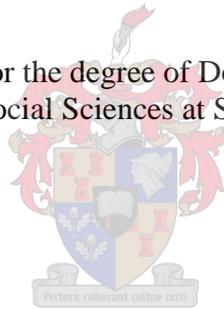


# **“SOOS ‘N VUIL HOND HET EK GEVOEL”<sup>1</sup>:**

## **Shame narratives in South African survivors of chronic trauma**

**Amelia van der Merwe**

Dissertation presented for the degree of Doctor of Philosophy in the  
Faculty of Arts and Social Sciences at Stellenbosch University



**Supervisor: Professor Leslie Swartz**

**December 2013**

---

<sup>1</sup> “Like a dirty dog, that is how I felt”

## **DECLARATION**

By submitting this dissertation electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that the reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: 10 August 2012

## ABSTRACT

Both chronic trauma and shame, as well as the relation between them, are understudied phenomena. This is despite particularly high levels of both trauma- and shame-related psychopathology in South Africa (Edwards, 2005). I conducted a qualitative study exploring experiences of trauma, shame, post-traumatic reactions and coping mechanisms in single interviews with 19 South African survivors of chronic trauma (intimate partner violence) using narrative analysis. Results from the categorical content analysis indicated that all but one participant reported a history of physical violence perpetrated by her intimate partner. Sexual and emotional violence were also reported by the majority of the participants. The most significant reported mental health outcomes were persistent fear, depression and suicidality, dissociation and somatic complaints. Coping mechanisms included religion, support from family, counselling and substance misuse. Using smiling as a mask to conceal difficult feelings and keeping occupied were cited as the most effective defenses. Shame was viewed as a social emotion, and often described as humiliation (and sometimes embarrassment), which required the presence of a mocking, hostile audience. This was interpreted in socio-cultural terms. Eleven women presented with a split self – the authentic self who admitted to a great deal of shame when asked indirectly, and the false self who was described in surprisingly positive terms. I analysed this split using categorical content analysis and narrative analysis from a social constructivist point of view at individual (clinical) level, organisational (micro-cultural) level, and broader cultural level. I used Gee's (1991) categorical form analysis to analyse five long complex shame and trauma narratives with the aim of determining if psychic fragmentation presents at linguistic level. I also analysed three short, compressed trauma and shame narratives. The structure of the short narratives tended to be circular, erratic, disjointed, and interrupted (Scarry, 1985; Simon, 2008). The three short, compressed trauma narratives were characterised by long pauses or silences, hesitations, avoiding eye contact, hunching over, covering the face with clothes, whispering, so making the narrative almost inaudible, crying, and defensive leaning in towards me, and laughing. These women were exceptions – most women expressed an urgency to talk about their experiences in great detail. Although the longer narratives are essentially fractured chaos narratives at linguistic level, they contain predominant trauma- and shame-related themes that are consistent throughout the narratives and that remain intact in spite of the signs of linguistic disruption and fragmentation. They are, in order of

narratives, 1) shame/self-blame and deservedness; 2) truth/lies and bearing witness; 3) shame, humiliation and dissociation; 4) the concealed, shame-based self, including amnesiac-like disorientation of place and time; and 5) patterns of cyclical leave-return reflecting perpetrator-instilled abandonment terror, including disorientation of time. I have argued that although language, or narrative structure, continues to mimic and reflect narrative content (fractured narratives vs fractured selves) – there is also the intriguing possibility of a disconnection between form and content; and that thematic coherence or consistency and narrative fracturing can co-occur; co-exist. There are a number of clinical features in the narratives which are either related to, or comprise diagnostic criteria for chronic trauma syndromes such as chronic PTSD and DESNOS, and intersect with shame themes in the narratives I analysed. Consequently, I argue that there is a substantial intersection or co-occurrence between exposure to chronic trauma, and trauma-related clinical symptoms, including shame, which emerge from the narratives, which without exception, demonstrate significant linguistic fracturing. In conclusion, a number of gaps in the literature were identified. Future research should triangulate methods and chronic trauma prevalence and longitudinal studies are needed both internationally and locally.

*Keywords:* chronic trauma, shame, psychopathology, narrative analysis

## OPSOMMING

Sowel kroniese trauma as skaamte, en die verhouding tussen die twee, is tot dusver onvoldoende bestudeer – ondanks die besonder algemene voorkoms van trauma- en skaamte- verwante psigopatologie in Suid-Afrika (Edwards, 2005). Ek het 'n kwalitatiewe studie onderneem en die ervaring van trauma, skaamte, post-traumatische reaksies en oorlewingsmeganismes ondersoek in individuele onderhoude met 19 Suid-Afrikaanse oorlewendes van kroniese trauma (geweld in intieme verhoudings). In my ondersoek het ek van narratiewe analise gebruik gemaak. Resultate van die kategoriese inhoudsanalise dui aan dat ál die vroue in die bestudeerde groep, behalwe een, 'n geskiedenis van fisieke geweld gerapporteer het wat deur haar 'partner' gepleeg is. Seksuele en emosionele geweld is ook deur die meerderheid van die groep gerapporteer. Die mees betekenisvolle uitkomst in verband met psigiese gesondheid was voortdurende angs, depressie, selfmoordneigings, dissosiasie en somatiese klagtes. Oorlewingsmeganismes was onder andere godsdiens, berading en dwelms. Om 'n glimlag te gebruik as masker vir die verberging van pynlike emosies, en om besig te bly, is genoem as die effektiwste verdedigingsmeganismes. Skaamte is gesien as 'n sosiale emosie, en is dikwels 'vernedering' genoem (soms 'n 'verleentheid'), wat die teenwoordigheid van spottende, vyandige toeskouers impliseer. Skaamte is in die studie in sosio-kulturele terme geïnterpreteer. Elf vroue het 'n gesplete self vertoon – die outentieke self wat 'n groot hoeveelheid skaamte erken het wanneer hulle indirek daarvoor uitgevra is, teenoor die valse self wat in verbasend positiewe terme beskryf is. Ek het hierdie gesplete self geanaliseer met gebruikmaking van kategoriale inhoudsanalise en ook van narratiewe analise uit 'n sosiaal-konstruktiewe perspektief – op 'n individuele (kliniese), organisatoriese (mikro-kulturele) en 'n breër kulturele vlak. Ek het Gee (1991) se kategoriale vorm-analise gebruik om vyf lang, komplekse skaamte- en traumanarratiewe te analiseer om te bepaal of psigiese fragmentering op 'n linguistiese vlak manifesteer. Ek het ook drie kort, gedronge trauma- en skaamtenarratiewe geanaliseer. Die struktuur van die kort narratiewe was geneig om sirkulêr, wisselvallig, onsamehangend en onderbroke te wees (Scarry, 1985; Simon, 2008). Die drie kort, gedronge traumanarratiewe is gekenmerk deur lang stiltes, aarseling, vermyding van oogkontak, vooroor buk, bedekking van die gesig met klere, fluistering (sodat die narratief byna onhoorbaar geword het), gehuil, defensiewe oorleun na my toe, en gelag. Hierdie drie vroue was uitsonderings – die meeste vroue het 'n dringende behoefte laat blyk om in fyn besonderhede oor hulle ervarings te praat. Alhoewel die langer

narratiewe op 'n linguistiese vlak wesentlik gefragmenteerde chaos-narratiewe is, bevat hulle dominante trauma- en skaamte-temas wat konsekwent deur die verhale aanwesig bly ondanks die tekens van linguistiese disrupsie en fragmentering. Hulle is, in die volgorde van die narratiewe, 1) skaamte/selfblaming en verdiende loon; 2) waarheid/leuens en getuie af lê; 3) skaamte, vernedering en dissosiasie; 4) bedekte, skaamte-gebaseerde self, insluitend die amnesieagtige disoriëntering van plek en tyd; en 5) patrone van sikliese vertrek en terugkeer, insluitend 'n disoriëntering van plek en tyd – 'n refleksie van die vrees om alleen gelaat te word, veroorsaak deur die gewelddadige optrede teen haar. Ek het geredeneer dat, alhoewel taal/ narratiewe struktuur geneig is om narratiewe inhoud na te boots en te reflekteer (gefragmenteerde narratiewe naas gefragmenteerde self) – is daar ook die interessante moontlikheid van 'n diskonneksie tussen vorm en inhoud; en dat tematiese samehang of konsekwentheid saam met narratiewe fragmentering kan voorkom. Daar is 'n aantal kliniese kenmerke in die narratiewe wat diagnostiese kriteria bevat vir kroniese trauma-sindrome soos kroniese PTSD en DESNOS, en wat verband hou met skaamte-temas in die betrokke narratiewe. Gevolglik redeneer ek dat daar 'n substansiële oorvleueling of saambestaan is van die blootstelling aan kroniese trauma en trauma-verwante kliniese simptome, insluitend skaamte. Dit kom na vore in die geanaliseerde narratiewe, wat sonder uitsondering deur linguistiese fragmentering gekenmerk word. Ten slotte is 'n aantal leemtes in die literatuur geïdentifiseer. Toekomstige navorsing behoort metodes en algemeen-voorkomende kroniese trauma te trianguleer en longitudinale studies, plaaslik en internasionaal, word benodig.

## ACKNOWLEDGEMENTS

Firstly, I would like to thank the Harry Crossley foundation for funding my doctoral research. Secondly, I would like to thank my editors, proof readers and my supervisor for their considered, generous and thoughtful input into my thesis, and for their encouragement and support. Thirdly, I would like to thank the Saartjie Baartman Centre for going to great lengths to facilitate my research, and to the women I interviewed who so courageously told me their stories. It is to these women that I dedicate the following quote by Orange (2011, p. 109-110):

*“By you who walk through my door in the next hour with your unique need to be met and embraced, despite whatever I may bring that hinders or complicates my compassion, I am humbled and changed. In the face of your grief so immense that it seems a dying of sorrow right here before me, I am transformed in ways for which I have no words. In the face of your challenge not to ignore your despair by taking up easier problems, I am changed. In the face of your apparent wealth and privilege<sup>2</sup> that reawakens my rotten shame, I am changed. In the face of your history of violence and abandonment that reminds me of my own degradation but also that we share a common humanity, I am changed. In the face of your soul murder by parents [partners<sup>3</sup>] who unleashed their hatred and cruelty upon you, and who even now thwart all my capacity to comfort and protect, I am humbled. In the face of your need and desire, child and adult, to be uniquely loved and cherished, and my own complex needs to love and to cherish as well as to be loved, I am challenged and changed. As a result of our personal “participation in the suffering of the patient” (Jaenicke) “we shall be changed” (Händel). Understanding all this, I owe first to my patients...”*

---

<sup>2</sup> I interpret this symbolically or metaphorically.

<sup>3</sup> My insertion.

## CONTENTS

Declaration	ii
Abstract	iii
Opsomming	v
Acknowledgements	vii
Contents	viii
List of Tables	xiv
List of Figures	xv
List of Abbreviations	xvi
<b>Chapter 1: Trauma and Violence in South Africa</b>	<b>1</b>
Overview of the Thesis	2
The Aim of the Remaining Part of This Chapter	4
Definitions and Seminal International Works on Chronic Trauma	5
Fragmentation of Self and Memory	13
Current South African Understandings of the Consequences of Chronic Trauma	
Trauma	17
Gender and Violence in South Africa	19
Additional Contributors to IPV	23
Health and Psychological Outcomes of Gender-based Violence:	
Findings from South African Research	27
Coping and Positive Outcomes of Trauma	31
Conclusion	32
<b>Chapter 2: Theories on Shame</b>	<b>34</b>
Theories on the Nature and Functions of Shame	37

Phenomenological Theory	37
Psychoanalytic and Psychoanalytic-based Understandings of Shame	41
<i>Self-psychology</i>	44
Evolutionary Theory	47
Affect Theory	51
Cognitive Attributional Theory	53
Conclusion	56
<b>Chapter 3: Theoretically and Clinically Relevant Distinctions Between Shame and Related Emotions</b>	<b>58</b>
Shame and Guilt	59
Shame and Embarrassment	75
Shame and Pride	78
Shame and Humiliation	81
Shame, Sympathy, Empathy and Personal Distress	82
Shame, Anger, Aggression and Hostility	85
Summary of Key Points	92
<b>Chapter 4: Shame and Culture</b>	<b>97</b>
Cultures of Honour	97
Is Shame Universal or Culturally (Linguistically) Constructed?	99
Guilt and Shame in Collectivistic and Individualistic Cultures	108
<b>Chapter 5: The Associations Between Trauma, Shame and Psychopathology</b>	<b>114</b>
Trauma, Shame and Psychopathology	115

1. Causes and Correlates: The Contributions of Emotional, Physical and Sexual Abuse to Shame and Psychopathology	115
2. Causes and Correlates: The Contribution of Parenting and Attachment Patterns to Shame and Psychopathology	120
3. The Aftermath of Trauma: Shame and Complex PTSD	125
4. The Aftermath of Trauma: Shame and PTSD	127
5. The Aftermath of Trauma: Shame and Dissociation	130
6. The Aftermath of Trauma: Shame and BPD	132
7. The Aftermath of Trauma: Shame, Depression and Anxiety	133
8. The Aftermath of Trauma: Shame, the Body and Eating Disorders	136
9. The Aftermath of Trauma: Excluded Syndromes and Symptoms, Including Trauma-related Shame and Narcissism, Externalising Disorders, Psychosis and Substance Abuse	141
Summary of Key Points	142
<b>Chapter 6: Method</b>	<b>145</b>
Overall Aim	145
Objectives	145
Research Design	146
Procedure and Research Participants	146
Data Collection Instrument	148
Using a Narrative Approach: Theory and Analysis	149
Theoretical Positioning	152
Types and Modes of Narrative Analysis	155
Reflexivity	163
Discourses, Narratives, and Counter-narratives	168

Evaluating Narratives	169
The Use of Narrative Analysis in This Study	172
Research Ethics	176
<b>Chapter 7: Results and Discussion I</b>	<b>180</b>
Contextualising the Study: Impressions Before and During the Interviews	180
Categorical Content Analysis	1843
Exposure to IPV	186
<i>Physical Violence</i>	186
<i>Sexual Violence</i>	187
<i>Emotional Violence</i>	188
<i>Most Traumatic Experience</i>	191
<i>Most Difficult Feelings</i>	192
<i>Post-traumatic Changes in Perception of the Self and Functioning</i>	193
<i>Feelings About Others</i>	194
<i>Feelings Towards Perpetrator</i>	196
<i>Health and Psychopathology</i>	197
<i>Descriptions of Shame</i>	199
<i>Supports and Coping Mechanisms</i>	202
Transgenerational Trauma	205
<b>Chapter 8: Results and Discussion II</b>	<b>209</b>
Shame From a Phenomenological Perspective: A Brief Overview	210
Theorising the Split Self	211
Extracts From Cases Which Demonstrate the Split Self	212

Linda	212
Chantal	214
Denise	216
Veronica	217
Isabelle	220
Janine	222
Mandy	223
Lilly	224
Christine	225
Annabelle	227
Patricia	228
Overall Interpretation From a Phenomenological and Social Constructivist Narrative Analysis Point of View	232
Psychic Splitting at Individual Level	232
Psychic Splitting at Organisational Level	233
External and Psychic Splitting at Cultural Level	235
<b>Chapter 9: Results and Discussion III</b>	<b>241</b>
Theoretical Positioning	247
The Analysis	249
Narrative 1	250
Narrative 1: Main line/off Main line of the plot	255
Narrative 2	257
Narrative 2: Main line/off Main line of the plot	262
Narrative 3	265
Narrative 3: Main line/off Main line of the plot	270
Narrative 4	272
Narrative 4: Main line/off Main line of the plot	283
Narrative 5	293
Narrative 5: Main line/off Main line of the plot	301

Urgency to Talk vs. Narrative Compression	306
Conclusion	313
<b>Chapter 10: Review of Findings and Conclusions</b>	<b>314</b>
Trauma and Shame Related Findings: Categorical Content Analysis	315
Exposure to Trauma	315
Post-traumatic Reactions and Psychopathology	317
Post-traumatic Changes and Coping Mechanisms	320
How Was Shame Described?	322
How Did Theoretical Understandings of Shame Fit Into My Study?	326
<i>Phenomenological Theory</i>	326
<i>Evolutionary Theory</i>	327
<i>Psychoanalysis and Self-psychology</i>	328
The Split Self: Categorical Content Analysis and Narrative Analysis	330
Psychic Splitting at Individual Level	332
Psychic Splitting at Organisational Level	332
External and Psychic Splitting at Cultural Level	333
Linguistic Analysis of Trauma and Shame Narratives	335
Self-reflexivity and Intersubjectivity in Data Collection and Interpretation	344
Limitations and Recommendations	354
Conclusion	356
<b>References</b>	<b>362</b>
<b>Appendices</b>	<b>410</b>

## LIST OF TABLES

Table 3.1	<i>Key Similarities and Differences between Shame and Guilt</i>	71
Table 3.2	<i>Key Dimensions on which Post-Traumatic Shame and Guilt Differ</i>	74
Table 3.3	<i>Normal Rage and Shame-Rage</i>	88
Table 6.1	<i>Demographics</i>	147
Table 7.1	<i>Findings: Categorical content analysis</i>	185

## LIST OF FIGURES

Figure 2.1. *An evolutionary and biopsychosocial model for shame*  
(Gilbert, 2007, p. 301).

50

## **LIST OF ABBREVIATIONS**

BPD = Borderline Personality Disorder

DID = Dissociative Identity Disorder

DESNOS = Disorders of Extreme Stress Not Otherwise Specified

IPV = Intimate Partner Violence

PTSD = Post Traumatic Stress Disorder

SAHP = Social Attention Holding Power

## CHAPTER 1

### Trauma and Violence in South Africa

The thread that runs through this thesis is based on the associations between 1) being a survivor of trauma – chronic trauma specifically; 2) shame, feelings of “badness”, inferiority, defectiveness, being flawed, contaminated and deserving of traumatic events; 3) impaired self-esteem; and 4) psychopathology. The analysis focuses on a particular aspect of trauma-related psychopathology - the split self, or psychic fragmentation (aspects of dissociation), which often manifests in language in particular ways. The associations between aspects 1 – 4 may seem obvious at first glance, but often remain implicit and unspoken, much like shame itself. It is staggering how seldom shame is indexed in texts on trauma, even in contexts like South Africa where there are high levels of violence that are likely to evoke shame, like for example intimate partner violence (IPV), or sexual abuse.

The two key features of interest in my study, shame and chronic trauma-related fragmentation of self, memory/consciousness or dissociation as outlined later in this paragraph, are associated with more inclusive and comprehensive complex trauma syndromes, such as Complex Post Traumatic Stress Disorder (PTSD) and Disorders of Extreme Stress Not Otherwise Specified (DESNOS). This fuelled my interest in the subjective experience of their co-occurrence.

My study is a qualitative study focusing on the associations between exposure to IPV of any kind, and experiences of shame. Both chronic trauma and shame, as well as the relation between them, are understudied. Despite high levels of both trauma- and shame-related psychopathology in South Africa (Edwards, 2005), research in this area remains lacking. This is particularly true of process-orientated research (research that focuses on the quality and experience of shame) and research which is qualitative in nature as opposed to quantitative and outcome focused.

The reason for my emphasis on trauma is that shame is embedded in trauma. It is often the invisible, unspeakable mediator or moderator between exposure to trauma, particularly chronic trauma, and psychopathological outcomes. While there is a massive literature on trauma, and a separate, considerable literature on shame and its role in psychopathology, what

is missing is the association between the two. When shame is mentioned in the context of trauma and trauma-related psychopathology, it is often in a transient or co-incidental fashion; to date, this association has infrequently been the topic of focused attention, rarely internationally, and to my knowledge, never in South Africa.

I believe the reason for this lack of association is located in the reluctance to engage with shame as an outcome of trauma. This is due to the theoretical and emotional complexity surrounding this association. Instinctively, one would expect someone who has been traumatised to feel hurt, injured, saddened, angered – a range of negative feelings directed towards the other, the perpetrator, not bad feelings directed at the self. However, as we will discover in subsequent chapters, shame involves the self feeling bad about the self, and therefore, intuitively, it does not “fit” with trauma. It seems the wrong way round. As I will argue many times in this thesis, shame can function as a defense among people who have been abused because it is more bearable to believe that the self is bad, to blame, deserving, and so in control, than to accept that the loved perpetrator, whose abuse is random and unpredictable, is bad (Fairbairn, 1943; Ferenczi as cited in Orange, 2011). This, at first, is counter-intuitive, which is what I believe has kept these literatures separate. I hope to address this more fully in the results chapters.

Finally, I would like to say at the outset that there is some repetition in this thesis. This is because it is a complex piece, and repetition was used as a means of assisting the reader in navigating his/her way through this dense manuscript, and make links between chapters. The repetition is most prominent in the three results chapters (for instance, the choice of analytic method and Gee’s framework) due to the complexity of the analytic approach.

### **Overview of the Thesis**

The thesis is divided into five literature review chapters, one methodology chapter, three results and preliminary discussion chapters, and one review of findings and conclusion chapter. A brief overview of each chapter follows:

- This opening chapter (**Chapter 1**) provides a review of exposure to chronic violence, self and memory fragmentation (aspects of dissociation) and IPV, with a focus on South Africa. This is the first of five chapters reviewing literature relevant to this study.

- **Chapter 2** departs from exposure to violence, and shifts to focus on shame. In this chapter I locate myself theoretically, and mainly focus on phenomenology, although I select aspects of other theories which also bear relevance to my understanding of shame.
- **Chapter 3** is also a theoretical chapter, which focuses on the distinctions between shame and related (self-conscious) emotions such as guilt, embarrassment, humiliation, and pride. I also describe and compare associated constructs such as empathy, sympathy, personal distress, anger, hostility and aggression. The purpose of this chapter is to provide the reader with a thorough and detailed understanding of shame, which, as a complex construct, is not easily defined.
- **Chapter 4** is a short chapter on shame and culture. In this chapter I provide a review of shame and culture, focusing particularly on the international literature on cultures of honour and shame which have bearing on urban, poverty-stricken, patriarchal South African communities. I also review guilt and shame in individualistic and collectivistic cultures, and universalist and cultural constructions of shame.
- **Chapter 5** is the final literature review chapter and explores the associations between exposure to trauma, shame and a range of psychopathologies. I will review the literature on the contributions of emotional, physical and sexual abuse to shame and psychopathology; the contributions of parenting and attachment patterns to shame and psychopathology; and the consequences of trauma for shame reactions and a range of psychopathologies. I focus on psychopathologies such as Complex Post Traumatic Stress Disorder (PTSD), Post Traumatic Stress Disorder (PTSD), Borderline Personality Disorder (BPD), depression, anxiety, and dissociation due to their frequent association with both trauma and shame. I stress both comorbidity, and the likelihood of shame and splitting or psychic fragmentation co-occurring in chronically traumatised individuals. The empirical tone of this chapter is at odds with the ethnographic nature of my study, but is a function of the kinds of literature on trauma-related outcomes.
- In **Chapter 6**, I outline my method, including a description of my main aim and objectives, my research design, and procedure. I describe my interview schedule, and describe and defend my approach towards data analysis (narrative analysis, with a social constructivist focus), followed by ethical considerations.

- **Chapter 7** is the first of three results chapters. This chapter is a background chapter which begins with a description of my rapport-building with my participants, and then presents a mainly descriptive account of the range of psychopathological outcomes associated with IPV exposure, based on the categorical content analysis.
- **Chapter 8** is located within phenomenological theory as well as a social constructivist approach to narrative analysis, and acts as a theoretical “bridge” between chapter 7 and chapter 9. It discusses the participants’ divergent descriptions of themselves, indicative of a split between the authentic self and the false self; the perpetrator-defined self and the survivor-defined self, a common post-traumatic response. I explore to what extent this split is shame-based, and how it occurs at individual, organisational and cultural levels. These results are mostly based on the categorical content analysis, and the social constructivist approach to narrative analysis.
- **Chapter 9** presents a categorical form analysis that dovetails with the method used in chapter 8. This chapter includes a more complex linguistic analysis of trauma and/or shame narratives with the aim of exploring narrative fragmentation (as well as compression) at linguistic level, deepening the analysis presented in chapter 8. Chapters 8 and 9 also include some substantial preliminary interpretation.
- **Chapter 10** reviews the results, and links them to the theory and the findings presented in the earlier literature review chapters. I discuss the limitations to my study, and conclude the chapter with recommendations for future research.

### **The Aim of the Remaining Part of This Chapter**

The purpose of this first chapter is to orientate the reader by providing a background or social context to the study for the reader. South Africa is a violent country, which increases the likelihood and prevalence of exposure to violence and trauma, often on an ongoing basis. Although rates of unintentional morbidity and mortality (burns, road traffic or pedestrian accidents, poisoning) are unacceptably high in South Africa (Van Niekerk, Suffla, & Seedat, 2008), my focus will be on intentional violence. In the first part of this chapter, I define chronic trauma, as shame has been more consistently associated with chronic trauma than acute trauma, and I draw on the work of key international experts on trauma who focus significant attention on chronic trauma and associated psychological symptoms, such as Herman (1997), Ford and Courtois (2009), and Van der Kolk and colleagues (Van der Kolk,

2005; Van der Kolk & Fisler, 1995; Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005), as well as a recent South African publication by Kaminer and Eagle (2010) which draws together a great deal of the most important (often international) literature in this limited field. In the chapters that follow, particularly chapter 2, I rely heavily on H.B. Lewis (1971), as it is her seminal phenomenological work on shame that is the lens through which I view my data, and on Gilbert's (1998) evolutionary theory. I am aware of my heavy reliance on these scholars, which is due to the lack of alternative solid scholarship in the field. In this section I will also refer to some studies on memory/narrative fragmentation and impairment due to the centrality of these concepts to my study. Most of the trauma literature focuses on acute, single incident trauma, as opposed to chronic trauma, but since my study is on chronic trauma, only brief mention will be made of this vast body of literature. Because my participants are a group of women who are survivors of IPV, I will include a review of the South African literature on IPV in the next part of the chapter. It is, however, important to note that the focus of my thesis is not on gender-based violence as such. I am more interested in questions concerning chronicity of exposure to trauma and violence. This does not mean that gender will be ignored in this thesis. Female gender is a significant risk factor for IPV; it is the reason that I have included a rather extensive review of IPV-related studies in this introductory chapter. It is also significant that IPV involves exposure to trauma of an interpersonal nature, which has been related to the highest probability of increased PTSD symptoms (Green et al., 2000). Furthermore, the consequences of gendered vulnerability is explored in detail in chapter 8, where women explain how so-called "cultures of honour" – particular types of patriarchal cultures - play an important role in their trauma-related splitting. But I must emphasise that in terms of recruitment, I selected women who have been exposed to IPV primarily because they have, without exception, been exposed to violence on an ongoing or chronic basis.

### **Definitions and Seminal International Works on Chronic Trauma**

An influential theorist in the field of trauma, Herman (1997), has argued that among the many examples of psychological trauma which have affected public consciousness since the late nineteenth century, three are crucial to understanding contemporary views on trauma, and each has been associated with particular political movements. The first was hysteria (affiliated

with the republican, anticlerical movement of late 19th century France); the second was shell shock or combat neurosis (affiliated with post-World War I England and U.S., and post-Vietnam war); and the third is sexual and domestic violence (affiliated with the feminist movement of Western Europe and North America) (Herman, 1997), and its sequelae, which I explore in my study<sup>4</sup>. In this chapter, I rely heavily on the work of Herman (1997), consequently, when citing her extensively, I will not provide a reference after each of her assertions, only where a reference is needed for the purposes of clarity, such as at the end of a paragraph (this I will do in all cases where citing authors extensively). The subject of chronic trauma deliberately perpetrated evokes a great deal of controversy. It involves attention to the unthinkable and unspeakable, which results in long periods of amnesia, periodically forgotten and periodically reclaimed.

Defining trauma is a challenging task. The English word “trauma” originates from the ancient Greek word for “injury” or “wound” (Ford & Courtois, 2009). Trauma may be used to refer to the traumatic stressor event, including the person’s experience during the event, and the person’s response whether peri-traumatic or post-traumatic (Ford & Courtois, 2009).

According to Weathers and Keane (as cited in Ford & Courtois, 2009, p. 14):

Achieving a consensus definition of trauma is essential for progress in the field of traumatic stress. However, creating an all-purpose, general definition has proven remarkably difficult. Stressors vary along a number of dimensions, including magnitude (which itself varies on a number of dimensions, e.g., life threat, threat of harm, interpersonal loss...), complexity, frequency, duration, predictability, and controllability. At the extremes, i.e., catastrophes versus minor hassles, different stressors may seem discrete and qualitatively distinct, but there is a continuum of stressor severity and there are no crisp boundaries demarcating ordinary stressors from traumatic stressors. Further, perception of an event as stressful depends on subjective appraisal, making it difficult to define stressors objectively, and independent of personal meaning making.

Two broad but helpful conceptual perspectives have emerged in the literature addressing exposure to violence. The first trend includes research examining the effects of acute exposure to violence on intrapsychic processes (simple, single-event trauma, otherwise known as Type I trauma) (Pynoos & Eth, 1987; Terr, 1983, 1991). Research within the second

---

<sup>4</sup> There are other defining political movements as well, such as the Nazi Holocaust, and Stalanism, as well as Rwanda, among many others. I am not suggesting that trauma is defined by these movements alone.

tradition is distinguishable from the first by its focus on continuous or multiple exposures to trauma (complex or chronic trauma, otherwise known as Type II trauma) (Terr, 1991). Green et al. (2000) demonstrate that exposure to an acute trauma (Type I trauma) increases the likelihood of exposure to further trauma (Type II trauma), and that multiple exposure is associated with worse outcomes. Thus, Type I and Type II can also be distinguished by the symptoms they evoke. Terr (1991) argues that Type I and II traumas can co-exist, but that what differentiates Type II trauma from Type I trauma (apart from chronicity) is the prevalence of denial and numbing, self-hypnosis and dissociation, and rage. Furthermore, in addition to the extreme fear, helplessness and horror experienced by those exposed to Type I trauma, those exposed to Type II trauma experience disruptions in the capacity for psychobiological self-regulation and secure attachment (Ford & Courtois, 2009). What is important to note in the context of this study, is that chronic (Type II) *interpersonal* exposure has been associated with the highest risk for elevated PTSD symptoms (Green et al., 2000).

