual for problems that are essentially social in nature" (Wilson & Strebel, 2004, p.433). However, I agree with Eagle (2002) that the medicalisation of traumatic stress appears to carry contradictions: whilst "offering legitimisation of the experience of victims in a constrained form" (p.79), in many instances this is "at the expense of the identification of the exploitative power enactments that their positions represent" (p.79). Eagle (2002) notes that despite the risks of stigmatisation, the articulation of the role of the stressor event and its impact on 'almost anyone' can also be experienced as de-stigmatising by traumatised individuals. He argues, "in its inception, traumatic-stress diagnosis was essentially liberatory, in that

it rendered the experiences of hundreds of victims normative and acceptable, rather than to place responsibility for distress at the door of the deficient individual" (Eagle, 2002, p.88). By focusing on context, these contradictions can be addressed. Young's (1995) assertion that the generally accepted picture of PTSD and its history is mistaken, is also important:

> The disorder is not timeless, nor does it possess an intrinsic unity … it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources. (p.5)

Young (1995) does not deny the pain that is suffered by people who are diagnosed or are diagnosable with PTSD and urges readers not to read anything he had written as "trivializing the acts of violence and the terrible personal losses that stand behind many traumatic memories" (p.10). However, Swartz (1998) agrees that even though PTSD is a lived reality for those affected by it, it is also "just a category created by cultural, social and political forces" (p.175). Exploring other constructions of trauma is therefore necessary if one is to take into account contextual factors and resilience in the face of trauma, as aimed at in this study.

3.2.2.1.3 Extensions of Post-Traumatic Stress Disorder: Complex PTSD (C-PTSD)

The category "Complex Post-Traumatic Stress Disorder" (hereafter C-PTSD) was proposed by Herman (1992) to capture the effects of prolonged, repeated trauma, as opposed to classic PTSD after exposure to a single event. C-PTSD recognises the fact that experiences of trauma may be complicated by chronicity of occurrence, or complexity in terms of the relationship between perpetrator and victim. Accordingly, trauma responses can be classified as a spectrum of conditions (as opposed to a single diagnosis) "that range from a brief stress reaction that gets better by itself and never qualifies for diagnosis, to classic or simple PTSD, to the complex syndrome of prolonged, repeated trauma" (Herman, 1997, p.119) where the victim is trapped in a relationship with the perpetrator. Although people in this category may meet PTSD diagnostic criteria, Herman (1992) argues that their primary problem is not PTSD. Instead, Herman (1992) proposes that their major problems concern impulsivity, affect regulation, dissociative symptoms, self-destructive behaviour, abnormalities in sexual expression, and somatic symptoms. C-PTSD can be viewed as an extension of Terr's (1991) differentiation between "Type I" and "Type II" traumas during childhood. Type I trauma is said to occur after a single, unanticipated, traumatic blow and resulted in re-experiencing, avoidance and hyper-alertness. Type II trauma is said to occur after prolonged, repeated traumatization and resulted in "denial, psychic numbing, self-hypnosis, dissociation and alterations between extreme passivity and outbursts of rage" (Terr, 1991, p.10).

The first criterion for the diagnosis C-PTSD (Herman, 1992) is having a history of subjection to totalitarian control over a prolonged period (months to years). Examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organised sexual exploitation. The fourth edition of the Diagnostic and Statistical Manual IV (DSM-IV) (APA, 1994) includes many of the criteria of complex traumatic syndrome under the diagnosis "Disorders of Extreme Stress Not Otherwise Specified" (DESNOS). Seven categories of symptoms are included in the C-

PTSD / DESNOS conceptualisation: a) alterations is affect regulation or ability to modulate emotions, b) alterations of ongoing consciousness, c) alterations of identity and sense of self, d) alterations in relations with the perpetrator, e) alterations in relations with others, f) alterations in physical and medical status, and g) alterations in systems of meaning (Van der Kolk & Courtois, 2005). There is controversy about C-PTSD as a distinct diagnostic identity from PTSD and the question still remains whether the constructs of DESNOS and C-PTSD should be legitimate diagnosis or of it is a merely a proxy for comorbidity (Van der Kolk, Roth, Pelcovotz, Sunday, & Spinazzola, 2005). The critique of medical diagnostic frameworks discussed earlier is also applicable to these constructs. However, the fact that multiple or prolonged trauma has been acknowledged in an diagnostic category and that greater emphasis is placed on contextual factors, on chronicity of occurrence, and on complexity in terms of the relationship between perpetrator and victim, may be experienced as a greater form of legitimisation of the experiences of victims.

3.2.2.2 Constructions of trauma informed by psychodynamic discourses

While space does not allow for an in-depth discussion of the complex and diverse field of psychodynamic trauma models, it is important to briefly outline the main considerations of such models. The psychodynamic concept of trauma is said to have evolved steadily over the last century (Kudler, Blank & Krupnick, 2004), with Freud and Janet cited as the first people to describe all symptoms of PTSD included in the DSM-IV-TR (Wilson et al., 2004). In 1895 Breuer and Freud made the proposition that mental disorders are sometimes rooted in psychological trauma in their publication, *Studies on Hysteria* (Kudler et al., 2004). Within the broad perspective of psychodynamic discourse, different aspects of trauma are highlighted and a range of definitions of trauma has been proposed. Very broadly seen psychodynamic perspectives on trauma propose that traumatic experiences may reactivate unresolved psychological conflicts and could manifest in a collapse of the intra-psychic structure (Sadock & Sadock, 2003). Emphasis is placed on unconscious and ego-defensive dynamics in the specific configuration of ego states (Wilson et al., 2004).

Recently, “allostatic psychodynamic approaches” (Wilson et al., 2004, p.125) to trauma have been developed. Within this framework it is argued, “ego defenses (for example repression, denial, disavowal, suppression, or projection) are organised around affects which have been dysregulated by traumatic experiences” (Wilson et al., 2004, p.412). These ego-control mechanisms can be overwhelmed through trauma. As Kudler et al. (2004) note, many commentators have criticised psychodynamic models as being too concerned with intra-psychic reality. However, its proponents argue that the clinical relevance and conceptual power of psychoanalytic perspectives of psychological trauma have been demonstrated (Kudler et al., 2004). Psychodynamic discourse has contributed to an extensive body of work within the field of trauma studies and to a greater awareness of the intra-psychic impact of trauma on unconscious processes.

3.2.2.3 Constructions of trauma informed by bio-psychosocial discourse

Within the contextual framework of bio-psychosocial discourse, the dualistic mind/body separation of the biomedical model is challenged with calls for a more holistic, ecological and integrated view of trauma and its

effects (Naidoo et al., 2004). As such, trauma is conceptualised as an integrated bio-psychosocial process situated within a specific context with effects not only on the individual, but also on community. Within this discourse "understandings of trauma must be read within its social, cultural and political context over time, not as a relatively static entity located and to be addressed within affected individuals" (Lykes, 2002, p.90). Psychosocial trauma is understood to reflect a process that "resides in the social relations of which the individual is only a part" (Martin-Baro quoted in Lykes, 2002, p.98). Proponents of this discourse acknowledge that "constructivist theories, human rights discourse and liberation psychology constitute resources of a resituating of 'trauma'" (Lykes, 2002, p.93). I agree with Lykes (2002) that within liberation psychology, it should be acknowledged that the meaning of trauma is co-constructed by those who experience it "in relationship (i.e. the therapist with the client) in a particular socio-historical time, culture and place" (p.99).

Martin-Baro (quoted in Lykes, 2002) notes the contribution of this discourse towards highlighting context and the need to challenge power abuses, since it proposes that "psychosocial trauma can be a normal consequence of a social system based on social relations of exploitations and dehumanising oppression" (p.98). Another contribution is that it highlights the need for therapists to position themselves. One has to "reposition oneself as a knower within the historical, cultural and political contexts of what one seeks to know, situating one's work within an interdisciplinary framework, and drawing on alternative psychological epistemologies and practices with survivors" (Lykes, 2002, p.90). The tendency to separate trauma responses into distinct categories (namely biological, psychological and social) should therefore be avoided, since the emphasis should remain on the complex, integrated process and social construction of trauma within a specific social, cultural and political context.

3.2.2.4 Constructions of trauma within discourses of resilience, growth and spirituality

Within post-traumatic growth (hereafter PTG) discourse there has been "a philosophical shift from a pathogenic to a salutogenic paradigm in which the focus is on positive, as well as negative, post-trauma changes" (Morris, Shakepeare-Finch, Rieck, & Newbery, 2005, p.575). The transformative power of trauma is therefore recognised within discourses of potential post-traumatic growth with its focus on resources and resilience (Wirtz, 2003). Chesler and Ungerleider (2005) note that a variety of terms describe the phenomenon of positive coping subsequent to a life crisis and that "meaningful, agreed-upon, empirically sound distinctions do not yet exist between terms such as post-traumatic growth, resilience, thriving, benefit finding, and others" (p.1). Different constructions of resilience and associated terms are discussed in more detail in section 3.3 of this chapter. Lindly and Joseph (2004) investigated "adversarial growth" (p.11) - positive change following trauma and adversity - and found that growth and distress are not ends of a continuum. Positive adaptation after trauma has also been associated with wisdom (Lindly, 2003).

Without diminishing the appreciation for the suffering people have been through, PTG theorists focus on a wider range of dimensions of trauma. For instance, Tedeschi and Calhoun (1995; 1996) propose that trauma questionnaires are often insufficient and do not record growth in the areas of spiritual change, new possibilities, relating to others, appreciation of life, and personal strength. According to Chesler and Ungerleider (2005) evidence of PTG can be seen in "greater compassion and empathy for others; greater psychological maturity;

recognition of vulnerability and struggle; a deeper appreciation of life; new values and life priorities; and greater existential or psycho-spiritual clarity" (p.2). Morris et al. (2005) reflect on PTG studies that have shown positive changes in relationships, attitudes, skills, knowledge, and confidence. According to Wirtz (2003), PTG can also contribute to social transformation in a community and can lead to greater respect, compassion and concern for life. Furthermore, trauma may result in a greater belief in the importance of love and greater belief in spiritual dimensions and after-life. PTG theorists acknowledge that transformation can also occur through the desire to leave a legacy (Wirtz, 2003). When working within this discourse it is important to bear in mind the critique that expectations of growth might put pressure on survivors. To conclude, it is important to note that the latter two trauma discourses, within which trauma is viewed as a bio-psychosocial process that may provide opportunities for stories of resilience and hope to be co-constructed, fit with the focus on context and resilience in this study.

3.2.3 Approaches to trauma treatment

A variety of approaches to trauma treatment and intervention, informed by different discourses and constructions of trauma, have been developed over the last century (Friedman, 2000). Within the medical discourse of psychiatry, there is an emphasis on medical treatments or pharmaco-therapy. A few South African studies (Stein & Levenstein, 1998; Stein, Schmidt, & Van der Linden, 1998) have confirmed the usefulness of pharmaco-therapy to address neurobiological aspects of PTSD. Diverse approaches have also been developed within psychodynamic discourse, with restoration of intra-psychic functioning as the broad goal (Wilson et al., 2004). Approaches such as Cognitive Behavioural Therapy (CBT), Critical Incident Stress Debriefing (CISD), hypnosis and behavioural techniques are also in use. However, Van der Kolk and Courtois (2005) note that there are "serious questions whether existing empirically validated PTSD treatments do constitute effective treatment for patients with histories of complex interpersonal trauma" (p.387):

> Of necessity, clinicians have learned to focus more on issues of patient safety, affect regulation, coping and self-management skills, as well as the therapeutic relationship itself, rather than on the processing of traumatic memories, the focus of most empirical research with PTSD patients. (p.387)

Internationally, contextual models have been developed in the field of traumatology in the past decade. Harvey's (1996) ecological model emphasises environmental contributions to individual variations in post-traumatic stress responses and recovery. The efficacy of trauma-focused interventions are said to "depend on the degree to which they enhance the person-community relationship, and achieve 'ecological fit' within individually varied recovery contexts" (Harvey quoted in Van Niekerk, 2002, pp.19-20). This fits with postmodern assumptions that responses to trauma and "symptoms" are not merely present or absent, but socially mediated (Swartz, 1998). For the purposes of this study, the range of approaches will not be discussed. However, psychological debriefing and cognitive behavioural therapy as trauma treatment will be reviewed in relation to narrative therapy in Chapter 4.

Although no specific therapeutic approach has been empirically rated as more effective than others in treatment of trauma survivors in South Africa (Van der Merwe, 1989; Van Niekerk, 2002; Kagee & Naidoo, 2004), some models have been recommended for our context. Many South African organisations provide services that attend to the

consequences of trauma and aim to help people with recovery from traumatic experiences. The scope of this study does not allow in-depth discussion of these. However, the interchangeable stages or components (telling/re-telling the story; normalising the symptoms; addressing survivor guilt and self-blame; encouraging mastery; and facilitating creation of meaning) proposed by Hajiyiannis and Robertson (1999) should be mentioned, since their model acknowledges the "critically important role of the broader sociocultural context in which the individual lives and is traumatised" (Hajiyiannis & Robertson, 1999, p.3). Ways in which narrative therapy incorporates some of the ideas contained in this model are highlighted in Chapter 4.

Van Niekerk (2002) suggests that possibly Herman's (1992) recovery strategy of "first establishing safety, then allowing space for reconstructing the trauma story through remembrance and healing, followed by reconnection and rediscovery of communality among people could be recommended to overcome South Africa's trauma" (p.46). Herman's (1992) model can be summarised as one favouring a process of re-integration and reconnection over one of catharsis. The importance of establishing a healing relationship, based on trust and empathy between survivor and therapist, is stressed. At the end of Chapter 7, I will argue that Herman's (1992) stages of recovery can be facilitated through narrative therapy. This study therefore supports Herman's (1992) emphasis on therapeutic practices that seek to create "healing narratives" (p.1). However, I agree with Lykes (2002) that Herman's (1992) support of a medicalised model for making meaning of trauma and its effects runs the risk of failing to capture trauma's community and social dimension. To offer a language that could facilitate the co-creation of healing narratives, I argue that attention should be paid to the socio-political context within which trauma is experienced on a collective level. Furthermore, healing narratives should also offer a language that speaks of resilience and hope in the face of trauma. In the discussion on resilience that follows, I highlight that this study is informed by constructions of resilience as an interactive process co-created in relationships. As such, resilience is recognised in the ability to maintain a connection to values and dreams despite trauma.

3.3 Resilience

3.3.1 What is resilience?

A basic dictionary definition of resilience is "being capable of returning to normal after stress" and "recovering quickly from shock" (Hanks, 1990, p.408). In the field of psychology, however, resilience is still loosely enough defined to "cover a multitude of virtues and cause an array of arguments" (Butler, 1997, p.25). Within broader resilience discourses, a variety of conceptualisations and constructs have been proposed and there is a lack of consensus regarding its definition (Todd & Worell, 2000). One school of thought defines resilience in terms of three types of outcomes, namely: a) positive outcomes despite a high-risk environment; b) competent functioning in the face of acute or chronic life stresses; and c) recovery from trauma (Masten, Best, & Garmezy in Kinard, 1998). In the study of individual resilience, which has featured in the literature for the past 30 years, a variety of terms have been used to refer to resilience. These have included "salutogenesis" (Antonovsky, 1987), "hardiness" (Kobasa, 1979), "fortigenesis" (Strumpfer, 1995) and "fortitude" (Pretorius, 1998).

Resilience discourse calls into question the long accepted *primacy effect* which assumes that psychopathology is shaped by events during childhood (Paris, 1998; Wolin & Wolin, 1993). A review of clinical literature on psychopathology led Paris (1998) to conclude that negative childhood events may be contributory factors, but not unique causes, of psychopathology. Resilience, defined as "the capacity to emerge intact from life experiences" (Paris, 1998, p.13), was found to be the rule rather than the exception. Research has shown that only about 25% of children exposed to severe trauma developed "demonstrable psychopathology" (Van Niekerk, 2002, p.15) as adults. Studies on adult PTSD support this argument. For example, one study found that only about 15% of Vietnam combat veterans developed chronic PTSD (Butler, 1997).

In his study of "salutogenesis" (the processes that promote healthy functioning generally) Antonovsky (1987) concludes that a sense of comprehensibility (understanding); a sense of manageability (being able to cope, manage and control); and a search for meaningfulness (being able to create meaning) are processes that promote healthy functioning generally. Kagee (2003) refers to the notion of a "hardy personality" (p.284) as playing a role in determining the level of resistance to stress in the case of survivors of torture. Commitment, control, and challenge are said to be three essential components of this concept:

> Commitment refers to an overall sense of belief in one's political agenda. Control implies a tendency to believe and act as if one could influence the course of events, and challenge is based on the notion that change rather than stability is a normative way of life. Challenge therefore involves being ready to respond to the unexpected. (Kagee, 2003, p.284)

Recently, the notions "thriving" (Strumpfer, 2003, p.70) and "post-traumatic growth" (Tedeschi & Calhoun, 1995), which imply a move beyond what was, have been explored. However, clear "distinctions do not yet exist between terms such as post-traumatic growth, resilience and thriving" (Chesler & Ungerleider, 2005, p.1). With the "evolution of the resiliency notion" (Liddle, 1994, p.170), the need to position oneself in terms of a preferred resilience discourse is confirmed.

3.3.2 Constructions of resilience

3.3.2.1 Constructions of individual resilience informed by structuralist discourse

Structuralists argue that resilience refers to an inborn ability to overcome adversity (Kobasa, 1979) and that it reflects an individual's "capacity to emerge intact from life experiences" (Paris, 1998, p.13). Rutter (1987) defines resilience as "the observation that some individuals, in spite of adverse circumstances or stress, do not develop negative outcomes but overcome life's hazards" (p.388). Seedat et al. (2000) argue that children are most likely to cope well with community violence if they have an "internal locus of control, a strong sense of self-efficacy and an optimistic attitude towards the future" (p.45). These can all be described as individual personality characteristics. Hawley and DeHaan (1996) caution that the study of individual resilience seems to be "grounded in a pathologically oriented framework, which is concerned with the long-term development of resilience and the discovery of risk and protective factors" (p.295). Butler (1997) confirms that "a growing number of clinicians and researchers are now arguing that the at-risk model burden at-risk children with the expectation that they will fail, and ignores those who beat the odds" (p.25). However, Rutter (1987), who investigated the notions of risk and protective factors, suggests that "resilience is not a fixed attribute, but a

dynamic interaction between risk and protective processes" (Ahmed et al., 2004, p.389). Although the emphasis was still on the individual, there was a realisation that risk and protective factors were not only intrapersonal, but also interpersonal. A shift towards acknowledging the importance of contextual and relational factors therefore developed within resilience discourse. This shift became apparent with the identification of three main categories of resiliency factors by Garmezy (1993) namely personal characteristics or disposition; family cohesion and warmth; and the availability and the use of external support systems. Engagement with "the long political and moral conflict over the relative importance of nature and nurture" (Butler, 1997, p.25) have been informative of notions of resilience, as Butler (1997) highlights:

> New research on resilience has not resolved this age old debate, nor older moral questions about free will, destiny and what we owe each other. We cannot yet create resilience artificially…But we now have clues how to challenge not only conservative American myths about stoicism and self-reliance but many unspoken assumptions of the liberal therapeutic culture. (p.25)

3.3.2.2 Constructions of relational resilience informed by poststructuralist discourse

From a poststructuralist perspective it can be argued that resilience is not dependent on "internal states" or inborn qualities, but rather socially constructed ways of being. Viewing resilience as an objective description of an inborn personality trait does not pay attention to contextual discourses that impact on skills and abilities. Relational conceptualisations of resilience recognise that resilience involves "organisational patterns, communication and problem-solving processes, community resources, and affirming belief systems" (Walsh, 1996, p.262) as reflected in values and goals. Furthermore, relational notions of resilience such as the concept of family resilience are grounded "in conceptual orientations that tend to emphasise wellness and adaptability" (p.295). Seeing resilience as a relational process rather than an inborn, individual trait opens up possibilities for multiple conversations (Egeland, Carlson, & Sroufe, 1993). Fallicov (1995) agrees that resilience should be viewed in a multi-dimensional, ecological way, to recognise that "families combine and overlap features of multiple cultural contexts, based on a unique configuration of many variables in their lives, such as ethnicity, socio-economic status, gender orientation, life stage and religion" (Walsh, 1996, p.269). The construct "family resilience" (Hawley & DeHaan, 1996, p.283) was proposed to describe how families adapt to stress. However, the need to locate studies of resilience in a much broader context than individual and family level factors is highlighted in the notion of "community resilience" (Doron, 2005; Sonn & Fisher, 1998). Hawley and DeHaan (1996) suggest that resilience should be seen as contextual and can be described at individual, family, and community levels, each of which was deemed to be unique and interdependent. White (1995) critiques individual accounts of resilience as follows:

> A naturalistic account of resilience was not enough, but when resilience was seen as an emblem for a range of alternative identity conclusions as well as knowledges of life and skills of living, when the histories of these were more richly described, and when this inquiry encouraged a significant re-engagement with certain figures in her history, many new options for action became available… These were options which enabled her to turn back the effects of abuses… (p.18)

From within the poststructuralist perspective that informs this study resilience can be seen as social processes that are co-constructed and circulated amongst people. Resilience is therefore viewed as "context-dependent, socially

constructed, and constituted primarily through language" (Kogan & Gale, 1997, p.102) in this study. White (1995) expands this conceptualisation of resilience by asking questions about resilience that include reflection on "ways of being and thinking that resilience is an emblem for" (p.30), the person's "relationship with resilience" (p.30), on "what has been sustaining of resilience" (p.30) and on the history of a "discernment of injustice" (p.30). Resilience can then be defined in experience-near terms that give the person the ability to remain connected to what she accords value to and holds precious. It refers to cherished notions of life, as reflected in responses to trauma, and to the values, commitments, intentions and dreams that provide the foundations of these responses (White, 2004, p.72). Exploring the history of skills and abilities may result in "double-storied accounts" (White, 2004, p.7) that implicate others in the development of resilience. The co-creation of such resilience can then be explored through a focus on wellness rather that pathology (Hawley & DeHaan, 1996) and therapy could seek to facilitate the co-creation of rich descriptions of the history and context of resilient processes, and of significant people involved in it. Within narrative therapy a relational conceptualisation of resilience is extended to include a person's "relationship with resilience", and their ability to change their relationship with respect to problems.

Relational, contextually sensitive notions of resilience were supported by a recent study in a low-income community in South Africa (Van der Merwe & Dawes, 2005). Whilst lamenting "a dearth of literature on factors and processes protecting children form the detrimental effects of violence exposure specifically", Van der Merwe and Dawes (2005, p.10) cite Ozer and Weinstein's (2004) study as an exception which demonstrates the protective effects of support from particular valued individuals. Low constraints for discussing violence for adolescents exposed to community violence also emerged as having a protective effect (Ozer & Weinstein, 2004). Van der Merwe and Dawes (2005) found parental monitoring, maternal closeness, time spent with family, and social support to be protective. They reported that distress "var[ies] significantly according to proximity to the violent incident, emotional closeness to the victim, and prior vulnerabilities and exposure" (Van der Merwe & Dawes, 2005, p.3). They conclude that children exposed to community violence showed varied post-traumatic effects depending on "the quality of care provided at familial level" and "the availability of social support" (Van der Merwe & Dawes, 2005, p.3). These findings support the notion that hope can be done in a community of caring others.

3.3.2.3 Constructions of resilience informed by discourses of hope and "ubuntu"

Ahmed et al. (2004) explored the notion of community resilience in a study focussed on three low-socio-economic neighbourhoods in the Western Cape of South Africa. They found that "all three communities reported high levels of hope, suggesting that despite the assumed impact of past apartheid-generated deprivations, persistent infrastructural limitations and violence, these neighbourhoods are still able to report positive feelings of hope and enthusiasm for the future" (Ahmed et al., 2004, p.403). An association between "community cohesion" (defined as the presence of networks and the quality of collective relationships) and "community hope" (defined as coping ability and a sense of the possible) was found (Ahmed et al., 2004). In this study the discourse of hope is informative. Epston (2002) and Weingarten's (2000) conceptualisations of hope as co-created between people is preferred in narrative therapy. Hope is viewed as "the practice of finding new ways of being, or co-creating alternative realities" (Ruane & Bakker, 2004, p.98). In this context hope

becomes evident in stories that speak of "desperate courage" (Epston, 2002) in the face of violence and violation. Weingarten (2000) adds an interesting community focus in her reflection on hope:

> Matters of life and death are too hard, too onerous, too painful, to 'do' alone. Hope is too important - its effects on body and soul too significant - to be left to individuals alone. Hope must be the responsibility of the community. (p.399)

Ahmed et al.'s (2004) conceptualisation of "community cohesion" (defined as the presence of networks and the quality of collective relationships) could be associated with practices of *"ubuntu"* - defined as support networks that emphasise "mutual assistance, compassion, respect, human dignity and empathy" (Collins, 1999, p.8). Collins (1999) describes the spirit of *"ubuntu"* as translating into "collective unity that will see to every person's survival" (p.9), with every person in turn expected to be loyal to the collective cause. The meanings ascribed to *"ubuntu"* are however neither inherent nor fixed. It is the variability and differing intensities of meaning attached to specific practices at particular times that gives them salience. In this study "*ubuntu"* is seen as a symbol that is socially constructed and culturally located. Its meanings are created and contested, both by its practitioners and by social researchers trying to understand the ways in which it is used. It is a way of relating to others and reflexively constituting oneself as belonging in society.

In this study questions can be raised about the applicability of notions of *"ubuntu"* as socially constructed value in the setting of this study. It can be argued that the meaning participants ascribed to the importance of social support and love in their community could be due to practices of *"ubuntu."* If there is an association between "community cohesion" and practices of *"ubuntu"*, Weingarten's (2000) ideas on "doing hope" gain significance in the light of the association that Ahmed et al. (2004) found between "community cohesion" and "community hope" (p.403). Weingarten (2000) wonders if those who practise *"ubuntu"* would find the work she has done on hope not strange, as North American audiences do. She further speculates if people who live in accordance with the spirit of *"ubuntu"* downplay the trauma sufferers' pain or withdraw from the interaction altogether, as North American researchers claim is common (Weingarten, 2000). Questions posed by Ahmed et al. (2004) need to be explored further, namely, "are hopeful communities more cohesive, or alternatively, are cohesive communities more hopeful?" (p.402). These questions support the possibility of "doing hope in a community of caring people" (Weingarten, 2000, p.400).

3.4 Concluding remarks

Diverse constructions of trauma and resilience were considered in this chapter. Critiques of the diagnostic construction of trauma as manifested in PTSD were highlighted. I pointed out that the poststructuralist perspective on trauma that informs this study is compatible with bio-psychosocial trauma discourse and post-traumatic growth discourse. A discussion of a poststructuralist perspective of resilience as a relational process concluded this chapter. In the next chapter the therapeutic position adopted in this study is discussed in detail.

CHAPTER 4: THERAPEUTIC POSITIONING

Using the narrative metaphor leads us to think about people's lives as stories and to work with them to experience their life stories in ways that are meaningful and fulfilling.
(Freedman & Combs, 1996, p.1)

4.1 Introduction

This chapter brings into focus the ideas and practices of narrative therapy. Attention is paid to key constructs and distinguishing practices of narrative therapy, as well as to ways in which narrative therapy is informed by poststructuralist thought. The chapter concludes with specific ideas in narrative therapy about attending to the consequences of trauma. These narrative therapy ideas are contrasted to two prominent therapeutic approaches in the field of trauma, namely psychological debriefing and cognitive-behavioural therapy, briefly discussed at the end of the chapter.

4.2 Introducing the discussion of narrative therapy

In this study I have favoured the notion of narrative therapy as an 'approach' rather than using the term 'narrative model'. I agree with Bird (2000) that "the very construction of the term 'narrative model' creates an environment of inclusion and exclusion" (p.ix) and may result in the temptation to replicate certain templates. This replication could encourage imitation, together with "definitiveness about what is and what is not an accurate representation of the work" (Bird, 2000, p.ix). Although narrative therapy with trauma survivors in South Africa is the focus of this study, a narrative therapy approach is not promoted as the only appropriate approach, nor is it presented as a definitive model. Caution should be applied so that "the idea that 'the Narrative model' actually exists" (Bird, 2000, p.ix) does not overshadow the existence of differences as practitioners attempt to engage reflexively with ideas and practices. I agree with Bird (2000) that the ideas and practices that have become known as "narrative therapy" should be "discovered and rediscovered, supported and challenged, confirmed and changed" (Bird, 2000, p.ix). Attempts to define narrative therapy in this chapter should be read with this caution in mind.

In this study the term 'narrative therapy approach' is used to refer to a range of therapeutic practices and ideas informed by the narrative metaphor. The term 'narrative' implies listening to and telling or retelling stories about people and the problems in their lives (Freedman et al., 1997). Narrative therapy ideas and practices impact on the questions that are asked and the descriptions that are co-created in therapeutic conversations. Furthermore, these ideas and practices are informed by specific assumptions about change, the role of a therapist, and consideration of power within therapeutic relationships, as discussed in this chapter.

4.2.1 "What is narrative therapy?"

Morgan (2000) introduces the ideas and ways of working that have come to be known as narrative therapy as follows:

> Narrative therapy seeks to be a respectful, non-blaming approach to counselling and community work, which centres people as the experts in their own lives. It views problems as separate from people and assumes people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives. (p.2)

Narrative therapy developed within the field of family therapy from a history of engaging with unorthodox ideas, of questioning commonly held views, and of developing creative practices (Horwitz, 2001). Its assumptions fit with other postmodern therapies that view therapeutic ideas and practices as social constructions, not as entitled truths (Shotter & Gergen, 1989). Many different themes have been emphasised in what is understood as the narrative metaphor, including ways of understanding people's identities and vantages from which to understand problems and their effects on people's lives (Morgan, 2000). Narrative therapy can also refer to particular ways of talking to people about their lives, problems, constraints, and their reflections on social, cultural, and political contexts (Hilker, 2005). Questions and practices used in narrative therapy are characterised by considering the problems people face in the wider context of life and considering people's identities as constructed through family relations and through history and culture (Horwitz, 2001).

The ideas and practices of a narrative approach to therapy described in this chapter are informed by the version of narrative therapy chronicled by Michael White and David Epston. I agree with Hilker (2005) that White and Epston's (1990) groundbreaking book, *Narrative Means to Therapeutic Ends*, represents an initial comprehensive effort to illustrate their conceptualisation of narrative therapy as well as the therapeutic effects of its operation. Over the last ten years many others have engaged with narrative therapy practices and have made significant contributions to what is a constantly evolving body of knowledge and ideas (Bird, 2000; Freedman & Combs, 1996; Morgan, 1999; Winslade & Monk, 1998; Zimmerman & Dickerson, 1996). White and Epston have also continued to evolve our understanding of the meaning and uses for the narrative therapy (Epston, 1998; Epston & White, 1992; White, 1995, 1997, 2001, 2004). Within the field of psychology, narrative therapy has recently been described as a "particularly promising critical approach" that provides "critical alternatives to oppressive and pathologising practices in psychology" (Prilleltensky & Nelson, 2002, p.89).

4.2.2 The narrative metaphor

The narrative approach to therapy outlined by Epston and White is broadly premised on the assumption that people's lives are socially constructed through the multiple stories they tell, and that these stories are coloured by the cultural and historical contexts within which they occur (Hilker, 2005). The use of the narrative metaphor developed out of "a deepening appreciation of the extent to which people routinely construct meaning by trafficking in stories about their own and each others' lives" (White, 2001, p.13). Reflection on the "sorts of frames of intelligibility" (White, 2001, p.13) that people and communities of people employ in their interpretive acts led to an appreciation that people make sense of the world by taking their experiences into narrative frames. Narrative therapy assumes that the interpretation of experience and the meaning given to it are linguistic and social achievements that occur by "locating experiences in the familiar stories of people's lives" (White, 2001, p.13). The narrative dimension therefore emphasises the importance of stories as sites of change. Freedman et al. (1997) elaborate on the importance of stories:

> The term narrative implies listening to and telling or retelling stories about people and the problems in their lives ... It is hard to believe that stories can shape new realities. But they do ... Language can shape events into narratives of hope. We humans have evolved as a species to use mental narratives to organise, predict, and understand the complexities of our lived experience. Our choices are shaped largely by the meanings we attribute to events and to the options we are considering. (p.xv)

Gerkin (1986) argues that "all things human are in some sense rooted in a narrative or story of some kind" (p.26). The African novelist Okri (1996) says, "Without stories we would go mad. Life would lose its moorings or lose its orientations" (p.25). This view is shared by Hardy (quoted in Gerkin, 1986):

> For we dream in narrative, daydream in narrative, remember, anticipate, hope, despair, believe, doubt, plan, revise, criticise, construct, gossip, learn, hate and love by narrative. In order to live, we make up stories about ourselves and others, about the personal as well as the social past and future. (p.29)

Given the emphasis on interpretation within narrative therapy, meaning is placed firmly at the centre of social inquiry and the focus is on the social construction of people's realities. Parry (1991) reflects that "a story is not a life, only a selection of events influenced by that person's beliefs about herself and others" (p.43). An assumption is that, in the process of interpreting lived experience as stories, certain events are elected and given preference and weight over others, thus forming our identities (Kecskemeti, 1997). Although problem-dominated stories are not the only possible stories, stories about ourselves can sometimes be filled with problems. Stories that speak of resistance to the dominant problem discourses may then be silenced. One of the practices of narrative therapy is to be curious about events (so called 'unique outcomes' or 'sparkling moments') that do not fit with problem-dominated stories. This allows people to tell alternative stories about their lives and identities (White, 1997).

It is important to distinguish narrative therapy practices from modernist approaches to stories. The latter seek explanations in underlying structures. In narrative therapy, however, healing narratives are allowed to "tell themselves" (Parry, 1991, p.37) as Hoffman (1990) explains:

> …traditional therapists believe that there are "essences" in the human experience that must be captured in some kind of narrative and offered to clients in a place of their old, illusory narrative. Going in, the therapist already has some idea of what these "essences" are. Postmodern therapists do not believe in "essences." Knowledge, being socially arrived at, changes and renews itself in each moment of interaction. There are no prior meanings hiding in stories or texts. A therapist with this view will expect a new and hopefully more useful narrative to surface during the conversation, but will see this narrative as spontaneous rather than planned. The conversation, not the therapist is its author. (pp.12-13)

Kesckemeti (1997) describes narrative therapy as a process that helps persons to "re-author their lives and uncover those neglected qualities, strengths, actions and thoughts that lie in the shadow of the dominant story." This process is mindful of the significance of people's values, belief, commitments and purposes in life, and allows hidden talents and resources, deprived of significance by problems, to "blossom and come to light" (Kesckemeti, 1997, p.3). Narrative therapy is a way of working that is interested in history, the broader context that affects people's lives and the ethics or politics of therapy (Horwitz, 2001). Freedman and Combs (1996) highlight the importance of seeing problems in the socio-cultural context in which they occur:

> As we work with the people who come to see us, we think about the interactions between stories that they are living out in their personal lives and the stories that are circulating in their cultures - both their local culture and

> the larger culture. We think about how cultural stories are influencing the way they interpret their daily experience and how their daily actions are the stories that circulate in society. (pp.16-17)

The narrative therapeutic approach therefore suggests that the 'text' within which the narratives of people are situated are socio-political, as Robertson, Venter, and Botha (2005) explain:

> …White and Epston theorise that people are subject to 'power' through normalising 'knowledges' or 'truths', which shape their lives and relationships. These dominant socio-political stories tend to serve as the norm by which people are valued and judged. In this sense, the socio-political stories by which human beings try to perform their own unique narratives can be seen as 'subjugating'. (p.339)

To summarise, the term 'narrative' refers to the emphasis that is placed upon the stories of people's lives. Ways of re-authoring these stories occur in collaboration between the counsellor and the people whose lives are being discussed. Narrative therapy fits with a poststructuralist position that views therapy not as hierarchical, strategic intervention, but rather as a collaborative and participatory process in which preferred self-narratives are continually socially constructed through language and maintained in narrative (Kogan & Gale, 1997). Language is used to continually create meaning, and by using new language to speak about the meaning attached to experiences, new possibilities can be created (Freedman & Combs 1996). Furthermore, within a social constructionist worldview the narrative dimension emphasises that not only individual stories are important, but also cultural and contextual ones:

> The narrative dimension emphasises that whether the viewer is a person, a family, a community, or a people, the world is unavoidably viewed through the lens of a succession of stories - not only a personal story, but gender, community, class, and cultural stories. (Parry & Doan, 1994, p.24)

4.2.3 Power and the position of the therapist

The therapeutic posture aimed at by a narrative therapist is contained in the notion of a "decentred" but "influential" position, as described by White (2002):

> The notion "decentred" does not refer to the intensity of the therapist's engagement (emotional or otherwise) with the people seeking consultation, but to the therapist's achievement in according priority to the person's stories and to the knowledges and skills of the people. … these people have a "primary authorship" status, and the knowledges and skills that have been generated in the history of their lives are the principle considerations. (p.4)

> The therapist is influential not in the sense of imposing an agenda or in the sense of delivering interventions, but in the sense of building a scaffold, through questions and reflections, that makes it possible for people to: a) more richly describe the alternative stories of their lives; b) step into and to explore some of the neglected territories of their lives; and c) become more significantly acquainted with the knowledges and skills of their lives that are relevant to addressing concerns, predicaments and problems that are at hand. (p.4)

Awareness of the potential for power-imbalance in the therapeutic relationship has led to attempts to negotiate power-sharing relationships through decentred practices in narrative therapy conversations. According to White (1997) "decentring" (p.202) provides opportunities for therapists to:

1. Establish a commitment to identify and take responsibility for the real effects of their work on the lives and the relationships of the persons who consult them.

2. Contribute to an acknowledgement of the power relations of everyday life that provide the context for the problems that persons bring to therapy.
3. Contribute to an acknowledgement of the power relations of therapy itself, and to steps that will provide opportunities for the monitoring of the power relation.
4. Establish therapy as a context in which the consciousness and the knowledges of the persons seeking consultation are at its centre.

Thoughts about the politics of power within therapeutic relationships are based on the ideas of Foucault, who views language as an instrument of power and proposes that "people have power in society in direct proportion to their ability to participate in the various discourses that shape our society" (Freedman & Combs, 1996, pp.38-39). Narrative therapists aim to facilitate power-sharing dialogues in which negotiating and collaborating are valued. For example, permission to inquire about problems and to take notes is sought rather than assuming this right. Clients are consulted about whether the conversation is going in a preferred direction. Curiosity about how progress is being achieved is encouraged and permission to record and document this knowledge is sought, so that it can be shared with others (Winslade & Monk, 1998).

The therapist's role is to "scaffold" (Gold, 2004, p.355) the conversational process through active listening, reflections and Socratic questioning so as to co-create alternatives and to facilitate the critical examining of different meanings. Scaffolding questions do not seek to confirm the already known, but come from a position of wanting to learn more about the meanings of the client's world. Viewing "the client as expert" (Gold, 2004, p.357) and adopting a tentative, 'not-knowing' position (Anderson & Goolishian, 1988) arguably safeguards against the tendency in Western counselling theories to colonize clients' interpretations of life (Swartz, 1998). The idea is that people "reconstruct" and create rather than "recover" (Howe, 1993, p.155) their pasts in narrative therapy conversations. A commitment to respect is shown for people's own knowledge, which is likely to be subjugated knowledge and therefore undervalued. This stance places generalized, professional knowledge beneath particularized, common sense or local knowledge, rather than vice versa (White, 1997). Specific narrative practices that are decentring of the therapist are discussed later in this chapter.

4.2.4 Current status of narrative therapy practice and research

Although narrative therapy is a "relative newcomer to the field of talk therapy – having first taken form in the late 1980s" (Hilker, 2005, p.1), it is growing in recognition as a critical and collaborative approach to doing therapeutic work with individuals, families and communities (Prilleltensky & Nelson, 2002). Numerous publications ground the ideas and practices of narrative therapy in practical examples (White & Epston, 1990; White, 1995, 1997, 2001; Epston, 1998; Freedman & Combs, 1996; Freedman et al., 1997; Morgan, 1999, 2000; Parry & Doan, 1994; Zimmerman & Dickerson, 1996). Recently, the "International Journal of Narrative Therapy and Community Work", a quarterly journal featuring developments in the field, has been launched. Well known websites, *www.narrativeapproaches.com* and *www.dulwichcentre.com.au*, provide access to articles about narrative therapy. Narrative therapy training occurs across the globe and the "International Narrative Therapy Conference" annually brings together many of the most prominent trainers.

Hilker (2005) notes that, compared to many other approaches, narrative therapy has been "receiving only modest attention" (p.16) in the research. Nevertheless, an accumulating body of qualitative research has been conducted that may assist in placing narrative therapy alongside other documented and researched therapeutic approaches. Etchison and Kleists (2000) tackle the issue of research into the effectiveness of narrative therapy and conclude that, although support for the use of narrative approaches with families is at best tentative given the small number of clinical studies, research indicate "that narrative approaches to therapy have useful application when working with a variety of family therapy issues" (p.65). They also highlight that "narrative therapy is based on principles that are congruent with context-sensitive research methodologies (e.g. ethnographic, grounded theory) that deemphasize generalizability" (Etchison & Kleists, 2000, p. 65).

In one ethnographic research project eight families described their experience of narrative therapy (O'Connor, Meakes, Pickering, & Schuman, 1997). Before therapy, the families described feeling defeated by their problems which included conduct disorders, family violence, grief associated with parental death or divorce, and aggression towards siblings. Narrative therapy was said to have helped the families realise that both they and the narrative therapy team (in terms of their approach) were "on the right track" (O'Connor et al., 1997, p.479). O'Connor and associates also published a later study evaluating therapists' experience as part of a narrative therapy team (O'Connor, Davis, Meakes, Pickering, & Schuman, 2004). Hilker (2005) points out that, overall, the authors conclude that "narrative therapy provides an excellent context for ideas and practices that empower personal agency in family members" (p.25). Merscham (2000), who discusses a family-focused example of attending to trauma using narrative therapy, concludes that narrative therapy was found to be effective in re-storying trauma in a way that led to the empowerment of participants. Horwitz (2001) agrees that clients experience narrative therapy as empowering since the approach centres people as the experts in their own lives, it views problems as separate from people and it assumes that people have many skills, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives.

Recent research studies conducted in South Africa support the usefulness of narrative therapy in South African contexts, in relation to a variety of problems (Botha, 1999; Botha, 2003; Choles, 2004; Dixon, 1999; Eva, 2004; Jansen van Vuuren, 2001; Hulme, 2002; Kotze, 2000; McLean, 1997; Morkel, 2002; Nieuwmeyer, 2002; Robertson et al., 2005; Roux, 1996; Schoeman, 2003; Standton, 2005; Steyn, 2001; Thiessen, 2003; Van Duuren, 2002). A few studies focussed specifically on the usefulness of narrative study in relation to attending to the consequences of trauma (Appelt, 1999; Louw, 2003; Sliep, 2004; Viljoen, 2001; Wilkinson, 2002) and co-creating hope (Martin, 2003; Ruane & Bakker, 2004). In many of these studies narrative therapy became a means of bringing light to existing alternative stories of hope (Epston, 2002). It is hoped that this study will contribute to this growing knowledge-base.

4.3 Key constructs of narrative therapy practice

4.3.1 Thin conclusion and thick/rich description

The notion of "thick/rich description", often used in narrative therapy, is based on the use of this term by the cultural anthropologist Geertz (1973). "Thick description" can be juxtaposed with "thin description." White

(1997) explains that thick descriptions are informed by "the interpretations of those who are engaging in these actions, and that emphasise the particular systems of understanding and the practices of meanings in regards to these actions" (p.15). White (2001) concludes that, in contrast to a thin conclusion, a thick description of an action is "inscribed with the meanings of the community of persons to which this action is relevant" (p.15).

Lykes (2002) argues that meaning-making can best be understood through "the thick descriptions of events of re-enactments of experiences as they are constructed or reconstructed by the survivors in dialogue and/or interaction with those who accompany them" (p.99). In narrative therapy it is therefore not enough to simply author an alternative story to be freed from the influence of problematic stories - these alternative stories have to be "richly described" (Morgan, 2000, p.15). Many things can contribute to alternative stories being "richly described", not least of which being that they are "generated by the person whose life is being talked about" (Morgan, 2000, p.15). Narrative therapists are interested in finding ways for the alternative stories of people's lives to be "richly described and interwoven with the stories of others" (Morgan, 2000, p.15). This process involves the articulation in fine detail of the story-lines of a person's life.

4.3.2 Telling and re-telling

In narrative therapy conversations alternative stories of people's lives are told and retold. Stories that counter constraining, dominant problem narratives are richly described through various "maps of re-telling" (discussed in section 4.11). White (1997) proposes that the outcome of a process of telling and re-telling is the "production of lives that are multiply contextualised" (p.16). White (1997) draws on the work of the prominent anthropologist Barbara Myerhoff in his explanation of the process:

> It is through a process of engaging with a community of persons in the telling and re-telling of preferred stories of one's history and of one's identity that lives are thickly described. It is in this context that the stories of person's lives become linked to shared values, beliefs, purposes, desires, commitments, and so on. (p.16)

This contributes to "the generation of narrative resources" (White, 1997, p.16) that in turn contributes to the range of possible meanings that a person might give their experience of the world and to the range of options for action in the world.

4.3.3 Knowledges of life and skills of living

Within a narrative therapy framework expert knowledge systems are critiqued in favour of local knowledge. Expert knowledge is seen as structuring of power relations that are often subjugating of the persons who consult therapists. Instead, the clients' own "knowledges of life" and "skills of living" are privileged in narrative therapy. In this context, the shared values, beliefs, purposes, desires, commitments, and so on that inform a person's preferred ways of living can be viewed as "knowledges of life" (White, 2001, p26). Maintaining connections to these knowledges of life can be called "skills of living" (White, 2001, p.26).

4.3.4 Unique outcomes or sparkling moments

Events that do not fit with dominant problem stories are sometimes called "unique outcomes" or "sparkling moments" in narrative therapy discourse. Curiosity about these events may contribute to thick descriptions of peoples' lives and may help people to co-author alternative stories about their lives and identities (White, 1997, p.3).

4.4 Epistemological assumptions that inform narrative therapy

Narrative therapy is informed by poststructuralist epistemological thought (see Chapter 2). Poststructuralism refers to a movement away from the idea that there are deep or real structures in people (such as a real / true self that can be discovered by experts) and resists the search for essential truths about people. Many of the practices of narrative therapy can be linked to a poststructuralist understanding of life and identity that is at times referred to as "folk psychology" (White, 2001, p.3). Bruner (quoted in White, 2001) points out that the expression "folk psychology" was "…coined in derision by the new cognitive scientist for its hospitality towards such intentional states as beliefs, desires, and meanings" (p.36). This tradition was largely displaced by modern psychologies, but began to be reinstated when the social sciences went through the 'interpretive turn' (Geertz, 1973) in the 1970s. According to Denborough (2004), the 'interpretive turn' was associated with cultural anthropologists (Clifford Geertz, Renato Rosaldo, Edward Bruner, and Barbara Meyerhoff, among others). Questioning what had widely been accepted practice in anthropology, these authors proposed that it was impossible for anyone to have an objective view in their research. They showed how anthropologists subjectively shape their research and in turn influence the communities they seek to study (Denborough, 2004). According to White (2001), many of the practices of narrative inquiry can be located within the context of this 'interpretive turn', and within the tradition of folk psychology. Both emphasise personal agency with people cast as "active mediators, negotiators, and as representatives of their own lives, doing so separately and in unison with others" (White, 2001, p.8). White (2001) explains:

> It is a psychology that foregrounds matters of values and beliefs with commitments to ways of life that characterise people. …the emphasis on personal agency, on the significance that is assigned to notions of purpose, and the weight that is given to notions of beliefs, values, and commitments, is a reflection of this folk psychology's theory of mind (p.8).

White (2001) argues that "in its appreciation of what it is that informs people's expressions of life, this tradition of folk psychology invokes 'mind'" (p.8). Howe (1993) agrees that "in talking about meaning and intentions, in recognising beliefs and desires, we are putting the mind back into psychology" (p.150). Narrative therapy practices are linked to the "mindedness" of folk psychology, as White (2001) explains:

> Many of the practices of this therapy routinely evoke notions of personal agency and contribute to rich description of a range of intentional states. These practices have the potential to bring forth the mindedness of folk psychology even in circumstances in which people's actions are routinely perceived to be discontinuous with what is known about them, and, on account of this, constructed as mindless or pathological or crazy. Practices that reinstate 'mindedness' also have the effects of restoring people's cherished understandings and preferred identity claims, and can contribute to a range of options for people to respond to untoward events in ways that are in keeping with these preferred claims. (p.13)

In order to highlight the development of narrative therapy in the context of poststructuralist thought, White (1997) untangles it from structuralist interpretations that take narrative therapy into discourses of psychological emancipation. He critiques interpretations of narrative therapy as an approach that assists persons "to challenge and overturn the forces of repression so that they can become free to be 'who they really are'" (White, 1997, p.217). White (1997) argues that notions of "growth, self-actualisation and fulfilment" (p.217) are emblems for certain modes of life and thought that are venerated in contemporary western culture and the effects of being informed by such dominant forms of individuality need to be explored. As a form of poststructuralist inquiry, narrative therapy practices aim to deconstruct structuralist systems of interpretation and understanding.

Structuralist therapeutic work becomes centred on the confirmation of the known, excluding expressions that do not fit with the grand narratives of human nature or with culturally venerated ways of being. Grand narratives, like "the will to truth" (searching for essentials), "the repressive hypothesis" (which states that we should look for what blocks our expression of our "true human nature/real selves"), and "the emancipation narrative" (White, 1997, p.225) should be questioned. White (1997) argues that structuralist ideas obscure acts of meaning or could render invisible the extent to which people are active in the shaping of their lives as they live it:

> In rendering us oblivious to the extent to which persons are active in shaping their lives as they live their lives, the repressive hypothesis and the theory of personal emancipation rule out possibilities for us to join persons in the development of some appreciation of the extent to which they are active in the negotiation of meaning, of the extent to which they are participants in the production of their accounts of their experiences of life, and of the extent to which this is an activity that is shaping their own lives. This also rules out the possibility for us to join with persons in the exploration of alternative meanings that contradict those that are routinely reproduced in their lives – it shuts the door on a curiosity about alternative meanings, and the development of a fascination with these. (pp.226-227)

Through poststructuralist inquiry we "break from the mission to discover something 'given' about nature" (White 1997, p.223) since it is assumed that "selves emerge from discourse" (Kogan & Gale, 1997, p.103). Narrative therapists therefore seek "thick descriptions" of people's lives by using "unique outcomes" as entry points to explore other ways of being and living.

White (2001) argues that looking for structure behind a story and measuring it to a norm may contribute to a pathologising and an invalidating tendency, since an expert is needed to translate experience into a more abstract level (it cannot be recorded in one's own voice). Lupton and Barclay (1997) agree that psychologists need to be aware that discourse issued forth from privileged and authoritative social institutions such as psychological institutions can take charge over the definition of what is considered "truth" (p.11). Therapy discourse, including narrative therapy discourse, should be engaged with critically. Since narrative therapy practice cannot escape the inevitability of relations of power, therapists should embrace the responsibility to include processes in the conversation that might identify power relations and that might contribute to the monitoring of the real effects of these power relations on people's lives. In structuralist approaches, however, the link between knowledge and power is concealed and opportunities for reviewing the real effects of power relations are lost.

The final effect of structuralist approaches identified by White (1997) is "the dissolution of history" (p.229). Structuralist approaches inevitably cast history in problematic terms as something that is to be resolved or undone. Options for creative re-engagement with history so that lives might become more richly described, are then powerfully restricted. Narrative therapy, on the other hand, allows for re-engagement with history through inquiry into how discourses informed our modes of life and thought. We can then explore the ways in which identity, subjectivity, and relationship were "all products of cultural knowledges and practices" (White, 1997, p.223). As re-authoring conversations evolve in narrative therapy, identity categories (for example of desire, personal quality, want, need, whim, motive, purpose, beliefs, intention, values, goals, hopes, aspiration) that contradict descriptions of problem-saturated stories can "fill out" (White, 1997, p.223). These alternative identity categories are, however, also culture bound and not the "truth" *per se* (White, 1997, p.223).

The notion of deconstruction is also relevant to therapy that is informed by poststructuralist thought on power. Parker et al. (1995) note that "deconstruction, in its 'purest' sense, identifies conceptual oppositions, recovers notions that have been excluded, and shows how the ideas that have been privileged are dependent on those they dominate" (p.3). Loose forms of deconstruction could involve an analysis of the practices of power that hold traditional oppositions in place and thus connects psychological critique with political context. The term "practical deconstruction" (Parker et al., 1995, p.3) has been used to refer to the process of attending to politics and power. Parker et al. (1995) explain an aspect of practical deconstruction that is particularly relevant in therapy, namely putting concepts "under erasure":

> To put something 'under erasure' is to question its taken-for-granted meaning, to mark it as a problem to be challenged. What appears to be commonsensical must be rendered strange. When we put concepts under erasure that does not mean that we will never use them again; we hold and transform them. We will use them in a different way. One thing we should not erase in a practical deconstruction is our memory, in this case a 'counter-memory', of how this state of things came to be. (p.5)

According to White's (1991) "rather loose definition, deconstruction has to do with procedures that subvert taken-for-granted realities and practices." Deconstruction then involves questioning "those so called 'truths' that are split off from the conditions and the context of their production" (White, 1991, p.27). Deconstruction is relevant to narrative therapy with its social constructionist assumption that "problems are anchored and supported by cultural discourses or taken-for-granted cultural prescriptions about how we should act" (Madsen, 1999, p.171) and make sense of our lives. Deconstruction is therefore part of narrative therapy practices that question the taken-for-granted, so that meaning is transformed and alternative stories emerge. For the deconstruction of the stories that persons live by, White (1991) proposes the objectification of the problems in externalising conversations. Externalising conversations and other narrative therapy practice are discussed next.

4.5 Narrative therapy practices

Narrative therapy practices offer linguistic resources with which to understand problems while co-creating, re-telling and thickening alternative stories. Morgan (2000) gives practical examples of such practices, including externalising conversations, re-membering, therapeutic letter writing, and the use of rituals, leagues and reflecting teams. The "maps of narrative practice" (White, 1998) that emerged as informative in the therapeutic

interviews conducted in this study included the practices of naming the problem, externalising the problem, discovering and naming alternative stories, and thickening alternative stories. As such, these practices are discussed next.

4.5.1 Naming the problem

Naming the problem is often recognised as an important first step in many approaches to therapy. From a narrative perspective, this step does not involve diagnostic evaluation, where the clinician is required to identify and label presenting symptoms. Narrative therapists sympathise with the various critiques of diagnostic and pathological discourses in psychology discussed in Chapters 1 and 3. Rather, in narrative therapy it is important that the name of the problem is an "experience-near name" (Morgan, 2000, p.44) in that it fits the experience of the person. Narrative therapists therefore pick up on people's own words or names for problems and phrase them in a way that clearly situates the problem outside of the person and the person's identity. Muntigl (2004) notes "although it may be the case that certain counsellors/therapists from certain psychotherapeutic traditions tend to align clients' problems with technical psychotherapeutic vocabularies, this tendency was not observed in narrative counselling" (p.195).

In narrative therapy, naming the problem should involve a co-creative process and the name chosen should allow for the politics of experience to be examined in that the powerful position that it may have assumed in a person's life is exposed. It is important to fully appreciate the impact of the dominant problem story on a person's life and to acknowledge the distress or worry it might have caused, so that he/she can feel listened to and understood. Once a problem has been 'named', questions which "mapped the influence" (Morgan, 2000, p.40) by exploring the relative strength of the problem can be asked. This helps to gain a much fuller understanding of what the problem was costing them and others. An exploration of the social context of the problem is also important, and this can be explored in externalising conversations.

4.5.2 Externalising conversations

Often naming the problem will be combined with externalising the problem. Hilker (2005) summarises the process of externalising as a narrative therapy practice that establishes a context where people experience themselves as separate from the problems in their lives. Externalising practices focus on the relationship between the person and the problem instead of upon a problem-person. Externalising conversations can then be defined as "ways of speaking that separate problems from people" (Morgan, 2000, p.17). Russell and Carey (2003) note that such conversations involve the identification of problems (separate from persons), locating the problem in history and in a storyline, and tracing the effects of the problem on the person's life and relationships.

More than a therapeutic technique, externalising practices assist in exemplifying the social constructionist worldview of narrative therapy. Externalising conversations establish a context in which people experience

themselves as separate to problems and this opens up space for a perspective where blame and shame become less significant. Hilker (2005) points out that externalising practices address wider implications about how clinicians view the world, understand clients' problems, and by association, how clients view themselves and their ability to make changes in their lives.

Externalisation requires a particular shift in the use of language. Morgan (2000) describes it as "an attitude and orientation in conversation" (p.17), not simply a technique or skill. In externalising conversations, the problem is often spoken of as an agent. Participants' own terms and words are reformulated in the co-constructive process. In his analysis of narrative therapy conversations, Muntigl (2004) notes the following:

> Even though the counsellor maintained a cohesive link to clients' formulations, the counsellor nonetheless, by reformulating, transformed clients' meanings. Reformulations create different grammatical constructs, and so they resemanticise what has been previously articulated. (p.195)

For instance, language can shift from "I am depressed", to the notion that "depression influences my life." Morgan (2002) compares examples of internalised language that locate problems inwardly (i.e. *I am a depressive sort of person and don't want to go anywhere)* to the externalising language that narrative therapists would use to reformulate these statements (i.e. *So, the Depression has made it hard for you to go out?*). In externalising conversations an adjective or a verb often becomes a noun (for example, the word 'depressed' would become 'the depression'). Morgan (2000) notes that asking people, particularly children, to draw what the problems looks like can sometimes be helpful, and that a variety of things can be externalised, including feelings (for example 'the fear'), problems between people (for example 'the blame'), cultural and social practices (for example 'mother-blaming' and 'racism') and metaphors (for example 'the block'). The importance of considering the broader context within which problems are experienced as a part of externalising conversations is highlighted in the following example:

> If I was consulting with a child in relation to their experiences of bullying in the schoolyard and they spoke equally about the effects of 'Sadness' and the effects of 'Hassling', I would be interested in asking some further questions to determine what to externalise. Knowing that focusing on externalising sadness in this sort of situation could inadvertently contribute to making invisible the relations of power that were occurring in this child's life, I might ask whether it is the Hassling that brings the Sadness? Or, is Sadness around more or less when Hassling is around? If the answer did link the Sadness to Hassling then I might ask if it would be all right to ask some more questions about Hassling. In this way I would be keeping an awareness of the politics involved in naming the problem, while also consulting with the child to ensure that we came up with a name for the problem that truly represented his/her experience. (Morgan, 2000, p.22)

Another example is that a problem might initially be called "temper", but through exploration of the social context it could be re-named "the rage" (Morgan, 2000, p.22), if, for example, anger was found to stand in relation to racism. This exploration would therefore take into account the relevant issues of power and injustice in people's lives. Determining the course of externalising conversations is "to be constantly checking out the broader context of people's lives" (Morgan, 2000, p.23). For example, if a problem such as fear/terror/nightmares is in fact related experiences of abuse, naming these problems as fear/terror/nightmares without exploring the broader context could silence the person's experience of abuse. Locating the externalised problem in the broader context of history and culture opens possibilities for exploring matters of gender, class,

race, sexuality and ability in therapeutic conversations. Acknowledgements can be made as to how broader relations of power have contributed to the construction of the problem (Morgan, 2000).

The notions of externalising conversations is also used in this study to encompass the pervading narrative therapy stance held with clients that regards people's sense of self, reality, and problems as socially constructed. Hilker (2005) points out that this stance is a distinctive element of the narrative therapeutic alliance between therapist and client.

4.5.3 Discovering unique outcomes and naming alternative stories

Once a problem has been externalised it becomes possible to identify unique outcomes – "times and ways in which a person has resisted the influence of the problem" (Russell & Carey, 2003, p.74). A unique outcome could be anything that does not fit with the dominant problem-saturated story. However, it is important that the client perceive an incident as a unique outcome. Unique outcomes are often storied when an invitation is extended to clients to evaluate the effects of problems. White (1998) describes what he calls a "statement of position map" that involves a) naming and externalising the problem, b) exploring and evaluating the effects of the problem, and c) justifying the evaluation of the effects. This map makes it possible to begin to "develop a different story about people's interests, beliefs, skills and preferences" (Morgan, 2000, p.43). White and Epston (1990) describe the process as follows:

> Tracking the problem in a two-staged process affords the benefit of gathering a solid history about the problem as well as searching for clues to a person's non-static relationship with and influence over the problem. The effect of these two modes of questioning is to encourage a person to move… out of a fixed and static world, a world of problems that are intrinsic to persons and relationships, and into a world of experience, a world of flux. In this world, persons find new possibilities for affirmative action, new opportunities to act flexibly. (p. 42)

The reflections on people's evaluation of a problem's effects often enable people to connect with preferred ways of living. Attention is drawn to preferred ways of living through interest in why people are unhappy about the effects of the problem. Furthermore, by listening carefully for any experience that stood apart from the problem story, where the problem has had less or no influence, fragments of experience can be collected as raw material from which the new story could be co-created. By asking questions about these 'unique outcomes' or 'sparkling moments', discoveries can be made about the participant's influence on the problem. Unique experiences that are not problem bound are used to invite participants to develop an explanation of the significance of these experiences. In this way, the plot of the alternative story is thickened and thematic links between different events can be drawn (Morgan, 2000).

4.5.4 Thickening the alternative story

In narrative therapy conversation stories that counter constraining, dominant problem narratives can be "thickened" and richly described through various "maps of re-telling" (White, 1998) in a re-authoring process. White and Epston (1990) explain:

> The evolution of lives is akin to the process of re-authoring, the process of persons' entering into stories, taking them over and making them their own. Thus, in two senses, the text analogy introduces us to an

> intertextual world. In the first sense, it proposes that persons' lives are situated in texts within texts. In the second sense, every telling or retelling of a story, through its performance, is a new telling that encapsulates, and expands upon the previous telling. (p.13)

Narrative therapy maps of re-telling may include "saying hullo again, re-membering and taking-it-back practices, audience retelling, and definitional ceremonies" (White, 1998). In some cases letters are used as therapeutic documents and outsider witnesses and audiences are invited to join in the co-constructive process. These maps of re-telling are discussed next.

4.6 Maps of re-telling to thicken alternative stories

Maps of re-telling that were used to thicken the alternative stories in this study included: 1) therapeutic documents and letters; 2) re-membering conversations and 'saying hullo again'; 3) building a wider audience through the use of witnesses, communities of concern and definitional ceremonies; and 4) reflection. As such, these narrative practices are discussed next and may be referred to when reading the case studies in Chapter 7.

4.6.1 Therapeutic documents and letters

Some narrative therapists make use of therapeutic documents. Letters and other forms of documentation can be used both to summarise developments that unfold in conversation and to engage other people who may contribute to preferred developments in people's lives. Since "…the words in a letter don't fade and disappear the way conversation does" but endure through time and space, letters have been described as "bearing witness to the work of therapy and immortalising it" (Epston, 1994, p.31). Morgan (2000) explains:

> As people re-author their lives and relationships, certain knowledges about the problem and the person's preferences for living become clearer. The dominant story's influence diminishes as new and preferred stories emerge. Therapeutic documentation records these preferences, knowledges and commitments so they are available for people to access at any time. (p.85)

Letters create possibilities of extending conversations with further questions and reflections about the conversation. Other forms of documentation include certificates, letters of invitation, declarations, videotapes, lists and pictures (Morgan, 2000). Therapeutic documents incorporate a heavy emphasis on a verbatim account of developments in an attempt to "rescue the said from the saying of it" (White, 1998) and to document the alternative story that is emerging. History, current developments, future prospects and new possibilities that opened up in the therapeutic conversation can be included (Freedman et al., 1997). Narrative letter-writing recognises the importance often given to the written word and uses this in a positive way. By documenting discoveries made by clients their significance can be strengthened (Winslade & Monk, 1998). White (1995) notes that in work with survivors of abuse, "for the dominant plot to be renamed in writing is entirely significant, and contributes to a form of testimony that can have the effect of substantially freeing persons from many of the real effects of the abuse that was perpetrated on their lives" (p.36).

4.6.2 Re-membering conversations and ‘saying hullo again’ (White, 1988)

“Re-membering” (White, 1997, p.22) is based on Barbara Myerhoff’s notion of “membered” lives. The metaphor of a person’s life as a club with members - some consciously invited and others included with little choice - opens up options for deliberately choosing who one would like more present, and whose membership should be revised or revoked, by “downgrading or upgrading specific memberships” (White, 1997, p.23). Exploring relationships that are or were important in people’s lives then becomes important. This is even more so in the knowledge that when faced with trauma, people often experience isolation and disconnection from important others (Morgan, 2000, p.77). The notion of re-membering seeks to redress this and to provide opportunities for persons to directly acknowledge the important and valued contributions others have made to their lives.

Practices of “taking-it-back” (White, 1998) encourage people to actively acknowledge others’ contributions to their lives. This in turn describes their own lives more richly, while at the same time making it possible for them “to experience the fuller presence of these figures in their lives, even when they are not available to be there in a material sense” (White, 1997, p.23). The “saying hullo again” (White, 1988, p.29) metaphor is sometimes used to guide questions in relation to losing a loved one. While acknowledging pain in having to say goodbye to the material reality of a loved one, ways in which people are “saying hullo again” to the knowledge that their loved ones had of them are explored. The aim is “the incorporation of the lost relationship” (White, 1988, p.29) into their lives so as to assist with the resolution of grief.

4.6.3 Building a wider audience: Witnesses, communities of concern, definitional ceremonies

Within the poststructuralist perspective in which narrative therapy is situated, identities are not viewed as the property of the person to whom they are attached, but as constructed within the cultural context in which the person lives. From the perspective that identity is relational, it follows that people’s beliefs and ideas about themselves are formed and maintained in relationships. Disconnection from others thus may lead to the experience of oneself as fragile or vulnerable. White (2004) stresses the responsibility that therapists have in the shaping of therapeutic conversations to contribute to the construction of “a robust sense of self”, rather than a “fragile sense of self” (p.12). Therefore it is crucial that the experience of self in therapy is anchored in the social world within which the client must live.

As Morgan (2000, p.74) points out, one way of thickening the alternative story involves finding witnesses who will act as an audience to performances of the new story. Narrative therapists are therefore interested in trying to engage audiences to the emerging alternative story. Re-membering conversations and taking-it-back practices as ways of acknowledging how people’s lives are linked are important. Freedman et al. (1997) note that it may be necessary to deliberately seek an appreciative audience to new developments in therapy:

> An alternative story can need plenty of confirmation to really take hold and to survive the “hiccups”, “backslides” and “come-backs” of a well-sustained problem story. The problem story has the strength of repeated historical experience and of mental habit to back it up and make it endure. It is not a simple matter to help the child and family grow roots for a new story that are strong enough to allow it to take over and branch out into their future lives. (p.223).

The notion of creating communities of concern implies that therapy can be broadened and made more community-oriented, although the implementation may be one-on-one. Madigan and Epston (1995) coined the term "communities of concern" (p.257) to describe groups of people who are struggling with similar problems who share and circulate ideas and knowledge. By linking people involved in individual therapy, therapeutic communities can be encouraged. A good example of this is the "Anti-anorexia Anti-bulimia League" (Madigan & Epston, 1995, p.257). League members share their struggles and ideas for revising their relationships with anorexia and bulimia, as well as their knowledges about social, gender, and cultural aspects of the problem. Individual conversations can then also influence a whole community, where, for example, league members choose to take an active role in revising the definition of the problem in the culture at large. This could for example be done through educational programmes at schools (Freedman et al., 1997).