Chronic exposure to traumas including abandonment, betrayal, physical abuse, sexual abuse, threats to bodily integrity, coercive practices, emotional abuse, and witnessing violence and death, produces patterns of ongoing affective, somatic, behavioural, cognitive, relational and representational dysregulation. When experienced in childhood, such trauma exposure can lead to changed attributions and expectancies, negative self-esteem, distrust, loss of the expectation of being protected, continuous fear of future victimisation and serious functional impairments in almost every dimension of functioning, including educational, familial, relational and vocational domains (Van der Kolk, 2005).

As I show in chapters 7 and 8, for the women I interviewed, trauma was ordinary, rather than extraordinary; it was part of their daily lives. Herman (1997) argues that traumatic events are unusual not in that they occur rarely, but that they overwhelm ordinary human adaptations to life. They usually involve threats to life or bodily integrity, and/or confrontation with violence or death (Herman, 1997). Trauma evokes helplessness and terror. Herman (1997) identifies key symptoms of PTSD – hyperarousal, intrusion and constriction. Each of these symptoms is exaggerated (in intensity and duration) in survivors of chronic trauma, particularly constriction. Hyperarousal includes exaggerated startle reactions, hyperalertness, and vigilance for the return of danger, nightmares, and psychosomatic complaints. In intrusion, survivors of trauma relive the traumatic event as if it was recurring in the present. Of particular relevance to my study is that intrusive memories lack verbal narrative and context. Instead, they are remembered in the form of intense, vivid sensations and images.

Traumatized individuals may also act on intrusive memories, recreating the traumatic event, either in literal or disguised manner, so demonstrating a diminished regard for danger. In constriction, the self goes into a state of complete surrender – s/he escapes from an intolerable situation by altering his/her state of consciousness. This tendency towards dissociation and emotional numbing may occur naturally (through changes in the regulation of endogenous opioids) or enhanced by the use of alcohol and other substances. Although constriction is an effective defense against overwhelming emotion, powerlessness and helplessness, it can result in amnesia, or at the very least, truncated memory, and often leads to a narrowing or restriction of life. It also interferes with plans for the future (e.g. a sense of foreshortened future), forcing survivors to live in an endless present, the past becoming a split off, dissociated fragment, never to be accessed. Intrusion and constriction often oscillate, with an emotional instability that may exacerbate the traumatized person's sense of unpredictability, uncontrollability and helplessness. The literature on chronic trauma-related shame emphasizes rejection and immense loss as important predictors of depression (Mollon, 2002). However, learned helplessness in particular is also a primary contributor to chronic trauma-related depression (H. B. Lewis, 1987b). The chronic hyperarousal and intrusive memories of post-traumatic stress amplify the vegetative symptoms of depression. The constriction also fuses with the concentration difficulties associated with depression. The numbing of initiative associated with chronic trauma combines with the apathy and helplessness of depression. The disruptions in attachment so typical of chronic trauma (as I shall discuss later) merges with the isolation of depression. The pervasiveness of depression is perhaps accountable for the high suicide rate among survivors of IPV (Herman, 1997).

As can be seen, a number of symptoms can be evoked as a result of prolonged exposure to trauma. One of the main distinctions between PTSD and Complex PTSD is chronicity of exposure. Ford and Courtois (2009, p. 13) emphasize that symptoms associated with ongoing exposure arise when the stressors are “1) repetitive or prolonged, 2) involve harm or abandonment by caregivers or other ostensibly responsible adults, and 3) occur at developmentally vulnerable times in the victim's life, such as early childhood or adolescence”. There has been some discussion about whether shame should be included as a criterion in a number of trauma-based syndromes in the next edition of the Diagnostic and Statistical Manual (DSM) framework of the American Psychiatric Association (American Psychological Association, 1994). This is true for childhood Complex PTSD, adult Complex

PTSD and Disorders of Extreme Stress Not Otherwise Specific (DESNOS) in the same diagnostic system. It is likely to fall under alterations in self-perception.

Diagnostic criteria for DESNOS include affect and impulse dysregulation, biological dysregulation (i.e. somatisation), disruptions in attention or consciousness, distorted perceptions of the perpetrator/s, distorted self-perceptions, including profound shame and guilt, difficulties in relationships, and problematic systems of meaning or sustaining beliefs (Ford & Courtois, 2009). DESNOS is most likely to develop following trauma in early childhood and when the trauma involves interpersonal violence or violation (Ford & Courtois, 2009). Overall, it takes into account the key features of chronic trauma which are dissociation, emotion dysregulation, somatic problems, relational or spiritual alienation, impaired self development, and disorganised attachment patterns (Ford & Courtois, 2009). This prevents the individual from being able to draw upon relationships for support (Ford & Courtois, 2009). Similarly, Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola (2005) found that survivors of prolonged interpersonal trauma, especially trauma early in life, had difficulties with (a) regulation of affect and impulses, (b) memory and attention, (c) self-perception, (d) interpersonal relations, (e) somatisation, and (f) systems of meaning. These criteria are not captured by the simple PTSD diagnosis. PTSD is an anxiety disorder, while DESNOS involves self-regulatory problems that involve deep and persistent difficulties with overwhelming emotional distress, dissociation, loss of trust and faith, and chronic unexplained somatic complaints (Ford & Courtois, 2009). The co-occurrence of what in the DSM system are categorised as Axis I disorders along with PTSD, as well as Axis II disorders (i.e. personality disorders) with PTSD often leads to a somewhat confusing array of comorbidity combinations that do not cohere as a syndrome (Ford & Courtois, 2009). PTSD often involves Axis I disorders that include anxiety (phobias, generalised anxiety, panic, obsessions), mood disturbances (major depression, dysthymia, mania) or disruptions in self-regulation (schizophrenia, dissociative disorders, eating disorders, substance use disorders), and with childhood externalising and internalising disorders (Attention-deficit/hyperactivity disorder) (Ford & Courtois, 2009). Axis II personality disorders are also supposed to be distinct from PTSD, yet BPD (in particular), schizotypal disorder and antisocial personality disorders occur frequently comorbidly (Ford & Courtois, 2009). This leads to frequent erroneous diagnoses, (often BPD or schizophrenia) (Kaminer & Eagle, 2010) which undermines clinical efficiency and the effectiveness of treatments (Ford & Courtois, 2009). These authors argue that DESNOS is the closest a clinician can come to an accurate, single

complex trauma syndrome for complexly exposed adults. An equivalent syndrome that has recently been developed for complexly exposed children is Developmental Trauma Disorder (DTD) (Ford & Courtois, 2009). It is interesting to note that disorganised attachments and chronic child abuse have been identified as significant risk factors for the development of personality disorders, particularly BPD, and dissociative disorders in adulthood (Brown, Linehan, Comtois, Murray, & Chapman, 2009). Shame has been identified as a core component on this syndrome (Linehan, 1993).

Of further relevance to my study is the potential for social disconnection that trauma represents. Trauma severely impairs the traumatised individual's capacity for secure attachments (Herman, 1997). When the perpetrator is an intimate partner, the traumatised individual is extremely vulnerable, because the person who should be the safest, who should protect her, is the source of danger. This kind of violence destroys the individual's assumptions of safety, the positive value of the self and the meaningful order of the world. It undermines the survivor's sense of initiative, autonomy and individual competence, returning him/her to earlier developmental conflicts (Herman, 1997). Trauma survivors also have difficulty in emotional regulation, and may oscillate between uncontrolled rage and total intolerance of any form of aggression, a pattern that may alienate others. Similar oscillations happen in the regulation of intimacy. Trauma causes individuals both to withdraw from intimacy and seek intimate relationships desperately. Because of their particular sensitivities in relationships, trauma survivors' psychological outcomes are severely impaired if they are exposed to harsh judgments from others, but simple, easy pronouncements absolving him/her of responsibility are also not facilitative of positive outcomes.

Prolonged or chronic traumatisation has long-term consequences. These experiences tend to produce extreme difficulty in trusting others which may result in social isolation and withdrawal; alternatively, the intense need for love and acceptance in these survivors may result in him/her trusting indiscriminately or becoming very accommodating of others' needs in an attempt to prevent abandonment from them. Both these patterns are typical of disorganised attachment styles (Herman, 1997; Kaminer & Eagle, 2010). This increases the likelihood that chronically traumatised individuals continue to be emotionally or physically abused by others.

IPV is unique because women are not held in captivity, and physical barriers to escape are rare (Herman, 1997). Women are made captive by their economic, social, psychological and legal disempowerment, in addition to physical force. Captivity, whether political or domestic,

means prolonged contact with the perpetrator, which creates a relationship of coercive control. Control is established by the systematic, repetitive perpetration of psychological trauma. The two most common techniques include disempowerment and disconnection. In addition to inducing constant fear in the survivor, the perpetrator also typically seeks to impair the survivor's sense of autonomy and dignity by scrutinising and controlling her body and bodily functions, and by using sexual threats and violations or humiliations. What is so compelling in the relationship between perpetrator and survivor is that once the perpetrator has achieved bodily control over the survivor, he not only continues to control her through fear and humiliation, but by intermittently granting her small indulgences. These rewards bind the survivor to the perpetrator: apologies, expressions of love, promises of change, appeals to loyalty and compassion, all break down psychological resistance and agency. But total domination is dependent on the successful destruction of the survivors' other relationships. This is why perpetrators isolate survivors from emotional support, information or material aid. Jealous surveillance is a common form of isolating survivors of IPV. This further binds the woman to her captor, enhancing her dependence on him because he is the only human connection she has left. As Herman (1997) points out, since women frequently draw pride and self-esteem from sustaining their relationships, the perpetrator ensnares the survivor by appealing to her core values. In sum, the perpetrator holds the survivor captive, entrenching submission and compliance through evoking terror, through intermittent rewards, through social isolation and forced dependency. This may render the survivor passive or helpless because she has learnt that any initiative she takes may be interpreted as insubordination, and punished (Herman, 1997).

In Herman's words (1997, p. 69), "from those who bear witness, the survivor seeks not absolution but fairness, compassion, and the willingness to share the guilty knowledge of what happens to people in extremity". A community which acknowledges and recognises the traumas the women have endured, and tries to take some form of corrective action, Herman (1997) argues, facilitate healing. This is important because there may be another layer to chronic deliberate trauma and victimisation, which involves the way in which the perpetrator may invite bystanders implicitly to collude in the abuse. As Herman (1997) suggests, for the perpetrator to be protected from the consequences of his actions, all he requires is a kind of passivity from members of society – forgetting, secrecy, silence and denial, a collusion (even if passive) with the perpetrator's attacks on the credibility of the victim. For the victim to receive justice, much more is required of bystanders. The victim asks the bystander to believe

in and share her pain. This silencing and secrecy (which reproduces and extends the asymmetrical power relationship between abuser and victim, but in a more public domain, and which protects members of that public from having to face what to them may be horrific or unthinkable) has been labelled second injury or betrayal trauma (Ford & Courtois, 2009). It may lead to what authors have termed a splitting in the personality, where the individual maintains a front or façade of an “apparently normal” personality which is functional and, crucially, gives the victim a role in protecting the public from being exposed to the unthinkable and unspeakable. This personality in itself may however be isolated, cut off or unaware of the trauma, and disconnected from an “emotional” personality that is crippled psychosocially by the knowledge of the trauma (Ford & Courtois, 2009, p. 18).

A great deal of research shows that battered women are strongly, albeit traumatically attached to their abusers, a phenomenon which is frequently rooted in histories of disorganised attachment patterns with caregivers (Renn, 2012). Renn (2012) argues that in such situations, disturbances in attachments are the product of increasing deviations in the caregiver-child relationship which make the child’s adaptive functioning less and less likely. If the caregiver’s responses to the child generate feelings of fear, shame, and rage, feelings of threat, anxiety and insecurity, the child’s anger may become dysfunctional and “split off” – become an alien, dissociated part of the self which has implications for adult psychopathology (Renn, 2012). Renn (2012) suggests that the dominant and controlling behaviour so typical of abusers is rooted in acute separation anxiety and fear of abandonment. It is also worth emphasising, in the context of intergenerational trauma, that:

An important motivational factor in the perpetuation of archaic attachment bonds in the here-and-now is the desire to recreate a familiar relationship pattern, however violent and self-destructive this may be, precisely because it is familiar and thus, in a paradoxical way, provides a modicum of felt security. (Renn, 2012, p. 143)

Repeated traumatic experiences in childhood “train” the brain to be responsive to danger or threat at the expense of focusing on learning language, flexible adaptation to change and stress, healthy attachments and fostering exploration (Kaminer & Eagle, 2010). Thus, the neural pathways associated with responding to danger or threat become overdeveloped, and those associated with other capacities remain underdeveloped (Kaminer & Eagle, 2010). Individuals who have been chronically traumatised tend to rigidly perceive the world as dangerous, others as untrustworthy and the self as incompetent, non-deserving and worthless (Kaminer & Eagle, 2010).

## Fragmentation of Self and Memory

Fragmentation of self and memory (key features of dissociation) is a key feature of complex trauma. Special attention is given to this symptom of chronic trauma because it provides background information to the examination of splitting or psychic fragmentation of self and memory and its possible co-occurrence with shame in the narratives of the chronically traumatised women later in the thesis.

The complexity and ease with which trauma narratives can be read depends on the peri-traumatic dissociation of narrators (Zoellner, Alvarez-Conrad, & Foa, 2002). Results of the Zoellner et al. (2002) study indicate that trauma narratives constructed by those with high peri-traumatic dissociation had higher grade levels and a tendency toward reading ease (indices of sophistication of articulation) than the narratives constructed by low dissociators. Finding the association with higher grade levels was contrary to expectation, since higher grade level has been associated with lower PTSD symptoms (Zoellner et al., 2002).

Van der Kolk and Fisler (1995) argue that trauma memories in those with PTSD are unique because they involve learned conditioning, difficulties in modulating arousal, and shattered meaning propositions. These difficulties are characterised by changes in neurobiological processes affecting discrimination (manifesting as increased arousal and decreased attention), the acquisition of conditioned fear responses to trauma-related triggers, and changed cognitive schemata and social fear (Van der Kolk & Fisler, 1995). It is declarative memory (explicit memory) which involves conscious awareness of facts or events that is seriously adversely affected by lesions of the frontal lobe and of the hippocampus, which have also been implicated in the aetiology of PTSD (Van der Kolk & Fisler, 1995). Dissociation (a central feature of PTSD) interferes with semantic memory and complicates the ability to communicate the trauma (Van der Kolk & Fisler, 1995). Interestingly, these authors report that during the provocation of traumatic memories, there was a reduction in the activation of Broca's area in the brain, the part of the central nervous system implicated in the transformation of subjective experience into language. At the same time, the areas in the right hemisphere associated with the processing of intense emotions and visual images markedly increased in activation (Van der Kolk & Fisler, 1995). This explains why traumatic experiences are initially organised without semantic or linguistic representations; traumatic memories tend to be experienced as fragments of the sensory components of the event, or as

intense emotions, particularly initially (Van der Kolk & Fisler, 1995). Participants in this study all reported that they initially “remembered” the trauma in the form of somatosensory flashback experiences, occurring as visual, olfactory, affective, auditory and kinaesthetic modalities (Van der Kolk & Fisler, 1995). One of the unique characteristics of traumatic memory is that it is characterised by intense autonomic hyperarousal, and the repetitive, fixed, intrusive reliving of traumatic memories when in similar situations (Van der Kolk & Van der Hart, 1995). It was only over time that the participants in Van der Kolk and Fisler’s (1995) study could construct a narrative that explained what happened to them; once they had become more aware and conscious of what the traumatic experience entailed.

This fragmented quality of traumatic memory is explained by Van der Kolk and Van der Hart (1995) as occurring because familiar and expectable experiences are automatically integrated, while terrifying or novel experiences may not fit as neatly or easily into existing cognitive schemas, and so resist integration. Pre-existing schemas determine to what degree new information is integrated (Van der Kolk & Van der Hart, 1995). New experiences are understood only in the context of prior schemas, which has implications for the association between childhood and adult onset abuse (Van der Kolk & Van der Hart, 1995). Unintegrated memories become subconscious fixed ideas; it is as if chronically traumatised people experience arrested personality development at the point of trauma(s), and they are unable to change or expand by the addition or assimilation of elements (Van der Kolk, 1994; Van der Kolk & Van der Hart, 1995). The most extreme form of this is Dissociative Identity Disorder (DID) (Van der Kolk & Van der Hart, 1995). The healthy mind creates flexible schemas, and constantly searches for new ways of putting experiences together, and for new categories to create (Van der Kolk, 1994; Van der Kolk & Van der Hart, 1995). In addition, the healthy mind is more likely to reflect accurate memories when new ideas and information are combined with old knowledge because it is able to create flexible mental schemas (Van der Kolk & Van der Hart, 1995). These authors argue that recovery could be encouraged by bringing a survivor back to the state in which the traumatic memory was first experienced in order to create the condition in which the fragmented, dissociated memory could be integrated into present meaning schemas.

The way in which the trauma is represented in memory affects how trauma narratives are articulated. Trauma can lead to either retention or forgetting – in some instances the event is remembered vividly and with clarity, in other instances all memory may be lost or absent, so totally resisting integration (Van der Kolk & Fisler, 1995). In instances where abuse began

early, and was prolonged, the survivor is likely to suffer significant memory loss or amnesia . When the survivor also suffers from dissociation, it makes it all the more difficult to construct a coherent autobiographical narrative; this is due to disruptions in memory (Van der Kolk & Fisler, 1995).

Many scholars argue that memories of traumatic events are more fragmented and disorganised than memories of non-traumatic memories; and that individuals with PTSD have the most fragmented and disorganised events (Amir, Stafford, Freshman, & Foa, 1998). These authors found that the level of articulation (simplicity/complexity) of rape narratives was inversely associated to chronic PTSD, which is consistent with the idea that simpler, less developed trauma narratives impede recovery (Amir et al., 1998). Unlike Amir et al. (1998), however, Gray and Lombardo (2001) found that differences between PTSD and no PTSD groups on writing complexity measures for trauma narratives disappeared when cognitive and writing skills were controlled for.

Contrary to Koss, Figueredo, Bell, Tharan, and Tromp's (1996) expectations, in a study of rape narratives (compared to narratives about other unpleasant and pleasant events), they found that these narratives were less clear and vivid, less visually detailed and less likely to occur in meaningful order, less well-remembered, less communicated about, less commonly recalled either voluntarily or involuntarily, with less sensory components, and including less re-experiencing of the physical sensations, emotions, and thoughts that accompanied the original trauma. Impaired recall was attributed to the blame and shame surrounding rape, which may facilitate cognitive avoidance of the incident (Koss et al., 1996). Other studies have also explored cognitive (and emotional) disruptions in processing associated with post-traumatic symptoms. Newman, Riggs and Roth (1997) found that individuals with PTSD and concurrent Complex PTSD experienced more difficulty in adaptively resolving trauma-related emotional themes (including shame) than individuals without PTSD and those with PTSD who did not have concurrent Complex PTSD. These individuals' narratives were also characterised by a great deal of thematic disruption or fragmentation (Newman et al., 1997). Thus, thematic (non-) resolution and disruption were only characteristic of those with the most severe post-trauma pathology, which the authors attributed to changes in basic cognitive-affective organisation.

Halligan, Michael, Clark and Ehlers (2003) also examined traumatic memory. These authors argued that although survivors may remember some features of the trauma with surprising clarity, the overall memory structure is typically confused, and characterised by uncertainty

around the sequence of events, with some aspects of the trauma erased from memory. It is important to note dissociation, surface-level, data-driven processing (i.e. processing sensory impressions and perceptual characteristics) or lack of self-reference processing (i.e. an inability to establish a self-referential perspective) during the trauma is associated with disorganised trauma memories, and this was particularly evident among current PTSD participants and recovered PTSD participants (compared to the no PTSD group). Trauma memory disorganisation was one of the factors that predicted chronic PTSD (Halligan et al., 2003).

A large body of research on trauma cognition suggests that traumatic memories in individuals diagnosed with PTSD should be dominated by sensory impression, perceptual characteristics and emotional experience; should lack interconnection and organisation, particularly in personal or event time; should lack a self-referential perspective, but where it does occur, be pervaded by themes of negative self-evaluation, ineffectiveness, disempowerment and loss of agency (all correlates of shame) (O’Kearney & Perrott, 2006). In their review of this body of literature, the authors demonstrate that there is a predominance of sensory/perceptual/emotional language in PTSD trauma narratives, and that there is an association between this kind of language and peri-traumatic dissociation and intrusive memories. The aspect of trauma narratives which was most severely affected was temporal organisation (O’Kearney & Perrot, 2006).

Sawyer’s (2003) work is also of relevance here. He supports the idea that narrative coherence increases across repeated utterances of the story. For him, narrative coherence is the conciseness with which the story can be told. Thus, his focus is not on interrelatedness, but on precision in narratives (Sawyer, 2003). This increase in precision and conciseness in narratives is known as narrative compression<sup>5</sup>, and it is thought to contribute to cognitive development (Sawyer, 2003). Whether narrative compression applies to trauma narratives remains to be seen. If it can be applied to trauma narratives, it might be used to explain why some women had shorter trauma narratives than others – perhaps these women had told their story many more times than the women with longer, more complex narratives. This proposition, however, is in conflict with the vast majority of research which indicates that longer and more complex trauma narratives are characteristic of recovery from trauma, e.g. Gray and Lombardo (2001).

---

<sup>5</sup> The term “compression” is used later in the thesis to refer to some of the narratives examined in the analysis chapters, but is not used in the same way as in Sawyer (2003) – in the analysis, it is meant only to point to the length of the narrative.

In this section we have looked specifically at fragmentation of self and memory as a very particular symptom of chronic trauma. In the next section I broaden my focus. Since traumatic experiences are always socially located, I turn now to a discussion of trauma and violence in South Africa.

### **Current South African Understandings of the Consequences of Chronic Trauma**

Published, systematically collected information about the impact of chronic exposure to trauma and violence is lacking (Kaminer, 2010). Most research focuses on “simple” or acute trauma, and its clinical consequences, without attention to continuous exposure in high-risk contexts such as South Africa, and possible mediators or mechanisms for activating this association. We still know very little about the psychological effects of prolonged child physical and sexual abuse and IPV. Though this gap in the literature is a problem world-wide, there is a special need for research in this area in South Africa, where rates of ongoing abuse are high (Kaminer & Eagle, 2010). Thus, the psychological consequences of multiple or chronic traumatisation still remain unclear – this is both because we lack the necessary data and because the clinical picture is complex. These survivors often develop psychological symptoms that are not consistent with PTSD or other diagnoses typically associated with acute trauma (Kaminer & Eagle, 2010). This is because there is no “post” trauma in the lives of people who are exposed to continual, ongoing trauma across their lifespan (Kaminer, 2010). As has been noted, some researchers have noted that the pattern of psychopathology accompanying complex trauma involves dysregulation of affect and impulses (ongoing distress, self-harming or high-risk behaviour), biological dysregulation (somatisation), dysregulation of attention or consciousness (dissociation), alterations in self-perception (intense shame and guilt, poor self-esteem, viewing the self as deeply damaged and ineffectual), distortions in the perception of the perpetrator (idealisation or constant preoccupation with revenge), disturbed relations with others (difficulty in trusting, revictimisation and avoidance of sexuality), and alterations in systems of meaning (loss of faith and hopelessness) (Benjamin & Crawford-Browne, 2010). This has led to suggestions that in the context of chronic and complex trauma, the diagnostic categories of Complex PTSD and DESNOS are more appropriate than PTSD (Benjamin & Crawford-Browne, 2010).

The psychological consequences of prolonged or chronic traumatisation are thus complex, and may differ from classic PTSD symptoms, thus rendering diagnosis difficult. Due to this, and the fact that survivors – due to feelings of shame – frequently do not share their traumatic experiences, these patients are often diagnosed with a “mixed bag” of different disorders (Kaminer & Eagle, 2010). As I have emphasised, without an understanding of the complex manifestations of chronic traumatisation, these individuals may repeatedly receive ineffective treatment (Kaminer & Eagle, 2010).

Trauma is implicated in the aetiology of most psychological disorders, and internationally, as in the South African context, substance abuse, phobias and depression, and particularly somatic symptoms are – in addition to PTSD – common responses to trauma (Kaminer & Eagle, 2010). Other psychological phenomena associated with chronic trauma include a disturbed sense of personal identity, manifest in feelings of fragmentation (e.g. experiencing feelings as being foreign, uncontrollable and frightening), detachment, feelings of non-existence, and alterations in consciousness (such as “blacking out” and not being aware afterwards of what s/he said or did while this happened). Echoing international literature, Kaminer and Eagle (2010) stress that survivors of chronic trauma may also experience feelings of helplessness, powerlessness and passivity, and typically blame themselves rather than the perpetrator for the abuse. This is because it is more tolerable to believe that the self is bad and deserving of maltreatment than to believe a loved one has chosen to hurt them. These feelings give rise to feelings of worthlessness, feelings of being despicable, unlovable, contaminated and possibly evil, all of which are accompanied by the experience of shame (Kaminer & Eagle, 2010).

Survivors of chronic trauma may engage in either or both behavioural self-blame (e.g. I was not vigilant enough or I didn't fight back hard enough) and characterological blame (I was chosen as a victim because of my character or personal qualities) (Kaminer & Eagle, 2010). There is some evidence that characterological self-blame occurs more frequently in those who have been chronically traumatised, and that it is associated particularly with depressive symptoms and low self-esteem (Kaminer & Eagle, 2010).

There are a small number of primary studies on chronic trauma in South Africa, but they focus on children and adolescents, and/or political violence, which make them inappropriate for citing in this study (Barbarin, Richter, & DeWet, 2001; Shields, Nadasen, & Pierce, 2008; Suliman et al., 2009; Ward, Flisher, Zissis, Muller, & Lombard, 2001; Williams et al., 2007), and thus they are excluded.

An exception is a nationally representative study emphasising the co-occurrence of various forms of violence, where the authors found that three quarters of South Africans had experienced at least one traumatic event during their lifetimes, the most common of which was the unexpected death of a loved one (Williams et al., 2007). Other traumas that occurred frequently included witnessing trauma, threats to one's life, criminal victimisation and IPV. In this study, exposure to one form of violence put the individual at risk of exposure to other forms of violence. As a result, participants experienced high levels of psychological distress, which put them at risk for developing clinically relevant disorders (Williams et al., 2007).

To conclude this section, as noted at the outset of the thesis, I will not be reviewing South African studies on acute trauma. For the interested reader, there is a huge body of research on both the prevalence and consequences of acute violence in South Africa (Barbarin & Richter, 2001; Bouver & Stein, 1998; Carey, Stein, Zungu-Dirwayi, & Seedat, 2003; Dawes & Ward, 2008; Ford & Courtois, 2009; Jewkes, Levin, Mbananga, & Bradshaw, 2002; Kaminer, Grimsrud, Myer, Stein, & Williams, 2008; Norman, Matzopoulos, Groenewald, & Bradshaw, 2007; Schoeman, Carey, & Seedat, 2009; Seedat, Stein, & Carey, 2005; Van der Merwe & Dawes, 2000; Williams et al., 2007).

### **Gender and Violence in South Africa**

Defining violence against women is a complex task – the terms domestic violence, gender-based violence, and IPV are often used interchangeably, although there are distinctions between them. IPV is the most specific of these terms, and describes perpetration of psychological, emotional or verbal abuse; social abuse (social isolation); economic abuse; and sexual abuse and physical abuse by an intimate partner (Woelz-Stirling, Kelaher, & Manderson, 1998). There is general consensus in the literature that interpersonal violence falls into two broad categories: predatory and psychopathic violence which is premeditated and emotionless, and where the perpetrator has no attachment relationship with the victim; and defensive or affective violence, which results in the belief that the individual's personal safety or sense of self are under threat, which is preceded by high levels of emotional arousal (Renn, 2012). Intimate partner violence occurs on a continuum from shoving on one end to homicide on the other (Renn, 2012). In the brief review that follows, I will include studies focusing on

all forms of gender-based violence, not only IPV, due to the limited literature available. None of the literature I accessed included shame as an outcome of IPV.

According to some estimates, one in two women in South African is exposed to IPV (Vetten, 2005). This is despite a legal and constitutional human rights framework which seeks to promote women's empowerment and which led to the passing of the progressive Domestic Violence Act in 1998 (Vetten, 2005). Critics have pointed out that although the legislative environment is considered enabling, many legislative and policy-driven interventions are not effectively put into practice (Smythe, Artz, Combrinck, Doolan, & Martin, 2008). To effectively address the needs of IPV survivors, there need to be integrated medical and legal responses (Smythe et al., 2008). These authors argue that in practice – in primary health care settings, at police stations and in the courts, the Domestic Violence Act is having “inconsistent and often ineffectual results” (Smythe et al., 2008, p. 155). In a study exploring the budget allocation to the Act's implementation, Vetten (2005) found that daily expenditure points to the Act being both under-funded and under-prioritised. Vetten (2005, p. 277) argues that “lack of budget and absence of political space demonstrates weak political accountability to women”. This may be due to the widespread tolerance of the use of violence against women in South Africa, again, despite a progressive legislative and constitutional framework (Jewkes, Levin, & Penn-Kekana, 2002).

In conflict with the findings reported at the beginning of the previous paragraph, a nationally representative study found a 19% lifetime prevalence of IPV among female participants, and 27% of men reported perpetrating IPV in their current or most recent relationship (Gass, Stein, Williams, & Seedat, 2010). The mortality rate of women as a result of IPV in South Africa is unacceptably high, more than double the rate found in the United States (Abrahams, Martin, Mathews, Vetten, & Lombard, 2009). IPV is one of the leading causes of morbidity and mortality for South African women (Gass et al., 2010). A recent epidemiological study, including a proportionate random sample of 25 mortuaries, found that of the 3 797 female homicides in South Africa between 1 January and 31 December 1999, 50.3% were from IPV (Abrahams et al., 2009). The mortality rate was 8.8 per 100 000 women, and death from IPV was especially prevalent among women aged 14 to 44, and among non-White women (Abrahams et al., 2009). Cause of death was most commonly through blunt force injuries, sharp injuries and gunshot injuries, whereas strangulation, asphyxiation, burns and drowning were less common (Abrahams et al., 2009).

Although accurate statistics are difficult to come by, rape and sexual coercion seem to be rife in South Africa (Jewkes & Abrahams, 2002). Available data indicate that 240 incidents of rape and attempted rape per 100 000 women are reported each year. Age is an important risk factor. Representative community-based surveys have shown that those between the ages of 17 and 48 are particularly vulnerable. In addition, approximately one third of adolescent girls were forced into sexual initiation. One point six percent of women reported being coerced into having sex before the age of 15, with 3.3% reporting having been sexually touched against their will, and 1.1% reporting having been forced to touch a man's genitals.

Community-based rape studies indicate that rape is more prevalent in Mpumalanga than other provinces. Studies indicate that the incidence of rape homicide is 7.2 per 100 000 or 1.2%. Finally, the under-reporting of non-consensual sex (sex agreed upon after blackmail, threats, trickery or pleading) occurring within marriages or dating relationships – due to self-blame or shame, for instance – is emphasised by these authors (Jewkes & Abrahams, 2002).

Different types of IPV tend to overlap and co-occur (Dunkle, Jewkes, Brown, Yoshihama et al., 2004). In fact, sexual and physical violence is more likely to occur when economic and emotional abuse are also present, suggesting that IPV, as a whole, is part of a broader pattern of dominant and controlling behaviour. In a study exploring the prevalence and patterns of IPV among women attending antenatal clinics in Soweto, the findings show that approximately one third of women reported physical and/or sexual violence from male intimate partners. The age of onset for IPV was 12 to 39 years, with a higher incidence from late adolescence onwards. Almost 8% of participants reported that the onset of adult sexual assault by a non-partner was at its highest before the age of 20 years, with no significant rise in cumulative incidence after this age. Eight percent of participants had a history of child sexual abuse, and 7% disclosed forced first intercourse at the age of 15 or more years (Dunkle, Jewkes, Brown, Yoshihama et al., 2004). Child sexual abuse and forced first intercourse was significantly associated with higher risk and earlier onset of IPV, and adult sexual assault by a non-partner (Dunkle, Jewkes, Brown, Yoshihama et al., 2004).

A recent large-scale study found a number of gender differences in exposure to violence and PTSD. Firstly, men were exposed to more violence than women (Kaminer et al, 2008). Secondly, the pattern of exposure differed between men and women. Men most frequently experienced criminal and miscellaneous assaults, followed by childhood physical abuse, physical assault that is not domestic, criminal, political or sexual in nature, then politically motivated violence, while they were at very low risk for IPV and sexual violence. For women,

physical assault by an intimate partner, childhood physical abuse and criminal assaults were most prevalent, while sexual violence or experiencing a physical assault that is not domestic, criminal, political or sexual in nature is less common, and they are at very low risk of being victimised by politically motivated violence. Furthermore, for men, political detention and torture were most powerfully associated with a lifetime diagnosis of PTSD, while rape was most robustly associated with PTSD in women. At a population level, it was found that criminal assault and childhood abuse were related to the most PTSD cases among men, while IPV was related to the greatest number of PTSD cases among women (Kaminer et al., 2008).

Similar findings are reported by Williams et al. (2007). Most South Africans experience multiple traumas, and that risk of exposure varies according to particular socio-demographic factors, including gender. Women were more likely to be exposed to intimate partner abuse and sexual assault and to be affected by traumatic events experienced by those close to them, while men were more likely to be exposed to criminal and political violence, threats to life and witnessing traumas. In this study, men were more likely to have been exposed to six or more traumas, however, the rate of sexual assault among men was low (3.5%) compared to the levels among women (5.6%).

It is important for completeness to mention that although (female) gender is a significant risk factor for IPV, and plays an important role in (more severe) reactions to traumatic stress, gender-based violence also affects men. Although the rate of sexual abuse of males in particular is lower than that of females, in one study this kind of abuse had similar effects on male survivors as it has been shown to have on female survivors. In this study, including male students from the former University of Natal, South Africa, the author found a significant association between contact (sexual intercourse, manual/oral genital contact, or sexual touching/kissing) as opposed to no, or non-contact sexual abuse (such as exhibitionism or sexual requests) and poor psychological adjustment, including severity of somatisation, obsessive-compulsive tendencies, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism (Collings, 1995). This association persisted even after the significant predictive effect of rejecting and abusive parenting on psychological adjustment was controlled for (Collings, 1995).

The causes of trauma may vary from one sample to the other, depending on the particular risk factors prevalent in their community. In a more privileged sample of students attending the then Pretoria Technikon, the most frequently reported traumatic event was death of a loved one, through motor vehicle accidents or suicide (Hoffmann, 2002). Negative changes in life

circumstances of quite different kinds was the second most frequently reported trauma, including the ending of a love relationship or the divorce of parents. The third most frequently reported trauma in this sample was being witness to injury or death, mostly through motor vehicle accidents (Hoffmann, 2002). The least reported traumatic event was a natural disaster (Hoffmann, 2002). For most trauma categories, the experience of intrusive thoughts was the most common symptom (Hoffmann, 2002).

### **Additional Contributors to IPV**

Supporting gender inequality and the normative use of violence in conflict or punishment situations have been identified as important contributors to IPV, but there are many others (Abrahams, Jewkes, Laubscher, & Hoffman, 2006; Jewkes et al., 2002). Risk factors for violence against women in the past ten years, perpetrated by men working in Cape Town municipalities, included no post-school training, witnessing parental violence in childhood, involvement in physical fights at work and in the community, drug use, alcohol misuse, the perception that physically assaulting women is acceptable, frequent conflict, women's problematic alcohol use, conflict about sex or about his infidelity (Abrahams et al., 2006). Forty two percent of men in this sample reported physically assaulting a partner in the past ten years, with approximately 9% reporting physical assault against a partner in the past year (Abrahams et al., 2006). Campbell (2002) similarly found that the characteristics which made males more likely to perpetrate IPV included histories of arrest, substance abuse, poor education, unemployment, and ex-partner status. It is interesting to note that although some research has indicated that there is an association between IPV and lower educational status, other research does not demonstrate this association (Seedat, Stein, & Forde, 2005). It seems that the relationship between these variables is more complex, and that women with the highest and lowest education levels are the most protected from IPV (Seedat, Stein, & Forde, 2005).

The role of socio-demographic variables in IPV was also explored by Jewkes et al. (2002). Their study showed that IPV was positively related to having no further education, either partner financially supporting the home, and living outside the Northern Province. Other variables that were positively associated with IPV included drinking alcohol, having another partner in the year, having a confidante, his boy child preference (a measure of the male

partner's conservatism), conflict over his drinking, and frequent conflict generally. Somewhat surprisingly, partners' ages, employment, migrant status, financial disparity, cohabitation, household possessions, urbanisation, marital status, crowding, communication, his having other partners, his education, her attitudes towards violence or her attitudes towards cultural norms on women's role did not associate significantly with IPV (Jewkes et al., 2002).

Cultural and socio-economic factors impact on the nature of both violence exposure and on protective factors against the adverse effects of such exposure. In a study located in three high schools in the Northern Province – one of them in a village (Graskop), one in a semi-urban area (Mahwelereng), and another in an urban city (Pietersburg), Madu and Peltzer (2000) found that four risk factors were responsible for discriminating between instances of child sexual abuse and non-abuse, namely, ethnicity not Northern Sotho (other ethnicities including Venda, Xitsonga, White, Coloured or Asian), mother being employed and above the level of a labourer, stepparent being present during childhood, and frequent violence at home (Madu & Peltzer, 2000). Unfortunately, these authors do not provide any explanation for the risk status of Northern Sotho ethnicity. In another study, single parenthood was also identified as a risk factor for child sexual abuse (Carey, Walker, Roscoe, Seedat, & Stein, 2008). A great deal of this risk can be explained by mothers being absent from home and current male partners having access to otherwise unsupervised children. Madu and Peltzer (2000) argue that in order to protect children from sexual abuse, the “cultural permissiveness of men to commit sexual abuse needs to be challenged and replaced with a moral belief which holds men responsible for channelling their sexuality within legal and ethical boundaries” (Madu & Peltzer, 2000, p. 267).

The importance of child abuse in the inter-generational cycle of IPV has been emphasised in a number of studies. For example, being physically abused in childhood and witnessing maternal abuse significantly influenced women's lifetime experiences of violence (Jewkes et al., 2002). Child sexual abuse is associated with heightened risk of both physical and sexual partner violence and adult sexual assault by a non-partner (Dunkle, Jewkes, Brown, Yoshihama et al., 2004). Gender has been identified as a risk factor for child sexual abuse (Carey et al., 2008). In a sample of children and adolescents drawn from a clinic in Stellenbosch emotional and physical abuse were also associated with higher levels of child sexual abuse, which once again points to the co-occurrence of different forms of violence exposure (Carey et al., 2008). Both depression (33%) and PTSD (63.8%) were the most common disorders associated with exposure to child sexual abuse (Carey et al., 2008).

Furthermore, this study indicates that having a forced early sexual experience, regardless of what age it takes place, increases the risk of later experiencing IPV (Dunkle, Jewkes, Brown, Yoshihama et al., 2004).

A large number of female students (31% of child sexual abuse survivors) from the then University of Natal reported that their sexual abuse was perpetrated by a family member (Collings, 1997). This replicates a number of findings which indicate that girls are at greater risk of experiencing intra-familial forms of sexual abuse. Sexual abuse was associated with more PTSD symptoms, higher levels of sexual conflict, more suicidal feelings and impaired self-esteem. It is emphasised that any comprehensive aetiological explanation of child sexual abuse also needs to take into account parenting variables such as parenting style (supportive or punitive), which can exacerbate or ameliorate the primary trauma (Collings, 1997).

Other factors, such as a rural setting, also play a role in rates of child sexual abuse. Madu (2001) found relatively low levels of child sexual abuse (both for men and women) among psychology students at the then University of the North (in the rural Northern Province), and attributes these rates to the likely low levels of substance abuse, the physical availability of caregivers, and to adherence to cultural values in the area. Findings are inconsistent. Peltzer (1999) found that 67% of children in a rural South African community had directly or vicariously experienced a traumatic event, including witnessing someone killed or seriously injured, violent or very unexpected death or suicide of a loved one, serious accident, sexual abuse or rape of a relative or friend, violent crime, child abuse and other life-threatening situations. Eight percent of the sample met criteria for PTSD (Peltzer, 1999).

Wood, Lambert and Jewkes (2008) argue that South Africa's history of colonialism, industrialisation and militarisation has allowed violence of all kinds to thrive. They suggest that high levels of violence in post-Apartheid South Africa should be viewed:

In the context of the redefinition of gender and the liberalization of sexuality entailed by democratic transition, which have posed serious challenges to orthodox, mainly authoritarian notions of masculinity, leaving many men with a disempowering sense of irrelevance in the domestic sphere. (p. 47)

It is this sense of "irrelevance" which has produced a culture of male disciplinary rights over women, where aggression against women became one manner of reclaiming power in a society from which men feel largely excluded (Wood et al., 2008). In modern, urban, poverty-stricken settings where economic power is beyond young men's reach, the energy and

competitiveness that these men may put into attaining and controlling their partners is not challenging to grasp (Wood et al., 2008).

Young men participating in the cited ethnographic study of IPV in the former Transkei report that behaviour requiring discipline include when women made “fools” of men through actual or suspected infidelities, refusing sexual demands, resisting their partners’ attempts to control their behaviour, resisting partners’ attempts to have control over the terms of the relationship (like when they meet), and their attempts to thwart their partners’ chances of pursuing a sexual relationship with another woman. Controlling women’s behaviour was interpreted as a key means of reducing their vulnerability and powerlessness (Wood et al., 2008).

The principal girlfriend (a *queen* or 5-60, after the Mercedes-Benz model of car) was invested in a great deal emotionally, but was reportedly the most likely to be assaulted (Wood et al., 2008). Abuse tended to be followed by apologies or “sweet talking”, and many men stated that the amount and quality of attention a man gave his partner after an assault “proved” how much he cared for her; conversely, lack of care was demonstrated by a lack of tenderness and attempts to reconcile after the violent incident (Wood et al., 2008). The oft heard saying that “if he beats you, he loves you” demonstrates a link between love and discipline, and suggests that women need moral supervision by a partner who cares enough to enforce appropriate behaviour, and that assault is a statement of the seriousness of his intentions and is constitutive of love (Wood et al., 2008, p. 62). There was an assumption by men and women that men simply knew better and were protecting the relationship because they prized it, and that such moral discipline is necessary because women can’t think for themselves (Wood et al., 2008). Many men seemed to have a hierarchy of assaults, with slapping being condoned, while other forms of violence, such as kicking and punching were resorted to only when violence escalated or a woman’s transgression was thought to warrant such behaviour (Wood et al., 2008). As noted by Wood et al. (2008, p. 54), however, injuries in general, but particularly those that disturbed everyday life, were considered “beyond love”.

In this study, men tended to justify their violence as a result of being a victim of their passions; as a victim of caring too much about a relationship. Women on the other hand, were resistant to report injuries because of a number of prominent discourses, such as the importance of Christian forgiveness and the intolerance towards women expressing anger. Wood et al. (2008) further argue that the discourse which constructs women as both strong and suffering also contributes to the privileging of male concerns.

## **Health and Psychological Outcomes of Gender-based Violence: Findings from South African Research**

In keeping with the international literature, individuals' coping style and perceived social support may impact on the development of PTSD. A recent study of police officers demonstrated that problem-focused coping (involving interpersonal efforts to solve and engage effectively with stressors) and emotion-focused coping (involving the reduction of stress through regulation of emotions) and perceived social support predicted PTSD scores, with emotion-focused coping and social support playing a protective role (Jones & Kagee, 2005). Problem-focused coping was positively associated with PTSD symptom severity, which was explained by the nature of police work – involving stressors that cannot easily be solved. Contrary to expectations, this study shows that gender and extent of service played a minimal role in explaining the development of PTSD symptoms (Jones & Kagee, 2005).

Severity of abuse, previous trauma and partner control and dominance play important roles in PTSD developing from exposure to IPV (Campbell, 2002). Women tend to be more vulnerable to PTSD, anxiety and depression across cultures, even when the severity of the trauma is taken into account (Seedat, Stein, & Carey, 2005; Suliman et al., 2009). Women are twice as likely to develop PTSD as men, the illness lasts about four times longer in women than in men, and the quality of life outcomes for women are poorer than they are for men (Seedat, Stein, & Carey, 2005) (although this finding has not been replicated consistently; see Carey et al., 2003; Madu & Peltzer, 2000). This is despite evidence that the lifetime prevalence of exposure to traumatic stress is higher in men (Carey et al., 2003; Seedat, Stein, & Carey, 2005) (although this has been disputed by the findings of Hoffmann, 2002).

Serotonergic, noradrenergic, neuroendocrine, glutamatergic, GABAergic and opioid systems have been identified as playing a role in the altered stress/fear response in women (Seedat, Stein, & Carey, 2005). The gender differences in terms of sexual trauma may also account for higher levels of PTSD symptomatology in women (Hoffmann, 2002; Seedat, Stein, & Carey, 2005). However, factors other than trauma type are implicated in the development of PTSD symptoms, including, for example, gender differences in perceptions of the traumatic events and peri-traumatic dissociation (Seedat, Stein, & Carey, 2005). There are also gender differences in the treatment of PTSD. Recent research has shown that women are more

responsive to pharmacotherapy than men, and that PTSD in women can be effectively treated with Selective Serotonin Reuptake Inhibitors (SSRI's), either alone or in combination with cognitive behavioural strategies (Seedat, Stein, & Carey, 2005). Furthermore, antiadrenergic agents and preventive cognitive behavioural treatments have been recommended for preventing the onset of PTSD (Seedat, Stein, & Carey, 2005).

In studies where the rates of PTSD were lower than expected among women survivors of IPV, the rate of partial PTSD was high (Seedat, Stein, & Forde, 2005). Although there was no significant relationship between the frequency of physical abuse and PTSD in Seedat, Stein, and Forde's (2005) study, there was an association between frequency of beatings and intrusive and hyperarousal symptoms, however, not with avoidance or numbing symptoms. In addition, IPV was found to be a risk factor for suicide attempts, although PTSD was not (Seedat, Stein, & Forde, 2005).

A recent review shows that there are a number of health consequences to IPV; women who have experienced this kind of violence tend to have poor health status, poor quality of life, and higher use of health services (Campbell, 2002; Gass et al., 2010). The physical injuries, as well as high levels of fear and stress can lead to chronic health problems such as persistent pain (particularly back pain and headaches), a suppressed immune system and central nervous system symptoms such as fainting and seizures (Campbell, 2002). Assaults such as choking and blows to the head that may result in loss of consciousness can lead to serious neurological symptoms (Campbell, 2002). Women who have survived IPV have more gastrointestinal problems (e.g. loss of appetite and eating disorders) and functional gastrointestinal disorders such as irritable bowel syndrome which manifest as a result of stress (Campbell, 2002).

Cardiac symptoms, including hypertension and chest pain are also more likely in survivors of IPV (Campbell, 2002). Other symptoms that have been reported include joint disease, asthma, arthritis, sexually transmitted infections, vaginal infections, abdominal pain and shortness of breath (Gass et al., 2010; Valente & Jensen, 2000). Abused women also have a higher probability of engaging in risk behaviours such as smoking, alcohol and cannabis use and the non-medical use of sedatives and analgesics (Gass et al., 2010). Poor health outcomes may be exacerbated by alcohol and drug abuse, used as a means of coping with PTSD symptoms, or as a means of escaping frightening realities (Campbell, 2002).

Gynaecological problems are the most consistent, robust and enduring difference between battered and non-battered women (Campbell, 2002). Forced sex in particular may lead to vaginal, anal and urethral trauma, which in turn leads to increased transmission of micro-

organisms, accounting for the association between IPV and sexually transmitted diseases and HIV (Campbell, 2002). The prevalence of IPV during pregnancy in South Africa is 6.8% (Campbell, 2002). This type of abuse is associated with compromised health outcomes during pregnancy, including sexually transmitted diseases, urinary-tract infections, substance abuse, depression and other mental health difficulties (Campbell, 2002). Evidence also suggests that IPV during pregnancy is associated with preterm deliveries, foetal distress, antepartum haemorrhage, and pre-eclampsia (Campbell, 2002). It is interesting to note that maternal low weight gain, smoking, or both, mediate the relationship between abuse and low birth weight (Campbell, 2002).

The relationship between gender-based violence, relationship power and risk of HIV infection among women attending antenatal clinics in Soweto, South Africa, has been explored in a recent study (Dunkle et al., 2004a). IPV and high levels of male control in the woman's present relationship were associated with HIV seropositivity. These findings emphasise the risks for HIV infection associated with having a violent and controlling male partner. IPV was related to a higher likelihood of HIV risk behaviour, including having multiple partners, having non-primary partners, taking part in transactional sex, and substance abuse. However, these findings did not explain the relationship between IPV and HIV status, suggesting that there are other variables which need to be taken into account. Although other factors considered in the study, including child sexual assault, forced first intercourse and adult sexual assault by a non-partner were related to sexual risk behaviour, they were not significantly related to HIV status (Dunkle et al., 2004a).

In a related study, the authors found that 21% of women attending antenatal clinics in Soweto engaged in sex for material gain with a man who was not her primary partner, and these women had a significantly higher likelihood of HIV seropositivity (Dunkle et al., 2004b). IPV, alcohol or drug misuse, urban residence, ever earning money or living in substandard housing were risk factors for transactional sex. Conversely, women who postponed first intercourse, were married, or had post-secondary education were significantly less likely to engage in transactional sex. These authors speculate that transactional sex may precede violence if the woman's primary male partner finds out that there is a relationship with a non-primary male, or if a woman refuses to have sex with her transactional partner after receiving goods or money. This study shows that South African women commonly engage in transactional sex and that it is related to IPV and substance use and a higher likelihood of HIV seropositivity. The relationship between IPV and transactional sex, and transactional sex and

HIV infection suggests a pathway through which IPV influences HIV risk among women (Dunkle et al., 2004b).

In another study which closely resembles and extends the findings of Jewkes et al. (2002), including a large representative sample of women from three South African provinces, findings show that IPV was significantly positively associated with violence in participants' childhood, having no further education, consumption of alcohol, having more than one partner annually, having a confidant(e), the perpetrator's boy child preference, conflict over his drinking, either partner being responsible for financially maintaining the home, ongoing conflict in general, and living outside the Northern Province (Jewkes, Levin, & Penn-Kekana, 2003). No significant relationships were demonstrated in terms of partners' ages, employment or migrant status, financial disparity, living together, household possessions, urbanisation, marital status, crowding, communication, his having other partners, his education levels, her attitudes towards violence or her perceptions of cultural norms, values and expectations on women's roles (Jewkes et al., 2003). The findings emphasise the strong association between the status of women in a society and the normative use of violence in attempts to resolve conflict or as part of intimidation and the exercise of power (Jewkes et al., 2003). The authors also discuss the relationship between violence, gendered disempowerment and the spread of HIV, and conclude that the findings from this study suggest the need to investigate critically the associations between gender inequalities and HIV prevention in South Africa (Jewkes et al., 2003).

Barriers to disclosure are caused mostly by survivors' feelings about the abuse, including intense shame, denial that the abuse was occurring, the fear of reactions of friends, family or medical professions should the abuse be exposed, fear of the consequences to their children, fear of losing the perpetrator's love or financial support, and lack of readiness to change the relationship with the abuser. This is particularly true of sexual violence, which in addition to fear of retaliation by the perpetrators, is under-reported due to fear of not being believed, poor access to the police, and fear of the legal process, including disrespectful treatment by police and police corruption (Jewkes & Abrahams, 2002).

In summary, the brief review of IPV shows that gender-based violence is normative in many South African communities, and that IPV-related morbidity and mortality are significant concerns in South Africa. A key point emerging from this review is that there is considerable overlap between the different forms of gender-based violence more generally and IPV specifically. Furthermore, child abuse has been identified as an important risk factor for IPV

in adulthood. Although the evidence is inconsistent regarding the relationship between some socio-economic and demographic variables and IPV, gender is a well-known risk factor for IPV, and women are more susceptible to IPV-related mental health problems such as PTSD than men. IPV is associated with poorer physical health outcomes, including risk behaviours such as substance misuse, greater reliance on health services, and HIV seropositivity. There are a number of barriers to disclosure of abuse, of which shame is one. For this reason, IPV is an important public health issue that needs to be addressed not only in the relevant legislation, but also by the public health sector.

### **Coping and Positive Outcomes of Trauma**

Coping, support and trauma survival are important areas of study because they can inform effective clinical practice. I also had to consider that my participants may have experienced some positive outcomes as a result of their experience of trauma. That is why I briefly touch on coping and positive outcomes of trauma, focusing mainly on the work of Herman (1997) and Kaminer and Eagle (2010). There is a wealth of literature on resilience, which is beyond the scope of this chapter (e.g. the extensive work of Michael Rutter). The capacity to cope may in part be established by the severity and chronicity of the traumas survivors experience (consistent with the “dose-response curve” where less exposure to trauma leads to greater coping), but this capacity may also be associated with previous vulnerability and the emotional robustness of the individual. Herman (1997) reports that those individuals who have high sociability, have an active coping style, and a strong sense of their ability to control their destinies, are more resistant to post-traumatic symptoms than others. Self-blame can also be viewed as adaptive. It is an attempt to gain some sense of power and control (through ownership and responsibility for the traumatic event/s), which may be more tolerable than confronting the reality of utter helplessness, although this will be problematised later. Shame is a characteristic response to helplessness, the violation of bodily integrity, and the indignity in another’s eyes, as is so typical of IPV (Herman, 1997).

Not all outcomes associated with trauma are negative. A recent study examined the associations between post-traumatic growth (positive changes as a result of the trauma, such as feelings of strength, becoming closer to family and friends, or greater appreciation of life), PTSD symptom severity and post-traumatic depression, and found that for adult assault

survivors at six months post-trauma, there was a curvilinear relationship between post-traumatic growth and PTSD symptom severity and depression, while at thirty-nine weeks post-trauma on average the curvilinear association only pertained to PTSD symptom severity (Kleim & Ehlers, 2009). In other words, survivors with very low or high growth levels reported fewer psychological symptoms than those with moderate growth levels (Kleim & Ehlers, 2009). This finding has been replicated (Kaminer & Eagle, 2010). Interestingly, predictors of post-traumatic growth included shame, fear, peri-traumatic fear, religiousness, non-Caucasian ethnicity and ruminative thinking style (Kleim & Ehlers, 2009).

Other research has identified greater compassion for others, more meaningful relationships with others, engaging in altruistic activities to help others, greater appreciation of “little things” in life, and feeling emotionally stronger as some of the positive outcomes associated with trauma exposure (Kaminer & Eagle, 2010). However, it is important to note that post-traumatic growth depends on a post-traumatic space or phase during which the survivor can reflect on his/her traumatic experience/s, and make some kind of sense or meaning of it. In the context of chronic or continuous traumatisation, a space for such self-reflection may not be available. These survivors may be in situations of continuous danger, and may have to shut down emotionally in order to cope, which does not allow for internal reflection (Kaminer & Eagle, 2010). In such environments, a preoccupation with survival is likely to dominate internal experience.

### **Conclusion**

The issue of psychological sequelae to chronic violence has been under-researched worldwide. This chapter has provided the reader with an introduction to the issues at stake, and has also provided the reader with an overview of the prevalence and nature of violence – chronic and IPV specifically – in South Africa, to provide a backdrop to my study. It is important to conduct research on chronic violence in South Africa in particular – it is a context which is rife with shameful forms of violence exposure. There are many negative psychological outcomes associated with exposure to any form of violence, and shame often mediates this association, as will be explored further in chapter 5. Yet, there is a virtual absence of studies linking shame to chronic trauma. In the next chapter, I turn to shame, and describe my

theoretical orientation, and why I believe it is the best perspective from which this complex construct can be understood.

## CHAPTER 2

### Theories on Shame

If I wish to touch you but you do not wish to be touched, I may feel ashamed. If I wish to look at you but you do not wish me to, I may feel ashamed. If I wish you to look at me but you do not, I may feel ashamed. If I wish to look at you and at the same time wish that you look at me, I can be shamed. If I wish to be close to you but you move away, I am ashamed. If I wish to suck or bite your body and you are reluctant, I can become ashamed. If I wish to hug you or you hug me or we hug each other and you do not reciprocate my wishes, I feel ashamed. If I wish to have sexual intercourse with you but you do not, I am ashamed.

If I wish to hear your voice but you will not speak to me, I can feel shame. If I wish to speak to you but you will not listen, I am ashamed. If I would like us to have a conversation but you do not wish to converse, I can be ashamed. If I would like to share my ideas, aspirations or my values with you but you do not reciprocate, I am ashamed. If I wish to talk and you wish to talk at the same time, I can become ashamed. If I want to tell you my ideas but you wish to tell me yours, I can become ashamed.

If I want to share my experiences with you but you wish to tell me your philosophy of life, I can become ashamed. If I wish to speak of personal feelings but you wish to speak about science, I will feel ashamed. If you wish to talk about the past and I wish to dream about the future, I can become ashamed. (Tomkins, 1963, p. 192)

The Proto Germanic, Indo-European, root meaning of the word “shame” is to uncover, or expose (Lynd, 1958). Until more recently, shame has been neglected in the psychological literature (Karen, 1992). Lately, shame has been the focus of a great deal of attention and debate, and has been seen by many scholars as “the master emotion, the unseen regulator of our entire affective life” (Karen, 1992, p. 1). It is seen as a regulator because it provides feedback on individuals’ social and moral acceptability, and plays an important role in guiding behaviour and motivating individuals to adhere to cultural prescriptions and moral standards, norms and conventions.

Shame may be studied in terms of its various component parts, including emotion, cognitions and beliefs about the self, behaviour and actions, as a mechanism that has evolved for reasons

of adaptation, and its manifestation in interpersonal dynamic interrelationships, but the emphasis varies depending on the particular perspective or theoretical understanding in question (Gilbert, 1998). Each theory adds a dimension to the understanding of shame, but H. B. Lewis' (1971) influential theoretical work will be foregrounded in this chapter. This is because phenomenology emphasises subjectivity and the self as it experiences the world; and the importance of reflective attentiveness to the individual's lived experience, all of which is consistent with an ethnographic study such as the one presented in this thesis. This theory also informs a great deal of the distinctions between shame and guilt in chapter 3, the majority of the empirical studies described in chapter 5, and the results presented in chapter 8 in particular. In this chapter, I limit full exploration to phenomenological perspectives on shame, with selected aspects of psychoanalytic theory, as well as selected aspects of evolutionary theory, each vast theories in and of themselves. I have explained why I am guided by phenomenology. I include aspects of psychoanalytic theory because of the relevance of Donna Orange and colleagues' (2008, 1997) work on intersubjectivity and its relevance to any qualitative study, and because self-psychology provides explanations for trauma-related attachment patterns, psychological cohesion and depletion. I also include the theoretical work of the psychoanalytically-orientated Fairbairn (1943) which is central to understanding the shame-based, split self. Finally, I include aspects of evolutionary theory because of its emphasis on shame as a social emotion (unlike psychoanalysis) and its emphasis on Social Attention Holding Power (SAHP), which has implications for those in subordinated, disempowered or socially "misattuned" positions, which mirrored the positions that many of my participants were in.

I will also mention other prominent shame theories, like affect theory and cognitive attribution theory, but only in passing, since theories such as these do not bear relevance to the theoretical basis of my study. My study does not focus on whether shame is innate (affect theory) or a developmental accomplishment (cognitive attributional theory). Clearly, since I was working with adult women rather than children, I assumed that they had already attained the capacity for experiencing shame, either because it was innately present since infancy or because it was achieved through objective self-awareness and self-reflection, core requirements of cognitive attributional theory. Only psychological theories on shame will be discussed here; sociological theories (from Darwin, Cooley, Durkheim, MacDougall and Goffman to name a few) are beyond the scope of this chapter since the focus of this thesis is intrapsychic (Scheff, 1988).

One of the limitations in the literature is that most of the more prominent theories on shame depend heavily on the role of intimate attachment relationships in theorising how shame comes about. There is no engagement with the influence of the broader context, where group-based experiences of discrimination, denigration and disempowerment may also influence the development of shame and shame defenses (Kaminer, personal communication, May 24, 2012). Personal identity and group identity intersect very powerfully (Kaminer, personal communication, May 24, 2012). This is a point to which I will return in my discussion and conclusion.