The notion of "definitional ceremonies" (White, 1997, p.93) is developed in narrative therapy and refers to a structured forum that provides space for persons to engage in expressions of the stories of their lives and for the expression of the knowledges of life and skills of living that are associated with these stories. Myerhoff (quoted in White, 1997) explains:

> When cultures are fragmented and in serious disarray, proper audiences may by hard to find. Natural occasions may not be offered and then they must be artificially invented. I have called such performances "Definitional Ceremonies", understanding them to be collective self-definitions specifically intended to proclaim an interpretation to an audience not otherwise available. (p.93)

Following the telling of these stories (stage 1), the outsider-witness group is invited to respond with a re-telling of the stories and of the knowledges and skills expressed (stage 2). This stage has the effect of "rescuing the said from the saying of it" (Geertz in White, 1997, p.94). In the third stage, the persons whose lives are at the centre of the ceremony have the opportunity to reflect on what they have heard in the re-telling. Every re-telling (also those taken back to people's lives after the ceremony) exceeds the boundaries of the previous, contributing further to the knowledges and skills of persons' lives being thickly described. The outsider witnesses then reflect on what they had heard. During the re-telling by the outsider witness group, members are in dialogue, using questions and comments. There is a focus on emerging alternative stories and unique outcomes. Curiosity is expressed when speculating (with hesitancy and respect) on meaning. In a bid to situate responses, the team has a shared responsibility for de-centred sharing that acknowledges how clients' stories resonate with their own lives. Weingarten (2000) refers to a similar form of outsider witnessing that she calls "compassionate witnessing", where witnesses should not initiate a discussion from an expert position (for example by giving advice based on own experience) but should rather focus what was evoked for them and what they will take with them into their lives.

White and Epston (1990) employ a "rite of passage" metaphor, where people negotiate the passage from novice to veteran, from client to consultant. This practice can be called "consulting your consultants." They contend that this metaphor lessens the risk of instituting a dependency on the "expert knowledge" presented by the therapist and other authorities, whilst enabling persons to arrive at a point where they "can take recourse to liberating alternative and

'special' knowledges that they have resurrected and/or generated during therapy" (White & Epston, 1990, p.280). Freedman et al. (1997) explains this practice further:

> The narrative practices of enrolling people in their own knowledges, creating communities of concern and celebration open up options for inviting people who consult with a therapist to become consultants to others. For instance, clients could be asked to co-present a workshop or to be an outsider witness. These conversations allow them to assume the unconventional role of being consulted as an authority on their own lives; of experiencing their pre-existing and newly acquired knowledges and abilities as effective and worthy of respect; and of seeing that their ideas are considered significant enough to be documented and circulated to others (pp.126-127).

Sparks (1997) argues that the practice of inviting former clients to rejoin the therapy process as consultants provides useful ways of expanding the traditional bounds of therapy, whilst decentring the therapist as expert. Sparks (1997) explains that "multiplying the voices in the therapy room in this way is rooted in a belief that traditional practices of therapy inadvertently support a climate of isolation" (p.369). In contrast, consulting with clients in this way opens the door to the creation of communities of concern. Furthermore, it highlights ways in which the inherent power difference in therapy can be acknowledged and worked with.

4.6.4 Reflecting on the conversation

Narrative practices stress the importance of continually consulting people about how "the reinterpretation and expressions of their experience is affecting the shape of their lives, and about what they understand to be the limitations and possibilities associated with our conversations" (White, 1995, p.87). They are thus assisted to take an active role in monitoring the real effects of the expressions of their experiences. Reflection is therefore an important aspect of narrative therapy conversations that are expressed in different ways. One way is to ask clients about how the conversation is going for them. Attempts are also made to establish which parts of the conversations were more or less helpful and limitations and constraints to therapy are reflected on. Contextual factors such as poverty, community violence, domestic violence, as well as personal factors such as abilities and interests of participants and researcher, are brought into the conversation. Practices of celebration and joy are also important in narrative therapy. These practices are often part and parcel of richly describing alternative stories. Reflexivity on the part of the therapist and acknowledgement of how clients' stories resonate with their own is not only part of outsider-witness team practices, but also in one-on-one therapy.

4.7 Critique of narrative therapy

Narrative therapy, as a therapeutic approach positioned within a poststructuralist framework, shares "considerable scepticism about the applicability of any kind of sweeping, universal, one-size fits all truth claims" (Freedman & Combs, 1996, p.265) with other postmodern therapies. In this broad framework, some critics have expressed concern that social constructionist ethics imply that one story or discourse is as good as another - that anything goes. The idea that "ethics should not be based in monolithic truth claims" (Freedman & Combs, 1996, p.265) supports a number of important shifts that can be used in defence of postmodern therapies:

> …a shift to making room for marginalised voices and marginalised cultures, a shift to people in the client position choosing what fits for them, a shift to therapists being clear about where we stand so that people know how to take our ideas, and a shift to considering both the local, interpersonal, moment-by-moment effects of our stands and practices and the ripples that those effects send into the world at large. (Freedman & Combs, 1996, p.265)

From within medical discourse narrative therapy can be criticised for its reluctance to label people through diagnosis. People who expect a diagnosis by an expert and strategic treatment may be disappointed by the tentative stance of a narrative therapist. For some, a diagnosis may be desired and could be experienced as a relief rather than a stigmatising label, since putting a scientific name to problems opens up possibilities of comparing one's experiences to the "textbook cases." Others might be disappointed that a predetermined "goal of therapy" is not formulated. The notion that the narrative therapy process should unfold "in the time that it takes" (White, 2002) could also leave people feeling uncertain. The shifting role of the therapist in a decentred position might be foreign to people who adhere to a more traditional, modernist view of the therapist as an authoritative expert. The people who consult with narrative therapists have a "primary authorship" (White, 2002, p.4) status that may be questioned from structuralist perspectives. In narrative therapy, the client is placed in an authoritative position in terms of the relevance of the meanings offered.

Discourse about "boundaries" in therapeutic relationships may also inform a critique of narrative therapy. Narrative therapists work towards a therapeutic alliance in which "the boundaries and parameters of being a psychotherapist are often stretched" (Smith, 2003, p.303). An expanded role as an "accompanier" (Smith, 2003, p.303) may involve ways of being with clients that may be considered inappropriate within certain discourses of professional relationships. Proponents of non-directive therapeutic approaches may critique the "decentred but influential" (White, 2002, p.4) therapeutic posture of narrative therapists. In narrative therapy the therapist is seen to direct the conversation in the sense of "building a scaffold through questions and reflections" (White, 2002, p.4), not in the sense of imposing an agenda or delivering interventions. On the other hand, people who expect to have an agenda imposed or to have interventions delivered, may be disappointed.

From within narrative therapy discourse itself, practices that are not informed by a poststructuralist view of the world can be critiqued. The use of narrative practices as "techniques", without encouraging collaboration, openness, and ongoing examination of the effects of practice, can be very problematic (Freedman & Combs, 1996). Narrative practices used outside of the context of the reflective, non-pathologising worldview within which it was developed run the risk of no longer reflecting the ethics that they were built on. From within the "narrative therapy community" (Freedman & Combs, 1996, p.274) the risk of becoming "monolithic movements" (Freedman & Combs, 1996, p. 275) needs to be addressed. That narrative therapy is just one of many postmodern therapies needs to be kept in mind. The "real effects" (Freedman & Combs, 1996, p. 275) should be monitored and discussed critically.

The unfamiliar terms used in "narrative language" may be critiqued as unnecessary jargon. However, as White (1997) notes, poststructuralist inquiry engages us in "terms of description that are not the taken-for-granted

terms" (p.ix) and therefore, the need for "terms of description that are unfamiliar" (p.ix) arise. He highlights that readers may ask:

> "Why does he have to use jargon which obscures what he is saying?" "Instead of talking about lives that are 'thinly described', why doesn't he just say the person lacks self-esteem?" "Instead of talking about work that is 'more richly describing of a person's knowledges and skills of living', why doesn't he just say that this work leads to self-fulfilment?" (White, 1997, p.ix)

White (1997) argues that taken-for-granted notions that might not be considered jargon are in fact also products of discourse; that there is no equivalence between structuralist terms like self-fulfilment on the one hand, and poststructuralist descriptions of "knowledges and skills of living" (p.x) on the other; and that poststructuralist thought provides options for deconstruction of taken-for-granted ways of "describing life and human action" (p.x). He explains: "The relationship with one's life and the proposal for action that is shaped by the conclusion 'poor self-esteem' is quite different from the relationship with one's life and proposal for action that is shaped by the conclusion 'thin description'" (White, 1997, p.x). The use of "narrative jargon" could therefore not be avoided in this study where the text is situated within a poststructuralist framework. Clarity is needed about the meanings of these descriptions that "the regular and taken-for-granted terms of the culture of counselling/psychotherapy cannot convey" (White, 1997, p.x).

4.8 Narrative therapy and attending to the consequences of trauma

In this section, narrative therapy ideas around attending to the consequences of trauma are highlighted. In order to contrast these ideas to other ideas about attending to trauma, brief reviews of Critical Incident Stress Debriefing and Cognitive Behavioural Therapy are included in the next section. These trauma-focused approaches posit that it is imperative to revisit the original traumatic experience in order to break free of it. However, Harvey (1996) and Bird (2000) warn that traumatic recall in therapy can re-traumatise people. White (1995) agrees that although people may be distressed during therapy, "there is no excuse for people to experience re-traumatisation within the context of therapy" (White, 1995, p.85). He therefore questions practices based on the theory of catharsis that "obscures the critical dimension of meaning" (White, 1995, p.85):

> In requiring people to return to the site of trauma, are we not reproducing conditions that are entrapping, that are dispossessing people of choice? …are we not also unwittingly reproducing this culture's phobia about flight... and its imperative of "facing up"? And in this complicity, are we not closing down the possibilities that might be available to people for honouring the special skills and the personal qualities that made it possible for them to navigate through the dark hours of their lives and into the present? (p.85)

White (1995) highlights that "it is possible and desirable for people to find options for giving voice to their experiences of abuse in ways that are profoundly healing for them, and in ways that they judge to be entirely expressive" (p.87). In the next section narrative therapy ideas and practices that assist people to stand in alternative territories of their lives where they can give voice to more positive stories of their identity - stories that make it possible for them to give different meanings to their experiences - are described. This study explores if narrative practices may facilitate the expression of traumatic experiences in ways that are "not likely to be re-traumatising" (White, 1995, p.86).

Pain and distress as a result of traumatic experiences is considered in specific ways within a narrative therapy framework, as highlighted by White (2002). First, pain can be described as a testimony to the significance of what a person held precious that was violated through the experience of trauma. This can include people's understandings of cherished purposes for their life; prized values and beliefs around acceptance, justice and fairness; treasured aspirations, hopes and dreams; moral visions about how things might be in the world; and significant pledges, vows and commitments about ways of being in life. White (2002) suggests that these understandings can be identified, resurrected and known. Often this leads to a displacement of many negative "truths" of identity people have been "recruited into" as an outcome of the traumas they have been subjected to:

> Day-to-day emotional distress in response to trauma might be considered a tribute to a person's ability to maintain a relationship to all of those purposes, values, beliefs, aspirations, hopes, dreams, visions and commitments held precious. In the context of therapeutic conversations, acknowledgement of people's refusal to relinquish what was so powerfully disrespected, and explorations of their skills in maintaining a relationship with these intentional states, can elevate their sense of who they are, and of what their lives are about. (White, 2002, p.13)

Pain and distress is therefore viewed as a proclamation of response. In this sense it is an expression of personal agency. White (2002) reflects that, although people might feel powerless to escape traumatic circumstance, they "always respond to the crises of their lives" (p.13). Narrative therapy inquiry emphasises actions taken that reflect people's exercise of personal agency and accords value to people's responses. The intentional states that supported these actions are explored. White (2002) points out, "it is in the context of such inquiry that people derive a sense of their lives unfolding according to preferred directions" (p.13). Finally, psychological pain and distress might be understood to be elements of a legacy expressed by people who are determined that the trauma will not be for nothing. Within the context of therapeutic conversations, the legacy can be honoured:

> The way in which people rely upon their insider experience of trauma in recognising what others have been through, and in responding to others with a compassion that touches their lives, and that evokes a sense of solidarity with them, can also be significantly acknowledged. (White, 2002, p.14)

White (2002) believes that, in the context of conversations shaped by the above-mentioned understandings of pain and distress people can derive a robust sense of their identities. They can experience themselves as uniquely-abled on account of what they have been through, rather than uniquely-disabled (as in damaged, messed up, etc) and as such, can achieve a significant reduction in felt experiences of psychological pain and distress. Furthermore, White (2002) notes the position of safety these kinds of conversations may lead to:

> …people find safe places in which to stand in the territory of memory – at first islands, then archipelagos, and then continents – that provide them with platforms for speaking of what hasn't been spoken about, for putting into more significant expression their experiences of trauma, and for the development of a 'knowing' about how to proceed in life. It is through the development of these safe places in which to stand in memory that it becomes possible for people to bring their experiences of trauma into the storylines of their lives; that is, to re-associate dissociated memories in a manner that locates these in personal history in a way that assigns beginnings and endings to traumatic experience. (p.15)

Narrative therapy practices of attending to the consequences of trauma can be linked to feminist paradigms of trauma treatment (Brown, 2004). In terms of trauma treatment, feminist models are said to attend to relational and process components of trauma, whilst exploring how context has "woven itself into clients' experiences of

trauma and life after trauma" (Brown, 200, p.68). Feminist models and narrative therapy both explicitly explore political and cultural factors and have empowerment and meaning-making as goals. Brown's (2004) conceptualisation of empowerment as assisting people to see themselves as "a source of authority about their life narrative" (p.69) also applies to narrative therapy. Narrative practice arguably employs "the feminist strategy of linking individual experience to its social meanings" (p.69) and therefore restores engagement and connection with relationships to others and to values, purposes and beliefs.

4.9 Brief review of two other prominent approaches to trauma

4.9.1 Psychological debriefing

Psychological debriefing originated in military psychiatry, where so-called 'battle fatigue' and its incapacitating anxiety attacks were treated according to the principles of proximity, immediacy and expectancy (also called the PIE model). The "expectancy part" (Friedman 2000, p.40) consists of providing education that acute stress reaction is a normal response to an overwhelming event and that the person is expected to recover soon. Psycho-education involves making sure the client understands PTSD responses and it is often incorporated into other treatment modalities. The aims are to normalise survivors' experience; to remove self-blame and self-doubt by setting actions and reactions into an appropriate context, helping them understand the symptoms in this context and realising that they are not losing their minds and motivating them for treatment (Friedman 2000, p.43).

Debriefing is also said to have emerged from crisis intervention with its emphasis on "regaining homeostasis" (Burns 2002, p.23). Crisis intervention has been described as urgent and acute psychological "first aid" offered if a person's response to an aversive situation results in the disruption of their "psychological equilibrium" if usual coping mechanisms fail to re-establish homeostasis and if there is evidence of functional distress or impairment (Everly & Mitchell, 2000, p. 212). The original form of Critical Incident Stress Debriefing (CISD) (Mitchell, 1983) was a form of crisis intervention in groups. This approach forms the basis for a variety of psychological debriefing approaches currently utilised by disaster workers, telephone support services and group interventions worldwide. Others, such as Raphael (1986), wrote up their own sets of guidelines for using debriefing in helping those responding to emergencies. The use of psychological debriefing spread quickly, partly due to the need for those not directly involved to overcome their sense of helplessness. For those directly affected it gave an opportunity to speak of what has happened, to try and understand it, and to gain control (Raphael, Meldrum, & McFarlane, 1995).

In 1996 an Australian conference agreed that the key elements of psychological debriefing were that it occurs soon after potentially traumatising events; is led by one or more trained people; it involves the sharing of emotions; teaches coping skills; validates individual experiences of those who shared similar exposure; allows evaluation of stress reactions; and provides an opportunity to identify those who may be at greater risk. Another key element of psychological debriefing was that it is usually a group intervention (Burns, 2002). However, it was often used on an individual basis as well. In 1997 a systematic review of single session psychological "debriefing", the so-called Cochrane Review, was undertaken (Wessley, Rose, & Bisson, 1998). The review

encompassed 11 studies which focused on persons recently (one month or less) exposed to a traumatic event, consisted of a single session only, and the intervention involved some form of emotional processing/ventilation by encouraging recollection/reworking of the traumatic event accompanied by normalisation of emotional reaction to the event. The results showed that single session individual debriefing did not reduce psychological distress nor prevent the onset of PTSD. In fact, one trial reported that there was a significantly increased risk of PTSD in those receiving debriefing. There was also no evidence that debriefing reduced general psychological morbidity, depression or anxiety. The reviewers concluded that compulsory debriefing of victims of trauma should cease (Wessley et al., 1998).

Burns (2002) refers recent measured reviews of research on Psychological Debriefing. Litz, Gray, Bryant, and Adler (2002) of the United Sates National Centre for Post-Traumatic Stress Disorder found little evidence supporting continued use of Psychological Debriefing with people who experience severe trauma; no evidence that the use of mass interventions prevented subsequent pathology; consensus that providing support and information did help coping after stressful events; and that it may have other uses even if not effective as treatment. The recommendation was that individuals should be offered a variety of interventions options, including individual therapy, as debriefing may not suit all (Litz et al., 2002). Burns (2002, p. 25) elaborate on some of the risks involved in psychological debriefing by asking: Does it encourage unhelpful expectations? Do debriefers also talk about the possible positive outcome of extreme events or focus only on what can go wrong? Does it lead to unhelpful re-experiencing of trauma? Is the focus in providing a more complete narrative or on emotional flooding? Does it interfere with natural recovery? Does it add to existing stress through vicarious traumatisation?

A study by the British Psychological Society (Ormerod, 2002) confirms that little empirical evidence could be found that demonstrated the effectiveness of debriefing in accelerating the recovery processes. The report cautions against the use of routine debriefings and arousing strong feelings during them, but suggested that debriefing could provide an opportunity for individuals to feel validated, empowered and de-stigmatised if it is used as part of a “post-trauma package” (Burns 2002, p.25). Kenardy (1998) echoes the problematic issue of the prescription of psychological debriefing following trauma, since the literature and evidence does not support this position. Results in a study by Stephens (1997) showed no difference in PTSD symptoms between police officers in New Zealand who had and those who had not been debriefed. The Litz review (2002) of current research proposes that “psychological first aid” (Burns, 2002, p.32) (rather than traditional debriefing) is an appropriate initial intervention, with support being focussed on practical help, comforting, education about responses to trauma, help with tasks and re-uniting with loved ones. Psychological techniques should not be incorporated and care should be taken not to intrude unless asked. It is thus important to determine what the individual wants to talk about. The final stage involves the identification of future interventions.

In response to the debriefing “controversy”, Everly and Mitchell (2000) reflect that recently some terms have become distorted from their original formulations or current representations within the field of crisis intervention, which in turn has led to misunderstanding and inaccuracies in research. They contend that the

studies did not follow standard clinical protocols for group debriefings and was often conducted with individuals, not groups. Everly and Mitchell (2000) conclude that the findings indicated that clinicians should use caution in implementing a group crisis protocol with 1) individuals; 2) primary medical patients with ongoing medical stressors; 3) as a stand-alone intervention. Implementation of individual crisis counselling and multi-component interventions was instead supported.

The most current model of CISD contains seven phases and typically takes place between 2 and 14 days after a critical incident, except in cases of mass disaster when it is not recommended until three or four weeks post disaster. Mitchell contends that CISD was never intended to be a "stand-alone" intervention, but should be one component of a larger, multi-component crisis intervention programme referred to as Critical Incident Stress Management (CISM). Interventions then range from the pre-crisis phase (preparation) through the acute crisis phase, and into the post-crisis phase. CISM is designed not only for groups, but may also be applied to individuals, families, organisations and communities (Everly & Mitchell, 2000, p.213).

4.9.2 Cognitive Behavioural Therapies (CBT)

Cognitive Behavioural Therapies (CBT) are based on principles of learning and conditioning and involve working with cognitions to change emotions, thoughts, and behaviours (Foa, Steketee, & Rothbaum, 1989; Foa et al., 2004; Rothbaum, Meadows, Resick, & David, 2004). Friedman (2000, pp.45-51) summarises the CBT approaches to trauma as follows:

- Exposure therapy involves techniques such as Imaginal Exposure (repeated exposure to traumatic stimuli through mental imagery) and In-Vivo Exposure (confronting the actual scene of the event) aimed at disconnecting the overwhelming sense of fear from trauma memories.
- Cognitive restructuring involves techniques focused on relearning thoughts and beliefs generated from the traumatic event, which impede current coping skills, by identifying automatic thoughts and correcting erroneous thoughts.
- Cognitive Processing Therapy involves techniques that focus both on the emotional and the cognitive consequences of trauma exposure, aimed at assisting people to move beyond inappropriate emotions and cognitive distortions.
- Stress inoculation training involves a variety of anxiety management techniques (such as social skills training, role playing responses to specific situations and distraction techniques such as yelling 'stop' each time a thought starts) designed to increase coping skills for current situations.
- Systematic Desensitisation is a technique designed to help clients substitute a relaxation response for the anxiety response typically elicited by a reminder of the trauma. Habituation, the gradual, naturally occurring reduction of anxiety or discomfort over time, if exposure is maintained, is the foundation of this technique. It involves repeated presentations of trauma-related cues, starting with cues rates as less stressful on the Subjective Units of Distress Scale (SUDS) scoring system, paired with relaxation.
- Assertiveness training is a technique focusing on replacing an assertive response for the anxiety response typically elicited by a trauma reminder by teaching clients to report their feelings and beliefs directly.
- Biofeedback (about heart rate and muscle tension) and relaxation training involve anxiety management techniques such as breathing exercises and meditation-like tensing and un-tensing exercises used to help clients master overwhelming anxiety feelings elicited by a trauma.
- Eye Movement Desensitisation and Reprocessing (EMDR) is said to involve elements of exposure therapy and cognitive behavioural therapy, combined with techniques (eye movements, hand taps, sounds) which create an alteration of attention back and forth across the person's midline. EMDR is based on the belief that saccadic eye movements (quick eye movements, jumping from one point of fixation to another) reprogram brain function so that the emotional impact of a trauma can be resolved (Shapiro in Friedman, 2000). Some authors have suggested that EMDR is really exposure therapy in disguise and that eye movements may be irrelevant (Foa et al.,1989; Foa et al., 2004).

The concepts and approaches described for individual CBT can also be applied in Cognitive Behavioural Focus Group Therapy (Friedman, 2000). During the exposure session, group members are "vicariously exposed to their own traumatic memories through observing someone else's treatment" (Friedman 2000, p.58). Group members provide social support, validate one another's post-traumatic reactions, share their struggles to cope with PTSD-related problems, and provide honest criticism of fellow members' maladaptive coping behaviour based on accurate empathy and their own experiences. Homework assignments are designed to expose survivors to traumatic material. These include writing exercises or repeatedly listening to an audio-tape previously recorded during a group session focused on exposure to traumatic material (Friedman, 2000). The potentially overwhelming character of intrusive trauma re-experiencing in trauma focussed treatments might inadvertently be re-traumatising and has been identified as potentially problematic (Ford & Kidd, 1998).

Kagee et al. (2004) note that CBT has had a short history in South Africa, with no clinical trials having been conducted to demonstrate its effectiveness in a South African context. They speculate whether local realities and social conditions may be seen as obstacles and assessed South African counsellors' attitudes towards CBT as a means to ameliorate trauma. They found that counsellors in their study thought that CBT could potentially yield positive benefits with their clients, 60% of which reportedly involved trauma cases in community counselling centres. Other South African authors (Els & Van Vuuren, 1998; Marais & Möller, 1998) consider cognitive behavioural treatment as an effective approach which can be carried out in a general practice. Marais and Möller (1998) stress that important parts of therapy are "to begin exposure to the feared situation"; to educate regarding the causes and symptoms of PTSD; to train in behavioural skills aimed at managing anxiety; to "encourage patients to re-experience the trauma"; to "identify, challenge and replace maladaptive automatic thoughts with more realistic, adaptive thoughts"; and to "attribute healthier meanings to the experiences" (Marais & Möller, 1998, p.122). Furthermore, they recommend an integrated and long-term approach and point out that patients suffering from PTSD often have co-morbid problems of anxiety, depression or alcohol and drug abuse.

4.10 Concluding reflections

In this chapter narrative therapy was discussed in terms of its epistemological underpinnings, assumptions and practices. Narrative therapy was described as a therapeutic approach that emphasises the importance of paying attention to the broader context in which problems occur. It is geared towards locating problems in their socio-cultural context, opening space for alternative stories, and thickening these stories through questioning and reflecting. Whilst being attentive to pain and trauma, on the one hand, listening for "double stories" also allows for a focus on resilience and hope. I argued that narrative therapy can be described as a liberating and empowering approach - not in terms of essentialist notions of liberation from repression to be your "true self" or who you "really are"; but in terms of the liberation that people may experience when questioning taken-for-granted or oppressive notions of their identities.

CHAPTER 5: METHODOLOGICAL POSITIONING

At the heart of the movement toward qualitative inquiry in psychology are three intertwined elements. First, qualitative inquiry embeds the study of psychology in rich contexts of history, society, and culture. Second, it resituates the people whom we study in their life worlds, paying special attention to the social locations they occupy. Third, it regards those whom we study as reflexive, meaning-making, and intentional actors.
(Marecek, 2003, p.49)

5.1 Introduction

This methodological chapter starts with a discussion of postmodern research and its implications for this study, since epistemological reflexivity - how the research design and methods "defined and limited what could be 'found'" (Willig, 2001, p.10) - is necessary in postmodern research. The study's qualitative research framework is discussed next, followed by the introduction to the participants and setting of the research. The research design and methods of data collection and management are then described, before the focus shifts to data analysis. Methods of data analysis include constructivist grounded theory, case study methods and conversation analysis. Finally, issues of validation and ethical considerations are highlighted.

5.2. Postmodern research

This study can be positioned within the broad framework of postmodern research. Postmodern research is concerned with "elucidating the processes by which people come to describe, explain and otherwise account for the world" (Gergen, 1985, p.266). Kogan and Gale (1997) note that postmodern research highlights "the fluidity and embeddedness of social interaction in the construction of meaning" (p.101) and has "an anti-objectivist, anti-foundationalist stance with regard to what is knowable" (p.102). There is "a growing realisation that no single story sums up the meaning of life" (Parry & Doan, 1994, p.10). Scepticism towards meta-narratives – "the supposedly universal, absolute or ultimate truths that are used to legitimise various projects, political or scientific" (Appignanesi & Garratt, 1999, p.103) therefore characterises postmodern research. Rather, "local, case-based meanings, acknowledging the value-laden nature of facts and the interactive nature of inquiry" (Denzin & Lincoln, 1994, p.100), are explored. Within postmodern research participants and their understanding of the external world is central. The focus is therefore on stories that are particular, local, and timely, rather than universal, general and timeless. These characteristics of postmodern research inform the methodological position adopted in this study.

The appropriateness of postmodern research for this study is confirmed by the fact that it brings into play the "values, perspectives, hopes, visions, aspirations and personal faith of the person" (Herholdt, 1998, p.217). As such, postmodern research supports the Truth and Reconciliation Commission's (1998) recommendation that "the values, interests, aspirations and rights advanced by those who suffered be affirmed" (p.13). Postmodern research is therefore compatible with the political agenda of this study, namely to co-create conversations in which the values and rights of victims of violence are affirmed.

Although methods that rely on quantification shaped the discipline of psychology in the past, postmodern researchers emphasise that the source of theories in psychology lies in everyday accounts of action and experience (Banister, Burman, Parker, Taylor, & Tindall, 1994). The usefulness of postmodern research for this study is confirmed by the fact that it allows for the acknowledgement of "indexicality" (that an explanation is always tied to a particular occasion or use and will change as the occasion changes); "inconcludability" (that an account can always be supplemented further); and "reflexivity" (that the way we characterise a phenomenon will change the way it operates for us, which will change our perception of it) (Banister et al., 1994, pp.3-4). In this study, reflexivity with regard to research questions - thinking about how they could have been investigated differently and to what extent this would have given rise to a different understanding of the phenomena under investigation – is informed by acknowledgement of the constructive dimension of language. The notion of "critical language awareness" (Fairclough quoted in Willig, 2001, p.10) within postmodern research is important in this study since it reminds us that the words we use to describe our experiences play a part in the construction of the meanings we attribute to such experiences. In this study, meaning attribution is explored through qualitative research.

5.3 Qualitative research

Qualitative research involves attempting to understand the complexity of people's lives by exploring individual perspectives in context through "exploration, elaboration and systematisation of the significance of an identified phenomenon" (Banister et al., 1994, p.3). It is aimed at "the illuminative representation of the meaning of a delimited issue or problem" (Banister et al., 1994, p.3). Denzin and Lincoln (2000) offer a working definition of qualitative research that is applicable to this study:

> Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretative, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including filed notes, interviews, conversations, photographs, recordings, and memos to the self. (p.3)

Qualitative researchers view knowledge as contextualised and local, and argue that "there is no burden of proof …there is only the world to experience and understand" (Patton, 1990, p.7). In contrast, quantitative research is represented by "practices such as experimentation, objectivity and accurate measurement of variables" (McLeod, 2003, p.41). In this study the consequences of trauma as experienced in the lives of individuals and families in the context of one low-income community in South Africa, and the appropriateness of narrative therapy in this context, are the identified phenomenon to be explored. Kagee (2004a) argues that the lived realities of people in communities such as Lavender Hill "do not easily blend with structured approaches that are characteristic of research in North America and Europe" (p.191). In qualitative research, however, unanticipated issues can be addressed and perspectives not usually represented can be documented. Qualitative research therefore fits with the epistemological assumptions as well as the setting and therapeutic approach of this study. Although narrative therapy was discussed in Chapter 4, the principles it shares with qualitative research are made more explicit here. A set of "interlocking themes, strategies and values" (McLeod, 2003, p.72) that can be described as central to both the therapeutic and methodological position adopted in this study, are discussed next.

Qualitative research methodologies and narrative therapy practices share the principle of careful consideration and inquiry about context, lived experience and local knowledge, and about how it contributes to meaning-making (Kopala & Suzuki, 1999). By focusing on the lived experience of participants, the researcher / therapist can attend to how they construct their worlds (Charmaz, 1990). Qualitative research and narrative therapy also share the aim "to explicate the ways people in particular settings come to understand, account for, take action, and otherwise manage their day-to-day situations" (Miles & Huberman, 1994, p.7). Data or narratives are then "not so much about 'behaviour' as about actions which carry with them intentions and meanings, and lead to consequences" (Miles & Huberman, 1994, p.10). In this study, as in narrative therapy in general, the intentions, meanings and interpretations that participants attached to their experiences are the focus of much of the inquiry. The assumption is that the consequences of trauma are informed by the meanings attached to it and that responses to trauma are informed by intentions and values.

Both qualitative research and narrative therapy can be qualified as narrative processes, since "most analysis is done in words" (Miles & Huberman, 1994, p.7) and stories assume central importance. Narrative processes that influence how trauma and resilience are experienced and spoken about in families and communities can be explored in both. In this study, the importance of narrative in meaning construction is emphasised by acknowledging the constitutive effect of stories. The voices of the co-researching participants and their stories of trauma and resilience assume central importance. However, it is important to remember that this is "not a simple or linear process of 'giving voice', but rather a collaborative exploration informed by multiple discourses within psychology" (Lykes, 2002, p.103), and by the local knowledge of the participants.

Within both qualitative research and in narrative therapy, the aim is to do responsible and accountable research or inquiry in a non-exploitative, non-dehumanising way. Consideration of power relations, both within the research encounter and in wider discourse, is emphasised. The need to consider "for whom and by whom" (Madriz, 2000, p.842) research is conducted, as well as to take note of "whose words are privileged" (Madriz, 2000, p.842) is of utmost importance. In this study there is an attempt to conduct research in collaboration with participants, not "on them or about them" (Greenwood & Levin, 1998, p.3). Although a power-differential is impossible to avoid, research participants are viewed as "purposefully involved in co-creating their social worlds and … as active co-equals in the research process" (McLeod, 2003, p.72). The structural power relationships set up by research is partially challenged by designating people who form the focus of research "participants" and "co-researchers" instead of "subjects." As researcher I consider myself a participant, where "all participants bring skills, knowledge and experience to the conversation" (Greenwood & Levin, 1998, p.11). Descriptions of research as "activist participatory" and "passionate scholarship" (Lykes, 2002, p.100) are therefore appropriate for the process envisioned in this study.

Another principle of qualitative research that is shared by narrative therapy is having "empowerment as research goal" (McLeod, 2003, p.72). This involves an awareness of the "social and political implications of the research, accompanied by a commitment to using the research process to benefit the research participants" (McLeod, 2003, p.72). As such, this study is geared toward being "participatory and freeing" (Heshusius, 1994, p.15) and

toward contributing to processes of "social change as well as the creation of valid social knowledge" (Greenwood & Levin, 1998, p.3). The study is geared toward actively involving "oppressed and disenfranchised people in collective investigation of reality, in order to transform their reality" (Mulenga, 1994, p.11) and toward increasing the ability of participants to control their own destinies more effectively (Greenwood & Levin, 1998). The research is geared toward empowering disadvantaged people in Lavender Hill by validating and publicising their views (Banister et al., 1994). In this study, narrative therapy can be described as a form of action research since its methods aim to create openings for collective reflection on new descriptions and situation analyses, which may be developed as the basis for new ways of acting (Greenwood & Levin, 1998).

5.4 Research procedures: Site selection and community entry

During the preparatory phase of this study, I did research for "The Trauma Centre for Survivors of Violence and Torture" (hereafter TC). TC is a non-governmental organisation (hereafter NGO) that provides support to survivors of violence. At that time TC had a team of six psychologists based at a community NGO centre called "The New World Foundation" (hereafter NWF) in Lavender Hill. The NWF provides a variety of community development and counselling programmes aimed at "building a new world of hope, justice and peace" (NWF Newsletter, 2003). It was through on-site consultations with this team that I was introduced to the Lavender Hill community.

It was important to develop a collaborative relationship between myself as researcher and the community, and to retain the complexity of the multicultural context in this study (Suzuki, Prendes-Lintel, Wertlieb & Stallings, 1999). The setting of this study in a disadvantaged community enhanced the need to ensure that the process of recruitment was experienced as collaborative. I developed rapport and a collaborative relationship with the NWF staff through a process of consultation meetings held with the team from TC (primarily involved in working with children in schools in the area), NWF educare staff and the NWF social worker.

Consulting with people with insider expertise is considered important in narrative therapy and community consultants are sometimes recruited. Although I had already consulted with various people working in the Lavender Hill community, I also wanted to meet with people living in the community. To this end, I attended a community-focused event at which there would be feedback about an "appreciative inquiry process" that involved door to door interviewing in the community to get information on a variety of aspects of community life. The aim was to work towards preferred directions as a community, and to gain a greater understanding of initiatives that were being developed. At that community meeting, I met two respected, elderly community members and asked if they wanted to participate in the study as "community consultants." My interviews with them were compatible with the research goals, and as such the consultation process is included in Case study 1.

5.5 Participants

5.5.1 Recruitment and sampling

In further consultation with the TC team and NWF staff it was established that people from the community might be interested in participating in this study. It was agreed that an introductory letter (Addendum A) to the study, and to what participation would involve, should be made available to these workers. They would, in turn, give the letter to interested community members they interfaced with. The letter included an explanation of informed consent. Although most participants were referred to the study by the NWF social worker, some were recruited by other participants. The aim was therefore not to accumulate "a 'representative' sub-set of the general population" (McLeod, 2003, p.72) but to recruit participants interested in the study through convenience sampling. The grounded theory principle of theoretical sampling informed recruitment, in that certain respondents or material were selected because I thought they would be helpful to clarify research categories and questions (Charmaz, 1990). This method is supported by the argument that

> … information derived from *any participant* is valid because that account is a product (albeit complex) of the social domain. If the domain is analysed in its specificity, the resultant interpretation will be valid without the support of statistical samples. (Hollway quoted in Long, 1999, p.48)

Long's (1999) application of these ideas are also relevant to this study:

> In this context, it is suggested that the kinds of struggles and experiences which emerged during the course of this intervention may be related to similar struggles and experiences in other interventions precisely because of their relationship to the social domain and to shared political, emotional and discursive experiences of being South African. (pp.48-49)

Criteria for participants were a) having had experiences of violence that they deemed traumatic; and b) living in the Lavender Hill community. Details of participants follow.

5.5.2 Details of participants

Five cases involving sixteen participants were conducted at the NWF, from April to September 2003. Each case study involved one or more participants. Table 1 summarises participants' details, with 16 participants in total. Participants were grouped together if they often participated in interviews together. Relationships between them are included in the short introductions to each case that follows. The demographic variables such as age, employment status, gender, and religion are also summarised in Table 1. In this study, participants will be identified by their initials in the data extracts.

Table 1

Participant details

Case	Name (Initial)	Gender	Age	Employment / income (monthly estimate)	Active in faith	Household size People / Rooms	Main traumatic incident
1	Bella (B)	Female	60	Pensioner / < R1000	Christian	3 / 2 (Flat)	Torture
	Nina (N)	Female	60	Pensioner / < R1000	Muslim	3 / 2 (Flat)	Emotional abuse
2	Kate (K)	Female	39	Waitress / < R2000	Christian	3 / 2 (House)	Son murdered
	Hilda (H)	Female	19	Unemployed / <R1000	Muslim	4 / 2 (Flat)	Ex murdered
	Tina (T)	Female	47	Unemployed / <R1000	Muslim	3 / 2 (Flat)	Son murdered
	Dusi (D)	Male	1				Father murdered
3	Francis (F)	Female	39	Unemployed / <R1000	Christian	7 / 1 (Shack)	Domestic abuse
	Sandy (S)	Male	15			7 / 1 (Shack)	Friend murdered
	Lettie (L)	Female	3			7 / 1 (Shack)	Shot at in car
	Poppie (P)	Female	9			7 / 1 (Shack)	Shot at in car
	Eva (E)	Female	38	Unemployed / <R1000			
4	Mita (M)	Female	40	Seamstress / < R2000	Christian	6 / 2 (Flat)	Mother of C & A
	Cheri (C)	Female	13		Christian	6 / 2 (Flat)	Sexually abused
	Aston (A)	Male	16			6 / 2 (Flat)	Perpetrated abuse
	Aunt	Female	43	Journalist			
5	Vanessa (V)	Female	21	Unemployed / <R1000	Christian	2 / 1 (Shack)	Gang raped

As can be seen in Table 1, while most participants were female, two teenage boys also participated with their families. The fact that most participants were female, even though the male partners in their families were explicitly invited to participate, is important. It may be an indication that adult males in the community are more reluctant to participate in therapy. It is also important to note that all participants reported struggling financially, with many household incomes estimated at less that R1000 per month. For some, household incomes were irregular or absent in times of unemployment. Many lived in cramped conditions. The range of housing included informal dwellings ("bungalows" or "shacks") with no bathroom; council flats; and a council house.

Active participation in organised religion was also indicated in Table 1. Many participants reported finding meaning in their faith and viewed their relationship with God as an important aspect of their lives. The prominent traumatic events in participants' lives are also included in Table 1. However, it is important to bear in mind that participants also experienced other traumatic incidents. They can be described as living in a context of "continuous trauma" as discussed in Chapter 1. In the following section, participants are briefly introduced and an outline of the interviews is summarised in Tables 2 to 6. All participants could speak both English and Afrikaans. As indicated in Tables 2 to 6 below, some preferred interviews in English, others preferred

Afrikaans. Since I am fully bilingual, this did not pose a problem. Further background to participants' lives and living conditions will be provided in Chapter 7.

Case study 1: Bella ("B") and Nina ("N")

Bella and Nina were approached at the beginning of the study about the possibility of being interviewed as community consultants when I met them at a community function in Lavender Hill, as discussed earlier. In our conversations it emerged that Bella had been tortured when detained by the apartheid government in 1986. Her husband, whom she reportedly missed dearly, died eight years previously. Nina divorced in 1994 after having been in "an emotionally abusive marriage" for twenty-five years, and is re-married. Bella and Nina are included as participants, although they did not seek therapeutic help, since the interviews with them were guided by the ideas and practices of narrative therapy and the data was therefore considered appropriate to help meet the goals of this study. Details of the interview contacts, follow-up interviews, as well as Bella's participation in a conference follow in Table 2.

Table 2

Interview details of case study 1: Bella ("B") and Nina ("N")

Nr	Interviews	Participants	Conference	Participants	Language
1	27 May 2003	B & N			English
2	5 June 2003	B & N			English
3	12 June 2003	B & N			English
4	25 June 2003	B & N			English
	Follow-up				
5	14 Sept 2004	B	17 Sept 2004	B	English
6	2 Nov 2004	B			English

Case study 2: Kate ("K"), Hilda ("H") and Tina ("T")

Participants in Case study 2 are Kate, Hilda and Tina. Kate's only son, Len (20 years old at that time), the father of Hilda's one-year old boy, Dusi, was shot and killed on 17 April 2003. Kate referred herself, Hilda and Dusi to NWF to seek counselling. Tina's son was stabbed to death in her arms on 13 April 2001 and two of Tina's deceased son's friends (who were like sons to Tina) were shot and killed on 1 April 2002 and 23 April 2003 respectively. The women believed that one person was directly involved in all four of these killings. With this shared experience in mind, Kate contacted Tina after Len's death. After discussing the possibility with me at our first interview, Tina joined us. Bella (from Case study 1) acted as a witness to follow-up interviews in 2004. Details of the interviews appear in Table 3.

Table 3

Interview details of Case study 2: Kate ("K"), Hilda ("H") and Tina ("T")

Nr	Interviews	Participants	Letters	Addressed to	Language
1	7 May 2003	K, H and D			Afrikaans
2	12 May 2003	K, H and T			Afrikaans
3	27 May 2003	H			Afrikaans
4	5 June 2003	K, H and T	15 June 2003	K, H and T	Afrikaans
5	23 June 2003	K and T	23 June 2003	K, H and T	Afrikaans
6	14 July 2003	K	16 July 2003	K	Afrikaans
7	22 July 2003	K			Afrikaans
8	2 Sept 2003	K, H and T	10 Sept 2003	K, H and T	Afrikaans
	Follow-up				
9	12 Nov 2004	K (B witness)	13 Nov 2004	K	Afrikaans
10	15 Nov 2004	T (B witness)			Afrikaans

Case study 3: Francis ("F"), Sandy ("S") and Poppie ("P")

Francis and her 15 year old son, Sandy, were referred to me by Kate (see Case study 2). Kate was concerned about Sandy's grief in relation to her son Len's death, since they were neighbours and close friends. Francis had five children. I only met one of her three sons, Sandy, who was 15. The youngest son was 12 years old and the eldest (20 years old) was in prison at that time. Her two daughters, Poppie (aged 9) and Lettie (aged 3) occasionally participated in the interviews. It emerged later that Francis's husband became abusive towards Francis and the children when he drank alcohol. At the third interview, Hilda and Dusi (Case study 2) joined us. Once again Bella (Case study 1) acted as a witness to a follow-up interview in 2004. Details of the interviews follow in Table 4.

Table 4

Interview details of case study 3: Francis ("F"), Sandy ("S"), Poppie ("P") and Lettie ("L")

Nr	Interviews	Participants	Letters	Addressed to	Language
1	9 June 2003	F, S & L			Afrikaans
2	12 June 2003	F, S, L & E			Afrikaans
3	18 June 2003	F, S, L, H&D			Afrikaans
4	24 June 2003	S			Afrikaans
5	30 June 2003	F			Afrikaans
6	22 July 2003	F & S			Afrikaans
7	23 July 2003	F & P			Afrikaans
8	28 July 2003	F, S & P			Afrikaans
9	4 August 2003	F & S			Afrikaans
10	7 August 2003	F & S			Afrikaans
11	2 Sept 2003	F & S			Afrikaans
	Follow-up				
12	12 Nov 2004	F&P (B witness)	13 Nov 2004	F & P	English

Case study 4: Cheri ("C"), Aston ("A") and their mother Mita ("M")

Cheri (aged 12), her brother Aston (aged 16) and their mother Mita ("M") were referred to the social worker at NWF by the school counsellor at Lavender Hill High School when an incident of sexual abuse came to light in May 2003. Aston sexually abused Cheri in February 2003. When I met with the family for the first time, we negotiated separating Aston and Cheri in interviews until Cheri felt comfortable with a joint interview. Mita accompanied each of her children to the first two interviews and at the fifth interview. At the fifth interview, a "team" of two witnesses as well as an aunt were present, as indicated in Table 5.

Table 5

Interview details of case study 4: Cheri ("C"), Aston ("A") and their mother Mita ("M")

Nr	Interviews	Participants	Letters	Addressed to	Language
1	19 May 2003	C & M / A & M			Afrikaans
2	26 May 2003	C & M / A & M			Afrikaans
3	2 June 2003	C / A			Afrikaans
4	23 June 2003	C / A			Afrikaans
5	28 June 2003	C, A, M, aunt & Team	28 June2003	C, A, M & aunt	Afrikaans
6	4 August 2003	C / A			Afrikaans
7	11August 2003	C & A together			Afrikaans

Case study 5: Vanessa ("V")

Vanessa (aged 21) referred herself to NWF since she wanted to speak to a counsellor about being raped at the age of 13. She was married and lived with her husband in a shack. Details of the interviews are summarised in Table 6.

Table 6

Interview details of case study 5: Vanessa ("V")

Nr	Interviews	Participants	Letters	Addressed to	Language
1	7 May 2003	V	11 May 2003	V	English
2	12 May 2003	V			English
3	15 May 2003	V	22 May 2003	V	English
	Follow-up				
4	4 April 2004	V			English
5	8 May 2004	V			English

In this study, the interview process was not viewed as something that needed to be controlled, but is seen as an important part of meaning making (Warren, 2002). In each case study, the number of interviews was determined by the request of the participants for further interviews.

In all but the first case, the venue was the "play therapy room" at NWF – a smallish room that had been brightly painted and was furnished with two desks, a couple of chairs and two shelves of toys. This provided a relatively

safe, contained space. Unfortunately, the room was not always available and on occasion another larger, less intimate conference room had to be used. On another occasion an interview had to be interrupted and re-located to this room due to an unexpected demand for the play therapy room. In Case study 1 the interviews were conducted in one of the participant's flat, since these participants were initially approached as consultants and preferred to meet there. The venue of these interviews provided me with more opportunities to witness the living conditions in the Lavender Hill community.

5.6 Setting: The Lavender Hill community

The setting of this study is central to the research exploration and as such is discussed next. The significance of Lavender Hill's history should be emphasised as shaping of some of the current socio-economic and safety challenges in the community. As such, these aspects are discussed next. Participants' words are included since the local, context-specific content of their stories captures the setting in unique ways.

5.6.1 History

Lavender Hill was established in the early seventies, when so-called "coloureds" (a controversial term used by the apartheid government in the classification of people of mixed race[1]) were forcibly removed from the centre of Cape Town to the outskirts of the city. This happened under the Group Areas Acts, an apartheid law that forcibly created separate living areas for people of different skin colours (Unterhalter, 1987). At present, the population of Lavender Hill is still predominantly "coloured." Many residents of Lavender Hill originally came from District Six, which was a vibrant area near the centre of Cape Town. It is interesting to note that Lavender Hill was named after a street in District Six and that many streets in Lavender Hill were named after courts (blocks of flats) in District Six (TC Report, 2003). Bella and Nina told me about how they experienced being moved to Lavender Hill. Ironically, Bella reflected that initially some people were happy about being moved. These women were some of the first tenants of the flats built in the seventies and were still living in the same flats when this study was conducted. They reflected on the loss of social support and financial means they experienced after being moved to the area:

> N: People were scattered. People had to learn to get to know one another again. People from all areas were moved here. They were all scattered around. All from one area were not put together.
>
> B: I moved from Claremont, by the Group Areas Act. We moved in here in about 1972. People were very happy to move, because we came out of very old houses. You know, where there were wooden floors. It was very old. We were very anxious to move because we had very old houses, but it was home. It was home, because the neighbours knew each other. We could share. I could run short of something and ask. If there were sicknesses or death, whether we were Muslim or Christian, we all went to help. We would do what we could. So in 1972 when we moved here, it was funny – we all so looked forward. You know, it was all so exciting and the attraction was that in our old houses we all had outside toilets and here we were going to have a bathroom. We used to make our water and bath in the rooms. Here we are going to have a bathroom and inside toilet! The water inside - it was very exciting, so convenient. We said amongst each other, "Now we are going to have the same as the white people." So we were disappointed when we moved in here to these ice-cold buildings. Just sand. That was not even so disappointing yet. The disappointment came as days

[1] *The use of the term "coloured" is subject to controversy. It is perceived by some as derogatory, whilst others argue the significance of a "coloured" identity. Here and throughout the term "coloured" will be used descriptively of a particular cultural community (De Villiers, 2006).*

went on. We discovered we were further away from work. We also discovered that the rent was much higher, so we were paying a lot more to the council and we had very little money. We had less money left now. So we had to learn to budget.
N: There was also the double expense of travelling by taxi as well as by train.
I: So when you were told that you could move here, did you have a chance to look at the place before or how did it work?
B: No, you got a flat and a number. We were anxious to leave the old houses, because they would not fix them.
I: So it was not that you had to be physically removed?
N: No, but we were forced to move, because the places we were living in were on demolition sites. They gave some choice, "You either move to your own place or to the place we can give you, but this place is going to be demolished."

5.6.2 Socio-economic challenges in the community

Lavender Hill has been identified as a socially disorganised community characterised by "widespread poverty, economic disadvantage, overcrowding, limited resources and opportunities, and antisocial behaviour such as gangsterism and crime" (Mapham, Lawless, Abba, Ross-Thomas & Duncan, 2004, p.7). Dinan et al. (2003) describe Lavender Hill as "an established subeconomic area" and many of the residents can be described as poor. Tomlinson et al. (2004) note that there is a growing realisation internationally that poverty is "part of a complex of social, interpersonal and psychological factors that impact on individuals, groups and entire societies" (p.410). A report by the World Bank (2001) supports this idea by highlighting dimensions of poverty:

> Poor people live without fundamental freedoms of action and choice that the better-off take for granted. They often lack adequate food and shelter, education and health, deprivations that keep them from leading the kind of life that everyone values. They also face extreme vulnerability to ill health, economic dislocation, and natural disasters. And they are often exposed to ill treatment by institutions of the state and are powerless to influence key decisions affecting their lives. These are all dimensions of poverty. (p.1)

The unemployment rate in Lavender Hill was 60% in January 2000 (TC Report, 2003). Housing is a problem for many in Lavender Hill and has resulted in overcrowding (TC Report, 2003). Council flats, like those that Bella and Nina lived in, were built in the 1970's. St Montague Village, where some of the participants lived, was started in 1990 and had 400 one-roomed homes built by 1994 as part of the government's Reconstruction and Development Project. At present, houses and flats are in need of repair and rewiring, but outstanding rent has limited available funds to address this problem. A rent assistance programme has been implemented to help with large overdrafts on rent and there has been a moratorium on evictions (TC Report, 2003). However, despite the socio-economic problems that many residents face, Bella reminded us that there had been "victories as well."

> B: People are still unemployed. People are still living in crowded houses. But, there were also a lot of developments in this area. We must not just be negative about this. Rent has come down. Parks have been built. Maybe not so beautiful, but it was there for our children. So we have to look at the victories as well.

5.6.3 Violence in the community

Prior to 1994, South Africa had a long history of political violence. However, in the post-apartheid era many communities continue to live in contexts where violence is "endemic, frequently permeating multiple settings,

including home, school and neighbourhood" (Van der Merwe & Dawes, 2005, p.3). As indicated in Chapter 1, Lavender Hill is such a high-violence community, where violence against women and other community stressors are "pervasive components of the environment in which these women (of Lavender Hill) live" (Dinan et al., p.737). Results of a questionnaire on exposure to violence conducted amongst parents in the Lavender Hill community indicated that 77% of respondents were afraid of gangs/violence in their community and 81% said that they hear gunshots/violent fighting while at home, typically at night (Petersen, 2002). Participants' stories illustrate the violent context in which they live, as these extracts show:

B: We have been struggling in this Lavender Hill area. You have the victory in the one thing and then another thing comes up. We have never had so much gangsterism before. The first death was a shock. Now it is one of those things. We never ever thought that they would go for our seniors; that they would murder children. I mean, I was watching the news this morning…you cannot ride safely. You are not safe in your car anymore. It was about how they hi-jacked these guys and how they burnt them. So a lot of things go through your mind. You are not safe any more. We fought for this, but what can we do? How can we get rid of this – the crime?

B: Gunshots go through here anytime of the night. And if the dog barks, it brings that (haaa) with it. And it is nothing. We have to watch the car – that they don't break in at the car. But then you are awake and a whole lot of things come back to you. You put on the TV and it sparks off something in you – this is was they did. There are a lot of things. How can we stop this gangsterism going into the area? The shooting has become one of those things. Children are not safe anymore. And these walls are so thin, they can shoot it away.

M: And she is not a child that plays outside. I don't let her go out. I don't let her walk around because I always tell her, "Cheri, our area where we live is so cruel." They picked up an eighteen year old girl one Saturday morning on the schoolyard. She was so badly raped that they broke open her legs. Her legs lay like this {indicates a 180 degree angle}. They murdered her. Her eyes stared into the sky, but she was dead. "I will not be able to handle it if anything has to happen to you. So stay in the house. There is nothing for you outside the house." Sometimes I will give her money just to keep her happy. "Take the money and buy yourself something nice and come back and sit with me."

M: I always say to him, "Aston, I just want to say my dad was not a thief. He was not a gangster. He was a hard-working dad who did not stand on the corners. He used to work until he died. He had two years at home suffering from cancer and it took him away. I am not going to raise gangsters, drug-addicts or anything like that. No abusive children in my house." And I told him on Friday night, "You are capable of becoming a murderer." Because two years ago another child we know took his mother's friend's child to the school grounds and brutally killed that six-year old. Raped her first and then killed her. And then I said, "And you are the same age, he was sixteen, you are now sixteen, and it can happen to you."

K: …I feel in the end I will be just as violent, because I will also want to do something to someone who does such things. Do you understand? It is like a chain reaction. I might see he stabs you, then I want to stab him, so it is a chain reaction.
I: So would you like to rather break that chain in some way?
K: Maybe, yes, but I don't yet feel these three that were together when my son was shot (.) One of the drug smuggler's people told me yesterday that one of those three was shot dead. Then I said, "It is not in our hands to kill someone." Then he said, "No, we don't worry, the other two will also die." See, so it goes on and on. I am almost like used to this life. That is why I told you I fear nothing. It is almost as if I have got used to this evil life.

F: ... Then just two Sundays after his death, they shot at my husband. He {points to Sandy} and she {points to Lettie} and my other little daughter were in the car. …They shot seventeen shots. According to these men, they fired seventeen shots.

K: And because it {death by shooting} is a regular thing here in Lavender Hill, in Montague Village, I have always feared something like this. That was my biggest fear that now came true. And I believe every parent fears that, especially those who have young sons.

K: … there are too many evil people in Lavender Hill. They will come to you, they will rob you, they will stab you with a knife or shoot you.

Kate's reflection on the violence in Lavender Hill as being "like a chain reaction" speaks of the complexity of the situation and the lack of safety and security in Lavender Hill. A community profile report (TC Report, 2003) indicates that gang violence, domestic violence, child abuse, assault, housebreaking and robberies, as well as drug and alcohol abuse are rife in Lavender Hill. Gang violence can be defined as "any relation, process or condition by which a group violates the physical, social and/or psychological integrity of another person or group" (Reckson, 2002, p.33). Gangs are about social networks, social situations and social interactions and gangs on the Cape Flats have been described as "alternative family forms" (Marais quoted in Reckson, 2002, p.33). Gang violence arguably constitutes "a form of structural violence" (Reckson, 2002, p.34) and it has a social history - it can be seen as a manifestation of historical oppression and inequality in South Africa.

A study conducted in Lavender Hill (Van der Merwe & Dawes, 2005) found that 70% of the sample of primary school children had witnessed violence, including murder, domestic violence and other forms of assault. Forty-seven percent of children had been victims of assault. The impact of this violence seems to be enhanced by the fact that "socially disorganised communities (such as Lavender Hill) preclude children from opportunities to engage in health promoting occupations" (Mapham et al., 2004, p.7). The principal at the school were that study was conducted reported that 48% of the pupil's parents were unemployed and the fathers of 40% of the pupils are in jail (Mapham et al., 2004). Mapham et al. (2004) express concern about the health compromising nature of the children's behaviour in Lavender Hill. Children growing up in Lavender Hill are "continually confronted with a number of challenges and restrictions to optimal development and participation in life opportunities" (Wonnacott, 2004, p.10). Poverty and the high rate of unemployment produce a number of socio-economic issues such as crime, substance abuse, physical, sexual and emotional abuse, and limitations in play opportunities. Wonnacott (2004) confirms that the violent environment in Lavender Hill is reflected in the games that the children play. Some of the games that she describes include "*skop mekaar*" (where the children kick each other) and "rape me - rape me" (where the boys catch the girls and simulate sexual intercourse) (p.10). Ways in which the children play seem to be particularly aggressive, for example, when playing soccer the winning team got to beat up the losing team. Wonnacott (2004) argues that aggression and violence could be seen both as "an attempt to act out and understand their world" and "as learnt behaviour" since they knew no other way of engaging (p.10). Interviews with community consultants touched on the limited sports facilities and youth activities in the area. This was said to be largely due to fear around children's safety, since gangs had used the soccer field as a "battlefield":

N: I had just actually spoken to Bella before you came. I met a guy who is now involved with the residents association, which was run by us. We want to discuss a little project with him. He is also on the Sports Board. That would also give us introduction to the youth.
B: Now that you are talking, there is some church youth that belonged to some of the soccer teams in Lavender Hill, but they are totally out of it because they say they have to play on the battlefield, you know where the shooting is …
I: Yes, that is what the mother of the boy I am working with was also saying.

B: And they said they are so scared because some of the gangsters got involved in some of the teams, like here they are seen as rival gangsters. They don't know peace, because [over two weeks in the year] they shot somebody, so they said this is not really peace.

Reportedly, children are used as shields in gang violence, with gang members waiting for the school bell to ring so that they can start fighting. As a result, certain schools decided not to ring the bell when releasing learners. The "Safe Schools" intervention programme, a provincial initiative, has been implemented in some schools in Lavender Hill to protect learners (TC Report, 2003).

I: And in terms of the current situation in Lavender Hill, does that also contribute to fear?
B: My granddaughter. She is fifteen. She lives with me. She has to go to high school and we have these gangsters, we have the shooting, we have our children being raped. And you know, these are all the things that sit with me when it gets to quarter to three.
I: Is that the time that she should be home?
B: Yes. And when she is delayed I go through a panic.

Despite the high levels of crime, the satellite police station that used to exist in Lavender Hill was closed. At present the nearest police station is in the neighbouring area, Steenberg. Police services have been deemed ineffective in combating crime due to a variety of factors, including lack of person-power, stress, working under pressure and not being validated by superiors (TC Report, 2003). The tremendous stress the South African Police Service is under, compared to the United States, become clear in Nell's (2001) report:

It is one thing to expect police efficiency from a homicide squad dealing with 90 deaths a year in a city of a million people – the rate to be expected in a typical US city where the homicide rate is 9 per 100 000 population per annum. It is quite another to have such expectations in Johannesburg, where - at the current incidence of nearly 90 per 100 000 per annum - there are some 2 700 murders a year in a conurbation of some 2 million people. (p.265)

Concern and dissatisfaction about inefficient policing in the area was expressed by a participant in this study:

K: It is being followed up but (.) the police take their time. Understand? One cannot anymore - to tell you the truth, we don't have faith in the police anymore, because if the police had done their work then we don't believe such things would still happen EVERY DAY. That same person that shot him that Wednesday night shot again on Sunday and shot again the Wednesday. And they are not yet caught. And I mean they live in this area.

K: Because I live opposite a smuggler, I could see how corrupt the police are, and that made me angry.

K: Yes. I have already tried. A week before Len's death I phoned one of the high positions in the police to tell them about the unfairness that is happening here and about the police not doing their work. A week after Len's death I phoned that same man and told him of Len's death. I asked if he could see now, in what kind of situation we live here in Lavender Hill. Then he said he understands, but their hands are tied, they do not know what to do with the corrupt police. Now we who live in the community, we see these things.

According to the New World Foundation Newsletter of July 1998 violence in the area may be influenced by the release of gang members from prison. Despite quiet periods each year, gang violence starts again once enough gang members had been released. Gangs operating in the area are said to be involved in drug smuggling, extortion, intimidation of children, using children to commit crimes, armed robberies, burglaries, theft, shootings and assaults (TC Report, 2003).

F: … we have been here for 10 years but we still don't know this part of Lavender Hill.
I: Really - why?
F: Because we don't want to walk this side, if we can help it.
I: And your area is Montague Village? Is that quieter?
F: Yes, it is quieter. But since the gangsters have taken over, it is not like it used to be. At that time we could still walk if we perhaps needed help at night. Now we cannot take those chances any more.

V: … The one is very popular in Lavender Hill. He is a guy who is abusive to a lot of girls. I only recently heard about it. My husband told me about this guy. He didn't know that I knew this guy and that this guy raped me, you see. And I was talking, "Oh yes, they call him X." He said, "I am so scared of X because X robs the guys and stuff at the station." …And I asked him "Who's this guy? Tell me about him." And he said, "He used to be a Naughty Boy and he used to be a gangster in Lavender Hill." And I thought, "Oh yes, that is him."

Although gangs might terrorise their communities with drive-by shootings, rape intimidation and murder of residents, Merten (2002) notes that they also, to a large extent, replaced local council authority: "They organise everything from cash for school uniforms, a free taxi ride to hospital, rent money and soccer tournaments" (p.24). In Lavender Hill, gangs have reportedly also gained recognition as part of the community, and some people are said to support gangs, benefiting from them financially and in the 'protection' they offer. It is also reported that gangs pay rent to unemployed people who store their drugs and weapons; they finance local soccer clubs and organise social events for young people. They also lure young girls into dealing in drugs and prostitution (TC Report, 2003).

B: …We have got gangsters, and some gangsters have others who support them. It is their children. It is family related when you look back. Schools now are not accepting children if they have not paid their fees. And so children have the feeling – they feel shy because there is unemployment and they cannot afford smart clothes. So they are already planting in children to feel ashamed, so they move out. Where do they move to? Where do they go?

N: I heard it through the grapevine that in actual fact in Capricorn the Bostons are taking over, so now I have heard that all the old gangsters are coming back, like the Hard Livings, the Jukkies, the Euro Katte. They are all going to come back, not to be gangsters in the area, but to go into Capricorn to actually get the Bostons to move right out of the area. All these old gangsters are going to unite and they are going to take on the Bostons.

"*Smokkelhuise*" (drug smuggling homes) where illegal drugs and alcohol were sold, are said to be common in Lavender Hill (TC Report, 2003). Living next to gang members or drug smugglers can place the neighbours at risk through their interaction and perceived connection. This became evident in Kate's story:

K: They are gangsters. They walk through the people and see who they can shoot. And because I live across the road from a drug smuggler, it put Len in danger. Because we live that side and we live across the road from this man and if you are neighbours, you will chat a word or two. We are not friends with them but if they chat we chat back with them. Now that is why Len's life was always in danger. And the people who shot him know he is not a gangster. And I know as a parent he has never hurt anyone. That is why I have peace and I feel he has been taken out of the evilness. Understand?

K: …And I feel that it is because I live opposite this man and this man is in danger. Everyone wants to kill him, because it is not the first time that they shot at his place.
I: So he is a drug dealer?

K: Yes, he is a drug dealer and we live opposite him. And when Len passed there, he would chat to him. He has also driven this man's car, this man has sent him with the car.
I: So he was associated with him.
K: Yes, but they know for a fact he is not a gangster. And Len has never done anyone any harm.

To summarise, participants' stories highlighted the context of poverty and violence in Lavender Hill community. However, they also spoke of their appreciation of the development of resources within the community.

5.6.4 Community resources

Within the context of poverty and violence in Lavender Hill, the need for community initiatives to address some of these problems has been identified. Two significant initiatives are included as examples in this discussion. One initiative is the "Heal Our Land Initiative" (HOLI), established in October 2002. According to the NWF website, HOLI was established when "it became clear that many authorities and role players had given up on the (Lavender Hill) community and the police had even labelled the area as too dangerous to enter" (2005b). HOLI developed out of the "identification of the need for the church to be used as a vehicle for love, peace and hope in the community" (NWF Website, 2005b). It has resulted in an extensive network of churches (across different faiths) that co-operate in initiatives to promote peace.

Another example is "The Lavender Hill Development Forum" that was launched in June 2003. The forum aims to co-ordinate the development efforts of non-government organisations, local government, community structures and other concerned groups and individuals in the community. Sectors identified by the forum include youth development, business development, education, social development, health services, infrastructural development, community safety, gender development, religious support, sport development, cultural development and environmental development.

5.7 Research design and implementation

In practice, the qualitative research process can be divided into two broad types of activity, namely gathering data and analysing data. These activities are often carried out in cycles of inquiry and may appear to be happening at the same time. In this section, methods of data collection and management are discussed. In each instance the actual procedures implemented in this study are highlighted once general principles about the methods and their "fit" within the epistemological framework of this study have been discussed.

5.7.1 Data collection: Narrative therapy interviews

In this study narrative therapy interviews were used as a means of data collection and conducting qualitative research. As discussed in Chapter 4, from a narrative therapy perspective the exploration of the consequences of trauma involves inquiry that result in "double-storied" (White, 2004, p.49) accounts. Such accounts not only explore the consequences of trauma, but also involve an illumination of people's responses. In interviews, "double-listening" (White, 2004, p.49) requires focusing on what participants' responses to and evaluations of

problematic consequences say about their beliefs, values, hopes and dreams (Mann, 2005). These responses are often linked to alternative stories of their lives which may previously have been silenced or unacknowledged. Narrative therapy interviews can be regarded as semi-structured, open-ended and in-depth. The interviewer is influential in terms of "building a scaffold" (White, 2002, p.4), as described in Chapter 4. Interviews are therefore "not neutral tools of data gathering, but active interactions with contextually based results" (Fontana & Frey, 2000, p. 646).

It has already been highlighted that narrative therapy interviewing shares many features with qualitative research interviewing (Kvale in McLeod, 2003). Both seek to describe and understand the meaning of central themes in a person's life through obtaining nuanced descriptions of specific situations and action sequences. Rather than coming with ready-made categories and schemes of interpretation, there is openness to new and unexpected phenomena. In both, the interview is neither strictly structured with standardised questions, nor entirely 'non-directive', but is focused on certain themes or practices. In narrative therapy interviewing it is it hoped that ambiguity and changes in descriptions and meanings about a theme may produce awareness of new possibilities.

To summarise, interviews are concerned with the subjective meaning accorded by participants and are flexible enough to explore issues that may be too complex to investigate through quantitative means. Schwandt (1997) notes that the interview is often viewed as "a form of discourse between two or more speakers or as a linguistic event in which the meanings of questions and responses are contextually grounded and jointly constructed by interviewer and respondent" (p.79). This makes it particularly suited to research informed by poststructuralist thought.

5.7.2 Data management: Tapes, transcriptions and translation

For each of the five case studies the initial interview and final interview of 2003 were audio-taped, transcribed and coded according to grounded theory protocol. As recommended by Willig (2001) I explained to participants at the outset of the study why the interviews were being recorded and in which manner it would be used. In order to ensure confidentiality, the audio-tapes were stored in lockable storage. As recommended by Charmaz (1990) I did the transcriptions, so as to engage with the data from the beginning of the research process. Transcription guidelines compiled by Mishler (1991) were used and anonymity was ensured by the use of pseudonyms. As recommended by Kvale (1996), transcriber reliability was addressed by listening to the taped interviews again while simultaneously checking the written material. At times, recordings were replayed a few times to make certain that words and phrases were presented as they had been spoken. As Bird (2000) points out, however, transcripts should not be read as accurate reflections of lived experience, since they belie "the complexity of the conversation by sheltering the reader from the emotional exchange between people" (p.1). In terms of validity, it needs to be emphasised that transcriptions can never be "copies of representations of some original reality" (Kvale, 1996, p.165). Instead, they are "interpretative constructions that are useful tools for given purposes" (Kvale, 1996, p.165).

In this study, another level of interpretative construction was added, since certain interviews (Case studies 2, 3 and 4) had to be translated from Afrikaans into English. Since language is potentially important in the development of rapport (Kagee, 2004a) and I am fluent in both English and Afrikaans, participants' language preference was honoured. Macleod (2004b) points out that translation and interpretation are areas that appear to be inadequately reflected upon in South African research. Translation raises issues of language and culture, and underscores the interpretive character of the research process. For both financial and practical consideration, I translated the Afrikaans interviews into English. Given the epistemological frame of the study, my participation in the interviews and resultant contextual knowledge of non-verbal communication arguably enabled me to complete the task of translation as a form of interpretation. In light of my participation in the interviews and the co-creative part that I was playing in the meaning-making process, the translations can be viewed as another level of interpretation. It needs to be pointed out, however, that in translation words might have lost parts of their implied meaning. Selected words considered to lose too much meaning in translation are included in the original language (*in italics and in brackets*).

In this study, the style of language used by participants was informed by their context. As such, it might seem peculiar to readers who are not familiar with the parochial language of the Cape Flats in which idiomatic, unique and descriptive words and phrases are often used. Willenberg (2004) highlights that "coloured communities in the greater Cape Town area display characteristic speech pattern which result from the juxtaposition of English and Afrikaans" (p.35) and that "working class coloured communities use a dialect of English which strongly reflects convergence with Afrikaans" (p.35). She notes that the use of calques or word-for-word-translation, is a common feature of language usage in these communities (for example "Give the book for me", for the Afrikaans *"Gee die boek vir my"*). Another common phenomenon is code-switching, which may involve the use of either single Afrikaans words or phrases within the utterance or switching of languages from one sentence to the next (McCormick, 2002). These language phenomena were at times implemented by participants in this study. A word-for-word translation strategy was used where this was considered to best reflect the context-specific language use of the speaker. These strategies are therefore important to bear in mind when reading the English extracts (both translated and non-translated) from the interviews.

5.8 Data analysis

Data analysis in this study fits within a narrative approach to research since it "treats interview data as accessing various stories or narratives through which people describe their worlds." As Silverman (2000) explains:

> This narrative approach claims that, by abandoning the attempt to treat respondents' accounts as potentially 'true' pictures of 'reality', we open up for analysis the culturally rich methods through which interviews and interviewees, in concert, generate plausible accounts of the world. (p.823)

It was considered necessary to use methods of analysis that facilitate an understanding of the ways discourses can be used to construct participants' stories in order to make them explainable and understandable to others. In this study, these methods included constructivist grounded theory, the case study method and conversational analysis.

5.8.1 Constructivist grounded theory

Grounded theory is a well-established method of qualitative data analyses in psychological research (Charmaz, 1995; Pidgeon & Henwood, 1997) and has been shown to be appropriate for exploratory studies evaluating the process in therapy (Woolley, Butler, & Wampler, 2000). However, grounded theory has been critiqued as paying inadequate attention to the role of the researcher – for not attending adequately to questions of reflexivity (Willig, 2001). Although grounded theory was at the forefront of the "qualitative revolution" (Denzin & Lincoln, 1994, p.ix) at one time, it has subsequently also has been criticised because early versions proposed a set of technical procedures and espoused verification. These early versions can be criticised for their continued assumption of an objective external reality, for their fragmentation of experience and for being aimed towards unbiased data collection. Constructivist grounded theory was proposed to counter criticism of the early versions of grounded theory as developed by Glaser and Strauss (1967) and developed by Strauss and Corbin (1998). Constructivist grounded theory is said to have "reclaimed the powerful tools of grounded theory for understanding empirical worlds with a revised, more open-ended practice that stressed emergent, constructivist elements" (Charmaz, 2000). Constructivist grounded theory emphasises the importance of contextual factors (Denscombe, 1998; Parr, 1998).

Constructivist grounded theory is informed by poststructuralist discourse and as such, it is based on the assumptions that there are "multiple social realities" and that knowledge is a "mutual creation by the viewer and the viewed" (Charmaz, 2000, p.510). An interpretive understanding of a subject's meaning becomes an important aim of constructivist grounded theory. There is an emphasis on the "social interpretation and the inter-subjective influence of language, family, and culture; on how people interact to construct, modify and maintain what their society holds as true, real, and meaningful" (Freedman & Combs, 1996, p.27).

Constructivist grounded theory methods involve processes of coding and constant comparative analysis. Coding is a process during which categories are identified by attaching descriptive labels to discrete instances of phenomena. At first, so-called low-level categories, grounded in the data, emerge. As coding progresses, so-called higher-level categories emerge, which systematically integrate low-level categories into meaningful units (Charmaz, 2000). Categories refer to the groupings together of instances that share central features. Categories can function as "descriptive labels" (Willig, 2001, p.33) which does not involve much abstraction. However, higher levels of abstraction can also lead to the emergence of analytic categories, which requires interpretation of phenomena. Ideally, categories should be "*in vivo*" (Willig, 2001, p.34), utilising the words or phrases of participants. Constant comparative analysis involves moving back and forth between the identification of similarities and differences between emerging categories. Emerging subcategories are identified by focusing on differences within categories, thus ensuring that categories are not just built up, but also broken down into smaller units of meaning. The aim is to "counteract homogenising impulses" (Willig, 2001, p.34) and to recognise the complexity and diversity of the data. Extensive verbatim material was used in this study to reflect the experiences of participants in their own language. Verbatim material of participants' own language was also used in describing the contextual setting of this study. This is done in an attempt to address the criticism that

grounded theory does not take language seriously enough and that it may decontextualise data by splitting it up (De Villiers, 2006).

In this study constructivist grounded theory analysis was used to analyse the first and final interviews of all cases. Grounded theory methods were used as flexible strategies rather than formulaic procedures, in what Willig (2001) describe as "an abbreviated version of grounded theory" (p.35). Time and resource constraints prevented the implementation of a full version of grounded theory. The abbreviated version works with the original data only. The process of coding and constant comparative analysis was implemented once the emerging categories grounded in the original data had been identified. Since the abbreviated version of grounded theory was used in this study, depth of analysis generated by line-by-line coding was needed to compensate for the loss of breadth that accompanies the researcher's dependence on the original data set (Willig, 2001). Line-by-line analysis helped to ensure that analysis was grounded in the data and not imposed upon it, as did the use of "*in vivo*" categories. The use of "*in vivo*" categories fits within the narrative therapy practice of privileging the client's voice, rather than putting interpretative labels on them. The results of this process are included in Chapter 6.

5.8.2. The narrative case study method

Case studies have played an important role in the history of counselling and psychotherapy as "effective ways of communicating and teaching concepts and methods associated with different approaches such as psychoanalysis, behaviourism, and a client-centred approach" (McLeod, 2003, p.99). More recently there has been an increasing acceptance that the case study represents a legitimate approach to research in the field of counselling and psychotherapy. McLeod (2003) summarises the potential of the case study method as follows:

> The case study method has the potential to contribute knowledge and understanding that is highly relevant to counselling practice. In comparison with large-scale statistical studies, the detailed analysis of individual cases yields information that is immediately applicable to the counselling relationship. Case study methods are also well suited to describing and making sense of processes of change. Finally, case studies are flexible enough to accommodate situations where the researcher may not have, and may not wish to have, any control over the behaviour of the "subject" of the study, or little control over the amount or type of data being collected. (pp.99-100)

Despite many advantages and positive attributes, case study methods have not been widely used in counselling research in recent years. However, as McLeod (2003, p.101) points out, "for many practitioners and researchers in counselling and psychotherapy case study research represents the best way of constructing a knowledge base that is relevant to practice." Fishman (1999), Elliot (2002), and Yin (1994) argue that more case-based studies should be a major priority in the field of psychotherapy. Prilleltensky and Nelson (2002) specifically highlight the need for case study research in narrative therapy. Hilliard (1993) suggests different forms of case study research and identifies qualitative or narrative case study as a study that "relies on the use of qualitative techniques to elicit and analyse descriptive accounts." Such case studies are "concerned with making sense of the stories people tell about aspects of their experience" (McLeod, 2003, p.101). Examples of this type of case study include works by Yalom (1989), Etherington (2000), Dryden and Yankura (1992), McLeod and Lynch

(2000), and McAdams, Josselson, and Lieblich (2001). Narrative case studies were chosen as a method for this research study due to its compatibility with both the epistemological and therapeutic positions that informed the study.

Storytelling was used as part of the research procedure and as a method of reporting the data in the case studies. A non-sequential structure was used so that the stories of the case material could be presented in thematic sections. This writing strategy allowed complex and interlocking material to be portioned into blocks of writing in themes (McLeod, 2003). A loose form of conversation analysis, based on the work of Muntigl (2004) was used to structure the case studies. As such, it is discussed next.

5.8.3 Conversation analysis

Although the importance of language in altering client realities has been recognised in social constructionist research on counselling, the linguistic means through which change occurs, has received scant attention (McNamee & Gergen, 1992). However, in his book "*Narrative counselling: Social and linguistic processes of change*", Muntigl (2004) explores linguistic change in systems of meaning-making that unfold in narrative therapy. His interest is in establishing whether the way that meanings is constructed in therapy interviews play a role in bringing about development in the client's meaning-making; and whether certain kinds of language resources selected during interviews are indicative of a certain counselling approach. As indicated in Chapter 4, language is central to narrative therapy interviewing and as such, the method of analysis seems appropriate. In this study, language is viewed as playing a central role in constructing reality - it is not reduced to mirroring internal or underlying reality. From this perspective language can be described as "a resource that speakers use to do things" (Muntigl, 2004, p.1).

Muntigl (2004) highlights two conversational genres as central, namely "problem construction" (p.115) and "problem effacement" (p.115) based on his analysis of narrative therapy interviews. Problem construction can be divided into two stages, namely "problem identification" (p.115) and "problem agency" (p.119), where the problem is "construed as the agent of negative client behaviours" (Muntigl, 2004, p.119). In narrative therapy literature practices that involve "problem construction" is termed "naming the problem", and exposing "problem agency" is referred to as "externalising the problem" (White & Epson, 1990, p.42). As discussed in Chapter 4, externalising conversations involve the counselling practice of "mapping the influence of the problem" (White & Epson, 1990, p.42).

Munigl (2004) divides the process of "problem effacement" into two stages, namely "Identification of Alternative Events" and "Alternative Event and Client Agency" (p.118). As such, "effacing problems translates into identifying alternative events to those that the problem causes and construing these events or clients, rather than the problem, as the agents of client behaviour" (Muntigl, 2004, p.118). In narrative therapy literature the processes of problem effacement is referred to as identifying unique outcomes and thickening the alternative story. The formulation of alternative events allows the client to instigate change. By associating the clients with the ability to instigate change, "problem agency is effaced" (Muntigl, 2004, p.124). Muntigl (2004) indicates that "the *how* of the problem construction and effacement unfolds as the interaction between counsellor and

client unfolds" (p.115). The genres identified by Muntigl (2004) were used to structure the case studies and are summarised in Table 7.

Table 7

Process headings used to structure case studies

Muntigl's counselling genre	Corresponding maps of narrative practice
1. PROBLEM CONSTRUCTION	1. PROBLEM-SATURED STORY / PLOT
1.1. Problem Identification	1.1.Naming the problem
1.2. Problem Agency	1.2. Externalising the problem
2. PROBLEM EFFACEMENT	2. ALTERNATIVE STORIES / COUNTER PLOT
2.1. Identification of Alternative Events	2.1. Discovering / naming an alternative story
2.2. Client Agency	2.2.Thickening alternative story through re-telling

Within narrative therapy a variety of practices are used in the process of "thickening the alternative story" (Morgan, 2000, p.73) through maps of re-telling, as discussed in Chapter 4. These practices are used to structure sections of the case studies that focus on the second stage of problem effacement, namely client agency. The narrative practices used to thicken alternative stories are summarised in Table 8.

Table 8

Narrative practices used to thicken alternative stories

Therapeutic letters and documents
Re-membering conversations and 'saying hullo again'
Building a wider audience: Witnesses, communities of concern, definitional ceremonies
Reflection on the process

Muntigl (2004) stresses that the genres of a narrative counselling interview are "interdependent" (p.118). Although they have equal status, problem effacement is an extension of problem identification, in that alternatives to the problem are often realised by the formulation of behaviours that opposed the problem in some way. Muntigl (2004) further notes that these stages recur at other stages in interviews. Both problems and alternative events are formulated and reformulated. Reformulations serve as "local transformations" and involve "an elaboration of the formulation" (Muntigl, 2004, p.119). As discussed in Chapter 4, this is called "re-authoring" or "retelling" (White & Epston, 1990, p.13) in narrative therapy. Muntigl (2004) highlights that in narrative therapy, questions are informed both by the client's story and by the therapeutic resources and practices valued by the interviewer - the end point is not known in advance. Muntigl (2004, p.124) argues that the narrative therapy interview is realised by a pedagogic discourse that includes both "regulative" and "instructional" registers. Regulation involves the degree to which clients' social actions are managed by the counsellor through language choices that foster and maintain the direction of the interview. As highlighted in

Chapter 4, White (2002) calls this process "building a scaffold" (p.4). The instructional register, on the other hand, largely involves the "content of knowledge" (Muntigl, 2004, p.124) or the field of meanings in construing experience. Muntigl (2004) notices that in terms of the unfolding process and language choices in the interviewing process, the interviewer asks questions that metaphorically reconstruct the problem as a thing associated with agency. Muntigl (2004) explains:

> In explaining change, social constructionists draw on Bateson's (1972, p.315) claim that information consists of "a difference which makes a difference." Thus changes that have significance for the client will occur when alternative constructions of reality that make a difference are presented in counselling. (p.134)

The social construction perspective of change as an ongoing accomplishment between people (McNamee & Gergen, 1992) is thus confirmed.

5.9 Issues of validation

According to Stiles (1993) valid and authentic qualitative research depends, firstly, on the clarity and comprehensiveness of the description of research procedures employed. Such a clear description is aimed at in this chapter, specifically by highlighting issues of validity related to the selected research methods in this study. From a positivist framework, case studies can be criticised in terms of the validity of knowledge gained through the technique. It can be argued that there are problems with objectivity and generalisability. New approaches to systematic case studies partially addressed some of these problems by making a distinction between extensive research designs (based on comparisons between groups) and intensive designs (based on detailed investigation of single or small numbers of cases). McLeod (2003) reflects that a case study published in the 1983 *Journal of Counselling Psychology*, "a journal that previously specialised in large-scale 'extensive' rather than 'intensive' studies", represented "a breakthrough in the legitimacy of this approach" (p.100). The method was given further recognition in a special section of the *Journal of Consulting and Clinical Psychology* in 1993 devoted to single-case research in psychotherapy (Jones, 1993). Dilemmas around generalising from single instances and finding criteria by which to judge the validity of a case study are addressed in the current research by a refusal to seek "conclusive evidence", but rather to opt for case studies that could yield rich descriptive accounts that should instead be regarded as "exemplars of what is possible" (McLeod, 2003, p.112).

In qualitative research validity can be defined in terms of the degree to which the research describes or explains what it aims to describe or explain (Willig, 2001). Denzin and Lincoln (1994) agree that valid qualitative research should enlarge personal constructions and should lead to improved understanding of constructions of others. In this study the notion of validity in also informed by Charmaz's (2000) argument that grounded theory results are valid if the categories developed provide a "useful conceptual rendering and ordering of the data" (p.511). Different constructions of relevant phenomena are therefore sought and the study is geared towards expanding understanding of the constructions of others. Denzin and Lincoln (1994) also relate validity to a study's trustworthiness and authenticity in terms of its production of reconstructed understandings and meanings.

Furthermore, Lincoln and Guba (2000) argue that authentic research needs to reflect fairness. In this present study I aspired to uphold fairness by listening to each participant in the interviews and by deliberate efforts to prevent marginalisation by including all participants' voices. Fairness in listening attentively during interviews was not as complex as achieving balance in terms of the space given to the voices of participants in this report. Balance was made difficult since some participant were much more vocal and descriptive than others, and therefore generated "richer" data. Some voices were therefore used more often since they contributed to a better understanding of constructions. However, an effort was made to work towards balance in terms of how participants and their stories were treated (Guba et al. in Lincoln & Guba, 2000).

Lincoln and Guba (2000) emphasise that valid research should stimulate action and empower action. Lincoln and Guba (2000) refer to these aspects of validity as catalytic and tactical authenticity - that is, the ability of an inquiry to prompt action on the part of the research participants, and of the researcher to train participants in social and political action if participants desire this (De Villiers, 2006). In this present study, this was aspired to by connecting participants to each other, referring participants for psychiatric and medical help where this seemed necessary, and by providing ongoing therapeutic support. We discussed violence prevention campaigns in the area and I was interested to find out more about the potential meaning participation in such interventions had for them. Validity is then related to the effect on the participants and the audience, and on the social utility, rather than on minimising alternative explanations for the sake of generalisability (Heppner, Kivlighan, & Wampold, 1999).

Challenges inherent to the use of narrative case studies are relevant to this study. A lot of time had to be spent on collecting and analysing detailed information so as "to capture the richness and texture of experience over a whole case" (McLeod, 2003, p.102). It needs to be made explicit that the authenticity or completeness of this information depended on the amount of trust between me as researcher, and participants. Furthermore, as discussed in the section on ethical considerations that follow, care had to be taken with the disclosure of sensitive information so as to ensure that the research subject may not be too readily identifiable. However, as McLeod (2003) notes, "the skills necessary to deal with these problems are much the same as the skills needed for effective counselling, and so it could be argued that counsellors are well prepared to employ narrative case study methods well."

According to Stiles (1993) validity also depends on sufficient contextualisation of the study. Chapter 1 of this study aspired to attend to this concern. A third criterion listed by Stiles (1993) is the need for systematic consideration of competing explanation / interpretations of the data. This is in fact also an aim of narrative therapy and as such, was incorporated in the interview process in this study. The scope of this study did however not allow for extensive investigation of competing explanation. It is important to bear in mind that this present study does not claim that there is only one way to interpret the data or that the way in which is was done is the "correct" interpretation (Janesick, 2000).

Validity in this study also depends on my credibility as researcher and on the experiential authenticity of the material (Stiles, 1993). These criteria make sufficient reflexivity (see 5.11) and the inclusion of extensive verbatim material important. To conclude, validity in this study is based on ethics of caring, which necessitates giving careful consideration to a number of ethical considerations in the research process.

5.10 Ethical considerations

Cieurzo and Keitel (1998) identify the following areas in qualitative research where the researcher may encounter ethical dilemmas: recruiting participants, informed consent, confidentiality and anonymity, protection from harm, dual roles of researcher and therapist, and interpretation and ownership. The ethical dilemmas in this study, related to these areas, are discussed next.

5.10.1 Recruiting participants and getting informed consent

All participants in this study were asked to give informed consent (see Addendum 1) and were each given a copy of the informed consent form to keep. It was highlighted that they could withdraw from the research at any time. Voluntary participation was encouraged in this study by giving prospective participants a choice as to whether they wanted to be referred elsewhere for therapy. However, the limited resources based in the community, long waiting lists at counselling organisations, and the fact that they would receive counselling free of charge as part of the study could have led to some participants feeling under pressure to participate in the study in the belief that they would not otherwise receive therapy (McLeod, 2003). Multiple opportunities were offered in interviews for participants to evaluate their comfort with the direction of the research (Cieurzo & Keitel, 1998). Participant gave explicit consent to having their words quoted. Although the general area of study was made known at the outset, the unpredictability about what would emerge during the course of the research process made true informed consent problematic. Informed consent was therefore viewed as “a process rather than a one-time event” (Cieurzo & Keitel, 1998, p.68) in this study.

5.10.2 Confidentiality and anonymity

Anonymity was aimed at and participants’ identities were concealed through changing names and identifying features. However, the risk of public exposure of private issues existed despite efforts to assure confidentiality and anonymity. McLeod (2003) notes that case study research often relies on detailed descriptive material provided by research participants and it may be necessary to use quotes in reports. Since it is easy to inadvertently reveal the identity of the informant, it can be valuable to ask the informant to read a draft of the report and to make suggestions for amendments to ensure sufficient anonymity. This option was given to participants. Many stated that they were not concerned about whether they would be identifiable and some were “proud” (McLeod, 2003, p.173) to share their story with others. Bella, for instance, appreciated the opportunity to tell her story in front of workshop participants at a conference; and Vanessa was happy to have aspects of her story included in a poster presentation. Participants in the workshop that Bella co-presented were, however,

asked to sign a confidentiality agreement, since Bella's anonymity could no longer be maintained in that context.

5.10.3 Protection from harm

The ethical principles of acting to enhance participants' well-being and avoiding doing harm to participants are central to this study. Fontana and Frey (2000) note that "self-exposure" (p.662) through reflection and disclosure can be risky, specifically in a study that focuses on painful topics. The disclosure of personal information by participants often involved sensitive and highly personal material. This warranted ethical consideration, since the potential for participants to "be damaged or humiliated was increased dramatically" (McLeod, 2003, p.114).

Furthermore, since case studies could be read by participants as authoritative interpretations of their lives, I attempted at all times to write with care and sensitivity. This caution also inform practices of narrative therapy utilised in this study, such as asking permission for note taking and emphasising that the participants' words rather than interpretations thereof, are being recorded. In line with a narrative approach to working with trauma, care was taken to allow participants to tell their stories at their own pace and to disclose only what they felt safe to do. It was anticipated that potentially harmful feelings of abandonment and betrayal at the end of the study might be experienced (Cieurzo & Keitel, 1998). To minimise the risk, telephone contact was maintained with participants and follow-up interviews were discussed and implemented. At the follow-up interviews the idea of six-monthly reconnecting meetings was discussed and arranged with interested participants. Also, the collaborative relationship that I established with the team of psychologists from the Trauma Centre who were involved in work at The New World Foundation opened up possibilities for the continuation of similar meetings with a different facilitator.

5.10.4 Dual roles of researcher and therapist

This study was intended be "for the greater social good" (McLeod, 2003, p.176) and as such investigated counselling issues associated with participants who could be described as belonging to "oppressed groups" (McLeod, 2003, p.176). The argument of feminist qualitative researchers that one of the aims of research should be to "empower those who participate in it" (McLeod, 2003, p.176) was highlighted by the fact that I had dual roles as researcher and therapist. As a therapist, I had a duty to "act in the service of the well-being of the participants" (McLeod, 2003, p.174). As researcher, I had a duty to "collect data and make a contribution to knowledge and understanding" (McLeod, 2003, p.174). It can be argued that these roles complemented and enhanced each other. Balcazar, Garate-Serafini and Keys (2004) reflect on the complex process of awareness, conflict resolution, negotiation, and compromise involved in case study research in disadvantaged communities. Balcazar et al. (2004) describe case studies in which they respectively had to take on roles as "instigators of change" (p.246), as "mediators" (p.247) and as "advocates" (p.247). I also had to take up these roles in this study, as will be discussed in Chapter 7.

5.10.5 Interpretation and ownership

Other ethical dilemmas are in the areas of interpretation and ownership. These are partially addressed by the in-depth interviewing implemented in this study since interviews explicitly involve conversations directed towards understanding participants' perspectives on their lives and experiences as expressed in their own words. A specific aim was to stay close to the interpretation of participants by relying heavily on their own words. Ownership of other's ideas was acknowledged by referencing the sources. Ownership of my own ideas as researcher requires reflexivity and an awareness of subjectivity, and is discussed next.

5.11 Reflexivity and subjectivity

Reflexivity is said to require "an awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgement of the impossibility of remaining 'outside of' one's subject matter while conducting research" (Willig, 2001, p.10). Two types of reflexivity have been identified as integral to this research process, namely personal reflexivity and epistemological reflexivity. Epistemological reflexivity was introduced in Chapter 2. Personal reflexivity is also needed since researchers are involved as active meaning-makers and interpreters of what is seen and heard in the research context. This inevitably depends on the researcher's position and place in the community, as well as their self-understanding, reflections, sincerity, authenticity, honesty and integrity. It leads to the researcher's "ethical imperative to examine his or her own ideas, occupational ideologies, assumptions, commonsense, and emotions as crucial resources for what he or she 'sees' and 'hears' in a particular research interview or project" (Johnson, 2002, p.105). Willig (2001) points out that personal reflexivity involves reflecting on "how the researchers' own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research" (p.10). Furthermore, it involves thinking how the research may have affected and possibly changed the researcher as a person. Therapeutic interviewing clearly entails the active involvement of the researcher and confirms the need for reflexivity on the whole process - from devising the research questions, to identifying and setting up interviews with participants, to the interview itself (your role, how you were seen by the interviewee, your reflections on the process), and to the work done to transform the interactive encounter into a written piece of research (Banister et al., 1994). I attempted to remain reflexive throughout this research process.

My identity as a white, middle class, Afrikaans-speaking, urban woman in my early 30s informs this research study in many known and unknown ways. I will probably remain unaware of many of the finer nuances, but tried to continually be reflective of my position. I share Shefer's (in Macleod, 2004b) concern and ambivalence about my "intention to 'represent' the experiences of a group of people who are not only 'different' to me but are in an unequal power relationship to me on a whole range of historical contextual lines, including colour, class, education" (p.534). Class, gender, age and race had potential to influence the interviewing relationship. South Africa's history of institutionalised racism enhanced this unequal power relationship and the impact could be seen in participants' reluctance to address me as "you", but insisted on using the more "respectful" form of repeating my name. This could also have been informed by my perceived position of authority as a researcher and mental health "expert." Since most of the participants were female, our shared gender might have

contributed to perceived solidarity as women. However, class differences influenced our differing experiences as women, wives, daughters, sisters. Gender as well as age difference played a role in relation to the two male participants. My ability (or lack thereof) to hear and understand their experiences may have been informed by these differences.

Reflexivity involves being attentive to "the multiple readings present within the context of psychosocial trauma, readings that include how we are being read as 'other' and how we re-read our colleagues, our collaborators and ourselves in this co-constructed space" (Lykes, 2002, pp.99-100). I identified with Kreimer's (in Lykes, 2002) argument that I had to learn "to stand within the multiple meaning-systems of the marginalised, i.e. to recognise the meaning of reparation or recovery within their cultural experiences" (p.99). My dependence on participants' expertise and subjective meanings necessitated that I position myself to them. I highlighted participants' positions as "insider-experts" on trauma and resilience in the context of their lives and community. Together we anticipated ways that my "outsider" position could interact with the therapeutic interviewing relationship. Some participants reflected that it took time to develop trust. Others argued that it was easier to trust someone from an "outsider" position, since fear of confidentiality being breached was less. For others, my "whiteness" was associated with professionalism and expertise, which established a certain form of trust and respect. Participants did not openly reflect on other possible associations with my "whiteness."

Traditionally, "the community context is defined as the setting in which research occurs" (Brodsky et al., 2004, p.229). However, Brodsky et al. (2004) propose that the community in which the research is designed and conducted – the community of the researcher – should also be included in the process of reflexivity. The proposal is that when these communities meet in the research process, "a new conditional setting is created through their interaction, and this new setting impacts the members of both communities and the research itself" (Brodsky et al., 2004, p.229). The community of mental health workers at the New World Foundation were important in this study. They provided practical and emotional support to me as the study progressed. However, I also experienced isolation, as I was not working in a team. Although I was connected to "narrative communities" (Freedman & Combs, 1996, p.274) and attended various workshops and peer supervision sessions within these communities, I did not have access to a resident "outsider witness team." I was able to arrange only one "definitional ceremony" even though I would have preferred many more. The fact that the mental health professionals in Lavender Hill were not actively part of a "narrative community" contributed to this problem. Reflexivity also involves understanding the researcher's interest and investment in a study. It is therefore important to bear in mind that this study was conducted as part of a doctoral dissertation through the Department of Psychology at the University of Stellenbosch. As such, various procedures and academic requirements informed the design, implementation and reporting of the study.

The "community" of my family also impacted on my participation in the study. I gave birth to my second child during the course of this study, soon after my first-born turned three. The demands and pleasures of motherhood took me away from focusing on the study at various stages in the research process. The "community" of my family-of-origin is also important to reflect on, since I have traced my interest in narrative therapy ideas and

practices to, amongst others, my parents. They set examples of showing respect while questioning the taken-for-granted and caring for people from other communities.

My involvement in the study was also supported by my own values and beliefs. My Christian faith informs my desire to follow Christ's example of caring for others, especially those less fortunate than me. Like Shefer (in Macleod, 2004b), I "believe that it is important for those who have skills, knowledge and resources to carry out research where it is most needed" (p.534). Despite the dilemmas surrounding research with 'different' communities, I was also invested in the research for this reason, since I wanted to make a small contribution toward redress. The compassion I feel for those affected by injustice contributes to the passion I continue to have for work that addresses the effects of violence. I am also committed to the active promotion of non-violence and social justice. My faith is informative of my work and I draw strength from the support and prayers of the community of believers with whom I fellowship. Discourses of hope and healing contained within the Christian faith provide a broad frame of reference for the optimistic stance that I approached participants with. This stance might have contributed to a silencing of discourses of despair, although I tried to remain open to participants' lived realities. The importance of not making assumptions about others' beliefs and values - a general principle of the narrative approach - was especially important in relation to participants who did not share my faith in Christ. Since some of the participants were active Muslims, I attempted to remain aware of the need to identify sensitive issues and conflicting philosophies (Williams, 2005), and to guard against imposing my views.

I have personal knowledge of some possible effects of violence – having survived an armed robbery during the first family outing with our two-week old baby. This personal experience of being violated, as well as bearing witness to violence against others, inspired me to seek ways of actively responding to violence in South Africa. I want to remain open to opportunities to bear witness to people's pain as a result of violence and violation.

In this study the need to remain reflexive about the effects of working with traumatised people on me was supported by the risk of vicarious trauma and by the complexity of problems in Lavender Hill. Smith (2003) addresses the experience of clinicians working with people traumatised by violence and gives an example where he had felt "lost, powerless, unsure of what to say or do, and clumsy" (p.315). I shared this experience at times in this study. However, from within a narrative therapy approach "permission not to know" (Smith, 2003, p.315) is confirmed. Holding on the knowledge that "there are no easy answers" and "progress often comes slowly" (Smith, 2003, p.315) countered putting undue pressure on myself. These realisations fit with the decentred practice of narrative therapy and are important when working in a context of multifaceted stressors such as those found in Lavender Hill. However, I also gained tremendously from my involvement in this study. I strongly identify with Smith's (2003) reflection on his personal investment in his work:

> In terms of my personal investment in this work, I have come to realise that even though I am exposed to some of the worst behaviours that mankind is capable of, I also bear witness to the miraculous resilience of the human spirit. I am blessed to work with people who have somehow found the strength to continue "fighting the good fight." They continue in the struggle to defend their humanity against seemingly insurmountable odds, and the progress helps reaffirm my faith that healing is possible. The ordinary people,

> heroes and “she-roes”, one and all, empower me to continue with my own personal and professional struggles. When I look into their eyes, I see endless possibilities for spiritual growth and emotional redemption in all of us. (p.316)

During this study, I felt privileged to hear participants’ stories of resistance to oppression in various forms. I will take their stories with me and trust they will continue to be very significant to me. I experienced my involvement with participants as encouraging and strengthening of my faith in Christ. Furthermore, having witnessed their resilience gives me hope for the future of my two young children in the context of living in South Africa.

5.12 Concluding remarks

In this chapter the research methodology of this study was placed in the broader frameworks of postmodern and qualitative research. I highlighted principles of qualitative research, such as placing importance on contextual awareness, local knowledge, and the use of interpretive and narrative frames. Given the philosophical assumptions of this study, much attention was paid to the preparatory phase and context of the research by considering site selection, community entry and the recruitment process of participants. The setting of Lavender Hill with its socio-economic challenges and widespread violence was described in detail. I argued that the methods of data collection (narrative therapy interviews) and data analysis (constructivist grounded theory, case studies and conversation analysis), allow for a descriptive analysis of the narrative therapeutic process that fit with the poststructuralist epistemology of this study. In the final section of this chapter ethical considerations and the need for reflexivity were highlighted. In the next chapter, grounded theory analysis of the consequences of trauma for participants is presented and discussed.

CHAPTER 6: THE CONSEQUENCES OF TRAUMA

I am also thinking very often, "How many people out there need this?" They need to talk; they don't want to talk; they can't talk. There is nobody advising them and who do they trust? (Participant)

6.1 Introduction

In this chapter I attempt to gain an understanding of the consequences of trauma for participants by starting with their descriptions of lived experience. I focus on how they construct the impact of trauma on their lives through the grounded theory process of coding data and creating categories. Participants' words are privileged since the focus is on how participants themselves understood the consequences of trauma. What they remembered and expressed are illustrated with extensive verbatim material from interviews. These excerpts are included to maintain a connection to their lived experience. Even though each participant responded in unique ways, common categories emerged. It is important to bear in mind that the intention was not to provide diagnostic or generalised categories, but rather to describe "grounded" experiences of trauma as described by participants. In grounded theory, existing literature is looked at to see how it compares to the emergent categories, once these categories have been labelled. Although this approach has been applied in this study, it is also important to note that all the quotes related to emergent categories will not be discussed in detail.

The poststructuralist framework of this study encourages not only identifying categories through which people impose meaning on their experience and make sense of their situations, but also exploring the ways in which meanings are constructed, sustained and modified in the course of everyday social interaction (Levett, 1988). The analysis showed that meaning was indeed informed by contextual discourses and affected by social interaction. Analysis suggested that when participants speak about trauma, three main areas of concern emerge. These areas of concern (which become the main categories for the discussion of the consequences of trauma) were the daily impact of trauma on thoughts, emotions and behaviour; the conflict about speaking out and staying silent; and the impact of trauma on relationships with self, others and God. The major categories and subcategories are summarised in Tables 9, 10 and 11 that follow in the discussion at the end of this chapter. The impact of trauma on relationships was so pervasive that it came up in almost all the categories and subcategories. While relationship consequences were thus not discussed as a separate category, the impact of trauma on relationships is summarised in Table 12. Within each major section, "*in vivo*" (Willig 2001, p.34) categories, utilising the words or phrases of participants, are used as subheadings to structure the text. They function as "descriptive labels" (Willig, 2001, p.33). When appropriate, corresponding psychological terminology is provided in brackets.

This systematic categorisation of trauma experiences seemed to be an important aspect of the documentation of the impact of trauma in a low-income community in South Africa. However, fragmentation of the experiences of participants was inevitable, given the use of grounded theory as method of analysis. It is therefore important to note here that these categories and subcategories are not mutually exclusive and do interact with each other in complex ways. It is hoped that the complex interaction of the different kinds of consequences of trauma will

become more apparent in the case studies in Chapter 7. Also, it was clear that the consequences of trauma were not simply viewed as areas of concerns by participants, but were often simultaneously constructed as their ways of coping. This supports the notion that what might be viewed as "symptoms", are often also adaptive ways of being resilient. In Chapter 7, where each participant's unique experience of trauma and recovery will be told, there will be a more specific focus on "double-storied accounts" of their trauma narratives. Grounded theory analyses of the data follow in this chapter. Each section opens with quotes from the interviews, followed by a brief discussion of the relevant category and related literature.

6.2 Consequences of trauma for thoughts and memories

6.2.1 "I still remember it like it was yesterday" (Intrusive thoughts and frozen memories)

> V: …if someone speaks about rape, then it comes back to me, you see. Then I pull myself back or think she is watching me now, the expression on my face or something.
>
> V: It is almost eight years that I kept it inside. And I still remember it like it was yesterday. I remember the date it happened. I was thirteen. And I remember it was on the thirteenth of March.
>
> V: To the graveyard - they took me there. I had my period. I was wearing like (..) I can still feel everything. I can see everything…I can still remember everything, the whole detail. You know it is something that I can't forget …I will never forget his face…
>
> I: Are there times when thoughts about what happened to Len come up to you?
> S: It just pushes up.
>
> A: I don't feel nice because it keeps on coming back to me when I am alone. That stuff comes back to me again…

Participants experienced memories of the traumatic events that could be described as intrusive or frozen. Vanessa spoke of reliving the traumatic experience as if it was "yesterday." Her words, "I can still feel everything. I can see everything", reflect the frozen or wordless quality of her memories. Vivid sensations and images of the event were present even though it happened eight years before. The intrusiveness of the memories seemed evident in Sandy's reflection that "it just pushes up." Aston, the perpetrator of abuse, also experienced intrusive thoughts. He kept on thinking about what he had done and this disturbed him.

In their work on bodily responses to trauma, Van der Kolk and Saporta (1993) note that the central nervous system seems to "react to overwhelming, threatening, and uncontrollable experience in quite a consistent pattern" (p.26). Intrusive memories of the trauma, poor tolerance for arousal and feeling emotionally numb have been traced back to changes in different areas of the brain that occur as a result of extreme stress. Herman (1997) notes that "traumatic memories lack verbal narrative and context; rather, they are encoded in the form of vivid sensations and images" (p.37). Vanessa's choice of the words "feel" and "see" reflect the way in which her memories had been encoded in the form of sensation and images. This effect can also be described as the "hierarchical dissolution" of memories that occurs when severe trauma contributes to "the failing of semantic memory, so that only procedural memory and perceptual memory representation systems are operative" (White, 2004, p.70). Traumatic memories seem to remain static and wordless if they are not transformed into a verbal

narrative. As discussed in the next section, these images or sensations can be triggered by seemingly insignificant events. Relatively safe environments sometimes held unexpected reminders of traumatic events.

6.2.2 "It is almost like I am being raped again" (Triggers evoke the reliving of experiences)

> I: And when you say that it comes up every day, has it been consistent or is it more at the moment because you have seen one of the perpetrators?
> V: I think it is now more than ever. When I was a little bit younger, like fifteen, sixteen, we moved and that took my mind away. We moved from Lavender Hill to Delft and I never thought about it. I had a relationship there and I forgot about it. But when we came back to Lavender Hill, it started all over again. Because when I walked on that place where I was then it just came back to me.
>
> V: …I just have this feeling and when he {her husband} touches me I just push him away. Or sometimes when we make love, I just feel like it is almost like I am being raped again or something. I just feel that.
> I: And do you think it would be helpful if he knew?
> V: Yes. I just push him and he says, "What is wrong?" and I just say, "Please."
>
> B: …You know, it is like now, also now with the amnesty - because we applied for amnesty - so my worry is of going back. I have to go on TV again. I have to talk. And I am sort of reliving. That has come onto me now.

Stimuli associated with the trauma such as seeing one of the perpetrators or being near the actual site of the rape or being touched by her husband triggered reliving experiences for Vanessa. Krista (in Muntingh, 1993) uses the term "intimate intrusions" (p.56) to describe reliving experiences of rape survivors. Accordingly, any rape-related perceptions such as smell or visual image can bring about a panic attack in the survivor, sometimes unloading fears and anger hitherto suppressed (Muntingh, 1993). This seems to have been the case at times for Vanessa. Bella described her experience of having to talk at the Truth and Reconciliation Commission amnesty hearings as "sort of reliving." According to Orr (1998), "none of the standing committees [of the TRC] was given a formal mandate to provide emotional support to those who approach the TRC" (p.142). This could indicate that drafters of the TRC failed to recognise the fact that recounting past trauma could be "immensely painful and potentially harmful to mental health" (Orr, 1998, p.142). Bella's experience seems to support Nomoyi's (2000) findings that, for some, making submissions to the TRC hearings were indeed traumatic.

Weingarten (2003) reflects that the memory process of "encoding" (p.48), during which we select and transform what is seen, heard, felt or thought into a memory, is a phenomenon that has both neurobiological and psychological dimensions. Under circumstances of extreme stress, conscious memory may suffer. This process of memory storage and retrieval may explain re-living experiences that Vanessa and Bella described.

> Extreme fear can cause such high levels of stimulation to the amygdale [area in brain] that it blocks the hippocampus from working properly to evaluate and categorise experience…Without the ability to evaluate, categorise, or supply context to experience, the hippocampus stores these kinds of memories differently from the way it usually does. These memories are stored without reference to time and place. Thus when they are retrieved, it is as if they are happening in the present. They are experienced as contemporary terror. (Weingarten, 2003, p.49)

As highlighted in Chapter 3, there has been some debate about the notion of traumatic memories (Young, 1995). The conception of traumatic memories that informs this study is based on the description of memory systems as discussed by White (2004). The principle effects of trauma on memory are (Meares in White, 2004, pp.70-71):

- dissociation (memories are not experienced as past experience, but are located and re-experienced in the presence)
- hierarchical dissolution (the greater the assault, the greater the regress in the developmental pathway of memory)
- uncoupling of consciousness (a familiar sense of myself is dissolved)
- meaning (negative and fixed meanings are attributed)
- devaluation (a sense of being 'damaged')
- chronicle (a breakdown of a sense of continuity).

White (2004) describes dissociated traumatic memories as memories that are "not experienced as memories of past experience, but are located and re-experienced in the present" (p.70). He highlights that "when these intrusions are severe, they can totally erase one's familiar sense of personal reality, and contribute to a sense of detachment, desolation, exhaustion, and to an acute sense of vulnerability" (White, 2004, p. 70).

6.3 Emotional responses to trauma

Participants described a range of consequences of trauma that were related to emotions. Experiences that involved feelings of hatred, bitterness, sadness, depression, irritability, mood swings and anger were evident in their lives.

6.3.1 "They make you so bitter" (Hatred, bitterness and vengeful thoughts / passion for justice)

> K: …I believe if every parent disciplines their child every now and then, they will not turn out such evil people, because there are too many evil people in Lavender Hill. They will come to you; they will rob you; they will stab you with a knife or shoot you. Their 'evilness' makes you evil as well. They make you so bitter. I am not a hard person – I would not say I am hard, but I am sometimes hard. I am not an evil person, but I will allow someone to bring such a person and cut off his hands. That I will allow. That is why I am saying, the hate that they put in parents.
>
> K: …I am very opposed to anyone who harms others. I don't like such people. It makes me hate.
>
> K: …That is why I am saying, the hate that they put in parents. I don't know if I will have so much hate in me in two years time. Like this other woman, Tina, she still has a lot of hate in her - for two years. And she is still very bitter.
>
> M: Mr. Linn said we must get an answer so that they can have confidence in each other again and love each other, because she hates Aston at the moment. When they enter the house, they are fighting. They cannot stand each other. If the one does something it disturbs the other one.

Kate struggled with bitterness as a result of her son's murder. At times she felt contaminated by the perpetrator's "evilness." The way she spoke about herself in relation to the perpetrators reflected that she questioned her values at times and struggled to hold on to what she believed to be right and wrong. She first positioned herself as "not a hard person", but then admitted "I am sometimes hard." She connected this "hardness" to the bitterness and hatred that the perpetrators' actions invoked in her. This, in combination with the frustration caused by the lack of legal justice, contributed to her desire for retribution.

Kate noticed "the hate that they (perpetrators) put in parents" through their actions. She thought that Tina needed help in order to change this. Mita thought that the way Cheri reacted to Aston after he abused her reflected hate. Their

teacher thought they needed to "find an answer" to this. However, for some participants, the hatred and bitterness they felt toward the perpetrators was expressed in the desire for retribution or revenge. Mita revealed that as the mother of a perpetrator she also had vengeful thoughts. However, she also realised that she could not "carry her child in hate":

> M: …And I got home the afternoon and then I said…he asked me something and I said to him, "I don't know why you ask me. I feel I could kill you. That is how I feel about you." Then I went to sleep and it was about just after five. And on Sunday morning I felt he must not get in my way. And when I looked at him it looked as if I could say something to him, because I said to him, "I did not expect it from you. I could have imagined that Walt might do it. Walt is more with it and he knows what it is, he knows about things like this. But I did not expect it from you Aston."
>
> K: …I believe one cannot take a life. It is not in your hands to take someone's life, but I feel people who do such things, without reason (…) because Len is not one who is violent - if he was a violent person, I could understand it. If he was violent with that person and they had come to take revenge or something like that, if that was the case, I would have understood it. But because they did it without reason - people who without reason hurt someone or shoot them or if I stab you with a knife without a reason - it means I have a cold heart. And such people - to throw them in jail just makes it worse because then they mix with other criminals. I say if I could do it I would chop such people's hands off. I am not a violent person and I don't feel that I would be able to do it; I will not be able to do it … but I feel the people who did it, their hands must be chopped off, because they are going to do it again to another parent. Understand?
>
> K: …I feel it is wrong. That is why I feel, and I told the police as well, if they bring those people who shot my son to me tomorrow, then I will cut off their hands, because I have an electric saw, I told the police. I will maybe not be able to do it myself, but I will have it done. That is how I feel. And it is wrong to feel like that. I am trying – I am probably not trying hard enough – to get that hate out of me. For me it feels like it will be with me for a time still.

Kate's response to a question about her feelings towards the perpetrators reflected the complexity of her thoughts and feelings. To "break the chain" of violence she proposed that perpetrator's "hands should be chopped off." She thought this a lesser evil, justified in the face of the threat of the greater evil of more young men dying and regarded her proposed punishment as a preventative measure. Her observation that the police are "unfair because they are so corrupt" provided a context for her frustration with continued perpetration of violence. Kate explained how her frustration with the "unfairness" and the lack of legal justice led to her wanting to "cut off their hands." Questions were asked to explore if her desire stood in direct relation to her helplessness with regards to the lack of justice.

> K: I feel this because the persons who did it, got someone again else. The same person shot another son again on Sunday night, also twice, with the meaning to kill him. And a week later, Len was shot on the one Wednesday and a week later they shot and killed another one. Once, but they killed him. They fetched the pastor at someone's house. That is why I would like you to talk to that mother as well.
>
> K: Cases are opened but if people don't come forward to speak, they cannot do anything.
>
> K: It is being followed up but (…) the police take their time. Understand? One cannot trust anymore. To tell you the truth, we don't have faith in the police anymore. Because if the police had done their work then we don't believe such things would still happen EVERY DAY. That same person that shot him that Wednesday night shot again on Sunday and shoots again the Wednesday. And they are not yet caught. And I mean they live in this area. They don't live far.

Other participants also expressed vengeful thoughts. Francis noted about Sandy, “He harbours revenge.” She was concerned about her son’s safety, since she knew that he had gone as far as making a gun. Ironically, the handmade gun was something Francis seemed proud of in terms of how well it had been crafted.

F: He harbours revenge. He harbours revenge against the people who shot that child. It is not (…) I do not think it is normal for a child of his age to say, “If I can get a gun, I will shoot them myself” (…) He sees that guy a lot.

S: I am going to get a gun and shoot that one.
F: He made himself one. He made himself one - made a gun. And then - I don’t know where he gets it - he plays with bullets. And it goes off exactly like a real gun. He has it. Me and him - we stress a lot about it.

F: ... It is nicely made.
I: Did he make it himself with his hands? Can he make other things with his hands as well?
F: I think so, if he wants to and puts a bit of effort into it.
I: So when you say it is nicely made, what do you mean?
F: For his age, he at least has a clue.
I: Where did you learn how a gun works - how to put a gun together?
S: I just used my brain, just thought.

I: What do you think about what your mom said - that it could be dangerous for you or for Lettie?
S: I can only rest one day when that person is dead.
I: Is that also a thought that goes through your head? And do you sometimes really think how you would do it or what you would do?
S: I just want him dead.
I: And do you ever have feelings against yourself or other people, to kill them?
S: Now how do they feel to shoot and kill my friend?
I: Is that what you sometimes wonder – how could they have done that?
F: He {Len} was a very lovely person. He was very fond of laughing. And he would make your day if you were feeling down. He always had something to tell you.

Unlike Kate and Sandy, Vanessa had the opportunity to witness the perpetrators being taken into custody by the police, although it was for another crime. She was not afraid to show them how glad she was about this. This was indicative of her desire for both justice and revenge.

V: … they were picked up. They did something, so the police van still came into our court. They picked them up in our court and I don’t know why. So they went to prison.
I: What was that like for you to see?
V: Oh, I was really like…I still told the one, “You will rot in prison.” And nobody knew why I said so, but I just said, “You will rot in prison.”
I: Did you tell one of them as they were being picked up?
V: Yes, they were sitting in the back of the van and they were looking out and shouting to people, “Open this van.” I said, “No, don’t open that van because they will rot in prison.” Only I and my friend knew why.
I: And for you being able to say that, do you think that was why your friend was saying you are so strong and you stand up for yourself - you speak your mind?
V: I don’t know but I was glad and I really showed them I was glad. I was like going on in the court. They saw me. The one still told me, “When I come out you’re dead.” And I said, “You won’t come out, you’ll rot in prison.”

Vanessa, who was threatened into silence by her rapists after the rape, remembered the fear she experienced when she realised that they would not be imprisoned that long. She saw the perpetrators on occasion and was afraid at times. She thought she would be able to retaliate now that she was older. She said: “I was scared a little bit and also I just wanted to go to him and just kill him.” Her desire to take revenge emerged.

I: What was the thing that wanted to come up?
V: I just wanted to go to him. (..) I was scared a little bit and also I just wanted to go to him and just kill him, you know.

V: …I thought if you go to prison, you are going to stay there for long. So they told me he was going to get five years, so I was scared, you know. I thought when he is going to come out he is going to kill me. And when my mom moved it was like nice. We moved for four years. After we came back and I thought, oh my God. When we came back I thought, "Oh is not five years up again, maybe he is going to be back." But I saw the one and I wasn't like scared. I thought, "If you try anything I'll really kill you now because I am big, I am not small anymore."

Herman (1997) notes that

> The survivor mission may also take the form of pursuing justice. Holding the perpetrator accountable for his crimes is important not only for personal well-being but also for the health of the larger society. (p.209)

Many participants were frustrated in their pursuit of justice. For some participants this resulted in bitterness, hatred and vengeful thoughts towards perpetrators. Their stories confirm Magwaza's (1999) findings of association between feelings of meaninglessness and perceptions that the principles of justice are violated if perpetrators are not prosecuted. These feelings disrupted assumption of the world as a benevolent place (Magwaza, 1999). For example, Tina who lived opposite the alleged perpetrator spoke about the turmoil that his proximity caused. Understandably, she found seeing him stressful. It was a constant reminder of her son's violent death and of the fact that the perpetrator had not been taken into custody. As Herman's words (above) imply, this had negative effects on personal well-being as well as on the health of the larger society. However, Tina and Vanessa were able to let the perpetrators know that they could not rule them by fear. Herman (1997) reflects that this is a step towards recovery:

> The survivor who elects to engage in public battle cannot afford to delude herself about the inevitability of victory. She must be secure in the knowledge that simply in her willingness to confront the perpetrator she has overcome one of the most terrible consequences of the trauma. She has let him know that he cannot rule her by fear, and she has exposed his crime to others. Her recovery is based not on the illusion that evil has been overcome, but rather on the knowledge that it has not entirely prevailed and on the hope that restorative love may still be found in the world. (p.211)

6.3.2 "I am angry all the time, any place" (Anger and aggression)

S: I am angry all the time, any place.
I: And when you get angry, what happens?
S: Then I am not myself.
I: How do you become then?
S: If I cannot get my way, then I do anything.
I: What are some of the things you have done in the past (.) if you did not get your way?
S: Then I will just hit anyone if I don't get my way.

I: Is there someone else that you can also talk to about it?
S: {shakes head} I get angry too quickly.
I: And Sandy, is this anger making things difficult for you at school and at home? What are your thoughts about this anger?... Would you like to have less of it in your life?
S: Yes.

T: … Do you know, Ilse, I felt on Sunday that I want to shoot my husband dead, that is how I felt. I could just kill him.

M: … There are times when they just want to attack each other and scream at each other, "Don't do that", or "You do this." Then it is actually nothing. They cannot tell me what it is about.
I: So do you think it is the hurt and anger that makes everything out of proportion?
M: Yes.

The anger that Sandy started expressing after his friend's death, evident in his narrative, affected his connection to others. Anger has been identified as a "typical response to the injustice of traumatization" (Cohen, Barnes, & Rankin, 1995, p.58). Furthermore, high levels of anger have been found to be strongly associated with health status, emotional distress and PTSD symptom severity (Connor, Davidson, & Lee, 2003). Reasons for trauma-based anger may include:

> …anger at those who are blamed; at oneself for not acting to protect yourself and for symptoms, limitations and self-defeating behaviour; at the lack of understanding of others; and at society for subsequently traumatizing you through a legal system that does not seem able to punish those responsible. (Williams & Poijula, 2002, p.88)

Many participants experienced anger at the perpetrators and at a legal system that did not seem able to punish those responsible. This is evident in the previous section of this chapter that focused on vengeful thoughts and a passion for justice. Tina's anger about her husband's refusal to let her talk about her deceased child was so intense she had fantasies of killing him. Sandy acted out his anger by engaging in aggressive acts with peers. Van der Kolk (2002) reports, "numerous studies have demonstrated that both adults and children who have been traumatized are likely to turn their aggression against others or themselves" (p.5).

Van der Merwe and Dawes (2005) note that "one of the most striking consequences of exposure to community violence recently reported in local and international research is an exposure-related increase in conduct problems, including hostile, aggressive, oppositional and other antisocial behaviour" (pp.7-8). They also note that exposure to community violence had been associated with "reduced impulse control, retaliatory or anticipatory aggression in children, and a decrease in prosocial behaviour" (p.8). Social contagion theory of violence has been supported in research that has found that "it is more difficult for families living in areas of high risk with high levels of violent crime, as compared with those living in areas of low risk, to mediate the effects of these environments on youth behaviour, including aggression" (Bogat, Leahy, von Eye, Maxwell, Levendosky, & Davidson, 2005, p.130). Many of these associated responses to exposure to community violence became evident in Sandy's life.

6.3.3 "You are breaking me as a mom" (Mistrust)

M: …I told them, Aston and Walt, when I found out, "How could you do it to her? You are not only hurting her, you are breaking me as a mom." To think my own son did it to me. That is what makes me so…I just felt, I cannot leave it just like that. It must come out and it must be set right.

A: And my dad does not trust me with my little brother.
I: Your dad does not trust you with your little brother? And how is that for you?
A: He thinks I will do it again.

M: But the piece that daddy said, “I don’t trust you with your little brother”, I said the same words to you. Before daddy said it, I said it to you. Why do you feel more hurt that daddy said it?
A: It is the same.

I: What was your relationship like then?
A: Then it was all right. We played a lot and we laughed a lot.
I: So do you think that is also part of her sadness and of your sadness now, that you have lost that trust and that play and that being together?
A: {nods}
M: The minute their older brother walks in, Cheri is with him. And when Aston tries to talk to her, she says, “No don’t talk to me, talk to Wayne.” And that is what hurts him, because he wants to win back her trust. {Turning to Aston} It will cost you hard work to win it.

I: And now when you see Aston, how do you feel? What thoughts come up in you?
C: Why are you here? Why did you do it?
I: Do you ask him that?
C: I don’t ask him, but that’s what I am thinking.
I: And are you angry with him also?
C: I just want him away from me.

Having the perpetrators of violence and the victim in the same family is a complex situation. When Mita found out about the abuse that Aston perpetrated she told her son, “You are breaking me as a mom.” Her words depict the complexity of being the mother of both the perpetrator and victim of abuse. Despite the devastating effect on her as a mother, Mita managed to hold on to her belief that the abuse should not be ignored - it “had to be set right.” Broken trust seemed to be an inevitable consequence of the abuse. Aston was upset that his step-father did not trust him anymore with his little brother. Trust and playfulness was also lost in the brother–sister relationship. Cheri noticed that there was much less talking in her relationship with her brother after the incident of sexual abuse. Her struggle to make sense of the abuse is reflected in her questions about the abuse. She seemed to express her anger by avoiding her brother’s presence.

6.3.4 “…that small group that brings fear over all the people” (Fear)

K: There are many good people in this community, very good people. And in such time you can see, in this evil place there are such good people. So it is just that small handful, that small group that brings fear over all the people. I think that is unfair. The people don’t want to talk because they are afraid they will also be shot. I think it is wrong.

V: … he fetched a knife and he was kicking and banging on the door. And he said he was going to kill this person. I was like scared. I was really scared, so I thought I am going to kill myself before he kills me. I was really scared at that time and really worried with anything. If they would threaten my family, I would do anything. I was really, really scared.

Kate lamented the fact that the gangsters, who make up a relatively small percentage of the people living in Lavender Hill, manage to silence people through intimidation and resultant fear. Vanessa’s experience of fear is clear in her description of another violent incident during which she was threatened by her boyfriend. This incident happened subsequent to being raped and her fear seems to have been informed by that experience.

6.3.5 “There are times that she just feels like crying” (Sadness and depression)

> M: …And the time when she told me about this, that she felt she just wanted to cry, there are times that she just feels like crying. When I then said to her, “Cheri, then something did happen to you”, then she CRIED. She cried a lot that night, but then I said to her, “You can tell me – did something happen?”
>
> F: I think today’s outing, there where they were {at the grave} made it fresh now again. Because it is now the first time since the funeral that he has been there.
> S: {crying}
>
> T: …I cry everyday. He saw me cry yesterday. After Kate phoned me then I cried again.
>
> B: …It is sometimes very confusing. You wonder all the time, “What is happening to me? Why do I feel like this? Why do I have so much pain?” There are things like, “Why wasn’t my husband here? – I could tell him. Why can’t I sleep? What is going on with my stomach? Is it cancer?” It is a combination so many things: not feeling good, wondering who to talk to, snapping at the children if they backchat.
>
> B: Can we talk? Is there somebody to understand me? Who understands me? Am I getting mad? Am I getting insane? What is happening to me? Because I am old, who can I talk to? Who can I trust? Am I saying too much? Am I stupid to think about all these things? Why has it got these affects on me?
> I: All the worries that come up with it…
> B: Yes. And my stomach, you know. I can’t take it. It is a combination of so many things.
>
> N: I was also depressed at one stage. I went through a very hectic time. I was mentally abused by my ex-husband and then I have got a schizophrenic son. It started in 1988.

Depression and sadness were common consequences of trauma amongst participants. They were sad about what was lost through the trauma. Reminders and anniversaries of these losses increased their sadness. For Bella, depression contributed to a constant questioning of herself. Nina recounted that she had also experienced depression at one time. Weingarten (2003) identifies a complex range of feelings of “sadness, helplessness and shame” (p.51) as a common combination that people might experience in the face of trauma.

6.3.6 “I’ve got moods” (Irritability and mood swings)

> I: So when you say, “I have to speak about it”, why is that? Is it a desire that you have - to be able to speak about it?
> V: Yes, because I’ve got moods you see. When I think about it and I am just quiet, I am just quiet. Even when my husband speaks to me and these things come into my mind, I just - I don’t want to speak to him. I’m just moody with him. I just tell him, “Just (..) shut up” or something like that. Or I’m just rude to him. I don’t now why. Even to my parents. Not my mother, but my father. It is almost like I can’t take it.

Vanessa reported that she was irritable and moody. She said that she “couldn’t take” it. Increased irritability as a consequence of trauma has been confirmed in the literature (Foa et al., 2004; Van der Merwe, 1999; Weingarten, 2003).

6.4 Behaviour associated with trauma

Participants described many behavioural consequences that they constructed as being related to bodily responses to traumatic experiences. Once again, participants own words are privileged in labelling categories, with psychological terms in brackets. In psychological terms participants' responses could be described as paralysis, numbing of responsiveness, avoidance, hyperarousal, hypervigilance and sleep disturbances. This sections ends with categories that involved behaviour and feelings that contributed to relational disconnection.

6.4.1 "I was glued to the ground. I could not move. It was shock" (Paralysed by shock)

> N: …What really happened was, when Bella was picked up, I knew that I might be next.
> I: And what was that like for you?
> N: It was traumatic. I am coming to that Ilse. It was very traumatic. My son was also getting married in a month's time. And this very Sunday we were going to go out. My son came, he went to fetch his future wife, and we were going to go out. And as they came in to fetch me, and as I came out a car pulled up. But the guns were out of both sides of the car. In actual fact, I came out Ilse, and I totally froze. I froze there were I stood. I could not move. My son was already at the door of the car and he came back and he said, "Mommy, walk!" And it was as if I was mesmerized. I stood there. I was glued to the ground. I could not move. It was shock. "Is it for me?" Do you understand?
>
> V: … And I was shocked, you see. He smacked me. The others asked what went on – and they ran. And I was standing and I asked him, "What are you doing?" Two other guys came from the road. I didn't know them. This was the people who came out of the prison. I don't know what he told them or whatever, but they grabbed me and they took me. You know I was like small - I was scared of them because the one had a knife.
>
> V: But now recently I saw this guy and so I just looked at him. ... I will never forget his face and he was sitting in front in a car, in the passenger side, and he was looking at me. And I was looking at him and there was this thing that wanted to come up but I just froze and I just looked at him.
>
> M: …it came out last Friday for the first time at home. … I asked, "What have you done then?" He said, "Cheri said I raped her." Then I got such a fright that I didn't know what was happening. I said, "Cheri, what? When did it happen?" February…I could not believe it had been such a long time.
>
> M: That is the biggest shock that I could get. I had to work on the Saturday but I could not work. ….I could not believe that Aston did it.

The shock associated with traumatic events had a paralysing effect on some participants. Vanessa just stood still after being smacked by one of her attackers, while her friends ran away. Nina vividly described how she felt "glued to the ground" when she was confronted with the possibility of being taken into detention as a result of her activism in the struggle against apartheid. She and Vanessa both use the word "shock" to describe their experience. Weingarten's (2003) choice of the words "common shock" to describe trauma seems appropriate. Similarly, Mita described the news of her son's sexual abuse of her daughter as "the biggest shock I could get." The term "paralyzing inertia" (Terr in Van der Merwe, 1999, p.182) has been used to describe the way people tend to be frozen by their feelings of helplessness often experienced in the first moments of trauma. This response is similar to the state of surrender observed in some animals that "freeze" (Herman 1997, p.42) when attacked. Certain ways of responding to trauma can be attributed to the "fight-or-flight reaction" (Weingarten, 2003, p.41) that prepares the body for defensive action and produces hyperarousal. This fight-or-flight reaction can be described as a normal and necessary response to threat. If the threat is extreme, the body may go into a

freeze response during which attention is both “narrowed and heightened” (Weingarten, 2003, p.44). This could explain Vanessa’s response – to “freeze” despite the emotion welling up in her – when she saw one of the perpetrators.

6.4.2 “I just sit” (Numbing of responsiveness)

S: I just sit.
I: And what do you think about when you sit like that?
S: Nothing.

I: What do you do at home?
S: Wander aimlessly (“*Dwaal*”).
I: Do you help your mom with stuff?
F: He sits in front of his radio the whole day.

I: The shock was so big when you heard it?
K: Yes. I did not cry. I just stood there. (…) But my shock came afterwards.

H: I almost went into a fit.
I: Very upset to hear that.
I: What helped you at that stage to get through it?
H: I just sat alone.

F: … Len was already shot. Then he did not show any emotion, he just looked very dejected.

These quotes seem to indicate that some participants experienced a numbing of responsiveness, as expressed in the state of “just sitting.” Sandy’s description of his inactivity at home as “*dwaal*” (wandering around aimlessly) could be a reflection of a degree of dissociation in the sense that he seems to be removed from his surroundings. Hilda, on the other hand, said she was “going into a fit” at the initial traumatic news of her ex-boyfriend’s death, but at the other end of the continuum “just sat alone” later. Her “just sitting” could be seen as an expression of numbness or a form of paralysis. Similarly, Kate recalled that she “just stood there”, trying to digest the news. Sandy seemed to have had a delayed emotional reaction. Similarly, Kate took note of the fact that she “did not cry” initially. Their experiences seem to reflect another kind of paralysis, not confined to the experience at the time of the actual traumatic event, but often translating into a general “numbing of responsiveness” (Van der Kolk & Saporta, 1993, p.27). According to Van der Kolk and Saporta (1993) this may be registered as “depression, as amotivational states, as psychosomatic symptoms, or as dissociative states” (p.27). They argue that numbing is a biologically based symptom of trauma and not primarily a psychological defence against remembering painful affects. Psychic numbing can then be defined as desensitising the mind to stimuli by “halting or distorting the process of creating images” (Van der Kolk & Saporta, 1993, p.27) and reducing the ability to experience pleasure or pain.

6.4.3 “Who is waiting around the corner?” (Vigilance)

F: ... He is very fond of a bike. When he sits on it he fears that they are going to kill him, they are going to shoot him. He cannot see behind himself.
I: Okay. So do you still ride your bicycle sometimes Sandy?
S: I swapped my bike for a car tape.

F: He gave his bike away and then the other boy gave him a car tape.

I: ...And so was the music worth swapping your bike for? Or is it also as your mom said that you experience anxiety when riding on your bike?
S: {nods} The anxiety ("*Die angstigheid*")
I: Does that anxiety come often when you ride on your bike?
S: Who is waiting around the corner? Which man is standing there with a gun behind you?
I: So are those the things that are going through your head when you are riding on your bike?
S: Yes. When I walk I also have to look behind myself. Whenever I walk I have to look behind my back.

F: …But from that night on he cried so every time, headaches, started getting panic attacks, head soaked in sweat.
I: Okay. And the times when the headaches and the sweaty hands come, when does that happen?
S: Anytime in the day or night.
I: And do you usually first think about something or does it just come by itself?
S: It just comes.

I: And did you try not to think about it?
S: No, death can come at any time.

Francis's description of how Sandy was affected by his friend's death included a persistent anticipation of danger, difficulty falling and staying asleep, crying, headaches, panic attacks and sweating. Sandy's fear of being shot made him vigilant, so that he "looked behind" himself often. He swapped his beloved bicycle for a car radio with a tape. He said he felt too vulnerable on the bicycle because he was not able to see behind himself when cycling. Sandy's fear could be related the body's physiological arousal.

As discussed earlier, bodily reactions to traumatic events include fear-based reactions such as "hyperarousal, a permanent state of alert and hypervigilance, permanent expectation of danger" (Herman, 1997, p.35). Hyperarousal is produced by the body's alarm reaction in stressful situations, a fight-or-flight reaction, which results in the autonomic nervous system being over stimulated (Weingarten, 2003). According to Williams and Poijula (2002) this over stimulation can have a serious impact, including "having difficulty falling and staying asleep; feeling irritable or having outbursts of anger; having concentration and memory problems; being hypervigilant; being startled easily; and having a feeling that you have no reserve of energy to help you heal" (p.79). Participants' experiences of these consequences are discussed next.

6.4.4 "I just stopped with my life" (Limiting activities due to fear)

V: …I just stopped with my life. I just thought, "Anything I do now, I have to take it step by step." "If I do this, will that happen?", I used to think. I was really like scared of everything. If I see someone doing something I said, "No. What will happen afterwards?"

K: …The people in my street, since this has happened, they are scared. Like my neighbour - I had to go to the shops with her yesterday. She does not even want to go the shops. Most of the women in the road feel like that - they do not want to go out of their street because they are scared. They live in fear.

M: And she is not a child that plays outside. I don't let her go out. I don't let her walk around because I always tell her, "Cheri, our area where we live is so cruel." They picked up an eighteen year old girl one Saturday morning on the schoolyard. She was so badly raped that they broke open her legs. Her legs lay like this {indicates a 180 degree angle}. They murdered her. Her eyes stared into the sky, but she was dead. I will not be able to handle it if anything has to happen to you. So stay in the house. There is nothing for you

outside the house. Sometimes I will give her money just to keep her happy. “Take the money and buy yourself something nice and come back and sit with me.”

Fear seemed to result in the need to carefully consider the possible danger in every activity. The consequences of trauma therefore extended to participants’ relationship to the community at large and it seems to have disrupted their assumptions of the world as a safe place (Janoff-Bulman, 1985). The complexity of living in a context of continuous trauma became clear in their stories. Vanessa describes how she became hypervigilant and was “really scared of everything.” These thoughts in turn resulted in her limiting her activities dramatically. Similarly, Kate described the women in her road as people who are living in fear. The movement of her neighbours had been drastically limited by the fear of going out. Mita, who viewed the area where they live as “so cruel”, limited Cheri’s movements and expected her to stay in the house. Van der Merwe and Dawes (2005) note that parental restriction of children’s activities in an attempt to protect them from physical danger in high-violence a community affects child’s development:

> Keeping children indoors to remove them from danger in high-risk neighbourhoods affects child development by reducing opportunities for exploration and thus, achievement of developmental tasks. Barbarin and Richter (2001) found that violence related restrictions in South African children’s development resulted in behavioural, cognitive and sleep disturbances, as well as impairments in somatic functioning and moral reasoning. It remains unclear whether the characteristics associated with developmental impairment in children are a function of the nature and quality of parental care in high-violence communities, or a direct psychological effect of violence exposure. (p.7)

6.4.5 “I fear nothing” (Acting tough)

K: I am almost like I am used to this evil life that is why I told you I fear nothing.