Before reviewing phenomenological theory and other complementary selected sections of theories on shame, it is important to consider the following: There is no consensus in the theoretical literature whether shame is an innate, universal potential in all humans, or whether it is a developmental achievement, or whether it is evoked by certain experiences, such as for example, trauma (Karen, 1992). The contention in this thesis is that shame is a universal potentiality in all humans, but that for shame to become manifest, the individual must have achieved self-consciousness, and experienced triggering events. As such, early infantile shame-like responses, as are described in affect theory, for example, and by Gilbert (1998) in this chapter, are believed to be primitive, innate, automatically activated precursors to shame, which, as a defense against threat of attack or trauma of some kind, are developed and elaborated upon to become the full aversive reaction they are in later childhood and adulthood, once self-consciousness and triggering events have occurred. In my view, shame does not manifest until these two events have occurred.

There are a number of other vexing questions arising from the theories on shame. One of these questions is whether shame can be experienced internally or when alone, or whether it can only occur in the presence of an audience. In agreement with phenomenology, I would argue that shame can occur in both instances. Shame can, for example, occur when the self feels that it has not measured up to, or attained the goals of the idealised object or ideal self, thus experiencing shame in isolation (e.g. Self psychology). Equally, shame may be experienced at the hands of an actively shaming, humiliating other, in a social context (e.g. Evolutionary theory). However, most theories, with which I concur, consider shame a social emotion. This brings me to the discussion of the main theory driving my understanding of shame: phenomenology.

## Theories on the Nature and Functions of Shame

### Phenomenological Theory

This study is rooted in phenomenological theory, which focuses on the subjective properties and structures of experience, although it does draw on selected aspects of other theories, such as psychoanalysis and evolutionary theory. H. B. Lewis' (1971, 1987a, 1987b, 1987c) work is based on extensive transcripts of therapeutic interactions between her and her patients. Her main thesis, which focused on the role of the self in distinguishing between shame and guilt, is further elaborated on in the third chapter. Here, the nature, development and functions of shame from a phenomenological point of view are reviewed.

H. B. Lewis' phenomenological formulation of shame is guided by three constructs: Freud's construct of the superego; the self; and psychological differentiation (H. B. Lewis, 1971). The superego is understood as fulfilling a psychological regulatory function which monitors the internal workings of the psyche, and maintains some kind of homeostasis in terms of self-evaluation. This regulatory process is informed by the personal and moral values of the individual. In this monitoring role, the superego regulates human drives which can evoke shame, such as the sexual drive, but it also functions as an inhibitor of excessive pride, which is the antithesis of shame. Thus, the superego works as a psychological regulatory agency which strives to maintain a "balanced" self-evaluation and neutral self-esteem, based on the preservation of neutral affective interpersonal relationships (H. B. Lewis, 1971).

There are four features which are integral to the phenomenon of shame. Firstly, shame involves the desire to hide or disappear; to sink through the ground and cease to exist (M. Lewis, 1992). Secondly, shame involves intense psychological pain, discomfort and anger. Thirdly, shame involves feeling that the self is inadequate, defective and unworthy. Fourthly, shame involves the merging of subject and object – this fusion means that the self is unable to think clearly and ceases all activity; it is accompanied by the inability to talk and the inability to take any action. This final characteristic of shame is one of the main ways in which shame can be distinguished from guilt. In M. Lewis' words:

Shame is the complete closure of the self-object circle. However, in guilt, although the self is the subject, the object is external to the self. The focus of the self is upon the behaviour that caused the interruption, namely the inadequacy to meet certain standards, and upon the object who suffers from that failure. Many have used terms like concern or regret as synonyms for guilt, suggesting a focus on something external to the self rather than on the self itself (M. Lewis, 1992, p. 34).

What is central to understanding this subject-object fusion is that it is “the social significance of the act, the eye of the other that produce[s] the shame” – in other words, shame is elicited when the self is able to see the socially inadequate or defective self (subject) from the perspective of the disapproving, contemptuous other (object) (M. Lewis, 1992, p. 30). Here, to see or perceive, literally means to judge or evaluate (M. Lewis, 1992).

The notion that shame is characterised by permeable self-boundaries revolves around specific conceptions of the self, and psychological differentiation. Because the source of the shame is outside the self, the self is able to observe itself from the point of view of the other, causing a fusion or merging between the self and the negatively evaluating other (H. B. Lewis, 1971). Thus, the self is divided in shame reactions – it is being criticised and scorned by the other, while it is simultaneously acutely aware of itself. In H. B. Lewis’ (1971) view, this divided activity of the self, and the difficulty in separating the self from its negatively evaluating surroundings, makes it very difficult for the self to function effectively.

Another characteristic of shame is that it manifests more readily in individuals who are field dependent (those who find it difficult to separate or decontextualise objects from an embedding context, such as a hidden figure in a maze of embedding lines, which illustrate their relation to significant others [separation or tendency towards enmeshment]), and have less differentiated self-concepts and body images (H. B. Lewis, 1971, 1986). Furthermore, field dependent perceivers are more influenced by the opinions of others and are more other-directed in their social relationships (H. B. Lewis, 1971). They also have more positive attitudes towards others (social skills), more self-directed hostility, and tend to have poorer cognitive restructuring skills (H. B. Lewis, 1986). Finally, they are likely to use the defenses of repression and denial, which are cognitively less differentiated defenses (H. B. Lewis, 1971). In contrast, field independent perceivers tend to isolate affect, rationalise and intellectualise, all of which are more differentiated defenses (H. B. Lewis, 1971). Thus, a field-dependent type of superego functioning would involve shame, whereas a field-independent manner of superego functioning would involve guilt (H. B. Lewis, 1971).

The stimuli which evoke shame are multiple and varied, including, for example, aggressions, defeats, disappointments or failures; however, guilt is only evoked by one's own transgression (H. B. Lewis, 1971). Guilt is more commonly evoked by transgressions of a moral nature, while there are both moral and non-moral varieties of shame (although its moral nature is often emphasised) (H. B. Lewis, 1971).

As in evolutionary theory, discussed later in the chapter, in H. B. Lewis' (1987a) phenomenological understanding of shame, shame is the unavoidable response to loss of love; the loss of an important social relationship. H. B. Lewis (1987a) argues that shame, the result of the loss of the other, is inevitably accompanied by humiliated fury, the purpose of which is to protest the loss and demand restitution of the other's positive feeling towards the self, which then leads to feelings of guilt. In order to preserve physical proximity to the love object, the self may choose to avoid him/her instead of reacting in aggression towards him/her. The self may also repress rageful longings towards the other to protect the social tie.

What is central to H. B. Lewis' understanding of shame is that shame is about the whole self; the totality, whereas guilt involves the activity of the self, with much less perceptual feedback as a result of the self's activities and experiences. Therefore, shame is a narcissistic reaction to the perception that the whole self has been attacked, and is evoked by an inability to live up to the ego-ideal (H. B. Lewis, 1971). It deeply affects the individual's sense of identity. It often results in externally directed hostility, or what H. B. Lewis has termed "shame-rage". Shame-rage can only occur in the context of an affective relationship between the self and a significant, valued other. Hostility expressed towards this other is understood as a means of "turning the tables" against the other who has scorned or ridiculed the self, yet because the other is loved and admired, guilt about the self's aggressive wishes or actions is evoked. In some cases, the idealised image of the other may be amended, and may become devalued, but in this case the loved or admired other is lost. More typically, shame-based rage is turned against the self because the self is passive and defective in relation to the idealised other (H. B. Lewis, 1971).

Lynd (1958, p. 50) captures H. B. Lewis' (1971) assertion of shame's pervasiveness and effect on the whole self by explaining that:

An experience of shame of the sort I am attempting to describe cannot be modified by addition, or wiped out by subtraction, or exorcised by expiation. It is not an isolated

act that can be detached from the self. It carries the weight of 'I cannot have done this. But I have done it and I cannot undo it, because this is I'.

It is this experience that makes shame unspeakable; shame comes with uncodified detail and with diffused feeling; there is no readily expressive language of shame – the irrational threat implied in shame is abandonment terror, in contrast to the fear in guilt of mutilation (Lynd, 1958). Implied in this inability to communicate shame is profound loneliness and isolation, and may lead to depersonalisation and dehumanisation (Lynd, 1958).

In H. B. Lewis' understanding, shame can occur in private or in public; of central importance is that the self perceives that it is being negatively evaluated, either in reality or in fantasy (H. B. Lewis, 1971). Shame involves a great deal of self-imagery and self-consciousness, and involves significant perceptual feedback, particularly autonomic activation, including blushing, sweating and accelerated heart rate (H. B. Lewis, 1971). These reactions make shame an involuntary, acutely painful experience. Shame has been recognised as an involuntary experience that consumes and overwhelms the self, takes the individual off guard, caught unawares, for a number of decades (Lynd, 1958). Shame reactions result in what has been described as "an implosion of the self", accompanied by the body curved in on itself, head bowed and eyes closed (H. B. Lewis, 1971, p. 37). M. Lewis (1992) similarly argues that the phenomenological experience of shame includes not only the wish to die, hide or disappear, but leads to the disruption of current behaviour, confusion and loss of speech, and a physical shrinking of the body. Consequently, shame is associated with more body awareness than guilt, and tends to be experienced as a primitive, irrational reaction in which body functions are out of control (H. B. Lewis, 1971; Lynd, 1958). Shame has been described as a wordless state, characterised instead by the imagery of watching or being observed (H. B. Lewis, 1971). Thus, in shame states, there is a split between affect and cognition – with limited cognitive activity and a flood of affective (and autonomic) activity (H. B. Lewis, 1971). Like H. B. Lewis (1971), Lynd (1958) argues that shame is also activated by a sense of incongruity and alienation in the social environment, manifest in the discrepancy between the reality of what is happening and what is expected to happen (Lynd, 1958). This is accompanied by a breakdown in trust (and associated social isolation and estrangement), which involves questioning one's own adequacy or questioning the values of the social context which contradict what one has been led to expect (Lynd, 1958).

H. B. Lewis' (and M. Lewis') phenomenological understanding of shame not only focuses on the emotional experience of shame, it includes as central feature a sense of heightened

consciousness of the self, self-awareness or self-attention, which is where these scholars overlap with cognitive attributional theorists. H. B. Lewis (1971) in particular argued that shame is located not only in the flood of affectivity and autonomic arousal which accompanies it, but also in our thoughts about our selves, and that these thoughts involve the real or imagined disapproval of significant others. For these scholars, shame is not only a disruption or reduction of positive emotions, but is also a state of exaggerated awareness of the self which is considered inadequate (M. Lewis, 1992).

### **Psychoanalytic and Psychoanalytic-based Understandings of Shame**

It is important to note at the outset that, surprisingly, Freud had “no consistent theory of shame. Shame received relatively little attention in the Freudian corpus, especially as contrasted with anxiety and guilt” (Broucek, 1991, p. 12). Freud’s limited attention to shame meant he understood it only as reactive, inhibitory, and prohibitive, opposing the pleasure principle and preventing engagement in natural but shameful behaviours, including sexual activities such as voyeurism and exhibitionism or activities centred round waste elimination (Broucek, 1991). Later psychoanalysts, such as Erik Erikson (1950) (focusing on the eight stages of the life cycle, of which one is the battle between autonomy and shame and doubt), Piers and Singer (1953) (focusing on the tension between ego and ego ideal), Wurmster (1987, 1995) (focusing on extending the classical psychoanalytic tradition of examining shame in relation to voyeurism and exhibitionism) and A. P. Morrison (1989) (focusing on understanding narcissism from the point of view of tension between ego and ego ideal) did however, attend to shame, but none of these theorists produced a full and substantial theory on shame, and therefore will not be included in this review in more than a cursory manner (Broucek, 1991).

Miller (1985) identified two subgroups of psychoanalysts who have made some contribution to shame, however limited: Freud, Anna Freud, Nunberg and Jacobson in the first group, and Knapp, Kohut and H. B. Lewis in the second group. Although there are minor differences between the members of the first group, they saw shame, as was identified above, as a reaction-formation against sexual exhibitionistic impulses; thus shame was interpreted as an emotion in the service of morality. In Freud’s understanding, the self-diminishing, hiding nature of shame is a defense against engaging in morally forbidden exhibitionistic excitement

(Miller, 1985). Indulging in this forbidden act was believed to produce guilt or fears of castration (Miller, 1985). The second group also have some minor disagreements among them, but generally understand shame as a defense against sexual exhibitionistic excitement and feelings of grandiosity and omnipotence (thus, an emotion designed to curb arousal), but they did not see it as a moral emotion (Miller, 1985). They emphasise the ego-disruptive impact of overstimulation and the need for a mechanism to subdue highly stimulated states, producing psychic homeostasis (Miller, 1985). One of the limitations of these scholars' work is their narrow and exclusive focus on issues such as psychosexual phases and the genital-exhibitionistic conflict. Miller (1985) painstakingly analyses data from ten interviewees about their experiences of shame from a psychoanalytic point of view, but comes to the same conclusion. Although prominent scholars have argued that sexual exhibitionistic impulses and genital inferiority (female sexuality as compared to the penile norm) are (always) the major sources of shame, Miller's (1985) data shows that these conditions may not in fact precede shame in every instance.

One useful contribution made by psychoanalysis, which ties in well with self-psychology discussed below, is the role of shame in the Oedipus Complex. Shame is typically linked to the struggles of the anal phase towards autonomy and self-control, as well as sexual developments associated with the Oedipus Complex (Nathanson, 1987b). According to Freud, the superego develops as a result of the identification process which occurs during the Oedipus conflict – through the identification with the parents, and the resolution of the conflict between the child's love and admiration for them, and his fear of castration due to his sexual and aggressive fantasies and desires (H. B. Lewis, 1971). The Oedipus Complex involves shame over desiring the rejecting parent (Nathanson, 1987b). Rejection from this parent results in a reduction in interest and excitement (and consequently, desire), which Nathanson (1987b) argues is one of the earliest manifestations of shame proper. Through identification with the parents the child internalises their values, in the absence of which, the child develops no moral code (H. B. Lewis, 1971). Identification takes place in two, related ways. The first route involves the incorporation of the castration threat. The second route of identification is through the imitation of an admired or beloved parent figure, which involves the incorporation of an ego-ideal or positive model for the child's behaviour (H. B. Lewis, 1971). This route involves the threat of loss of love or positive regard from the ego-ideal, and the associated loss of self-esteem (H. B. Lewis, 1971). The differences in routes of identification regulate whether shame or guilt will be evoked in a particular child.

Identification with the threatening parent and internalisation of that threat leads to guilt (over perceived transgression), whereas identification with the ego-ideal evokes pride and triumph, and failure to live up to this internalised image results in shame (H. B. Lewis, 1971).

I would like to pause for a moment to consider a recent shift in psychoanalysis which has been developed by Orange (2008) and Orange, Atwood and Stolorow (1997). Their thoughtful and thorough scrutiny of psychoanalytic theory and practice examines the possible sources of shame in the therapeutic relationship. This is relevant to my examination of the unfolding of the relationship between me and the participants, and to my exploration of self-reflexivity in the final chapter. Unlike Miller (1985) and other “purist” psychoanalytic colleagues’ exclusive focus on sexual exhibitionistic impulses and genital inferiority as the (only) source of shame, Orange and colleagues broaden their focus to examine the intersubjective or relational origins of shame. Orange (2008) describes the therapeutic interchange as inherently shameful: clients often have a stigmatised or shameful status; the client risks exposing painful vulnerabilities and/or personal limitations which may be experienced as shameful; emotional life itself, with all its pain and woundedness, is often rife with shame; and finally, society sets the analyst up to be the expert who knows the client better than s/he knows herself, so creating a power differential which is disempowering and shaming (Orange, 2008). Orange et al. (1997) argue that transference and countertransference create an intersubjective system of mutual influence – neutral analysts, pure, objective interpretations, and uncontaminated transferences are considered mythological and cannot and do not exist in this kind of system (Orange et al., 1997). While remaining loyal to yet critical about psychoanalysis as a whole, Orange et al. (1997) bring the analyst into the therapeutic dialogue, and emphasise the role played by his/her subjective world (which is typically defended against, denied, not reflected on), which may facilitate or impede the analytic outcome. This kind of work humanises psychoanalysis, and makes it compatible with more contemporary theoretical work which focuses on the construction of social relations.

Finally, before considering self-psychology below, I would like to emphasise the theoretical postulations of Fairbairn (1943). Feelings of “badness” constitute a common defense among people who have been abused. Abuse survivors identify with and internalise intolerably bad objects and carry the burden of “badness” and shame because it is more tolerable to believe that the self is bad, and so in control, than to accept that the loved perpetrator, whose abuse is random and unpredictable, is bad. According to Fairbairn (1943, p. 67), internalisation is an attempt to control these bad objects who have wielded power over them in the external world;

however, “these objects retain their prestige for power over him [the survivor] in the inner world. In a word, s/he is ‘possessed’ by them, as if by evil spirits”. Fairbairn (1943) argues that the ego seeks relationships with these internal objects; and that repression is primarily directed against these internalised objects. Once internalised and repressed, these objects are both unsatisfying and frustrating, and tempting and alluring; retaining both contradictory qualities simultaneously. This causes a great deal of ambivalence. The individual deals with this in the following way: 1) by splitting the individual into two objects, one good and one bad; 2) by internalising the bad object in an attempt to control it; 3) by splitting the internalised bad object in turn into two objects, a) the exciting or needed object, and b) the rejecting object; 4) by repressing both these objects and using aggression in the process; and 5) by using further aggressing in splitting off from his/her central ego and repressing two subsidiary egos (the libidinal ego and the saboteur ego, so challenging Freud’s tripartite structure of the psyche) which remain attached to these internalised objects. This gives rise to the multiplicity of ego (identity) which we associate with trauma-related dissociation. It is also important to note that this attachment to bad internalised objects is additionally a means of avoiding being objectless and abandoned. This is why individuals who have been abused tend to cling to painful experiences because it enables them to continue relating to relationships with bad internal objects (Fairbairn, 1943).

### *Self-psychology*

The inclusion of self-psychology is due to the important role it plays in attachment patterns, including trauma-related attachment patterns: the need for mirroring and merging – involving the regulation of emotional distance/intimacy, as well as explaining the cohesion and depletion of self.

As I have noted, shame scholars have postulated the existence of two types of shame, one internal (intrapsychic), and one external (A. P. Morrison, 1987). In the case of the former, negative or punitive affect is imposed by the superego for the self’s failure to live up to some ideal; in the case of the latter, it is the self’s failure to achieve an external, reality-derived goal (A. P. Morrison, 1987). In internal shame, self-criticism and self-persecution is determined by imaginary audiences which have been created on the basis of experiences with others (Gilbert, 2007). Self-psychologists such as Kohut argue that the experience of shame is entirely

internal, and as such, may develop in isolation (A. P. Morrison, 1987). Not all theorists agree that shame can be experienced entirely internally, like for example, Gilbert (1998), but that will be discussed later in the chapter.

Originally, the selfobject (experienced as an extension of the self) exists as a significant and valued person to whom the self is attached and not clearly differentiated from; this selfobject is then internalised as the idealised parental imago (A. P. Morrison, 1987). In order for a cohesive self to develop, the self needs to attain its ideals through the responsiveness of the idealised parental imago (A. P. Morrison, 1987). Experiences with the selfobject promote development and cohesion of the self through processes such as mirroring, idealising and merging (Brown, 2004).

Central to Kohut's theory is the construct of the bipolar self, which refers to the two chances there are for the self to achieve cohesion: firstly, the empathic mirroring of the exhibitionistic grandiose self, usually by the mother, and secondly, the presence of an empathic, idealised selfobject later on, usually the father, who accepts the child's identification, idealisation and desire for merger (A. P. Morrison, 1989). For Kohut, a selfobject which is unresponsive to the self's need for mirroring and idealised merger contributes to a vulnerability towards shame. In his understanding, as is evident, shame is neither interpersonal nor social. Instead, it is a manifestation of weaknesses or deficiencies in the self with regards to the ideal self (A. P. Morrison, 1987). Specifically, shame was seen as the consequence of overwhelming, unmirrored grandiosity and selfobject unresponsiveness. Even the need for the selfobject can bring about shame, particularly in environments where the selfobject continually fails the self (A. P. Morrison, 1989).

Although Kohut explicitly rejected the notion of linear development, there is an implied developmental progression from:

- 1) Investment in the grandiose self, to 2) movement outward, in an object-seeking direction, toward investment in the idealized parental imago, to 3) firming of the idealized parental imago and its internalization (with the formation of psychic structure) through idealization of the superego and resultant establishment of ideals (A. P. Morrison, 1989, p. 70).

So, there is a developmental progression from primary narcissism (reflected in the mirroring of the grandiose self) towards the self's increasing affiliation with objects (merging and idealisation) (A. P. Morrison, 1987). Affiliation in the form of merging, and later

identification refers to selfobject experiences that facilitate a sense of belonging (Brown, 2004). If the parental imago is unresponsive to the self's needs for mirroring, idealisation or merging, it leads to the experience of shame, which is associated with fears of rejection and abandonment (A. P. Morrison, 1987, 1989). Due to his/her unrealised needs, such a child may have a predisposition to low self-esteem, and lack of self-acceptance, which also accompany experiences of shame (A. P. Morrison, 1987).

Kohut described the consequence of the selfobject's failure to mirror and affirm age-appropriate exhibitionistic needs as fragmentation and disintegration, the opposite of cohesion (A. P. Morrison, 1989). Psychological depletion, on the other hand, is understood as a response to the absence of the needed, wished-for, omnipotent and idealised selfobject (A. P. Morrison, 1989). Specifically, it is noted that (A.P. Morrison, 1989, p. 74), "depletion/enfeeblement anxiety reflects threatened absence of the early, longed-for configurational objects – the idealized selfobject – leading to feelings of emptiness, depression and shame." Such a self does not have realizable ideals and is weighed down by exaggerated and unattainable ideals and goals (A. P. Morrison, 1989). It is worth emphasising that A. P. Morrison (1989) argued that shame is more characteristic of self-depletion than fragmentation.

If the selfobject fosters adequate validation, nurturance, protection and belonging, a mature sense of self develops; one which is characterised by cohesion (maintaining a stable connection with the self during times of emotional upheaval), continuity (the ability to maintain a consistent sense of self over time), colour (the capacity for appropriate affect regulation), and agency (the ability to maintain an independent sense of initiative) (Brown, 2004). If any of these aspects is missing, an immature sense of self emerges (Brown, 2004). The immature sense of self is one which is characterised by either fragmentation, as one finds in psychotic and borderline conditions, or depletion, as in neurotic individuals, which is accompanied by a need for merging with an idealised selfobject, and associated feelings of failure and emptiness, as well as vulnerability toward shame (A. P. Morrison, 1987). For an immature self, the (infantile) need to merge with another, associated with complete identification and internalisation of the idealised other, continues to be the foremost selfobject experience in adulthood (Brown, 2004). Often, romantic partners in adulthood function as attachment figures or selfobjects, which allow for the immature self to recreate and relive relationships from the past in an effort to get selfobject needs met (Brown, 2004). Where merger experiences are searched for in adult selfobjects, particularly intimate partners, an

inability to endure any separation or difference between oneself and one's partner is likely to develop, which could lead to shame-rage spirals as are seen in domestic violence situations (Brown, 2004).

When trauma occurs, individual development may be arrested, and narcissistic vulnerability, associated with marked grandiosity manifest as unrealistic, idealistic expectations of self, may develop (Brown, 2004). This is thought to be accompanied by impaired affect regulation. These conditions result in an all-consuming sense of shame at the failure to achieve set goals, ideals and expectations, and a yearning for connection with the idealised parent (Brown, 2004).

## **Evolutionary Theory**

I will briefly outline some of the core tenets of evolutionary theory, because it is such an important theory in terms of external shame, and external shame is likely to emerge in non-Western participants such as those I interviewed (Goldberg, 1991). One of the key debates in shame theory is whether the underpinning psychobiological mechanisms of shame are of recent origin and associated with self-consciousness and self-awareness, or whether shame is the result of elaboration of phylogenetically older mechanisms (Gilbert, 1998). It is Gilbert's (1998) belief that shame is the result of the latter, which is based on the contention that evolution does not create new designs but adapts existing designs, so ensuring evolutionary continuity.

A core tenet of evolutionary theory is that human beings are social animals who are motivated to engage in behaviours which promote survival and reproduction. According to evolutionary theorists, shame is an interpersonal phenomenon, and can therefore be understood as originally fulfilling the function of ensuring and enhancing social cohesion, by promoting conformity to the group, which is associated with the development of skills and competencies that are essential for the continuation of both the individual and group/species (Izard, 1977; Will, 1987). Shame is elicited in situations where there is a defect in cooperative relationships, failures in competition for prestige, when non-conformity occurs, as well as in situations where an individual is subordinated (Fessler, 2004). The key threats to survival and reproduction are exclusion and intrusion (Gilbert, 2007). There are a great number of evolutionary pressures which motivate the need to create positive feelings about the self in

others – including those we have primary, early attachments with, to co-operative, emotionally supportive and sexual relationships in adulthood (Gilbert, 2007). Being securely attached in these relationships involves positive feelings and feelings of safety, while loss of attachment constitutes a threat (Gilbert, 2007). Caring, supportive and affiliative relationships, and being loved, valued and respected by others (and knowing that one is) deactivates threat systems, provides important resources for coping with challenges, and facilitates physiological changes that promote health and well-being (Gilbert, 2007). Shame is an emotion that alerts individuals (through threat-processing systems which signal loss of safety) when love, acceptance and positive regard from others has been lost, or are in the process of being lost (Gilbert, 2007).

In order to avoid shame, and to ensure ongoing SAHP (Social Attention Holding Power), individuals may rely on attractiveness or aggression (Gilbert, 1998). Aggression signals are designed to stimulate fear/submission brain areas in others, while attractiveness strategies are designed to stimulate the reward/approach areas of others' brains (Gilbert, 1998). Human shame is typically not focused on being physically attacked or injured, but rather on having SAHP damaged in some way. In modern societies, SAHP is associated with prestige rather than with dominance (Fessler, 2004). Loss of SAHP signals has a dysregulating effect on humans, possibly at least partly because SAHP has serotonin regulating properties (Gilbert, 1998).

Shame is a “two-edged sword” (Gilbert, 1998, p. 114). It can both help limit or avoid breaches in social attractiveness or SAHP, and it may even evoke forgiveness and reconciliation, but at the same time, if the shame system is overly sensitive and leads to disproportionate or excessive displays of submission, it can lead to rejection by others, because such displays are seen as unattractive. In this context it is pertinent to note that unfavourable social comparisons (along a continuum of “inferior-superior” and “same-different”) are highly correlated with shame (Gilbert, 1998). In order to maintain SAHP (which is dependent on social success that involves behaviours like sexual partnering) the individual must learn to engage in displays that evoke sympathy and reconciliation, rather than those that demonstrate excessive submission, which is illustrative of weakness or vulnerability.

Interpersonal misattunement has been identified as an important elicitor of shame by evolutionary theorists (Gilbert, 1998). This occurs when two or more individuals are not affectively matched in their roles towards one another (e.g. when a person's sexual advances are not reciprocated, or an infant is not comforted by a mother's nurturance). Misattunement with others may be responded to in a range of ways, including polite requests for adapting or changing behaviour to overt attacks and rejection, depending on the intensity and duration of the misattunements. The person in question may also respond in a range of ways, exhibiting confusion, anxiety, anger or shame. The relative social rank of the individuals involved will determine who must attune to whom, with the subordinate typically having to attune to the dominant partner. If the lower rank individual does not display compliance and deference, more serious attempts at making him/her realise the error of his/her ways are embarked upon, like for instance ostracism and social exclusion. Gilbert (1998) argues that rank and status in social roles can be domain specific, and include being valued as a sexual mate, as a close personal ally, as a carer, as a group or team member, as a status seeker, or, in some cultures, as a care seeker (care seeking is shamed in Western cultures which value self-sufficiency).

The term "regulation" is useful in the context of the discussions about misattunement of roles. It refers to a physiological and psychological state where systems are functioning optimally, in perfect balance, and can be compared to the state described by the medical term, "homeostasis" (Gilbert, 1998). In a regulated state, "one feels well, has the energy and confidence to do what one wants to do, thinks clearly, feels in control of one's own thoughts and feelings, and is asymptomatic" (Gilbert, 1998, p. 106). In contrast, the term "dysregulation" refers to physiological and psychological states which are atypical and symptomatic, and which compromise capacities to concentrate and act effectively. Dysregulation and defense system activation is likely to occur when social signals indicate that there is role misattunement. Shame is a form of dysregulation which alerts individuals to the need for some defensive, reparative, or retaliatory actions. It is also associated with psychopathology in those vulnerable to mental disorders. This may in part be further determined by the role that social signals such as deference and respect, and associated social status, play in contributing to the regulation of serotonin (including levels in the blood and sensitivity) (Gilbert, 1998).

Based on the primacy of the social dimension in evolutionary theory, Gilbert (2007) has proposed a biopsychosocial model for shame, seen below in Figure 2.1. It includes all the contributions to shame, from biological to psychological and social perspectives.