In contrast to those who limited their activities due to fear, Vanessa and Kate both denied experiencing fear. In fact, Kate reflected that she feared nothing. Although her neighbours all lived in fear, she refused to. In their review of studies related to children exposed to high levels of community violence, Van der Merwe and Dawes (2005) note that “counter-phobic response patterns”, which included “acting tough” and “acting uncaring” (p.8) in response to persistent fear and repeated loss was commonly reported in youths exposed to community violence. Desensitization to violence had also been noted as a response pattern to exposure to community violence. This was sometimes associated with impulsivity and compulsive risk-taking (Van der Merwe & Dawes, 2005).

6.4.6 “I cannot sleep, mommy” (Sleep disturbances)

F: … In the night he wakes me up, “I cannot sleep, mommy.” Then I ask him what he is thinking, and then he says he is thinking about Len. He feels it is not right that he should have met his death like that; he had never hurt anyone else. Then I will always tell him that is how some people treat life and everyone knows it is not right. So he is very upset about it.

I: And once you are asleep, how do you sleep then?
S: I wake up again.

V: I get nightmares sometimes.

Nightmares as well as difficulty falling and staying asleep, reportedly common occurrences after experiencing trauma (Van der Kolk & Saporta, 1993; Williams & Poijula, 2002), affected some participants.

6.4.7 “I don’t want to do anything that will remind me of that day” (Avoidance)

> K: …I am a different kind of person. I was baking fish that night, now I don’t want to bake fish for a long time. That is how I am. I don’t want to do anything that will remind me of that day. I baked cake the whole day and that night I baked fish, so I don’t want to do anything that will remind me of that day.

> K: … I cannot go to the graveyard. I cannot go to the place where Len lay. Such things I cannot do.
> I: The place where he lay {was shot}, you say, and the graveyard?
> K: Yes, and the graveyard. I cannot yet go. It will take me time.
> I: But this is not connected to fear? What does this stand in relation to?
> K: No. With (..) probably the hurt that I still have. It is that. When that is over, I will be able to go, because I had the same with my dad. I could not go to the graveyard.
> I: So is his {her father} death something that still affects your life?
> K: No, it does not affect me anymore. I will be able to go to his grave now. But the first two years I could not go. But I accept his death now. (..)

> F: Initially Lettie was afraid of the car. My husband said she said, “I want to go to mommy.” She was nervous and then she would grab hold of him. She is now getting used to it again.
> I: And her sister?
> F: Yes, Poppie does not want to drive at all or to be in that car, in other cars, but not in that car.
> I: And you, Sandy, can you still go in that car, or is it also a problem for you?
> S: It is okay.

Participants like Kate avoided certain activities and places connected to a traumatic experience or to receiving traumatic news. She ascribed this to the emotional hurt that she still experienced in relation to her son’s death and to needing time to “digest it.” Similarly, Sandy’s sisters avoided the car that they were driving in when they got shot at. However, Sandy seemed to have overcome his fear of driving in that car. Weingarten (2003) proposes that under extreme stress the brain can “forge connection between elements in the threatening situation and a fear response, without the person having any conscious awareness that this is happening” (Weingarten, 2003, p.45). She notes that people exposed to domestic or community violence may find they have developed “sensitization” (Weingarten 2003, p.45) that is evident in heightened reactivity. Bodily responses to trauma may therefore result in people being left with “a fear response to triggers in the environment that make no sense to them” (Weingarten, 2003, p.45). These responses seemed to have informed participants’ avoidant action and contributed to being vigilant.

6.4.8 “When I was raped I spoke to no one” (Relational disconnection)

Data showed that trauma affected participants’ behaviour in ways that impacted on their relationships with others. Many of the relational consequences of trauma were linked to the silence that followed in its wake, as discussed in the next section. Ironically, the fear of being stigmatised or ostracised seemed to lead to self-imposed isolation and withdrawal from social dealings in Vanessa and Cheri’s lives. In Bella and Nina’s case, depression contributed to their isolating behaviour. Various degrees of disconnection from others were experienced. However, traumatic experiences also seemed to have lead to a closer connection to certain significant people and to God. This will be discussed in Chapter 7.

6.4.8.1 "I couldn't sit with friends like I used to"

V: …And when that happened, I couldn't sit with friends like I used to. I used to be talkative and I used to sit ongoing and that. But when I was raped I spoke to no-one - only my best friend. I was like different. I didn't have that self-confidence anymore. I used to have that. I was like very popular between my friends and that. But when that happened I stopped speaking to anybody and girls, especially girls. I thought that they were always better than me. I wanted to be like them.

C: …now after this I have lots of friends again.
I: After you have spoken about it? So is it easier for you now to talk to your friends?
M: She started to be nasty. I understand the point she is making now, because she told me as well. I wanted to know how it happened that she now spoke about it at school. She said she did not have friends anymore that sat with her and so, and this upset her so much that she just started to cry. And the one child then asked her, "Cheri, what is wrong?" and then it came out. Then it went to the teachers and then it got to me, because she became so catty ("katterig").
I: The cattiness - is that something you noticed? Do you also think you became nasty or what happened?
C: I became like that because of what happened.
I: And did you also change in the class after it happened? Do you think Ms Roux saw something had changed?
C: Yes, now I talk a lot in the class.

N: Depression makes you withdraw very much. Depression makes you see your best friend not as your friend but as your enemy. If I call you, you don't want to talk. I don't want to share my problem with you because you might go and tell someone else this is my problem.
I: So does it make you suspicious of people?
N: Depression makes you feel like, "I don't want to talk to anybody. I just want to sit here in this little corner alone."

Trauma impacted on participants' social lives. Vanessa withdrew from her circle of friends and changed from a talkative person to someone who spoke to no-one. In Vanessa's case, withdrawal seemed to be related to feelings of shame and inferiority. Cheri also found it difficult to stay connected to her friends. She became nasty towards them and "did not have friends anymore that sat with her." In Cheri's case, her friends seemed to withdraw from her due to her aggressive behaviour. Cheri's silence about being abused affected her social interaction. Her teacher noticed how she returned to her usual talkative ways once the abuse had come out into the open. Not speaking about traumatic experiences therefore had a broader impact - the silence seemed to spread to other areas of their lives. Nina described how depression silenced and isolated her. For some participants the initial shock of the traumatic event made it difficult to connect to others. Others changed from being talkative to being silent. The reasons for withdrawal not only included shock and feeling inferior to others, but also feeling "out."

6.4.8.2 "I am feeling so out"

V: …I need to talk. Sometimes I will sit at home and when young people come past they will say, "Do you want some tea?" and I will say "No", even though I want to. I just don't know how to communicate. I need to communicate more, sit in company, meet young people, just talk.
I: If you are in settings were you are able to relax will it come to you with practice?
V: Yes, I have been so out of it. For a long time I have not sat with young people – one, not a crowd.

V: When I don't talk to them I don't talk to them for a week. So they ask me what is wrong, I will say, "It is nothing. Must there always be something wrong with me?"

Vanessa desired to reclaim her ability to socialise in a group of young people, but felt disconnected and she did not know how to communicate. Her withdrawal and silence was also due to the effect that the rape had on her self-confidence. She struggled with shyness and "feeling out" after the rape, which made it difficult for her to speak to friends. Silence in relation to trauma seemed related to being silent when angry or frustrated at home.

6.4.8.3 "I didn't want to be around boys"

> V: …At thirteen my life changed and I said he had to stay away. I didn't want to be with boys anymore, I didn't want to be around boys. I just blocked myself.

After the rape, Vanessa, who was thirteen at the time, lost interest in boys. At a time when girls often become interested in boys, she purposefully restricted her contact with boys. It seemed she mistrusted males in general due to the trauma of rape.

6.5 Introduction to the dialectic of trauma: "I kept it inside, but I have to speak about it"

> C: {crying} I wanted to tell mommy. I wanted to tell mommy.
> M: But you didn't know how.
>
> V: …I have not told him but I just wanted to. Something inside me says, "Just tell him, tell him."
>
> T: …I must not mention his name, because then he feels hurt again. But Ilse, he will not overcome his pain like that, Ilse. ("*Maar Ilse, hy sal dit nie so oorkom nie, Ilse*"). If he shares with me and if he talks about it, then he will feel much, much better. He does not think so.
>
> K: I speak about it everyday with different and various people - people who live in my area.
>
> T: …And I said, "Do you know how good it is to talk about it?"
>
> I: On the way up to the room you said you are quite nervous about speaking today?
> V: Yes. It is the first time that I am speaking to someone about this, really someone who is a professional, who knows about these things. But I have to speak about it…I have to speak about it. It is not easy. It sounds easy, but it is not… I know you have to speak to someone.
>
> I: And in terms of your ideas about your future, do you think you are at a point now where you have witnessed your own strength, that in terms of your future the rape is not going to hinder you from where you want to go?
> V: If I don't speak about it, it is going to. I think if I speak about it, I may forget.
>
> V: …If it comes to that part it is so heavy to talk about it. It is like I am shivering inside, but I have to speak about it. I told myself that time and time again, because every day I think about it and it makes me mad….

Conflicting desires to speak about trauma and/or to be silent about it emerged from participants' narratives. Some verbalised a knowledge that it is good to speak about trauma or believed they "had" to speak about it. Some reported speaking about trauma "every day." Others remained silent. Participants' words reflected their complex feelings about speaking and remaining silent.

> V: It is almost eight years that I kept it inside …I don't want someone to know about it. She [her mother] sometimes asks me, "What is wrong? Talk about it." Then I say, "It's nothing mommy, it's nothing." So I always cover up.

M: And I said to you, “If something is bothering you, then you must talk about it so that it can come off you. Did something happen to you?” “No Mommy.” Then I said, “It causes stress and it builds it up so that crying is now the only way for you to get rid of it. But something is bothering you Cheri,” I said. “Tell me what it is.” “No mommy, it’s nothing.”

Silence about traumatic experiences seemed most common in the lives of the two participants affected by sexual violence. Both Vanessa and Cheri deliberately did not speak about their experiences of rape and an incident of sexual abuse respectively. They kept it secret from their families and did not seek outside professional help. Their mothers were concerned about the visible distress they witnessed in their daughters at times, but this was covered up. Both Vanessa and Cheri’s words to their concerned mothers were “it is nothing.”

M: This is the biggest shock that I could get. I had to work on the Saturday but I could not work. I could not speak. When my boss got there, I could not talk to her. I could not even say to her that I don’t feel well.

F: They {Sandy and Len’s father} don’t talk about Len at all. I think they are avoiding it.

N: I could not tell people those problems were in my life. I had to keep a bright face.

B: I don’t talk. I cannot speak to the children, so I go within. I went within and I am still like that.

Mita, on the other hand, was silenced by shock when she heard her son had sexually abused her daughter. The discovery made it difficult for her to talk. It seems that the shock of the discovery had a paralysing and disconnecting impact on her, as her words illustrate. Although Sandy was not affected by sexual violence, he did not talk to significant men like his own father or to Len’s father (to whom he was very close) about his deceased friend. Nina and Bella reflected they could not share their problems in the past. Nina believed she had to “keep a bright face” and Bella was silent for her children’s sake.

Herman (1997) powerfully articulates the oscillation between silence and speaking out as part of “the dialectic of trauma” (p.1). She describes “the will to deny horrible events and the will to proclaim them aloud” as “the central dialectic of trauma” (Herman, 1997, p.1). Despite the desire to speak about traumatic experiences, many participants remained silent for a long time. Goldsmith, Barlow and Frey (2004) refer to a number of studies that seem to indicate that it is common for trauma survivors not report trauma, to underreport trauma, to deny that trauma was harmful or to report impaired memory for trauma. Cultural influences in trauma reporting are said to be important. In this study, participants’ silence could be attributed to being informed by a variety of discourses. In the next section discourses and contexts related to both silence and speaking are discussed. Other contextual factors such as relational disconnection and the way in which the audience is perceived, are also discussed.

6.6 Manifestations of the discourse of silence

Participants' stories indicate that for some, silence was an active strategy informed by a variety of discourses in their context about trauma, identity, rape and abuse. Silence was related to expected responses from the audience. Furthermore, bodily experiences, behavioural reactions and emotional responses that were said to accompany talking about traumatic experiences also contributed to their reluctance to speak. Although silence surrounding an experience of sexual violence may constitute part of the trauma of the experience, it has been noted that silence is often also an active strategy from the woman herself. Levett (1988) argues that "a powerful set of ideological constructs which lead to stigmatic effects" (p.129) compel women to silence. Discourses which seemed to inform silence are discussed next, namely the discourse that psychological trauma causes permanent damage, discourses of stigma and shame after rape and sexual abuse, discourses of gender- and personality-specific speaking, and discourses of catharsis.

6.6.1 "He gave her a life-time scar" (Discourse of psychological trauma as damaging)

> M: Yes, I cannot digest it, that he is the one that brought her down like that. He gave her a life-time scar – that is how I see it.

Within a social constructionist view it can be argued that the common and shared expectations of the effects trauma can play an important role in the consequences of the experience (Levett, 1988). For example, expectations that sexual abuse leaves a life-time scar could ironically construct such an experience. Mita's concern about Cheri having "a life-time scar" is an example. By implication Mita drew a direct link between the experience of abuse and being "scarred" for life. White (2004) argues that drawing a linear link between trauma and psychological pain/emotional distress and "damage" can lead to feeling "ever susceptible to being trespassed upon" (White, 2004, p.12). White (2004) explains how certain conversations can therefore contribute to a fragile sense of self:

> There are contemporary understandings of psychological pain and emotional distress as an outcome of trauma that obscure many of the complexities and particularities of people's experiences of trauma, and of their expressions of this experience. Some of these understandings draw a "natural" and linear link between trauma and psychological pain/emotional distress, and these can lead to a thin grasp of the consequences of therapeutic conversations. Therapeutic conversations informed by some of these contemporary understandings can contribute to the construction of a significantly fragile or vulnerable sense of self, and leave people with a keen sense that their person is ever susceptible to being trespassed upon in ways that they will be hard-pressed to defend themselves against. This closes down options for the people to take action in regards to their predicaments in life, and is diminishing of their general sense of knowing how to proceed in life (p.12).

It was necessary to question the notion that trauma causes permanent psychological damage to prevent it from informing "a fragile sense of self" (White, 2004, p.12). When Mita was invited to question this discourse, she reflected that damage was not inevitable. She further realised that acceptance assisted her as mother to focus less on damage. In Chapter 7 more will be said about the co-construction of a robust sense of self that challenges the discourse of trauma as damaging (White, 2004).

6.6.2 "I don't want to be someone who was raped" (Discourses of stigma and a shame-based identity)

> V: …I don't want to be someone who was raped. I don't think about myself as someone who was raped. I put that out of my mind. I think about myself as someone who is normal, who had a good home, a mother who loved her. I never think I was raped. When I talk about it then it comes back to me, all those things.
>
> I: What are the ideas about a girl that has been raped in this community? Ideas that you don't want to be associated with since you know you are not like that, but that you think people might have about you if they knew…
> V: Like what do they do that I don't want to do? Like that?
> I: I am wondering why you don't want people to think of you as "someone who has been raped."
> V: Some of them, like most of them that I know, they give up. They do things like they go and stand in the road (prostitution). They just give up. They don't think anything about themselves. They sell themselves. They go smoke Ganza. They go do drugs. They think they are nothing anymore. You don't have to do that. If you speak to someone – I know you have to speak to someone. I had a friend who understood me and a mother – but they just give up. I don't think that about myself, because I know, I know that I can make something of my life or I can speak to other young people if I have the courage to tell them what happened, you know. I'll try to change someone and tell them, "Don't think that because that thing happened to you, you must give up."
>
> V: …They do a lot of things, like if they were raped. For example, this one girl that came to me. And this person - like a week after she came to me - got drunk and when I asked her what is going on, she said she just can't, she'll just give up because her life is messed up and she must mess it up. I don't understand that sometimes.

The tendency to remain silent about trauma was more pronounced in this study in the lives of those affected by sexual trauma, namely Vanessa and Cheri. Discourses of stigma and shame after rape and sexual abuse seemed to inform this silence. In that community survivors of rape or abuse carries the risk of being stigmatised, being marked as shameful or deserving blame (Herman, 1997). These discourses informed Vanessa's active resistance in refusing to think of herself as "someone who was raped." Vanessa feared that her credibility and her reputation would be compromised if people in the community knew she was raped. It seems as if being known as "someone who was raped" carries a whole set of possible labels with it, both in the eyes of others and of the rape victims themselves. It seems that "rape myths" (Robertson, 1998, p.140) - discourses about negative identity conclusions that can be drawn about someone who has been a victim of rape - informed Vanessa's fear of being known as someone who was raped. Robertson (1998) notes that rape is more common in societies that accept and believe in "rape myths" (p.140). Rape myths may include:

> …false ideas about what rape is, such as: men rape because they cannot control their sexual lust, women encourage rape, rapists are strangers, and women enjoy being raped. These myths serve to "label women as in some way responsible for the rape and to view men's actions as excusable, thereby giving silent consent to their actions. These rape myths also reduce the likelihood of women reporting their rape, for fear of being blamed and stigmatised. (Robertson, 1998, p.140).

However, her fear is also largely informed by what she had witnessed happening to other victims in the community. Vanessa seemed to be aware of the impact of rape on young women in her community and was determined not to be identified with the actions and attitudes that she had witnessed in other rape victims. She noticed that many rape victims just "gave up" and they did not respect themselves. Vanessa positioned herself as different from them since she had the knowledge that she could "make something of her life." Having had support from her friend and her mother enabled her not to give up and she wanted to extend this support to

others. Silence was used as an active strategy to protect resist the labelling associated with rape. According to Williams and Poijula (2002), discourses of stigma and shame associated with rape and sexual abuse may contribute to the formation of a "shame-base identity" (p.116). Vanessa's story showed how trauma can have an impact on self-perception. Her view of herself seems to have been informed by a "shame-based" identity and "rape myths" in the community. Robertson (1998) notes that rape is more common in societies that accept and believe in "rape myths" (p.140).

6.6.2.1 "I thought they were much better than me"

> V: …I thought that they {other girls} were always better than me. I wanted to be like them. You see, I had all those things.
> I: So after the rape you felt that they were better than you, for some reason?
> V: Yes. I thought they were much better than me…I got rebellious, you see.

> V: …So I give them [other rape victims] like advice, but I never tell them I was [raped], because I am always scared they won't come to me if they know that I was. You see, because they look up to me. I don't know what they think about me, but they always come to me and we sit. And I always treat them with respect, so that they must think a lot about themselves, they mustn't think less about themselves.

> V: …I was like different. I didn't have that self-confidence anymore. I used to have that. I was like very popular between my friends and that. But when that happened [the rape], I stopped speaking to anybody…especially girls.

> V: …And I had friends at that time. I didn't want anyone to think different about me.

> V: …But just the thought that if he {her husband} knows that I was raped, maybe he will change.
> I: Why would he change or how could he change?
> V: Because he runs to the past. He throws that in my face. I don't know. I just…sometimes I want to tell him, but when we argue I think, "I will never tell you." You see, because he is someone who runs to the past.
> I: Are there fears that it might affect his respect for you?
> V: Yes, I've got that fear sometimes - everyday when I think. I always think that one day if we get cross with each other he is going to say, "Yes, you were…" Or something, you know. ... But just the thought that he will think that I was raped makes me mad, makes me … the thing is he looks up to me. And he and his friends think I'm like so…if I say something they will do it. If I say, "No smoking in my yard", then they won't smoke in my yard. If I say; "You don't drink here because my husband doesn't drink here", then they don't drink here. But just the thought that he knows that I was raped…maybe he will change.

Vanessa attributed changes in her social behaviour to her evaluation of herself as inferior to her friends. However, she was able to encourage others to hold on to a sense of themselves as worthwhile people. By implication, her desire for others not to think less of themselves as people reflects the fact that she thought less of herself. She described how she experienced herself as different after being raped. She lost her self-confidence and feared that others would also loose respect for her opinion. Her struggle to speak to her friends could have been related to the shame she experienced. The relational consequences were reflected in her concern about what others would think of her if they knew that she was raped. She did not want anyone, especially her husband and friends, to "think differently" about her. Again there is a clear suggestion that women who have been raped are stigmatised. Vanessa could not bear the idea that her husband would know that she was raped since he "looks up to her" and was afraid this could change. The knowledge would give him a degree of power and authority over her which she feared he might use against her.

Levett (1988) notes that "when a girl or woman is identified and labelled as a victim of sexual abuse she becomes a focus of fascination for others; the labelling effect can be incorporated by the woman herself and sets up a sense of being different" (p.129). Williams and Poijula (2002) note that rape survivors often experience "a form of self-torment that includes feelings of inadequacy, inferiority, embarrassment, and disappointment and can lead to the formation of a shame-based identity" (p.116) and that they experience the most feelings of shame and guilt, and feeling debased, amongst Post Traumatic Stress Disorder patients. Weingarten (2003) highlighted some of the complexity around shame and shaming:

> Shame is often the hardest feeling to bear for many reasons, one of which is that there is no obvious way to express it. If we are sad, we can cry; if we are angry, we can yell. But pause a moment. You can mimic shame by looking down and averting your eyes, but how can you discharge it? In trying to discharge we tend to look for actions as straightforward as tears or shouting. Yet shame's release may take something more complex than this; it may take the making of amends if we have injured others, or a forgiving of the self, if we are unduly harsh with ourselves. (p. 51)

Weingarten (2003) extends that notion of shame as follows: "Shaming can occur between individuals, but there is a more insidious, invisible, and continuous source of shaming; systematic structural inequity, structural violence, which occurs between groups and classes of people" (p.53). Although participants did not openly speak about experiences of shame related to racism and poverty, some of their experience such as delays in treatment at community health centres, could have been experienced as shaming. Within the South African context of racial and class division amongst people, one could speculate that many participants may also have experienced shaming related to structural violence.

6.6.2.2 "I always blamed myself"

> V: …But now, when I was bigger, I heard about these rape cases and I thought, I always blamed myself, because if I didn't walk with friends and stuff or if I listened to my mom and so. But now I am a little bit over it, because I speak to a lot of people. They come to me, I don't know why, but I never tell them I was raped as well. They always come to me, "This happened to me or that happened to me" and I always tell them, "Don't blame yourself." So I give them like advice but I never tell them I was {raped}, because I am always scared they won't come to me if they know that I was. You see, because they look up to me. I don't know what they think about me, but they always come to me. …I didn't use myself, I used a cover and said, "I know someone who had been raped, and that person did not give up, she went on with her life."
>
> M: And I said to her, "To be scared is right, but not to feel maybe I did something that he felt he had to do it", because that is what she said to me, "Maybe I did something wrong that he did it to me." Then I said, "No, it happened while you were sleeping, Cheri."

It emerged that both Vanessa and Cheri put blame on themselves at some stage. For Vanessa, self-blame contributed to a negative self-evaluation. However, through other victims' stories she realised that she should not blame herself. Although Vanessa encouraged other rape survivors to talk, she maintained the silence around her own experience. It seems that the shame and self-blame she attached to the rape prevented her from identifying herself as someone who had been through a similar experience. Cheri also expressed the idea of being to blame for her brother's actions by wondering if she did something that could have led him on. Her mother reminded her that this was not the case, since she was sleeping. However, her initial uncertainty contributed to her reluctance to tell her mom. According to Lewis (1999), children often do not spontaneously

disclose that they have been through a trauma. Many children fear that they will be blamed for what has happened to them. For some children this fear becomes a reality when they are judged and punished. In Cheri's case, she was given a hiding because she did not tell her mother about the abuse. Van der Merwe (1999) notes that children may label themselves as bad or weak and that this may lead to a loss in self-confidence. Their "unrealistic and unfair ways" (Van der Merwe, 1999, p.206) of viewing themselves can contribute to a fragile sense of self. According to White (1995) establishing an account of "the politics of their experience helps to undermine the self-blame and the shame that is so often experienced in relation to the abuse itself" (p.88). Discourses of shame and stigma associated with rape and sexual abuse affected the expectations that Vanessa and Cheri had about how people would respond to the knowledge and thus impacted on their relationships. As discussed in the next section, their fears included not being seen as "strong" anymore, not being "liked" anymore, not being consulted for advice anymore, being "looked" at and judged and being blamed.

6.6.2.3 "She won't think I am so strong anymore"

> I: What are your thoughts around that - that you have not told your mother? Is it something that you would like to be able to share with her or…?
> V: No. Sometimes I want to but then I think she won't think I am so strong anymore. I don't want to tell her.
>
> V: I don't want them to pity me. You see, they are always depending on me. I don't want them to pity me. That is something that I will really feel then. And I know, if she knows something happened to you, she will only be with you, pull you through and she will always give you the support. I don't need that. Oh believe me.
>
> V: … My mother is very understanding. She will…I know my mother won't judge me, but I don't want her to know because then I will be the only one who went through something. See, not one of her other daughters… the others went to college. I am always the one who went out of school, who didn't…I had the most problems. And she was always there for me. I want to be there for her. I don't want someone to know about it.

Vanessa kept the fact that she had been raped from her mother for eight years because she did not want her mother's perception of her to change. She said that she remained silent because she wanted her mother to regard her as strong, not weak and vulnerable. Other unwanted responses that Vanessa anticipated from her mother included pity and attention. She saw herself as the one her family could depend on and seemed not to want this to change. She knew her mother as someone who would support her in such a time, but she did not want the attention. Vanessa's silence was therefore also informed by a fear of being set apart from others – being different. She thought the rape would set her apart from the rest of her siblings in yet another way. She had the most problems growing up and felt that sharing her secret would jeopardise the supporting role she played.

6.6.2.4 "She won't like us anymore"

> C: Mommy must not tell auntie.
> M: Why not? We cannot hide it from auntie. If auntie hears it she will be very upset. She will be very upset and will ask me, "Why could you not tell me?" Why is she not allowed to know?
> I: Why are you afraid to tell her about it?
> C: She gives us too much.
> I: What do you mean?
> C: {Crying} She won't like us anymore.

I: Are you afraid she won't like you anymore. Are you afraid you will loose her love if you tell her?
M: She won't, Cheri. Cheri's Christmas clothes are already hanging in the cupboard. Such a good auntie they have.

I: And was this also a reason why you were scared to tell your mommy, that your mommy might - that her love for you might be affected if she knew about it?
C: {nods; crying}

Cheri was reluctant to divulge the secret of the abuse to her aunt, since she was afraid that her aunt's perception of her and her family might change - that their aunt would stop liking them and would thus stop giving them gifts. Mita pointed out that, on the contrary, their aunt would be even more upset if she was not informed and heard about it from someone else. A further question revealed that Cheri was initially also concerned about her mother's love for her being affected by knowledge of the incident.

6.6.2.5 "The whole school knows about it and they look at me"

C: Yes. I thought if I am going to tell, then everyone will look at me. They will think, "She kept herself so cool (*"kwaai"*) and look what happened to her."
I: You were afraid everyone would look at you? And what did you think they would think when that saw you?
C: She kept herself so cool and look now.
M: She wanted to think so well of herself, but look what she is.

S: Cheri could have told mommy, but she told the school, now the whole school knows about it and they look at me.
I: It is something a lot of the children know of now?
A: I don't know.
I: But it feels as if they are looking at you?
A: {nods}

V: …if someone speaks about rape, then it comes back to me, you see. Then I pull myself back or think she is watching me now, the expression on my face or something. But I also at the same moment think I wasn't really raped. I just tell that to myself. I told that to myself for many years and I believed it. I told myself I wasn't. It was just something that happened. It had to happen…I thought everybody knew and I couldn't sit in their company, I thought they knew.

I: And if you think about Len or if something reminds you of him, what do you feel?
S: In my mind Len has not died yet.

Vanessa and Cheri experienced "the gaze" of others, imagining that others could read their thoughts from their expressions when rape or abuse was spoken about. They shared a concern that people would "look" at them differently. Despite the knowledge that it was not their fault they assumed that others would become negative about them. Cheri believed that others would judge her differently if they knew that she had been sexually abused. With the words, "…look what she is", her mother, Mita, hinted at the negative identity conclusions others might draw. Aston was also concerned about being looked at and judged as a perpetrator. He was upset about being under "the gaze" of the other children at school, although he did not know if many children knew about the abuse that he perpetrated. When rape was spoken about in the community, Vanessa became guarded, imagining that others could see how the conversation impacted on her. To counter this, she reported that she denied her own experience as well as the significance of the experience. Similarly, Sandy seemed to avoid

painful memories by thinking in his mind that his friend "has not died yet." Vanessa's and Sandy's denial can be considered to as an adaptive strategy to defend themselves against anxiety and distress.

6.6.3 "Everyone is not the same" (Discourses of gender- and personality-specific speaking)

Participants affected by the traumatic loss of a loved one noticed that certain members of their families did not speak about the loss or the deceased person, while others did. In many cases, distinctions between speaking and silence were in accordance with gender, with males being silent and female speaking. Silence seemed to be due to personal style differences in some cases; for others it seemed to be informed by discourses of silence contained in community 'rules'. These discourses centred on the benefits and appropriateness of speaking versus silence as discussed next.

6.6.3.1 "He says we are opening old wounds; I say it is good to cry everyday"

> T: …I had a terrible, terrible, terrible weekend. I had someone visiting on Saturday… We were talking about Third Degree and about Felicia's {TV} show about the woman from Marina Da Gama where the man murdered the children and shot himself. Then my husband had a nice drink. Then he came down the stairs from the bedroom and he told me and my friend we must stop judging the people. (..) Ilse, I just took him in front of his breast and threw him on the chair, I was so angry. Because Tuesday night Felicia came on and Wednesday night I told him in bed, "You know Carl, I can still thank God that I still have you and my son and my grandson." I said, "That woman has nothing left." Her children are gone, her husband is gone, there is no-one left to comfort her. Then he said to me, "Where did you watch that?" Then I said to him, "On Felicia's show." Then he said, "Why does Felicia always dig up the old things?" (..) Then I did not give him an answer. {laughs} I thought, "What are you now trying to say to me? Felicia digs up old things." He said, "Yes, she brings up old memories for people." Then I said to him, "Carl, how good is it for that woman to speak? Felicia offers it to her." Then I said, "If she had to ask me, I would go on to every programme and tell them how I feel." He just looked at me.
>
> T: Then he was too drunk. Then he said that we judge others. I asked him what he means with the word "judge." He was drunk. Then I said to him, "Do you know what the word judging means?" He was then out of the door. Then his friend asked him what he said. His friend said to him, "Do you know what is judging?" "Do you know how good it is for that woman to talk about how she feels each time?" he said. Then my husband said that my friend and I are opening up old wounds.
>
> I: Why were you so angry with him?
> T: Because he does not want me to talk about my child that has died. He says we are opening old wounds. Then I said, "It is not old wounds. It happened recently." And I said, "Do you know how good it is to talk about it? And it is good to cry everyday."
>
> T: ...His friend said to me, "You know Tina, if I don't start talking he would just say, Mmm, Aaa." He is almost like – Ilse, he wants to overcome. He thinks he can overcome by not talking about it and not thinking about it.
>
> T: Then he must not stop me when I want to talk to someone about my child. He does not want me to bring back any memories. He must not stop me.
>
> T: …he is scared he is going to become emotional, he will cry. …I must not mention his name, because then my husband feels hurt again.

Tina and her husband had very different opinions about the usefulness of talking about the traumatic loss of their son. He believed that talking led to "opening up old wounds"; she believed it was "good to cry everyday" and to speak about traumatic loss. Their differing views around speaking, both in public and in private, were

very upsetting to Tina. The intensity of Tina's feelings became clear. Tina's frustration was not only due to her husband's silence, but that he wanted to silence her as well. Tina thought her husbands persistent silence was due to his belief that he could overcome his grief by not talking or thinking about it and the fear of becoming emotional if painful memories are evoked when talking about the experience.

6.6.3.2 "He is not a person who talks, he just listens"

I: And your husband - how is he doing?
K: I talk to him a lot.
I: Do the two of you talk together a lot? What kinds of things do you talk about?
K: I explain a lot to him. He is not a person that speaks a lot. That's why I don't think it is necessary for him to come, because he will not talk to us. He is not a person who talks, he just listens.
I: And your daughter – how is she?
K: I am not really worried about her, because she is an extrovert - her reaction shows how she feels. She does not hide feelings like her dad. She is the opposite to her dad.

K: Your husband might be such a man. I know my husband is a man that does not speak. That is why I don't expect him to speak now.

T: ... But I think it is maybe just my husband who is like that, but perhaps the majority of the men are like that with their wives. I think my husband is the only one like that with me.
K: No, my husband is exactly the same. And I accept it because he is a man that does not speak.

T: They don't reply, and one does not want that. You want them to remember, "He was not like that." I want him to say on weekends, "If Frank was still alive his friends would have been in and out." That is how I think he should speak, but he does not speak.
K: You know your husband like that, so you have to understand.
T: But it is now the first time that we lost a child. It is now two years. It was my first experience. I want him to support me. He must work with me on this matter. He must share more with me. I don't know, Ilse.

T: ... Then I went and lay on the bed and cried myself to sleep. He will not comfort me and say, "Okay, it had to happen." Or, "He is better off," or so.

Some participants recognised difference in terms of how much people speak in their everyday life. Kate attributed her husband's silence about the death of their son to the fact that he was not an extrovert. She saw him as someone who "hides his feelings" and did not think he would want to be part of the therapeutic interviews, because he would not talk in such a context. She constructed and accepted her husband's silence as his personal coping style consistent with his "introverted" personality. She did not expect him to speak. Tina, on the other hand, found her husband's silence problematic. It emerged that Tina thought only her husband (not other men) was silent. Kate encouraged Tina to give recognition to personal difference in terms of talking about pain and offering comfort. However, Tina wanted her husband to participate in the conversation, "share more" and "work with her." In contrast, it seemed as if Kate felt that her husband was listening to her even if he did not respond. Tina stated that she needed a more active form of response - perhaps a comforting remark. Kate thought that Tina should accept her husband's silence, since this was his usual response. Tina reported that her sadness made her cry everyday. Although she lamented the fact that her husband did not offer her comfort, she was grateful for support of friends.

I: On Sunday you thought about some of the things that Kate has told you? What things?
T: She always told me, "He is just as hurt as you. Even if he does not talk, he feels the same."

K: He handles it differently.

K: Yes. My husband is the same as Tina's husband. He does not speak about it at all, but I can speak to him about it. That's why I told Tina to speak to him about it, but as I am hearing now, he does not allow her to speak to him about her son. But my husband allows me to speak to him about Len. I speak to him. But he does not reply.

T: Everyone's feelings are not the same. Look at Rick's mommy – she is just over it, over it. I can see she does not take it like I have. Why, because she was never a mother for him. The day - it was the Monday that he died – the Tuesday I walked with her to the doctor, then we were sitting in the taxi and all the taxi drivers and taxi guards said to me, "Deepest sympathy, ma. We are sorry to hear about ma's further loss." Then I said, "I am not his mother, here his mother is sitting" …And she got over it quickly.
I: So people have different styles in which they handle things or ways of expressing themselves?
T: Everyone is not the same.

Kate recognised that people express psychological pain in different ways and having different coping styles. She noticed that, for her husband, silence seemed to help him cope. Not only did people seem to have different coping styles in terms their own speaking or not speaking, they also seemed to differ in terms of their response to others' coping styles. Kate's husband did not talk about their son's death, but he allowed her to speak about him. Tina's husband did not want her to speak about their son. Tina realised that the time it took for people "get over" a traumatic loss was personal. She thought that Rick's mother "got over (her son's death) quickly", whereas she was still very affected by Rick's death. Rick was her son's friend but he was "like a son" to her.

6.6.3.4 "A man is not as open as a woman"

I: What was it like for you just to know he does in fact think about him and he did love him so much?
T: Kate has told me already that he feels just like me, when she heard me say he does not care. She said he feels just like me, just as hurt, but a man is not as open as a woman.

Kate seemed to believe pain and distress caused by traumatic loss was experienced in similar measures by both men and women. However, she saw speaking or not speaking as gender specific. She viewed men as closed and silent, while women were perceived as open. As indicated above, this seemed to be the case in both her and Tina's families. Tina generalised this to include all men in her statement: "a man is not as open as a woman."

6.6.3 "You have to start way back" (Discourses of the imperative for "catharsis")

B: The doctor looked through my file and said, "You at one stage had depression. Are you depressed?" And I just burst out crying. And I thank the Lord for that, because you don't want to talk about … because I think the moment you start talking a lot of things come back and now you have to start way back … and I was sort of like, "I am not sure. These aren't things that I can talk to you about. I am worried about my pain."

K: …it was not nice for me to come in here and tell everything from the start again. It was very heavy for me.

The discourse of catharsis, the notion that in order to "move on" from a traumatic experience, it is imperative to "face the experience" and to speak about it in detail, seemed to be known to participants. However, participants recognised the difficulty or "heaviness" in talking about traumatic experiences.

Psychological distress and physiological reactivity were re-experienced when remembering traumatic experienced in detail. Many participants were distressed by the idea that you "have to start way back" in telling your story. Emotions such as sadness and anger seemed to be experienced in conjunction with talking. For example, Bella reflected that she "thanked the Lord" for encouragement to talk about depression because "you don't want to talk about that." She knew that "the moment you start talking a lot of things come back." Although she "thanked the Lord" for the opportunity to talk, the fact that she felt that she had to "start way back" made her uncertain if she could talk to others about her traumatic experiences. Even though I did not ask Kate to tell me "everything from the start", discourses that one need to speak about the details of trauma seems to have informed her experience of what I expected. This necessitated more explicit statements about participants' right to choose what they feel comfortable with sharing – on ways of talking about their experiences that they deem helpful.

6.6.5 "I was afraid that if I tell mommy, then mommy might die" (Expected risk to audience)

> V: …Their [the rapists] court was next to our court. I was really scared. They said, "We are not scared of your parents. We will just come and burn your house down if you say anything." And I believed them. I was very scared to tell my parents….I left it just like that because they told me if I told anyone they'd burn my mother's house. And I never spoke about it….Then I was young and I thought like …they said they are going to burn our house down. I was really scared that they would hurt my family.
>
> V: I want to tell my husband but I am also scared of what he will do. He will want to know, "Who did it?" He will want to get them.
>
> M: The first words that she uttered when I asked her, "Why did you not tell me?" were, "I was afraid that if I tell mommy, then mommy might die."
>
> I: …Cheri, what made it so hard?
> C: I thought that if I tell my mother, she could die. That's what I thought.
> M: I had a pain in my chest that I could not breathe and I could not sleep because the pain was so bad. I saw four doctors and the fourth one solved my problem. It was a nerve pressed between my spine and chest bone and that caused the pain. That is why I could not breathe or sleep correctly. And in the time that this happened, she was so scared that if she told me, I will get sicker.
>
> C: I thought if I tell mom she would die right there.
> I: So it was too terrible for you to find the words to tell your mom, it was not that you did not want to tell her. You were scared something would happen to her?
> C: Yes.
> I: Okay. And is it important to you that your mommy will not keep it against you but will understand why you did not say anything?
> C: Yes.
> M: We did talk about it. I said to her "Cheri, it must just never happen again, because that is why I am here. I will not keel over dead from such a shock." A shock that causes your death must be extreme, it could be something falling on you, or if someone comes and tells me Walt has been killed, he's lying on the road, then I could, but not for this. I can get a big fright, because this did give me a big fright. It affected me very much.

Some participants refrained form speaking about the traumatic experiences in order to protect their loved ones. Silence was a way of coping and breaking it would involve considerable risk. The risk was perceived in different ways. It ranged from fear of retaliation by the perpetrators to fear of how the knowledge might affect loved ones' health and general well-being. In Vanessa's case not talking about the experience was initially due to fear of the perpetrators' threats. The perpetrators lived in the block of flats (court) next to theirs and quite

explicitly threatened her. Lewis (1999) confirms that perpetrators of violence and abuse against children are known to threaten to harm the children's parent(s). They might also try to convince children that they can protect parents emotionally by keeping abuse a secret. Robertson (1998) notes that inadequacies in the South African criminal justice system has contributed to the fact that rape has one of the lowest conviction rates of all serious crimes in South Africa. Consequently, offenders who have evaded arrest and conviction continue to intimidate their victims and their families. She highlights that "in the absence of effective witness protections services, women often withdraw or fail to report cases as they fear intimidation by the perpetrator" (Robertson, 1998, p.140). This seems to have been the case for Vanessa.

Vanessa also feared that her husband would demand to know who raped her so that he could take revenge. What she needed, however, also in their sexual relationship, was "a sense of autonomy and control" (Herman, 1992, p.65). Herman (1992) notes that the "regulation of intimacy and aggression often needs restoration after traumatic experiences" (p.61). Reportedly, rape victims often fear their partner's possible aggressive response to knowledge of the rape and this could lead to feeling more anxious and out of control. Fear also inhibited Cheri from talking, but not the fear of retaliation from her brother, the perpetrator. In fact, she told him and their older brother Walt not to tell their mother what he had done. Her fear was about her mom's ill health. She was concerned that her heart might not be able to handle such a shock. As will be highlighted in Case study 4, contextual factors such as her family's health history were stressed as a contributing factor to Cheri's silence. This was done to undermine the blame the she was given for being silent. The fact that three of her mother's siblings had died of heart attacks, made her fear more realistic.

> M: She is crazy about Cheri (*"Sy is oor Cheri"*) …she does not yet know what has happened to Cheri. And if I am going to tell her, she is going to explode.
> I: Are you scared to tell her?
> M: Yes, I don't really feel scared to tell her, I just don't know how she will react, because she really loves Aston and she feels the same about Cheri. But Aston is the apple of her eye.
>
> I: And do you understand that it was actually her love for you and the importance she attached to the family that made it so hard for her {Cheri} to talk. {Turning from Mita to Cheri} It seems to me the family was also something important to you, Cheri, and it is hard to talk about something that feels as if it might break things apart or change everything.
> C: {nods; crying}

Mita and Cheri were also concerned about how Cheri's aunt would react to the news of the abuse perpetrated by her beloved nephew against her beloved niece. I reflected on Cheri's desire to protect her aunt and herself, after Cheri revealed her fear that her aunt would not like them anymore. She was trying to protect the relationship.

> B: …I always used to wear plasters, because if someone would ask me what is wrong with me, I would say, "No, the nail is sore. The nail is sore." Because my husband made me never say. I only let it out at the New World Foundation after Peter {husband} died. Peter is seven years dead. And I think it was about a year after his death that I started to talk about it.

Bella spoke about the silence she felt she had to maintain about her experiences of torture and detention without trail. Her husband believed she should not tell others so as to protect their children from the pain of this

knowledge. Bella did start to speak about her experiences after her husband's death. Recently she had to retell her story in detail as part of an application for reparation at the TRC, and this led to "reliving" some of the trauma discussed earlier. Levenstein (1998) notes that many ex-detainees are reluctant to discuss the experience of detention, with some dismissing it as 'part of the struggle', while others acknowledge the suffering it caused but do not discuss their pain with others, including family and friends. This is said to have the following results:

> The inescapable impression is that there is a strong feeling of guilt and shame attaching not so much to the experience itself (although, like many rape victims, many blame themselves for getting into that situation) but to the effects of the experience on them. It is as if complaining about the deleterious effects of detention was a sign of weakness and lack of commitment to the cause of liberation. Ex-detainees therefore seem subjects to two traumas – the detention itself and the guilt about the effect it had on them. (Levenstein, 1998, p.143)

6.7 Manifestations of the discourse of speaking about trauma

Speaking is a relational activity that involves an audience or witnesses. As such, perceived or anticipated audience responses gained significance in participants' lives. Fear of unwanted audience responses ranged from getting more attention in the form of pity, to being ostracised and stigmatised. The latter was discussed earlier. Desired responses from the audience and ways of relating to others encouraged speaking. This included the desire to be understood; to be honest; to connect to others; to help others; and to leave a legacy. Although these contextual factors, discourses, values and desires are discussed in more detail in Chapter 7, they are introduced here as part of the dialectic of trauma. Wallace (2003) notes some of the possible freeing consequences of speaking about trauma:

> Raising one's voice and speaking the truth regarding one's experience is the first step toward potential dialogue, as well. Only such an act of giving voice to one's experience can create potential for dialogue between the oppressor and oppressed. Such an act also serves to redefine one's identity, as one can now be conceived as resisting one's oppression or creating a new identity as a defender of one's self or a new identity as a social activist seeking social justice. (p.24)

Participants' indicated that certain other contextual factors informed the ability to speak about trauma, such as taking substances that make it easier to talk, the time that had passed since an experience, or access to written accounts as tools to explain to others what happened.

6.7.1 "I think he will understand more" (Understanding)

> T: …It was the first time he told me on Sunday, "Listen to how you are carrying on. Do you know how much I loved that child and how much that child loved me?" He said, "You don't know what I gave that child quietly on the side. That you don't know about." He said to me, "I think everyday, at work where I work, I think about that child everyday." And he misses him, he said, even if he does not speak about it, he told me.
>
> V: …But sometimes I just think maybe I have to speak to him, maybe I must just tell him…but I don't want to do things my way. You see, I want to do it professionally. I want to speak to him. He must understand what happened and how it happened and so on. Because I think he will understand more - my moods, the things I do.
>
> I: Do you think you might want to invite your mom or husband here to tell them here, or rather at home?
> V: I can speak to my mom, but my husband, he really needs not only me. He won't understand. I'd like to invite him, because then he will understand more. Someone will explain. Then even I can speak to him, but not alone.

Some participants' ability to talk about traumatic events was informed by a need to be understood. Even Tina's husband broke his silence in an attempt to make Tina understand how much he loved their child. This was in response to Tina's accusations that he did not love their deceased child. For Vanessa, a motivating factor in wanting to speak to her husband about being raped as a girl was that he would understand both her moods and her actions better. However, she thought that she needed someone else to assist her in telling him in a way that he would understand. With a caring witness present, she would be able to tell him herself.

6.7.2 "My mother knows already, I don't have to worry anymore" (Relief)

I: How is it for you now that you mommy knows about it – is it better or worse?
C: I feel better.
I: Why is it better that she knows?
C: My mother knows already, I don't have to worry anymore.

A: She cried. When I asked her, "Cheri, what is wrong?", she said, "You know.." Then I asked her, "What?" And she did not want to tell me. Then I said to her, "I am going to tell my mother." Then she said, "No, don't tell." Then I told my mother on Friday night.
I: And was it difficult to tell your mother? Were you scared to tell your mother?
A: I had to tell her, it would have come out in the end.
I: And is it better for you now that your mom knows or worse?
A: It is better.
I: Why is it better for you?
A: Because now my mother knows.

The relief associated with not having to keep abuse a secret was reflected in both Cheri and Aston's statement that they felt better since their mother knew about the abuse.

6.7.3 Connection in relationships to others and God (Connection through faith, love, trust and honesty)

6.7.3.1 "I knew there was a God that I can speak to"

V: …Some of them don't even know what way to go, you know. We went to church. I had something to go on. I didn't forget to pray at night, I knew there was a God that I can speak to, and mostly or all the time I spoke to God. I thought that He was there, that He was listening to me. My mother always taught us there is a God you can speak to.

B: Nobody knows. People will talk, but your experiences go unknown. I can go to God on my knees. God knows me. That was the way I felt.

N: I asked God to make me a pillar of strength.

K: If I think about it, it is because I pray a lot. I don't know. I think it is that. One does not get your strength from yourself. It is only God that gives you strength. And He gives me the strength.

Faith in God and the experience of God listening and knowing ones pain seemed to strengthen many of the participants. Spiritual values provided meaning and purpose beyond the family unit and had an influence on how participants made sense of their situations (Walsh 1996). Watt (1995), who conducted a life course study of resilience found 43% of the participants in that study relied on spirituality (usually in a religious context) to help them cope with severe stress; 30% engaged in psychotherapy and 26% utilised both. Watt (1995) reported that

"God gave me the strength to continue no matter how difficult the obstacles" (p.233) was a common response of participants in that study. This seems to the case for some participants in this study.

6.7.3.2 "I have got someone who loves me"

> V: …I had a friend who understood me and a mother – but they {others who had been raped} just give up.
>
> I: How do you think it changed, that you don't have that feeling anymore that everybody knows?
> V: I think I am married; I have got someone who loves me. I think it is that, because since I am married and since we went out, I have not thought about it, because he is like someone – nobody can say something about me – he will cover.

Vanessa was able to tell her best friend about being raped. She believed that having had this friend to talk to had helped her enormously in coping with the experience. She stated that having "had a friend who understood me and a mother" made it possible for her not to "just give up" like other girls who had been raped. The fact that she was married and felt loved by her husband also had a significant effect on how she experienced speaking about the rape. Being married offered some protection from stigma and countered her fears that she would be judged. She felt that this made it possible for her to speak about rape. However, she feared her husband's own response to the knowledge. The relational nature of identity is clear in the security Vanessa experience in her husband's views about her and the fact that he will defend these views if others questioned them.

6.7.3.3 "I know that you are someone that I can have confidence in"

> V: Maybe {she could speak to me} because I know that you are someone that I can have confidence in. I know it is not going to go out of this room. But if I don't know people, it is hard for me to trust people. I can't trust people and I need to because …I mean, nobody did something to me that I am not supposed to trust them - not trust, but some trust - to speak to them and greet them.

The therapeutic relationship seemed to have provided a space for Vanessa where she felt safe. She had confidence that she could trust me in terms of confidentiality. This led to the articulation of her desire to trust others as well.

6.7.4 "I can't give them advice if I have got a secret" (Desire to help others)

> V: I want to speak about it because I want to go on with my life. I have come a long way.
> I: Secrets are not really working for you?
> V: It is making me bad inside. I don't want to be…I used to be like open and I know if I speak about it that secret will be out of my life. You know, it is good. I will start over again. I can freely speak. I know I can begin my life over again if I just speak about it. It makes ….I can't speak to people or give them advice. I give them advice without them knowing, but I can't give them advice really because I've got a secret. I always tell them not to keep secrets and they all think that I don't.
> I: Okay. So you have to practise what you preach?
> V: Yes (laughs).
>
> V: I just want to be free of my secrets, and then I can speak to them. If I can speak to my husband and my mother, I will be free to tell them, "You can speak to your husband, and this won't happen"…. I can give them advice.

V: …I never felt guilty about anything then. But now I feel guilty when I hear about secrets. I can't speak openly to my mom. She will say "You must pray for that person." I will think, "How can I pray for someone and I still have a secret." It feels so difficult. That is why I want to be open.

Vanessa reflected that speaking about the rape and not keeping it a secret from those who love her would be the starting point to recovery and starting over again. A big incentive for her to talk about it was that this would also open the way for her to give advice to others without being hypocritical. Her silence was causing uncomfortable feelings of guilt.

6.7.6 "We can comfort each other" (Being connected in communities of concern)

K: I will say if you talk to someone who has lost a child, or if it is still fresh, it is better to talk together (*..dis beter om saam te praat*). It lets that person feel better.
I: To talk together – what do you mean "talk together", in which way?
K: ….we must get a support group, then we can all talk together and we have all had similar experiences and we can comfort each other. Do you understand, Ilse?

Kate felt strongly that talking about her loss was only comforting in the context of a group of people who shared similar experiences and could "talk together." Her position supports the notion of creating communities of concern and facilitating support groups.

6.7.7 "It must be set right" (Repair)

M: …To think my own son did it to me. That is what makes me so…I just felt; I cannot leave it just like that. It must come out and it must be set right.

The idea that injustices needed to be come to light in order for restoration to be accomplished, also emerged. Cheri and Aston's mother believed that the secret had to "come out" in order to be "set right."

6.7.8 "Many men, when they are drunk, talk - they open up" (Escape)

T: …this woman, who he goes and sits with when he drinks said that he will not talk about his child, it does not matter how drunk he is. Many men, when they are drunk, talk - they open up - but not he.

K: But he had a drink, didn't he?
T: Yes, he was drunk. I just told him on Sunday, "You did not love Frank. That is why you don't want to talk about him." Then he said to me, "If you could see what goes on in my mind. I think about that child every day." So, he thinks about the child and he is in pain about it, but he does not want to talk about it, Ilse.

Participants' descriptions indicated that drinking alcohol seemed to be an accepted way in the community to assist men who were not open about their feelings to open up. However, Tina's husband usually did not open up even when he was drunk, except on the odd occasion.

6.7.9 "I don't hurt anymore if I speak about it" (Time as healing)

V: …I can see everything. I am not scared to talk about it now. I don't hurt anymore if I speak about it. I used to talk about it - I used to talk about it everyday to my friend and I just cried when I talked about it.

I: Hilda, can you tell me a bit about Len and how your relationship was?
H: Hoo (….) (becomes tearful and sighs)
I: Or is hard to talk about that now?

H: Mmm (…) (breathes deeply and sighs heavily)
K: Hilda still needs time… It is still sometimes hard to talk.

K: We see each other regularly and we speak a lot. And I want to talk about it.
I: Is it easier for you {Hilda} to talk to her {Kate} about it? Or are you someone who prefers to listen more? Can you tell her how it has affected you?
H: I talk to her. I would rather talk to her than my mother.

I: Do Sandy and Kate sometimes chat about Len's death?
F: Not with her, no, it depends on me to chat to him ("*Dit hang van my af om met hom te gesels*"). But he is at her house often and looks at his stuff. Every now and again he talks about him. This morning he started to talk again. (…) I leave him. But we do not talk if it is not necessary. We let him always start first.
I: If he wants to talk?
F: Yes. And then we let him speak. In the night he wakes me up, "I cannot sleep, mommy" . Then I ask him what he is thinking, and then he says he is thinking about Len. He feels it is not right that he should died like that; he had never hurt anyone else. Then I will always tell him that is how some people treat life and everyone knows it is not right. So he is very upset about it.

Vanessa reflected that even though she could still feel everything and see everything, she could talk about her experience of rape. Speaking seemed to hurt less than when she first spoke to her friend soon after the experience. She reported that at that time she just cried. It seemed that healing had taken place, possibly due to being in a different context and in a permanent relationship. In contrast to Vanessa, who was able to speak about the trauma she experienced eight years ago without the tears she used to experience, Cheri started to cry immediately when trying to speak about the traumatic event.

Hilda also initially found it very distressing to speak about the death of her boyfriend. Kate's reflection that Hilda "still needs time" seemed valid. Although Hilda found it hard to talk to me, she reported that she talked openly to Kate at times. Sandy's distress about his friend's death brought him to tears when trying to speak about his loss. He had, however, been speaking to his mother about how his friend Len's murder affected him. She left it up to him to initiate the conversation, but was willing to listen to him even in the middle of the night.

6.7.10 "My mom read this letter, the letter you gave" (Access to non-verbal tools)

V:…My mom read this letter, the letter you gave. I went out. I gave it to her.
I: Did you tell her what it was about?
V: Yes, I told her. She knows that I have been going to therapy, but she does not know why. So then I gave her the letter. And she read it. And I came in and she was like normal. She did not ask me about it. She did not know when to ask me.

T: I will tell you the truth now. The night I got home with that letter that Ilse gave me, then I said to him, "Look here what Ilse gave me." Then he took the letter and put it down. I watched him. I don't know if he was scared, or if he is scared he is going to become emotional, he will cry, or what it is Ilse.

Vanessa used the therapeutic letter I wrote to her as a tool to break the silence. It seemed easier to share the contents of the letter than to speak about the rape herself initially. Ironically, however, the discourse of silence manifested in her mother's reluctance to talk about the rape once she had been informed about it. Like Vanessa, Tina used the therapeutic letter as a tool to communicate to her husband what we had been speaking about. However, he seemed not to have read it and Tina speculated whether this might have been due to fear of the emotional distress it could lead to.

6.8 Concluding discussion

In this chapter the consequences of violence-related trauma for participants from the low-come South African community of Lavender Hill were discussed. It was showed that participants themselves emphasised the impact of trauma on their daily functioning (emotions, thoughts and behaviour). Participants also described how trauma impacted on their sense of safety and on the way they related to themselves, others and God. Trauma not only affected individuals, but families and the community as a whole. The consequences of trauma for each participant were informed by discourses in the community. Janoff-Bulman's (1985) proposal that exposure to trauma challenge three basic assumptions about the self and the world - the belief in personal invulnerability, the view of oneself in a positive light, and the belief in a meaningful, orderly world – seemed to be applicable for participants. For some participants, trauma contributed to an intensified search for meaning-making, to a fragile sense of self, and to mistrust of others. Similarly, Herman's notion that trauma is experienced as simultaneously disconnecting and overwhelming, was also supported by the current data. For many participants, however, religious beliefs seemed to have been a mediating factor, limiting the shattering of meaning sometimes experienced in the wake of trauma (Janoff-Bulman 1989; Magwaza, 1999). Participants often experienced a conflict about whether to speak out or stay silent about what happened. Based on the grounded theory analyses of the data, the consequences of trauma on participants' lives have been summarised in the Tables 9 to 12. Table 9 focuses on daily impact of trauma on thoughts, emotions and behaviour.

Table 9

The psychological consequences of trauma for participants' daily lives

Consequences for thoughts and memories	
"I still remember it like it was yesterday"	(Intrusive thoughts and frozen memories)
"It is almost like I am being raped again"	(Reliving experiences)
"I told myself I wasn't raped and I believed it"	(Denial)
Emotional responses	
"They make you so bitter"	(Hatred, bitterness and vengeful thoughts)
"I am angry all the time, any place"	(Anger)
"You are breaking me as a mom"	(Mistrust)
"They live in fear"	(Fear)
"There are times that she just feels like crying"	(Sadness and depression)
"I've got moods"	(Irritability and mood swings)
Consequences related to behavioural reactions	
"I was glued to the ground….It was shock"	(Paralysed by shock)
"I just sit"	(Numbing of responsiveness)
"I just stopped with my life"	(Limiting activities due to fear)
"I don't want to be reminded of that day"	(Avoidance)
"Who is waiting around the corner?"	(Hyperarousal and hypervigilance)
"I cannot sleep, mommy"	(Sleep disturbances)

As is evident in Table 9, participants' descriptions of the consequence of trauma correspond with many of the symptoms of PTSD. However, it can be argued that the consequences of trauma in participants' lives are normal reactions to extremely dangerous and stressful situations. From this perspective it follows that the consequences described above do not suggest that participants are "mentally ill", but simply reflect their normal reactions to a terrible situation.

In Table 10 and 11 the focus is on manifestations of the discourses of silence and speaking; and in Table 12, on how psychological consequences interacted with the consequences of trauma on relationships. In this chapter it was showed that participants' stories confirmed conflicting desires to speak and to remain silent about traumatic experiences. It emerged that participants' ability or difficulty in finding a voice could be placed within broader community discourses about trauma, rape, abuse and loss. Manifestations of discourses that informed silence and discourses that informed speaking are summarised in Tables 10 and 11.

Table 10

Manifestations of the discourse of silence

"It is so heavy to talk about it"	(Avoidance of distress, reactivity)
"…one does not want that"	(Avoidance of responses)
"I didn't want anyone to think differently of me"	(Avoidance of shame)
"She won't think I am so strong anymore" *"She won't like us anymore"* *"Tthey won't come to me if they know"* *"The whole school knows and they look at me"*	
"…. I spoke to no one"	(Pattern of withdrawal)
"I don't talk to them for a week" *"I could not speak"* *"I spoke to no one"* *"I am feeling so out"*	
"I was afraid that if I tell, mommy might die"	(Protecting loved ones)
"I was very scared to tell my parents" *"I just don't know how she will react"*	
"Everyone is not the same"	(Different coping styles)
"He says we are opening old wounds" *"I say it is good to cry"* *"He thinks he can overcome by not talking"* *"He is not a person who talks, he just listens"* *"A man is not as open as a woman"* *"He handles it differently"*	

Table 11

Manifestations of the discourse of speaking

"I think he will understand more"	(Desire to be understood)
"Men, when they are drunk, talk - they open up"	(Being inebriated)
"I don't have to worry anymore"	(Desire to stop worrying)
"Having a friend who understood"	(Having an audience)
"I knew there was a God that I can speak to" *"I have got someone who loves me"* *" you are someone I can have confidence in"*	
"I can't give them advice if I have got a secret"	(Desire to help, leave a legacy)
"We can comfort each other"	(Communities of concern)
"It must be set right"	(Restoration)
"I don't hurt anymore if I speak about it"	(Healing with passing time)

One can thus conclude from the analysis that traumatic experiences are articulated in very individual ways and profoundly shaped by the context of Lavender Hill. An exhaustive comparison of this study with other studies falls outside the scope of this study, but it should be noted that certain response patterns that have emerged in another study in South Africa were apparent in this community. The effects of trauma on participants' lives were similar to those reported by Skinner (1998), who conducted a study in two economically disadvantaged, urban communities on the Cape Flats in the Western Cape (similar in terms of high levels of violence and poverty to Lavender Hill) (Skinner, 1998). The short-term effects of trauma were found to manifest in high levels of emotion and shock, being immobilised by shock, being "unable to eat, sleep disturbances, crying all the time, and wanting to be alone" (Skinner, 1998, pp.153-154). Long-term effects ranged from medical problems to psychological problems such as PTSD symptoms, depression, anxiety, substance use, psychosomatic symptoms and relationship problems (Skinner, 1998). In the present study there are many similarities. Some participants experienced effects that corresponded to symptoms of post-traumatic stress such as increased arousal, intrusive thoughts and reliving experiences, and psychological consequences such as irritability, anger, fear and behavioural changes. A difference that emerged in this study was that no substance abuse was initially reported as a current problem in the lives of participants themselves. However, some participants abused alcohol when they were younger. One reported that her father abused drugs. Two participants reported that their husbands abused alcohol regularly and one was concerned about her children abusing drugs.

As discussed earlier, it emerged that speaking interacted with the way in which participants related to themselves, others and God. Some participants reported a loss of confidence in themselves and others. Experiences of having been betrayed made it difficult to trust again. Although some participants experienced a sense of outrage, none reported a permanently shaken religious faith. Instead, their experiences seemed to have strengthened their faith.

On a community level, traumatic experiences seemed to have had both isolating and connecting effects. The connecting effects on relationships are discussed in the case studies in Chapter 7, since these consequences can be seen as forming part of the process of "problem effacement" (Muntigl, 2004). The relational consequences are summarised in Table 12.

Table12

The relational consequences of trauma for participants' lives

Relationship with self / identity conclusions	
"I didn't have that self-confidence anymore"	(Less confidence)
"I thought they were much better than me"	(A shame-based identity)
"I am always scared they won't come to me"	(Fear of rejection)
"I always blamed myself"	(Self-blame)
"He gave her a life-time scar"	(Discourses of damage)
"I don't want to be someone who was raped"	(Resisting rape myths)
"… look what she is"	(The gaze of others)
Relationships with significant others	
"I couldn't sit with friends like I used to"	(Isolation)
"I could just kill him"	(Impact of anger)
"I didn't want to be around boys"	(Avoiding groups of people)
"There is nothing for you outside the house"	(Isolation and restricted activity)
Responses to perpetrators in the community	
"They make you so bitter"	(Bitterness)
"She still has a lot of hate in her"	(Hatred)
"I would chop such people's hands off"	(Vengeful thoughts)
"… that brings fear over all the people"	(Fear of perpetrators)
"I fear nothing"	(Counter-phobic response)
"You are breaking me as a mom"	(Family disruption and mistrust)
"I just want him away from me"	(Avoidance and silence)

The consequences of trauma discussed in this chapter often formed part of the process of "problem identification" or "naming the problem" that is further considered in Chapter 7. The need to support people in finding ways to talk about traumatic experiences in ways that they deem helpful was confirmed by the findings in this chapter. In Chapter 7, ways in which traumatic experiences were spoken about as part of the process of narrative therapy are illustrated through five case studies.

CHAPTER 7: FIVE CASE STUDIES: CO-CREATING HOPE AND RESILIENCE

Our talking has given me peace of mind. I have been pouring out and pouring out and pouring out. And it has made me think back about how I should be...Now I realise where the strength comes from. I am so happy to know that I don't have so much pain. And it is good.
(Participant)

7.1 Introduction

In an attempt to "impose simplicity and order upon a process that is inherently turbulent and complex" (Herman, 1997, p.155), interviews with participants are reported in five case studies. The case studies describe the application of narrative therapy ideas and practices as a means of attending to the consequences of trauma in one low-income, high-violence South African community. As discussed in Chapter 5, the case studies are structured in accordance with Muntigl's (2004) analysis of narrative therapy interviews. Although the scope of this study did not allow for a detailed analysis of all the interviews that formed part of the process, important aspects of the process are highlighted in each case study. The aim was not to measure the impact of narrative therapy in a quantifiable form, but to make narrative therapy assumptions and specific "maps of narrative practice" explicit. The process is illustrated with quotes from interviews and extracts from therapeutic letters that were written to some participants.

Chapter 6 focused on the consequences of trauma that emerged from participants' stories. In this chapter, reference is made to these problems, but the focus is on the construction of problem agency and on problem effacement. It is showed that an awareness of "double-storied accounts" of trauma narratives - that it included not only stories about the impact of trauma on people's lives, but also stories about people's responses to traumatic events - informed the evolving process and content of the interviews. The aim was to work towards both the reconstruction of trauma stories and the co-construction of stories of hope and resilience. The focus was on what participants thought their responses said about their preferred values, purposes and identities. In this way, narrative therapy was used to create richer descriptions of participants' identities which served as "islands of safety" (White, 2002, p.5) from which to review traumatic experiences.

7.2 Outline of case studies

The case studies serve to capture the complex and multi-layered experience of trauma and recovery of individuals and families in the community of Lavender Hill. As noted in section 5.5 of Chapter 5, Case study 1 centres on conversations with Bella and Nina, community consultants to the study. In Case study 2, the story of Kate, Hilda and Tina's shared grief and ability to "stand united" is told. In Case study 3, difficulties faced by Francis and her children, related to living in a context of continuous trauma, are described. Case study 4 involves interviews with Mita and her teenage son and daughter, Aston and Cheri. The family wanted to talk about the consequences of an incident of sexual abuse that Aston perpetrated against Cheri. In Case study 5, Vanessa's struggle to break free from the secrecy about being raped as a teenage girl is described.

7.3 Case study 1: Bella and Nina – "Becoming inspired again"

These conversations have … brought us very close and…I am not seeing that Bella that is so down anymore. I am seeing that Bella that is becoming inspired again.
(Nina)

7.3.1 Introduction to Bella and Nina

Bella and Nina, both in their early sixties, had been living in the same block of council flats in Lavender Hill since they were moved there in the seventies. I arranged to meet with them in Bella's flat. On the first occasion, Bella met me at the NWF so that we could drive to her flat together. As we drove through the "upper class" neighbourhood en-route to her flat, she commented that the area was often targeted for crime as the residents had more possessions and were out at work during the day. We had lovely views of the mountains in the background behind a field, but we turned the corner and faced the cluster of grey, unpainted blocks of flats that Bella called home. While we parked at the courtyard of the block of flats Bella assured me that it was safe to park there, since the residents saw me arrive with her. She warmly welcomed me into her flat and showed me around. Her 15-year old granddaughter and her 35-year old daughter lived with her. Her daughter had a hair salon in a shack in the back yard. Nina lived in a nearby flat with her second husband and adult son. Once Nina arrived, I re-established their consent to having our conversations recorded (see Table 2 in Chapter 5).

At the start of the first interview I reflected on my "outsider" status in their community. This made me all the more grateful to them for agreeing that I could consult with them about living in Lavender Hill. Bella and Nina were keen to reflect on their shared history and told me about the disappointment they experienced when confronted with the living conditions in Lavender Hill after being forced to move from their previous homes in Claremont in the 1970s. They both became involved in the struggle against apartheid and had been active in the local Lavender Hill Advice Office in the past. In 1986 Bella was detained without trail. We reflected on some of the difficulties of living in Lavender Hill in more recent times. However, opportunities were also created to remember and tell stories of courage and creativity in the past. This is reflected on in two stories that are included in the discussion at the end of this chapter.

7.3.2 Problem construction: Naming the problem and exploring its effects

The importance of co-creating "experience-near" (Morgan, 2000, p. 44) names to problems affecting people's lives was highlighted in Chapter 4. These names should allow for the politics of experience to be examined, by exposing the oppressive power of problems. The impact of the problem story on a person's life and the distress it caused should be acknowledged (Morgan, 2000). Bella spoke about "depression" as a problem she was experiencing at that time. Nina had also experienced depression in the past.

7.3.2.1 Depression

Both Bella and Nina viewed depression as a consequence of traumatic experiences they have had - Bella as a survivor of torture and Nina as a survivor of an emotionally abusive marriage. Although the term "depression"

is a diagnostic term, Bella introduced it. As such, it seemed to be a term that was "experience-near" to her. In order to gain a fuller understanding of what depression had cost the women, questions that "mapped the influence" (Morgan, 2000, p.23) and explored the relative strength of the problem were asked. The social context of depression was also explored. These externalising conversations highlighted how depression seemed to have gained agency as an independent force in their lives. It established a context in which Bella and Nina could experience themselves as separate to depression. This was achieved through explicit externalisation of "depression" as an entity separate to themselves, with which they had a relationship.

> N: Depression makes you withdraw very much. Depression makes you see your best friend not as your friend but as your enemy. If I call you, you don't want to talk. I don't want to share my problem with you because you might go and tell someone else this is my problem.
> I: So does it make you suspicious of people?
> N: Depression makes you feel like, "I don't want to talk to anybody. I just want to sit here in this little corner alone."

> N: Depression is something where you feel you just want to keep everything to yourself.
> I: Is that what depression does? Is that how it operates? It kind of makes people withdraw and makes it hard for them to reach out?
> B: Yes, it does.

In Bella's experience, depression was linked to mistrust and isolation, and on a physical level it resulted in her developing of a stomach ulcer. Kagee (2003) notes depression as a common consequence of torture, since torture is associated with loss, "particularly the loss of body parts, normal bodily function, health, work, status, family, and credibility" (p.277). During her detention under the apartheid government, Bella experienced various forms of torture including beating, electric shocks and having three fingernails pulled out. She referred to a time "before the nails" and told us that the torturers put plasters on her hands to hide that her nails had been pulled out. I did not want to invite Bella into free recall of the torture through open-ended interviewing about the experience, since this has been shown to "generate emotional distress" (Kagee, 2003, p.279) and does not fit with a narrative approach. However, I actively listened to her when she volunteered information about her experiences. According to Kagee (2003), survivors report appreciating opportunities to provide information about their experience of torture as a "testimony of their experience" (p.279) to a concerned health professional. Bella confirmed this by co-creating opportunities to share with us and by expressing appreciation for our conversations. She was also enthusiastic about her participation in a conference (see section 7.3.4.3) where she could testify about her experience to a larger audience of mental health professionals and pastoral therapists.

7.3.2.2 Isolation and silence

Externalising conversations about depression exposed its contribution to isolation, silence and inactivity in their lives. Bella talked about the ways in which depression isolated her from others, even her daughters. Despite Nina's availability, depression "convinced" Bella that she wanted to be alone and that she would be a burden on others, including Nina. It could be argued that depression managed to temporarily 'steal' her ability to experience "doing hope" with others. Ironically, in this way depression managed to do what the incarceration of the apartheid government failed to achieve, which illustrates the "politics of the experience" of depression as an oppressive, isolating force in Bella's life:

I: Who are some of the people that you think are of assistance in standing with you against depression? If you feel depression "lurking at the door", are there people around you, maybe friends like Nina …?
B: You sometimes think, "Oh, they have got their own {problems}." You cannot {ask}. Now that you are talking about it, I realise that I can always ask her to come over. You feel more comfortable in your house when you really want to talk and I am sure she is a person I can really talk to. During this time I think I was thinking of too many things to think of going to Nina.
I: And for you, if she talks to you, do you experience it as a burden, or how do you experience it?
N: I would not experience it as a burden. It would be a friend in need, even if she has to call.
B: And I know that.
N: If she calls me any time of the day.
B: I know that. I know I can call her anytime of the day. Nina is the kind of person - even if there is no food I don't have to be shy to ask her for a few slices of bread. She is that kind of person. And she would not tell others. But I can't explain how it is. I cannot get myself to go. I want to be alone.

B: I was feeling, "I just cannot go and talk to anyone." At first you don't realise that you are going through a depression. Like a lot of things happen first. Like you snap; you get up four o'clock in the morning because you can't sleep. Then you tidy the house and by six o'clock the house would be clean. And my daughter would say, "Mommy, you are not sleeping", but I would find any excuse not to tell her exactly why I can't sleep. I think she would worry. I think I did that for many years. You know, like handling things on my own. My husband was a very quiet chap, but I could talk to him.
N: I think what actually really happened was both of us lost our husbands within a week.
B: Within a week.
N: But I remarried. Okay. So for me, I have got somebody that I can speak to. But for Bella there is nobody that she goes to bed with at night. There is nobody to whom she could say, "I am not feeling well." So that can also be part of the cause of her depression. Her children are married. They have got their own lives. So she does not want to burden them with her problem.

Nina thought the isolation and loneliness associated with Bella's experience of depression was related to Bella's loss of her husband, since he was someone she used to speak to. For Bella, depression was also associated with fear.

B: In my experience I would base my depression on fear… Fear of those perpetrators. Fear for my children - that they would still do what they said they would do {harm her children}. With amnesty I thought, "Will these people still get me? Are they still alive? Are they going to come?"
I: So have these fears come back recently?
B: Yes. I don't know where they are, these guys.

Bella related her experience of depression to the fear she experienced due to the threats made by her torturers about what they might do to her children. Openly talking about what they did at the Truth and Reconciliation Commission meetings brought the fear to the foreground once again.

7.3.3 Problem effacement: Identification of alternatives and personal agency

While listening to how they described the impact of depression, I was also listening carefully for any experiences where depression had less or no influence. These fragments of experience were built on so that the new stories could be co-created. Many examples of experiences that reflected their skill in lessening the influence of depression were voiced. Alternative ways of being were named and described. These included "being more calm", "speaking what is on your mind", being able to "open up", "relating to the good memories you have had", "knowing you have good comrades", and "not neglecting your spiritual life." How these alternatives had been effective in countering the influence of depression become clear in the following extracts:

7.3.3.1 "Being more calm"

> B: You know, it {the ulcer} is still going on. But the more I can concentrate on being more calm, the less pain and spasms I have. I can really honestly and truly say that I feel so much better with my stomach. The pain used to be terrible. I thought the medication made it worse. The doctor looked through my file and said, "You at one stage had depression. Are you depressed?" And I just burst out crying. And I thank the Lord for that, because you don't want to talk about … because I think the moment you start talking a lot of things come back and now you have to start way back … and I was sort of like, "I am not sure. These aren't things that I can talk to you about. I am worried about my pain."
> I: So although you did not want to talk about it, you found it helpful? Relating the pain {physical pain to the psychological pain} enabled you to be more calm?
> B: Yes.

Bella realised that she had been avoiding talking about depression since this required having to "start way back." However, her doctors' direct question made it possible for her to speak about depression and to realise that her physical pain was related to the psychological pain she was experiencing. She found that having learnt how to concentrate on "being more calm" had lessened her physical pain.

7.3.3.2 You have to "speak what is on your mind" and "relate to the good memories"

> N: Depression is something where you have to speak what is on your mind, but also try to relate to the good memories that you have had in life.
> I: Have you found that helpful?
> N: That has been very helpful.
> I: To recall that and to reclaim some of the knowledge for your life now?
> N: Yes.

Nina realised that in order to counter "depression's strategies" (as spoken about in externalising conversations), it was useful to recognise counter-strategies. These included "purposefully speaking what is on your mind" and trying to "relate to the good memories that you have had in life." It could be argued that two strategies were incorporated into our interviews and this could explain why the women reported that they experienced the interviews as helpful.

7.3.3.3 "I could open up"

> N: I have had depression at one stage, because of lots of things that also happened to me, but I had a good friend who in actual fact was my supervisor at New World Foundation. I'd phone him and say, "*Carl, ek voel vanoggend ek wil op die ashoop gaan sit*" (Carl, this morning I just feel like sitting on the rubbish dump). He asked me, "What is wrong?" He encouraged me. That is why I say, I had somebody right outside of my community, right outside of my family, a stranger that I could relate to, that I felt it will be between me and you. That is where I think Bella is still struggling, because she has not had that kind of person to talk about not feeling well.

In contrast to Bella, Nina had a supportive person to talk to about her experience of depression. Nina's relationship with her supervisor at work created opportunities for her to "open up" to someone she trusted. In terms of establishing trust, it is interesting to note that she emphasises the need for someone from "right outside" of the community, "a stranger." As indicated in Chapter 5, my outsider position lessened the perceived risk of having confidentiality broken within the community.

N: I could open up to my supervisor (Carl) at NWF. I could open up and I think I could off load. He used to say, "*Ag man Nina, huil as jy wil huil*" (Oh man, Nina, cry if you want to cry).
I: So is that advice that you still keep today?
N: Yes. And what was also very, very encouraging that Carl taught me was "Don't neglect your spiritual life." I think I took it from there to begin to bridge that abuse.

Nina was allowed to cry. She found this helpful. She also thought the advice she got, "Don't neglect your spiritual life", was significant in helping her to "bridge that abuse" - to lessen its effects on her life. Her emphasis on the importance of "your spiritual life" was echoed by other participants in the study, as indicated later. Through participation in the interviews, Bella was reminded that she too had a friend that she could "open up to" in the person of Nina.

N: And at the advice office we were prepared for what they would do to you if you were detained. Put a sack over your head and all that. We were all prepared for that. But still, you are human, and if it has not happened to you, you cannot speak of the experiences. But it has happened to Bella and I share deeply with her what she has gone through.

Nina's availability as someone who "shares deeply" with Bella in her suffering stood in contrast to what Kagee (2003) identified as the "reluctance of others to hear and acknowledge accounts of torture experience" (p.284). This could be seen as an example of "doing hope" with others in a community of caring people as qualified by Weingarten (2000). Weingarten (2000) wanted to know: "Do people who live the spirit of *ubuntu* downplay the trauma sufferers' pain or withdraw from the interaction altogether, as North American researchers claim is 'natural'?" (p.400). Nina's ability to "share deeply" seems to be one example to the contrary. She realised that she could not speak on Bella's behalf and would never fully understand her pain, but she was willing to listen and to share the pain in that way.

7.3.3.4 "I think my comradeship helped me a lot through it"

N: I think my comradeship helped me a lot through it. I knew I had good comrades. I knew I had good friends. Some of them knew my husband. They could understand what I was going through. Some of them in actual fact knew the ways he had.

B: I knew that they {my comrades} were there for me. I knew that they would look after my children and inspire my husband. I knew that.

Comradeship – a term used by Nina not only to refer to people she was joined to in the struggle against apartheid, but also to friends who understood her situation – was also seen as a way of countering the effects of depression. Furthermore, the way in which Nina and other comrades supported Bella's family while she was detained spoke of their commitment not to isolate Bella's family due to fear of association with them. This commitment to help Bella's family in spite of the risk and in the knowledge that she was unable to help them herself, could be viewed as another example of how the community was "doing hope" for her at a time where she felt powerless. The knowledge that her friends would take care of her family supported her. Kagee (2003) notes that the aim of torture is not only "to extract information or to attack the identity and dignity of the victim,

but also to destroy families and to terrorise entire communities" (p.274). The form of comradeship between these women seemed to have contributed to limiting the intended impact of torture.

7.3.3.5 Faith and thankfulness

> B: When I was tortured, I could scream that I was hurting – there was no-one who heard me. But just that I had God and that I believed that God would get me out of it. I must go though this, but God sees what is happening and He will make the changes. And He knows my striving. He knows the goals I have in sight. That helped me.

Bella is an active Christian and said her faith sustained her during times of suffering. The knowledge that "God sees" and that "God would get [her] out" helped her in the moment that she must have felt powerless. At a time when no-one cared to hear her, the knowledge that God knew her beliefs and her goals seems to have countered her sense of powerlessness.

> B: …But I also knew my family would be going through something. All I wanted them to know was that I was all right. But there was no way I could notify them.
> I: So what was that experience like? Helpless frustration?
> B: Yes, but just to come out of interrogation alive – that to me was a victory. I was like, "Thank God." I was thankful. Even in my sleep, my comrades lying next to would tell me, "You kept saying 'Thank you God'. You are thanking God for being in prison!" And all that {laughter} … Then I would say, "Comrade, please man, you don't understand. One day I will share with you." I would always keep that in mind, because I was very grateful for being alive. I saw death. I thought, "Well, this is it"….I went into interrogation five times, and every time I thought, "What today?" You think you are far away. Out of the five times, I was blindfolded four times. The very first time I went with open eyes - passages and keys and from this room to that room. And the next time when I was blindfolded I thought, "They are not going the same way." It is totally confusing. So by the time you find yourself getting into a car, you don't know where you are going to. Are we going into the bush? Are they going to shoot me? I felt trees where we were going and then I went into another building. All I said was, "God must keep me safe." And I was very frightened. I always thought, "This is it. I am definitely going to die here."
> I: So was that why, even in the midst of that terror, you could still be thankful?
> B: Yes

Reflecting on the helplessness she experienced in relation to not being able to contact her family reminded Bella of a story in which she spoke of herself as a survivor rather than a victim. Inquiry into the importance of her faith reminded Bella that faith enabled her to notice small victories and to be thankful. Since she expected to die at the hands of her torturers, "just to come out of interrogation alive… was a victory." Her thankfulness in these difficult circumstances attests to the resilience and hope that her faith contributed to.

Bella and Nina's ability to act as appreciative audiences for each other emerged from the way they related to each other despite their strong commitments to different faiths. Although Bella was Christian and Nina Muslim, they witnessed how each relied on their God for strength.

> B: Nobody knows. People will talk, but your experiences go unknown. I can go to God on my knees. God knows me. That was the way I felt.
>
> N: I asked God to make me a pillar of strength.

Nina reflected that her commitment to God was put into action in commitment to help others.

N: I have gone from a comrade to a person who actually does not miss one prayer a day - that prays five times a day. That gets up three o'clock in the morning to pray. I have actually changed my life and this is very important for me. It is an important step in my life. I have always been a Muslim, but to be honest, I have never been a committed Muslim as I am now.

N: Although I had been a comrade for many years, I never thought of changing my religion. I always thought that this is what I am. And I think I have been through the ways and woes of life, I would say. I have been to the dance floors. I have simply been everywhere. And to think that God has come at this stage of my life and has actually changed my life to a completely new person is a wonderful experience.
I: So how is this new person different? Or how would you describe this new person?
N: I enjoyed the joys of life and now I am enjoying the joys of religion.
I: Your commitment to God seems to have become really enhanced. And how do those joys still relate to your sense of commitment to people as well?
N: That has not actually changed, Ilse. The fact is I have become even more committed to helping people. God has really – look I have been a community worker for plus minus 10 years. I have worked with gangsters. I have worked with people. And I still do get people that come to my house for assistance and I cannot turn them away. It is almost as if I have a little satellite advice office from my home. I am still involved, on the level of running a little satellite. Bella might send people over to me if she does not know how to help them.

Bella's faith was put into action in the work that she is doing with elderly people in the community during home visits with her church. As she reflected, "We are just doing what we are doing because we care", memories of the neglect of old people that she had witnessed brought her to tears.

B: We work in the old age homes. Since I've seen these homes I have said, "Never put me in a home." I was in tears. We could give people a word of comfort. They just broke down. No-one has been to them. They pleaded for us to come back. We now go every week.

Bella and Nina continued to be very actively involved in helping others. In 2005 Bella told me with great pleasure about the dramatic play that they produced with the "old" people, with actors all being between the ages of 60 years and 80 years old. It was a very successful fundraiser for the Old Aged Home. Apparently, members of the audience were so inspired that they have requested the group to consider producing the show at one of the premier theatres in Cape Town.

7.3.3.6 Knowing "I am quite strong"

B: While I was in prison I became even stronger.

B: …Eventually the smack and the fist was nothing, compared to what they can do, you know, like the shocks. (..) So I am quite strong.

Bella came to the conclusion that she was "quite strong." She attributed her strength partly to her faith and reliance on God. She told us that she was blindfolded four out of the five times she was tortured. Her words, "it is totally confusing", "you don't know where you are", and "I was very frightened" confirmed that being blindfolded intensified "feelings of helplessness" and increased "the sense of unpredictability" (Kagee, 2003, p.274). However, questions about her ability to be thankful in the midst of terror led her to an alternative identity conclusion, namely that she is "quite strong."

7.3.3.7 "I had a role to play"

B: I believe I had not been to prison in vain. I had a role to play.

Bella's belief in the political changes she was working towards and her awareness of the role she played in the struggle against apartheid helped her. Maintaining a connection to the values and principles that informed her participation in the struggle against apartheid seemed to help find meaning in her imprisonment. It had not been "in vain." Seeing herself as part of a bigger movement in which she "had a role to play" was sustaining. Bella and Nina transformed Bella's traumatic captivity into a meaningful experience in the knowledge that the political struggle which they were part of was continuing both inside and outside the prison.

N: …But I also say we have had many good times. When Bella was detained, we had to go on in this community.
B: Yes, I wanted that.
N: We were told, no matter what happens, even if it is your best friend, you must carry on.
I: Is that a sign of courage to you?
B: Yes, that people would carry on, even with me being in, that they would remember this is part of the way forward.
N: It is part of the struggle. It is part of the comradeship.
B: They had a job to do.
N: We had to carry on.

On a community level, remaining connected to the values and principles that inform a political stance also seemed important to Nina and Bella. I was curious about the broader effect that Bella's detention had on the level of community, family, friends and comrades. According to Nina, they "rallied" to support her. An effect of her detention was therefore "social mobilisation of people against detention and hence against apartheid" (Kagee, 2003, p.288). The social mobilization of supportive people in the wake of traumatic experiences has been found to be helpful (Van der Merwe & Dawes, 2005). I agree with Dowdall (1992) that torture, as indeed any traumatic experience, "cannot be understood separately from the historical, political and economic context of power relations" (p.452). All acts of violence can be seen as "repressive" and the social, historical and political contexts of such acts should be explored.

7.3.3.8 Liberation

N: But then it {abuse} became so bad, because I was involved. Look we were running around for the elections. We were preparing for the elections. Things were so uptight. It is election time, we are going to win, the ANC and Mandela are free - all these things.
B: Excitement! Wow!
N: Excitement. You know, tonight we are going to have something with this comrade. And the abuse was just becoming more and more and more. And I said to myself, "Man, maar ek kan mos nie my lewe so om maak nie" (Man, I cannot go on living my life like this). There was no other man in my life.
I: So you got support and you realised that you were worth more than that?
N: With all the excitement of being free, I just thought, "Hoekom moet ek dan dit vat?" (Why must I take this?) Why?
I: So was it liberation in a broader sense?
B: Yes, very much {laughs}

> N: Yes, yes. Why should I go through all this. I mean I don't need this in my life. I have grown up children. I have looked after them. Why must I go through this? So I decided that I would leave. I packed up and I left after 25 years. It was peace for me.

For Nina, the depression and abuse she had experienced in her marriage stood in contrast to the excitement of political freedom. The new political freedom she experienced served as an inspiration to question her "captivity" in an abusive marriage. It became a metaphor for the possibilities of breaking free from the oppression of abuse. With the support of those around her, she left this relationship. Omer (1996) notice that narrative therapists sometimes talk about "oppression", "recruitment" and "liberation" (p.328) in relation to problems and their effects on people's lives. He points out that narrative practices evoke "a sense of indignation and the dawning consciousness of possible freedom" (Omer, 1996, p.328). While problems and "unique outcomes" were explored with Bella and Nina, I was also listening for examples of the influence they each had to "counter depression" and its resultant isolation. I asked questions to invite them to develop an explanation of the significance of these experiences. In this way, the plot of the alternative story was thickened and thematic links between different events were drawn.

7.3.4 Narrative practices aimed at thickening the alternative story

7.3.4.1 Therapeutic letters and documents

In this study, participants were consulted about the idea of receiving letters. Their interest was assessed once some of the possibilities as to the content of letters were explained. Since issues of confidentiality are important in therapeutic relationships, this influenced who the letter were addressed to, how it was delivered and how was kept. The cases where letters were written, the documents were viewed as an extension of the conversation, and participants were invited to comment on them. In this case, Case study 1, transcripts of the interviews were made available to Bella and Nina, so that they would have a written version of the "important" things they did not want to forget. Letters were not written due to time constraints, not because they would not have been appropriate. In our reflection, Bella and Nina spoke about their knowledge about depression and about their preferred ways of living. Bella reflected that she was documenting this knowledge by making notes after our talks:

> B: …Like today, I can go and sit down or lie and down and look at all the kinds of things that we have spoken about. It is almost like a kind of computer going here {points to her head}. From the minute you walked in, I try to memorise and put it on paper. I have quite a couple of notes. I think of all our sessions we had here. I might not remember everything, but there are things that are so important, that I cannot forget, you know.

The value that Bella attached to the alternative stories was reflected in her statement: "there are things that are so important, that I cannot forget." This is why documentation has been established as a narrative therapy practice. An audiotape was made of the conference presentation (see section 7.3.4.3) that was co-presented by Bella and she was given a copy of this. A copy of an "outsider-witness" therapeutic letter, written by a member of the audience of that conference, was given to both women (section 7.3.4.3). Furthermore, Bella and Nina were awarded "Certificates of appreciation" (Addendum B) at a celebratory meeting held in August 2005. More

will be said about these later. They expressed their thanks for these documents since they found meaning in the fact that they seemed to have been an inspiration to others.

7.3.4.2 Re-membering conversations and 'saying hullo again'

The interviews were also aimed at providing opportunities for Bella and Nina to acknowledge the important and valued contributions others had made to their lives. For Bella the loss of the companionship of her husband ("uncle Paul") was a factor which contributed to sadness and silence in her life. His loving ways stood in sharp contrast to the abuse that Nina used to experience in her marriage.

> I: Do you think he supported your cause?
> B: Oh, yes.
> N: He supported us very much.
> B: I would start something for supper, and when he sees, he says, "The people are here, just leave" and he would carry on - for many years.
> I: And what do you think he would be saying if he could be saying something to you now in relation to the struggles that you are coping with now?
> B: I don't think he would like to see me like this. He knew me as someone who was strong.
> N: He wasn't a man of many words, but he was a man of action, who really would show support. I could come in here and I could go and sit in the bedroom and he would talk, but not like other men…
>
> N: Uncle Paul was a wonderful man. He really was a wonderful man. He never used to complain. When I would come in and say, "Come Bella, we must go to the meeting", he would never say, "But Nina, Bella still has to do this." He was always there for both of us.
> I: Do you think he was also in a sense someone who strengthened you and gave you that courage to…
> N: I always used to admire Uncle Paul. I used to go and sit there in the room – sit with Uncle Paul. I always used to admire Uncle Paul. I don't know – I have always said that Unlce Paul was a very good husband. He has never, ever said a word out of place to this woman in front of me. No, no, whereas my husband would go out of his way {to insult me}.

The "saying hullo again" (White, 1988, p.29) metaphor guided questions I asked in relation to Bella's deceased husband (uncle Paul's) contribution to their lives. While acknowledging pain in having had to say goodbye to him physically, we explored ways in which Bella and Nina were "saying hullo again" to the knowledge he had of them. The aim was "the incorporation of the lost relationship" (White, 1988, p.29) into their lives now so as to assist with the resolution of grief. I was curious to know what he would be saying about the new kinds of struggles they were involved in. I also inquired what his reflections might be about the way they were coping with life in Lavender Hill. I wondered what he would identify as skills they have displayed in carrying on with life as they had. The realisation that he would not like to see her depressed served as an additional support for Bella to resist the silence and isolation associated with depression.

7.3.4.3 Building a wider audience: Witnesses and communities of concern

7.3.4.3.1 Consulting your consultants: Participation in a conference presentation

In September 2004 the South African Association of Pastoral Therapists (SAAP) held a conference titled "Responding to violence." I invited Bella and Nina to co-present a workshop at a conference with me. The narrative practices of "enrolling people in their own knowledges, creating communities of concern and celebration" (Freedman et al., 1997, p.126) informed this invitation. Workshop attendees could learn from their skills,

experience and "expert" knowledge of living on the Cape Flats. Unfortunately, Nina was not available at that time, but Bella was able to participate. This event allowed Bella another opportunity to assume the role of being consulted as an authority on her own life; of experiencing her pre-existing and newly acquired knowledges and abilities as effective and worthy of respect; and of seeing that her ideas are considered significant enough to be documented and circulated to others (Freedman et al., 1997). The workshop was titled "Faith and love: 'Doing hope' in response to violence on the Cape Flats." Bella was introduced as a community consultant to the current research project. It was made explicit that "doing hope" as defined by Weingarten (2000) informed the study. I explained that, from a narrative perspective, resilience is not seen as a personal trait but rather as an emblem for a range of alternative identity conclusions, as well as knowledges of life and skills of living (White, 1995). The interim findings of this study, namely that love, faith and prayer were connected to and sustaining of resilience for many of the participants in this study, was reported. The workshop was opened with a dedication to the women I met in Lavender Hill. It was also dedicated to the memory my friend's baby that died earlier that month. Despite vastly different circumstances, the way my friends and the women of Lavender Hill responded to traumatic losses in their lives had similarities. I appreciated the opportunity to publicly honour both sets of people in a dedication with which the workshop was opened:

> *The stories of the women I met in Lavender Hill bear testimony of their love for children; their belief in justice and fairness; their hope for a safer future; and their commitment to community. Their "doing hope" in the midst of pain is a proclamation of their care and concern for others; their belief in God; their hope of eternal life; and their commitment to leave a legacy. This workshop is dedicated to the memory of 8 month old Ruben. His parents' response to his tragic death on 2 September 2004 echoed the testimony of the women of Lavender Hill.*

After introducing the project, I played an extract from an interview with Bella and Nina, so that the audience could hear both the tone and content. I then interviewed Bella around her realisation that "there is hope still." I wondered about the difference this realisation had made in her everyday life in Lavender Hill. I also wanted to know how she had implemented her idea of "just showing love" and what effect this had on her life. Questions were asked around her faith in God and her experience of prayer. Through these questions Bella got the opportunity to re-tell aspects of her story. Workshop participants who had knowledge of narrative therapy acted as "outsider witnesses" to this telling. An audience member, Elize Morkel, was one of the workshop participants. She wrote a letter in response to the ripple effect that witnessing the interview had on her life. How the workshop "did hope" for the members of the audience was reflected on. Extracts of that letter are included to serve both as an indication of the "rippling effect" (a concept used in narrative therapy to describe the ways in peoples' stories have an impact on the stories of others) of my conversation with Bella for the audience. She was "doing hope" for them:

From Letter 1:

> *I was filled with hope for our country and its people when I left there on Tuesday.*
> *Listening to your voices on that tape filled my heart with hope and joy for our country where difference was made into segregation for so long. Your friendship in that time sets an example to us, the white Afrikaners, of what can be achieved when people who are different share a common goal to serve a bigger community.*

The letter summarised some of the stories that were told in the workshop. During outsider witness feedback, a participant expressed regret and shame at having been ignorant of the suffering that people like Bella had to endure during apartheid. The letter was used as an extension of the conversation and served as a tool to apologise to Bella, as

well as to honour her resilience. The way in which Bella's commitment to caring for others set an example, as well as her courage was acknowledged. Her commitment to caring for others and showing love were richly described.

From Letter 1:

> *I have to share the tears of shame, guilt and regret that Jessica shed when she spoke about being a white Afrikaner who was ignorant of your pain and the injustices perpetrated by our people. She spoke about how she was able to carry on with her happy, privileged life while so many suffered so badly. Like her, I am deeply sorry and like her, I honour and salute your resilience and the way in which you have managed to do hope with your people.*
> *I loved your understanding of job creation as acts against crime and how you mentioned small acts of care that have to be done over and over in order to build trust. You said it a few time: "It does not happen over night!" Knowing that and not giving up, that is resilience.*
> *I thought about your experiences in detention and all the pain and hardship, the physical and emotional torture and your love and care for each other and your faith keeping you going.… I am so sad that you are still struggling with infections. It reminded me that the pain and wounds of the injustices and cruelty of apartheid will stay with us for a long, long time. I will not give up doing sorry and care. Meeting you has strengthened that resolve.*

In the interview, Bella told the story about a time when she had to collect guns and knifes at the entrance to a community meeting which focussed on resolving conflict between gangsters. She vividly described the big apron she was wearing and how she stashed the ammunition way in its pockets. The courage that this must have taken was also reflected on:

From Letter 1:

> *I saw in you a woman of great courage, Bella: one who puts her life at risk for her people. The stories about your care and love for the gangsters gave me hope for the future.*

The way in which Bella's faith moved her into action led to a reflection that Bella's life was a living testimony to "the radical Jesus" that was referred to in the keynote address of the conference. For Bella, the letter served to capture some of the commitments and valued principles that she described in the conversation. A "richer description" of her life was thus co-created through a process of telling and re-telling.

7.3.4.3.2 Ripple effects: Being an advocate for alternative ways of being in Lavender Hill

An example of another ripple effect of Bella's participation in the conference is included since it demonstrates one of the ways in which narrative therapy practices can have an impact on communities of people. Mr. Botha attended the pastoral conference in the hope of learning about healing in relation to two tragic episodes in his life, one of which was the murder of his mother in May 1997 by someone from Lavender Hill. Mr. Botha reported that this left him with a view of Lavender Hill as "a vile environment and community." He saw Lavender Hill as "a grossly infected place that was repulsive" – infected by values, practices and ways of living that he "never wanted to be associated with in any form whatsoever." It was with this background that he attended the conference and he reflected on his initial negative reaction to the notes on the workshop.

> *That morning I wondered about my reactions to the Lavender Hill workshop and had to answer a number of questions that I was asking myself – for instance: 'What could the experience of living in Lavender Hill really be like? Who stayed there? Why? What did it mean to stay there? What do you have to do when staying there? Are there people with values and beliefs that do not support activities of drug dealing, gangsterism etc? If so, what kind of life do they have there - how do they make meaning of their lives? What is it like being a policeman in Lavender Hill? Given my experiences, would I be able to hear and understand*

the stories of some 'other' Lavender Hill residents? What was it that interested and allowed a young white lady to be involved with a community that to me was so repulsive?

He described a shift in his perspective during the workshop and acknowledged his appreciation for Bella's commitment to "making a change":

As the workshop unfolded, I found myself becoming engaged with a reality of differences of experiences. …I was particularly moved by Bella's strength of commitment to the 'making a change' in the community. The power of faith, love and prayer was so evident. The workshop enabled me to be transported into some understanding of other ways of living for people in Lavender Hill – ways that I was not able to consider as possible given perceptions created by my past experiences. I was able to hear about real changes that were taking place in the lives of people in the community; I was also able to get some understanding that the community suffered its own type of trauma that affected people in different ways as well. It essentially moved me into some understanding of the meaning of violence in Lavender Hill, how it impacted on the community, and how some members lived with it through their belief and faith. The experience helped me 'let go' of a number of my perceptions of Lavender Hill (I use the name as representative of a type of community).

Bella's co-presentation of the workshop thus served as living example of someone who is committed to non-violence in a violence-ridden community. Her example had brought some form of reconciliation to the life of Mr. Botha and had the ripple effects of inspiring others to "do sorry" and to "do care." Bella expressed appreciation for the fact that she had been given the opportunity to "inspire" others and said that this gave meaning to the trauma she had been through. It was confirmation of the fact that "it had not been for nothing."

7.3.4.3.3 Witnessing each others alternative ways of being

Bella and Nina acted as witnesses for each other's unfolding stories and provided an audience for each other for the "performances of new stories" (Morgan, 2000, p.74). Acknowledging how their lives were linked became important. Opportunities for deconstructing "depression's versions" of who they were, while resurrecting and generating alternative descriptions, were created. In a sense, Bella and Nina became a small "communities of concern" (Madigan & Epston, 1995, p.257) since they were struggling with similar problems and shared and circulated ideas and knowledge. They shared the conviction that "community members need support for themselves." They were committed to setting examples as community members providing support from within the community itself.

B: They are both such caring men. They are very concerned about the youth. Maybe we would be the first that show the interest and showing it could be motivating.
I: Just by showing an interest you might strengthen and extend their ideas?
B: And it is a good idea that he has. And we can see his heart attitude. And we can help him see where we can help. We can tell him we are there.
I: Could you be curious about the history of that caring attitude? How come he has got this ability to be quite a different kind of man? … You spoke about having to think about what your priorities are and where you would like to fit in. It seems like you are quite noticing of things that are happening in the community and you express appreciation for small things that people are doing. Those are often the things that go unnoticed. …It seems like you are already skilled at doing "mini appreciative inquiries." If you see this man who is a real example or role model or has a team that could make a difference, you just chat to him and are curious and find out how it is going.

I inquired more about how they saw this commitment. I noticed their ability to take note of contributions others were making in the community. I reflected on the way in which they seemed to be doing "appreciative

inquiries", since they were curious and appreciative of the steps others were taking to change the community for the better. This seemed especially true with regards to the two men they spoke of who was concerned about the youth and set examples as role models to counter the examples set by gangsters.

7.3.4.4 Reflection

Reflection on the therapeutic process involved thinking about what enabled speaking, trust and connection.

> N: I remember the first day when we met, I noticed it. I am sorry, but I am very observant. I noticed that the first day that the two of us sat down with you, we were like – "Are you saying the right thing?" We were sort of holding back. I don't think you would have noticed it, but we were sort of holding back. But then we started to open up so that we are now speaking so freely.
> B: But we have to be. If there is something that bothers me, I know I can go to Nina and, you know, we can listen. She would share with me. She would also give me some advice. She would relate it to something that has happened, and what she did. And it is strictly confidential what we talk. We feel it is very important.
>
> I: I am wondering, do you think this kind of get-together has been in a sense a mini example of how to work against mistrust or how to reconnect with people?
> N: How can we reconnect? You will find at stages it is not always as easy as we have done it. Some people just do not want to reconnect.
> I: But by just being in conversation and reflecting on=
> N: =on what you have been through together and on what we have done, has brought us closer again.
> B: Definitely.

Nina noticed that she could not immediately trust me. She realised that it took time for them to develop their trust in me and in each other again. They were quite guarded initially, but in the end felt reconnected to one another. They argued that people from their community would benefit from opportunities for similar kinds of conversations. However, the complexity of creating such opportunities was reflected in terms of the difficutlties in the community around establishing trust.

> B: …I am also thinking very often, "How many people out there need this?" They need to talk; they don't want to talk; they can't talk. There is nobody advising them and who do they trust?
> I: So you think there is a huge need out there?
> B: There is a huge need, but who do they trust, Ilse? Ilse, I am telling you, this is a very big thing in our area – who do you trust?
> N: And people will only talk to you, Ilse, if they know they can really relate to you. And they don't let out immediately. They will let out a little.
> B: Yes. That is very important to know that people are very scared.
> N: People don't easily talk, especially in the community and knowing that you live in that very same community. They will not easily share, but later they will come to you and look at what you are able to do.
> I: I must also thank you for trusting me enough to talk to me. I mean, I am like stranger coming from the outside, so I really appreciate the trust that you have had in me and that you have talked to me in such an open way.

Although Nina knew that people "don't easily talk, especially in the community and knowing that you live in that very same community," she argued that the leadership positions in Lavender Hill should come from people in the community themselves. When Bella and Nina reflected on launch of the Community Forum and appreciative inquiry process discussed at the community meeting where we initially met each other, they commented on the need for the leadership structures in community to be more united.

N: There are lots of nitty-gritty issues in the top structure that need to be worked out before we can actually go to the community and say, "This is what we really want." Unless they can work that out, they are actually re-living things that in actual fact has happened to Lavender Hill already - things that have already been started in Lavender Hill by the community. Now they come in with new players, I'd say.
B: =They are not interested in learning.
N: =Yes. And they say, "Listen, these are the people that are going to be the driving force." I don't believe that people outside of Lavender Hill can be the driving force, because they come for a 9 to 5 or 9 to 3 job and leave. They are not here to drive Lavender Hill. The driving force should be the people of Lavender Hill themselves.

Contradictory positions with regards to involvement of "people from the outside" seemed to be expressed. Nina twice reflected that speaking to someone from "right outside the community" had been helpful in terms of establishing trust, since an outsider position lessened the risk of her story being told within the community. However, in organisational structures, she preferred seeing people from Lavender Hill involved. In terms of therapeutic intervention, her ideas confirm the need to maintain a collaborative stance and to treat community members as "experts" in their community. In line with the "decentred practice" of narrative therapy I consulted with Bella and Nina about how the interviews were going for them. I also attempted to establish which parts of our conversations were more or less helpful to them. Bella and Nina both spontaneously offered appreciation for aspects of the conversations that had an effect on their lives. They expressed appreciation for the opportunity to talk about their lives. Quotes from the interviews reflect this appreciation:

I: I would love to continue these conversations because there is such richness in your stories, but I don't know how it was for you? Would you like to meet again?
N: Yes.
B: Yes, we are both at home. I think it would also be appropriate for me.
I: And in terms of how we spoke today, was that okay for you?
N: It was nice.
B: Yes, it was nice. It was reliving, but it was good to get out. I think to me it was even like a therapy, you know, just talking. And spilling some tears. It also made me realise a lot of things about Nina's contribution and also knowing that she is there – I don't have to go through this alone. Also knowing that you where there. Knowing that I can share with her - it is definitely like a consolation.

B: And it was like a God-send when you came. I needed someone to talk to.

B: We are so grateful to you. It is nice talking.
N: Yes, it is nice talking.
B: We are also getting a load off us. I felt so much better, Ilse, after talking to you last week. And I am sure Nina would feel so much better today. Even I do. Every time I feel good. This is the second time I am talking to you. I have to share this with you. Our talking has given me peace of mind. I have been pouring out and pouring out and pouring out. And it has made me think back about how I should be. Why should I allow myself to get so thick? Now I realised where the strength comes from. I am so happy to know that I don't have so much pain. And it is good.

I reflected on the privilege it was for me to meet with them and expressed appreciation for their courage and creativity. The historical reflection in our conversations enabled Bella to acknowledge the courage and strength she embodied, although she hastened to add that it was with the help of God. Nina realised that looking back at their past actions highlighted their courage. Nina's curiosity about "what made it possible" was in-line with my own curiosity about the history of their skills and strength:

I: It was a privilege to meet two women as yourselves, with such courage and creativity.

B: It was not so easy then, you know. If we look at it now, it was real courage and strength and also with the help of God - especially if you look at it now.
N: Yes, especially it you look at it now. You really ask yourself, “Did I really go through all of that? Did I have the courage to do all those things? How …what made it possible for me to be so strong and to carry on?” I mean I remember we had the field hospital and the lawyer coming in and them shooting onto the lawyer’s van. And we went out there and told the police, “You can’t shoot here. You can’t come in here, because we have children that have been shot here. We are getting our doctor and our lawyers in here.” Standing up to the police - telling them, “This is a church. You cannot come in here and come and shoot.”
I: Maybe that is something we could talk more about. As you said, you wondered what gave you the courage, what made you so strong, and what is still sustaining you now? I would be very curious to hear that.

I noticed how their shared “comradeship” supported them in the past and reflected that they were still comrades of a sort in their current relationship.

I: But I can also see that part of what is sustaining you is what you called your “comradeship” and what that means to you; and how you still are comrades today.

I: And do you think that the comradeship that Nina was talking about could be something that could stand with you?
B: Oh yes, every bit. My knowing that she could be going through the very same thing… But everybody is now living so in fear. We are more concerned about our own families, our own homes - that sort of thing. And comradeship like, how do you share? I am busy here and when do we get to each other? You know, that kind of thing. I am only at home now for the past five months. I had always been at work.
I: Do you think it is almost like you have to develop new strategies of comradeship for your situation?
N: I would say we have to look at new strategies.
B: Definitely.
N: We again, as one – not as one, because we both have different lives to live now – but I think we have to develop some kind of … work out when we can meet; where we can say, “Okay, let us meet once a week. And let’s just talk.”

Bella and Nina mirrored each other’s suggestions. This could be an indication of their agreement on how their new form of comradeship could be expressed and practiced.

B: Lets have a cup of tea.
N: Let’s have a cup of tea and let’s talk about old times, how we see the future now, my plans for this year, and your plans for this year.
B: How can we help each other?
N: How can we help each other?
B: Be there for each other?
N: Be there for each other.

Bella said that she gained knowledge about the role she could play in helping Nina.

B: I know the role I can play to be of assistance to Nina. You know, being there for her for a change.

Bella and Nina therefore noticed changes in a variety of areas of their lives. Bella indicated how our conversations contributed to her feeling less alone. It had the effect of reminding her that Nina was still “very much in her heart.”

B: And also just talking to you, Ilse, you brought a lot of healing. I felt alone, but not anymore. I feel that people care if they see you are alone. I would sit here by the window alone. They don’t see me outside. It is just when I go to church and so. But that has really changed. Like I say, I go out Tuesdays with the seniors to visit the sick. I also now on a Wednesday I take stock of what we did, so it is good. Like today, I can go and

sit down or lie and down and look at all the kinds of things that we have spoken about – it is almost like a kind of computer going here, from the minute you walked in, I try to memorise and put it on paper. I have quite a couple of notes. I think of all our sessions we had here. I might not remember everything, but there are things that are so important, that I cannot, you know. Nina is very much in my heart, you know, like she has always been. She has always been there, building. Whatever feast they have, we get this plate of cake. She never forgets that. And then I used to think, "It must be this or that." But we did not see each other and she would always remember my family. And so we don't forget. But this whole gathering of ours, every time we met, has made me also realise her needs. And that I can turn to her and that she does not have to be scared to turn to me. And whatever little that we can share we would share. That's life, you know. We have come on a long way and none of us are perfect. But we strive together and we look past each other's mistakes and look to see how we continuously can build.

Inquiry about their friendship contributed to an expansion of possibilities and a sense of re-connection. Quite often during our conversations I noticed Nina's hand on Bella's knee as a gesture of closeness and support. They both wiped away tears as they remembered difficult and painful experiences, but also out of appreciation for each other.

I: You have a lot to offer each other?
B: Yes, we have a lot to offer. And I feel very, very much better. We are together. We are three. We are carrying on again. The gap is so small, I think it is only from here to there {indicates from her to Nina}.
N: {laughs}
I: It is not a very big gap.
B: No, it is not a very big gap. …But to look at life more positively.
N: I think we have overcome…I would say it was just a stretching out of a hand.
B: Yes, yes. Everyone used to just do his own thing.
N: Yes, everybody just went his own way, but coming together again has made us realise how much we had in common and how much we can still share.
B: So true.
N: And how much we can still do together. How much the two of us can still do together.

The idea of getting "rid of that bitterness" and looking "positively at the things that we can develop" seemed to excite Bella. She wanted to reflect on how they could "contribute to changing this place."

B: That all brought me back while you were talking to us and Nina explaining. It is so true what we are saying, but yet, maybe we should get rid of that bitterness and whatever, and look positively at the things that we can develop. There are a lot of things that can grow. We can see how we can contribute to changing this place. I think we should maybe look at that focus and maybe we can also change our hearts and minds and attitudes towards other people. Look at what people want to do.
I: To notice what they are trying and to [build...
B: [And it is not easy, as Nina is saying. We need to speak to Winton and point out these little things. Look carefully at how we start.
I: Not to make it like a burden on yourselves and to feel that you now have to carry this.
B: No, we won't. We know about carrying. We know about taking initiative. We know what it is like to leave your house to canvas.
N: I think we must now actually learn to delegate.

Their realisation of "how much" they could still "do together" highlighted the personal agency that they experienced. I felt privileged to witness their "comradeship." My appreciation grew in the knowledge that this was so despite their different religious beliefs. I reflected on how witnessing their stories strengthened me in the work I was doing. I invited them to reflect on the possible effect of reclaiming forgotten knowledges and skills:

I: … Just also for me - it strengthens me when I leave here to know that there are people of such courage living here.

N: The impact these conversations had on me was inspiring – it proved that I still had so much to give.

B: You also have the negative people thinking this and that about you, you know.
I: So maybe holding on to this other knowledge about yourself and reclaiming it from the past - do you think doing this might help you in those moments as well?
B: Yes, definitely. I think sometimes remembering what you were like and what you have done - just getting together and sharing - just bring us a little bit back to that other knowledge of ourselves again. And it brings us closer again.

7.3.5 Concluding thoughts on Case study 1

This case study demonstrated how important connection to others and to God was for Bella and Nina to experience a measure of recovery from trauma. Through the interviews Bella and Nina were reminded of the value of their relationship. Although their relationship seemed to have been compromised in the past, due to the mistrust and isolation associated with depression, they realised that the "gap" between them was actually very small. It only required a "stretching out of a hand" to bridge. The interviews also highlighted the value that both Bella and Nina attached to their respective faiths. They acknowledged that there had been instances in which their faith suffered and was questioned by others – for instance when Bella was in detention. However, they agreed that God gave them strength.

This case study also illustrated how narrative therapy ideas and practices were used to reconnect Bella and Nina to the skills and creativity expressed in surviving difficult past experiences and problems such as depression. Whilst acknowledging the far-reaching effects of depression, it was demonstrated how depression could be countered through the co-creation of hope and resilience when connecting to others and to God. Bella and Nina reflected that the safe space that was opened for discussion and exploration in the interviews contributed to feeling more hopeful. Bella thanked me as follows:

B: Most of all I want to thank you for bringing Nina and I together again, to share all our experiences, tears, laughter and joy again; and to know that God loves us with all our faults and failures. Thanks for your patience, love, sincerity, care, concern, and for believing in us and in God.

7.4 Case study 2: Kate, Hilda and Tina - “United we stand”

For such a community where there is such a lot of violence, I never knew that there is so much love among the people. I did not think there are people that could support one like that.
(Kate)

7.4.1 Introduction to Kate (“K”), Hilda (“H”) and Tina (“T”)

Len, a young man of 20 at that time, was shot and killed in Lavender Hill in April 2003. Len was Kate’s only son. Kate came to the New World Foundation to seek counselling after her son’s violent death. She was also concerned about Len’s one-year old son, Dusi, and Dusi’s mother, Hilda. Hilda and Dusi were living with Hilda’s parents. Three weeks after Len’s death, Hilda and Dusi accompanied Kate to our first meeting. Kate was married and had a nine-year old daughter, but neither her daughter nor husband wanted to speak to a counsellor. Although Len and Hilda had separated and Len had another girlfriend at the time of his death, he used to visit Dusi every day and helped with his son’s bedtime routine in the evenings. At the first interview I was struck by how young the 39-year old Kate looked with her grandson on her hip. She gave the impression of being a healthy and strong woman. Hilda was a delicate, beautiful young woman. She was very quiet at first and became quite breathless and tearful when asked a question. She found it hard to talk about Len and mainly responded with gestures. However, she mentioned that she had the support of Kate and of her parents, and reported that she could speak to them. Kate’s emotional, financial and practical support of Hilda became evident during the interviews.

During the first interview, Kate decided to invite Tina to join us. Tina was married and lived with her husband and adult son, unemployed at the time. Tina’s son, Frank, was stabbed to death in her arms in April 2001. Two of Frank’s best friends that Tina treated as sons, were shot and killed in April 2002 and April 2003 respectively. Kate and Tina suspected that one person was directly involved in all four of these murders. With this shared experience in mind, Kate contacted Tina after Len’s death. After meeting with Tina, Kate realised that Tina was struggling with hatred and bitterness and that she needed support. She thought Tina would benefit from meeting with us, since Tina told her that she appreciated the times that Kate had spoken to her. During the second interview Tina said she was eager to talk and that she appreciated Kate’s invitation. I met with Kate, Hilda and Tina between May and September 2003 (see Table 3 in Chapter 5). I had seven interviews with Kate, with Hilda and Tina joining her for four of those. Dusi accompanied his mom and grandmother to two of our sessions. Hilda was alone in one interview. The final interview was with all three women together once again. I had follow-up interviews with Kate and Tina in 2004. At both follow-up interviews Bella (from Case study 1) acted as outsider witness. Hilda had found employment in the meanwhile and could not take time off.

7.4.2 Problem construction: Naming the problem and exploring its effects

7.4.2.1 Grief and loss

The violent deaths of their sons had far-reaching consequences for Kate and Tina, as well as for Hilda, who lost a friend and the father of her child. Problems they reported can be labelled as intrusive thoughts, shock,

numbing, fear, sadness and anger (discussed in Chapter 6). The multiple losses with the death of a family member identified by Walsh and McGoldrick (2004) as "a loss of the person, a loss of roles and relationships, the loss of the intact family unit, and the loss of hopes and dreams for all that might have been" (p.396), were experienced by these women and their families. Violent deaths have been identified as "particularly traumatic because of the frightening and vulnerable feelings they create in survivors" (Kinchin & Brown, 2001, p.43). Walsh and McGoldrick (2004) also note, "the impact of violent death can be devastating, especially for loved ones who witnessed it or narrowly escaped it themselves" (p.402). Furthermore, an "entire community can be traumatized by persistent violence and ever-present threatened loss" (Walsh & McGoldrick, 2004, p.402).

The meaning and impact of death vary from person to person and also from family to family. Walsh and McGoldrick (2004) identify the death of a child or early widowhood as "untimely losses" (p.409) that may be experienced as unjust. A sense of injustice may in turn lead to questioning the meaning of life. The deaths of Kate and Tina's sons could be described as sudden, untimely and horrific. According to Kinchin and Brown (2001), "sudden, untimely or unexpected death or those that are horrific" (p.41) represent the highest risk of poor outcome in terms of resolution. For Tina, who not only lost her son but also two of his friends (who were like sons to her), the past trauma and loss experiences seemed to have heightened her vulnerability to the subsequent losses (Walsh & McGoldrick, 2004).

The fact that the women had complex relationships with the deceased loved ones contributed to ambivalent feelings after their death. Kate's struggle in raising Len and in trying to "keep him on the right road" became apparent and it emerged that mother and son frequently disagreed about his choices in life. Kate spoke about the anger that she felt towards her son at times. It also emerged that Len and Hilda had an argument the day before his death. These unresolved areas in their relationships added to their anger about the lives being "cut short" and to the sense of the death being "untimely." This contributed to the distress the women experienced.

> K: But he did not listen when one spoke to him. That made me angry. Sometimes I just wanted to slap him.
>
> T: …And when I think alone I get so angry to think about these children's lives. I said to the Lord this morning, "They have been murdered. Their lives have been cut short. The Lord must be merciful to them. Their lives where just cut short like that." They all died immediately – they did not have a day or two. That same minute, or in half an hour they passed away - died.
> K: They did not get a chance.

7.4.2.2 Bitterness, anger, hatred, vengeful thoughts and fear in relation to perpetrators

Difficulties in relation to the perpetrators included bitterness, hatred, vengeful thoughts and fear, as discussed in Chapter 6. These were complicated by the fact that the perpetrators lived in the community. Kate reflected on the struggle to come to terms with the injustice of the fact that the perpetrator had not been taken into custody; and with the possibility that he might kill again. The double listening that was used to engage with these problems is evident in an extract from the second therapeutic letter that I wrote to Kate. This extract from Letter 2 illustrates my curiosity about the opinions of Kate's loved ones, as well as about the values and beliefs that have informed her preferred ways of living:

From Letter 2:

> *Kate, you said that the idea of "chopping off his hands in order to stop him from killing anyone else" was still at the back of your mind. However, you knew that the people who love you would be "disappointed" in you if you did this. You also realised that this action would have many negative consequences in your life. You concluded that, in line with your faith, you would rest in the knowledge that you can "leave judgement over to God." You mentioned "taking advice" from people who care about you as helpful in this regard. Advice included "Don't worry about the perpetrator" and "Leave him, he will get his day."*

Kate and Tina remained angry with the perpetrators and continued to struggle with thoughts about acting out aggressively towards them or in Tina's case, against her husband who was silencing her. We spoke about constructive ways to express their feelings in relation to their "passion for justice" (discussed in section 7.4.3.4).

7.4.2.3 Differing desires to speak or to be silent about deceased loved ones

Different coping styles, that often translate into differing desires to speak or to be silent about deceased loved ones, was named as problematic for some participants. As indicated in Chapter 6, Tina experienced her desire to speak about her deceased son as problematic, since this desire was not shared by her husband. Tina related that she expressed anger at her husband when he wanted her to talk less about their son. However, in response to her anger he told her for the first time that he really missed their son and that he loved him very much.

Kate reported that her husband also did not talk much and that this was not unusual for the men she knew. I attempted to broaden the possible meanings that Tina could ascribe to her husband's silence and to his desire for her to be silent. Questions that explored what it meant to Tina that her husband did eventually speak to her about losing their son were included in Letter 4.

From Letter 4:

> *Tina, you told us how upset you were at the weekend by your husband's comment that you should not speak about your deceased son. However, he also said something that you "heard for the first time from his mouth" namely that he "thinks about Frank everyday", that "he loves him" and that "he misses him." You said you never knew that he cared so much, although the way he treated Frank did speak of his love. I wonder what difference it makes to know that this is how your husband feels? Do you think that, like Kate's husband, your husband might have different ways of living with and expressing sadness? I would like to talk to both of your husbands to learn from them about how they (and possibly other men in the community) feel about the violence and murders. I would also be interested to find out about ways that they have found helpful to cope with their loss.*

Tina's experience seems to confirm Walsh and McGoldrick's (2004) comment that different responses of men and women to loss can increase marital strain, since "men are more likely to withdraw" and "may be uncomfortable with their wives expression of grief, not knowing how to respond or fearful of loss of control of their own feelings" (p.408). Walsh and McGoldrick (2004) further note that "grieving individuals may perceive their partners' emotional unavailability a double loss" (p.408). This seems to have been Tina's experience.

7.4.3 Problem effacement: Identification of alternatives and personal agency

Many alternative stories were told that reflected the women's resilience and ability to "do hope" for each other in response to the pain and loss they experienced. These alternatives emerged from the process of attending to the

factual circumstances of the deaths as well as the meanings that each person in their social context attached to the loss in terms of the past, present and future. As Walsh and McGoldrick (2004) argue, it is important to bear in mind that families and communities that live with a heightened risk of a continuous threat of violence "cannot simply return to normal life, but must construct a new sense of normality, vulnerability, and interdependence" (p.402). Walsh and McGoldrick (2004) further note that in such circumstance "resilience, commonly described as bouncing back, can more aptly be thought of as bouncing forward to meet new challenges and uncertainties in a changed and less secure world" (p.403). In this context "healing and resilience are fostered through remembrance and stories honouring the courage, perseverance, and mutual support" shown (Walsh & McGoldrick, 2004, p.403). The alternative stories that were named in the process of remembrance and story-telling in this case are summarised here.

Firstly, the knowledge that "he lives in my heart" was identified as a comfort to Tina. The "saying hullo again" metaphor was used to explore the way in which the deceased loved ones were still part of their lives. Kate and Sheila also remembered the love and commitment that Len showed towards his son. Secondly, it emerged that the deaths strengthened participants' faith, especially for Kate. Kate's faith enabled her to accept her son's death. The women's shared adherence to the notion that every person had a "time to go" assisted them with acceptance. They shared the experience of the helpfulness of prayer in difficult times. Thirdly, through narrative therapy inquiry, the women's desire to help others and their compassion for others were articulated and explored. I was curious to find out more about how Kate was taking up a role as community supporter of others who were grieving or struggling. Kate noticed that her involvement in helping others had the effect of making her more hopeful about the community. Fourthly, stories that reflected the women's passion for justice were also elaborated on in our conversation. Identifying themselves as women who shared a passion for justice enabled them to join with each other in their opposition to injustice. More general "survival skills" were also identified and our conversations included some discussion around their identities as "good mothers." The sixth alternative described in this case study was finding "normal" ways of talking about their deceased loved one. These alternative stories of who they are were thickened to reveal the agency of the women in relation to their contextual situation. The following sections illustrate how the named alternatives were thickened in conversation and through therapeutic letters.

7.4.3.1 "I believe they live in my heart" (Re-membering loved ones)

In our conversation, opportunities were created to speak about the pain of losing a loved one. However, we also spoke about ways in which the knowledge they had about their loved ones and the knowledge their loved ones has of them, comforted and sustained them. For example, the belief that Frank and his friend Shane, continued to live "in her heart" was comforting to Tina. We also explored the significance of the fact that they were buried close together.

> T: …Shane's mommy told me to go to the grave, she said, "Everyone says Frank and Shane lie near each other." She said she was there herself the previous Sunday and she saw "Frank lies here and Shane lies there." Then I said, "No, I don't want to go."
> I: Why don't you want to go?
> T: I said to her, "They live with me and they are in my heart everyday. I just see sand lying there. Even if I put the nicest flowers there, it will not comfort me. I believe they live in my heart", I told her. Then she told me I must go and see how close together those two are lying.

I: Do you think that was a comfort for her?
T: Yes, to see that they lie near each other. She said that everyone said they were lying in a circle, but she said, "No, Frank lies here and Shane lies there."
I: Just to know that they were buried near each other was a comfort to her. Is it also good for you to know that?
T: Yes, "Frank kept a space for him, there next to him", I told her.

Len's love and commitment towards his son was remembered through our conversations, as reflected in Letter 1:

From Letter 1:

Hilda, as the mother of a young son myself, my heart goes out to you and Dusi. I was curious to find out more about the kind of father Len was for Dusi. We speculated that Dusi might like to know more about his father when he is older. We spoke about what you could tell him about his father and the way he showed his love towards his little son. You and Kate thought that you could support each other in keeping these memories alive for Dusi.

The support Hilda got from her family and from Len's family and friends since the murder was discussed when I met with her alone once. She reflected on how they both loved Dusi. It was an opportunity to thicken the description of who Hilda was as mother, friend and person. At the same time, descriptions of Len as Dusi's father were provided. It was hoped that these conversations might help Hilda to keep the memory of his father alive for Dusi, especially in relation to what Dusi's father would have encouraged and appreciated about Dusi.

7.4.3.2 Strengthened faith and related acceptance: "I have to accept it…it is in God's hands"

Kate reflected that her son's death led to spiritual growth in her family.

K: What I say about myself is that it has strengthened my faith. My husband does not talk about it, but I can see it has also affected his faith. His faith is also stronger. I can see. He never went to church, but now he goes. Every service he is there. This shows me that his faith also got stronger.

This was reflected on in a letter.

From Letter 3:

I could hear that you were happy that your husband now seems like a "different person" in terms of his attitude towards God. You told me that he comes to church with you now and that he has realised that "God is there." I wonder if this shift has affected your relationship. We also spoke about how happy you were when your daughter recently requested that you read the Bible to her.

Kate's faith had been strengthened since she believed she got answers at church. Once she had told me that she was drawing strength from God in difficult times, I was curious to find out more about how her faith was supporting her. I reflected on her strengthened faith in Letter 3. In an attempt to extend the conversation and thicken the range of stories of how her faith supported her, I reminded her that I was curious to hear more about the answers she had found in the church.

From Letter 3:

Kate, you told me that your faith became stronger through all the difficulties. You said you found many answers in church around issues that you had been struggling with. I was curious to hear examples of the times when you experienced the sermon "as if it is just for you."

Acceptance of her son's death was closely related to her faith, as the following extracts illustrate. Questions about the significance of her belief "God is in control" revealed that this belief is a "comfort" to Kate.

K: It is not in my hands. It is in God's hands. If we did not serve a living God - and He is like a Master - if it was not like that, then I would not have accepted it.

K: Because I pray a lot and I take it so (……) my hum (…) how I see the thing is it is God's will. And if it was not His will, Len would still be alive. If it was not Len's time to go, he would still be alive, through those two bullets that he got. So that is why I have to accept it. It is not in our hands, it is in God's hands.

K: At such times you really realise there is someone that rules your life, who is higher than you; who controls your life. Sometimes you think you are in control of your own life, but it is not so. God rules your life and one should keep this in your mind forever.
I: What is this knowledge like for you?
K: It is a comfort to me, because if we did not have a God, then it would be difficult to accept. But because I know that we have a God and He rules and he allowed it, I am comforted. If I did not believe in God, it would have been difficult.

Kate related her ability to refrain from living in fear directly to her belief in God and to her relationship with God through prayer. Christian discourses about strength and courage through faith in God supported her, since she had experienced that "God gives you strength." Her ability to use prayer to resist living in fear enabled her to assist friends who were afraid. It seemed that her faith led her to see herself as a fearless survivor. Kate viewed prayer as an important aspect of finding the strength to live with the pain.

K: I think the reason that I don't have a fear in me is because I am very believing.
I: Yes. And how does that help you not to have fear?
K: (..) If I think, it is because I pray a lot. I don't know. I think it is that one does not get your strength from yourself; it is only God that gives you strength. And He gives me the strength. As I talk to the people they tell me how they fear. And since Len's death the people live in fear, but I cannot fear.

K: If I think about it, it is because I pray a lot. I don't know. I think it is that. One does not get your strength from yourself. It is only God that gives you strength. And He gives me the strength.

I reflected in a letter on the women's experience that prayer helped to reduce the felt power of the perpetrator.

From Letter 2*:*

You told me that is seems as if the murderer feels powerful. He builds on his power by spreading fear. Despite this, you have found ways to reduce his power over your lives. Prayer was a shared strategy that all three of you have used to lessen his power. A prayer that one of you prayed was to ask the Lord to "close my eyes" and "tie my tongue." Another person experienced how prayer led to "calmness" and "healing of pain." Tina, we speculated about the usefulness of writing down some prayers and putting them on the wall near the window from which you see the murderer so often.

The history of the importance of prayer in participants' lives became better known in our conversations. Kate's advice to Hilda had been, "Try to pray a lot, then I believe the sadness will become lighter, because it helped me to pray everyday." However, Kate lamented, "the less sad I am, the less I pray." This gave us the opportunity to explore other reasons for praying. Kate believed prayers of "thanks for a change" led to being happy.

K: …I say a person should always stay prayerful, but for me it feels like I am praying less and less. That is why things are not working out – everything is dragging because I am praying too little now. When things go like that – they say if you don't have circumstances, then you ask the Lord to give you circumstances so that you can remain prayerful. That is why my priest always says he worries if he does not have circumstances because then it seems to him he prays too little. Ask the Lord then, "Give me circumstances so that I can stay

prayerful on my knees." Do you understand? And it is quite true. If you do not have circumstances, then you don't stay prayerful.
I: You must either have discipline or circumstances {laughs}.
K: Yes, discipline I think is the best, because who wants circumstances?
I: Yes, it might be easier to have discipline [
K: [Than to ask for circumstances {laughs}.
I: So you said you found that staying prayerful brings power into your life?
K: Everything feels right. You will never believe what prayer does. …But now it seem the less sad I am, the less I pray. {laughs}
I: So do you think one can also be prayerful if you are full of joy? Can you also pray – maybe a different kind of prayer?
K: Then you must, yes.
I: A prayer where you don't ask for support, but where you can say thank you?
K: Say thank you, yes. That is why when I am full of joy I always say thank you.
I: That is also prayer in its way.
K: That is prayer. It is to thank God. I think it is better than to ask the whole day. Thanks for a change. If you thank a lot you will also be happy.

In the follow-up interview with Kate in 2004, where Bella (from Case study 1) acted as an outsider witness, the healing and sustaining power of Kate's faith in Christ was more richly described. The strength that Kate found in her faith enabled her not to position herself as a fearful victim, but rather as an outspoken helper of others in distress. This positioning, which opened up different ways-of-being in the world and ways-of-seeing the world, was explored. The link that Bella noticed between the "healing power" of Kate's faith and the way in which this healing had empowered Kate to show compassion to others, was captured in Letter 5.

From Letter 5:

Bella reflected on the bitterness of losing a son. Yet she recognised and appreciated "the healing power of your faith in Christ" in your life and how this translated into action in the way that you show compassion to others who have lost loved ones.

Kate's continued search for meaning also came under discussion in the follow-up interview in 2004. The way in which her faith supported her in accepting her son's death was reflected on in Letter 5. I tried to summarise what Kate had said in the follow-up conversation about her acceptance of her son's death and the comfort she found in the knowledge that God was in control:

From Letter 5:

You told me how you have accepted Len's death. You ascribed your acceptance to "serving a living God" and "having Jesus as your master." If it was not for your relationship with God, you said you could not have accepted it as you have. You said that your "loss has increased your faith." "Keeping your belief that God is in control" in mind all the times, is a comfort to you.
You said that you have asked God to help you grapple with the meaning of your son's death. Many possibilities have crossed your mind. The special "departed services" at your church for those that have died are especially meaningful to you now. Having an opportunity to pray for him is something that you appreciate and find comforting. You said the meaning you have given to his death and your acceptance of it is deeply linked to your faith in Christ and the hope you have in Him. You reflected that prayer has also become important to you in other areas of your life.

Meichenbaum (1994) notes that, often, "prayer and faith reflect the most widely used method of coping with traumatic life events" (p.547). As in the lives of Bella and Nina, this seems to have been the case for Kate. Herman's (1997) caution that trauma may contribute to "a loss of trust in God" (p.56) did not seem to apply. The meaning that participants found in traumatic events through religion could be explained as follows:

> Religion and rituals provide powerful culturally accepted metaphors and a framework to construct a new adaptive narrative. Religion provides a plausible way to cognitively reframe events and a means to provide guidance for healing. (Meichenbaum in Van Niekerk, 2002, p.210)

Walsh and McGoldrick (2004) emphasise the significant influence that belief systems can have on adaptation to trauma and loss by referring to studies that have found evidence of the positive physiological effects of deep faith, prayer, and congregational support.

7.4.3.3 Pain as elements of a legacy: Compassion and commitment to helping others

The women articulated a desire to support others who were grieving. I was touched to learn that Kate first expressed this desire the day before her son got murdered. On that day she read about a young girl who had lost both her parents. I asked the women to reflect on specific ways they might like to put this desire to help other into action in Letter 1:

From Letter 1:

> *A "tool" that you said would make you stronger was working towards helping others. You spoke about working with children, in hospitals and with older people. I am curious to hear if you have had any more specific ideas around the kind of work you might enjoy doing with these people.*
> *Kate, you spoke about your desire "to encourage others who have lost loved ones" even before Len's death. You reflected that your own personal loss of a child has given you an even greater desire to encourage others. You said that your "compassion had grown through this loss." How has this compassionate attitude affected other areas of your life?*

At the follow-up meeting in 2004 Kate reported that she had started a soup-kitchen at the local Baby Clinic. The long wait that Hilda had there one day with a sick, dehydrated Dusi inspired her into this action. Through her involvement in providing food to people at the Baby Clinic, she experienced "hope for the possibility that Lavender Hill could become a better place." I captured her reflections in Letter 5:

From Letter 5:

> *After Hilda and Dusi's experience you decided to provide food at the clinic. The way in which you responded to the need you saw at the Baby Clinic spoke to me of your care for others in the community.*
> *Bella told you how it had helped her to "keep your goal in sight", even if it takes more time than you anticipated; and to be encouraged by the small bits of growth as they become visible. You then told us about the young man that you would never have suspected had a need – "a good-looking young man" - that came and asked you for some soup at the clinic. Previously you "would have just walked passed him." You said this experience encouraged you to become more involved. Although you are sometimes scared to offer help in the area where you live, you said you feel safe at the Clinic. You wanted people to feel free to come there. You reflected that your involvement had given you "hope for the possibility that Lavender Hill could become a better place."*

Tina spoke about her compassion for "directionless" youth. I wondered if this concern and her regret that her own son's life had been "cut short" contributed to her desire to help young people.

> T: Ilse, I am a person (..) I am a very soft hearted person for anyone or anyone's child. Such a person I am. I can quickly get attached to someone as well - precisely to these children who are so directionless, Ilse, precisely to those types. When I go ( ) the taxi and see the youngster all standing around I think, "Yes, you stand like that, you are probably missing cigarettes, and the Devil wants to get into your thoughts." I said to someone, "If I had a lot of money I would say to each, 'Here is ten rand for you, just don't take people's things. Go and buy cigarettes or whatever you want' (..)" I am very sorry for the young children.