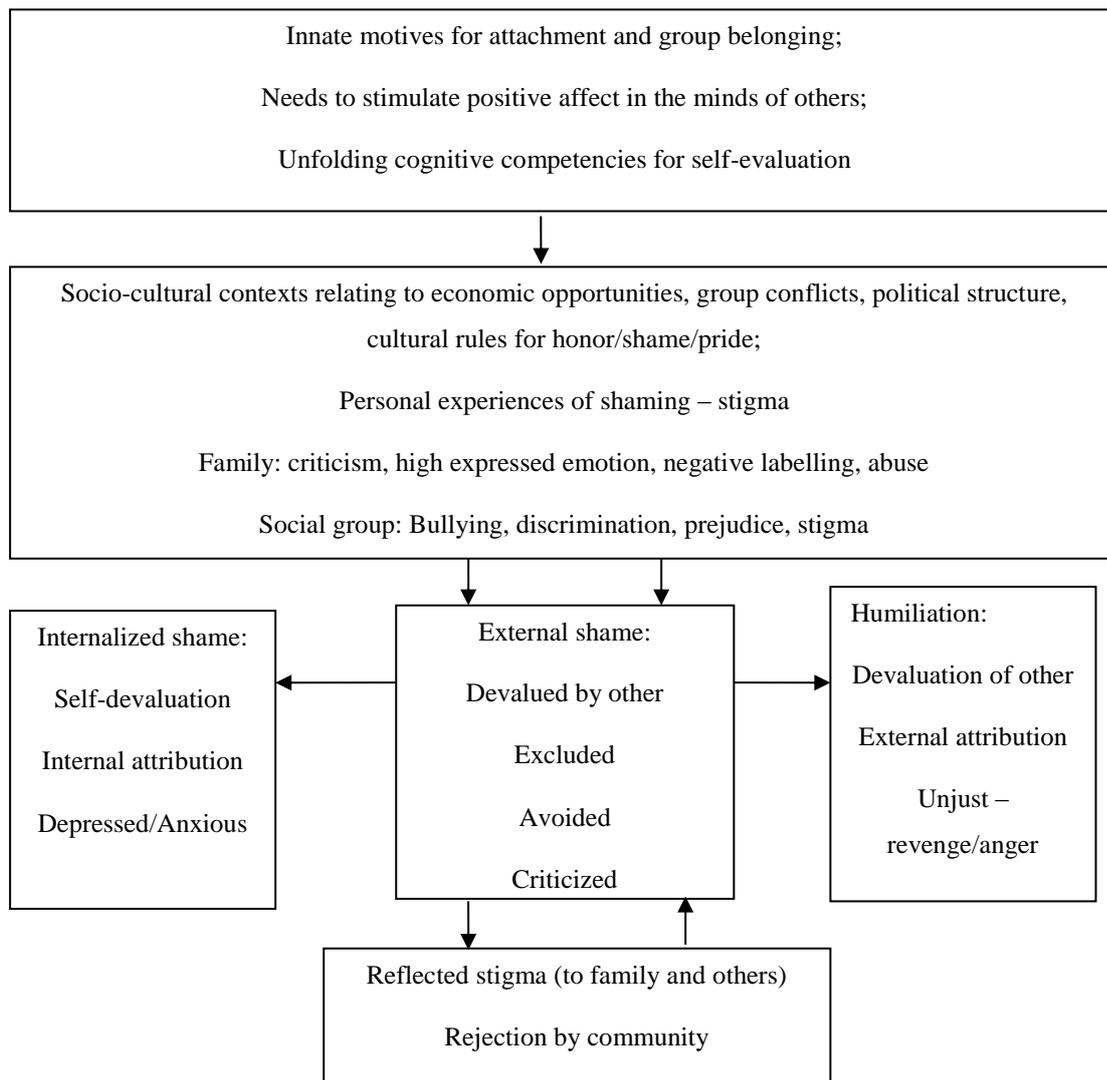


Figure 2.1. An evolutionary and biopsychosocial model for shame (Gilbert, 2007, p. 301).

In this model, the importance of generating positive feelings in the minds of others for group belonging and cohesion is clear. As humans develop the cognitive competencies necessary to experience shame, they are able to understand that shame signals that the self is unattractive to the other, and this activates threat systems. These cognitive capacities also determine our experience of the social context for shame that arise from local, historical, cultural and ecological conditions – how different contexts vary in terms of how they socialise and construct shame (Gilbert, 2007). This, in turn, has influences on personal experiences of child rearing practices which may inhibit or enhance shame reactions. The wider social domains of peers may also be accepting or rejecting and bullying. In these broader social contexts, individuals may also experience prejudice and discrimination, which lead to stigmatisation.

Gilbert (2007) argues that at the centre of his model is external shame – how the self believes it exists in the minds of others (which may or may not interact with internal shame). High levels of external shame exist when individuals believe that because of certain characteristics they will not be able to create positive or acceptable images of the self in the eyes of the other. External shame, however, may also be associated with humiliation, which is associated with desires for revenge and aggression towards the other who has humiliated the undeserving self. In this model, the core source of shame is the experience of lack of social safeness; a sense of heightened social threat and uncertain sense of social positioning. Finally, in cultures where shame and honour systems are closely linked to the behaviours of other group members, the self may experience reflected shame or honour or conversely, the other may experience the reflected shame of the self (Gilbert, 2007).

In summary, Gilbert argues that evolution has resulted in a range of biosocial goals and strategies (e.g. finding a sexual mate, caring for offspring) which enhance the likelihood of survival and reproduction of the species. Social signals are humans' most significant source of information, showing us whether our search for these evolutionary goals has been successful or not (Gilbert, 1998). These social signals are crucial in the maintenance of internal regulation and in indicating how attuned individuals are to their social roles. Shame signals misattunement, which leads to physiological dysregulation and indicates the need for defensive, reparative or retaliatory action. Shame activates the need to hide from view what is considered worthy of rejection, attack or ostracism (Gilbert, 1998). It may also be accompanied by depression or anxiety associated with the perception that there has been a reduction or diminishment in social status, respect and social attractiveness. The implications of external shame, including diminished social status, respect and SAHP with respect to this study will be explored in the results and discussion chapters.

### **Affect Theory**

I will not be discussing Tomkins' (1987) affect theory at any length. It is a biologically driven theory, not a social or phenomenological one, and focuses on the presence of inherent shame-like reactions present from infancy, something which is in stark opposition to what I am proposing. I am proposing that trauma produces shame, and make no claims about whether or not it is an inborn emotion present in the absence of a traumatic trigger.

Briefly, Tomkins (1987) argues that there are seven innate affects that are present at birth and which share a common characteristic – each is motivated by a specific pattern of neural activity and accompanied by a particular facial display. They will be described in the next paragraph. Before describing them, it is worth noting that Tomkins postulates that each of the seven affects (located in specific parts of the brain) is triggered by information carried through the neural pathways, and that the intensity of neural firings activates the affect in question. Any decrease in density of neural firing activates the affect of enjoyment; such reduction is responsible for producing laughter (Tomkins, 1987). Laughter has previously been found to dispel both shame and hostility (H. B. Lewis, 1987a). Conversely, fairly constant levels of stimuli at relatively uncomfortable levels activate distress, while higher levels of stimulation at a more uncomfortable level activate affects such as fear, startle reactions, anger and rage (Kaufman, 1993; Tomkins, 1987). For Tomkins (1987), affects are displayed primarily on the face. It is particularly the eyes which are responsible for communicating affect. Tomkins (1963) argues that they are the organs of expression, communication, contagion, escalation and control of affects.

The positive affects include interest-excitement, which is accompanied by the eyes down and the stare fixed on tracking or following an object; the second is enjoyment-joy, accompanied by the smiling response (Tomkins, 1987). The third innate affect is surprise-startle, with the eyebrows raised and eyes blinking (Tomkins, 1987). The negative innate affects include distress-anguish, accompanied by the crying response; anger-rage, accompanied by a frown, clenched jaw and red face; next, fear-terror, with the eyes held open or in a fixed stare, or looking away from the source of fear; and finally, shame-humiliation, with the eyes and head lowered (Tomkins, 1987). These affects are known as “drive auxiliaries” (Tomkins, 1987). These innate affects are not related to drives, unlike the innate affects of *dissmell* (accompanied by the raising of the top lip and nose in response to a unpleasant odour) and *disgust* (accompanied by the spitting out or vomiting out of the mouth or nostrils something noxious which has been ingested) which are related to the drive, hunger (Tomkins, 1987). Like *disgust*, which is an auxiliary to hunger, *shame* is an auxiliary to the affects interest-excitement and enjoyment-joy (Tomkins, 1987). Thus, *shame* emerges only when there is interest involved; it sensitises us to a number of behaviours that have either brought shame upon ourselves, or upon others (Zembylas, 2008).

Tomkins does not consider *shame* from the perspective of violating social norms, but instead sees it as being elicited as a means of “blocking desire”; an automatic mechanism for

interrupting pleasurable sensations (M. Lewis, 2003, p. 1184). Thus, in his understanding, an event which elicits shame is one that leads to a reduction in interest, and causes disengagement (Mills, 2005). In other words, frustration involves the blocking of interest or excitement, and it is that frustration that leads to shame (Lee, 1999).

Tomkins' theory has been widely criticised, with scholars arguing that shame is more likely to be evoked in situations where there is a loss of positive affect associated with the devaluation of self specifically. For Tomkins, shame is the product of automatically activated, mechanistic inhibitory mechanisms, while for M. Lewis and H. B. Lewis, shame is the result of a conscious or self-conscious attribution or process (M. Lewis, 1992). The focus of the self is on the whole self's failure or inadequacy, and the evaluation of that failure evokes shame, rather than an automatic elicitor (M. Lewis, 1992). In addition, unlike Tomkins, both H. B. Lewis and M. Lewis, as well as Gilbert (1998), considered next, view shame as a social emotion, one whose main function is to restore threatened affectional bonds (H. B. Lewis, 1986).

### **Cognitive Attributional Theory**

Cognitive attributional theory will not be foregrounded in this thesis since developmental concerns are not a focus of my study. The primary difference between evolutionary theory and cognitive attributional theory on shame is that in evolutionary theory, shame is not considered to be a self-conscious emotion. Instead, shame is considered to be dependent on more primitive psychological mechanisms that evolved to ensure that animals are responsive to social threat and take the necessary defensive actions. In contrast, cognitive attributional theory focuses not on the innate nature of shame, but rather on the learnt capacity, through the ability to reflect and evaluate both the self and the environment, to experience shame.

According to cognitive attributional theory, there are three prerequisites to the shame experience: 1) the capacity to reflect upon the self; 2) the acquisition of culturally prescribed standards, conventions, rules and goals (transmitted through socialisation from an early age - these standards will differ from society to society, and across different time periods, as well as across individuals, in terms of age or gender, for instance); and 3) the internalisation of standards and the ability to anticipate others' reactions to one's capacity to meet these standards (M. Lewis, 1992, 1993; Mills, 2005).

The individual evaluates the success or failure of his/her thoughts, feelings and/or actions in relation to these standards. Individuals' evaluation of success or failure with regard to standards may be accurate or idiosyncratic (standards are either too high or too low) (M. Lewis, 1992, 1993). Moreover, some individuals may tend to internalise blame, while others are prone to externalising blame for violations or transgressions. Shame is elicited when the self negatively evaluates the whole or total self (global attributions), while guilt is elicited when the self negatively evaluates specific actions (specific attributions) (M. Lewis, 1992, 1993)<sup>6</sup>. The violation of standards which are integral to the definition of self tend to evoke shame (M. Lewis, 1992, 1993).

Emotions can be divided into two groups – those which are self-referential and those which are not. Broucek (1991) and M. Lewis (1992) believe that shame, because it requires introspection, is not a primary but a secondary (self-referential) emotion. The experience of shame requires objective self-awareness – this is awareness in which the self focuses attention on the self; where we become the “objects of our own consciousness” - one that emerges only once we have a capacity for abstract knowledge (M. Lewis, 1992, p. 42). Abstract knowledge refers to the developing capacity to generate representations that are not restricted to the realistic, the capacity to categorise or classify objects and people, the ability to think about both past and future events, and the ability to fuse and reconcile discrepant events (M. Lewis, 1992). So, self-reflection is not something that is present at birth; it is learnt and develops over time once a capacity for abstract knowledge has developed, one that is dependent on the acquisition of sensorimotor affective knowledge (initially involving evolutionarily adaptive reflexes, which develop into behavioural patterns that demonstrate the infant is engaging with his/her object and social environment), and representational knowledge (involving the development of active memory) (M. Lewis, 1992). Objective self-awareness emerges after subjective self-awareness, which involves attention directed outwards, towards external objects, rather than inwards, as is the case in objective self-awareness (M. Lewis, 1992). Thus, objective self-awareness develops only if the objective self becomes differentiated from the subjective self, and this depends on three conditions: there must be someone with a different point of view from the child; the two different points of view must involve the same object; and the child must be aware of the two different opinions simultaneously (M. Lewis, 1992). The conflict between the child's action or behaviour, and that of others, leads to the

---

<sup>6</sup> Women, as opposed to men, tend to make global attributions for failure, and specific attributions for success, while younger children, as opposed to older ones, tend to make global, rather than specific attributions (M. Lewis, 1992).

objectification of his/her thoughts, feelings and behaviours, which is central to the development of objective self-awareness (M. Lewis, 1992).

According to M. Lewis (1992, 1993), certain cognitions need to be in place before self-conscious emotions<sup>7</sup> emerge. The self-conscious evaluative emotions are thought to develop in a predictable sequence, starting with the presence of primary emotions, including joy, fear, anger, sadness, disgust and surprise (emotions that involve simple or limited cognitive processes). As the child matures, at around the age of two-and-a-half to three years, s/he achieves the cognitive capacity of knowing him/herself, having developed objective self-awareness. Once this is in place, the exposed emotions, consisting of embarrassment (non-evaluative type), empathy and envy can emerge (M. Lewis, 1992, 1993). These emotions are not evaluative, as the self-conscious emotions are – they are not based on correct or incorrect, or appropriate or inappropriate thoughts, feelings or behaviours (M. Lewis, 1992, 1993). Instead, they are associated with feeling the self being exposed to others (M. Lewis, 1992, 1993). Next, the child develops the cognitive capacity for owning social standards, rules and goals (which cannot occur without objective self-awareness), and begins to understand his/her own behaviour in relation to these standards (M. Lewis, 1992, 1993). This capacity needs to have developed in order for the self-conscious evaluative emotions, which involve the evaluation of thoughts, feelings and actions as correct or incorrect, appropriate or inappropriate, to develop (M. Lewis, 1992). These emotions include embarrassment (evaluative type), pride, shame and guilt (emotions that require complex cognitive processes) (M. Lewis, 1992, 1993). Although there is some debate around the timing of the emergence of evaluative self-conscious emotions, particularly whether the development of shame precedes the development of guilt or vice versa, it appears that these two self-conscious emotions emerge more or less simultaneously (M. Lewis, 1992). Like H. B. Lewis and Gilbert, those studying self-conscious emotion from a cognitive attributional point of view tend to perceive shame as a social emotion.

Below, I distinguish between shame, guilt, pride, embarrassment and humiliation<sup>8</sup>, and in doing so, rely heavily on the work of June Tangney and her colleagues, which is primarily based on the earlier theoretical understandings put forth by H. B. Lewis' phenomenological

---

<sup>7</sup> The term "self-conscious emotion" is a cognitive attributional term. Its use in this thesis does not point towards an investment in this theory. The term is simply used to usefully group a range of related emotions.

<sup>8</sup> Envy will not be discussed here due to the lack of research on this emotion in relation to shame; however, it is acknowledged that both are associated with a sense of inferiority, dependency, powerlessness and rage at the object of shame/envy (Berke, 1987). In addition, both involve comparison between self and other (although shame may involve a shaming internal figure). Furthermore, both involve the defenses of concealment, denial, magical self-defense, appeasement, and aggressive counter-attack (Berke, 1987).

theory (particularly her distinctions between shame and guilt). I will also describe and compare associated constructs such as empathy, sympathy, personal distress, anger, hostility and aggression<sup>9</sup>.

### Conclusion

The primary function of shame is to interrupt any activity that violates internal or external standards, norms or rules. These standards will differ from society to society, across groups and individuals in societies and across various time periods, but are all derived from the information acquired during the acculturation process in a particular society.

In this chapter I have located the study in phenomenological terms. I have also indicated why affect and cognitive attributional theories are not relevant to my study, due to their developmental focus (and my study was conducted with adults, who had already developed the capacity for shame). I retained specific elements of other psychological shame theories that have relevance for my study, including intersubjectivity in dialogic work; trauma-related splitting and attachment patterns, particularly the need for mirroring and merging – including the regulation of emotional distance/intimacy, as well as the cohesion and depletion of self (self psychology) and SAHP (evolutionary theory).

As can be seen from the theories reviewed in this chapter, shame is a highly contested, multi-dimensional construct which is difficult to capture in a single theory. It is generally seen as a negative, pathological emotion. Not all scholars support this position. Bradshaw (2005) distinguishes between toxic and healthy shame, and believes that healthy shame is important because it puts us in touch with the limits of our abilities and motivates us to seek new information and learn new skills. It also reminds us that we often require help, and that we need to be in loving and caring relationships with others. Relatedly, healthy shame facilitates the ability to experience intimacy. It is at the core of humility and modesty. This is also touched on in chapter 4 on shame and culture. This is starkly contrasted with toxic shame, which is the experience of the self as being wholly, fundamentally flawed and characterised by crippling self-contempt (Bradshaw, 2005).

---

<sup>9</sup> Although not discussed further here, it is important to note that social anxiety, shyness and shame have been identified as closely related constructs (Gilbert, 1998). Shyness, social anxiety and shame are all associated with fear of negative interpersonal evaluation in real or imagined social settings, specific physiological symptoms, self-consciousness, generalized tension and inhibition (Gilbert, 1998).

In agreement with Gilbert (1998), I maintain that shame is based on primitive psychological mechanisms which have adaptive functions that have evolved over time to enable animals and humans to defend against social threats. However, in excess, shame is toxic, and has extremely detrimental effects on psychological functioning (Bradshaw, 2005).

In the following chapter we turn to the factors which distinguish shame from related emotions.

## CHAPTER 3

### **Theoretically and Clinically Relevant Distinctions Between Shame and Related Emotions**

Shame is a complex construct, which is not easily defined. Although this thesis is only based on shame, not theoretically and empirically related emotions, I compare shame to these emotions instead of trying, and inevitably failing, to define shame in a single sentence or paragraph. Therefore, elucidating shame through comparison to other related constructs was chosen as a more appropriate approach to understanding the construct than attempting to provide a single, all-encompassing definition of shame. Consequently, the function of this chapter is to define shame through its relation to a number of other related emotions. Many of these emotions are closely related, and overlap, but I also focus on the important distinctions amongst them. It is important to understand both the commonalities and the distinctions between shame and these associated emotions in order to understand shame in all its complexities. The understanding of shame and other related emotions will be based on psychoanalytic, phenomenological, cognitive and empirical approaches, most of which were described in the previous chapter. I begin the chapter with a brief description and comparison of shame and other self-conscious emotions (defined below), and then go into greater depth in terms of the similarities and differences between shame and related constructs.

Before beginning the theoretical review, it is important to make a distinction between shame and stigma. In M. Lewis' (1998, p. 126) understanding, shame can be defined as "an intense negative emotion having to do with the self in relation to standards, responsibility, and such attributions as global self failure" (an internal experience), whereas stigma is a "public mark" or violation (an external experience), something that is noticeable to others and involves a "spoiled identity". Thus, the stigmatised person is publically marked by his/her deviation from the norm in appearance or in behaviour (M. Lewis, 1998; Nussbaum, 2004). However, there is a great deal of overlap between these two constructs. Significantly, shame may precede and/or follow stigmatisation. Nussbaum (2004) argues that individuals project aspects of themselves of which they feel ashamed or out of control, and wish to conceal, onto vulnerable groups, thus stigmatising them. Shame is also one of the core emotional consequences of stigmatisation (M. Lewis, 1998). For example, individuals who manifest

psychotic behaviour often describe the sense of estrangement from others, alienation, a sense of isolation and social failure, as well as the awareness of belonging to a feared or unwanted group, which are all characterised by substantial despair and shame (Will, 1987).

Furthermore, the degree to which the stigmatised person is blamed for his/her deviation is associated with the degree of shame experienced (M. Lewis, 1998). A related construct, is stigma consciousness. It refers to an individual's expectation that s/he will be prejudiced against or discriminated against on the basis of dispositional or situationally induced differences (Mosley & Rosenberg, 2007). Stigma consciousness does not only refer to an individual's awareness that s/he has a stereotyped status; instead, it refers to the individual's focus on his/her stereotyped status (Mosley & Rosenberg, 2007).

### **Shame and Guilt**

From the earliest writings on shame, scholars have suggested that the desire to hide or to disappear is a key feature of the experience of shame. In fact, Schneider (1987, p. 199) argues that "at its core, shame is intimately linked to the human need to cover that which is exposed", a characteristic which is quite clear in the Proto-Germanic, Indo-European root *\*(s)kem-*; *\*(s)kam-*, which means "to cover", and gives us the English word *shame*. Yontef (1996) argues that the difficulty with the hiding associated with shame is that it isolates the individual, and without interaction and feedback from others, no growth is able to take place. However, hiding may be inevitable because shame comes with such extreme pain, discomfort, and anger, which is what distinguishes shame from shyness or embarrassment (M. Lewis, 1992).

Early scholars emphasised the overlap between self-conscious emotions, and mistakenly conflated shame with a range of related constructs, including, among others, discouragement, self-consciousness, embarrassment, shyness and guilt (Kaufman, 1993). These emotions have a core affect in common, but there are marked differences in their activators, targets and reducers (Kaufman, 1993). Shame and guilt in particular have been a challenge to disentangle in some of the literature (Mollon, 2002). The confusion between shame and guilt in particular can be traced mainly to the belief that both shame and guilt are social emotions – affects that arise when there is a threat to significant social bonds (Gilbert, 1998; H. B. Lewis, 1986; Will, 1987). Although both shame and guilt develop in interpersonal contexts, shame is evoked

when a person fears the loss or ruptures of an attachment to a valued or admired other (Will, 1987). This fear functions to encourage compliance with cultural or group prescriptions, norms, standards and values (Will, 1987).

As we saw in the previous chapter, it is H. B. Lewis who first developed the distinctions between guilt and shame, discussed below. H. B. Lewis (1971) and later, M. Lewis (1992), Nussbaum (2004) and Mollon (2002), differentiate between shame and guilt on the basis of specific and global attributions – in shame, global attributions involve the negative evaluation of the total self, while in guilt, the individual's attributions focus on the particular actions of the self. Thus, researchers such as Dearing, Stuewig and Tangney (2005) have shown that shame-proneness (a tendency or readiness to experience certain kinds of emotions and engage in certain types of behaviours, such as feeling bad and self-conscious about the whole self; and having more severe negative emotions and behaviours activated in potentially shameful situations), relates to a variety of problems and pathologies, whereas guilt-proneness, which involves the tendency to feel bad about a particular behaviour or incident, is more likely to be adaptive. Because the self is not debilitated by guilt, and because guilt involves focusing on specific and controllable behaviours, it is more likely to be accompanied by reparative action, hence the demonstrated association between guilt and prosocial feelings and behaviour (Lazarus, 1991; H. B. Lewis, 1971; Tangney, 1991). When guilt occurs, the individual focuses on fixing or “undoing” the failure, or preventing its re-occurrence (M. Lewis, 1992; Nussbaum, 2004). In the words of Kingston (as cited in Goldberg, 1991, p. 54):

Unlike the guilty act for which one can make confession, expiation, penance, or reparation, the shameful act requires an alteration of the person. The person thinks ‘I can not have done this. But I have done it, and I can not undo it because it is I.’

Gilbert (1998) has made a distinction between internal (the self's negative evaluation of the self) and external (others' negative evaluation of the self) shame. He argues that although the two are often correlated, shame can either be entirely internal or entirely external; however, the core aspect of both types of shame is the experience of the self as “unattractive social agent”<sup>10</sup> (Gilbert, 1998, p. 22). By contrast, H. B. Lewis (1971) argues that shame includes the vicarious experience of another's negative evaluation of the self (which involves a great deal of visual and verbal imaging of the self from the other's perspective), hence, for shame to occur, there needs to be a relationship between the self and an admired or valued other. Guilt

---

<sup>10</sup> This is defined as the closeness to the undesired self as opposed to distance from the idealized self (Gilbert, 1998).

is also understood as a vicarious experience, however, it is the experience of having done (or not done) something that harmed, injured or caused another suffering (H. B. Lewis, 1987a). As such, H. B. Lewis argues that shame can be interpreted as the experience of losing self-esteem in both the self and/or others' eyes as a result of perceived failure, while guilt is the experience of injuring others which requires corrective action.

Other important distinctions between shame and guilt besides in focus (self vs. a specific incident) is the experienced emotion (worthlessness and powerlessness vs. tension, remorse and regret); the effect on the individual's conception of self (global impairment vs. unimpaired self), and the reactions (a desire to hide, escape or strike back with hostility, scorn, contempt and ridicule vs. a regret, remorse, concern and a desire to confess, apologise or repair) (Crowe, 2004; Lazarus, 1991; H. B. Lewis, 1971; Tangney, Steuwig, & Mashek, 2007). Seligman and Teasdale (as cited in Tangney & Dearing, 2002) distinguish between locus (internal vs. external), globality (global vs. specific) and stability (stable vs. unstable). Guilt and shame are both internal attributions, but they differ in terms of globality and stability – with shame being more likely to involve global and stable attributions (See Table 3.1 for a summary of the differences between shame and guilt at the end of the section). In addition, causal controllability impacts on guilt and shame, with internal, controllable causes for personal failure leading to feelings of guilt (for example, lack effort in an achievement task), and internal, uncontrollable causes for personal failure leading to shame (for example, lack of ability in an achievement task (Weiner, 1986). It is also worth noting that shame results in a reduction in achievement striving, while guilt is associated with renewed motivation (Weiner, 1986).

It is worth briefly noting however, that largely on the basis of criticisms of the commonly used measure known as the Test for Self-Conscious Affect (TOSCA), Ferguson, Brugman, White and Eyre (2007) have argued that shame and guilt cannot be distinguished on the basis of perceived controllability. In addition, they question whether shame is inevitably associated with poor adaptation, and guilt with healthy adaptation. In fact, they suggest that it is the combined tendency toward guilt and shame that characterises sophisticated moral self-regulation. They also question the focus in existing research on emphasising the importance of guilt and detracting from the importance of shame. On the basis of this, these authors demonstrate that withdrawal/avoidance/self-criticism so typical of shame is not a warranted reaction to minor or isolated transgressions. However, when expressed as a response to repeated transgression, the pattern of submissive-appeasement displays of shame is used to

elicit sympathetic understanding from others (Ferguson et al., 2007). This finding has not been consistently replicated.

Shame is an involuntary affective state that may arise in response to events or circumstances for which the individual cannot be held responsible, and over which the individual has little control (Goldberg, 1991; H. B. Lewis, 1971). Because of its irrational nature, the self is not open to rational solutions when shamed (H. B. Lewis, 1971). Guilt tends to involve more cognitive activity than shame, such as preoccupation with wrongdoing, and rationalisation (Izard, 1977; H. B. Lewis, 1971). Guilt involves negative feelings, but with or without the painful affect – particularly the heightened or acute self-consciousness characterising shame – and the accompanying autonomic (e.g. blushing, tears, increased heart rate) reactions (Izard, 1977; H. B. Lewis, 1971). It involves less emotional disorganisation, more rational ideation and tendency to make amends; the self is much more able, less helpless than in the case of shame (H. B. Lewis, 1986). Shame is understood as a wordless, primitive and irrational emotion which is associated with excessive uncontrollable autonomic reactions, which may be experienced as a flood of sensations (Izard, 1977; H. B. Lewis, 1971). Blushing ironically heightens the visibility of the face, the primary site for communicating affect, at a time when the blushing individual desires to be inconspicuous, so compounding helplessness and shame (Tomkins, 1963). Other mental and physical indicators of shame include mentally blanking, numbness, becoming very still or quiet, and hanging of the head (Yontef, 1996).

As is clear, because of the heightened self-awareness that accompanies shame, it involves greater body awareness and activity (Izard, 1977; H. B. Lewis, 1971). In shame reactions, the body “implodes”, with head bowed, eyes closed and body curled in itself, to make the individual as small and as inconspicuous as possible (Izard, 1977; H. B. Lewis, 1971). This is understood by evolutionary theorists as a form of appeasement (Gilbert, 1998). The hanging head and the averted eyes cause an immediate reduction in facial visibility, which is why shame has previously been referred to as “loss of face” (Kaufman, 1993, p. 20). Facial defenses against shame include a frozen face and the “anti-affect” head-back look which involves a facial display opposite to the shame response with head and chin up (Kaufman, 1993, p. 20). Retzinger (1987, p. 171) argues that the external bodily manifestations of shame include: 1) the hand covering all or certain parts of the face; 2) turning in, biting, or licking the lips, or biting the tongue; 3) gaze avoidance, eyes lowered or glancing; 4) blushing; 5) forehead wrinkled vertically or diagonally; and 6) false smiling and masking behaviours. Nonverbal markers of shame also include shame phrases (e.g. It was sore, it hurt; I am

nothing; I am dirty), repetitious speech, and fragmented speech (Retzinger, 1987). Behaviours involved in the shame response include these physiological reactions, behaviours that are activated to cope with or conceal shame (e.g. secondary reactions to shame such as fear or anger), behaviours triggered to avoid being shamed or to avoid shame being discovered (e.g. social withdrawal, secrecy, competitiveness, addictions, unrelenting high standards or perfectionism), and behaviours used to repair or compensate for shame (e.g. acknowledgement of wrongdoing, public demonstrations of shame to ensure reconciliation and forgiveness) (Gilbert, 1998).

When the guilt reaction includes affect, it may vary considerably in intensity, while in shame the negative emotion is typically intense (H. B. Lewis, 1971). Thus, shame is an intense negative state which results in an interruption of current behaviour, confusion in thought, and speechlessness (M. Lewis, 1992). Often, the shamed individual finds it difficult to identify the exact cause of his/her uneasiness, which is why it is so difficult to find the words to communicate the painful experience of shame (Goldberg, 1991). One of the reasons for these difficulties in speech is because “normal” or universal shame experiences occur prior to language development (before the hypothalamus and hippocampus of the brain are fully developed), in infancy, and thus the experience becomes internalised in terms of imagery rather than language (Goldberg, 1991).

Recent empirical work has begun to study the psychobiological markers of shame, and have found that shame reactions are associated with increased proinflammatory cytokine activity (leading to the suppression of the immune system) and increases in cortisol levels, potentially leading to autoimmune and inflammatory disturbances (Mills, 2005; Tangney et al., 2007). In addition, Tangney et al. (2007) found increased cardiovascular reactivity and risk factors for hypertension in shame reactions. The same biological reactions were not evident in guilt experiences.

Another key difference between guilt and shame is that in shame, self-other boundaries are much more permeable – the individual is able to take the perspective of both the self, and vicariously experience that of the other (Izard, 1977; H. B. Lewis, 1971)<sup>11</sup>. This duality or doubleness of experience is the basis for what Freud called the “internal theatre” of the self (H. B. Lewis, 1987c, p. 107). Furthermore, shamed individuals frequently experience others behaving towards them as they treat themselves unconsciously (Yontef, 1996). Soft self-other boundaries also have implications for the contagiousness of shame – shamed people tend to

---

<sup>11</sup> This differs from empathy, which requires not only perspective-taking, but also affective matching.

evoke shame in others (Goldberg, 1991). Guilt on the other hand, is more contained and is localised within the self (i.e. not involving seeing the self from the perspective of others) (H. B. Lewis, 1971).