T: Ilse, so many things go through my mind, because I loved these children so much.
I: And would you like to convey some of this concern to the children who still have a chance? Perhaps this group could reach out to such children?
T: It is true.

We reflected on the legacy left by their pain in our last conversation in 2003. This legacy included the realisation of the value of "showing love" and "creating a better world." I summarised this in Letter 4:

From Letter 4:

At the end of our conversation you agreed that you all had "grown through the death of your loved ones despite the grief and pain." You highlighted the discovery of the awareness of how important it is "to show love" and "in doing so, to create a better world." You reflected that through your pain you have learnt how to "encourage others" and how "to talk to them." I wondered if your beloved sons would have been proud of you if they could have seen this way of being in the community. I am curious to know if they would have wanted to support you in the way you are taking a stand against injustice and violence.
You all agreed that you would like to see justice done with regards to the perpetrator. We spoke about the value that you place on justice. Did your son(s) know this about you? If they did, how did they know this?

The questions included in Letter 4 (above) were intended to encourage the women to consider how they were "re-membering" their loved ones in the actions and values that they had at that time. Walsh and McGoldrick (2004) agree, "personal suffering may be transcended in …community social action" (p.405). When I got an opportunity to interview Kate on her own, we took the time to read through my previous letter to her. Kate had tears in her eyes as I read about how the sadness affected her life. She reflected that she was glad that I found our conversations helpful in my work, because she had "been saying to God that she wanted to be helpful to others." I reflected that this commitment of hers was evident to me in the way that she was supporting people like Tina, Hilda and Francis. I reflected that it was a privilege to have her as a support for me in the connections she had with the other people that I worked with in Lavender Hill.

7.4.3.4 Sense of fairness and a shared passion for justice

The women shared a "passion for justice" due to the injustice they suffered. The fact that the alleged perpetrator had not been taken into custody and that they saw him in the community was a living testimony of this injustice. Kate's roles as a voice for the community and an activist for fairness were already active before her son's death. It seems that her own loss had strengthened her identification with these roles.

I: So you think the unfairness has to be addressed.
K: Yes. The police are unfair because they are so corrupt.
I: So do you think this whole – Len's death and the community in which you live – have in some ways increased your sense of fairness and your disapproval of unfairness?
K: It did strengthen it, but it was already strong enough, because I live opposite a smuggler. I could see how corrupt the police are, and that made me angry.
I: Okay. And are there ways in which you are using it - perhaps with other people or organisations - where you feel you can use your sense of fairness?
K: I don't think anything is being done.
I: And would you have like to do something if you could? Or are there areas in your life where you stand up for fairness?
K: Yes. I have already tried. A week before Len's death I phoned one of the high positions in the police to tell them about the unfairness that is happening here and about the police not doing their work. A week after Len's death I phoned that same man and told him of Len's death. (..) I asked if he could see now, in what

kind of situation we live here in Lavender Hill. Then he said he understands, but their hands are tied. They do not know what to do with the corrupt police. Now we who live in the community, we see these things.
I: It must be hard to see it [and
K: [Not being able to do anything.
I: Do you feel that you have done something? You did phone. You did raise your voice about it. You did not just sit back.
K: Yes, I spoke to Captain M.

In the midst of the situation where Kate felt as if her hands were tied, her act of speaking out was a "small act of everyday resistance to violence" (Wade, 1997, p.23). Tina provided another example when warning the person she feared might be the target of an attack by gangsters. Subsequently, she heard that the gangsters were accusing someone else of giving the warning and were planning to murder this boy. Tina therefore sent a message to the perpetrator to inform him that it was she who sent the warning and that she was not afraid to be a witness against him. With the women's consent, I phoned the Steenberg Police Station to inform them about the plots that Tina overheard. The Inspector recommended that they should come in to make a sworn statement, which Tina and Kate did. I was concerned about their safety but glad that the police was informed. To me, these actions reflected the women's bravery and passion for justice. Kate's opposition to unjust treatment was also expressed in the way she addressed the lack of speedy service at the Baby Clinic, as reflected on in Letter 5.

From Letter 5:

You spoke out at the Baby Clinic in response to the bad treatment that Hilda and Dusi experienced there. As a mother of young children myself, I was angered, shocked and saddened to hear how long some mothers and sick babies have to wait to get help. I wonder what the mothers would say if they knew that you stood up for them. Ironically, your speaking out was also on behalf of the nursing sister you reprimanded, because your response pointed to the fact that she was overworked and the clinic was understaffed.

Bella, the outsider witness to the follow-up interview with Kate in 2004, could relate to my appreciation for the way Kate accepted her son's death whilst maintaining a position of non-acceptance of injustice.

I: So, although you noticed that she accepts his death in the light of her belief in God, you also see that she is not someone who accepts injustice? She speaks out against injustice if she sees it somewhere. She goes on the marches. So she accepts it in the bigger picture of the Lord's will but she does not accept injustice against people?
B: Yes. Not just because it happened to her son, but she does not accept injustice against any person. I greatly appreciate her fight against injustice.

In this study the socio-political and historical context of the deaths in these families were seen as significant (Walsh & McGoldrick, 2004). Historically, the community suffered under an unjust political system. Under the new government, they had gained significant rights. However, they are still confronted with injustice, often linked to the active gangsterism in the community that seemed to be putting the community at the mercy of another brutal and unjust "system."

7.4.3.5 Survival skills related to living in the community

The women expressed feelings of powerlessness in relation to the perpetrator. Whilst acknowledging their legitimate frustration with the limitation so the legal system, I was curious to find out about the ways in which they have countered this. Tina reported on ways in which our talks were helping her to cope with living close to

the alleged perpetrator. I was interested in both general survival skills and specific strategies that seemed to help in this regard. For example, Tina found it helpful to ignore the perpetrator. She reported that she did not feel so affected anymore when she saw him, since she was able to think about something else. In fact, she had seen him that morning before we met and managed to stay calm by ignoring him. I reminded her of this in Letter 4:

From Letter 4:

> *Tina, in our last conversation you told me that you have found ways of "keeping yourself strong" by "thinking about something else" at times when previously you would have been preoccupied with thoughts about the murderer.*
> *You said that you could reduce his power over your life by "thinking about him less"; by "not inquiring about him"; and by "looking out of the window less." "Ignoring" him and his family was another strategy that you all agreed could lessen his power. I was curious to find out what helped you to "ignore"? Could you "ignore" him and his family whilst paying attention to injustice and continuing to stand up to violence?*

Living in the Lavender Hill community not only posed challenges in terms of the proximity of the perpetrator, but included broader contextual problems such as poverty, housing and unemployment. Some of their general survival skills in this context were described. For example, we explored Kate's philosophy that "money problems are not really problems." My curiosity about the origins of the philosophy revealed that her survival skills were developed when both she and her husband had been unemployed for two years. I wondered who else, apart from me, would not be surprised to hear about their skills – who else knew her as a skilful person. I was curious about how Len would have described his family's survival skills, so as to make this knowledge more available to Kate. These skills were reflected on in Letter 3.

From Letter 3:

> *Kate, I was not surprised to hear that you and your family had learnt some "survival skills" previously at times when the adults in the family were unemployed. I wonder what the rest of the family would have to say about your skills. Which of the skills you learnt are most useful today? If Len was here today, how would he describe your survival skills?*

7.4.3.6 "I like peacefulness"

Being reminded of these skills gave Kate more hope for realising the dream of moving out of Lavender Hill. In fact, this dream became a reality for Kate and her family in August 2005. Although they are now living in a much smaller house on a family-member's plot, it is in a more peaceful area. Two years before this, Kate realised that her desire for a peaceful life had in a sense become hi-jacked by the violence in the area. Her sense of herself as a peaceful and peace-loving person was challenged by the violent action she proposed to stop the murders, namely "chopping their hands off."

> K: ….I want to live in a peaceful place. This has always been my desire. I like peacefulness. When I sit in my house I want to take a book and read and be peaceful. But in the end you become just as evil as these people, do you understand?
> I: Do you think that will happen to you?
> K: No, I don't believe it will happen.

7.4.3.7 Finding "normal" ways of talking about deceased loved ones as time heals

Kate said that she preferred to talk about her son in "normal" ways, not only about his death. Decentred narrative therapy practices allowed participants to determine what they were more of less comfortable with

talking about. I respected her wish and our conversation moved away from a focus on sadness and comforts in sadness. She reflected that she experienced "time as healing", as seen in Letter 5:

From Letter 5:

> *I was interested to hear on Monday that you "feel more at ease as time goes by." You said you've experienced the truth of the old saying that "time heals." However, you still experience intense sadness when you think about what has happened to Len. I was curious about what helped to lessen the intensity of the sadness and you responded: "To talk normally about Len" and "to accept is was destined like that." I am curious to know with whom you can talk about Len "as normal." I wondered if your talking might also be a solace to these people.*

7.4.4 Narrative practices aimed at thickening the alternative story

7.4.4.1 Therapeutic documents and letters

As indicated in Chapter 5 (see Table 5.3), I wrote three therapeutic letters to the three women in 2003. I also wrote a letter to Kate after an individual session in 2003 and in 2004 after our follow-up conversation (Letter 5). Extracts from these letters have already been used in this case study to illustrate both the process and content of our therapeutic interaction. Some of the more general aspects of these letters were the focus of this section. I started Letter 1 with an expression of my "appreciation for the open way" in which they spoke about the terrible losses they had experienced with the deaths of their sons and their friends." I introduced the reason for writing in Letter 1 and included reflections about the impact that bearing witness to their stories had on me in Letters 3 and 4. In this way, I was taking back to them the way in which they were supporting me in my therapeutic work with others, as can be seen in the following examples.

From Letter 1:

> *I am writing this letter to reflect on what we spoke about and also to extend our conversation with some questions you might like to think about.*

From Letter 3:

> *Kate, hearing about how you have grown in faith and how you have stood united with people like Tina has taught me a lot. It has strengthened my commitment to work collaboratively with people who suffer. It has also challenged me in terms of my faith and has encouraged me to have more faith.*

From Letter 4:

> *It has been a privilege for me to meet with you over the last couple of months. I have learnt so much from you, amongst other things about standing united against the consequences of violence; about the good people in the community in which you live, despite the violence; about the pain of losing a child to a violent death; about how you find ways of being strong; about the importance of remaining prayerful; and much more.*
>
> *Thank you that I can take our conversations with me into the future as an inspiration to join you in speaking out against violence and to be more active in my caring for others.*

7.4.4.2 Re-membering conversations and 'saying hullo again'

In Letter 1, I introduced questions used by White (1988) as an extension of the "saying hullo again metaphor."

From Letter 1:

> *I have heard it said that 'Death ends a life, but it cannot end a relationship'. The way you spoke about your sons made these words ring true. It reminded me of a couple of questions that I have heard another counsellor ask people who have lost someone they loved. Perhaps we could look at some of these questions next time we meet:*

- *If you were seeing yourself through your son's eyes right now, what would you be noticing about yourself that you could appreciate?*
- *What difference would it make to how you feel if you were appreciating this about yourself now?*
- *What knowledge about yourself are you awakened to when you bring alive enjoyable things that he knew about you?*
- *What difference would it make if you could keep this realisation alive everyday?*
- *How could you let others know that you have reclaimed some of the discoveries about yourself that were clearly visible to him and that you also like?*
- *How would remaining aware of his ideas about you enable you to intervene and take steps in difficult situations in your life?*

In response to these questions the women told me that their deceased loved ones would have been proud of the way in which they were supporting each other. They were able to experience themselves as people who are important to others and whose care was appreciated. They believed that holding on to the knowledge that their loved ones had of them could be supportive of their efforts to carry on with plans for the future, as well as in speaking out against injustice. In Letter 2, I reminded them of the advice they believed their sons would have given them in relation to seeing the perpetrator.

From Letter 2:

> *You believed the advice that your sons would have given you is: don't allow him {the perpetrator} to influence mummy's life; ignore him. At times, you have been able to follow this advice. What has helped you to do this?*

The questions led to richer descriptions of the women's identities as mothers. Kate was asked to speculate on Len's experience of Hilda as the mother of his son. The trust he had in her as a mother to his son was remembered.

> I: And, hum (..) what do you think he would be appreciating in you today? If he could have been here today and I could have asked him, "Len, what is it that you notice in Hilda – in the way in which she is continuing with life and how she is taking care of Dusi?" Do you think he would have said something about how you are caring for Dusi? (….) What do you think, Kate?
> K: Len knows Hilda takes good care of Dusi.
> I: So do you think it was good for him to know that Dusi is with her, he does not have to be worried – she is a good mother?
> K: Yes, he was never worried, because he knew Hilda looks after him well.

Kate's acceptance of her son's death helped her to resolve some of the anger she used to feel towards him in the face of his "never mind" attitude. She remembered that she expressed her anger towards her son. Despite ambivalent feelings towards her son, Kate was sure that he knew she loved him and wanted him to be happy. He knew that she was angry at the perpetrators of violence in the area and that this anger supported her in not compromising her own values and belief in parental discipline. She did not regret being firm with her son and emphasised the need for discipline in Lavender Hill as follows:

> K: …I believe if every parent disciplines their child every now and then, they will not turn out such evil people. Because there are too many evil people in Lavender Hill - they will come to you, they will rob you; they will stab you with a knife or shoot you.

In the follow-up conversation with Kate in 2004, Bella shared her understanding of the difficulties faced by mothers in the context of this community. According to both Bella and Kate drug-lords try to befriend mothers

and bribe them into ignoring the involvement of their children in dubious activities. It became clear that Kate had always taken a firm stand against this kind of behaviour.

From Letter 5:

> *The pain we witnessed in connection with your son's death spoke to us of "your love and deep care for your children." You confirmed Bella's story about the way the drug-lords try to befriend mothers and told us about your resistance to this. The courage you showed by going to the Police Forum and speaking about what they were doing showed us how your stand against injustice remained firm.*

7.4.4.3 Building a wider audience: Witnesses, communities of concern, definitional ceremonies

7.4.4.3.1 Being an audience and community of concern for each other

The rationale for speaking to Kate, Hilda and Tina together was linked to ideas in narrative therapy around needing an audience to witness the unfolding of alternative stories. It was also related to the a shift away from focussing on the individuals toward focussing on groups and to the notion of creating communities of concern, where people who are faced with similar problems could join together and support each other. The women expressed appreciation for the fact that we met together as often as we had. Throughout the interviews I witness the strength that Kate, Hilda and Tina drew from supporting each other. They named "*saamstaan*" (standing united in a cause) as significant in helping them cope with the loss of their children. I reflected on the significance of meeting together as a group in Letter 1, and in Letter 2, I reminded them of the "the power" they experienced in supporting each other.

From Letter 1:

> *That you all came to speak to me together said something to me of the support that you are giving each other. I am curious to find out more about the meaning that sharing your thoughts and feelings with each other and with others in the community has for you.*

From Letter 2:

> *It was a privilege for me once again to witness the way you "stand united and walk united" ("saamstaan en saam loop"). I agree with you that this is proof of "the power that you have" in supporting each other. I remember your words, "We get stronger when we stand united and see the love of other people." These words strengthen me in the work that I am doing with you and with others here in Lavender Hill. Do you think that people in the community who witness the way in which you stand united with each other and with others who have been affected by violence could also be strengthened?*

At our final meeting in 2003 all three women reported being well. Kate and Hilda told us that they had been to a Women's Solidarity March the previous week and found the solidarity with others who were concern about violence prevention encouraging of them in their struggle against injustice. Tina wanted to attend, but was sick on that day. I enquired about the experience of being part of this social action event, so as to create a platform for a practical example of joining with a wider community of concerned others. However, what struck Kate most about this event was the reality of how many young people had died in the recent past, as this extract shows:

> I: So one reality that struck you at the march was the number of people who have lost loved ones?
> K: Yes, how many children loose their lives – children. And I see now the old people are burying the young people, it is not the young burying the old anymore.

In an attempt to describe the values that supported them and others in standing together, I was curious to hear more about the meaning that their participation had for them. For Kate, the event highlighted the need for support groups. She also confirmed the notion of the need for people to "do hope" for each other when she reflected that "it helps to be united" since "where that person is weaker, you might be able to strengthen that person." It seemed that they experienced a sense of empowerment in being joined in a cause with others.

I: And the fact that all the people got together and stood together, did that mean something to you?
K: Yes, it did.
I: What did that say to you? What reality did that show you?
K: It showed me that - I think I feel alone in my sadness – but there are people who feel like that everyday. And I feel what we actually need in this place is a support group.
I: And what would you like to see happening in such a support group?
K: Even if one just sits and talks everyday, to hear how people feel. As it carries on, keep each other informed about how each one is doing. Talk about your feelings - if it is improving or so. And make each other strong – where that person is weaker, you might be able to strengthen that person.
I: And that is something that you believe in your life as well – that you see people who support each other strengthen each other?
K: Yes. It is better. They say, "United we stand." It helps to be united.

I summarised the meaning they attributed to being part of this social action in Letter 4:

From Letter 4:

We chatted last week about the "Women's March" in which you participated. I was curious to find out what this participation meant to you. You all agreed that what stood out most was "the knowledge that you are not alone." You saw how many other people have also been affected by violence and have lost loved ones. A reality that you found difficult to face, Kate, was that "so many young people had lost their lives" and that "old people burry young people these days." However, the knowledge that you were "not alone" in your sadness was important to you because it creates opportunities to "talk together" and "to comfort each other."

The other women agreed that there was a need for support groups for bereaved people in the area and they were keen to be involved in creating such a group.

I: So you think there is a need specifically for a group for parents who have lost children or what kind of support group?
K: I think so. For parents who have lost children and children who have lost parents.
I: Okay. (…) I was thinking I would like to be involved in something like that, but with my baby arriving soon I will only be available early next year. Otherwise I could talk to the social worker in the meanwhile, or do you think if we planned ahead, you can start informally.
K: Yes, I think you can join us next year, because every day people are dying. I think of the fourteen year old son who, now recently – two weeks ago – his friend stabbed him to death. That woman needs support.

I learnt that the New World Foundation had a similar idea and we collaborated with them in setting up the first meeting of the official "United we stand" group. I summarised our ideas:

From Letter 4:

We spoke about the desire to be part of a support group that you all share. You have noticed the need for support of bereaved people in Lavender Hill. You even suggested a name for such a group, which I thought described the little group that the three of you had already informally formed: "United we stand." As agreed, I spoke to the social worker at New World Foundation about the possibilities of linking with them in this and it turns out that you were not the only people who noticed this need. Such a group is already planned and they would welcome you as the finding members!

I know you would make valuable consultant-participants to such a group. I know that you all would contribute to such a group not only in terms of your knowledge about loss, but also in terms of your skill at "standing united" and caring for each other. Since I am leaving on maternity leave soon, I am glad to know that you will continue to support each other not only in the course of everyday living, but as members of your "United we stand" group.

7.4.4.3.2 Love and support in the community

Alternative ways of being in a community became apparent in our conversations. Love in the community stood in sharp contrast to the violence. I encouraged reflection on support received from others in their community.

I: And are there people in the community or church that have supported you?
K: They are still supporting us. For such a community where there is such a lot of violence, I never knew that there is so much love among the people. I did not think there are people that could support one like that.
I: Can you tell me a bit more about that – about how you noticed that or give examples of that?
K: Umm. The evening that Len died, from the Thursday night they put flowers there at the place that he died – I did not go and look because I cannot go to there. I don't feel right yet. I don't want to walk in that street again. But they lay flowers on the place. They are still putting down fresh flowers every day, the people tell me, and the cross stands there. And for a whole week, till he was buried, they held church there, on that spot there. But it is people that I do not know.
I: And what does it mean to you that the people are doing this, that they lay flowers there and held church on that spot?
K: Then I could see he was really popular amongst the people and the people loved him. Because the people who came to me – I was surprised. It was people who I did not know. And because of the big funeral, people who came from far. He was buried on a Friday and a lot of people sacrificed their work to come to the funeral. Then that could prove to me he was quite popular amongst the people. Young and old came. And they come now still to support me. And the church people support me a lot as well.

I highlighted the support in Letter 1 and asked Kate to reflect on the intentions of the people who acted in this way towards her, so as to extend the meaning of these acts. I also expressed my curiosity about what difference a greater awareness of support and love in the community could make to them.

From Letter 1:

Kate, you reflected that you felt really supported by the fact that you were "the one person selected to receive the church flowers on Mother's Day." What do you think the people wanted to express by giving you the flowers?
You mentioned other examples of community support and that your experience has opened your eyes to the "love that there is in the community." What difference does it make to be aware of this love?

Kate believed that there were "many good people" in the community. However, many were also intimidated by fear and remained silent in the face of injustice. Kate once again clearly positioned herself as someone who thinks silence in the face of injustice is wrong.

I: And do you find it surprising that there is - despite all the violence and evil you have mentioned in the community – that there is also so much love?
K: Yes, definitely. I am surprised.
I: And where do you think it comes from?
K: There are many good people in this community, very good people. And in such times you can see, in this evil place there are such good people. So it is just that small handful, that small group that brings fear over all the people. I think that is unfair. The people don't want to talk because they are afraid they will also be shot. I think it is wrong.

In the follow-up interview in 2004, Kate reflected once again about the experiences of getting support and her desire to give support, as summarised in Letter 5:

From Letter 5:

> *You reminded us of how people reached out to you in your time of need and how their support helped you and sustained you. This experience has left you also "wanting to support others in need." Your desire to reach out to this community is supported by the question you sometimes ask yourself: How would I have survived without the people around me supporting me?*
> *You said you "don't believe you would have gotten this kind of support in another area, where people just live for themselves." This is what you believe "makes Lavender Hill special – the people care about each other." You admitted that it "does not look like that when you just see the gangsters, drug abusers and alcoholics", but in times of need you have "experienced how people care for each other." You said that is why you are prepared to help people in this community.*
> *We were inspired by your example of making your voice heard in the face of injustice, as you did with your participation in the "Black March." You wanted to "show others who suffer that you feel like them" and that you are "united against the crime in your area."*

7.4.4.4 Reflection

As the process of therapy unfolded, Kate, Hilda and Tina expressed their grief about the loss of their loved ones in different ways. The interviews provided them with the opportunity to consider "saying hullo again" to the people they were in relation to the loved ones they lost. Thinking about their relationships with their deceased loved one in this way helped them to hold on to the knowledge of themselves as good mothers and caring members of the community.

Problems around seeing legal justice - the perpetrator had not been prosecuted – helped to unite the women against injustice. At times, discourses about acceptance and forgiveness, as well as discourses of revenge seemed to be informative of the women's preferred ways of coping with living in the same community as the perpetrators. In terms of their place with the context of the Lavender Hill community level, reflection on the complexity of the community highlighted the privilege of being connected to the "good" people in Lavender Hill – people who really knew how to express love and care. However, the women's passionate frustration with the powerful positions that certain "evil" people maintained, was also expressed. These frustrations contributed to Kate's fantasies of taking the law into her own hands by "chopping such people's hands off." Her frustration was compounded by observation that "the police are unfair because they are so corrupt" and by the fact that it seemed like a "chain reaction" since "the same person shot another son again on Sunday night."

The women also spoke about positive changes in their lives that our conversations could be linked to.

From Letter 4:

> *Hilda, I was excited to hear that you have found a job and I trust that you will enjoy it. Tina, I was glad to hear that have felt "so much better" after our conversations. In fact, you said you felt "like a different person." I know that as a group of women who stand united, you will continue to help each to be "different people" who work together for a community in which hope and caring can counter the effects of violence.*

However, in our reflection, Kate seemed to indicate that individual therapy was too restricted for her. She preferred speaking about her loss with a participating audience or community of concern of people who have had similar experiences. Kate said that for her, it was better to "talk together" with others.

I: And was it better for you that Tina and Hilda were with us?
K: Yes, because it was not nice for me to come in here and tell everything from the start again. It was very heavy for me.
I: Okay. So the idea that "it is good to talk about it" did not work so well for you?
K: It did help, but to come here did not actually help me so much at the beginning, because I speak about it everyday with different and various people - people who live in my area. But at the beginning I did not always feel like coming here.
I: I can imagine that it was not easy.
K: Yes, it is not easy to start from the beginning to talk about it. And Ilse did not talk together with us ("*Ilse het nie saam met ons gepraat nie*"). It would have been better for me if Ilse spoke with us. Okay, Ilse could not speak with us, but that is why I say it is better if someone can speak with us – it makes you feel better. (..) But as the time went on, I did feel better to come and talk here.

Although I thought I had positioned myself as being joined with Kate against the injustices caused by violence in the community, she had difficulty with the fact that I did not theorise about professional knowledge of loss or verbalise personal knowledge of experiences of loss ("*Ilse het nie saam gepraat nie*"). Kate reflected that she would have preferred more discussion instead of questions. She therefore preferred the interviews where she was one of a group of women who shared the experience of losing a loved one to a violent death. Also, telling me about her son's death "from the beginning" was painful. Kate did not want to talk about Len's death. She preferred discussing other areas of her life. Our discussions about her interests seemed to have inspired her to enquire about a catering course at NWF after one interview and to getting her CV copied. Despite moving forward with her life, Kate's continued struggle to find meaning in her son's death remained apparent. There were no easy answers. She held on to her faith and trusted that God would show her "the reason."

K: Sometimes one wonders about the meaning of things. Then I think the Lord must show me what the meaning is. But I know I will still think and struggle with what it really means - what the reason is. A person wonders what the reason is if the Lord allows something to happen. But as the time has passed I have said, "He will show me what the reason is."

Kate did however seem to accept death as a part of life:

K: I believe death is part of our life. It is not something that you have to keep out of your mind. You should not block it out. It can happen to me or anyone at any time. So we should not block it out, we should make it part of our life.

7.4.5 Concluding thoughts on Case study 2

This case study demonstrated how utilising a narrative approach to therapy allowed for a shift away from working with individuals toward working with groups of people in a community of concern. The complex and multi-layered consequences of trauma in a high-violence community such as Lavender Hill became apparent. Contextual factors such as the women's continued confrontation with the physical proximity of the alleged perpetrators contributed to continuous trauma. However, in this case study, practical ways in which Kate, Hilda and Tina actively "stood united" reflected their philosophy that people needed to support each other, especially in communities such as Lavender Hill. They also emphasised the need to "stand united" in speaking out against injustice. These women's stories demonstrated the notion of "doing hope" in community with others.

7.5 Case study 3: Francis, Sandy, Poppie and Lettie – Surviving multiple trauma

I want a lovely life…A lovely life would be quiet. (Poppie)

7.5.1 Introduction to Francis ("F") and her children

Francis and her family were referred to me by Kate, their neighbour (from Case study 2). Kate was particularly concerned about Francis' son, Sandy (15), who was grief-stricken after Len's death. Len (Kate's son) was "like a big brother" to Sandy. Sandy was one of Francis' five children – three sons (aged 20, 15 and 12) and two daughters, Poppie (9) and Lettie (3). I also met the two young girls in the course of the interviewing process (see Table 4 in Chapter 5). Francis's husband, Grant, did not want to join us. Grant was self-employed, but did not have a stable income. He reportedly became abusive towards Francis and the children when he was under the influence of alcohol. The family lived in a one-roomed flat, with the boys sharing a bunk bed, while the parents and two girls shared a double bed. According to Francis they "had enough space" to sleep relatively comfortably. Francis reported that Sandy struggled socially and academically. He had been placed in Grade 6 earlier that year, but stopped going to school a few months before we met. He had been in the "special class" four years previously and still longed to be in that class. His advanced age for his grade contributed to him being teased at school. This, in combination with his problem to control his aggression, was said to have contributed to him not attending school anymore.

7.5.2 Problem construction: Naming the problem and exploring its effects

7.5.2.1 Experiences of violence in the community

Francis and her children's lives seemed to be affected by a variety of problems, many of which were related to living in a context of continuous trauma. The family had been deeply shocked and saddened by Len's violent death (see Case study 2). Another example of violence they experienced in the community occurred two weeks after Len's death and not long before we met. Lettie and Poppie were in the car with Sandy and their father when it was shot at 17 times. Francis told the story:

> F: ...Then just two Sundays after his death, they shot at my husband. He {points to Sandy} and she {points to Lettie} and my other little daughter were in the car. According to my friend, the people who shot at the car phoned her and said they were sorry. They only realised afterwards it was my husband who drove the car. It was not the person they were looking for. They were driving in a Mercedes, and there are lots of cars like that here. They shot seventeen shots - according to these men - they fired seventeen shots. Okay, no one got hurt. It was just the windows that fell out. My husband wanted to stop to tell them that he is not a gangster, and then he {points to Sandy} told his dad he could not stop then, he would have to drive now. (..) And all those little things, in the end I am realising it is now a bit of a bigger problem.

No-one was injured. Francis noticed that Lettie started wetting the bed again after this incident. When a group of gangsters were at their gate one night Francis was reminded of Sandy's comment that his two little sisters could have died in the shooting incident.

> F: On Tuesday night, he was sitting on his bed and then I heard the dogs bark. Then I looked out of the window and I saw gangsters standing by the gate, but I did not know who it was. He then said to me, "It must be at the neighbour's house." But it was not like that. It was the same gangsters that shot Len. They were in front of my house. He then said to me, "Mommy, we would have had two funerals." I asked him,

> "What are you talking about?" Then he said, "No – of Lettie and Poppie. Then I said to him, "But have you forgotten that you were also in the car and your dad?" Then he said, "No." He believed the two of them would have died. Kate told me the other day about these gangsters in front of my gate. We don't know them at all. I think he knows. And their ages – it is so sad to think they are still so young. They are like 17 and 16.

The context of violence in the community was also illustrated in Francis' concerns related to Sandy's desire to start playing soccer again. He was a good striker, but Francis was worried about safety at the soccer field. She reported that gangs were involved in soccer in Lavender Hill and she feared that Sandy might establish links with gangsters who wanted revenge for Len's murder. Her fear increased after Sandy told her that he witnessed a shooting once and had shouted that they should shoot the girl that the alleged perpetrator was using as a shield, in the foot. As noted in Chapter 6, she was also very concerned about a gun that he had made. While we explored the possible dangers of keeping such a gun, the intensity of Sandy's feelings against the perpetrators emerged. In a conversation about the violence perpetrated in Lavender Hill, Francis reflected that it was "so sad to think they {the perpetrators} are still so young." Sandy responded with "no mercy":

> F: And their ages – it is so sad to think they are still so young. They are like 17 and 16.
> S: For such people one should not feel sorry. They can take you now just like that. There is no mercy.

7.5.2.2 Experiences of violence and abuse in the family

Domestic problems such as spousal violence, fighting, alcohol abuse and cramped living conditions emerged as problems in this case. Not only was the family exposed to high levels of violence in the community, they were witnessing and experiencing violence in the home as well. Francis thought the way her husband "abused her emotionally and verbally" affected the children. When I met with Francis on her own, I enquired about examples of the abusive ways in which her husband treated her and the children. She mentioned him throwing cups at her; pouring water from the kettle on her (which fortunately was cold because she emptied the hot water for the children's safety); threats to kill her; locking the door and losing the key; following her when she slept at a friend's place and shouting at the gate all night. He made a habit of belittling her by "calling her names in front of the children and friends" and of "accusing her of being unfaithful." She added that when he was drunk he often woke the children up in middle of the night. Kate (Case study 2) testified to Francis' husband's abusive behaviour when he abused alcohol on weekends. Kate's concern about Francis was intensified by the knowledge that Francis has had a "nervous breakdown" in the past. At one stage Kate informed me that Francis could not attend an appointment because she had to take her husband to hospital. He had been beaten up after cheating a neighbour in business. Francis' daughters witnessed their father's injuries. Their father was covered in blood since he was so badly beaten up that he needed an operation on his mouth. They found him in the bathroom, which was covered in blood. The sight was traumatic for both girls.

7.5.2.3 Violence in other contexts in the lives of other family members

Francis was very upset about the news that her eldest son, who was serving a sentence of 18 months for theft at that time, had been raped in prison. He was previously let out on bail in a murder trial, where he reportedly was forced to stab the already dead victim. She went to visit him and spoke with the authorities to arrange that he could get a transfer from that prison. A couple of months later she got the news that he had been raped again.

She was very concerned about the risk of HIV/AIDS infection. Francis arranged a follow-up conversation with me in 2004 after hearing about her son's second experience of rape. I assisted her in contacting the health professional involved at the prison to enquire about his treatment and preventative measures that were being taken. The nurse informed Francis that her son was physically healthy at that time. I maintained contact with Francis telephonically. She requested that we meet again early in 2005 to discuss her concern about her youngest son's (12 years old at that time) disappearance. She reported his disappearance to the police. Francis was very worried in the week that her son was missing. It turned out that his uncle, her husband's brother, abducted him when he left the community in a stolen the car. He was supposed to service the car, but stole it instead. Her son was not physically harmed and she reported that he seemed emotionally stable after his return. Vig's (1996) discussion of the multiple stresses that may be faced by parents in violent communities aptly describes many aspects of Francis's stress as a mother in Lavender Hill:

> Parents living in violent communities are apt to experience multiple stresses, not only because of effects of violence but because of poverty…community violence can increase the potential for family violence through both specific stresses for the family and a general climate of violence in the community. Parents may fear for their own safety and worry about their children's safety. They may feel helpless and frustrated about their inability to protect their children from community or domestic violence. They may be overwhelmed by their own grief for family members and friends who are victims of violence, or by the stress that caring for others facing grief and loss. (pp.320-321)

7.5.2.4 PTSD symptoms, sadness, anger and aggressive behaviour

As discussed in Chapter 6, PTSD symptoms and associated sadness, anger and aggressive behaviour were experienced as problems by different members of the family. Sandy identified anger as a problem and reported that when he got angry, he "was not himself." We explored some of the effects of acting out his anger aggressively, which included "getting into trouble" at school and at home. Upon evaluation of the effects of aggressive behaviour on his life, Sandy concluded that he wanted change. Aggressive behaviour had contributed to him not attending school at that time, which both he and his mother experienced as problematic.

> F: He said it is mostly when he gets certain lessons. With oral he was very good, but with the writing and the understanding it did not go that well. Then he starts to work himself up, because he cannot do it. His hands sweat and his head hurts. Then he has headaches for days.
>
> F: I think he feels very unhappy about the anger as well.
> I: Okay, so is that something that you would really like to change?
> S: I stress too quickly.

Sandy also identified sadness as affecting him when he thought about his deceased friend. He told me that he dreamt how they all played together and then woke up in a sweat. Francis told me that Sandy suffered from "headaches, panic attacks and excessive sweating" after his friend's murder. She reported that he had trouble falling asleep and waking up in the mornings. She noticed that he cried very often. In the first interview, Sandy avoided eye contact and seemed to find it difficult to speak at times due to intense emotion. He was very sad when speaking about Len's death and rested his head in his arms to cry when the topic came up. In the second conversation he again expressed sadness in tears when talking about Len's death. These emotions, associated with depression and post-traumatic stress, were discussed in Chapter 6. Sandy expressed hatred towards the

person who was suspected of murdering his friend. I was thus very concerned to learn that he had made a gun and had thoughts about using it to shoot the alleged murderer. My concern motivated me to recommend a psychiatric assessment for Sandy, as discussed in the section that follows. My concerns were strengthened in the following meeting when I heard that he had removed the gun from their home and had hidden it somewhere outside since he was afraid his mom would take it. We continued to explore the possible consequences if he should decide to use the gun. Sandy agreed that the gun posed a danger not only to the alleged perpetrators, but also to himself and his family. Upon questioning, he admitted that his deceased friend would have taken the gun. I enquired if Len would have put it away:

> I: And Sandy, what do you think Len would have said if he heard about this revenge that your mom is talking about? (…) Do you think he would perhaps agree with your mom that you have to be careful with the gun?
> S: He would have taken it off me.
> I: Would he have taken it off you? And what would he have done with it? (..) Put it somewhere safe?
> S: {nods}
> I: So if he was still here today, would he have told you, "No, let you mom rather put it away"?
> S: He would have taken it himself.
> I: And put it away?
> S: {nods}

7.5.2.5 Delays in access to public mental health services

Due to my concern that Sandy might endanger himself or someone else, I sought their consent to seek psychiatric help.

> I: And I wondered if it would be okay with you if we tried to get a medical assessment in terms of the panic attacks, sleeplessness and sadness. There could be some medication that could be helpful. We would thus continue with these conversations but I could try and get you an appointment with a psychiatrist to see if you could benefit. They could perhaps give you something to help you sleep better or lessen the panic.
> S: I would like a pill so that I can just get down.

I consulted with the Psychiatric Registrar at the Trauma Centre, who advised me to refer Sandy to the Red Cross Family Unit. They advised me to refer him to Grootte Schuur Hospital for an assessment. I was relieved to find out in the second interview that the family honoured the appointment I arranged at Ward C23 at Grootte Schuur Hospital. The memorandum from the hospital read: "Major Depressive Episode and Bereavement disorder." An anti-depressant was prescribed and Sandy was referred to William Slater Adolescent Centre, were he would have access to conversational and group therapeutic input. At our third interview Sandy asked his mother to tell me about the problems they had in getting the medication prescribed at C23 from the Day Hospital. I phoned the person in charge at Ward C23 with regard to the problems they experienced and informed them that he was not yet on the waiting list at William Slater Adolescent Centre. After a couple of calls to different people, we arranged for a nurse to help them at the Day Hospital on the following Monday. After follow-up enquiries at William Slater Sandy got into the programme. Since educational assessments were also done at William Slater, a request was put in for an assessment to assist in finding appropriate schooling.

At the fifth interview Francis reported that they were still unsuccessful in obtaining Sandy's medication. Frustrated with the lengthy wait at the clinic and suspecting disappointment, Sandy left before he got a chance to see the nurse. I phoned her and she assured me that they would get the medication the following Thursday when she had an appointment with them. I was relieved to hear at the sixth interview that Sandy finally got his medication. He reported with a smile that he slept so well – "as soon as he lay down at night." He still experienced nights of not sleeping well and being tearful. Francis made him tea and they listened to music together on these occasions. Intermittently he still complained of headaches and had experiences of being hot and cold as a result of panic. I consulted with the person he was seeing at William Slater about this. She said that it would take 4 to 6 weeks for the medication to work effectively and warned that he should expect headaches initially.

7.5.3 Problem effacement: Identification of alternatives and personal agency

7.5.3.1 Francis' survival skills

In the fifth interview, when I spoke to Francis alone, we spent time reflecting on her ability to cope with the stress of the traumatic experiences she and her children have had. My curiosity about the history of this ability took her back to the time she spent in Lentegeur Psychiatric Hospital. She referred herself to Lentegeur for an assessment when Poppie (then 9) was 8 months old because she experienced panic attacks. She was diagnosed with Major Depressive Disorder (post-partum onset). She said she learnt a lot there about "keeping herself positive even if the situation gets too much." She particularly enjoyed the group work and wanted me to look into women's groups in her area, which I did. Furthermore, we explored supportive connections and Francis reflected that both Kate and her cousin were people she could always rely on and talk to if she was stressed. Her cousin helped her to put her survival skills into action. They shared their faith as Christians and appreciated the unity that this resulted in. In terms of domestic abuse Francis found prayers helpful in "getting the weekend to be over quickly." We explored ideas about alternative housing options as well, but options seemed extremely limited, since Francis did not want to take her children to live in a shelter. However, in 2005 Francis was offered a live-in position at the local old age home in Lavender Hill that was seen as an answer to her prayers. She accepted the position.

7.5.3.2 Taking a stand against abuse: Getting a protection order

In the course of our conversations in 2003 Francis decided that she would get a protection order for the court to stop her husband's abusive behaviour. She reported that Sandy had often told her to leave his father. Sandy confirmed this. He had to protect his mother when his father was drunk and this led to a scuffle with his father the previous weekend. Francis remembered that her eldest son was so angry with his father once that he threatened to poison his father. She revealed that this son had tried to commit suicide four times, once by swallowing all his epilepsy tablets. She thought his despair was related to the abusive situation at home. I introduced Francis to the social worker at New World Foundation and they arranged to meet the following day to discuss the process of obtaining a protection order. Francis showed me the statement that she had written for

the court the next time we met. The statement focussed on her husband's abusive language and sexual name-calling, as well as how he insulted her in front of neighbours and his friends. She added that he threw objects at them and that he said he would shoot her if he had a gun. She said that taking this stand indicated that she was not going to tolerate his abusive behaviour anymore. Francis did not immediately get a protection order, but reported that since her husband was under the impression that she had, it had made a difference. She officially got the protection order in 2004.

7.5.3.3 Sandy's schooling and steps towards limiting aggressive behaviour

At our last conversation in 2003 I was excited to hear that Sandy had started to attend school the previous day. He looked very smart in his uniform. Although anger still got the better of Sandy at times, he had experimented with some strategies that seemed to help him control acting out aggressively. For instance, he "just went outside" the previous night when he got angry. "Listening to music" was also identified as helpful, but his player broke. "Talking to girls" also took his mind off his anger. I arranged with the social worker at New World Foundation that Sandy could be included into a therapeutic group for boys with special needs. The group was also aimed at assisting boys with anger management and behavioural problems. I also spoke to the principal at his new school, who had to allow him to leave a bit early to attend this group. She reported that she was very pleased with the way Sandy was trying to fit in at the new school. I was happy to report back to Sandy that she noticed and appreciated his good manners:

> I: The headmistress told me that she could see that you – let me see where I wrote it down {look at notes from telephone conversation with principal} (..) She can see that you are "really trying hard to do your best at school." She said she was "glad to see that you are so well mannered, because you asked if you could leave your bike in the entrance", hey? (..) She told me that her "heart was filled with joy when you took your hat off for her when she walked past you." It really gave her "a good feeling to see this well mannered Sandy." It seems to me that you acted differently to the reputation that has followed you from the other schools. The unfairness of a reputation is that it tends to let people think the worse: "Sandy has a reputation for anger; he is someone who gets angry quickly." This may prevent them from seeing what you are really doing or how you are trying hard. But I could hear that she did see it, because she said it really warmed her heart. She could see that you were really trying hard.

Sandy was happy to be back at school and Francis reported that his reading and writing has improved a lot. I informed the nurse at William Slater about these developments. I attempted to expose the impact that his "bad reputation" may have had, and made the need to counter this actively at school explicit.

> F: And he is much more interested in his schoolwork, Ilse, than previously. He puts in a lot. Even at night he reads. He could not read at all, Ilse. And he could not write a full word. So I can see the cleverness is there. It is there. And at his age Poppie could already write a sentence, and he could not. And in his work, as I page through, I can see.
> I: Is he making good progress?
> F: For the time that he has been there.

> I: …as your mom says, trouble brings you a bad reputation. So perhaps teacher and the other children need to know you are someone who does not want to give Trouble a chance - that you are someone who wants to stand against trouble. Do you think that will also help - if you told people and showed people?
> S: I have not fought at school. I have not kicked someone or stepped on someone.
> I: Have there been times that you have wanted to fight, but you stopped yourself?
> S: Yes, they can scratch, scratch. They don't leave you.

I: So did you manage to control yourself when someone bothered you?
S: {nods}
I: How?
S: I don't know.

Highlighting the effects of a "bad reputation" is aimed at opening up possibilities to counter its limiting descriptions of who a person is, as Taylor (1994) notes:

> The thesis is that our identity is partly shaped by recognition or its absence, often by the *mis*recognition of others, and so a person or group of people can suffer real damage, real distortion, if the people or society around them mirror back to them a confining or demeaning or contemptible picture of themselves. Non-recognition or misrecognition can inflict harm, can be a form of oppression, imprisoning someone in a false, distorted, and reduced mode of being. (p.25)

Sandy continued to struggle with anger and aggression. Although he wanted to be "peaceful", he struggled not to retaliate if he was provoked by other children. Sandy was "kicked out" of his new school due to an incident where he asked two friends to wait at the gate after school to fight with other children. One of his friends had a knife. It has been proposed that "youth may act out violent ways to 'cover up' or cope with feelings of depression or distress" (Lambert, Ialongo, Boyd, & Cooley, 2005, p.43). An alternative reason for aggressive behaviour in boys - particularly in high violence communities – is that they may have little experience or role models to assist in directly labelling or expressing their sad, helpless or hopeless emotions (Lambert et al., 2005). Research has also demonstrated that aggressive behaviour in school is associated with exposure to community violence (Boyd et al. in Lambert et al., 2005). All of these factors may have contributed to Sandy's aggressive behaviour. A teacher also reported that he swore at children in front of his teacher. The tragedy is that he wanted to learn and to attend school. Sandy's enthusiasm about being back at school made it all the more difficult to face the reality of his having been asked to leave. The family was referred to the social worker at New World Foundation firstly to try mediation between them and the school, and secondly to find out what their legal position was. In follow-up telephone conversations I heard that Sandy was not allowed to return to that school, but was attending a private school for underprivileged children.

7.5.3.4 Meeting Poppie and connecting her to others

Francis made an appointment for Poppie to come and talk to me. Poppie's teacher reported that she had been tearful at school. They had to do a project about their homes and families and this seemed to have sparked her sadness. I met with them the following day. Poppie not only witnessed the abuse of her family in the home, but had been abused herself. She had a big scab on her shoulder where she had been injured the previous weekend when her father threw a tool at her because she made tea for herself. She then ran to her mom, who was at a friend's place. This abuse was reported to the relevant authorities by the teacher at Poppie's school. In the interview Poppie said that she was sad about her dad's drinking and did not think he would change, although she wished he would. We spent some time talking about the many supportive people in Poppie's life. She trusted her teacher and said she had some good friends in her grade. The neighbours were also very fond of her. They had in fact asked Francis if Poppie could not move in with them and Francis took up this offer when she was offered the job at the old age home. In our conversation Poppie's good relationship with Francis's cousin

and her cousin's daughter was richly described. Since members of the Trauma Centre's Children and Violence Team were working in Poppie's school at the time, Poppie was referred to them for further counselling and assessment. This provided her with a more accessible source of professional psychological support. I checked with Francis about how she was doing from time to time. The therapeutic letter to Poppie and Francis after the joint conversation follows in the next section.

7.5.4 Narrative practices aimed at thickening the alternative story

7.5.4.1 Therapeutic letters and documents

Due to time constraints and in the light of Sandy's literacy problems, I did not write therapeutic letters to him. However, I thought Poppie and Francis would appreciate a letter. An aim of the letter was to capture on paper the desire that Poppie expressed for "a lovely life." I wrote to Poppie and Francis to summarise our conversation:

Letter 1:

Dear Francis and Poppie
It was a pleasure to see you again, Francis, and it was also nice to meet you Poppie.
Poppie, you said you would like "a lovely life" and that a lovely life would be "quiet." In the light of this, I was very sad to hear about the abusive ways in which your daddy behaved at home when he had been drinking. As your mommy said, "It is not right that your daddy hits you and makes so much noise while you are trying to sleep." You said, "I would like to live away from daddy as soon as possible." You wanted this even if it meant staying with someone else for a while.
Poppie, I could hear that your mommy was proud of you. She told me about how you play with Lettie and how you protect her. I think Lettie is lucky to have a big sister like you. Poppie, you said, "Sandy gets too angry with his dad." Would he also support any moves towards a quieter life? Do you think Lettie also shares your desire for a quiet life?
Francis, you said you had decided that you could not live with that abusive behaviour any longer. You told me that your husband drank too much every weekend and then became "like a different person." Since he did not want to seek help, you said you could not see it changing. This is why you want to leave.
Francis, it must have been very frustrating to look for alternative places to stay without finding anything. However, I was glad to hear that you are determined not to give up. Could it be helpful to keep your children's desire for a quiet life in mind? Has this helped you in the past when you stood up to the abuse? I noticed that you and Poppie agreed that you had had enough of this abuse? Who else could assist you with the practical step towards moving away?
Francis, in a previous conversation you remembered how you enjoyed being in a group that supported you when you were in Lentegeur. Do you think joining a similar group now, like the women's group at New World Foundation, could also help you?
Thank you for trusting me enough to tell me about the pain you have experienced and for sharing your hope for a quiet life with me.
Regards, Ilse

Francis did not leave her husband until early in 2005 when she got the position at the local old age home. The financial independence that she gained enabled her to move her daughters into safer living conditions. Her eldest son, who had been released from prison, agreed to help look after her younger sons, who stayed with their father. Reportedly, her sons were happy that their mother got the opportunity to leave their father. Francis contacted me again telephonically in 2005 when her husband disturbed her at the old age home. He tried to convince her that she was a bad mother. With her consent, I spoke to her new employer and informed him of my conversations with the family. He had a joint meeting with Francis and her husband the following day and supported her in the move to leave her husband. He reminded her husband of his obligation as father to support

his children. In a sense the traditional boundaries of therapy was extended in that I had to become an advocate of Francis's rights.

7.5.4.2 Re-membering conversations and 'saying hullo again'

In this case study different members of Francis' family, as well as Sandy's deceased friend Len, were re-membered. Francis thought about her grandmother when I inquired about the history of Francis' skills. Francis's grandmother set an example of the kind of lifestyle that Francis valued. Francis recalled moving to her grandmother after her mom died when she was 12 years old. There was no "skelling" (yelling) in their house, just "smoothness" and Francis realised that she wanted to incorporate the "smoothness" of her grandmother's approach to life into her present life.

In an attempt to "incorporate the lost relationship" so as to assist in "the resolution of grief" (White, 1988, p.29), I inquired about Sandy's relationship with his deceased friend, Len. Sandy described Len as a "brother of mine." Upon remembering that Len was dead, Sandy said: "Who is going to care about me now? He was a brother to me." I inquired about what made their relationship special – about what Sandy had lost. He told me that he and Len did everything together. Len knew all his secrets and "watched over" him. They used to tease each other endlessly. We discussed ways in which Sandy's relationship with Len's family was helping him maintain a form of relationship with Len. Sandy had a very good relationship with Len's father and they did a lot of things together. Sandy experienced these times as providing some connection to Len. Memories that were not directly connected to Len's traumatic death, but rather to the relationship with Len, were treasured. Sandy treasured things that served as a reminder of his connection to his decease friend. For instance, he was so attached to a music cassette (tape) that he used to listen to with his friend that he said he would "have someone take the TV for that tape." Our conversations thus included a focus on the way Sandy and Len used to listen to music together and the way they chatted. Francis was concerned that the music made him more depressed and we talked about alternative activities that worked against depression. Acknowledging the importance of the music for Sandy helped him to focus on it less. I asked him to bring the tape the following time we met and to ask a friend to write down the words of that song for him. The chorus included the following words, "My heart's gotta find a reason to keep me breathing, but I am lost in pain and I don't have much time." Sandy said that since he had the words written down, he was not listening to the music so much. This in turn has been helping him to stay calm.

7.5.4.3 Building a wider audience: Witnesses, communities of concern, definitional ceremonies

7.5.4.3.1 Communities of concern around shared grief

Francis reflected that Sandy was the only boy in the area who could be described as having two families – he was so much a part of Len's family. She thought Len's family trusted Sandy and they knew that he was always willing to help them if he could. We spent time acknowledging the uniqueness of Len's caring. However, I also inquired about other people who cared about Sandy. The people included his family, Len's family, Hilda, Len's girlfriend and his mother's friend Eva. Sandy and Hilda (Case study 2) were also connected in their grief about

Len's death. The third time I met with Sandy and Francis, Hilda and Dusi arrived with them. Sandy and Francis were happy for us to meet together. The way in which Hilda and Sandy were connected in their love for Len became apparent in our conversation. I was curious to find out more about the ritual that they had for tending to Lens's grave. They said that this shared activity joined them to each other and to their memories of Len. However, at the next interview Sandy was upset with Hilda because she did not want to lend him a photo of Len so that he could get a copy made. She was afraid that he would lose it, and it was very precious to her. I spoke to Kate, who arranged for Sandy to get a photograph. Hilda and Sandy continued to tend to Len's grave together. Hilda reported that Sandy played an important role in Dusi's life and Sandy said that he would like to remind Dusi in future of the friend that Dusi's father had been to him. Francis recollected another example of the support gained in sharing grief with others:

> F: One Sunday I sat with one of the pamphlets of his funeral. I sat and looked at it. I was alone that day. And then one of my neighbour's children came and he said, "Wow, Aunt Francis, I also sat in our lounge now like you are sitting now with that pamphlet about Len." Then I said, "Yes, we probably missed him at the same time." "That is why I am sitting with it," I told him. Then I asked him how he felt. Then he said, "Now I feel good because I missed him, but looking at it made me feel good."
> I: And for you, what did it mean that you were looking at it at the same time?
> F: It made me feel better.

The supportive role of Francis's friend Eva was spoken about. Francis said that she could "talk to her about everything." I suggested that she could invite Eva to our next conversation. Eva was a witness to the steps Francis was taking in protecting herself and her family from abuse. The joint meeting also provided an opportunity to acknowledge the supportive role that Eva had been playing in Francis's life. We reflected on their friendship and what it meant to each of them. In this way, their contributions to each other's lives become more informative of their realities and of their descriptions of themselves.

7.5.4.4 Reflection

Contextual factors related to poverty, alcohol abuse and domestic and community violence affected this family and multiple traumatic incidents characterised their experiences. I attempted to help Francis to address the broader needs of her family and attempted to counter pathologising and self-blame by making explicit the contextual problems that affected the Lavender Hill community. These included gangsterism, drugs and alcohol abuse, and poverty, placed limitations on the extent and speed at which this family could live in preferred ways. Personal factors such as Sandy's intellectual and academic problems, seen in combination with the argument that "developing cognitive capacities can be seen as a barrier to therapy - particularly with aggressive adolescents" (Currie, 2004, p.279), posed significant challenges to the process. The usefulness of the semantic resources of narrative therapy in this context could be questioned. In a context like Lavender Hill, where "childhood trauma is a risk factor for both reduced ability to articulate emotional experience and for higher anger and aggression levels in adolescence" (Currie, 2004, p.279). The experience of anger may become too difficult to speak about. Currie's (2004) suggestion of using experienced-based tools within group work, for example by utilising drumming as a therapeutic tool, seems appropriate for a boy like Sandy. I did in fact arrange for Sandy to participate in a local group for boys his age struggling with anger and aggression, but he

did not attend regularly. His commitment to that group could thus be questioned. In contrast to this, Sandy seemed very committed to the narrative therapy interviewing process.

The limitations of narrative therapy with regards to medical intervention made it necessary to arrange a psychiatric assessment. However, our therapeutic relationship and advocacy on his behalf seemed vital to maintain and support that process. This became clear in the repeated telephone calls that were needed to ensure that Sandy did eventually receive his medication. At times, I shared their sense of being overwhelmed by the continuous struggle and trauma in their lives. However, remaining curious about small acts of resilience helped us all to continue with the process. Celebration of seemingly small pocket of hope was also part of the process. In the midst of the stresses that the family faced, we celebrated the open communication between Sandy and his mother:

F: I must write letters, Ilse. {To his girlfriend}
I: {laughs} Must you write on his behalf?
F: Yes, I must write. He told his friends, “I can chat nicely to my mom” and they said, “Wow, we wish we could speak like that to our moms.”
I: Really?
F: I am writing letters. We speak very openly. There are no secrets or so. Then they laughed because they could not believe it. We understand each other well and he can talk to me about anything. So I have to write the letters.
I: And what is it like for you Sandy, to know that your mom is someone with whom you can speak to openly?
S: I can tell my mom everything.

7.5.5 Concluding thoughts on Case study 3

This case study highlighted the importance of attending to context and to work towards ecological well-being when working in a community like Lavender Hill. People in such communities, like Francis and her family, experience multiple exposures to violence in the home and in the community. This case study also confirmed that the consequences of trauma are complex, multi-faceted and context specific. Contextual problems such as limited access to special schools and limited housing options added to the family’s stress. However, stories that spoke about resilience, survival skills and love within this family emerged in the exploration of double-storied accounts of trauma. Family members could voice their preferred ways of living. Inquiry about experiences of being cared for and caring for others strengthened the base from which to build a new sense of connection and direction for the family. Possible ways in which preferred lifestyles could be grown were continually explored through respectful curiosity about different areas of the family members’ lives.

7.6 Case study 4: Cheri and Aston – "Naming abuse and breaking from its effects"

As people reference their experiences of abuse to context, they become less vulnerable to the pathologising of their identities, and less likely to be recruited into the shame that this pathologising is in league with. (White, 1995, p.96)

7.6.1 Introduction to Cheri ("C"), Aston ("A") and their mother Mita ("M")

In May 2003, Cheri (13) tearfully told a friend at school that her brother, Aston (16) "had sex with her." The incident reportedly happened in February 2003. Subsequently the school counsellor referred the family to the social worker at NWF and she referred them to me. Initially I was unsure about the ethical and practical implications of working with both the victim and perpetrator of an incident of sexual abuse. Within the area of therapeutic work with family sexual abuse, different opinions and assumptions about the nature of the problem and the goal of intervention exist. Some advocate separating family members while others argue family members should be seen together (Maddock & Larson, 2004). Maddock and Larson (2004) discuss some of the approaches used in working with incestuous families and note that, "in its purest form, victim advocacy assumes a pathological individual in a neutral context traumatizing an innocent and less powerful individual" (p.368). At the other end of the spectrum, the family systems approach assumes interdependence of family members' functioning, with all members contributing to pathology (Maddock & Larson, 2004). As an alternative to these approaches, Maddock and Larson (2004) recommend an ecological approach that recognises the extreme complexity of incestuous behaviour and "carries an attitude of personal ethical concern for everyone involved, even perpetrators" (p.369). This approach fits with the ethics of narrative therapy.

After reflecting on the referral with two colleagues, I decided to consult with Cheri first. I informed her of different options in terms of referring her brother to someone else, but Cheri wanted me to interview her brother. However, she did not want us all to meet together initially, which we agreed on. I met with Cheri and Aston individually seven times between May and August 2003 (see Table 5). Their mother, Mita, joined each of them at the first two conversations. Our fifth meeting took the form of a "definitional ceremony" (described in Chapter 4). The children's favourite aunt was invited to attend. Within narrative therapy, it is customary to invite family members or significant others to be part of the process if the clients agree. My final conversation was with Aston and Cheri together. Working collaboratively with this family created "new contexts for meaning and behaviour – a key element of trauma resolution" according to Maddock and Larson (2004, p.372).

My first impression of the family was of their gentleness. Cheri and Aston were wearing school tracksuits and seemed a bit shy, but greeted me with big smiles. They seemed physically healthy and well looked after. Aston agreed to wait while I chatted to Cheri and her mom first. Initially we could not find Aston when it was his turn and were all surprised when the social worker found him participating in a sex-education class. Mita mentioned that Aston had a learning problem. He was in Grade 8 at the time, but Mita said he "just gets pushed through to the next class." According to his mom, he could not read. She was concerned about his schooling and had contacted the school clinic about arranging an assessment for him. In the following extracts Mita reports the problems Aston has with insight, judgement and impulsive behaviour, and how this had gotten him into trouble in the past:

M: I must tell you something about Aston's life, because Aston has a problem. He is not normal like she is normal. He does not think like us. He is very slow. He learns slowly. He does everything slowly. And I have spoken to all the teachers about it. None ever felt they could do anything to put him in another class where he could learn more. He must get more out of it because he cannot learn with all the other children around him. He is very slow.

M: But Aston cannot read. He cannot read.
I: And the school cannot help him?
M: Mr. Linn said he will let the head know that he is going to the board with Aston's problem and then they might be able to sort something out, but at the moment I have spoken to his teacher. She gives an hour extra class every week.
I: Do you think it will be all right if I spoke to Mr Linn and chatted to him about Aston's schooling?
M: Please. I will appreciate it a lot.

I: And how was it for him {Mita's husband} to hear what Aston had done?
M: He is so shocked. He says, "Mita, if I touch Aston I will hit him non-stop." Then I told him, you don't have to, I am there to sort them out and I will sort it out. And he is very much more…he sees it in a different light.
I: How does he see it?
M: That Aston is not normal. He said to me this morning, "Mita, Aston needs psychological help."
I: So he thinks the fact that Aston learns so slowly could have contributed to him doing=
M: =Yes.

M: =Yes, Aston is a child, what his mind tells him to do, he will do. He does not think about it, he just does it. There have been many times that I have told him, "You don't think about what you are doing." That is why you did this now. Because if you first thought it is wrong, you would not have done it. Aston has gone with friends and then they stole a bike at the CHURCH. Because the children told him, "Aston, you don't have a bike, take it", and then he took it!

7.6.2 Problem construction: Naming the problem and exploring its effects

7.6.2.1 Sexual abuse incident

Initially, in an attempt to get to know both Cheri and Aston apart from the problem, I asked about general aspects of their lives. Since I was wary of re-traumatising Cheri, I inquired in general terms about what brought them to me. Once they had named the incident of sexual abuse, I got Cheri's permission to inquire about what happened on that night, and I tried to ensure that Cheri knew she was under no pressure to talk. Cheri spoke very softly and was visibly sad and tearful when she spoke about the abuse. She moved even closer to her mom and they seemed to draw support from closeness to each other. Cheri told me that her brother "tried" to have sex with her, but he "stopped" when she woke up. She said she "did not know much about sex", but believed she was still a virgin. After the incident she told her brother Walt (19) that Aston had "touched" her. Walt comforted her and allowed her to share his bed with him for the rest of that night.

This incident had many consequences, many of which were evaluated as problematic by the family. My first aim in interviewing Aston was to invite him to take responsibility for his actions. He had to be aware of the pain and distress his actions had caused. However, as part of "the invitation to responsibility" (Jenkins, 1997) contextual factors that contributed to the abuse were also explored. As will be discussed in section 7.6.2.4, naming these allowed for others to support Aston's steps towards ensuring that he did not perpetrate abuse again. The notion of "doing sorry" (as opposed to just saying sorry) implies actively living in ways that speak of regret and this version of the notion of "restorative justice" informed our conversations (Jenkins, 1997).

7.6.2.2 Secrecy and silence

Due to her knowledge of the widespread incidence of child sexual abuse perpetrated by family-members in the community, Mita repeatedly warned Cheri to tell her if anything should ever happen to her. She specifically addressed the possibility of abuse within the home. It seemed as if she did not fully trust her husband (Cheri's step-father) or Cheri's older brother. She wanted to create a safe space, free of guilt, for Cheri to report any abusive behaviour to her.

> M: …And I said to her, "Daddy may not touch you Cheri." There are times like now after school when I am not at home. Aston goes out to play, Walt goes out to play and then it is just her and him and the little one. "He may not touch you and if he touches you and I get home, you tell me immediately. I will let him go to jail for you. He will go to jail because I won't allow my husband to abuse my child." And they know how I feel about them and how I feel about my husband in relation to them. I don't give him the right to abuse them. I don't give him the right to sometimes use abusive language, which he doesn't do.

> M: I always…I warned them a lot, because they sleep in one room, "You may not - you are her brothers. Not daddy, not Walt, may touch you Cheri. If they touch you, you must tell me immediately and don't let them tell you they will do this or that if you tell mommy, because you are not the guilty one. They are the guilty ones and I will deal with them, so tell me immediately." And that hurt me very much - to think I told her that so clearly and explained to her what to do if one touched her, to tell me immediately. She must not keep it away from me, because I am a very open mother. I don't hide anything from my children. I make them aware of what is happening in the world. The world is very wild. Come and talk to me.

As discussed in Chapter 6, Cheri did not tell her mother about the incident. Cheri's silence stood in contrast to their usual way of talking and sharing. Mita reflected that she was "hurt as a mother" by Cheri's secrecy since she had asked the children to tell her if anyone "touched" them.

> M: … But just one thing that hurt me very much, I felt at that stage when I heard it, that Cheri is not real with me, and the two of us are close. At night when I come from work then she comes with me to the room and we will sit and we will talk. She will tell me things and that.

Mita struggled to come to terms with the fact that her daughter did not talk to her about the sexual abuse despite her open encouragement that she should disclose any abuse. Lewis's (1999) words seemed to apply to their situation:

> Research shows that, even where children have a warm and accepting relationship with a caregiver, very few disclose the trauma, particularly in cases of sexual abuse. It is important for adult caregivers to know this as they often blame themselves when children do not confide in them after being abused. (p.19)

She was very upset that she only heard three months after it had happened. In her anger she gave Cheri a hiding for keeping the incident a secret.

> M: I did hit them. I hit her as well. Just to make them conscious, "Don't keep such things from me." I told her, "Do you know why I am hitting you?" "Because you did not come and tell me. If something happens to you, then I must hear about it first. Not someone else and then I must hear it afterwards. That is not right."

In our conversation, Cheri's silence was placed into context. The larger discourses in the community about girls who have been abused, as well as more practical factors such as her mother's health, were highlighted. Cheri's

fear that her mother might die of the shock if she was told was better understood. This fear was based on the fact that Mita was really sick and had heart cramps at that time. Four of her nine siblings had died of heart failure.

M: …I have five sisters. The others also love me a lot. We are now still four. We were nine girls and three brothers. One brother has died and three sisters have died. So there are four sisters left.
I: How did they die?
M: Heart disease. They all had heart failures - and my mother also. My brother was the youngest child and he just collapsed one night on the way back from work. He died instantly.
I: Do you think that is also why Cheri was so scared?
M: Yes, because she knows this.
C: I cannot loose my mom now. {Crying; hugging mom}
I: So are you happy that you have your mom so close to you now?
C: {nods and smiles; mom and daughter have arms around each other}

I tried to establish if Cheri's secrecy could also have been related to shame, informed by discourses in the community about victims of abuse. She conceded that she had been concerned that "everyone will look" at her and judge her. It seemed that Cheri's silence was also informed by a fear of stigma and being labelled by others.

I: Were you shy to talk about it? Did that also make it hard to talk about it?
C: Yes. I thought if I am going to tell, then everyone will look at me. They will think, "She kept herself so cool and look what happened to her."
I: You were afraid everyone would look at you. And what did you think they would think when they saw you?
C: She kept herself so cool and look now.
M: She wanted to think so well of herself, but look what she is.

7.6.2.3 "You are breaking me as a mom"

Mita's experience of being "broken" as mother was acknowledged in our conversations. However, ways in which she was respected and built up as a mother were also discussed. The love between her and her children became more known.

M: … I told them, Aston and Walt, when I found out, "How could you do it to her? You are not only hurting her, you are breaking me as a mom." To think my own son did it to me.

7.6.2.4 Acknowledging contextual factors

In line with a narrative approach, I considered the acknowledgment of contributing contextual factors important in this case. Mita worked very long hours as a seamstress in order to meet the financial needs of her family. Her husband was unemployed. Although Mita worked such long hours, they only just made ends meet, as is evident in the following extracts:

I: Where do you work?
M: In the city. Then I bring work home, then I work at night. That's why I said she helps me a lot with the work. She sews buttons on and will cut the threads for me. … They {the family} don't want me to work like that anymore. The doctor told me I should rather do either day work or night work but he would recommend that I keep the day work. That is why I had the pain.
I: Were you over-worked? Too much stress at work?
M: I sat like this {demonstrates a hunched over position} too much - 24 hours.
I: In front of the sewing machine? So the night work, is that what you used to do at home?

M: Yes, I would get home and work at night and then go back to work the next day.
I: Are you struggling financially or why did you work so much?
M: It is to earn money, because my husband does not work. He finished at the council now four years ago, so I am actually the breadwinner. And I feel…I went and worked again on Saturday just to earn some extra money. I left home at one o'clock and came home at eight thirty.

I: How do you manage (financially)?
M: Only just.
I: Does it depend on how much you work?
M: It helps a lot that I can pay school fees. I don't pay it all at once, but I pay it off and make sure that it gets paid. I can pay my rental and I can pay my rates, electricity. I must keep us alive as far as food goes. I can almost not get them…when I spoke to the school now, they said, "Mommy, we must have tracksuits." So I said, "Okay, I will sacrifice to get your tracksuits made." So we gave half the one week and said you must just eat what there is to eat, and next week it will be the same, because then I have to give the other half. It cost R420 for the three, because Walt also still went to school. Just after the tracksuit I found out, "Mommy no, I am going to find work." Now he is busy with a CV that must be drawn up and then he will.
I: So has he left school recently? What grade did he complete?
M: Grade 10.
I: So what do you earn as a family per week?
M: I earn alone. I get R600 a week and then whatever I work extra then gets added. Like last week I got another day's pay because I worked on Saturday and so I got almost R800 for the week, but it is not always like that. But there are times when I say, "I don't know why I am working so hard. Why am I killing myself like this?" Because there are times when I don't see what I have worked for. When Saturday comes I say to them, "I have no money left." When they ask, "Mommy, give 50 cent" or "Mommy, give a rand", then I say, "I don't have." When I have, I give. Sometimes I do my duty to say to them on Friday night, "Here is five rand for you and five rand for you", and maybe for the big one ten rand. If I can give more, I give more. When she has helped me a lot in a week, I give her, "Cheri, there is ten rand for you." But then there are times when I say, "I don't have money. Don't ask me for money, because I don't have."