A related issue is the different roles played by shame and guilt in terms of boundaries protecting the self. Wurmser (1995, p. 62) argues that each person is surrounded by an inner and an outer limit or boundary; the inner limit is the boundary around the person's intimate areas and protects his/her privacy, while the outer limit is the boundary of "power expansion", which, if crossed, violates the other's integrity, power, and social prestige. Guilt ensures that the outer boundary of another is not infringed, while shame ensures that there is no infringement of the inner boundary (Wurmser, 1995).

There are important differences in how the other is perceived in shame and guilt reactions. In shame reactions, the other is the source of scorn, contempt or ridicule; is seen as intact, powerful and active; as abandoning; and focal in awareness (H. B. Lewis, 1986). In guilt, the other is seen as injured, suffering or hurt; dependent; and the other is only present in thoughts related to guilt, not as a pervasive focus (H. B. Lewis, 1986).

At its core, shame involves feelings of banishment, ostracism and abandonment, while guilt involves awareness of engaging in a specific act which is in violation of a standard of conduct (Yontef, 1996). For example, shame involves fears of abandonment when caregivers withdraw from the child, withholding love, when they are contemptuous or disgusted with the child, and when they threaten to leave the child, all of which communicate rejection (Kaufman, 1993). Caregivers, siblings and peers can also evoke shame and abandonment fears through communicating that the child is a source of shame or embarrassment to them, by disparaging, by blaming, humiliating, and having performance expectations (Kaufman, 1993).

Abandonment is of key importance in shame experiences. Perceptions of exposing the self's weakness, defectiveness and dirtiness (the core ingredients of the shame experience) are centred around fears of evoking rejection, contempt and abandonment from others (Wurmser, 1995). That is why the subject of shame is internalised or hidden, while the object(s) (those perceiving another's shame) need to be displaced or "neutralized" (Wurmser, 1995, p. 59). Wurmser (1995) argues that the primary aim of shame is to stimulate hiding behaviours, whose function it is to prevent abandonment. This pertains to both levels of shame, namely, the activity of being exposed, and the content of what is being exposed (Wurmser, 1995).

From a Gestalt point of view, shame is the “experience of negative evaluative and emotional reactions to one’s own being”, whereas guilt is the experience of violating a standard of conduct (Yontef, 1996, p. 353). Shame involves both thought and affect, and includes feeling inadequate, incompetent, weak, defective, stupid, disgusting, repugnant, loathsome, untouchable, unwanted, a bother or a nuisance, not “enough”, as unentitled and unworthy of belonging, respect, love, and comfort, and includes the experience of being uncomfortably seen by significant others, exposed, naked and vulnerable to contempt. According to Yontef (1996), there are three types of shame: situational, group and existential. Situational shame is a response to a situation in which particular failures, weaknesses or inappropriate behaviour are exposed (Yontef, 1996). Existential shame is broader than situational shame, and involves the negative evaluation of the essence of the individual; his/her entirety (Yontef, 1996). Group shame refers to shame that is the result of belonging to a particular stigmatised social grouping. Existential shame, in particular, develops in shaming environments, which result in the child turning against the part of the self that needs love and nurturance from (shaming) significant figures in his/her life; blaming him/herself for these needs, rather than the environment which should foster them. Because it feels unfathomable to the child that his/her parents are “bad”, s/he feels shame for being “needy” or “weak”. From a Gestalt point of view, shame is the introjected message (a toxic message absorbed – “swallowed whole”, unintegrated, from the environment) from significant others such as parents, that s/he is never enough to deserve love from them (Yontef, 1996).

It is worth briefly noting that what kind of event evokes either guilt or shame is also at least partly dependent on the nature and temperament, as well as socialisation experiences of the individual. Although there are very few prototypic situations for eliciting shame (or guilt), M. Lewis (1992) suggests that love withdrawal, which implies the rejection or abandonment of the whole self, is one such situation.

It has long been held that shame may be evoked by moral or non-moral transgressions, and from relatively trivial events, to serious moral wrongdoings (H. B. Lewis, 1971). It may be evoked for irrational or illogical reasons, and commonly involves disappointment, defeat or frustration, usually as a result of perceived or actual abandonment, which tends to be linked to past experiences (H. B. Lewis, 1971; Lazarus, 1991). H. B. Lewis (1971) argues that guilt, in contrast, is evoked by the acceptance or acknowledgement of moral contravention. More recent empirical work, however, indicates that shame and guilt are not distinct in terms of the

types of transgressions or failures that evoke them. According to Tangney (2003), there is a great deal of overlap in the kinds of occurrences that evoke shame and guilt.

Findings, however, are inconsistent. Ferguson, Stegge and Damhuis (1991) found that guilt was evoked for pre-adolescents when moral violations occurred, whereas shame resulted from both moral transgressions and social blunders. Guilt was associated with approach-avoidance conflict in terms of the victim, self-criticism, remorse, desire to make amends, and fear of punishment for both 7 – 9 year-olds and 10 – 12 year-olds, whereas shame was associated with embarrassment, blushing, ridicule and wish to escape among 7 – 9 year-olds and 10 – 12 year-olds when shame was characterised as involving feelings of stupidity, being unable to do things the right way, and being unable to look at others (Ferguson et al., 1991).

There is an enduring belief that shame is a more “public” emotion (experienced in the presence of others) than guilt, which is viewed as a more “private” experience (experienced when alone) (Tangney & Dearing, 2002). A large body of research, however, calls this distinction into question, demonstrating that shame and guilt do not in fact differ on this dimension (Tangney & Dearing, 2002; Tangney et al., 2007). Shame may involve internally focused, private self-consciousness, or externally focused public self-consciousness about the self (Gilbert, 1998). Shame and guilt are both likely to be experienced while in the presence of others; and solitary shame experiences have been found to be as frequent as solitary guilt experiences (Tangney, 2003; Tangney et al., 2007). Both shame and guilt are elicited by social situations, whether imagined or real, although shame is associated with more intense feelings of exposure (Tangney et al., 2007). Unlike guilt, shame is also characterised by a tendency towards self-criticism, unfavorable social comparison (on dimensions of inferior-superior and same-different) and dependency (Gilbert, 1998). However, the major distinction between shame and guilt remains the differential role played by the self.

The belief that guilt is adaptive, and shame maladaptive, is not universally held. Kaufman (1993) argues that shame is not necessarily debilitating; that its effects depend on its frequency, intensity, duration and consequences. Dost and Yagmurlu (2008) suggest that any emotion can be both adaptive and maladaptive, depending on the function of the emotion, its context and circumstances (including culture). Researchers supporting this contention suggest that guilt is a multi-dimensional construct, which comprises some adaptive dimensions, and some maladaptive dimensions (Dost & Yagmurlu, 2008). The maladaptive dimensions of guilt can be seen in studies where guilt has been associated with depression, somatisation, obsessive-compulsiveness, psychoticism, paranoid ideation, anxiety and anger (Dost &

Yagmurlu, 2008). Guilt has also been associated with negative perfectionism (Dost & Yagmurlu, 2008). Furthermore, there are different types of guilt, like for example, chronic guilt (continuous guilt feelings without concrete cause) and predispositional guilt (guilt feelings that are evoked by specific incidents) (Dost & Yagmurlu, 2008). Research indicates that chronic guilt, but not predispositional guilt, is associated with poor outcomes, including depression, somatic complaints, obsessive-compulsive tendencies and paranoid and anxious symptoms (Dost & Yagmurlu, 2008). Scholars in the past (Izard, 1977; H. B. Lewis, 1971, 1987a, 1987b, 1987c) have theoretically associated guilt with thought disorders – particularly obsessive ideation and paranoia. Guilt is transformed into paranoia through the projection of hostility outwards (H. B. Lewis, 1987b). Finally, it is important to note that under certain circumstances, shame may also be constructive. For instance, in societies which are characterised by the promotion of human dignity and equality, individuals may uphold particular values, such as the inclusion of all human beings in a community, and the associated notions of interdependence and mutual responsibility (Nussbaum, 2004). Not upholding such values may lead people in such societies to feel shame, a kind of shame that is distinguished from more primitive varieties, which are typically associated with rage and revenge or retribution fantasies, by its essentially anti-narcissistic character (Nussbaum, 2004).

It is interesting to note that, similar to Freud, in the early writings of Piers and Singer (1953), guilt was considered more pathological than shame. Although their assertion that guilt is typically accompanied by restitution (sacrifice, atonement) concurs with the later writings of other scholars, they argue that shame-driven individuals are more likely to reach their potentialities, to mature and progress in healthy ways (due to healthier primary and secondary identifications), than those who are guilt-driven and who tend to regress or stagnate, as well as experience feelings of resentment, frustration and rage (Piers & Singer, 1953). However, as will be seen, some of the more recent empirical work calls this assumption into question.

Recent studies have demonstrated that shame-free guilt mostly does not contribute to psychological symptoms (Tangney et al., 2007). In fact, greater guilt has been associated with higher ideal and real self-image, educational achievements, fewer learning difficulties, and less acting-out behaviour (Bybee & Zigler, 1991). In contrast, shame is associated with a host of interpersonal problems such as retaliation or withdrawing, hiding, and wishing to escape (Tangney, 1991). Shame-proneness is negatively associated with self-esteem, stability of the self, and positively related with self-consciousness, fear of negative evaluation, and splitting

(Tangney, Burggraf, & Wagner, 1995). Conversely, shame-free guilt is positively related to self-esteem, stability of self, and is unrelated to self-consciousness, fear of negative evaluation and splitting (Tangney et al., 1995). In addition, in shame, but not guilt reactions, individuals may experience a range of secondary defenses and catastrophic reactions, which prevent the individual from feeling shame, but which cause significant distress (Goldberg, 1991). In Goldberg's (1991) view, these "explosive" responses temporarily overwhelm the individual's sense of being insignificant, debased, abject and disregarded. Another way in which individuals counter feelings of shame is by putting on a front of arrogance, self-glorification, aggressiveness and pseudo-masculinity (Goldberg, 1991).

Tangney, Mashek and Stuewig (2005) assert that guilt becomes maladaptive or problematic only when it becomes enmeshed with shame, and it is the shame aspect of the fused construct that facilitates pathological outcomes. The kind of maladaptive or fused shame-guilt proposed by Tangney et al. (2005) is characterised by chronic self-blame and obsessive pre-occupation with wrongdoings (Tangney, 2003). Alternatively, another recent study speculated that there are two types of guilt – one constructive and restorative, the other destructive and maladaptive, and that shame remains a distinct affective construct (Tilghman-Osborne, Cole, Felton & Ciesla, 2008). Problematic guilt may emerge when individuals develop a magnified or distorted sense of responsibility for events that were not within their control and/or in which they had no particular involvement, such as in the case of survivor guilt (Tangney et al., 2007).

It is worth pausing for a moment to focus on shame exclusively and to consider that these psychopathologies develop both in individuals who have a temperamental vulnerability to shame-proneness and in those who experience high levels of shame-promotive experiences (Mills, 2005). Children who are disposed to high levels of anxiety more readily attribute transgressions or wrongdoings to internal traits than those who experience lower levels of anxiety (Mills, 2005). In addition, it has been shown that individuals who are prone to more self-focused attention are less able to create barriers to protect themselves from negative internal stimuli, and are at increased risk for developing a disposition towards shame (Mills, 2005).

As I have noted, unlike guilt, shame results in complete helplessness. In guilt reactions, the individual has the option of changing his/her behaviour; repairing the negative consequences of his/her behaviour; extending an apology; as well as resolving to behave differently in the future (Tangney et al., 2007). By contrast, the self is much more incapacitated and powerless

in the case of shame responses (Tangney et al., 2007), which is possibly one of the reasons it bears a strong relationship to psychopathology, for example, depression.

The research findings on a related construct, self-blame, and its relationship to anger (as distinguished from verbal and physical aggression and hostility) have not been consistent. Gilbert and Miles (2000) found that self-blame rather than blame of others was associated with anger; and that self-blame was also positively related to hostility, whereas blaming others was related to fewer hostile attitudes. Self-blame can also paralyse the self into passivity, and contribute to feelings of being overwhelmed and being unable to control one's life (Goldberg, 1991).

Shame is often understood as the dissonance or disjuncture produced in the self-concept as a result of thoughts, feelings and actions which are inconsistent with who one believes one is, or ought to be (Stone, 1992). Thus, shame is associated with discrepancies between the actual self (attributes that the individual or others believe s/he actually possesses), the ideal self (attributes the individual or others would like him/her to possess), and the ought self (the attributes the individual or others believe s/he should possess) (Tangney & Dearing, 2002). Unlike the theory proposes, self-discrepancies of all kinds are related to shame (Tangney, Niedenthal, Covert, & Barlow, 1998). Tangney and her colleagues also found that both anxiety and depression were associated with all types of self-discrepancies, and that unlike the theory states, affective states (dejection and agitation) were not differentially related to these self-discrepancies.

In psychoanalytic terms, these discrepancies are described as the inability to live up to the ego-ideal; the inability to live up to an idealised image, an image which to the internal eye is searingly deficient (Izard, 1977; Lazarus, 1991; Wurmser, 1995). Alternatively, shame can be described as a discrepancy between expectancy and realisation (Wurmster, 1987). According to Piers and Singer (1953), in shame, there is a discrepancy between the ego and ego ideal whilst guilt is the tension generated when the barrier erected by the superego is transgressed by id impulses. This diverges from Freud's sexual understanding of shame, where shame is understood as a reaction formation against exhibitionism in particular (in Freud's writings, shame is usually described in the context of drives and impulses that require restriction, including sexual impulses, as well as aggression and toileting practices) (Freud, 1986). Specifically, Freud held that shame, disgust, pity and the societal structures of morality and authority inhibit sexual instincts (Freud, 1986). For Piers and Singer (1953), unlike guilt, shame is generated by a goal not being reached (one which is held by the ego-ideal). Thus,

shame is accompanied by a sense of failure, while guilt is the anxiety associated with transgression, made evident by the workings of the superego (Piers & Singer, 1953). Another distinction, in psychoanalytic terms, between shame and guilt, is that the unconscious, irrational threat associated with shame is that of contempt, ostracism and ultimately, abandonment, while in guilt it is mutilation (castration) (Piers & Singer, 1953). Although these two constructs are clearly differentiated, even in early writings, these authors found in their clinical practice that they tend to co-occur in that one can lead to the other, and that one may conceal the other (Piers & Singer, 1953). For example, guilt can follow shame when feelings of weakness, passivity and helplessness, as is characteristic of shame, lead to feelings of anger and retribution towards the injuring other, resulting in feelings of guilt (Mollon, 2002).

Although also from a psychoanalytic perspective, H. B. Lewis (1971) argues that in shame, it is not the discrepancy between the ego and the ego-ideal that determines failure and abandonment terror, but the perception that one has failed in the eyes of an imagined or real idealised other, who is perceived as punitive and rejecting. Thus, in H. B. Lewis' (1971) view, shame can be experienced only in the context of an emotional relationship with another person who is valued.

Prior to concluding this section, it is worth briefly pausing to consider a very different theory, posited by Elison (2005). He argues that shame is an affect, a basic emotion, evolved through social selection and caused by perceived devaluation, whereas guilt is considered a socio-legal condition, an objective description, which may be associated with any affect through socialisation and scripting. So, shame is considered a single construct (an affect) while guilt involves multiple affective-cognitive hybrids (an affect combined with cognitive awareness of being guilty). What is interesting here is that Elison (2005) defines shame differently from some of the other scholars whose work I have reviewed. Specifically, he believes that although self-evaluation and standard violation are related to shame, shame is caused by a social antecedent – devaluation – where such devaluation refers to all occasions or events where social status or acceptance by others has been lost, reduced, or is less than desired. It is this devaluation, irrespective of standard violations, that produces shame; while it is the focus on the responsibility for negative consequences to others following the guilty action that produces the affective-cognitive hybrids of guilt. Thus, violation is integral to the definition and understanding of guilt (Elison, 2005).

Elison (2005) criticises the methodology of previous studies (the questionable validity of the instruments used), including those conducted by Tangney and her colleagues, on the basis of which distinctions between shame and guilt have been made. He argues that shame and guilt are often associated (that shame is the primary emotion involved in guilt affective-cognitive hybrids); specifically, that shame is commonly reported when feelings of guilt are reported, although the reverse is not true. This overlap is why people often cannot distinguish between the two constructs. In addition to shame, anger, fear, sadness and joy are seen as pure affects. Affective-cognitive hybrids include embarrassment, humiliation, shame-guilt (subordinates of shame), fear-guilt (subordinate of fear), sad-guilt (subordinate of sadness), anger-guilt (subordinate of anger), and joy-guilt (subordinate of joy). The pure nature of the shame affect, in contrast to the multitude of affects and cognitions association with guilt is why shame is often considered more painful. The multiple and varied responses to guilt, the greater complexity of guilt, and the greater cognitive content of guilt are also explained by the number of affective-cognitive hybrids. The presence of the sadness/remorse hybrid further explains why guilt, but not shame, is often associated with attempts at reparation.

Elison (2005) understands shame in evolutionary terms – as signalling submission and acceptance of norms in the face of aggression or perceived devaluation or loss of attractiveness by others. Behaviours associated with shame include hiding through retreat or making the body smaller (e.g. slumped shoulders); it also brings confusion, which disorganises behaviour and makes it difficult for the individual to continue engaging in the sanctioned action. Further evidence of the evolutionary origins of shame and other affects are their having modular neural bases, rapid onset, automatic appraisal and uncontrolled or involuntary occurrence (Elison, 2005).

To conclude this section, I summarise the similarities and differences between shame and guilt, including post-traumatic shame and guilt, in table form, see Table 3.1 below.

Table 3.1

*Key Similarities and Differences between Shame and Guilt*

---

*Features shared by shame and guilt:*

---

Both fall into the class of “moral” emotions – emotions that keep us “on the straight and narrow”;

---

Both are “self-conscious”, self-referential emotions;

---

Both are negatively charged emotions<sup>12</sup>;

---

Both involve internal attributions of one sort or another;

---

Both are typically experienced in interpersonal contexts;

---

The negative events that give rise to shame and guilt are highly similar (frequently involving moral failures or transgressions).

---

*Key dimensions on which shame and guilt differ:*

	Shame	Guilt
<i>Focus of evaluation</i>	Global self: “ <i>I did that horrible thing</i> ”	Specific behaviour: “ <i>I did that horrible thing</i> ”
<i>Stimulus</i>	Disappointment, defeat, or moral transgression Deficiency of <i>self</i> Involuntary: self <i>unable</i> Encounter with “other” or within the self	Moral transgression Event; <i>thing</i> for which the self is responsible Within the self
<i>Conscious content</i>	Painful emotion Autonomic responses: rage, blushing, tears Identity thoughts; “internal theatre”	Affect may or may not be present No identity thoughts

---

<sup>12</sup> It is worth noting that some authors such as Bradshaw (2005) and Zembylas (2008) have emphasized the positive potential of shame, including facilitating humility, encouraging awareness of our need for others and facilitating intimacy, as well as enabling emotional connectivity and reconciliation in groups who are historically opposed.

Table 3.1 *continued*

<i>Position of self in field</i>	Self passive	Self active
	Self focal in awareness	Self absorbed in action or thought
	Self-imaging and consciousness; multiple functions of self	Self intact, functioning silently
	Vicarious experience of the other's negative view of self	Pity; concern for welfare
<i>Nature and discharge of hostility</i>	Humiliated fury	Righteous indignation
	Discharge blocked by guilt and/or love of "other"	Discharge on self and other
<i>Degree of distress</i>	Generally more painful than guilt	Generally less painful than shame
<i>Phenomenological experience</i>	Shrinking, feeling small, feeling worthless, powerless	Tension, remorse, regret
<i>Operation of "self"</i>	Self "split" into observing and observed "selves"	Unified self intact
<i>Impact on "self"</i>	Self impaired by global devaluation	Self unimpaired by global devaluation
<i>Concern vis-à-vis the "other"</i>	Concern with others' evaluation of self	Concern with one's effect on others
<i>Counterfactual processes</i>	Mentally undoing some aspect of the self	Mentally undoing some aspect of behaviour
<i>Motivational features</i>	Desire to hide, escape, or strike back.	Desire to confess, apologise or repair.
<i>Characteristic symptoms</i>	Depression; and affect disorders	Obsessional; paranoid; "thought disorders"

(Drawn from H. B. Lewis, 1987c, p. 113 and Tangney, & Dearing, 2002, p. 25)

To complement the discussion by Tangney and Dearing (2002) above, I will draw on the work of Wilson, Drozdek and Turkovic (2006), who focus on the distinction between post-traumatic shame and guilt specifically. According to these authors, post-traumatic shame and guilt can be compared across eight domains of psychosocial functioning (see Table 3.2).

Table 3.2

*Key Dimensions on which Post-Traumatic Shame and Guilt Differ*

Psychological dimension	Post-traumatic shame	Post-traumatic guilt
Self-attribution processes	Focus on self-evaluation, loss of self-worth, moral virtue, self-esteem, sense of failure	Focus on evaluation of actions, self-recrimination over behaviour rather than self as object of appraisal
Emotional states	Humiliation, powerlessness, helplessness, sadness, anger and rage	State-dependent guilt, remorse, regret, apologetic, embarrassment
Action appraisal	I did something to cause it; therefore I am shameful or bad	I failed to act properly or acted badly; my actions were wrong but I am a good person
Impact on personal identity	“Loss of face”, loss of self-continuity and self-sameness, ego fragmentation, self-dissolution	No “loss of face”, no loss of identity, no fragmentation of self
Suicidality	High potential; suicide as self-obliteration	Low potential; defense: rationalization of guilt
Defensiveness	Repression, avoidance, suppression, denial	Denial, rationalization, minimization, undoing, counterphobic
Post-traumatic stress disorder proneness	High	Variable
Dimensions of self-structure negatively affected	All (e.g. decreased sense of continuity, coherence connection, vitality, autonomy, energy)	Part (e.g. vitality, connection)

(Wilson et al., 2006, p. 124)

Post-traumatic shame and guilt are considered important, multi-dimensional features of simple and Complex PTSD (Wilson et al., 2006). Dimensions of post-traumatic shame are described as including:

- loss of self-worth, virtue, self-esteem, wholeness, goodness and moral integrity;
- loss of sense of self-continuity in upholding culturally defined values, norms, and respected patterns of behaviour;

- feelings of worthlessness, powerlessness, inadequacy, failure, humiliation and smallness;
- perception of shame in the eyes of others (condemnation and failure);
- suicidality in fantasy or action (self-obliteration, desire for escape, isolation, withdrawal, self-imposed exile, and alienation);
- self-consciousness over disappointing others, letting down kinship, family, friends, fellow survivors, etc.; devalued self-appraisal (“loss of moral goodness”); and
- loss of self-respect within culturally defined roles, status and expectations (Wilson et al., 2006, p. 125).

By contrast, dimensions of post-traumatic guilt include:

- self-recrimination for failed personal enactments;
- survivor guilt over surviving perils of trauma;
- death guilt over being alive when others died or were injured;
- bystander guilt for failure to help others in need;
- personal guilt for acts of transgressions with negative consequences for others;
- situational guilt for acting contrary to personal values under coercive processes; and
- moral guilt for failed enactments inconsistent with personal ethics and moral responsibility (Wilson et al., 2006, p. 125).

It is clear from these descriptions that post-traumatic guilt is less severe, powerful and detrimental in its effects on psychological functioning than post-traumatic shame (Wilson et al., 2006).

Next we turn to the similarities and differences between shame and embarrassment.

### **Shame and Embarrassment**

Early seminal works by scholars such as H. B. Lewis, (1971) and Izard (1977) used the terms shame, shyness and embarrassment interchangeably. This is because they share a number of features, such as feelings of self-consciousness, exposure or fear of exposure, feelings of incompetence, stress, and inappropriate behaviour (Goldberg, 1991). However, M. Lewis

(1992, p. 79) has defined shyness as a biological predisposition including a “sheepishness, bashfulness, a feeling of uneasiness or psychological discomfort in social situations”, a state which originates owing to the oscillation between fear and interest or avoidance and approach, and one which is elicited by experiences of novelty and conspicuousness. Shyness is a mood, not an emotion like embarrassment, and is not associated with self-evaluation in relation to standards, rules and goals, whereas embarrassment may be self-evaluative or not (M. Lewis, 1992, 1993; Miller, 2007). The type of embarrassment which is associated purely with exposure can be termed self-consciousness, while the other, self-evaluative type of embarrassment has been termed mild shame, and is based on global failures in relation to standards, rules and goals which are less central to the self than they would be in shame reactions (M. Lewis, 1992, 1993). The latter type of embarrassment has been so termed because it contains the same self-evaluative essence that shame does, but is a less powerful, aversive emotion, and is associated with quite different physiological responses (M. Lewis, 1992). Shame has been described as a “darker, angrier and more intense emotion” than embarrassment (Miller, 2007, p. 246). It is important to note that despite the misleading terminology, embarrassment and shame remain quite distinct emotions.

Further theoretical and empirical distinctions have been made between embarrassment, guilt and shame in the more recent literature (Tangney et al., 2005; Tangney, Miller, Flicker, & Hill-Barlow, 1996). Tangney, Miller et al. (1996) and Tangney et al. (2005) have demonstrated that shame, guilt, and embarrassment are not simply different terms for a single emotion, but differ in terms of physiological reactions, subjective experience, attributions and appraisals, perceptions and concerns around audience, and motivation for future behaviour. Embarrassment specifically was found to be quite different from shame and guilt, and the distinctions among the three constructs could not only be explained by intensity of emotion (Tangney, Miller et al., 1996). Although shame and guilt were rated as more powerful, distressing emotions than embarrassment, they were also associated with a greater sense of moral wrongdoing than embarrassment (Tangney, Miller et al., 1996). Shamed or guilty participants felt greater responsibility, regret and remorse than they would have felt if embarrassed (Tangney, Miller et al., 1996). In addition, they felt more enraged and repulsed with themselves and believed that others also felt anger towards them (Tangney, Miller et al., 1996). In contrast, embarrassment emerged as a result of more inconsequential and amusing events (where the individual has been absentminded or clumsy for instance), and participants indicated that it occurred more suddenly and with a greater deal of surprise (Tangney, Miller

et al., 1996). However, as in shame reactions, embarrassment was associated with involuntary physiological changes, and with a significant sense of exposure and conspicuousness (Tangney, Miller et al., 1996; Tangney et al., 2007). Physiological changes unique to embarrassment include increased systolic and diastolic blood pressure, and increased heart rate in the first minute of the experience of embarrassment (after which the heart rate drops), and blushing (Miller, 2007). The most important function of blushing is that it sends out an easily recognizable signal to others that the individual is both aware of his/her predicament, and regrets it (Miller, 2007).

There is some overlap between the nonverbal behaviours accompanying embarrassment and those that accompany shame, like for instance the averted gaze (Miller, 2007). Other nonverbal behaviours which are unique to embarrassment include (initially) compressed lips or lips pulled down at the corners; when attempting to stifle a smile but fail, embarrassed individuals generally break into an abashed, sheepish grin which they may cover up with one hand; restlessly shifting their position; gesturing broadly; and if attempting to speak, may stammer or stutter (Miller, 2007).

Many scholars believe that embarrassment is caused when implicit social rules, norms, conventions and scripts are disrupted, or when an individual is negatively evaluated by another (Tangney, 2003). What is crucial to embarrassment, is that it only occurs when others are present, while shame can arguably be experienced both in the company of others (external shame) or when alone (internal shame) (Miller, 2007; Nussbaum, 2004). When embarrassed, individuals tend to behave in compensatory, conciliatory ways to win social approval and (re)inclusion – the primary function of embarrassment is to interrupt misbehaviour and produce behaviour that remedies the situation (Miller, 2007; Tangney, 2003). Embarrassed individuals tend to apologise for their behaviour and engage in action that repairs any damage or inconvenience caused by the embarrassing situation, and in cases where no harm was done, embarrassed individuals tend to use humour (Miller, 2007). Less often, they ignore or make no mention of the embarrassment and continue as if nothing has happened (Miller, 2007). Only in approximately one tenth of cases does the embarrassed person flee the situation, a behaviour which compounds negative impressions of him/her (Miller, 2007). An even more rare response is anger or aggression, which is only evoked when someone else has intentionally caused the embarrassment (Miller, 2007).

A key difference between embarrassment and shame is that although both are accompanied by the urge to hide or conceal, embarrassment is not characterised by the self-blame that is

associated with shame (Tantam, 1998). Another key difference between embarrassment and shame is that embarrassment results from relatively trivial social *faux pas* and transgressions, while shame tends to result from more serious and moral transgressions, or questions of honour (Tangney, 2003). In Miller's (2007, p. 246) words, embarrassment occurs when someone "violates a norm of deportment, civility, self-control, or gracefulness by making a mental error, behaving clumsily, or losing control of their possessions". Interestingly, though, Miller (2007) argues that overall, embarrassment is a positive or desirable response to social misdemeanours, because onlookers generally respond to another's embarrassment with sympathy and support; they tend towards more favourable evaluations than if the embarrassing situation had not taken place. However, exaggerated embarrassment or embarrassment in the absence of an embarrassing predicament does not evoke positive responses from others, it makes the embarrassed individual look inept or overly anxious (Miller, 2007).

People differ in terms of their capacity to be embarrassed – this is determined by the extent to which an individual pays attention to cues that give away what others are thinking of him/her, and the fear that others' evaluations will be negative and involve rejection (Miller, 2007). Tangney (2003) argues that embarrassment is not caused by a lack of social skills, but rather by a greater sensitivity towards, and high levels of concern for, social rules and standards (Tangney, 2003). Those vulnerable to experiencing embarrassment are thus at higher risk of being influenced by peer pressure, and tend to have higher levels of neuroticism, negative affect, self-consciousness and fear of judgment from others (Tangney et al., 2007).

### **Shame and Pride**

Pride and shame occur on an axis, and psychoanalytically, the manifestation of the emotion is determined by the distance between the actual self and the ego ideal (Nathanson, 1987a). Pride has received the least empirical attention of all the self-conscious emotions (Hart & Matsuba, 2007; Tangney, 2003). The purpose of pride is to enhance individuals' sense of self-worth and through this process to encourage and facilitate future conforming behaviours (Tangney, 2003). Current theoretical work suggests that pride can be an important motivator of sustained altruistic behaviour (through having such behaviour supported and reinforced by the social judgments of other people) (Hart & Matsuba, 2007). These authors argue that pride

motivates prosocial behaviour by helping individuals improve the image of the self that other people see and evaluate (the image improvement hypothesis), or by helping individuals feel better about themselves (the positive state improvement hypothesis). These theoretical arguments are largely confirmed by a recent empirical study which identified pride as a significant predictor of volunteering (Hart & Matsuba, 2007). This study also shows that pride is associated with individuals' perceived control over their volunteering work, and on whether others perceive their work as meeting particular internal standards (Hart & Matsuba, 2007). Some authors have argued that the primary purpose of pride is to promote good feelings and thoughts about the self, based on acting in accordance with internalised standards that enhance social status, which in turn, leads to high self-esteem (Tracy & Robins, 2007).

However, certain types of pride can also be maladaptive, such as when prideful individuals distort and invent situations which enhance and inflate the self, which can lead to significant interpersonal problems (Tangney, 2003). False pride, which is a response to chronic feelings of inadequacy, is one of the more pathological forms of pride (Nathanson, 1987a).

Furthermore, similar to the distinction made between guilt and shame, where shame involves negative appraisal of the whole self, and guilt involves negative appraisal of a particular behaviour, pride can be divided into "alpha pride" (positive evaluation of the whole self) and "beta pride" (positive evaluation of a particular behaviour) (Tangney et al., 2007). M. Lewis (1992; 2003) and Tracy and Robins (2007) have drawn a distinction between hubris (pridefulness) and pride. These scholars argue that hubris occurs when the person makes a global attribution as a consequence of success ("alpha pride"), while pride occurs when a person makes a specific attribution ("beta pride"). Positive events which have internal, unstable causes promote pride, while positive events with internal and stable causes promote hubris (Tracy & Robins, 2007). Hubris is seen as the counterpoint to shame (M. Lewis, 2003). According to M. Lewis (1992, p. 78) hubris is problematic because 1) it is a short-lived and addictive emotion; 2) it is not related to specific action and consequently requires changing patterns of goal setting or changes in the evaluation of what constitutes success; and 3) it interferes with interpersonal relationships because of its "contemptuous and insolent nature". Hubris has been associated with narcissism, which undermines and reduces the likelihood of prosocial behaviour; instead, it is associated with aggression and hostility, particularly when perceptions of the self are threatened (Hart & Matsuba, 2007). In addition, it has been negatively associated with self-esteem and positively associated with shame-proneness, while pride is positively associated with self-esteem and negatively associated with shame-

proneness (Tracy & Robins, 2007). Finally, pride has been positively related to the socially desirable and adaptive traits of extraversion, agreeableness, conscientiousness and emotional stability, while hubris has been negatively associated with agreeableness and conscientiousness (Tracy & Robins, 2007). These findings demonstrate that pride is an adaptive, achievement-orientated and prosocial self-conscious emotion, which facilitates the development of a sound self-esteem, while hubris is associated with arrogance, narcissistic grandiosity and superiority, which in part are defenses against a deep sense of shame (Tracy & Robins, 2007). It is interesting to note that pride and hubris cannot be distinguished by the nature of the events that evoke them; it is the way in which the event is evaluated that determines how it is experienced (Tracy & Robins, 2007).

Shame and pride are characteristically seen as opposites (Fischer & Tangney, 1995). While the antecedents of shame include a flawed or unacceptable action, statement or characteristic of an individual, the antecedents of pride are virtue or successful or desirable action, statement or characteristic of an individual (Fischer & Tangney, 1995). Similarly, responses to shame and pride are divergent, including hiding, escaping, a sense of shrinking, and feelings of worthlessness in the case of the former, and displaying, engaging, a sense of growing large and feeling worthwhile in the latter (Fischer & Tangney, 1995; M. Lewis, 1992). Furthermore, an individual experiencing shame is likely to disguise or deny the presence of a negatively evaluated action, statement or characteristic, or to blame other individuals or events for it, while in pride, the individual tends to draw attention to the positively evaluated action, statement or characteristic and take credit for it (Fischer & Tangney, 1995). By the age of three years, children have developed the capacity to experience pride, but it is not until age four that children can recognise pride in others; however, full understanding of pride does not emerge until children have reached the age of nine or ten years (Tracy & Robins, 2007).

Pride is associated with showing dominance/superiority; believing in the importance of the standards one has upheld; maintaining good feelings about oneself; believing that others will think one is good; inclinations to show or tell others about one's achievement; the self as agent; moderately tense voice, flushed face and high heart rate (Barrett, 1995). Other non-verbal behaviours typical of pride include the head tilted slightly back, upper body in expanded posture, arms akimbo with hands on hips (or up in the air), and a small smile (Tracy & Robins, 2007). Shame, in contrast, involves distancing oneself from the evaluating agent; communicating oneself as small, including showing deference/submission; a goal of

maintaining others' respect and affection and preserving positive self-regard; beliefs that the self is "bad"; beliefs that others think one is "bad"; feeling exposed; withdrawal and avoidance of others; belief that the self is helpless; and lax, "thin" voice, and low heart rate (Barrett, 1995).

It is interesting to observe that abusive parenting experiences impact on young children's capacity to feel pride. Differences in levels of pride were found in the maltreated vs. non-maltreated preschoolers when completing assigned tasks (Alessandri & Lewis, 1996). Specifically, children of maltreating mothers showed less pride at accomplishment of tasks, and more shame at unsuccessful completion of tasks than non-maltreated controls (Alessandri & Lewis, 1996).

### **Shame and Humiliation**

Humiliation can be defined as an intense and unpleasant emotion involving a lowering of estimation in the eyes of others; a loss of esteem, social status or dignity (Elison & Harter, 2007; Miller, 1985). Gilbert (1998) argues that humiliation is similar to shame in that it is experienced when an individual is subordinated; put in a debased or powerless position by someone more powerful. The most common causes of humiliation include 1) being harassed, teased, ridiculed, and debased; 2) public behaviours or accidents that go against social norms; and 3) incompetence or mistakes seen by others (Elison & Harter, 2007). What is crucial is the role played by the audience in that they mock or laugh at the victim (Elison & Harter, 2007). Humiliation therefore usually occurs at the hands of another, and in most cases, there is a broader audience that observes the humiliating event; a contemptuous and hostile audience is a key predictor of humiliation (Elison & Harter, 2007). Critically, in humiliation the victim is seen as undeserving; the event tends to be viewed as an unprovoked attack (Elison & Harter, 2007). In other words, there is no acceptance that the negative judgment from another is justified (as in shame), and no re-evaluation of the self takes place; instead, the individual may feel motivated to make the other give up or take back his/her negative judgment (Tantam, 1998). The intensity of the emotion will depend on the size of audience, the importance of the audience (loved ones or friends vs. strangers), whether the audience is hostile vs. friendly or sympathetic, whether the victim acknowledges or recognises the characteristic which is being devalued, and the magnitude of the devaluation (Elison &

Harter, 2007). However, generally, the intensity of humiliation is somewhere between the intensity of guilt and shame (Elison & Harter, 2007).

Humiliation overlaps a great deal with shame; they tend to co-occur (Elison & Harter, 2007)<sup>13</sup>. There is very little literature on the differences between these two constructs, but that which does exist emphasises the position of the self in relation to a real or imagined other (H. B. Lewis, 1971). Unlike shame, humiliation does not involve the negative evaluation of the self by the self: instead it involves a focus on the other as bad; external rather than internal attribution for negative events; a sense of injustice and unfairness; and a strong desire for revenge and retaliation (Elison & Harter, 2007; Gilbert, 1998).

Other emotional correlates include embarrassment and anger, and in the longer term, sadness and depression (Elison & Harter, 2007; Miller 1985). Violence against self and others has been identified as a key behavioural correlate of the experience of humiliation (Elison & Harter, 2007). A study conducted by these authors demonstrates that peer humiliation, in the presence of low parental support, leads to depressive and aggressive responses, including both homicidal and suicidal ideation (Elison & Harter, 2007). Humiliation acted as a necessary mediator between bullying and mocking and anger, violent ideation and suicidal ideation (Elison & Harter, 2007). In this study, violent ideators had higher levels of both internalising and externalising symptoms, and scored significantly lower on peer likeability, physical appearance and scholastic competence, as well as peer support (Elison & Harter, 2007). Interestingly, humiliation was self-esteem congruent – those with low self-esteem were more likely to experience humiliation in situations that could potentially humiliate than those with healthier self-esteem (Elison & Harter, 2007).

### **Shame, Sympathy, Empathy and Personal Distress**

Empathy is a multi-dimensional construct that involves both cognitive and affective components (Tangney & Dearing, 2002). Specifically, it involves the cognitive ability to take another person's perspective; the cognitive ability to precisely identify another's emotional experience; and an affective ability to feel an array of emotions and "match" them to the other's affective experience (Fechbach as cited in Tangney & Dearing, 2002). By contrast,

---

<sup>13</sup> Another related construct is indignity, which is about being in control of oneself, although it does not involve the self-blame that characterizes shame (Gilbert, 1998).

sympathy is the feeling of concern for someone else's situation or the emotional state of another person, but does not involve the affective matching that takes place with empathy (Tangney & Dearing, 2002; Tangney et al., 2007).

Another related emotion is personal distress, which is a self-oriented rather than an other-oriented emotional experience (Tangney & Dearing, 2002). Unlike empathy or sympathy, in personal distress the focus is on the feelings and thoughts of the self, and as such, it is not related to altruism and prosocial behaviours, which is often the case with the former two constructs (Tangney & Dearing, 2002). A great deal of research has shown that empathy, but not personal distress, motivates altruistic, helping behaviour, and that it facilitates warm, close interpersonal relationships and inhibits antisocial behaviour and aggression (Tangney, 2003).

The self-focus of shame makes it a narcissistic emotion (Gilbert, 1998). It has been demonstrated repeatedly that shame, low empathy and high self-preoccupation tend to co-occur (Lindsay-Hartz, De Rivera, & Mascolo, 1995; Tangney et al., 2007). In shame reactions, the individual is typically more concerned about others' evaluation of the self, while in guilt, the individual is more concerned about the self's effect on others (Tangney & Dearing, 2002). Research indicates that the shame-prone person is unlikely to have an empathic disposition, and that shame is more likely to be related to poor interpersonal relationships (Tangney & Dearing, 2002; Tangney et al., 2007). By contrast, the guilt-prone individual is much more likely to display an ability to shift perspectives and empathic concern (Tangney & Dearing, 2002).

The relationships between empathy, shame, guilt and interpersonal conflicts have been explored in depth by Leith and Baumeister (1998). Firstly, the authors found that shame was associated with personal distress, and guilt was associated with perspective-taking, the cognitive component of empathy. In their second and third studies, they found that guilt feelings were associated with perspective-taking, which was associated with better relationship outcomes (lower levels of interpersonal conflict), whereas shame had no, or a negative, effect on relationship outcomes (Leith & Baumeister, 1998). Thus, guilt feelings are helpful in interpersonal contexts, because guilt-prone people react to conflicts by taking into account the consequences of his/her actions, and by taking the perspective of the other, whereas shame appears to be counter-productive (Leith & Baumeister, 1998; Yang, Yang, & Chiou, 2010). Shame seems to be connected mainly to the affective features of empathy, including personal distress, which is unlikely to facilitate improvement in relationships or interactions (Leith & Baumeister, 1998).

In an exploration of the interrelationships between guilt-proneness, shame-proneness, personal distress and empathic responsiveness across three samples of young adults, proneness to shame was related to impaired empathic responsiveness, while guilt-proneness was related to enhanced other-oriented empathy (Tangney, 1991). The self-focus that accompanies shame means that shame-prone individuals' focus tends to move away from a distressed other, back to the injured self (Tangney, 1991). Therefore, as would be expected, personal distress was positively related to shame and negatively associated with guilt (Tangney, 1991).

Tangney (1991) explains the associations between shame, guilt and empathy in the following ways. Firstly, she asserts that guilt-prone individuals, through their enhanced capacity for empathic responsiveness, are more able to notice when they have wronged another. Secondly, the lack of self-focus also means that the guilt-prone individual is more likely to notice the distressed other, and is so more likely to respond empathically. Thirdly, the capacity for empathy and guilt comes from what Tangney (1991, p. 605) terms "psychological differentiation or cognitive complexity". Contrary to guilt or empathy, there is no clear distinction between self and behaviour in the shame experience – shame-proneness is accompanied by a global, undifferentiated approach. Tangney (1991) asserts that this lack of distinction is also reflected in the blurring of boundaries between self and other. The lack of distinction between self and other and between behaviour and self results in the shame-prone individual having difficulty in maintaining other-oriented empathic responsiveness (which relies on the knowledge that the self is distinct from other), and a tendency to lapse into personal distress reactions (Tangney, 1991).

In a recent study, Joireman (2004) examined the relationships between self-rumination and self-reflection and shame, guilt, empathy and personal distress. In this study, self-rumination is defined as "recurrent thinking or ruminations about the self prompted by threats, losses, or injustices to the self", while self-reflection was described as an "intellective category of self attentiveness characterised by reflection on the self motivated not by distress about the self but by epistemic curiosity, that is, pleasurable, intrinsic interest in abstract or philosophical thinking" (Joireman, 2004, p. 227). It was hypothesised that proneness to shame would be positively associated with the more maladaptive self-rumination, and that both would have positive relationships with personal distress. By contrast, it was predicted that proneness to guilt would be positively associated with the more adaptive self-reflection, and both would be positively related to perspective-taking and empathy (Joireman, 2004). The findings of the

study largely confirmed these hypotheses: shame-prone individuals experienced more personal distress, while guilt-prone individuals experienced more perspective-taking, and these relationships were mediated by self-rumination and self-reflection respectively (Joireman, 2004). These results, however, also demonstrated that self-rumination was associated with higher levels of shame, suggesting that shame and self-rumination are part of a reciprocal cycle that inhibits perspective-taking and empathic concern.

Externalisation is typically negatively associated with empathy: a number of studies have pointed to the role of empathy in inhibiting aggression and other antisocial behaviours (Tangney et al., 2007). It seems that amidst a personal distress reaction, the shame-prone individual is less likely to take responsibility for the aversive situation and resort to blaming others to reduce his/her own pain (Tangney, 1991). This tendency to externalise blame further tends to impair empathic responsiveness (Tangney, 1991). This, however, has not been replicated consistently.

### **Shame, Anger, Aggression and Hostility<sup>14</sup>**

In shame reactions, the person may withdraw and hide, but s/he may also respond in rage (Mollon, 2002). There are a number of differences between anger and rage. In anger, the reason for the emotion feels justified, whereas in rage, it does not, and the spiral described below, ensues (M. Lewis, 1992). Injury to the self is acknowledged in anger, but denied in rage, and pushed from consciousness (M. Lewis, 1992). Therefore, although anger is not displaced, rage is. In addition, whereas anger is focused on a real cause, rage is a generalised response, one which has many more negative consequences (M. Lewis, 1992). Consequently, anger is a more restricted, contained and focused response whereas rage is not; anger has a particular object, while rage is diffused both in terms of its object and its occurrence (M. Lewis, 1992).

Before examining the empirical evidence of the associations between shame, anger, aggression and hostility, it is worth briefly considering theoretical contributions to the understanding of shame and anger. One useful formulation is Retzinger's (1991) model for understanding shame-related anger. The basic premise of this model is that shame is a social

---

<sup>14</sup> Nathanson (1992) maintains that common defenses against shame may include attacking the other, attacking the self, or withdrawal or avoidance.

emotion; one which ensures survival through the preservation of significant relationships. Underlying this model is the tension between togetherness and separateness; the capacity to regulate social distance. This ability to regulate distance is dependent on differentiation, which refers to individuals who have a solid, cohesive sense of self, and who are able to move freely and flexibly between togetherness and separateness with limited or no distress or emotional reactivity. However, those individuals characterised by low levels of differentiation have low levels of cohesion, and have much more permeable self-other boundaries. These individuals feel incomplete without a significant other, and find it difficult to move between states of togetherness and separateness; they tend to feel engulfed when emotionally close to another, and alienated and isolated if distant from the other. High levels of emotional reactivity and resultant intolerance of emotion is common, as well as ineffective communication characterised by blaming, distracting and avoiding. The interpersonal system in cases such as these is narrow, unyielding and inflexible (Retzinger, 1991).

In Retzinger's (1991) model, the most important pre-requisites for the evocation of shame are that: 1) the social bond (including the attachment system and the capacity to differentiate emotionally from another) is threatened, and this threat typically involves disrespect; 2) shame is the product of a disruption in the bonding system; 3) when shame is not acknowledged, the self feels alienated and isolated, and the other is perceived as the source of attack; and 4) anger is then evoked, amplifying threat to self and social bond as a means of protesting or resisting against the threat. When the bond is not considered, anger is a way of "saving one's own face" (Retzinger, 1991, p. 56). Shame and anger frequently co-occur, and have previously been shown to alternate rapidly in facial response sequences (Retzinger, 1991).

In this model, there are three types of shame-related anger response styles. Firstly, in secure attachments, when conflict arises, partners in conflict tend to be responsive to the shame or hurt in each other, and the threatened bond remains intact (Retzinger, 1991). Partners are able to retain feelings of pride in these situations, and it leads to mutual cooperation and connectedness. Secondly, in situations where there are weaker bonds, partners may not be responsive to one another, and they start to feel disconnected from each other, and become ashamed. However, if shame, hurt or the state of the bond is acknowledged (through apology, a feeling statement or taking responsibility for part of the conflict), and mutual respect is demonstrated (there is no further shaming), the system can readjust, and the conflict can be experienced as constructive, leading to greater cooperation and connectedness. Conflict of this

kind is functional, and results in reparation of the bond and feelings of attunement. It is constructive because it can lead to change and increased cohesion. However, in the third instance, in partnerships which are reactive and where there is insufficient differentiation, escalation occurs when shame is not acknowledged, in a manner which is experienced as disrespectful, and anger is evoked. Key in these situations is that shame is evoked but not acknowledged. In these situations, each partner feels injured and attacked by the other, and responds with a more vehement attack on the other (using, blame, disgust, contempt or withdrawal). Neither party acknowledges his/her injury of the other or responsibility in the conflict; neither sees anything but the unjustness of the other party's behaviour. So this loop continues, with each partner blaming the other for the conflict without considering his/her own role in the interaction. This kind of conflict is destructive, and erodes rather than restores social bond, and is often the kind of escalating conflict which leads to emotional and physical violence (Retzinger, 1991).

The third response style outlined by Retzinger (1991) has a great deal in common with what H. B. Lewis (1971, 1986) called "shame-rage" or "humiliated fury". Shamed individuals tend to either withdraw and escape the shame-inducing situation, or shift the blame onto others, an effective strategy, but only in the short term (Lindsay-Hartz et al., 1995). H. B. Lewis (1971) argues that shame-rage, which usually involves the breaking of social bonds or the inability to control attachment objects (in other words, a reaction against separation from a significant other), cannot be directed outwards indefinitely; the shamed individual begins to feel guilt or shame at his/her "inappropriate" or "unjust" anger, and then it is turned inwards once again. In other words, the rage itself becomes a source of shame (or guilt) (H. B. Lewis, 1986, 1987a; M. Lewis, 1992). As such, a sequence or circular pattern emerges, where the individual experiences shame-rage, which is followed by shame or guilt about his/her anger, which is then turned inwards and results in further shame-rage (H. B. Lewis, 1987a). Thus, shame-based rage or humiliated fury is anger which is turned back against the self, both because the self is characteristically passive with regards to his/her position relative to the other and because the self values the other (H. B. Lewis, 1971, 1986). This shame-rage-shame-rage spiral is important in understanding a range of interpersonal conflicts (M. Lewis, 1992). It is suppressed, humiliated fury, due to the accompanying feelings of unjustness and inappropriateness, which contributes to depression (H. B. Lewis, 1986). The differences between "normal" rage and shame-rage are presented in Table 3.3.

Table 3.3

*Normal Rage and Shame-Rage*

Normal rage	Shame-rage
1) Simple bodily response	1) A process (shame and rage alternation)
2) The rage feels justified	2) One feels powerless
3) The injury is recognised	3) The injury is denied
4) It remains conscious	4) It is pushed from awareness
5) It may easily be resolved	5) A circular feeling trap
6) Rage is not displaced	6) The rage is displaced
7) It is focused on the actual cause	7) The rage becomes generalized
8) An individual phenomenon	8) A social phenomenon
9) Few negative results	9) Negative results

(Retzinger, 1987, p. 157)

Turning to the empirical evidence for these theoretical postulations, a classic study on the relationship between shame, rage and laughter was conducted by Retzinger in 1987. In an analysis of video footage of individuals expressing shame and rage, Retzinger (1987) was able to differentiate the sample into two groups – the laughter and non-laughter groups. In the laughter group, permission had been given to participants to express rage, which led to shame being reduced and laughter occurring. After laughter had occurred, the amount of rage displayed in the facial expressions of participants was significantly reduced (marking the disappearance of asymptotic anger), and shame levels were normalised, suggesting a break in the shame-rage spiral. In contrast, in the non-laughter group the shame-rage spiral continued with very little change – throughout the interview, both emotions stayed at approximately the same levels, although the duration and frequency of the emotions suggested a movement towards asymptotic shame and the generation of new anger (Retzinger, 1987).

As can be seen, shame and anger or rage tend to interact, with one emotion acting as a defense against the other (Miller, 1985). These emotions alternate, and play different roles in different contexts (Miller, 1985). For example, sometimes, anger or rage develops in response to being shamed (due to intolerable feelings of exposure) (Kaufman, 1992), and may be turned against the self, but shame also sometimes constitutes a judgmental emotion against unacceptable anger or rage: thus shame may relieve anger or rage; shame may be emphasised to de-

emphasise anger or rage; and shame may flourish when anger or rage is inhibited (Miller, 1985).

According to Mills (2005), rage is a response to intense wounding of the self due to repeated shaming experiences. The shame-rage which develops results in aggression targeting the individual who induces shame, or it is shifted onto less threatening targets. Either way, over time, this shame-rage cycle begins to foster a hostile interpersonal style, which is characterised by distrust of others, hostile attributions, and hostile solutions to interpersonal problems (Mills, 2005).

In contrast to shamed individuals' humiliated rage, guilty individuals feel righteous indignation directed against the self's actions or inactions (H. B. Lewis, 1986; Tangney & Dearing, 2002). Unlike humiliated rage, righteous indignation is diffused by amending the transgression which evoked it (Tangney & Dearing, 2002). Those feeling guilt therefore tend to be more likely than shamed individuals to take responsibility for their actions through righting transgressions or wrongdoings (Tangney & Dearing, 2002).

Because both rage and anger are potent, authoritative emotions, they counter some of the helplessness and paralysis of shame, giving the individual back their sense of power and agency (Tangney & Dearing, 2002). Attacks on others, and putting others down, helps to (defensively) repair a shattered sense of self-worth (Kinston, 1987; Lindsay-Hartz et al., 1995). The anger response is facilitated by two factors: imagining a disapproving other, and an impaired capacity for empathy, which is likely to facilitate externalisation of blame (Tangney & Dearing, 2002; Tangney et al., 2007). Guilt, by contrast, appears to be associated with other-oriented empathy which prevents anger and aggression (Tangney et al., 2007). In addition, guilt-prone individuals are less likely to imagine critical and disapproving others, and so tend not to retaliate against the "observing others" with anger (Tangney & Dearing, 2002).

Although anger is generally assumed to be a negative emotion, there can also be positive outcomes associated with it. Tangney and Dearing (2002) propose three types of non-aggressive anger management strategies: 1) adaptive behaviours (e.g. non-hostile discussion with the target of anger), 2) escapist/diffusing responses (e.g. minimising the importance of the event), and 3) cognitive reappraisals (e.g. reinterpreting the motives or actions of the target). As noted previously, it is interesting that shame-prone individuals are not only prone to more anger, but to less constructive responses to anger, compared to guilt-prone

individuals. Shame-proneness was associated with malevolent intentions towards the target, and engaging in direct verbal, physical and symbolic aggression, displaced aggression, self-directed aggression and anger held in (a ruminative, unexpressed anger) (Tangney & Dearing, 2002).

In a study on the relationship of shame and guilt to constructive and destructive responses to anger through the lifespan, the authors found that shame and guilt had quite distinct relationships to anger (Tangney, Wagner, Hill-Barlow, Marschall, & Gramzow, 1996). Shame-prone individuals experienced more anger than those less shame-prone, and this shame-proneness was associated with much less constructive responses to anger, including malevolent intentions and a greater likelihood of involvement in direct, indirect and displaced expressions of anger (Tangney et al., 1996). In addition, shame-proneness was associated with more ruminative, unexpressed anger, self-directed hostility and a tendency to withdraw from anger-related situations (Tangney et al., 1996). Thus, shame-prone individuals tend to react in one of two destructive ways to anger-inducing situations – either passive withdrawal or active aggression – both of which are maladaptive responses which are unlikely to resolve the situation (Tangney et al., 1996). By contrast, guilt-prone children, adolescents and adults were more likely to adopt constructive behaviours, including non-hostile conversations with the target of their anger and direct, reparative action (Tangney et al., 1996). In addition, guilt-proneness was associated with constructive re-evaluations of the target's and the self's role in the situation (Tangney et al., 1996). These findings are supported by earlier work by Tangney, Wagner, Fletcher and Gramzow (1992), which demonstrated an inverse relationship between guilt and externalisation of blame, anger, hostility and resentment, and a positive relationship between shame-proneness and anger arousal, suspiciousness, resentment, irritability, blaming others for negative occurrences and indirect expressions of hostility.

Shame-proneness has demonstrated an association with anger arousal and externalising attributions for one's own behaviour in men who assault their partners (Dutton, Van Ginkel, & Starzomski, 1995). In this study, memories of shaming by parents were significantly related to abusiveness, anger, trauma symptoms, and BPD in adult perpetrators of physical violence. The authors propose a two-step model where shaming develops the abusive-prone personality, which is a necessary but not sufficient antecedent of abusive behaviour. Modeling of the abusive behaviour is the required second developmental step, pointing to a pattern of transgenerational shaming and abusiveness (Dutton et al., 1995).

In a review of the literature, however, Stuewig and Tangney (2007) remind the reader that existing studies do not always find a strong and reliable relationship between shame and overt aggression (it is likely that there would be a stronger relationship between shame and covert or internalised aggression); but that guilt-proneness has been consistently and robustly associated with the inhibition of aggression. In terms of criminal behaviour, the picture is still unclear. Guilt seems to have a distinct inhibitory function in relation to criminal behaviour, but the findings with regards to shame have been inconsistent and context-dependent, which may be due to sampling variability across studies or due to the influence of as yet undiscovered variables (Stuewig & Tangney, 2007).

Not all studies make clear distinctions between the constructs of anger, rage, aggression or hostility. This is reflected in the imprecision of measurement tools that, for example, tend to confound verbal and physical aggression, anger and hostility (Stuewig, Tangney, Heigel, Harty, & McCloskey, 2010). Anger is an affective state, while aggression is a behavioural response to anger – one of many possible responses (Tangney & Dearing, 2002). A recent, more methodologically sophisticated study, which differentiates between these constructs, came to five conclusions drawn from data across four (diverse) samples. These conclusions are: that there is no direct relationship between shame and aggression; that there is no direct relationship between shame and impaired other-oriented empathy; that there is an indirect relationship between shame and physical as well as verbal aggression through externalisation of blame; that guilt is directly related to low levels of aggression; and finally, that there is an inverse, indirect relationship between guilt and aggression through both (low levels of) externalisation of blame and (high levels of) empathy (Stuewig et al., 2010). Therefore, the path to (lower) aggression through (greater) empathy is unique to guilt (Stuewig et al., 2010).

Interestingly, the kinds of situations that evoke anger are different for shame-prone and guilt-prone individuals – shame-free guilt is far more likely to arise from reality-based violations than for shame-prone individuals (Tangney et al., 1996). There was also remarkable stability from middle childhood to adulthood in these findings – in the association between shame-proneness and a defensive, retaliative and destructive response to anger, and between shame-free guilt and constructive anger-management strategies and outcomes (Tangney et al., 1996).

It is worth noting in conclusion that most of the studies on shame and anger or aggression are correlational, and thus, the precise nature of the relationship between these constructs and their directionality cannot be determined (Keltner & Harker, 1998).

### Summary of Key Points

- Crucial differences between shame and guilt are in focus (self vs. a specific incident); their experienced feeling (worthlessness and powerlessness vs. tension, remorse and regret); their effects on the individual's sense of self (global impairment vs. unimpaired self), and their reactions (a desire to hide, escape or strike back with hostility, scorn, contempt and ridicule vs. a regret, remorse, concern and a desire to confess, apologise or repair) (Crowe, 2004; Lazarus, 1991; H. B. Lewis, 1971; Tangney et al., 2007). Seligman and Teasdale (as cited in Tangney & Dearing, 2002) also distinguish between locus (internal vs. external), globality (global vs. specific) and stability (stable vs. unstable), with shame characterised by internality, globality and stability. Shame-proneness relates to a variety of problems and pathologies (possibly through its association with helplessness and self-blame), whereas guilt-proneness, which involves the tendency to feel bad about a particular behaviour or incident, is more likely to be adaptive (Dearing et al., 2005). Because the self is not debilitated with guilt, and because it involves focusing on specific and controllable behaviours, it is more likely to be accompanied by reparative action, hence the demonstrated association between guilt and prosocial feelings and behaviour (H. B. Lewis, 1971; Lazarus, 1991; Tangney, 1991). Another key difference between guilt and shame is that in shame, self-other boundaries are much more permeable – the individual is able to take the perspective of both the self, and vicariously experience that of the other (Izard, 1977; H. B. Lewis, 1971). Guilt on the other hand, is more contained and is localised within the self (i.e. not involving seeing the self from others' perspective) (H. B. Lewis, 1971). Furthermore, when guilt includes affect, it may vary considerably in intensity, while in shame the negative emotion is typically intense (H. B. Lewis, 1971). Thus, shame is an intense negative state which results in the interruption of current behaviour, confusion in thought, and speechlessness (M. Lewis, 1992). Shame is an involuntary affective state (H. B. Lewis, 1971). Guilt also tends to involve more cognitive activity than shame, such as preoccupation with wrongdoing, and rationalisation (Izard, 1977; H. B. Lewis, 1971). Because of its irrational nature, the self is not open to rational solutions when shamed (H. B. Lewis, 1971). Guilt involves negative feelings, but with or without the painful affect -

particularly the heightened or acute self-consciousness characterising shame - and the accompanying autonomic (e.g. blushing, tears, increased heart rate) reactions (Izard, 1977; H. B. Lewis, 1971). Thus, shame is understood as a wordless, primitive and irrational emotion which is associated with excessive involuntary autonomic reactions, which may be experienced as a flood of sensations (Izard, 1977; H. B. Lewis, 1971). Because of the heightened self-awareness that accompanies shame, it involves greater body awareness and activity (Izard, 1977; H. B. Lewis, 1971). In shame reactions, the body “implodes”, with head bowed, eyes closed and body curled in itself, to make the individual as small and as inconspicuous as possible (Izard, 1977; H. B. Lewis, 1971).