Bloom and Reichert (1998) point out that family poverty "inhibits parental processes of family control" (p.37). In this family, poverty also contributed to cramped housing and not being able to buy a bed for each of the children. I was ignorant of the fact that Cheri had to share a bed with her brother Aston and was shocked when I realised that she had to continue sleeping in the same bed until their mother found out about the incident via the school 3 months later.

I: And did you get a fright or what went through your head when it happened?
C: Who is this? What is going on?
I: So at first you did not know who it was?
C: I looked down and saw he was not lying at the bottom, and then I saw it was him.
I: Then you looked at his bed and saw his bed was empty?
C: He sleeps with me in the bed.
I: Oh. (..) In the same bed (…) and since it happened, did you still have to sleep in one bed?
C: My mom said he has to sleep on the floor.
I: Okay. And when your mom did not know yet that it had happened, where did he sleep then?
C: He still slept there {in the bed with her}.
I: What was that like for you that he slept there in the bed with you?
C: I wanted him to sleep in another bed.

It can be argued that the likelihood of abuse is increased in cramped living conditions. For this very reason Mita had warned the men in the house repeatedly not to touch Cheri and told Cheri to tell her immediately if something should happen. Mita's fear could have been supported by her knowledge of the high levels of sexual abuse that is said to occur in the community. In narrative therapy, contextual factors and events that lead up to abuse need to be made explicit in conversations with both the victim (Cheri) and perpetrator (Aston). The

exploration of contextual factors that contributed to the abuse allowed both Cheri and Aston an opportunity to express anger and frustration they might have been experiencing with regard to their circumstances. A contextual understanding of what leads to abuse can help victim and perpetrator alike in becoming "less vulnerable to the pathologising of their identities, and less likely to be recruited into the shame that this pathologising is in league with" (White, 1995, p.96).

I: Is that something that you have thought about, Cheri - the fact that you had to sleep in the same bed? Is that something that you are angry about? Not angry at someone, but just about the circumstances – that you have so little space in you home that you had to sleep in one bed.
C: Yes.
I: Is that a case where you are angry about the circumstances, not necessarily just at Aston, because he did not plan that you have to sleep in the same bed. It was because there was not enough space, hey?
C: {nods}

I: Cheri, did you say you were angry about the situation - that you had little space and had to share a bed?
C: Yes.
I: Do you think it was also part of the problem?
C: Yes.

Mita mentioned in passing that Aston had been watching a sexually explicit programme on television that night just prior to going to bed, but did not emphasise this as a possible contributing factor to the incident. When Mita caught him watching this film she told him to go to bed immediately. The rest of the family was asleep, including Cheri in their shared single bed. He pulled both their pants down, lay on top of her and "tried to have sex with her." Acknowledging the legitimacy of Cheri's anger, while clarifying who or what it was directed at, seemed like an important step in opening up other options in terms of the future of the brother-sister relationship.

I: Aston, do you think watching that on TV was part of the reason that you did it?
A: Yes.
I: So you watched it and then what happened?
A: They had sex there and then it was in my head.
I: Was it still in your head when you went to bed?
A: Yes.
I: Was the sexual abuse something that you planned before – that you wanted to do that to Cheri, or did you do it on the spur of the moment that night?
A: It happened.
I: How did you feel about what you did?
A: I got a fright.
I: Were you surprised that you could do something like that? Did you ever think you would do something like that?
A: It just happened. {Cries; sniffs in distress}

I: …So, on the one hand it was Aston who made a very big mistake by firstly watching that movie and then not controlling himself. He should have done something else or should not have gotten into the bed if he thought it might be dangerous. The fact that he tried to have sex with you - that was the biggest mistake. However, it seems that the situation was also part of it. He had to sleep in the same bed as you and he watched that movie. Do you think that was part of the problem?
C: Yes.
I: Does it make sense for a part of your anger to be against the TV people who show such movies and against the fact that some people don't have enough money to have enough space in their houses. Do you think some of your anger can also be about that?
C: Yes.

I: So a part of the anger is against Aston, but not all of it? Is that right?
C: Yes.

Jenkins (1997) notes differences in emphasis when working with adolescent instead of adult sexual offenders. Although adolescents must accept full responsibility for their abusive actions, they do not have full adult rights and are not regarded as fully responsible for their own welfare legally:

> Their caregivers have a responsibility to establish a family environment which promotes the development of responsible and sensitive behaviour in children. Caregivers of adolescents who abuse are not responsible for the abuse but they do have quite different responsibilities from members of the families of abusive adults. They are expected to help their abusive sons to face responsibility for abuse and relate respectfully to others. (Jenkins, 1997, p.207)

I therefore saw Aston and his mother together at first and attempted to contextualise the abuse within a systemic as well as a developmental context (Jenkins, 1997). It became clear that factors such as the history of Aston's impulsive behaviour and lack of judgment, his age, and contextual factors such as sharing a bed with his teenage sister contributed to the incident. The fact that Mita found it necessary to warn the children suggests that she was aware of the risk of sexual abuse:

M: I tried so many times to pre-warn them that it must not happen.
I: So do you think it was also partly the situation that has made the abuse possible? The fact that you warned them so often could speak of a premonition you had that it is hard for the children to sleep so on top of each other. Were you worried about it, that it might happen?
M: That is why I spoke to them so much.

I remained curious about the possible significance of the sexually explicit programme Aston watched on television just before the incident since it could be helpful for Mita, Cheri and Aston to be more aware of what preceded the abuse. On the one hand, such a connection could assist Cheri to understand the context of what happened to her better. Mita and Aston could decide to ensure that it does not happen again.

I: Do you think the abuse had something to do with you watching that movie? Was that part of your mistake?
A: Yes.
I: Why do you think it was part of the mistake?
A: I should not have watched it on the TV. When my mom said I should go and sleep, I should have.
I: Was it still in your head, or why do you think you did it just then?
A: It came to me.
I: Do you think you learnt something about watching such movies? Would you watch such a movie again?
A: {shakes head}
I: And why won't you?
A: Something might happen again.
I: Do you think you have become more careful now about how such a movie can affect your body and how it can lead up to you doing something which is not good?
A: {nods}

Bloom and Reichert (1998) reflect on many studies that show that pornography desensitises men to the abuse of women. Russell (in Bloom & Reichert, 1998) makes the case that pornography "lays a psychosocial foundation for rape through eroding inhibitions and creating desire" (p.77). This seems to have been the case in hand for Aston. On a broader, cultural level, it can be argued that pornography strengthens the social construction of sexism (Bloom & Reichert, 1998).

7.6.3 Problem effacement: Identification of alternatives and personal agency

7.6.3.1 My mother knows already, I don't have to worry anymore

Cheri said it was "better" when her mother found out about the incident. I was interested to find out why her mother's knowledge was a relief to her and found out that she did not have to "worry" anymore about keeping the secret. The opportunity to speak about the incident lessened sadness and tears in Cheri's life.

I: Why is it better that she knows?
C: My mother knows already, I don't have to worry anymore.

I: So now that you have spoken about it, how has it affected you in terms of the crying and how you feel?
C: I don't cry that much anymore.

For Mita, the fact that the family was speaking to a counsellor - that the abuse was "coming out" - was a step in the direction towards "setting it right."

M: ….I just felt, I cannot leave it just like that. It must come out and it must be set right.

7.6.3.2 Safety

Mita said she "took Aston away immediately" when she found out about the abuse. Although he then had to sleep on the floor, he continued to sleep in the same room as Cheri. Walt also slept in this room. Cheri was given opportunities to speak about her feelings about this arrangement and said that she was eager it should change. We agreed that she should sleep in the "workshop", an annex next to her parents' room with Mita's sewing machines. This brought a smile to her face for the first time in the interview. It emerged that Cheri had in fact already spent a couple of nights in this room at the time that she started menstruating.

I: And now since you have found out as well, Mita, does he sleep apart from her now?
M: Yes. I took him away immediately when I found out. I told him the reason why I spoke to them so much about sexuality was because they sleep together. I have to trust them. And because I spoke so openly to them, I felt that they would not touch each other. And then I told him, "I cannot trust you anymore. I can't, because you can do it again, Aston." And he is sleeping on the floor now until I am ready to buy another bed. And I said if I buy another bed it is for her and then she can sleep in my workroom.
I: Okay, so is there another space in the workroom?
M: Yes, where I work. I do sewing, clothing. I make a place where she can sleep.
I: How will that be for you?
C: It will be better.
I: Would you like that to happen soon.
C: {nods and smiles}
I: And if you can get something in the meanwhile, a mattress …
M: Last night I said to Peter, I must see if I cannot get her a sleeper couch. Then it does not look like a bedroom. Then I can hang a curtain there, so that she can feel safe at night, because you go from my room to the workroom. So it will be away from their side.

M: And I have let her sleep there before. And she was fine.
I: When was that?
M: Just after it happened. But I was not aware of it, because then she became a young woman {had her first period}. When she became a woman, I said to her, "Cheri, you must come and sleep in the workshop near mommy for a while."

It was importance to establish whether Cheri felt physically safe (Herman, 1992) at home. She reiterated that she did not have a problem with him being in the house, as long as he slept in another room.

I: If you are in the other room, would it be okay for you with Aston still in the house, or what are your thoughts?
C: That would be okay.
I: Are you sure it is okay if he is in the house? So you just don't want to sleep in the same room as him?
C: Yes, he must not sleep with me. He must be in another room.

In our final interview in 2003, where Cheri and Aston were both present, Cheri said that she was not scared of Aston. She thought she could trust him not to violate her again.

I: And did it only happen that once or did he try to do something again?
C: He did not do anything again.
I: Are you still worried that something might happen?
C: {shakes head}

I: And the fear that you felt that day - is that something you ever feel at home? Is there something that you are scared of at home?
C: No.
I: So you are also not scared of Aston?
C: No.
I: Do you think there is enough trust between you? You know he won't do something like that again?
C: Yes.

At the fourth interview Cheri reported that since her birthday (8 June 2003) she did not think much about the incident anymore. This coincided with her moving from the shared room to the "workshop" attached to her parents' room. Cheri had developed a strategy to avoid thinking about the incident in a way that would upset her. I was curious to hear more.

C: When I see him, then I think about it, and then I do not want to talk to him. At other times I do not think about it.
I: So it is just sometimes that you think about it? And what helps you to think about it less – at the times when you think about it less often or where it does not bother you so much?
C: I do not let it bother me because I don't think about it.
I: So do you succeed in telling yourself that you do not want to think about it?
C: Yes.

Cheri also reflected that she experienced her relationship with Aston as "okay", although she would have liked it if the incident never came between them. Cheri was able to articulate the fact that she preferred a lesser form of connection to Aston at that time.

I: How is the relationship for you now? Is it okay for you or would you like it to change?
C: It is okay as it is now.

7.6.3.3 Not a life-time scar

As highlighted in Chapter 6, Mita viewed the effects of abuse as a "life-time scar." This created an opportunity to question this notion with Cheri as a witness to our conversation. This opened possibilities for a more robust

sense of self for Cheri and her mother. Ritterman's (1987) perspective is that the notion of "the client as psychologically damaged may be challenged in the context of a new message – namely, that the social system which exerts hegemony over the individual is instead damaged" (Kagee, 2003, p.285). Narrative therapy would aim to contribute to Basoglu and Mineka's (1992) suggestion that therapy should lead to "a transformation of the survivors' negative self-perception, as well as the negative evaluation of their helpless behaviour" (cited in Kagee, 2003, p. 285).

7.6.3.4 Accepting and forgiving as a mother

Mita reflected that despite feeling that she was "broken" as a mother at one stage, she had experienced some healing. She had decided that she had to forgive Aston and worked towards acceptance.

> M: ….I could not accept it at first - that it was Aston and that I spoke to them about it like that, that it may not happen. But I am now at the stage where I have forgiven him and I must accept it. There is nothing else I can do about it now.

In my last conversation with Cheri and Aston, it emerged that Mita expected Cheri to forgive Aston as well. However, she did not want to forgive him. She did not even want to accept a letter of apology that he wrote to her in one of our interviews.

> C: When I think about forgiving him, then I think about it again, and then I am angry again.
> I: Does the anger make forgiveness hard for you?
> C: Yes.
> I: And do you think a part of you can continue to be angry about it, while another part of you could forgive him? Could you say, "I am angry about what he had done, but I want to have a different relationship with him as my brother in the future"? Do you think it will help you if you forgive him or not really?
> C: Not really.
> I: What would you find more helpful?
> C: I don't know. I just need my mother's help a lot.
> I: And this forgiveness thing, is that something you still want to think about - if it would help you or not?
> C: Yes. It would help my mother more, but not me.
> I: Okay, so at this stage it is something that you are still thinking about. It is a puzzle-piece that does not fit nicely yet. You are not sure yet how it fits - if it fits - if it is needed or not?
> C: Yes.

Cheri's words illustrated that "forgiveness is a choice" (Enright, 2001) that cannot be taken lightly or forced on someone. According to Enright (2001), forgiveness firstly involves acknowledging that an offense was unfair and will continue to be unfair; secondly, we have a moral right to anger since it is not right for people to hurt us; and thirdly, "forgiveness requires giving up something to which we have a right – namely our anger and resentment" (p.25). Cheri knew this experientially. Although her mother's wish was for her to forgive her brother, she was not yet willing. The reason seemed to be the intensity of her anger when reminded of the incident, as well as uncertainty about the benefits of forgiveness. In the last conversation of 2003 Cheri agreed that knowing and accepting that Aston was sorry was not the same as forgiving. Upon reflection she realised that she preferred to accept that he was sorry, as opposed to thinking that he did not care. Although she thought their relationship would never be what it had been, she did see possibilities for good times together in the future as brother and sister.

7.6.3.5 Countering blame

> M: …And I said to her, “To be scared is right, but not to feel, ‘Maybe I did something so that he felt he had to do it’.” Because that is what she said to me, “Maybe I did something wrong that he did it to me.” Then I said, “No, {it happened} while you were sleeping.”

Mita taught Cheri that should she ever be molested, she would not be to blame. As mentioned earlier, Mita was so upset by the fact that Cheri kept the abuse secret that she gave her a hiding. I asked questions to try and increase our understanding of what contributed to Cheri remaining silent at that time. Mita clarified that the hiding was not because Cheri was to blame for the incident. I wanted confirmation that Cheri knew that she was not to blame for the abuse. Her mother had taught her that this was the case. Her explanation was logical: She did not tell him to do it and could not be held responsible and was not to blame. Cheri thought that her mother’s confirmation that she was not to blame helped her not to feel guilty.

> M: Yes. I do not keep it against her. And she did not lead him on. She was not awake when it happened. She was asleep.
> I: Do you understand that it was actually out of her love for you and the importance of the family that made it so hard for her to talk? It seems to me the family was also something important to you, Cheri. Is it hard to talk about something that feels as if it might break things apart or change everything?
> C: {nods; crying}

> I: Your mom said she always told you that if something happens it is not your fault. Is that something you believe?
> C: I did not tell him to do it.
> I: Okay, so you did not ask him, you did not want it, so it was not something you brought on yourself, hey?
> C: {Nods}
> I: Are there times when you feel that it is your fault or that you did something wrong?
> C: {Shakes head} It was not my fault. If I would have said he had to, it would be. But I did not.
> I: But you did not say that. So you know for sure it was not your fault.

7.6.3.6 Prayer

Cheri said she prayed every night and this helped her to sleep better. She asked God for help and protection.

> I: What helped you at night when you were afraid?
> C: I prayed. I pray every night.
> I: Who do you pray to?
> C: To Jesus.
> I: And did that help you to sleep at night? What did you pray?
> C: I said He must help us to sleep and asked that Aston he will not touch me.

7.6.3.7 The love got more

Cheri and her mother’s love for each had been strengthened by the incident. This seemed ironic since Cheri’s initial fear was that her mother would love her less. She also feared that her aunt, who often spoiled them, would not like them anymore if she knew about the incident.

> I: And was this also a reason why you were scared to tell your mommy, that your mommy might - that her love for you might be affected if she knows about it?

C: {nods; crying}
I: And with your mommy - did it affect her love for you?
C: No. It got more.
I: It got MORE? {Everyone laughs}
M: I can squeeze you against my heart, Cheri {hugs her}. You are my baby, man. She is my only girl and I love her very much.

7.6.3.8 Aston as a kind and loving child

Mita's shock when she heard about the incident was intensified by the fact that she knew Aston as a kind and loving child. He was a gentle person. An example of his gentleness was that he often washed his mother's feet as an expression of his love and appreciation for her. Aston habitually offered to wash her feet and massaged them after a long day at work.

M: …Once a week he did my feet when I got back from work. He said, "Mommy, are you tired?" He would always ask me if I was tired. "Mommy, would you like some tea?" Then he would make me some tea. He is a loving child. And that is why I said to him, "Aston, I cannot believe you did it." Not for the type of child he is. I could not get that over my heart.

I: And do you also miss the times that you helped your mom by massaging her feet?
A: {nods}
I: Why did you like to do that? Why did you help her like that?
A: She is my parent, I must do it. My mom has blessed me a lot. {Crying}. ( ) my mother's feet. That is why I did it {sobs}.
I: So you really wanted to do that for your mom just because she is your mother.
M: {Crying} Where is a tissue?

In a later conversations Aston told us that he really enjoyed going to work with his mom the previous day. He washed her feet that evening and saw this act as symbolic of the way their relationship was being restored.

7.6.3.9 Hate the abuse but love the child

Mita had tears in her eyes when she spoke to Aston about how difficult it felt at times for her to love him in the same way as she had, because she hated what he did. He reached out to her and they hugged. He said he wanted to continue that kind of loving relationship with her. I was moved by the open way in which they seem to express love and concern in the family. Their love highlighted the tragedy of the incident. However, their love also inspired us all with hope for a future where non-abusive, loving actions could be reclaimed.

M: …And I said to him, "I hate you. I hate you for what you did, because you should not have. I have spoken to you about it already."

I: I just want to go back. So you said to him that you hate him for what he had done. Now you realise you hated what he had done, but you do not hate him, you love him. He is your child.
M: Yes.
I: Aston, does that make a difference - to know your mother still loves you as her child? She was very sad and shocked by the incident; she hates the fact that there has been such an incident in her house and that you committed it, but she still loves you. Do you understand the difference - that she loves you, but hates what you have done?
A: {nods}

M: …I have {forgiven him}, because the Bible says you may not …one that hurt you, you may not carry in hate. I cannot carry my child in hate. I have to forgive him, otherwise God will not forgive me. But there is just one part in me that hurts a lot when I look at you {looking at Aston}. My heart is sore for what you have done, Aston.
A: Yes mommy.
M: It is going away slowly. I said to you it will take time before I can be the same with you as I used to be.
A: Yes mommy.
M: And there were times, before this happened, that I looked at you in the workshop and we listened to the same music and we hugged each other and said we love each other. I have not done that again yet, because I cannot do it. If I have to do it, it would be false. And you would really have to show me that you are sorry for what you have done.
A: Yes mommy.
M: So that I can do that again.
A: Yes mommy.
I: So it sounds to me, Mita, that you are saying there is a deep sorrow. Even though you don't want to judge Aston, you do condemn what he has done; but you still love him as your child.
M: Oh yes.

Aston seemed grateful to have his mother's love for him confirmed, despite her condemnation of what he did.

7.6.3.10 Accepting responsibility by acknowledging pain caused

My conversations with Aston extended invitations to him to accept responsibility for his abusive behaviour (Jenkins, 1997). In our last session together Aston spoke about the guilt he felt for having caused so much pain. He knew that abusive behaviour was wrong and wanted to ensure that he would not hurt his family like that again.

I: What did you feel, knowing that you caused them so much pain?
A: It made me feel very bad because it was because of me that she felt such pain.
I: And after seeing what it had done to her, what are your thoughts about the incident? Do you think it is something that is very wrong or do you think it is not so wrong? What do you think?
A: It is very wrong what I have done.
I: Why is it so wrong?
A: I let it happen. ( )

7.6.3.11 Re-building the brother-sister relationship by "doing sorry"

Aston wanted to reclaim some of the previous ways of being, such as being playful, which had been part of their brother-sister relationship before. However, he needed to accept that Cheri had to determine what "doing sorry" would involve. We also reflected on aspects of Aston and Cheri's relationship that they both appreciated in the past.

I: And when you laughed, what kinds of things did you do then that made you laugh?
A: We played games, cards. Then I might let her win. Then we laughed.
I: So are these things that you miss now after it happened?
A: Yes, because I cannot do that again. I would like us to play together again.
I: Do you think it will take time? Will it require you to show her that she can trust you again in some measure? And would she have to see how sorry you are that you hurt her so, before she might be able to play and laugh with you again?
A: {nods} Yes.

I: Do you think if you and Cheri can rebuild your relationship it would make a difference to you?

A: {nods}
I: What difference would it make to you?
A: She will want to laugh with me and we will talk together, because at the moment if I talk to her, she says, "I don't want to hear anything from you."
I: So do you also miss your relationship with her?
A: {nods}

I: And do you think that is something that you would like to try and rebuild, if it was at all possible? Would you want to build such a brother-sister relationship with her again?
A: {nods}
I: And from your side, are you…what will you do to help that it might be like that again, or that a little part of it maybe could be like that again?
A: I will promise her I will not do it again.
I: Okay, and if you have promised that, is there still something else you could do?
A: I did a lot of things for her when she asked me.
I: Like what, for example?
A: I helped her a lot…with washing dishes. And I ironed her clothes.
I: Do you think… she appreciates it? Do you think she wants you to do it?
A: She would say thank you, or so, but I don't know if she would appreciate it.
I: Okay. If she says thank you, do you think that is because she appreciates it, or why does she say it?
A: Probably because she appreciates it.

I: I wonder if your mom has any ideas about that - if Aston wanted to show that he was sorry, how he might do it? Or do you think Cheri should perhaps say what would feel sincere to her?
M: She might be able to say what she would like him to do for her so that she can forgive him or so, because I don't know if she has forgiven him yet.

Mita realised that Aston was in a dilemma in terms of "doing sorry", since Cheri did not want him to do anything for her. The surprising way in which they sometimes managed to talk to each other gave Mita hope that they might "get over it."

I: And Mita, what do you think about their relationship? What was it like? Do you think Cheri will appreciate what he does or do you think she would prefer having nothing of him at this stage?
M: Nothing. She does not want him to do anything for her. She will do it herself rather. But there are times when they surprise me with their behaviour. Sometimes I look at them then I think, "Is it true what I see?"
I: How come?
M: If they talk to each other reasonably, then it surprises me. I look at them and wonder if they will get over it. But I say nothing.
I: So sometimes you see that they manage well despite what has happened?
M: So I believe it will happen, it will just take a bit of time.

At that stage they often "attacked each other" verbally. Our reflection on this highlighted the complexity of "doing sorry", since Cheri actually did not want to accept a sorry at that stage.

I: Do you think it will take a lot of sensitivity from Aston towards Cheri?
M: That he can talk to her out of his own. That he can say to her, "Cheri, what happened I cannot change because it already happened but I promise I will never in my life do it again, because I love you as my sister." {Turning to Aston} Then she might accept you again.
I: But I am also thinking about what one might do to slowly rebuild the relationship if Cheri wants that. Could checking with her what she wants be helpful? For example telling her, "Cheri, I would like to do things for you but I also understand that it is hard for you now. I want to do what is best for you. So if you don't want me to do something, I won't. However, I would like to do things for you. Can I help you with this or would you prefer me not to?" In other words, talk to her and show her that you respect her wishes.
M: To show that you are trying to make up for what you have done.

I: What makes it hard for you to know how he feels?
C: If I just don't take notice of him and tell him off.
I: Do you think that makes it hard for him to show how he feels?
C: Yes.

Cheri did not want to meet together with Aston until our last session. At our joint session, Aston wanted to inform her about the regret he had for perpetrating the abuse – he wanted to say sorry. We also spoke about what "doing sorry" would entail and specifically consulted with Cheri about what she would see as "doing sorry."

I: Do you think he should be feeling bad about it?
C: Yes.
I: And do you think he does feel bad about it?
C: No.
I: Why do you think he does not feel bad about it?
C: Because he does not worry so much about it. He does not talk about it a lot. He will not come and ask me, "Cheri, do you forgive me?" or something like that.
I: I wonder, do you think he might be a bit confused about it? Because on the one hand you sometimes say he should not talk to you about it, and on the other hand you want him to talk about it. Do you think it might confuse him?
C: I don't want to talk about it, but he is supposed to think about it and then I can tell him I don't want to talk about it. But he does not even mention it.
I: Okay. Aston, does it sometimes come up into your thoughts that you want to tell her you feel bad about it but then you think, but she does not want me to talk about it?.
A: If I say something she could cry and then my dad wants to know what's wrong.
I: So are you then afraid to talk about it? When you feel bad about it, do you know how to show it to her?
A: {shakes head}
I: Can he show it to you in a way that will not upset you, that might actually make it better for you? Perhaps if he now continues coming to you he might make things worse for you? How can he make things better for you?
C: He cannot make it better.
I: But if you know he feels bad about it, would that make it a bit better for you?
C: Yes.
I: But you say you don't really know that he feels bad about it.
C: No.
I: It is not as easy as it seems, hey. All the pieces of that ball don't want to fit nicely. I think it is a bit confusing for Aston – I don't think he knows how to show you that he feels bad. I believe he does feel bad, having spoken to him. I could see that he cares about you and about how you are. I could see this in the way he is towards you and how he speaks about you.(.) I don't know - would you agree that he is a person who cares and who would not like to hurt you?
C: Yes.

The complexity of the situation was highlighted once again when Cheri reflected in our last conversation that she did not need Aston's help.

I: …I think it might be confusing for Aston to know how to show you that you might believe that he feels bad about it. What can he do so that you would believe it?
C: I don't need his help.
I: Okay, so you don't need his help, but it is one of the "puzzle pieces" which you said does not fit, right? - the fact that you don't know how he feels.
C: Yes.
I: So if he cannot help in letting you know how he feels, who is going to help you?
C: My mother.
I: How is she going to help you?
C: {laughs} My mother knows him.
I: {laughs} Okay. Do you think with your mom's help you will sort out those puzzle pieces that still don't fit so well?

C: Yes.
I: And the puzzle pieces that do fit now is that you "give each other space and time on your own", and that you "can laugh together" at times.
C: Yes.

Cheri remained angry with Aston and acknowledgment of her feelings involved allowing her the "space and time" she requested. Aston acknowledged that he was responsible for his actions and that he wanted to show Cheri that he deeply regretted his abusive behaviour. However, Cheri could choose how she wanted to respond to his "doing sorry." Her reluctance to accept any help from Aston was not seen as an obstacle. It could be seen as an indication of one area in which she experienced herself as empowered after the silence had been broken.

7.6.4 Narrative practices aimed at thickening the alternative story

7.6.4.1 Therapeutic letters and documents

I wrote a therapeutic letter to the family after the fifth interview, which had the structure of a definitional ceremony with two narrative therapists as witnesses (discussed in the next section). The children's beloved auntie also participated. The letter was a "re-telling of a re-telling." I started the letter with an acknowledgement of the visible expression of love in this family and of the family's punctuality, since these qualities spoke of a commitment to each other and to the process that we were engaged in. The letter continued with an explanation that I did not realise that their Aunt had not seen them since the incident became known, since I would have introduced the interview differently if I had known.

From Letter 1:

Once again it was a privilege for me to witness the love and care that you as a family show towards each other. The team members noticed this love as well. I appreciated your punctuality, despite the challenge of using public transport and early rising with children, Mita!

I was a bit surprised that this was the first time since the incident came to light that the children had spoken to Auntie. Had I known this was going to be the case, I could have summarised what Cheri, Aston and I had spoken about previously as an introduction to our conversation. There had been many developments that you all could have been brought up to date with. I would have wanted to share Cheri's view that she was "still a virgin" and her knowledge that "what has happened was nothing for her to be ashamed about." Aunt seemed concerned about these issues. At our meeting we spoke about different possible meanings of being a virgin. We agreed that "anyone who had not agreed to sex was a virgin" and that physical proof of virginity would not be helpful in terms of healing. We agreed with Aunt's sentiment that "we should treasure Cheri's feelings and respect her knowledge."

Different notions of virginity came up in the conversation, since for Cheri and her aunt it was important that others should see her as a virgin. Cheri's views were acknowledged and affirmed. The letter continued by "thickening the alternative story" of Aston by reminding them of his abilities and commitments that were made despite the incident. Aston's preferred ways of being in relation to his sister, mother and aunt were described:

From Letter 1:

We heard Aston voice his commitment to being the loving son, brother and nephew that he had proven himself to be at many occasions in the past. He told me that he wanted to be known as "the kind of young man that others would speak well of." He also wanted to be known as someone who "is helpful"; someone who "will not have more than one girlfriend at a time" and someone who "will not force anyone to do anything against their will."

Aspects of the conversation about trust between Cheri and Aston were reflected and speculation about the possibility of reclaiming some of the playful aspects of the brother-sister relationship, which both appreciated and missed at that time, was invited.

From Letter 1:

> *Cheri, you said that you believed Aston when he said he would not hurt you like that again. You said you "knew you could trust him." When you asked him things in the recent past, he promised to get it later and he did keep his promises. Do you think this kind of trust between you, even though it might be limited, can help you both to reclaim some of the playful parts of you relationship?*

The letter continued with an exploration of the fact that Cheri reported that she did not have many disturbing thoughts about the incident anymore.

From Letter 1:

> *Cheri, you told us that you did not think about the incident much anymore and that it did not disturb you at home. You mentioned in another conversation that being in a different bed (and room) had helped in this regard. I am curious to know how you managed your thoughts in the way that you have. Do you think the fact that you talked more with you mom has helped? Had the knowledge that Aston regretted what he had done and had promised never to do that again helped you in any way?*

Reflections and questions of the witnesses (see next section) were also included in the letter. These were focused on consolidating knowledge that the family had gained through the painful incident. Emphasis was put on avoiding "totalising" Aston as a bad person and on providing a territory for him to stand in where he was safe enough to take responsibility for his actions, past and present. "Guidelines" for the family, articulated by them in the interviews, were recorded in the letter.

From Letter 1:

> *The team reflected on valuable new knowledge that you as a family seemed to have gained from this experience. The first new knowledge was that safety in the home (including sleeping arrangements) should be done with consideration to the sexual development of the children. The previous sleeping arrangements were not acceptable. Mita, you said that as a mother you "wanted to make more time to listen, show love and be available" to your children. As a family, you wanted "to encourage Aston to be the kind brother, child and friend he can be." You agreed that you did not see Aston as a "rapist." However, you all knew that he did something very wrong in a moment of not thinking about the consequences for Cheri, himself and the family. You realised that isolating Aston was not the best way to ensure that he could talk to you if he had confusing desires.*
>
> *When you thought about the way forward, Aunt said that "clear guidelines as a family could be helpful." Importantly, "Aston should understand what these guidelines meant practically." A broad guideline you suggested was "respect all people and their property." What else would you like to add? How would you recognise that these guidelines are being practised in your home and in your lives?*

Questions about ways of putting ideas about the future in practice were included and the family's motivating belief that "nothing is impossible" was highlighted, since this seemed like something that inspired hope for them. Their ability to support each other was acknowledged and questions about the history of this ability were included. The letter was concluded with the hope that we would have the privilege of witnessing more about the ways in which they had moved forward along "the way of new possibilities."

From Letter 1:

> *Aunt echoed Cheri and Aston's desire from our previous conversation, namely "to strive for a better future." What would this mean for each of you, also in relation to your relationships with each other?*
>
> *Your words, "Nothing is impossible", stood out for me from our conversation. These words seemed to gain importance in the face of the way you all supported each other. You said, "We can overcome anything together." "If we appreciate each other and show love, we know that we can overcome our problems together." I am curious about the history of these knowledges. Aunt, you mentioned some of the hard times the family had had to*

overcome. I wondered if witnessing the way Mita and her children had coped with those difficulties had contributed to your confidence in them now.
I hope that we will have the opportunity to meet together in a similar way soon and look forward to finding out how each of you had been moving forward along "the way of new possibilities" that you spoke about in the meeting.

When I met with Cheri again a few weeks later, I asked her about her experience of receiving the letter. What struck her most was the fact that I was still thinking about them. She expressed appreciation for the process, but did not reflect on the content of the letter.

I: What was it like for you to get that letter?
C: It was nice.
I: Can you remember why it was nice? Was there something specific that you remember about it?
C: It was nice to know that you are still thinking about us.

Cheri's words could imply that one of the aspects of the therapeutic process that she appreciated most was the knowledge that someone else cared about her and her family. She therefore confirmed the importance of a therapeutic relationship, as well as therapeutic practices that communicate care and consideration of others.

7.6.4.2 Re-membering conversations and 'saying hullo again'

Due to her valued place in the extended family, Aunt was invited to join the family in participating in the "definitional ceremony" with outsider witnesses. This invitation was extended both as a means of getting a valued audience for preferred stories and as an acknowledgement of the important place that she had in the family's life. I learned about Aunt when I asked about supportive people in their lives. At the first interview, Mita named her sister (Aunt), as an important member of the family. I tried to get a richer description of this so as to make her support more accessible.

I: … So with Aunt you are also a bit scared about how she will react? What will she think?
M: She is a very reasonable person. She can listen nicely and do things well. And she will sometimes tell me as well, "Don't get so worked up because it is not necessary. You must handle it nicer. You jump to quickly, don't be so quick." She is one who can keep me under control. If something happens and I get very upset, she will say, "Calm down, I don't know why you are shouting at me. You are not yourself now. Leave it."
I: So do you think she will be a good person to help and support you, and Cheri and Aston?
M: Yes. If I ask her to come to chat about it, she will. And she can do it in a very nice way. She is older than me. That is number one. And number two - I have a lot of respect for her. There are many things that I have spoken to her about.

7.6.4.3 Building a wider audience: Witnesses, communities of concern, definitional ceremonies

Cheri appreciated the fact that her mother joined her in the first two interviews. In a general reflection of her experience of the first interview, she reflected that her mother's presence made it easier for her to speak to me. She needed her mother as a witness and support.

I: Tell me Cheri, what was it like for you to come here and chat about this today. I can imagine it must have been quite a big step. You must be very brave to chat to a strange person. What was it like?
C: When I spoke it was all right because my mom was here. If my mom was not here, I would not have spoken.
I: So does it give you strength that your mom is here with you?

C: {nods}
I: And the way in which we spoke, was that okay? Was there something that bothered you or so? Something you might have wanted different?
C: {shakes head}
I: And would you like to come again so that we can speak some more and can see how we can go further and what some of the things are that might also bother you and so?
C: {nods}

At one stage Cheri reached out to her mom who hugged her back and held on to her - a symbolic expression of their support of each other. I checked this with them. They agreed with tears in their eyes as they reflected on their love for each other.

7.6.4.4 Reflection

In this case study, the complexity that accompanies working with both the perpetrator and victim of sexual abuse became apparent. The impact of contextual factors on abusive situations and behaviour was also highlighted. The process provided opportunities for Cheri and Aston to become more aware of the context of the experience, which seemed helpful. In terms of narrative therapy questioning, Aston's scholastic problems posed some difficulty in that the language I used had to be simplified and he might not always have comprehended my language. Cheri was reluctant to hear how Aston felt about the incident. This made it difficult for us to create ways for him to express his regret.

I maintained contact with the school counsellor, Mr. Linn, to whom the children had access every day. With their consent, I met with him once and we connected telephonically from time to time. After my last conversation with Aston and Cheri, he reported that they both seemed to be doing well emotionally at school. During the last interview in 2003 Cheri reported that things were going well at home and that she did not think about the abuse that much anymore.

C: It is going well at home.
I: What is it that is good? Why is it going well?
C: I don't do…I don't think about it anymore.

The use of metaphors (and a concrete object to illustrate the point) provided an appropriate resource for the process. At our final meeting, Aston and Cheri arrived playing with an interesting round wooden toy that consisted of colourful pieces that fitted together like a puzzle. They showed me how it worked. I thought that the toy could be seen as symbolic for the pieces of their lives fitting together in different shapes and forms. They found this analogy interesting and we explored what was helpful in getting the pieces to fit better.

I: Cheri, what was it like for you to talk together today? I know at the beginning you thought it would be difficult for you, but you said it would be okay for us to talk together today. What was it like for you to talk together with Aston?
C: It was nice.
I: Yes, I want thank you because I know it was not easy to talk together like this for the first time. But I think it is a problem that affects you both. Just as with the bundle of sticks you spoke about earlier, maybe if one hears what the other one thinks and feels, it might make that bundle even stronger. What do you think?
C: Yes, I agree.

Mita said that she had found the open talking about the incident helpful. She said that it gave her hope that they could eventually move towards more preferred ways of interacting. To me this indicated that the inclusive conversations with both her children had been helpful despite my initial uncertainty. When Aston was invited to see himself in terms of the reputation he would like to have in 10 years' time, he said he would like to be known as "a man who does not hit women; who treats women well; who has only one girlfriend; and who helps others with difficult or heavy things." Mita and Cheri were present at the celebratory meeting in 2005 and were presented with certificates of appreciation. Mita was commended for her "loving ways of seeting things right and for her commitment to her children's well-being." Appreciation was voiced for Cheri's "concern and care for her mother, for her willingness to work towards putting the puzzle pieces together, and for the courage she had shown in speaking out about abuse." Mita reported that her children were well and their relationship had improved. Cheri seemed happy and was full of smiles on that day. However, Mita also told me that she had a heart attack earlier that year. She praised God for still being alive.

7.6.5 Concluding thoughts on Case study 4

In this case study the interviews with Cheri and her brother Aston illustrated a therapeutic process that involved both the victim and perpetrator of an incident of sexual abuse. Aston was invited to take responsibility for his actions, while we also acknowledged contextual factors that contributed to the situation. Although Aston was therefore invited to accept responsibility for his abusive behaviour and other aspects of his development and lifestyle, equal weight was put on the engagement with his caregivers, in this case his mother, by "inviting them to find effective ways to promote self-responsibility and sensitivity in their adolescent charges" (Jenkins, 1997, p.208). The process can be summarised as one aimed at ensuring physical safety as well as co-creating a safe space for Cheri and Aston to speak about the abuse, whilst also searching for ways of restoring relationship and self-responsibility within the family.

7.7 Case study 5: Vanessa – "My mother's love"

…I always tell her it is my mother's love because she knows how much my mother loves me. And I always tell her that. She said, 'Vanessa, how can you handle these things?' I don't know. Maybe my mother knows that something happened to me but I have never told her.
(Vanessa)

7.7.1 Introduction to Vanessa ("V")

Vanessa grew up in Lavender Hill and lived there all her life, except between the ages of 15 and 19, when she moved to Delft with her mother and her three sisters. Her father was serving a five-year prison sentence for theft at that time. Vanessa's was twenty-one years old and had been married for a year when I met her. She was living with her husband in a "bungalow" (wooden shack) in a backyard that they rented from the owner of the property. The shack had a kitchen and bedroom, but no bathroom. Vanessa was unemployed and her husband was a casual labourer in the building industry, with no fixed salary, since his work depended on the weather and availability of jobs. Vanessa left school early, having completed grade 8. She was a committed Christian and active in her Pentecostal church. Vanessa was very fond of her mother, but was unhappy that her father "smokes drugs." I interviewed Vanessa three times in 2003 and had two follow-up interviews in 2004 (see Table 6). Vanessa heard from friends that there was a social worker at NWF. She plucked up the courage to seek help since she believed she needed to speak to "someone who is professional." The social worker informed her that she does not work with rape survivors, but referred her to me. Vanessa gave her permission to tell me the reason for the referral, namely that she was gang raped at thirteen.

7.7.2 Problem construction: Problem identification and problem agency

7.7.2.1 Secrecy about having been raped

As highlighted in Chapter 6, Vanessa experienced her secrecy about having been raped as problematic. Her reasons for secrecy included avoidance of distress and stigma. Her general pattern of withdrawal from people after the rape as well as her desire to protect loved ones also supported her silence. However, her belief that it would be helpful to talk about this experience informed her desire to speak to a counsellor. I asked her to tell me what she felt comfortable sharing. I regularly checked with her about the way the conversation was going for her. To facilitate a transparent note-taking practice, I asked her permission to take notes and I used a flip-chart so that she could see what I was writing. Vanessa said she had been waiting for an opportunity to talk to "a professional" about her life and seemed to trust me for this reason early on in our conversation.

> I: …And it is quite nerve-racking for you to be here today, you said on the way up here?
> V: Yes. It is the first time that I am speaking to someone about this, really someone who is a professional, who knows about these things. But I have to speak about it. It is almost eight years that I kept it inside.

As she described the events leading up to the rape, she experienced some physical and emotional reactivity and reflected on how difficult it was to talk about:

> V: I don't know what happened, but he smacked me. And I was shocked, you see. He smacked me. The others asked what went on – and they ran. And I was standing and I asked him: "What are you doing?" Then two other guys came from the road. I didn't know them. They were people who came out of the prison. I

don't know what he told them or whatever, but they grabbed me and they took me. You know, I was like small. I was scared of them because the one had a knife. And they took me (.) If it comes to that part it is so heavy to talk about it. It is like I am shivering inside, but I have to speak about it. I told myself that time and time again, because every day I think about it and it makes (..) it makes me mad just to see them walking. And they are now, they were in prison for a long time, but they are back now and I saw the one the other day and (...)
I: Did it bring the memories back even more?
V: Yes.
I: Were they in prison for something else, not the rape?
V: Yes. I think for something else, I don't know why. I left it just like that because they told me if I told anyone they'll burn my mother's house. And I never spoke about it.
I: So you didn't tell anyone at that time?
V: Only my best friend. Only she knew. And at that time I had my period when they raped me, when I got my period. And first the one raped me and then the other one. I wanted to stand up and then he hit me like that (demonstrates) in front of my chest and he also raped me. I have to speak about it, it is not easy. It sounds easy, but it is not.

The named problem, "the secret" surrounding the rape, was externalised in our conversations. We explored some of the problematic consequences it had on her life. I was curious about who was benefiting from "the secret." Vanessa stated clearly that she was not happy about the negative effects that "the secret" had on her moods, her ability to talk to others and her relationships. Keeping the secret was also linked to some negative identity conclusions. She said, "Secrets are making me bad inside." The way in which "the secret" was externalised was illustrated in Letter 1, in which her words were quoted:

From Letter 1:

> *You were unhappy about the effects of the secret, examples of which included "having moods", "not talking" to your husband and "being rude" to him. We reflected on the possible changes that sharing the secret might bring. You said: "If I don't speak about it, it is going to be there for the rest of my life. But I think if I speak about it, I will forget about it. Secrets are making me bad inside. If it is out, I can start over again and speak to people. I feel I cannot give advice if I have secrets. I would like to speak to young people but have to get rid of my secret first."*

Discourses that informed Vanessa's secrecy were discussed in Chapter 6. Vanessa was also concerned that her husband would take revenge if the secret came out, as reflected in Letter 1:

From Letter 1:

> *We wondered what the effects of speaking out might be in your relationships. You were concerned that people might see you differently if they knew that you have survived rape. You said that "people look up to you and have a lot of respect" for you. You were not sure if this respect would be affected. You spoke of your concern that "people won't come to you if they know you were raped." You did not want them to "judge" you. However, your words reflected your ability to separate your experience from who you are as a person: "I don't want to be someone who was raped. I don't think of myself as someone who was raped. I think about myself as someone who is normal, who had a good home, a mother who loved her."*
> *Although you said you know that your husband "is really against guys who rape" and speaks out against abuse against women and girls, you were apprehensive about telling him about the rape. You said that you know "he does not like violence", but you were nervous that he might want to hurt the perpetrators. Does he know that you respect his stand for non-violence?*

7.7.3 Problem effacement: Identification of alternatives and personal agency

Alternatives identified in our conversations centred on Vanessa's desire to break the power of the secret by speaking to her loved ones about the rape. Her ability to talk to God and the realisation that she was not to be blamed helped her to this end. Vanessa also seemed to become more aware of her personal agency in terms of

her view of herself as "normal" and "strong." Her future plans and desire to leave a legacy was also co-constructed in the conversations.

7.7.3.1 Desire to break the power of the secret

Factors associated with her desire to break the silence and to limit the effects of the secret were also discussed in Chapter 6. The "statement of position map" (Morgan, 2000, pp.43-44) made it possible to begin to develop a different story about Vanessa's preferences around secrecy. Attention was drawn to some of Vanessa's preferred ways of living through my interest in why she was unhappy about the effects of the secret, as illustrated in Chapter 6:

> I: And in terms of your future, do you think you are at a point now where you have witnessed your own strength so that the rape is not going to hinder you from where you want to go?
> V: If I don't speak about it, it will. I think if I speak about it, maybe I will forget about it.
> I: To whom would you like to speak?
> V: My husband and my mother.
> I: why is it quite important to you to speak to them?
> V: I want to, because I want to go on with my life. I have come a long way.
> I: Secrets are not really working for you?
> V: It is making me bad inside. I don't want to be…I used to be like open, and I know if I speak about it, that secret will be out of my life. …I will start over again. I can freely speak. I know I can begin my life over again if I just speak about it. It makes ….I can't speak to people or give them advice. I give them advice without them knowing, but I can't give them advice really because I've got a secret. I always tell them not to keep secrets and they all think that I don't.
> I: Okay. So have to practice what you preach?
> J: Yes (laughs).

7.7.3.2 Ability to talk to God

Apart from speaking to her best friend, Vanessa also spoke to God. These conversations stood in contrast to her silence in relation to others and gave her "something to go on":

> V: …We went to church. I had something to go on. I didn't forget to pray at night, I knew there was a God that I can speak to, and mostly or all the time I spoke to God. I thought that He was there, that He was listening to me. My mother always taught us, "There is a God you can speak to."

7.7.3.3 Stepping away from self-blame

The realisation that she could strive for a better life and future was linked to Vanessa's discovery that the rape was not her fault.

> V: You still have a life. I mean it is not your fault. That's what I recently discovered, "It is not my fault."

She discovered this by taking note of a role-model who spoke on television about being raped. This woman emphasised that, despite discourses to the contrary, it was not the victim's fault.

7.7.3.4 Robust sense of self

Vanessa did not label other women who were raped. This contributed to a the development of a "robust sense of self", based on the realisation that she could think about herself as "normal" and "strong" despite the rape:

V: …I don't think about myself as someone who was raped. I put that out of my mind. I think about myself as someone who is normal, who had a good home, a mother who loved her. I never think I was raped. When I talk about it then it comes back to me, all those things.
I: Do you think you can be both those things. A strong person, who has a loving mother, who comes from a good home and who also, was raped. It does not have to be the one or the other. Do you think it all can be part of what happened in your past…it doesn't define who you are as a person?
V: Yes, I think so…

7.7.3.5 Desire to leave a legacy

Vanessa had a sense of knowing about how to proceed in life (White, 2004). She wanted to become actively involved in shaping her future and to do things that counted. I was curious to find out about activities she was already engaged in that "counted."

V: … I am at that stage where I just want to do something. I don't want to keep on sitting. Like I am seeing my future, it is going to be nothing. I don't want my future to be nothing, it must count. Not to become someone, but just to do something with my life. For my children, you know. I don't want my children to have a lack of education. I want to have all the answers if they come to me when they are at school.
I: Or some answers {laughs}? And so you said you want to make your life count in some way. Is there anything else, apart from work that you are maybe doing now, that you feel you are making a contribution or that it does count in some way?
V: Okay, not actually. I am part in the youth at the church. I am the secretary there and I sing in the choir. And that's all. And I come to therapy {laughs}. That is another thing.

The legacy Vanessa wanted to leave in the wake of her experience was to help other young girls and women who had been through similar experiences. It became apparent that secrets stood in the way of her wish to use her experience to the benefit of others. Vanessa said, "I would like to speak to young people but have to get rid of my secret first." The secret also stood in the way of her ability to pray for others without feeling guilty about not speaking openly to her mother.

I: And when you were open, did you not have this "stuckness"?
V: No. I never felt guilty about anything then. But now I feel guilty when I hear about secrets. I can't speak openly to my mom. She will say, "You must pray for that person" and I will think, "How can I pray for someone and I still have a secret" or so. It feels so difficult. That is why I want to be open.

Her unhappiness about the effects of the secret also spoke of her desire to be congruent in terms of her words and deeds, to "practise what she preached." She felt that she could not give advice if she was not willing to implement it herself. Her commitment to being truthful and open thus became more known. An aim of narrative therapy is to restore a sense of control and to create opportunities for a greater "appreciation of adaptive resources" (Herman, 1997, p.204). "Double listening" (White, 2004, p.48) allowed for a focus on aspects of her story that spoke of agency. Her actions could be seen as small acts of resistance which stood outside the dominant story of powerlessness during the rape. I noticed the fact that she "said no" and "did fight back":

V: …I said no. I was crying already because of the first one, I mean I was young; I didn't know anything about sex or anything. And it was really heavy. And when I wanted to fight against him, he just hit me.
I: So you tried to fight back, but they just…you said, "No."
V: Yes, I did fight. Yes, I did say no. And I was walking like at the back when we came back, through Vrygrond.

Vanessa became aware of the limitations of isolating oneself through secrecy, but also became aware of her strengths. Her awareness fit with an aspect of recovery that Herman (1992) describes:

> The survivor remains fully aware of her ordinariness, her weakness, and her limitations, as well as her connection and indebtedness to others. This awareness provides a balance, even as she rejoices in her strengths. (p.204)

7.7.4 Narrative practices aimed at thickening the alternative story

7.7.4.1 Therapeutic documents and letters

Letter 1 was written after the first interview. As noted in Chapter 4, therapeutic Letters serve to "rescue the said from the saying of it" (White, 1998). Extracts from letters were included in this section of this case study as a means of illustrating how they functioned to "thicken the alternative stories." Letter 1 was introduced with an explanation of why it was written and the opportunity was also used to acknowledge the courage that it took for Vanessa to come and talk to me. Letter 1 extended the conversation about Vanessa's faith and her ability to talk to God, by asking a question about the implications of her faith for her life.

From Letter 1:

> *I am writing this letter to remind us of some of the things we spoke about and to reflect on our conversation. As we were talking, I began to understand why your friends and family say that you have "a lot of strength." That you want to get rid of "the secret" of being raped when you were 13 speaks of this strength to me. Do you also see speaking out as a courageous step?*
>
> *You told me about your belief in God and being able to talk to Him. I wondered if your faith was related to your knowledge that your "life does not have to be messed up due to rape." The interview you saw on TV with a successful singer who had also been raped as a girl confirmed this for you. You thought that people respected her more because she was doing something with her life.*

Vanessa's "referred identity conclusions" were more richly described in the re-telling of our conversation in Letter 1. Reflections on her knowledge that it was not her fault and on ideas about blame were included in Letter 1. Implications of the realisation that it was not her fault were explored as well:

From Letter 1:

> *You agreed that one experience in your life does not define who you are as a person. You said that some girls who had been raped "give up." They do things like prostitution and drugs. They "don't think anything of themselves." However, you said, "I know that I can make something of my life or that I can speak to other young people if I can have the courage to tell them what happened." Would you tell them (as you have told yourself) that they "still have a life" and that it is "not their fault"?*
> *You brought up some ideas around blame. You said: "I always blamed myself, but now I don't." When someone who had been raped comes to you, you now tell them, "Don't blame yourself." You said: "I recently discovered it is not my fault." I wondered what has helped you to make this discovery and if this discovery has strengthened you in your desire to get rid of the secret?*

Letter I was also used to extend the conversation by expressing curiosity about Vanessa's ability to "handle things":

From Letter 1:

> *I am as curious as your friend to find out more about "how you handle these things." You said that your friend's support contributed to make you "so strong." She witnessed you "speaking up for yourself" often in the time that you've became friends at the age of two. You told me that you "can tell her anything." She was the one person you confided in about the rape. You said she "never judges" you and respects you. Would you say that she is someone who could have quite valid descriptions of who you are as a friend and person in the community? I would like to hear from her about what contributes to her respect for you.*

Letter 1 was concluded with an expression of appreciation for the trust that Vanessa placed in me. It also served to acknowledge how our conversations had already impacted and benefited me in terms of what I had learnt:

From Letter 1:

> *Vanessa, I thank you for trusting me with your story. It was a privilege for me to meet you. I have already learnt a lot from you about courage and the hope that lives in people if they have love around them – like your mother's love, your husband's love and God's love.*

I read Letter 1 with Vanessa at our next meeting. She said that she was appreciative of it and was excited about having some of her words captured for the future. She reflected that the emphasis on her mother's love and God's love in her life was accurate.

At a follow-up meeting I asked Vanessa about her experience of receiving the letters. She responded as follows:

> V: I think the letters are a wonderful idea. I really think that writing a letter is good therapy, because it makes me feel good that someone wrote me letter. I feel so important. I can also show it to people who was raped. And the people I meet are men and women who went through hurt - young boys and old men, women and young girls.

7.7.4.2 Re-membering conversations and 'saying hullo again'

The contributions of significant people such as her husband, best friend and mother were re-membered in the interviews. The fact that Vanessa was married was significant in terms of the way she viewed herself. Discourses about marriage and the knowledge that her husband would stand up for her, assisted her to challenge the fear of what others might think of her:

> I: How do you think it changed, that you don't have that feeling anymore that everybody knows?
> V: I think I am married; I have got someone who loves me. I think it is that, because since I am married and since we went out, I have not thought about it, because he is someone – nobody can say something about me – he will cover up.

Having a friend to talk to, someone who "understood" and "did not judge", was greatly appreciated by Vanessa. This friend was also someone who acknowledged and appreciated her as a "strong" person. I was curious to hear more about this. The idea that identity is relational, constructed in relationships with others, informed my questions:

> V: …my best friend says, "Vanessa, how can you handle all these things? You have never spoken to anyone. You are like so strong." "I am not strong", I said.
> I: There were a few things that you said – the one thing was that your friend said that you are "so strong." What do you think she saw in you that made her say that?
> V: She thinks I - I am not soft, you see - I am hard. If someone tells me something, she knows I'd rather fight or something. I'll say, "You don't speak to me like that, or so." I am always offensive. And now (.) she thinks I am strong because some people…are soft and they don't speak to anybody, but I am like talkative. Only with her, though. With other people I am always shy.
> I: What is her name?
> V: Elizabeth. She's been my best friend since we were two years old. We went to crèche together.
> I: Oh, really? That is amazing.
> V: She understands me. I can speak to her about anything. She never judges me. She never tells anyone, you know.

Vanessa repeatedly reminded her friend that it was her "mother's love" that strengthened her through difficult times. Her mother's love was appreciated as a sustaining power in her life. In some ways, however, her mother's belief in her strength prevented her from showing vulnerability.

> I: …how does that affect you? Is it almost like you have to be the strong one or are there times when you can actually admit to someone that you are not feeling that strong?
> V: I don't ever admit to someone. I try to admit to my best friend. I always tell her that I am not so strong. I say, "I am also soft." She says, "No, you handled a rape case." I don't know. I always tell her, "It is my mother's love", because she knows how much my mother loves me. And I always tell her that. She said, "Vanessa, how can you handle these things?" I don't know. It is because maybe my mother knows that something happened to me - but I have never told her that.

Vanessa thought that it could also have been her mother's love that helped her to overcome fear. The way her mother brought her up to "stand up for herself", was something that she appreciated. Her mother's love for her contributed to a robust sense of self. Her mother saw her daughter as "pure gold" and Vanessa had this description of herself to re-member at times when she needed encouragement. Vanessa made explicit the way that her mother's love contributed to her make her "feel good about" herself:

> I: So does your mother's love sustain you and make you feel stronger?
> V: Yes, I think so. She thinks the world of me. She thinks I am the strong one, you see. She thinks if she gets into trouble I will always be there. And my mouth is always in. I won't let someone hit my sisters either. It makes me feel good about myself. It makes me feel that I am someone and that she thinks something of me.

> V: …I saw the one and I wasn't scared.
> I: What helped you to "stand up to" the fear?
> V: I don't know - maybe my mother's love. Because she really…before this happened or after - but she never knew - she always told us, "Stand up for yourself. Always love someone else and you must always forgive. No matter what people do to you, you must always forgive." I think it was my mother's love. It always comes back to that. She loved us continuously. She never made…we were pure gold. She never said this one is better. She always treated us the same. …Just my mother's love.

Vanessa's words about her mother's love were captured through verbatim quotes in Letter 1:

From Letter 1:

> *You said that your "mother's love" played a big part in your strength. She taught you: "Always stand up for yourself. Always love someone else. Always forgive." She loved you and your three sisters continuously and treated you all the same. She "thinks the world of you" and sees you as "the strong one." You said this makes you "feel good about yourself" and it gives you the knowledge that you "are someone." Your father also knows you as "someone who will stand with those you love."*

However, ways in which her mother's belief in her strength contributed to her "putting up a front" were also reflected on in Letter 1. I was curious to hear if she was able to step outside of these limitations around showing vulnerability and was interested to know if her mother knew what kind of support she found helpful. I hoped that this question would be considered and discussed at home:

From Letter 1:

> *You said that you "don't show your parents when you are scared or that you are soft." You "always put on a front." Have there been times when you felt you had to be the strong one, when actually you could show that you "are also soft"? They often depend on you and you "don't want them to pity you." Do you think there is a chance that your parents' respect for you might be strengthened rather than changed to pity if they realise that you have coped and have established a life for yourself? You said you "don't need the kind of constant support" that you mom would usually offer. Does she know what support you would appreciate from her?*

At our third (and last) interview in 2003 I was surprised to hear that Vanessa had shown Letter 1 to her mother and to her husband. I did not plan the use of the letter as a tool to give voice to "the secret." In retrospect, Vanessa said it was easier to let her family know about the rape in this manner. The letter had the additional advantage of giving them insight into our conversations. Furthermore, it served as a tool for engaging in a "taking-it-back" practice, in that their significant contributions were taken back to them. It described how they had been helpful in the past and could continue to be helpful in the future. Through the letter, Vanessa was able to take some of the meanings she attached to her mother's love back to her mother. I would have been interested to hear how her mother received the knowledge of the sustaining power of her love and to find out more about the history of this love.

7.7.4.3 Building a wider audience: Witnesses, communities of concern, definitional ceremonies

As mentioned earlier, Vanessa contacted me again in 2004. This gave me the opportunity to ask and obtain her consent for the inclusion of her story in a poster that I prepared for presentation at a conference of the South African Family and Marriage Association (SAAMFT) in Durban in 2004. The presentation was titled "My mother's love." It included an introduction to Vanessa's story as well as extracts from our first conversation. These extracts focused on how the companionship of Vanessa's best friend, her marriage to her husband, and the certainty of both God and her mother's love had been examples of people "doing hope." Extracts of my letters to Vanessa were also included. Vanessa got an opportunity to read, edit and comment on the poster. The rationale for the poster presentation was to create a platform for the voices and experiential knowledge of a participant from Lavender Hill to be heard by conference attendees. The goals stated on the poster were to describe the impact of trauma on the life of a woman living in Lavender Hill; to show how people close to her, especially her mother, were "doing hope"; to demonstrate that narrative therapy could be used when working with trauma; and to invite written feedback from readers in the form of reflections regarding participants' stories and the effect of hearing these stories. A couple of reflections were offered by readers and I was able to take these back to Vanessa. These included being moved by her "courage" and "bravery" and by the "true freedom she found in God." Her story was said to have "given hope"; it was experienced as "very inspiring"; and it was reported to have "touched hearts."

7.7.4.4 Reflection

Vanessa found employment after our third and last interview. She said that the short process was helpful. Letter 1 was used to celebrate helpful aspects of our conversations and to reflect on future directions. An extract is included here:

From Letter 1:

> *In your life, you seemed to be reclaiming some of the things that you lost for a while after the rape, like "being out-going and self-confident." You used to feel that "other girls were better than you" and that "people could see that you were raped." However, now that you are married, you seemed to have reclaimed some self-confidence in your own home. Are there other areas or aspects of your life that you have been reclaiming? How has your relationship with God helped you to reclaim who you are in His eyes? You mentioned your desire to study again and I wondered if this would be a form of reclaiming your life?*

In a sense, Letter 2 can be seen as a celebratory re-telling of the helpful aspects of therapy. The conversation was extended by the inclusion of questions Vanessa could reflect on. Letter 2 read as follows:

From Letter 2:

Thinking about our last conversation brings a smile to my face. I was encouraged to hear that you had taken a big step to follow through on your knowledge that the "secret was not good" for you. You did this by showing the Letter I wrote to you to both your mother and husband as a means of telling them about the rape. I suspect your friend would not be surprised to hear about your courage since she has witnessed this in other areas of your life. Were you surprised by your courage or did you know you had the ability to speak out?

You told me that getting rid of the secret has made you "free." You now have "more confidence in yourself." You "can speak" and "don't feel watched" anymore. You "have nothing to hide" and "feel healthy" again. You were surprised to realise you "feel like going out and dressing up"!

I had some questions which you might want to think about:

Could holding on to these changes help fulfil your desire to "do something with your life?"

How may it assist you in "reaching the goals you have in mind: going to night school, doing a computer course and speaking out against abuse and rape with other young people?"

What or who could help you to keep these reclaimed knowledges about yourself alive at times when self-doubt might want to steal them?

Could these knowledges also help you in times when you "feel shy", when your "words get stuck" or when you "worry about what you said"?

Vanessa, as we discussed, I hope I will be able to meet your husband some time in the future. Please feel free to contact me if you'd like us to meet again. Regards, Ilse

Vanessa's said the therapeutic process contributed to feeling "free" and "being more confident." She could "speak" and "didn't feel watched" anymore. To me, the freedom that Vanessa spoke of reflected the way narrative therapy can co-create alternatives to "restricting" stories of people's lives. This freedom seemed to be felt in different domains of living, socially and in terms of her sense of self. Vanessa also gained freedom from the oppressive thoughts associated with discourses of guilt and secrecy. When asked to reflect on our conversations at a follow-up meeting Vanessa responded as follows:

> V: The conversations had a wonderful impact on my life and the relationships with my family and friends. Ilse, my whole life has changed. I am not scared or shy to say that I was raped and that I forgive. So many people come to me with their problems and when they feel ashamed of themselves, I can tell them boldly that I was also raped and that they must not give up on life. I thank God for sending you my way. My sister is not scared anymore to speak to me about her being raped and I am not ashamed to tell my family and my husband. It changed my life completely - I can tell them of my past boldly.

7.7.5 Concluding thoughts on Case study 5

Vanessa's story illustrated the freedom that may be gained in other areas of life when secrecy around rape is broken. Together we constructed a "double-storied account" (White, 2004) of her experience of rape and the silence that surrounded this experience. I tried to understand the impact of trauma on her life, but also encouraged curiosity about her responses to traumatic events and what this might say about her preferred values, purposes and identities. In this way, narrative therapy was used to create "islands of safety" for Vanessa to stand on when reviewing traumatic experiences. She said this contributed to feeling "free" to continue with her life. Breaking the silence about the rape also enabled her to reconnect with important people in her life. This case study illustrated how Vanessa's mother's love was 're-membered' and how narrative therapy practices contributed to restoring control to her so that she felt empowered to continue with her life a preferred way.

7.8 Discussion of case studies

In this section the case studies are discussed by focusing on three ways of reflecting on change. Firstly, Herman's (1992) well-known work on trauma and recovery is used as a reference point. Ideas that are context-specific with regards to recovery from trauma in a low-income community in South Africa are also brought into the discussion. Next, Muntigl's (2004) ideas of therapeutic change are touched on. Finally, in line with narrative therapy, the emphasis is placed simply on participants' stories and how they seemed to have changed. Ways in which certain stories seemed to be linked to hope are also highlighted.

7.8.1 Recovery

Within the field of psychology, different discourses of "recovery" after trauma inform different therapeutic approaches. Van der Merwe (1989) highlights that it is important to note that recovery takes on "an idiosyncratic course, depending on the victim's coping skills, mental and physical health, support systems, the nature of the trauma, life history and extraneous factors, such as recent loss or a repeated trauma" (p.70). Even if assuming that recovery is always an idiosyncratic process, a general definition of recovery is provided by Repper and Perkins (2003): "Recovery is about rebuilding a meaningful and satisfying life, whether or not there are ongoing or recurring symptoms and problems … Recovery is not about independence, it is about interdependence" (p.90). From this perspective recovery may involve "restoring hope" (Repper & Perkins, 2003, p.51) since it is "a way of living a satisfying, hopeful, and contributing life even within limitations and involves the development of new meaning and purpose in life" (Anthony quoted in Repper & Perkins, 2003, p.46). These ideas fit with notions of preferred ways of living or alternative stories that are informative of a narrative therapy approach.

Wirtz' (2003) findings with regard to therapeutic practices that trauma survivors identified as especially helpful in terms of recovery include the following:

- Therapists who positioned themselves by taking an active stand and forming an alliance with the client
- Liberation and empowerment advocated as core concepts in therapy
- Having choices about therapeutic options most meaningful to them
- A focus on the fact that one's choice about how to respond cannot be taken away
- Respect for local forms of healing and curiosity about how they coped
- Therapeutic practices that are aligned with fighting for justice and reconciliation
- Therapeutic relationships with less restrictive boundaries in terms of the expression of care
- Conversations that do not involve "just talk and self-disclosure", but contribute to alternatives
- The use of images, story telling, music, art, and humour
- Facilitating a search for resilience and courage
- Help with housing, food and shelter so that narration can develop

Herman (1992) outlines different stages of recovery after trauma. The first stage involves establishing safety and the second involves strategies to empower and restore control. In the third stage, efforts are made to reconstruct the trauma story and to restore connections. It is important to remember that movement between stages should not be viewed as a linear progression, but rather as a complex process. In this section, I attempt to show how these aspects of recovery were viewed and attended to through the narrative therapy interviews conducted as

part of this study. In terms of restoring connections, participants' connections to others; their connection to preferred ways of living; their connection to God; and their connection to "a sense of self" (White, 2004, p.69) are discussed.

7.8.1.1 Safety within the context of a therapeutic relationship

Establishing safety is said to be an important step in healing relationships (Herman, 1992). Fostering a feeling of emotional safety goes hand in hand with developing a therapeutic relationship of confidence and trust (Smith, 2003). In this study, relational safety, created in relationships in the therapy context and in other areas of people's lives, is stressed. However, in conjunction with emotional and relational safety, physical safety is important. Since participants lived in Lavender Hill, an area that cannot be considered safe, Crawford-Brown and Benjamin's (2002) suggestion to identify areas in people's lives where they do feel a sense of safety was implemented. Participants considered their homes relatively safe spaces. Ironically, however, both Cheri and Francis were abused in their homes. The fact that Kate lived opposite a drug-dealer compromised her family's safety at home. Tina lived opposite the alleged perpetrator of her son's murder and was confronted with seeing him often. The task of working towards establishing safety – physically, emotionally and relationally - was therefore a complex one.

In the selection of an interview-venue for this study, the need to establish a "safe environment" (Herman, 1992, p.162) from which to work, was taken into consideration. The New World Foundation has implemented various safety measures such as access-controlled entrances to the building. Furthermore, signs on the walls indicate that the building is "a gun-free zone." These measures became necessary after armed men entered the building during gang wars in the past. The interviews were therefore conducted in a relatively safe space. However, outside of this venue participants' physical safety could not be guaranteed. In fact, Aston and Cheri reported that they had to walk "the long way" to get to the venue due to fear of gang-violence en-route. For some participants, physical safety was constantly compromised. In Case study 1 Francis and her children continued to live in a context of domestic violence for a long time. The need arose for this family not only to find a physical place of shelter, but also to develop a plan for "future protection" (Herman, 1992, p.165) by assessing the degree of continued threat. I encouraged Francis to get a protection order against her husband and to make plans to ensure her children's safety. In conversations with Mita (Case study 4), the need to ensure that Cheri was given a safe, private sleeping space was stressed. Narrative therapy not only supports the notion of assisting the development of healing narratives, but incorporates the ideals of the "Just Therapy approach" (Waldegrave, Tamasese, Tuhaka, & Campbell, 2003) that stresses the importance of focussing on broader social structures and assisting people in getting access to basic needs such as housing, food and shelter.

White (2004) takes the priority of establishing safety a step further by addressing the need to co-create "safe places in which to stand in the territory of memory" (White, 2004, p.15). He argues that safe spaces can be created "in the context of therapeutic inquiry informed by narrative understanding of psychological pain and day-to-day emotional stress" (p.14). White (2004) describes the development of safe places as "at first islands, then archipelagos, and then continents – that provide … platforms for speaking about what hasn't been spoken

about" (p.15). In the case studies safety was provided in richer descriptions of participants' identities that created "safe places" (White, 2002, p.15) from which to review memories. An example of this development of safety in the territory of memory emerged in Case study 5. The therapeutic relationship that had been established in the three interviews in 2003, as well as the knowledge Vanessa reclaimed that the rape was "not her fault" provided a "space" for her to stand. This enabled her to make a follow-up appointment the next year to talk about sexual abuse at the hands of her father. Her request was precipitated by the discovery that her father also abused her sister.

In order to negotiate safe conversational processes in this study, the decision to talk about past experience lay entirely with the participants (Bird, 2000). Such a process goes hand in hand with empowering the client and restoring control. These aspects are discussed next.

7.8.1.2 Empowering the client and restoring control

Therapeutic contact in low-income South-African communities often covers only one to three interviews (Crawford-Browne & Benjamin, 2002). In the light of this reality, Crawford-Browne and Benjamin (2002) suggest that each interview must empower the client by developing a sense of control and partnership, rather than dependence. In this study, care was taken to listen for even the smallest signs of control (even if this was done through refraining from doing anything) that participants had in traumatic situations and I was curious about how these influenced the course of events. In all case studies I tried to engage in double-listening in an attempt to hear the trauma story as well as the story of participants' active response. Double-storied accounts of trauma were therefore co-constructed so as to assist participants in reclaiming skills and regaining a sense of control (Crawford-Browne & Benjamin, 2002). In Case study 1, for instance, Bella reported being much less apathetic about the situation in Lavender Hill. She was planning involvement in a variety of social problem-solving activities in the community. Similarly, Kate (Case study 2) planned and executed her family's move out of Lavender Hill after our interviews. With Kate's help, Francis (Case study 3) decided to leave her husband when she was offered a position that included accommodation. The emphasis on context in Case study 4 and Case study 5 allowed Cheri and Vanessa to bear witnesses to the circumstances that had silenced their voices (Collet, 2003). Vanessa's (Case study 5) discontinuation of therapy has a positive side, since she found much wanted employment.

Since this study was conducted in Lavender Hill, where people live with limited resources in a context of continuous trauma and poverty, an expanded role as therapist was needed. In all the case studies I leaned towards a position that constructs less rigid boundaries between researcher and participants, or therapist and clients, seeking rather to be "collaborative" (White, 1995, p.63). As noted by Smith (2003), the boundaries and parameters of being a psychotherapist may often need to be "stretched" (p.303) in working with trauma survivors, expanding the therapists' role to that of an "accompanier" (p.303). Therapists may be enlisted to help in a variety of ways, including being advocates and translators. These roles could be linked to Herman's (1992) description of the work of therapy with trauma survivors as "both a labour of love and a collaborative commitment" (p.147). From a narrative perspective it is not unusual for therapists to take up the role as advocate, translator or mediator (Kotze &

Morkel, 2000). For instance, I contacted prison authorities to help Francis to establish her son's health status; I phoned various state mental health agencies to ensure that Sandy received psychiatric care in combination with our conversations; I contacted the headmistress at Sandy's school to establish what his schooling options were; and I phoned the police to enquire about the procedure for reporting crimes.

The need to address power differences and to reflect on their effects was highly relevant to this study. Herman (1992) argues that the therapy relationship is "unique because of the contract between the patient and the therapist regarding the use of power" (p.134), where "the patient enters therapy in need of help" (p.134) and thus by virtue of this fact "voluntarily submits herself to an unequal relationship in which the therapist has superior status and power" (p.134). As a narrative therapist I actively attempted to counter and deconstruct this power imbalance. I needed to be mindful of the ways in which power was shaped systematically and structurally, especially since I was an outsider working in a low-income, so-called "coloured" community. Good intentions and depth of caring were "not enough" (Heward, 1993, p.185). Narrative therapy practices allowed me to always be in a process of trying to give power up responsibly. I attempted to embody my power in such a way that it could be "transformed into mutually creative energy" (Heyward, 1993, p.185) between participants and myself. As highlighted in the case studies, I attempted to address the power imbalance by privileging participants' voices in the conversations and letters; clearly positioning myself as non-expert in terms of their lives and the meaning they attributed to events; and checking how the conversation was going for them. These form part of establishing "decentred practice" (White, 1997, p.200), discussed in Chapter 4.

In each case, a collaborative stance was communicated by reminding participants that I am interested in learning about the context-specific ways in which they were coping with the experiences that they deemed traumatic. My dual role as researcher / therapist allowed me to communicate the fact that I, as outsider to their community, was not the expert on their lived realities. My power as researcher and therapist was questioned as I consulted continually with participants about the way the interview was going for them. Herman (1992) agrees that "the survivor should still be consulted about her wishes and offered as much choice as compatible with the preservation of safety even where rapid intervention is required" (p.134). Smith (2003) also emphasise that clients should be enlisted as active participants in prioritising their needs and desires. Smith (2003) notes:

> Elevating the client in terms of the therapeutic relationship, helping him or her realise that it is a relationship between two human beings – not just an authoritative helper and helpless victim – is a process that helps the client to find his or her voice in the relationship. One valuable way the clients can be empowered in the therapeutic relationship is by clinicians taking a "collaborative" rather than an "expert" stance. (p.301)

I argue that narrative therapy is compatible with the discourse of liberation psychology (Wallace, 2003) since both promote an awareness of the power relationship, critically examine dialogue to see if it fosters freedom or serves to oppress, and question oppressive practices explicitly (Heyward, 1993). The narrative practices of "consulting your consultants" (Epston, 1998, p.128) and circulating clients' local knowledges through the establishment of communities of concern, were use to transform suffering into knowledge. The practice of "consulting your consultants" was used when Bella (Case study 1) was invited to act as witness to a conversation with Kate (Case study 2) and Francis (Case study 3) respectively. This demonstrated to Bella that

she was seen as knowledgeable and compassionate. She reflected that she regained a sense of purpose by feeling useful in helping other people. This may have been related to the overall improvement in psychological health that she reported. Bella, as well as Kate, transformed the meaning of their personal tragedy by making it the basis for social action.

Herman (1992) confirms that "while there is no way to compensate for an atrocity, there is a way to transcend it, by making it a gift to others" (p.207):

> Social action offers the survivor a source of power that draws upon her own initiative, energy and resourcefulness but that magnifies these qualities far beyond her own capacities. It offers her an alliance with others based on cooperation and shared purpose. (p. 207)

Some participants linked concern for the next generation to the question of prevention. There actions highlighted that the "trauma story is part of the survivor's legacy" (Herman, 1992, p.207). Herman (1992), however, points out that only when it is "integrated can the survivor pass it on, in confidence that it will prove a source of strength and inspiration rather than a blight on the next generation" (p.207). This was visible in many of the case studies. In Case study 1 Bella was able to use her trauma story as a source of strength and inspiration for her children, for others in her community and beyond her community (as seen in the responses to the telling of her story at a conference). The legacy of her survival inspired others. Kate (Case study 2) wanted to be a source of strength in the community by being united with others who has lost loved ones to death. In Case study 4 Vanessa could tell her story of surviving rape to others victims in an attempt to inspire them to carry on.

7.8.1.3 Reconstructing the trauma story: Telling and re-telling

Reconstructing the trauma story, a stage of recovery described by Herman (1992), is approached differently in different therapeutic approaches. Ideas about how stories can or should be told differ. Crawford-Browne and Benjamin (2002) discuss the implications of working in a context of continuous trauma for reconstructing trauma stories. As highlighted in Chapter 1, they argue that lack of safety in combination with the evocation of previous incidents may make a therapeutic process based on the premise that the client needs to cathart and verbalise pain to gain insight into a traumatic experience, extremely distressing. If there is a strong possibility that that client may again be victim of violence in the near future, they question whether it is helpful to relive the story as there are no guarantees about their physical safety. The premise is that people do not regain any control simply through retelling. In fact, as Crawford-Browne and Benjamin (2002) point out, detailed telling of the story encourages confrontation in a context where the natural defence of avoiding aversive stimuli may be required for survival and functioning in a violent community. These defences could therefore be seen as adaptive and should be respected as such. These ideas fit well with narrative therapy ideas. In this study I negotiated with participants the requirements for psychological safety, namely that they could decide what they wanted to talk about and what not. If they wanted to talk about a traumatic event, they could signal to stop the conversation before being overwhelmed by emotions (Bird, 2000).

Herman (1992) points out that "the fantasy of fast, cathartic cure" (p.174) and "the desire for a quick, magical cure is fuelled by images of early, cathartic treatments of traumatic syndromes which by now pervade popular culture" (p.172). She warns against "premature or precipitate engagement in exploratory work, without sufficient attention to the tasks of establishing safety and securing a therapeutic alliance" (p.172). Smith (2003) agrees that there is significant danger of "re-traumatising clients by adhering strictly to information-gathering techniques" (p.300). He notes that insisting on uncovering the whole story could be counterproductive if the client was emotionally unprepared to do so. In accordance with a narrative therapy approach, each participant was seen as the expert in terms of emotional preparedness to speak about traumatic events. Therapeutic practices that make revisiting the details of traumatic experiences imperative could be re-traumatising. Bird (2000) warns that re-traumatisation occurs when people engage with their memory to the extent that they experienced what happened in the past in the present. She proposes that "if telling is important for people, then it must occur by reflecting on the past rather than by becoming submerged or lost in it" (p.50). These ideas informed the way in which telling was engaged with in the case studies. As narrative therapist, I agree with Burns (2002), Smith (2003) and Herman (1992) that it is better to err on the side of safety. In narrative therapy "telling is not a prerequisite for healthy psychological functioning" (Bird, 2000, p.51). However, an exploration of the effects of carrying knowledge in silence can be negotiated. Such an exploration may support people in their decision or may contribute to them deciding to speak. In this study Herman's (1992) emphasis on "truth-telling" (p.148) is thus adapted to fit with a narrative approach - the emphasis is on uncovering or richly describing neglected aspects of the story that reflect clients' resilience and ability to "do hope" for others. In the case studies, "telling" involved reflecting on the meanings that the experience had taken on, while exploring alternative meanings. Metaphors were used to facilitate telling and re-telling in meaningful ways. The metaphor of a journey, used by some participants, created a "view of the future with many potential directions" which punctuated "the notion of choice" (Adams-Westcott & Isenbart, 1990, p.50). Bella and Nina (Case study 1) were invited to think about the obstacles they had overcome in their journeys and what this said about them. The metaphor of a puzzle was used with Cheri and Aston (Case study 4) since they brought a puzzle to an interview. The concrete image helped them to remain aware of the complexity of their situation and that all the "pieces" do not easily fit. Different and sometimes contradictory perspectives on the problem could also be highlighted.

Griffin (1992) reflects that when "looking back over a life, certain seemingly small events later take on the aura of prescience, as if pointing to what will come" (p.207). Weingarten (1998) explains that "simply believing that the current version of our lives is just that, a version, can promote the search for alternatives to a story that diminishes us in its performance" (p.11). Herman (1992) advocates the need for greater appreciation of traumatised people's "adaptive resources" (p.204). In narrative therapy, describing adaptive resources involves attending to peoples' responses to trauma through "double-listening" (White, 2004, p.48) - listening for "signs of what the person has continued to give value to in life despite all that they have been through, and for any expressions that might provide some hint of the person's response to trauma" (p.48). Participants were thus assisted to articulate some of the painful consequences of trauma, while also allowing a focus on what their response and evaluation of traumatic experiences say about their beliefs, values, hopes and dreams (Mann, 2005). For instance, Cheri's (Case study 4) silence was informed by her love for her mother. Aston's (Case

study 4) commitment to not being abusive in future was confirmed by his acceptance of Cheri's reluctance to forgive him. Vanessa's (Case study 5) initial silence was informed by her refusal to be diminished by the label - "someone who was raped." Bella's (Case study 1) prayers and ability to be thankful while in prison spoke about her belief in God and her hope for a democratic future for her country. Kate, Tina and Hilda's (Case study 2) grief spoke of their love, while the active stance they were taking in speaking out against violence reflected their passion for justice.

This study provided a context for participants to share what they felt safe to share about their experience of trauma and provided opportunities for both telling and re-telling. Herman (1992) distinguishes between private (confessional and spiritual) and public (political and judicial) telling, both of which are catered for in narrative therapy practices:

> When the survivor tells her story only to one person, the confessional, private aspect of testimony is paramount. Telling the same story to a group represents a transition towards the judicial, public aspect of testimony. The group helps each individual survivor enlarge her story, releasing her from her isolation with the perpetrator and readmitting the fullness of the larger world from which she has been alienated (pp.221-222).

The "definitional ceremony" that formed part of Case study 4 is one example of how narrative therapy practices create opportunities for re-telling that incorporates the public aspect of testimony. The practice of "consulting your consultant" and the way in which this idea informed inviting Bella (Case study 1) as a conference presenter, is another. Herman (1992) argues that "in the absence of a socially meaningful form of testimony, many traumatised people choose to keep their symptoms" (p.184). Weingarten (2000), who wrote about different forms of witnessing, explains that she has started seeing voice "not as an individual's achievement of self-knowledge but, rather, a possibility that depends on the willingness of the listeners that make up the person's community" (p.323). This focus turned her attention away from voice itself to the contexts within which voice is produced. I agree that it is 'unjust' for people to bear their pain alone, and disavow the idea that pain is inherently an individual and personal matter. This belief added motivation to the exploration of how narrative therapy could assist participants to expand the boundaries of their support beyond their family to a "community of caring persons" (Weingarten, 2000, p.400). Smith (2003) describes an example that incorporates some of these ideas, where the group he worked with engaged in a "Ceremony of Remembrance and Thanksgiving" for those who have lost family members.

In August 2005 participants were invited to attend a 'celebration meeting for women' arranged by the small Christian church that I attend. The function provided an opportunity for us to testify about God's blessings to us. To me, it seemed appropriate to invite the women I met during this study in Lavender Hill. The privilege of having met them had been a spiritual blessing to me. I contacted the female participants telephonically, told them about the planned celebration and invited them to attend. I also discussed the possibility of including them in an award ceremony, since I wanted their consent for this public activity. I did not want to compromise confidentiality and would not reveal the details of their trauma. I got their consent to read the certificate to the audience, so as to publicly acknowledge the contribution they had made to my life and to reflect on their commitments and values. The celebration was held at a

scenic venue and breakfast was served. Bella and Nina, Kate, Tina, Francis, Mita and Cheri were able to attend were. During the ceremony, I read each certificate to the audience before awarding it to the participant. The "certificates of appreciation" read as follows:

> …Bella, in honour of her courage in the face of pain and loss, and her ability to act on "the sparks" and to close "gaps" between people. I will remember how Bella's faith got her into action and kept her thankful.
>
> …Nina, in honour of her commitment to comradeship as "being bonded together", and her delightful sense of humour. I will remember Nina's creative ideas and the pink tracksuit with letters of love it gave birth to.
>
> …Francis, in honour of her ability to "keep herself positive" even if the situation is tough, and to show love for her family by taking a firm stand against abuse. I will remember the examples of Francis' practical love for children.
>
> …Kate, in honour of her compassionate encouragement of others who have lost loved ones, and her ability to "stand united" with others against injustice. I will remember Kate's prayerful faith and selfless support of others.
>
> …Mita, in honour of her loving ways of "setting things right" and her commitment to her children's well-being and future. I will remember Mita's intolerance of secrecy around abuse.
>
> …Cheri, in honour of her concern and care for her mother and her willingness to work towards "putting the puzzle pieces together." I will remember Cheri's courage in speaking out.
>
> …Tina, in honour of her "undying love" for her sons and her commitment to speak out against injustice. I will remember the way Tina stood united with Kate and how they supported each other.

When I asked Bella and Nina for their reflections on the ceremony and certificates they responded as follows:

> B: The certificate makes it so worth all the effort and pain. I am glad that a broader range of people are aware of our plight in Lavender Hill. It was and is therapy for our hearts and souls that people have some idea of the good that is happening in Lavender Hill and knowing that there are so many people praying with us for that peaceful change.
>
> N: To receive a certificate after such a session gives a person some feeling of achievement and makes you feel good about yourself and what you have done. You also realise how much your involvement is valued.

Herman (1992) argues that "compassion and respect for the traumatised victim self" should be joined with "a celebration of the survivor self" (p.204). Ways in which trauma strengthened participants' ability to cope were therefore celebrated.

7.8.1.4 Restoring connection: to others, to preferred ways of living, to God, to a "robust sense of self"

In a narrative therapy approach, where attention is given to the social, cultural and political context of trauma, emphasis is also placed on the community as "a source of recovery and resiliency" (Harvey, 1996, p.7). In this study, participants were encouraged to invite supportive others to come along with them in the process through active participation in therapeutic interviews, or less direct participation through letters or reflections. I agree with Herman (1992) that, while the trauma survivor should be "in control of decision making" (p.167) about who should attend sessions, the therapists can work towards "the mobilisation of caring people" (p.164). Many

examples of the connections that were encouraged in this study can be listed: Kate decided to invite Tina to join us (Case study 2); Francis brought a supportive friend along to an interview (Case study 3); Sheila and Dusi participated in an interview with Sandy and Francis (Case study 3); Bella acted as a witness to some interviews (Case study 2 and Case study 3); Cheri and Aston's aunt participated in a "definitional ceremony" (Case study 4). Re-membering and taking-it-back practices were therefore incorporated and participants were often interviewed in small groupings. Herman (1992) observes how "the example of individual courage and success inspires a group with optimism and hope, even as the group is immersed in horror and grief" (p.223) and she reflects on the protection that groups and witnesses can offer:

> The solidarity of a group provides the strongest protection against terror and despair, and the strongest antidote to traumatic experience. Trauma isolates; the group re-creates a sense of belonging. Trauma shames and stigmatises; the group bears witness and affirms. Trauma degrades the victim; the group exalts her. Trauma dehumanises the victim; the group restores her humanity. (p.214)

Participation in conversations with others could provide a place where a sense of family could be reformulated psychologically and where an increased sense of community and belonging could be fostered. In this study, some participants seemed to view each other as "extended family" (Smith, 2003). Kate, in particular, confirmed that individual sessions can lead to feeling lonely and alone. In contrast, being part of a small group facilitated a sense of unity and solidarity for her.

Assumptions underpinning narrative therapy fit well with an approach where "the goal of therapy may be to invert an introspective and self-absorbed process of psychological distress into one of shared social concern" (Kagee, 2003, p. 285). As such, it is geared toward reconnecting people with preferred ways of living. Narrative therapy attends to the need to connect with and "revisit old hopes and dreams" (Herman, 1992, p.202), values and preferred ways of living. Narrative therapy conversations can facilitate moving away from polarities with regards to issues such as forgiveness by facilitating a process that Bird (2000) describes as creating "opportunities to generate language for the in-between" (p.23). If, for example, this process was centred on generating language about forgiveness, the therapist could facilitate considering "the activity of for example forgiveness, the activity of not forgiving and the relationship between forgiveness and no forgiveness" (Bird, 2000, p.23). In Case study 4 and Case study 5, the need to "generate language for the in-between" (Bird, 2000, p.23) with regards to forgiveness arose for both Cheri and Vanessa. More questions could have been asked so as to "generate an experience of movement" and to generate language such as the notion of "partial forgiveness." This might have enabled Cheri and Vanessa to consider their experience beyond the definitive and fixed. In Case study 5, some relevant questions were in fact asked about the relationship between forgiving and forgetting. However, more questions could have facilitated a broader consideration of others' lived experience so as to give Vanessa and Cheri "the opportunity to consider / see beyond dominant, and thus taken-for-granted and not consciously known, values and ideas" (Bird, 2000, p.22) about forgiveness.

Many participants openly declared their faith and actively incorporated the dominant discourses within their faith communities as informative of their lives. Further inquiry into how faith and the faith community contributed to their lives thus seemed important. Spiritual beliefs seemed to be linked with coping and resilience

for many participants. Bella and Nina's (Case study 1) friendship provided an example of religious tolerance in Lavender Hill, where Muslims and Christians have lived side by side for a long time. Many examples of how participants experienced being reconnected to God were included in the case studies. Martin's (2003) exploration of spirituality as a source of hope for trauma survivors in South Africa provides rich descriptive accounts of the power of faith to heal.

Poststructuralist conceptualisations of identity were applied in this study to the task of helping participants to become the persons they want to be. By integrating aspects of oneself that were most valued before the trauma, as well as aspects from the experience itself and from the period of recovery, Herman (1992) argues that "a new self" (p.202) can be co-created. This corresponds to White's (1997) idea of working towards becoming other than who you were, rather than who you "truly" are. Participants were therefore invited to reflect on these aspects and to speculate about what their histories of survival implied about the identities, skills and abilities. In this way many participants experienced themselves as robust, rather than fragile. One example was highlighted in Case study 5 were Vanessa describes herself as "normal" and refused to label herself as someone who carried the stigma of "someone who was raped." Vanessa said: "I don't think about myself as someone who was raped. I put that out of my mind. I think about myself as someone who is normal, who had a good home, a mother who loved her."

7.8.2 Reflection on therapeutic change in the case studies

Muntigl's (2004) ideas on therapeutic change are briefly included in this chapter to support the argument that narrative therapy is an appropriate model for therapy in South Africa. Narrative therapy conversations are geared toward "multidirectional change" (Muntigl, 2004, p.2). Multidirectional change de-emphasizes movement toward pre-determined end states, whilst retaining the idea of progression from an initial state. Three kinds of change were identified by Muntigl (2004) in his examination of language changes and meaning changes in narrative therapy: a) the unfolding counselling process (the unfolding process within which texts are instantiated), b) individual development (resources that the individual has at his/her disposal to instantiate texts and how these resources develop alongside the developing individual), and c) cultural evolution (the evolving language and meaning resources of a culture which individuals may draw from to instantiate texts). I have identified a few examples from conversations that reflected these changes. Change within the counselling process and individual development was described by as follows by Bella:

> B: Nina, it was really good. You are making me more and more serious. You are stirring the fairy. {everyone laughs} The more we talk the more I get a different picture. The more I see – who of us is perfect? In spite of whatever, we can take the good out of it. We went through a lot and we got a lot of knocks and bumps, despite our hard work. But, there are still sparks.

For Bella and Nina, the alternative stories or "different pictures", and agency expressed in a "robust sense of self" that emerged in our conversations were noticed by both women. Nina commented on the transformation she was witnessing in Bella. Bella in turn realised: "The more we talk the more I get a different picture." Nina reflected that this inspired the knowledge that "there is still hope":

I: So there is some hurt but there [is also…
N: [There is hope still. There is lots of hope still.
B: That spark – can we not light that spark again - at our pace? We cannot do that running around anymore, but we can start delegating and give guidance. Take them along with us.
N: We should actually set up a meeting.
I: I will also write up bits of our conversations and give it to you to remind you of what we spoke of.
B: But just listening has just brought another thing to me now. Get started. Just get the good out of this. There is a lot that we know.

N: I am very glad for this.=
B: =I am glad.=
N:=Because this has also brought us very close and I seem to, every week, I seem to see that – I am not seeing that Bella that is so down anymore. I am seeing that Bella that is becoming inspired [again.
B: [I have been. I used to not feel good. I didn't want to communicate. I felt like that. I don't feel like that anymore. I mean, you can ask New World when they last saw me. I don't even pop in. I built up a lot of things. But through these talks, with you and Nina – she's seen me go to church and then I come back –
I: What are you seeing now, Nina?
N: I'm seeing inspiration in Bella.
B: Yes, I could not say that in the beginning when you came here.

Bella and Nina questioned the apathy they experienced in the past and this left them feeling inspired.

B: We look at things happening and it goes past. What do we do? First we used to jump and did something.
I: So that apathy kind of infiltrated your lives, but now you are looking at changing that?
B: Why were we standing before? And we closed our doors and our curtains to happenings. Why? We were never like that. So this has also brought a lot of inspiration. We want to say thank you very much to you.
I: {laughs} No, I want to thank you.
B: Really, for all these things.

Our conversations seemed to have connected Bella and Nina to each other and to their dreams for the community. For instance, Nina wanted to rekindle the idea of painting a mural in their court and to get the youth involved in something constructive. Nina said that the conversations made her realise that for them to connect to each other required "just a stretching out of a hand." Bella explained that our talks resulted in "other ideas" coming up for her.

B: I am telling you Ilse, when you came into our session, I wasn't really feeling good. I was feeling very traumatised – mentally, physically. I was just saying things, but things have really – things have gone so different. Our talks have really healed me. It made me think … other ideas came up for me. Maybe you should take out the bad and look at the good, and take the good and build on that. And also when you show love, irrespective of people talking or saying things about you, if you show love at all times, they will eventually find that you are not as bad as they think. You know what I mean?

In Case study 2 participants had opportunities to consider "saying hullo again" to aspects of their identities that were related the people they lost. This can be considered an example of resources that individuals have at their disposal to instantiate texts, since thinking about their relationships with their deceased loved one in this way helped them to hold on to preferred knowledge of themselves, such as knowing themselves as good mothers and caring members of the community.

Case study 1, Case study 4 and Case study 5 involved the deconstruction of various discourses, including religious discourses about acceptance and forgiveness and discourses of revenge. These conversations could

also be seen as resources to instantiate texts and involved what Muntigl (2004) described as evolving semiotic resources of a culture that individuals may draw from to instantiate. The process of creating "opportunities to generate language for the in-between" (Bird, 2000, p.23) (described in section 7.8.4.2) is an example. Generating semiotic resources in the form of "language for the in-between" (Bird, 2000, p.23) enabled participants to consider their experience beyond the definitive and fixed. In Case study 3, Francis's values of caring, justice and peace were affirmed and "richly described" despite the violent context within which the family live. She could take small steps towards considering the "lovely life" that Poppie envisioned. Change in terms of the evolving language and meaning resources of a culture which individuals may draw from to instantiate texts, was further encouraged by exposing gender discourses of male domination and privilege.

7.8.3 Stories of hope and dignity

Arguably, the success of narrative therapy lies in the fact that a "new story, no longer about shame and humiliation" but "rather dignity and virtue" (Mollica in Herman, 1992) is often co-constructed. The importance of opening spaces for alternative stories to be told was demonstrated in the case studies. Two example stories from Case study 1 are included. Re-membering conversations, intended to redress the way in which problem stories make certain partnerships or histories in people's lives invisible by "incorporating and elevating significant people's contributions to the lives of those consulting the therapist" (Morgan, 2000, p.77), created opportunities for Bella and Nina to reflect on the past. In these conversations they told stories of hope and dignity. The first story is set at the time of Bella's detention in prison by the apartheid government and I have titled it: *"Doing hope" in pink and purple pants.*

B: …She also played a very big role in my life while I was in prison - a very big role. My first tracksuit – long pants – was when they all organized it.
N: I think the nicest part of it all was that we had a tracksuit made for her.
B: My first tracksuit. That was the best tracksuit anyone could have made me. Let Nina explain to you why.
N: In each seam of that tracksuit, a message was written to her. It was closed in the seam.
B: It was sewn closed.
N: There was a little message on a piece of paper and then it was sewn closed.
B: So nobody could find it, because they {security police} shake the clothes to see is there is anything hidden. And there were messages from my family, from Nina, from each comrade…That was one of the greatest things that could have happened to me.
I: Whose idea was that?
N: It was actually myself and another comrade. We thought, "How are we going to get messages to Bella?" And I said, "Bring the messages to me, and I will sew then into the tracksuit."
B: Even from my husband. Even from my children… Oh, gosh.
N: And I think that was wonderful to know, because we could not visit her. We could not make any contact with her. The only way was to send in some clothes.
B: It was searched. And then my husband had to make an application to see me and after a month he could see me. Then we had to make an application for the children to see me, and that also took another month.
I: And when you saw them?
B: It was indescribable. I can't…
N: Only her family were allowed to see her.

B: It was pink and purple. I will never forget. It was so huge. They made it warm because it was very cold.
I: So was it symbolic for you of their warmth?
B: Exactly. It had little bits of embroidery that said "We love you." The notes they had secretly sent me in the seams of the pants had to be destroyed immediately, you know… Just the fact that it came from New

World, that it came from my friends, meant so much to me. The effort they took to let me have it; the risk of putting the little notes in. They cannot know what it meant to me – just to find it there.

Since Bella had never heard about all the careful planning of symbolism that went into creating the tracksuit pants, she appreciated my question in this regard.

I: And Nina, when you were making the tracksuit, what went through your mind?
B: I would like to hear that!
N: The first thing was that myself and K got together and decided, "What would make Bella happy? What would show her our love? What would give her that encouragement and that strength to be there and know that we as comrades are there for her?" We cannot make contact with her. We cannot speak to her. We cannot visit her. So how are we going to, in actual fact, let her know? She knows it, but how can we let her feel, "Although I am here, my comrades have not deserted me. They are still there for me." And we said, "What would she need most that she could wear during the day and during the night?" I mean, there are prison clothes, but they were allowed to wear private clothes. So in actual fact, "What would she be able to wear that would make her know when she goes to sleep, "My friends are with me." Do you understand?
I: Yes.
N: When she gets up in the morning, "I know you love me. I know you will be there for me." And we decided on a tracksuit. Fortunately, we also thought of not making it black. It would give encouragement, but it would also be very gloomy to wear black. So we decided on a colour that would also make her feel like 'bright inside', because of what she was wearing. So we decided on pink. I was a deep pink and maroon purple. Those were the colours we decided, because we did not want the tracksuit to be signified - that they would not easily identify, this comes from comrades. You see, if we would have made black with green, they would have torn that tracksuit apart.

Bella got the opportunity to reflect on how her experience of receiving and wearing the tracksuit matched the intentions of those who made it.

B: …I have never asked Nina yet, "What did they think?" We have just … I was too overwhelmed. And we always said to them, "You know, it was the first tracksuit that I wore in my whole life. I had never, ever worn one." So it was the first one - in prison. But what was so significant was that I could wear it during the day. It was so warm. Then I after we bathed, I would even go and sleep in it. It was cold.
I: So their thoughts were very considerate - that they knew [
B: [and exactly what she said there, you know, that my friends love me. I would sleep and I would think about them and about what we did together. And I would picture them. And at night I would pull it so up like {gestures} and I would just go into a sleep knowing that they are thinking of me, and also knowing that they are caring for my family.

Nina went on to explain that letting Bella know that she was not alone was very important to her. My question as to why this was important to her led to a richer description of what commitment meant to her. She saw commitment as "being bonded together as one."

N: …That is why we could share what she was going through. Although I was not there, I couldn't share what she really went through, but we could actually try and understand what she was going through. (.) These are things that actually led to all those little messages; those words of encouragement. Those words of knowing, feeling, having to know that - no matter that you have left the family behind, we will be the mothers. We can't replace you, but we will try and do what we can for your family. That is exactly what we did. Many a time - of course, these girls were big – but many a time I would go over at night and say, "Listen, don't be shy. Don't be afraid. Whatever there is, I am there. If ever there is something that needs to be done – like filling in the application to go and see your mommy - don't you run around, we will do it at the office." We couldn't replace Bella, but I think we tried to the best of our ability to make her family feel that they are not alone and she is not alone.
B: That is very important.

I: And why is that so important to you?
N: It is ... Ilse… let me put it this way. I see commitment as being bonded together as one; as always being there for one another. As feeling the hurt that that person shares, and the joy, not only the hurt. There were lots of joys and there were lots of hurts; and sharing.
I: And was it a commitment to find out and to walk alongside someone in the hurt and in the joys?
N: Yes. And also sharing those joys and then being there for one another - knowing that whatever happens, that comrade will be there for me. That is very, very important - knowing that whatever happens, I will have people who will be there; people who will really look back and see what they can do for me. I think what really proved our comradeship and our love for Bella was that tracksuit.

This story is a colourful example of "doing hope" for and with others. Bella recalled the joy and support she experienced while in detention when she received the handmade pair of tracksuit pants from people in her community. Through narrative therapy inquiry she found out more about what made the pants extra special, apart from the physical warmth and comfort they provided. The care taken in creating the pants became clear when Nina told us about the thought that went into making them symbolic and multi-purposed. The scraps of paper with messages of love and encouragement that were sewn into the seams of the pants attest to the power of words in a context where words might seem powerless. Exploration of the symbolic meaning of the tracksuit revealed that the colours were chosen to confuse the security officers who would confiscate anything which seemed to have political connotations. However, they were also meant to bring brightness and warmth. Bella reflected on the sustaining power of the knowledge that "although I am here, my comrades have not deserted me." The importance that these women place on remaining connected to others is highlighted by Nina's description of commitment as "being bonded together." The realisation of how important it would be for Bella and her family to know that "they are not alone and she is not alone" seemed to have been informative of the effort and risk that it took to "do hope."

Another story about the "kinds of things" that they did "to actually keep the struggle going" served as a vehicle for a demonstration of Nina's theatrical skills. I have titled it: "*Giving birth" to a video.* It gave us an opportunity to laugh about what was "not so funny then."

N: When the caspirs came in, Johan, a German man, was here working with us at New World. He and an African man were walking together, and they were stopped because they were a European and an African walking together. And they {armed forces} wanted to know what they were doing and they started hitting them and somebody videoed it. And that very night somebody was leaving for Germany and we wanted to get that video to the airport. But now we have to get that video out of Lavender Hill. And they said, "What are we going to do? How are we going to get this video out? All the roads are sealed off." And I remember having a green skirt… and we took a little pillow and we opened it up and we put the video inside. And Sue was driving the car and I was at the back of the car with this huge sweater and this pillow was here {demonstrates}. And the video was in there. And we came to the blockade here and they hear me breath, "Haa, haa, haaa!" {Breathing very heavily}
B: She was going to have a baby! {laughter}
N: And they looked in the car, and he said, "*Ry, ry, ry! Sy gaan 'n baby kry!*" (Drive, drive, drive! She is going to have a baby!).
B: Those were experiences. We can laugh at it now when you think of it, but it was not so funny then.
I: You are a good actress!
N: He was looking at me and said, "*Ry, ry, ry! Sy gaan 'n baby kry*!" (Drive, drive, drive! She is going to have a baby!) And then we would get to the next blockade and they would say, "Nina, blockade ahead!" And I am already prepared, "Haa, haa, haa, haa!" {Breathing very heavily}
B: {laughs} That was all part of it.
I: So you gave birth to the video?

> N: Yes. This video was delivered. And we came back and I said, "We cannot go back the same way. I must get out somewhere and walk in, because you cannot take me back in this same car." They were still standing there. And I said to them, "Wait, wait, wait. Take me to my sister's house." I went to my sister and asked her to give me another dress to put on and then she could take me home. I was not the same person. I was somebody else. That person was wearing a green skirt. So these were the kinds of things that we did to actually keep the struggle going.

This story attests to Nina's courage and willingness to take risk to achieve something important. The value that was placed on informing the world about the injustices inflicted by the apartheid government also becomes apparent. Stories such as these could form part of an "Archive of Resilience" envisioned at the outset of this study. In fact, Bella and Nina gave permission for me to share their first story with Weingarten, whom I had met at a local family therapy conference in 2000. Weingarten (2000) agreed that this was indeed a beautiful example of "doing hope" and requested Bella and Nina's permission to share their story at the Harvard School of Psychiatry where she teaches. These liberating stories seem to have had the effect of countering the constraining recount of depression. They connected Bella and Nina to their creative skills and to each other. Their responses to the oppressive situations they were facing could be seen as examples of "small acts of everyday resistance to violence and other forms of oppression" (Wade, 1997, p.23).

Many of the therapeutic practices identified by Wirtz (2003), listed earlier, were implemented in the processes described in the case studies. For example, in Case study 2, Kate, Tina and Hilda grieved over the absence of justice (Collet, 2003) and our conversations were aligned with actively striving towards the implementation of justice by participation in social action. The way the women in Case studies 1 and 2 witnessed each others' stories supports Weingarten's (2000) assertion that "witnessing creates a synergy of recognition, support and action that is affirming, restorative and energising" (p.8). As such, Weingarten's (2000) argument that witnessing others' stories is "a crucial way we can respond to suffering and injustice in our daily lives" (p.8) was used to create opportunities to respond to injustice.

In all five case studies there was an emphasis on resilience. As indicated in chapter 4, narrative therapy discourse stands outside of the discourse of disease, pathology and treatment, and seeks rather to work in collaboration with communities in non-pathologising ways. Stories that did not fit with the problem-saturated stories of depression, shame and silence were elaborated on as "threads of hope, resourcefulness and capability – previously excluded from her descriptions of self" (Collet, 2003, p.27). According to Repper and Perkins (2003) resource-centred approaches strengthen resilience and enables people to engage with interventions and supports. The alternative stories co-constructed in each case study assisted participants to gain a sense of agency. This is significant if we assume that we are "shaped by the stories we tell ourselves and are told by others about who we are and can be" (Griffith & Griffith, 2002, p.82). In Case study 5, Vanessa provided a clear example of how the choice that came with having access to alternative stories (as reflected in my first letter to her) translated to a greater sense of agency. This enabled her to break the silence about being raped by showing the letter to others.

Weingarten's (2000) argument that "hope is too important - its effects on body and soul too significant - to be left to individuals alone" (p.399), and her contention that "hope must be the responsibility of the community"

(p.399), proved significant in this study. Table 13 was created to reflect dimensions of the consequences of trauma for relationships, as witnessed and described in participants' lives. Although the table presents the consequences as definitive positions, it is important to note that these positions were viewed as fluid or moving (Bird, 2000). In this study these consequences seemed to contribute to a process of moving towards a greater or lesser sense of hopefulness, depending on the meaning that each participant attached to the consequences.

Table 13

The consequences of trauma that contributed to a greater or lesser sense of hopefulness

Relationships		
In general	Disconnection and apathy	Connection and agency
Family, friends	Silence	Speaking out
Community	Noticing "evil" people in the area	Noticing supportive people
Self	Doubt	Resilience and a robust sense of self
God	Doubt	Faith
Perpetrators	Vengeful thoughts	Ignoring; Doing sorry

As reflected in Table 13, trauma impacted on participants' relationships in general, with family and friends, within the broader community, with themselves, with God, and in some cases with the perpetrators of violence. Participants seemed that have found ways of contributing to a process of moving from a sense of hopelessness toward "doing hope" in their relationship. For example, Case study 1 illustrated that Bella and Nina's reconnection to each other countered the sense of hopelessness experienced at times when they were disconnected from each other and from the commitments they shared. As a result of their reconnection they experienced themselves as active agents in their lives. This stood in contrast to the apathy they described in the community at large. For Vanessa (Case study 5) and Cheri (Case study 4), a sense of hopelessness was compounded by the silence that followed in the wake of sexual trauma. On the other hand, the connection and agency involved in speaking out about trauma in ways that they deemed safe, seemed to be associated with hope. Once Vanessa and Cheri had spoken to concerned family members about sexual trauma, they both described their view of the future in more hopeful terms. In Case study 3, Kate realised that noting "evil" people in the community contributed to feeling hopeless, whereas realising how "good" many in the community are, enlarged her sense of hope. Engaging with supportive people enabled participants to draw on the community's solidarity and co-creation of resilience. Faith and a close relationship with God also emerged as an important source of hope for many participants. In terms of participants' relationships with perpetrators, harbouring thoughts of revenge seemed to be linked to feelings of hopelessness whereas "ignoring their presence" and seeking justice was experienced as helpful. In Case study 4, Aston, the perpetrator of abuse seemed to find that "doing sorry" was related to having more hope for the future.

The data seem to indicate that "hope-inspiring relationships" (Repper & Perkins, 2003, p.77) were created in this study since participants were valued as equals and I tried to accept and to understand their reality. In Lavender Hill, this process involved trying to understand the despair and hopelessness often felt within the context of continuous violence. Within such contexts, Goldsmith, Barlow and Freyd (2004) propose that

approaches that focus on "listening, mutuality, compassion, ethics, and community" (p.457) are powerful antidotes to trauma. In the case studies (in Chapter 7), I highlighted ways that narrative therapy encouraged these antidotes by creating opportunities for participants to speak out, to notice supportive people, to experience themselves as robust and resilient, to speak about their faith, and to "do sorry." Hope was created as participants forged connections with significant people, and with valued commitments, hopes and dreams, and in "the refusal to accept the reading of reality which is the majority opinion" (Brueggemann, in Collett, 2003, p.90). Within the context of a poor and violent community such as Lavender Hill, the need identified by Repper and Perkins (2003) to accept failures and setbacks as part of the recovery process, as well as the fact that the future is uncertain, gained significance. However, acknowledging these realities did not lead to a sense of hopelessness or to pathologising their post-trauma reaction. The context highlighted the need to believe in participants' abilities and potential, and to attend to their priorities and interests (Repper & Perkins, 2003). These are priorities in narrative therapy. Repper and Perkins (2003) also warn that mental health practitioners need to find ways of sustaining their own hope so as to guard against despair. As discussed in Chapter 5, I drew sustenance from my family and friends, from my faith, from peer supervision, and from the privilege of witnessing participants' stories. Although I still feel overwhelmed by the plight of the Lavender Hill community, I have experiential knowledge of the resilience, love and faith that I witnessed in the community to "do hope" for me. Ruane and Bakker's (2004) emphasis on pursuing hope through the research process was therefore echoed:

> Hope is the life source of existence. Without hope the future seems impossible. Hope is created through a community of people, which has now expanded to include the conversational partners of this study. The participants showed how they pursue hope; hope emerged from relationships between participants and was shown to work against isolation and despair. (p.101)

7.9 Concluding thoughts

In this chapter, five case studies were presented in an attempt to meet the second goal of this study, "to describe a therapeutic approach that emphasises context, resilience, empowerment and ecological well-being." Contextual contributions to post-traumatic responses were acknowledged in each case and through-out the interviews attempts were made to situate problems in their socio-political context. In each case there was an emphasis on participants' skills and co-created resilience. I strove towards forming an empowering alliance with participants by adopting a "decentred but influential" (White, 1997, p.200) position as interviewer and therapist, whilst acknowledging participants' resilience and their solidarity with others. The case studies illustrated that narrative therapy shifts the focus from the individual to groups and communities of people. In each case the interviews were informed by an ecological view of well-being and were geared towards collaboration and creating communities of concern. In Chapter 8 each case study will be summarised briefly to conclude this discussion of the appropriateness of narrative therapy in the context of attending to the consequences of trauma in a low-income community in South Africa.

CHAPTER 8: CONCLUDING REFLECTIONS AND RECOMMENDATIONS

I think we have overcome…I would say it was just a stretching out of a hand.
(Nina)

8.1 Introduction

In this final chapter reflection on the research journey includes revisiting the goals of this study. The chapter starts with reflection on participants' descriptions of the consequences of trauma on their lives. Next, I reflect on the argument that narrative therapy is an appropriate model for attending to trauma in a low-income community context in South Africa. A brief summary of each case study is included to this end. Reflections on the strengths and limitations of this study follow. Finally, recommendations with regard to psychological intervention with trauma survivors and future research are made.

8.2 Descriptions of trauma and its consequences

In an attempt to meet the first goal of this study, namely "to contribute to the growing body of context-specific knowledge of the consequences of trauma", *in vivo* categories that emerged from constructivist grounded theory analysis of interviews were discussed in Chapter 6. The consequences of trauma were discussed in terms of thoughts and memories, emotional responses, and behaviour associated with post-trauma reactions. Participants' stories seemed to endorse Summerfield's (1995) view that "post-traumatic symptoms are not just a private and individual problem but also an indictment of the social contexts which produced them" (in Lykes, 2002, p.104).

Chapter 6 also focused on the dialectic of trauma by analysing discourses that inform silence and speaking. Categories that emerged in the analysis confirmed that survivors in South Africa might evidence symptom constellations that fit the criteria of PTSD. However, the case studies in Chapter 7 indicate that "this constellation of physical and psychological responses capture only a small dimension of who they (the participants) are" (Lykes, 2002, p.104). The latter part of the first goal of the study, namely "to contribute to context-specific knowledge of resilience and 'doing hope' in a low-income community in South Africa", included a focus on some of these other dimensions in "double-storied accounts" of participants' lives.

8.3 Narrative therapy case studies

The second goal of this study was "to describe a therapeutic model that emphasises context, resilience, empowerment and ecological well-being." Five descriptive case studies were used to this end. These five case studies were by no means "definitive cases" or "show cases" of narrative therapy, but illustrated my application of many aspects of narrative therapy ideas. In each case, ways in which problems were constructed and effaced were described. The case studies showed that narrative therapy practices incorporate South African priorities in attending to trauma highlighted in Chapter 1. In the case studies, narrative therapy practices allowed us to focus on resilience, context, liberation and empowerment and to shift the focus from the individual to the ecological well-being of groups and communities of people.

In Case study 1, Bella and Nina identified depression, isolation, silence and fear as problems that affected them. Ways in which "comradeship, faith and thankfulness" countered these problems were described in our conversations. Alternative ways such as "being more calm", "speaking what is on your mind", and "opening-up" were preferred. Bella and Nina shared a few stories that reflected the courage, creativity and connection that sustained them through difficult times in the past. Our conversations contributed to re-establish their connection to each other. In the process the women could step more fully into the "roles they had to play" and into the knowledge of themselves as "quite strong." Their personal agency became more apparent and we celebrated the consequent liberation from abusive relationships and the isolation associated with depression. The ripple effect of narrative practices used to thicken the alternative stories, such as consulting Bella at a therapy conference, became evident. To summarise, Case study 1 provided a description of interviews as a form of co-research that provides respectful ways of consulting with people as the experts on their own lives. I argue that the connection and agency that was expressed in the process are good examples of "doing hope."

Case study 2 told the stories of three women who experienced the traumatic death of a loved one to a violent death. Their grief and loss seemed to be complicated by the bitterness that they felt towards the perpetrators. The context of continuous trauma and lack of legal justice enhanced these feelings. The women's sense of fairness and passion for justice were acknowledged and their survival skills celebrated. We spoke about their shared commitment to peace and to find "normal" ways of talking about deceased loved ones. The conversations provided opportunities for the women to "re-member" their loved ones and to reflect on their beliefs about life and death. The women described the legacy of their trauma as compassion and a commitment to helping others. Kate clearly gave examples of how the love and support from others in the community was "doing hope" for her despite the fact that she saw certain people in the community as "evil." This case study provided an example of how people from different families can be brought together in therapy. The notion of "enhancing resilience through multiple family groups" (Stoiber et al., 2004, p.433) was thus supported by this case.

In Case study 3, continuous trauma was evident. Community and family violence seemed to have affected every member of Francis' family and contributed to vicarious trauma. Francis not only had to cope with living with an abusive husband, but also with her teenage son's depression and his vengeful thoughts after the murder of his friend. They feared for his life too. Shortly before we met, her husband and children were shot at. Furthermore, her eldest son, who was accused of murder, was raped in prison. Within this context of continuous trauma Francis' survival skills were described and her stand against abuse was affirmed. Sandy, who experienced many of PTSD symptoms, took small steps towards reclaiming areas of his life. Speaking out against abuse seemed to help Poppie, his little sister, to gain clarity about her values in life. Although this case illustrated the ongoing struggle that many people in low-income communities face, it also demonstrated how small steps of support from others can "do hope" in the midst of despair. With the support of her friends and neighbours, Francis managed to leave her abusive husband. She and her two daughters relocated to safer living environments. At times there did not seem to be much hope for Sandy and his brothers, given the violent context within which they live and the aggressive behaviour they engage in. However, Francis' independence from their abusive

father was something Sandy had hoped for and it gave her a more secure base from which to support him and his brothers.

In Case study 4, Mita and her two teenage children, Cheri and Aston, realised that stepping away from secrecy by naming abuse was a first step towards breaking its effects. This case study illustrated the importance of placing abuse and trauma in context by exploring the impact of poverty-related living conditions on families. In this case study, deconstructing discourses of blame and guilt, as a well as challenging the notion of being "damaged" or "scarred for life", was helpful. Furthermore, Mita's love for both her children inspired hope. In this case study I attempted to provide invitations for Aston to take responsibility for his actions. However, it was important to separate the problem from the person, so that the totalising effects of abuse both for Aston as the perpetrator and for Cheri as the survivor, could be countered.

In Case study 5 Vanessa provided clear descriptions of the dialectic of trauma. She reflected on her conflicting desires to talk about having been raped and to continue keeping it a secret. This case study illustrated that narrative therapy practices can assist in co-creating a robust sense of self in that Vanessa's negative identity conclusions were challenged.

In the case studies I did not set out to compare narrative therapy to other approaches to trauma treatment. However, I trust that the case studies illustrated that narrative therapy is one approach that incorporates stages of recovery identified by Herman (1992), practices that trauma survivors find "helpful" (Wirtz, 2003), and ways of working that are appropriate for South Africa in that the focus is on resilience, context, community and ecological well-being.

The case studies illustrated that double-listening allowed double-storied descriptions of trauma to be co-created – stories that included rich descriptions of resilience and hope. Whilst the context of violence in which participants lived was acknowledged in this study, a therapeutic context was created in which alternative stories of participants' lives could be celebrated and honoured. As such, I argue that narrative therapy is appropriate for people from a low-income, high-violence community in South Africa, since narrative therapy practices "establish a context so that the multi-layered nature of people's responses to trauma can become richly known, powerfully acknowledged and honoured" (White, 2004, p.49).

8.4 Strengths and limitations of this study

In writing this thesis it was clear from the beginning that words could not do justice to the multi-layered, co-constructed reality of the research journey. I was painfully aware of my limitations as a writer to bring to life the rich and vibrant lives and stories that I witnessed. Furthermore, it is important to remember that "the representation of any clinical work is just that, a representation" (Bird, 2000, p.viii). Despite these limitations, I attempted to include participants' voices and I trust that the richness of their stories was evident.

The discipline of maintaining a reflexive stance can be taxing, especially if one moves between different roles (Reckson, 2002). A limitation of this study is that, as I moved between the different roles of researcher, narrative therapist and narrator, "reflexivity is repeatedly lost and found" (Reckson, 2002, p.78). As Reckson (2002) reflects, reflexivity is not a stance one "acquires and keeps consistently" (p.78), but a realisation that meaning is coloured by discourses, beliefs and feelings. As noted, interviews were co-constructed, informed by both my own and the participants' realities. The interpretations and practical presentation of participants' stories were further coloured by my perceptions and values. The "lense" of narrative therapy was selected as informative in this study. If other "lenses" had been selected the outcome would have been different. This study should therefore not be seen as a reflection of "the truth" about participants' lives. Rather, the study reflects a co-constructed reality between my personal lived experience as well as academic and clinical experience, the theoretical and academic resources I consulted, and the stories of the participants. I view this non-essentialist stance as a strength of this study. It is important to note that a change in the setting or participants of this study would have had implications for the understanding of trauma and resilience, since these are context-specific.

On a practical level, my relative isolation as a narrative therapist working in Lavender Hill placed limitations on the study. Although I was working in collaboration with the Children and Violence team of the Trauma Centre who were based in Lavender Hill, they were not available to act as witnesses. Access to professional outsider witnesses therefore entailed arranging a meeting at a venue outside of Lavender Hill, and hence formed part of only one of the five case studies. However, many of the participants witnessed other participants' stories. Arguably, this strengthened the study since local knowledge and community expertise were acknowledged.

This study can be critiqued for methodological limitations. Research questions in this study limited the inquiry to narrative therapy as a possible appropriate model for trauma counselling in a low-come South African community. Narrative therapy is not researched in direct comparison with other approaches to trauma treatment. This limits the scope of comparative analysis. A study in which different intervention approaches are implemented and compared could have yielded different results in this regard. This study was not designed to obtain quantifiable measurements of either participants' diagnostic status in terms of PTSD (although most reported some of the symptoms) or of the reduction of their symptoms. Quantitative measures, such as pre- and post-implementation questionnaires, might also have yielded interesting and more easily comparable quantitative data. Taylor (2004) indicates that such measurements could be used to estimate treatment efficacy. The study was also not designed to include comparison with a control group. However, this study is strengthened by the fact that, although many commonalities emerged amongst participants' lived experience, the specific meaning that each participant attributed to their experiences was given preference over generalising. Rich descriptions of each participant's life were sought. Although the study was not geared at generalising its findings to a larger population, I hope the richness and in-depth nature of the stories in this study could lead future researchers on new paths of inquiry (Stanton, 2005).

The fact that this study focuses on the neglected Cape Flats community of Lavender Hill (Dinan et al., 2004) and that it was designed to have "social significance" (Kazdin in Tomlinson et al., 2003, p.210) for people from

Lavender Hill, can be seen as strengths. The emphasis on the specific context and history of the community in which the participants resided facilitated the acknowledgement of problems such as poverty, housing, drug abuse and the problem of violence in South Africa, highlighted in Chapter 1. These contextual factors continue to expose people in Lavender Hill to traumatic experiences on a daily basis (Dinan et al., 2004).

As discussed in Chapter 5 in this study, validity was related to the production of reconstructed understandings and meanings that lead to improved understanding of constructions of others whilst stimulating action and empowering action (Denzin & Lincoln, 1994). Validity was therefore related to the effect of the study on participants and to the social utility rather than minimising alternative explanations for the sake of generalisability (Heppner et al., 1999). The aim was not to arrive at an "agreed truth" (McLeod, 2003, p.103) and the possibility that "each interpretation is open to re-interpretation in an endless hermeneutic cycle" (McLeod, 2003, p.103) was upheld.

A limitation of this study is that written testimonial validity was not obtained from participants (Stiles, 1993). However, participants were asked to reflect on the research throughout the process and were encouraged to speak about difficulties or possible gains (Stanton, 2005). Furthermore, each participant was given a copy of their case study and asked to give feedback with regard to possible changes or additions. Most participants reported that they did not want any changes, although a few changes and additions to details were suggested. One participant (Kate) did not want to read the document, since she did not want to read about her grief. A limitation with regards to asking feedback is that it is questionable whether participants would accept that they had the power to disagree, and may have complied with my version on the case just to please me. Despite the limitations of this study, rich descriptions of trauma and its consequences were co-constructed.

8.5 Recommendations for intervention and research

8.5.1 Intervention: Prevention at primary, secondary and tertiary levels

Given the importance of contextual factors in mental health, this study supports the contention that "prevention is a neglected focus" (Naidoo et al., 2004, p.515) within the field of psychology, especially in the context of low-income communities in South Africa where poverty, violence, crime, abuse and social injustice are rife. Participants' stories illustrate that their problems are not individual problems, but cast light on social causes. Their stories are "ultimately a matter of serious religious, cultural and political concern" (Collett, 2003, p.100). One of the biggest needs for change indicated by this study is therefore that interventions should focus on the context within which problems occur, by reducing the prevalence of violence in South Africa (Luthar & Goldstein, 2004). National-level policy efforts to address factors associated with violence in communities and families should be a priority (Luthar & Goldstein, 2004). This study supports the continued development of a public health approach that includes prevention on primary, secondary and tertiary levels (Bloom & Reichert, 1998). Although violence prevention interventions already exist in South Africa in many forms, this study seems to indicate that much more needs to be done.

The recommendation that the processes of "peacemaking" and "peacebuilding" (Suffla, 2004, p.313) should be a concern within the field of psychology is supported. This study highlights the need for interpersonal peace instead of violence. This study therefore supports the need for more funding and involvement in initiatives such as the "Heal Our Land Initiative (HOLI)" and the development of peacebuilding initiatives such as the "Peace Park" created on what used to be "The Battlefield" in Lavender Hill (NWF Website, 2005a).

This study adds a voice to calls for broadening the focus of psychology to making a difference at community level (Naidoo et al., 2004) and to be "just" (Waldegrave et al., 2003). Justice requires acknowledgement that "giving meaning and significance to their stories requires an understanding of how these stories are communicated within or against specific discourses" (Collett, 2003, p.101). Furthermore, within the helping professions, Collett (2003) argues that seeking justice means "addressing the issues that adversely affect people's lives, their earning power, safety, social status and self-worth" (Collett, 2003, p.101). It is therefore recommended that traditional notions of therapeutic boundaries need to be extended in low-income community settings in South Africa. There should be a focus on overcoming material barriers (such as issues of childcare, transport, choice of counsellor in terms of ethnicity, location and language) to accessing therapeutic services (Chantler, 2005). Prillentensky and Nelson's (2002) argument that "informal support and de-professionalized approaches to helping" (p.89) may be necessary and that therapists may need to accompany and advocate with clients, if asked, in stressful and oppressive situations, is thus supported.

There should be an engagement with issues of class, 'race' and gender within South African therapeutic services, since "therapy cannot extricate itself from social, cultural, and political practices" (Chantler, 2005, p.253). This study supports the development of an awareness of the notion of "intersectionality" (Chantler, 2005, p.245) that attends to multiple positions of marginalisation simultaneously: "Intersectionality argues for a *both/and* position so 'race' *and* gender (or religion) together come into focus" (Chantler, 2005, p.245). I argue that Chantler's (2005) proposal of anti-racist and gender sensitive therapy is also relevant to South Africa where it is important that therapy would not let gender or other inequalities go unchallenged in the name of cultural respect, so that "calls for 'cultural privacy' is not used to disregard the concerns and experiences of marginalised groups within minoritised communities" (Chantler, 2005, p.244). In South Africa, psychology should not deny or ignore the social and material realities of minoritised people, but should critically and reflexively engage with both 'cultural' and structural explanations so as to highlight the power dynamics in relationships and settings, including therapeutic ones (Chantler, 2005).

A further recommendation with regard to intervention is the use of multiple family groups (Stoiber et al., 2004). Narrative therapy would be well suited to use with multiple family groups to help meet the mental health needs of a greater number of people in communities such as Lavender Hill, where many people are poor and socially isolated. The expansion of local networks of community-based survivor self-help groups is also recommended. This study also confirms the need to establish a mental health information system that could make mental health care more available and appropriate for low-income communities in South Africa, as suggested by Seedat, Kruger and Bode (2003). Bloom and Reichert's (1998) argument that the problem of violence in South Africa

should be addressed on multiple levels - by preventing family violence, promoting resilience, sharing wealth, using the media to promote safety not violence, reworking the justice system towards facilitating restitution not retribution, dealing with violence by refusing to be a bystander, responding as a community to violence, and by bearing witness so as to facilitate human liberation – is therefore supported.

8.5.2 Research

Sadly, traumatic experiences of violence will not be reduced overnight in South Africa, especially not in low-income communities such as Lavender Hill. Continued research into appropriate, cost-effective and capacity enhancing therapeutic approaches to trauma in South Africa is therefore needed. Context-specific research focusing on trauma and resilience is needed. More funding and research into community mental health initiatives to "promote and enhance the well-being of individuals, groups and communities, and to engage in the prevention of social problems that undermine mental health" (Naidoo, 2004, p.467) is therefore recommended. This study also supports Martin-Baro's (in Lykes, 2002, pp.98-99) suggestion that future psychological research and practices should include 1) a focus on the liberation of a whole people (i.e. the collectivity) as well as personal liberation; 2) a new epistemology in which the truth of the popular majority is not to be found, but created, i.e. wherein truth is constructed 'from below'; and 3) a new praxis, in which we place ourselves within the research-action process alongside the dominated or oppressed rather than alongside the dominator or oppressor.

Research methodologies that provide opportunities for people's stories to be heard, explored and reflected on are recommended, since they are appropriate to local and contextualised realities in a developing country (Kagee, 2004a). Nussbaum's contention that "stories show us the distressing character of life and make us aware of subtle nuances within moral practice" (in Collett, 2003, p.100) supports this recommendation. Furthermore, as Kagee (2004a) notes, responsible researchers should ensure that communities and participants receive some benefit of having participated in a study. In this study this involved sharing descriptive research findings with representative organisations, individual participants, and at public forums such as therapeutic conferences.

Naidoo et al. (2004) lament that within the field of psychology in South Africa, "the status quo has largely been maintained with traditional diagnostic systems, therapeutic approaches and training methods that perpetuate a victim-blaming stance and adhere to the biomedical model for conceptualising the consequences of social problems" (p.515). This study supports their call for a change in the status quo by increasing prevention science research to combat the development of psychosocial problems. Furthermore, attention should be paid to the language and rhetoric employed in research so that victim-blaming will not be perpetuated (Goldsmith et al., 2004). Shifts to contextualised models for research into trauma and to more positive variables, including values and beliefs that step away from pathologising, recommended by Lykes (2002), are supported.

There is a need for further research into the healing qualities and powerful restorative attributes of faith, and into spirituality as a resource in client adjustment and functioning. Ford and Kidd (1998) suggest incorporating moral and spiritual issues into trauma treatment so as to address a sense of shame and emptiness. They note that many

people find relative peace for their existential crises in their religion of choice. The notion that "a spiritual approach can be helpful in restoring hope, and acquiring a more balanced view about justice and injustice, safety and danger, good and evil" (Connor et al., 2003, p.487), should be researched. Continued research into communities' healing or cleansing rituals after trauma to re-establish good family relationships and community care, is also recommended (Straker et al., 1992). How these rituals acknowledge the importance of community involvement in healing and of mobilising resources within the community itself to facilitate reintegration, can be investigated.

Finally, continued research into different applications of narrative therapy with individuals, families and communities is recommended. An example of useful ways in which narrative therapy ideas have been applied can be found in the work of Bird (2000). Bird (2000), who highlights that the narrative way of working has provided a challenge to those therapeutic models that adhere to fixed psychological truth, prefers not the use the term 'narrative model' since this construction "creates an environment of inclusion and exclusion" (p.ix). Future research should engage with ideas and practices that are described as narrative, in ways that allow for differences as practitioners attempt to engage reflexively with these ideas and practices. Prilleltensky and Nelson (2002) also emphasised the need for continued research that can support the effectiveness of narrative therapy.

The usefulness of narrative therapy as a means to peacebuilding should be researched, since the dominant themes of peacebuilding identified by Christie (in Suffla, 2004), namely "challenging dominant cultural discourse, the honouring of multiple voices and co-construction of social change, and adopting an activist agenda" (Christie in Suffla, 2004, p.318), inform narrative therapy.

On a community level, continued exploration of narrative therapy approaches to working with communities affected by trauma, conflict and war is recommended. A creative application of narrative therapy that should be explored further is the narrative theatre approach (Sliep, 2005). This involves collaborative consultation with communities to identify and externalise a "problem character" (for example "Mr/Ms Aids", or "Alcohol"). Its history and its real effects are exposed, before an alternative character (for example "Ms Care") that represents traditions and practices of collective care and the skills and abilities of communities is identified. Community members are asked for their ideas, reflections and suggestions for actions that the alternative character could take to try and reduce the influence of the problem (Sliep, 2005).

8.6 Concluding reflections

This research journey has been a multi-layered experience for me and I trust that this journey's end is the beginning of new paths. I hope that this study can contribute towards the re-conceptualisation of trauma, resilience and hope in South Africa in ways that will honour the many survivors in our country. I trust that this study has confirmed Prilleltensky and Nelson's (2002) contention that narrative therapy is "conceptually and ideologically appealing" (p.91) and that its potential to work with disadvantaged clients towards outcomes of "empowerment, community integration, and acquisition of valued resources" (p.91) has been demonstrated.

In this study the ideas and practices of narrative therapy allowed participants (myself included) to experience both sadness and joy as we were joined in outrage and in "doing hope." Participants' stories continue to challenge and inspire me to seek opportunities to "do hope" with others. As researcher/therapist I drew inspiration from the steps participants took "to dispossess perpetrators of their authority" and in "having the 'last say' about their lives" (White, 1995, p.86). May these last words inspire us to work collaboratively towards "things that can grow":

> K: We can make each other strong. Where that person is weaker, you might be able to strengthen that person…It helps to be united.
>
> V: I don't want my future to be nothing, it must count.
>
> B: …There are a lot of things that can grow. We can see how we can contribute to changing this place. I think we should maybe look at that focus and maybe we can also change our hearts and minds and attitudes towards other people.

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Addenda

Addendum A: Informed consent form

‘Doing Hope’ In Families and Communities: Co-Creating Alternatives After Trauma

Information sheet for participants/parents/caregivers/teachers

Thank you for your interest in the ‘Doing Hope’ project at the New World Foundation. Please read this information sheet carefully.

What is the aim of this project?

This project is being undertaken as part of the requirements for a Doctoral degree in Psychology. The aims of this research project are twofold: 1) to find out what the effects are of experiencing and witnessing trauma on individuals, families and communities; and 2) to look at how narrative therapy can be an appropriate model for trauma counselling with individuals, families and communities in the South African context. It is hoped that the research project will contribute to facilitating ‘doing hope’ and co-creating resilience so as to lessen the negative effects of traumatic experiences and will lead to better service provision in the future.

What will participants be expected to do?

You and significant people in your life (family and friends) will have the opportunity to engage in therapeutic conversations with the researcher, who is a qualified therapist. You will be asked to give consent for the information obtained during our therapy sessions, which will be handled anonymously and strictly confidentially, to be used in the research project. There will be opportunity for follow-up therapy sessions, determined by individual needs. Please note that you can decline to answer any questions and may withdraw from the study without any disadvantage to yourself.

What data or information will be collected and what use will be made of it?

The therapy sessions will be discussed with my supervisor and will be written about in a research report. With your consent, the therapy sessions will be video and/or audio-taped and notes will be taken. A summary of our sessions will be made available to you at the conclusion of the therapy sessions for your review. Your comments, corrections and/or feedback will be included in the final report.

Results of this project may be published, but any data included will be anonymous (i.e. identity not revealed) and will therefore in no way be linked to any specific participant. You are most welcome to request a copy of the results of the project should you wish that.

Informed consent

I have read this information sheet and give consent for the anonymous use of information obtained during therapy sessions. I understand that participation in the research project is voluntary and that I am free to ask questions, not to answer questions and to end the therapy sessions at any time. I understand that if I have any problems or questions I can contact the researcher, Ilse Appelt, at (021) 785 5921.

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Signature of participant/parent/caregiver Date

Addendum B: Certificate of appreciation

CERTIFICATE OF APPRECIATION

awarded to

Kate

In honour of her

Compassionate encouragement of others who lost loved ones

and

her ability to stand united with others against injustice

I was privileged to meet wonderful women in Lavender Hill.

Their lives, like Kate's, bear testimony

love for children - their own and others,
commitment to community,
belief in justice and fairness,
and hope for a safer future.

The women's support of each other - "doing hope" in the midst of pain - is a proclamation of their

care and concern for others,
commitment to leave a legacy,
belief in God,
and hope of eternal life.

I will remember ***Kate's prayerful faith and selfless support of others.***

Signed: Date: 20 Aug. 2005 At: Grace Celebration, Noordhoek

Addendum C: Transcription guidelines

(Based on Mishler, 1991)

Symbol	Example	Explanation
[	B: quite a [while N: [yeah	Left brackets indicate the point at which current speaker's talk is overlapped by another's talk
=	W: that I'm aware of= C: =Yes.	Equal signs, one at the end of a line and one at the beginning, Indicate no gap between the two lines.
(.)	to get (.) treatment	A dot in brackets indicates a tine gap, probably no more than one-tenth of a second.
::	O:kay	Colons indicate prolongation of the immediately prior sound. The length of the row of colons indicates the length of Prolongation.
WORD	I am ANGRY	Capitals, except at the beginning of lines, indicate especially loud sounds relative to surrounding talk.
.hhh	I feel that (.2) hh	A row of h's prefixed by a dot indicates an inbreath; without a dot, an outbreath. The length of the row indicates the length of the in- or outbreath.
( )	future risks ( ) and	Empty brackets indicate the transcriber's inability to hear what was said.
(word)	I saw a (dog)	Words in brackets are possible hearings
{ }	confirms that {agitated}	Parentheses contain transcriber's descriptions rather than transcriptions.