- Shamed or guilty participants feel greater responsibility, regret and remorse than they would have felt if embarrassed (Tangney et al., 1996). In addition, shamed individuals are more likely to feel angry and disgusted with themselves, and to believe that others also feel anger towards them, than embarrassed individuals (Tangney et al., 1996). Embarrassment may be self-evaluative or not. Shame has been described as a “darker, angrier and more intense emotion” than embarrassment (Miller, 2007, p. 246). Embarrassment arises from more inconsequential and amusing events or trivial *faux pas* (where the individual has been absentminded or clumsy for instance), and it occurs more suddenly and with greater feelings of surprise (Tangney et al., 1996). However, as in shame reactions, embarrassment is associated with physiological changes, and with a significant sense of exposure and conspicuousness (Tangney et al., 1996; Tangney et al., 2007).
- Shame and pride are characteristically seen as opposites (Fischer & Tangney, 1995). While the antecedents of shame include a flawed or unacceptable action, statement or characteristic of an individual, the antecedents of pride are virtue or successful or desirable action, statement or characteristic of an individual (Fischer & Tangney, 1995). Similarly, responses to shame and pride are divergent, including hiding, escaping, a sense of shrinking, and feelings of worthlessness in the case of the former, and displaying, engaging, a sense of growing large and feeling worthwhile in the latter (Fischer & Tangney, 1995; M. Lewis, 1992). Pride is associated with distancing oneself from those who are believed to be evaluating us; showing dominance/superiority; believing in the importance of the standards one has upheld; maintaining good feelings about oneself; believing that others will think one is good; inclinations to show or tell others about one’s achievement; the self as agent; moderately tense voice, flushed face and high heart rate (Barrett, 1995). Current

theoretical and empirical work suggests that pride can be an important motivator of sustained altruistic behaviour (through having such behaviour supported and reinforced by the social judgments of other people) (Hart & Matsuba, 2007). Pride motivates prosocial behaviour by helping individuals improve the image of the self that other people see and evaluate (the image improvement hypothesis), or by helping individuals feel better about themselves (the positive state improvement hypothesis) (Hart & Matsuba, 2007). Similar to the distinction made between guilt and shame, where shame involves negative appraisal of the whole self, and guilt involves negative appraisal of a particular behaviour, pride can be divided into “alpha pride” (positive evaluation of the whole self) and “beta pride” (positive evaluation of a particular behaviour) (Tangney et al., 2007). M. Lewis (1992, 2003) has similarly drawn a distinction between hubris (pridefulness) and pride. Unlike pride, hubris is associated with narcissism, and through this association, with lower levels of prosocial behaviour and higher levels of violence, hostility and aggression (Hart & Matsuba, 2007).

- Humiliation can be defined as an intense and unpleasant emotion involving lowering in the eyes of others; and loss of esteem, social status or dignity (Elison & Harter, 2007). The presence of a mocking audience is central to this experience (Elison & Harter, 2007). Gilbert (1998) argues that humiliation is similar to shame in that it is experienced when an individual is subordinated; put in a debased or powerless position by someone more powerful. Unlike shame, however, it does not involve the negative evaluation of the self by the self. Instead it involves a focus on the other as bad; external rather than internal attribution for negative events; a sense of injustice and unfairness; and a strong desire for revenge (Gilbert, 1998). It has been associated with violence, both against the self, and others (Elison & Harter, 2007).
- Research indicates that the shame-prone person is unlikely to have an empathic disposition. It has been repeatedly demonstrated that shame, low empathy, high self-preoccupation and high personal distress tend to co-occur (Lindsay-Hartz et al., 1995; Tangney et al., 2007). The self-focus of shame makes it a narcissistic emotion (Gilbert, 1998). This means that shame is more likely to be related to poor interpersonal relationships (Tangney & Dearing, 2002; Tangney et al., 2007). By contrast, the guilt-prone individual is much more likely to display an ability to shift perspectives and empathic concern, which translates into prosocial behaviour (Tangney & Dearing, 2002).

- Rage is a response to intense injury to the self, due to repeated shaming experiences (Mills, 2005). The shame-rage which develops results in aggression targeting the individual who induces shame, or it is displaced onto safer targets (Mills, 2005). Either way, over time, this shame-rage cycle begins to foster a hostile interpersonal style, which is characterised by distrust of others, hostile attributions, and hostile solutions to interpersonal problems (Mills, 2005). The kinds of situations that evoke anger are different for shame-prone and guilt-prone individuals – shame-free guilt is far more likely to arise from reality-based violations than for shame-prone individuals (Tangney et al., 1996). Because anger is a potent, authoritative emotion, it counters some of the helplessness and paralysis of shame, giving the individual back their sense of power and agency (Tangney & Dearing, 2002). Attacks on others, and putting others down, helps to (defensively) repair a shattered sense of self-worth (Lindsay-Hartz et al., 1995). The anger response is facilitated by two factors: imagining a disapproving other, and an impaired capacity for empathy, which is likely to facilitate externalisation of blame (Tangney & Dearing, 2002; Tangney et al., 2007). There is also remarkable stability from middle childhood to adulthood in the association between shame-proneness and a defensive, retaliative and destructive response to anger, and between shame-free guilt and constructive anger-management strategies and outcomes (Tangney et al., 1996).

In conclusion, shame is an uncontrolled, tremendously painful and incapacitating self-focused emotion that has a profoundly negative effect on individual psychological outcomes and on interpersonal functioning (Tangney & Dearing, 2002). Tangney (2003) suggests that non-shame-prone, high ego-strength individuals with a solid sense of self may be able to utilise shame constructively (to modify behaviour in positive ways). However, for the vast majority of individuals who are experiencing shame, it is a debilitating, ego-threatening experience, which makes constructive outcomes extremely unlikely (Tangney, 2003). Although shame and guilt are sometimes used interchangeably in the literature, recent research on shame and guilt demonstrates that they are theoretically and empirically distinct, albeit related, concepts. In distinguishing between shame and guilt, it is useful to focus on the role of the self – in guilt, the self negatively evaluates specific behaviours, while in shame, the entire self is perceived as diminished, defective or fundamentally flawed, as failing to meet standards, as inferior or worthless in comparison to others (H. B. Lewis, 1971; Miller, 1985; Tangney, 1991). Therefore, shame is a more global, undifferentiated and consequently painful and

challenging experience than guilt, in which the whole self, not just a particular behaviour, is perceived or evaluated as negative (Tangney, 1991). As noted by Lindsay-Hartz, Rivera and Mascolo (1995, p. 295), “when guilty we feel ‘as if’ we are bad”, while with shame, this “as if” condition falls away, and we become the “anti-ideal”. Shame is often attended by a sense of “shrinking” and feeling “small” and feelings of worthlessness and powerlessness (H. B. Lewis, 1971; M. Lewis, 1992; Tangney, 1991, p. 599). Guilt-prone individuals do not feel the same powerlessness, and tend to view the self as flexible and malleable; amenable to change (Tangney & Dearing, 2002).

Most scholars agree that all self-conscious emotions, including shame, guilt, embarrassment and pride, are fundamentally affects of self-regulation (Tangney, 2003). According to Izard (1977) and Tangney (2003), these emotions provide feedback on individuals’ social and moral acceptability, and play an important role in guiding behaviour (particularly sexual behaviour), motivating individuals to adhere to cultural prescriptions and moral standards, norms and conventions. As noted by M. Lewis (1992), self-conscious emotions are designed to interrupt any behaviour that disrupts either internally or externally derived norms, standards or rules. Although scholars coming from a phenomenological point of view believe that shame can be experienced internally and externally, a number of authors argue that self-conscious emotions, including shame, are inherently social emotions.

Shame is associated with withdrawing, hiding, and wishing to escape (Lazarus, 1991; Miller, 1985; Tangney, 1991). It is associated with retaliation, internalisation and externalisation of blame, and increases in anger and hostility, as well as high levels of personal distress. Shame has been implicated in the aetiology of a range of trauma-related mood and personality disorders (Harder, 1995; A. P. Morrison & Gilbert, 2001; Tangney et al., 2007). Owing to the self-focus of shame, shame-prone individuals also tend to have impaired empathic capacity, which is a key pre-requisite for prosocial behaviour, hence the association between shame and antisocial behaviour and disorders of conduct (Tangney & Dearing, 2002).

In the next chapter, we briefly look at the role of culture in shame.

## **CHAPTER 4**

### **Shame and Culture**

A diverse context such as South Africa will include a range of different cultures which will differently conceptualise, express and respond to different emotions, including shame. There was more than one cultural group among my participants, and consequently, I expected different cultural understandings of shame, perhaps even different shame-related psychological outcomes. The purpose of this chapter is to provide a background to the likely culture-bound ways in which shame is expressed in South Africa. In order to do this I review the literature on culture and shame, specifically considering the research on cultures of honour and shame, which I will justify below (paired because, in my interpretation, they are responses to one another), guilt and shame (paired because of their culturally relevant similarities and differences) as they manifest in individualistic and collectivistic cultures, and universalist and cultural constructions of shame.

#### **Cultures of Honour**

There is an acute lack of literature on shame and culture in South Africa, so what follows is extrapolated from the international literature. I have begun this literature review with a very specific focus, because of its relevance to many South African cultural contexts. The other debates which I cover, as described above - guilt and shame (paired because of their culturally relevant similarities and differences) as they manifest in individualistic and collectivistic cultures, and universalist and cultural constructions of shame, are part of a wider discussion about shame within culturally oriented psychological theory.

The specific focus on cultures of honour is particularly relevant to my study, because it affects the kinds of communities my participants came from - urban (and violent) poverty contexts, which are characterised by the oppressive patriarchal values that are so rife in South Africa (see for example, Hearn & Morrell, 2012; Shefer, Ratele, Strebel, Shabalala, & Buikema, 2007). Cultures of honour are cultures in which male strength and power are highly valued and in which men are prepared to kill to defend their status as honourable men (Cohen,

Vandello & Rantilla, 1998). Because of widespread poverty, status is also important in these communities, and deference must be paid to those occupying a higher social rung (Cohen et al., 1998). These views are collectively held (Cohen et al., 1998). The more cohesive the community, the more culturally sanctioned violence may be; in such cultures, social organisation is a risk factor (Cohen et al., 1998). Cultures of honour develop where people have only themselves to rely on for protection (Cohen et al., 1998). Cohen et al. (1998, p. 277) argue that lack of law enforcement and lack of order construct the conditions necessary for a culture of honour to come about; that cultures of honour and associated cults of manhood develop in places where “living is hard”. In such cultures, as in many South African communities, wrongs are not only things done to the individual’s physical person, but also to the individual’s reputation (or those close to him, particularly females for whom men are deemed responsible) (Cohen et al., 1998).

Using the example of the U.S. South and West, Cohen et al. (1998) show that regions dominated by cultures of honour are the most violent regions when it comes to honour-related infractions (violence due to lack of respect or deference to honour-based values and belief systems); however, the rates of felony-related violence are comparable to other areas of the country (Cohen et al., 1998). Honour-related violence is, in these regions, part of what it means to be a “real” man (Cohen et al., 1998). What makes the readiness for responding aggressively to affronts so powerful is that these views are collectively held – when the conflict escalates, both individuals are aware that the other may be thinking of violence as a means to save face (Cohen et al., 1998). In these societies, collective representations, such as laws, policies, media, and institutions may further amplify the beliefs and principles of cultures of honour (Cohen et al., 1998). One paradox remains: despite high levels of honour-related violence, cultures of honour emphasise politeness, congeniality and generosity; perhaps because since an individual cannot escape conflict without losing face, the best thing to do is to avoid conflict before it starts (Cohen et al., 1998). This kind of deference is described in evolutionary theory (Gilbert, 1998). A characteristic way of interacting in cultures of honour is to engage in initial politeness and suppress anger, which is inevitably followed by a sudden explosion of anger and aggression once a certain line has been crossed (Cohen et al., 1998) – as noted by Carter (as cited in Cohen et al., 1998, p. 271), “the southerner is proverbially gentle in manner. It has been said that until he is angered enough to kill you, he will treat you politely”.

What is particularly relevant to South African urban poverty contexts is the emergence of cultures of honour as in American inner cities. Anderson (as cited in Cohen et al., 1998, p. 275) has written that:

The code of the streets is actually a cultural adaptation to a profound lack of faith in the police and the judicial system...the street code emerges where the influence of the police ends and the personal responsibility for one's safety is felt to begin.

It is argued that the harsher the environment and the scarcer the resources, the more likely it is that honour-related definitions of manhood are emphasised as desirable (Cohen et al., 1998). In such places – because they are threatened – the 3 P's of manhood are considered especially important: protecting, providing and procreating (Cohen et al., 1998). In these societies, honour is a virtue and an ideal in the same way that dignity is for those who do not belong to cultures of honour (Cohen et al., 1998).

I would argue that cultures of honour are a reaction to shame. Cultures of honour develop in poverty-stricken communities where men do not have access to material status, for instance, and have to create other means to counter feelings of disempowerment and humiliation. Investment in patriarchal values which emphasise male power, strength and dominance functions to subjugate and disempower other groups, such as women, so bolstering men to a higher social position while simultaneously dissipating their defensive shame. I would argue that at a cultural level, this may be one explanation why IPV is so prevalent in South Africa.

### **Is Shame Universal or Culturally (Linguistically) Constructed?**

The social functions of emotion can be categorised at four levels – evolutionary (universalist) approaches are more likely to pay attention to the individual or the dyad as the unit of analysis, while social constructivist approaches tend to focus on the group or culture as the unit of analysis (Goetz & Keltner, 2007). At the individual level of analysis, emotion-related changes in experience, cognition and physiology are considered; at the dyadic level of analysis, researchers focus on the communication of emotion through facial, vocal and postural means; at the group level of analysis, how emotions facilitate groups of individuals to meet shared goals is the focus; while at the cultural level of analysis, attention is paid to the shaping of emotion through historical factors, and the entrenchment of emotion in cultural institutions, practices, norms and discourse (Goetz & Keltner, 2007). Thus emotions,

including shame, fulfil different functions at each of these levels – they determine and orient the individual, they regulate dyadic interactions, they influence group identities and values, and transfer cultural practices, identities and ideologies (Goetz & Keltner, 2007).

There is limited research on cross-cultural differences in shame, but in the literature that does exist, there are two major debates. Firstly, scholars disagree on whether shame is universal or culturally constructed, and secondly, they disagree on whether individualistic societies are so-called guilt cultures and collectivistic societies are so-called shame cultures. In other words, the debate is centred around whether individualistic cultures are characterised by people predominantly feeling guilt, and collective societies are characterised by people predominantly experiencing shame (as these constructs have been defined in the previous chapter) (the latter debate will be returned to later in the chapter). Universalism views emotions as the outcome of phylogenetic development that has particular specialised, adaptive functions in humans (Breugelmans & Poortinga, 2006). Relativism involves seeing emotions as social and cultural constructions (Breugelmans & Poortinga, 2006). Recent research provides evidence for the presence of a form of universalism; one which is tempered by the recognition that there may be cultural differences in the manifestation of different emotional processes (Breugelmans & Poortinga, 2006).

Proponents of the universalist approach argue that all self-conscious emotions, including shame, guilt, embarrassment and pride, are fundamentally affects of self-regulation, which serve this key function in all contexts (Tangney, 2003). According to Izard (1977) and Tangney (2003), these emotions provide feedback on individuals' social and moral acceptability, and play an important role in guiding behaviour, motivating individuals to adhere to cultural prescriptions and moral standards, norms and conventions. These moral standards, norms and conventions may differ in terms of their context, nature and expression, however, these scholars maintain that the antecedents and mechanisms underlying the evocation of shame (when standards are transgressed, when the failure is attributed to the self, and when the focus is on the self instead of action) remains the same (M. Lewis, 1992; Tomkins, 1963).

Most scholars who support the universalist approach emphasise that both shame and guilt are social emotions – affects that arise when there is a threat to significant social bonds (Will, 1987). Shame develops in interpersonal contexts, where a person fears the loss or rupture of an attachment to a valued or admired other (Will, 1987). As noted by M. Lewis (1992), self-conscious emotions are designed to interrupt any action that violates either internally or

externally derived norms, standards or rules. Thus, shame functions to inhibit transgression against culturally-specific standards, and encourage conformity to particular norms and ideologies, which ensures continued membership to social groups.

Fessler (2007) argues that shame is a bipartite emotion including an ancestral part that is shared with nonhuman primates, and a derived or socially constructed component that is unique to humans. The two differ in that the former is cognitively simpler, focuses only on social rank and does not involve concerns around conformity to cultural standards for behaviour (Fessler, 2007). Edelstein and Shaver (2007) also broadly agree, although their focus is on language. They argue that there is no indication in the limited group of lexical studies on shame that different cultures, or people speaking different languages, have significantly different understandings or experiences of shame, although it is acknowledged that certain emotions, like shame, may occur with greater frequency in one culture than another, may be more focused on and conceptualised in greater detail, may be valued more highly, and may be captured in language with greater precision.

From an evolutionary perspective, self-conscious emotions are universal, and are associated with social status/hierarchy, co-operation and reciprocity across cultures. However, anthropological studies indicate that self-conscious emotions vary in their lexical representation, the degree to which they are valued, the (un)pleasantness of the experience, the nature of elicitors and the degree of associated moralisation<sup>15</sup> (Goetz & Keltner, 2007). Research demonstrates that self-conscious emotions involve displays that are universal across cultures, particularly appeasement gestures recognised as shame and embarrassment, but there also seem to be culture-specific displays and behaviours (Goetz & Keltner, 2007). A social-functional approach to self-conscious emotions suggests that there is both universality and variation across cultures, and that the evolutionary and cultural forces that evoke self-conscious emotions should be considered complementary rather than opposing. In their words:

Through display and feeling rules, through moralization and valuation of the self-conscious emotions, culture has created profound variation in emotion processes that are, at their core, universal. Research shows that self-conscious emotion concepts exist in virtually all languages, have similar appraisal profiles across cultures, and may have cross-culturally recognizable facial displays. However, self-conscious emotions serve

---

<sup>15</sup> Goetz and Keltner (2007) suggest that research evidence points to collectivistic cultures being more moralising.

to help the individual act according to group norms, and these group norms vary greatly across cultures. These norms result in variation in the specific events that tend to elicit self-conscious emotions, in the elaborate concepts around particular self-conscious emotions, and in the functional value and normative beliefs associated with self-conscious emotions. (Goetz & Keltner, 2007, p. 154)

Contrary to many other (individualistic) leaders in the field of shame, Greenwald and Harder (1998) argue that shame is adaptive if it is not excessive or chronic. They argue that shame, irrespective of culture, places a major role in promoting genetic fitness through behavioural regulation in the domains of group identity, social bonding, and competitive mating success. Taking an evolutionary (universalist) approach, all humans are hardwired to experience shame and guilt by natural selection, however, it is conceded that the triggers and the manner in which these feelings are expressed may vary according to culture (Greenwald & Harder, 1998). The purpose of shame from this perspective is a signal to the individual to change his/her behaviour in such a way that it ameliorates the damage to one's status and reputation, and to prevent social rejection, greater shame and anxiety (Greenwald & Harder, 1998).

These authors suggest that there are four types of shame which are related to separate domains of human functioning, and which are important for fitness: conformity, prosocial behaviour, sex and status/competition (Greenwald & Harder, 1998). The purpose of conformity shame is to identify members of a group, and so, it regulates behaviours related to dress, language, food consumption, rituals etc. (Greenwald & Harder, 1998). If these conventions are not adhered to, individuals may be marginalised or ostracised, which impedes or challenges fitness (Greenwald & Harder, 1998). Humans are unique in that they not only value and adhere to cultural standards, they also enforce them by punishing those who deviate from them (Fessler, 2007). Cultures vary in terms of the importance attached to conformity, and it is suggested that conformity shame is more likely to be prominent in collectivist (as opposed to individualist) societies (Greenwald & Harder, 1998).

Although some research in individualistic cultures has found an association between shame and antisocial behaviour (e.g. Tangney & Dearing, 2002), research in other contexts has found that prosocial behaviour may be enforced by fear of shame, encouraging altruistic and cooperative behaviour (Greenwald & Harder, 1998). Humans are able to assess other's emotional states and knowledge with very little effort (something which is not possible for nonhuman primates), which is why humans habitually engage in mutual watching behaviour – this underlies all cooperative endeavours (Fessler, 2007). In deciding on a partner for a

cooperative endeavour, humans are motivated to observe whether another person is able to behave appropriately in a range of culturally-specific activities, so giving him or her information with regards to whether his/her potential partner has the cultural knowledge relevant to any given cooperative endeavour, and whether s/he is motivated to comply with cultural standards in a manner that allows for co-ordination (Fessler, 2007). The more serious the violation of cultural standards is, and the more it harms an individual's prized reputation as co-operator, the more severe and aversive the shame reaction will be (Fessler, 2007). Furthermore, the more people who are aware of the rule violation, the more serious the experience of shame will be (Fessler, 2007). Fessler (2007) also argues that shame will also be more intense if those who witness it are from the individual's social group – if they are similar to the individual – and if a prominent figure condemns the rule violation.

To return to Greenwald and Harder's (1998) types of shame, it is worth noting that while there are some universal values in relation to sexual behaviour (e.g. around incest), sexual values and the circumstances that evoke sexual shame are remarkably varied. Some status hierarchies may well be associated with attractiveness to potential mating partners, while other status hierarchies function to elevate the individual's position in other ways, so increasing his/her access to resources and alliances. It is important to note that these status hierarchies tend to overlap, so those who have achieved high status in one area are likely to have high status in other hierarchies as well (Greenwald & Harder, 1998).

The form and expression of shame can be fairly consistent according to culture, although the elicitors of all these types of shame differ. It is important to consider individual differences, like for example, the types of shame individuals are most sensitive to, and how intensely they experience the emotion (Greenwald & Harder, 1998). There are consequences to the particular sensitivities a person may have - for example, those who are especially sensitive to conformity shame may experience a strong sense of group membership, but simultaneously are also likely to experience diminished freedom to follow their own desires, a great deal of worry about whether their behaviour is socially appropriate, and vulnerability to excessive worry about minor infractions of social regulations (Greenwald & Harder, 1998).

Shweder (2003, p. 1115) argues that the abstract idea of shame is universal, and can be defined as “the deeply felt and highly motivating experience of the fear of being judged defective”. However, the local manifestation of shame will vary, as will be apparent from culturally specific situational determinants, self-appraisal features, somatic phenomenology, affective phenomenology, social appraisal, self-management and communication (Shweder,

2003). For example, among Oriya Brahmans, *lajya* may be translated into *shame, shy, modest, embarrassed* or *bashful*, and is associated with downcast eyes, a veiled face, and physical withdrawal from the situation, a set of words which among modern Anglo-Americans is associated with meekness, timidity, mousiness, sheepishness, shrinking, self-deprecation, weakness, humiliation and degradedness (Shweder, 2003). In Oriya Brahman culture, however, *lajya* is associated with being “*unpretentious, unobtrusive, reserved, self-restrained, humble, proper, civilized, self-effacing, not brazen, decent, elegant, delicate, undefiled, unsullied, powerful, virtuous, good*” – in fact, the ego or self of the person with *lajya* is thought to be mature and elevated, enhanced by an advanced sense of propriety, knowledge and compliance with societal roles and rules, adherence to social order, awareness of virtues and responsibilities of sacrifice and self-control, and sensitivity to preserving the honour of others (Shweder, 2003, p. 1125).

Edelstein and Shaver (2007) argue that there are both substantial universalities and cross-cultural differences in linguistic categorisation of emotion, which points to a core, common set of emotions that are given a particular shape and flavour by specific cultural influences. It is interesting to note that in some lexical studies of shame, the concept is often categorised within the “sadness” domain, and other times within the “fear/anxiety” domain (Edelstein & Shaver, 2007). Its particular categorisation depends on whether shame occurs before the individual engages in a transgression (in which case it would resemble or overlap with anxiety, apprehension or fear), or whether s/he experiences shame after committing a shameful act (in which case it would be similar to regret, remorse, and more broadly, sadness) (Edelstein & Shaver, 2007).

From a cultural constructivist point of view, there are significant cultural differences in the meaning, antecedents, experience of shame and associated action tendencies (Li, Wang, & Fischer, 2004). It has been argued that affect, cognition and behaviour are determined by historical, cultural and political factors (Shi-xu, 2009). Shi-xu (2009) suggests that cultural values are central to cultural emotions, and that 1) cultural affective experience is dynamic and changeable; 2) cultural affective experience is a product of historical contexts; and 3) cultural affective experience is embedded in history (Shi-xu, 2009). In order to understand cultural affective experience we need to pay attention to the historical circumstances in which such emotions occur, as well as acknowledge that no feeling, thought or action exists independently of comparable or parallel emotions in different cultures (Shi-xu, 2009). In stark contrast to individualist understandings of shame, people in Orissa, India, experience shame

as a healthy emotion, and one which is an effective antidote to rage (Menon & Schweder, 1994). In China, for example, shame is “not a mere emotion, but also a moral and virtuous sensibility to be pursued” (Li et al., 2004, p. 769). In addition, in Spain, shame is more closely associated with family and masculine honour and female sexuality than in the Netherlands (Fischer, Manstead, & Rodriguez Mosquera, 1999; Rodriguez Mosquera, Manstead, & Fischer, 2002).

From this perspective, it is important to note that in different cultures, shame may be differently conceptualised, experienced and expressed (Bedford, 2004; Bedford & Hwang, 2003). This is because of different perspectives on morality and identity (Bedford & Hwang, 2003). In Western individualism, the focus is on the individual self, on rights and freedom of choice, where morality is objectively determined, and guilt is often the mechanism for social control (Bedford & Hwang, 2003). In contrast, the Confucian relationalism characteristic of China, for example, focuses on the relational self, obligation to the relational other, and subjective (relational) morality, and the mechanism for social control tends to be shame (Bedford & Hwang, 2003). Bedford (2004) identifies four types of shame among the Chinese, known as *diu lian* (*loss of face*), *can kui* (*the shame that results from failing to achieve one's best or ideal state, usually associated with carrying out a positive duty*), *xiu kui* (*involves the discovery of something negative in the self that has harmed another*) and *xiu chi* (*a general type of shame that involves feeling inadequate as a person*) (Bedford & Hwang, 2003). All of these types of shame involve exposure, inadequacy or feeling deficient in some way, and concern with identity, but they are different in terms of their intensity (e.g. *can kui* is the least intense feeling and *xiu chi* is the strongest), function (e.g. the function of *diu lian* is to maintain an individual's reputation; the function of *can kui* is to motivate the individual to strive towards his/her ideal self; and *xiu kui* and *xiu chi* function to prevent the individual from engaging in inappropriate social action and to protect social harmony) and the nature of transgression (e.g. in one's own eyes or in others' eyes) (Bedford, 2004). In each case, the aspect of the identity which is threatened varies – with *diu lian* it is the public identity; with *can kui* it is destruction of personal ideals; *xiu kui* is caused by threats to the private identity; while *xiu chi* is both public and private (Bedford & Hwang, 2003).

As a result, Bedford and Hwang (2003) suggest that the emotional experience of shame may be different in different cultures, because of the way it is conceptualised and expressed in language. Not all languages discriminate so clearly between different dimensions of shame and shame and other self-conscious emotions. Some have argued that languages in which

concepts are highly elaborated, and which are more discriminating are likely to belong to cultures which are more sensitive to shame (e.g. Bedford & Hwang, 2003). Some scholars have suggested that because of the highly elaborated nature of the concept of shame in Chinese language, it might be worthwhile for Chinese researchers to work with Western, English-speaking researchers to achieve a more discriminating and precise conceptualisation of shame (Edelstein & Shaver, 2007). However, the theory that more elaborate and discriminating language necessarily points to a greater knowledge or understanding of shame is not consistently supported – for example, the Japanese word *haji* does not distinguish between embarrassment and shame (Lebra, 1983), and this is despite the fact that Japan is traditionally viewed as a “shame culture”. Not distinguishing between shame and other self-conscious emotions in language does not mean that the constructs are not viewed separately. For example, the Raramuri Indians in Mexico only have one word for shame and guilt but the authors show that these individuals nonetheless differentiate between these constructs, much like cultures which use two words for shame and guilt (although the expression of these emotions is somewhat different to expressions documented in Western cultural samples) (Breugelmans & Poortinga, 2006).

In a similar vein, Heider’s (1991) study of three cultures in Indonesia demonstrated highly differentiated features or dimensions of shame which are not evident in English-speaking cultures. However, Indonesia has not consistently proven more shame-orientated (Li et al., 2004). In a study of the organisation of emotion words in English, Italian, Chinese and Indonesian, only the Chinese produced an additional emotion family for shame (Shaver, Murray & Fraley, 2001; Shaver, Wu, & Schwartz, 1992). The Chinese have more consistently been found to emphasise shame (Li et al., 2004). In their study of Chinese shame concepts Li et al. (2004) found that at the highest abstract level (superordinate) participants distinguished between shame state, self-focus (shame that focuses on the self) and reactions to shame, other-focus (consequences of and reactions to shame directed at others). The former contained three additional meanings (at basic level), including fear of losing face, the experience of already having lost face, and guilt; while the latter contained a further three meanings, including disgrace, shamelessness and embarrassment (Li et al., 2004). The second superordinate category (shame, other-focus) was considered particularly interesting, because it pointed to the high level of involvement and engagement of the group in each member’s emotional life in Chinese culture compared to Western cultures (Li et al., 2004).

In a cross-cultural comparison of shame in Bengkulu (Indonesia) and California, Fessler (2004) found that 1) based on the frequency of the use of the term shame, shame was more prevalent in Bengkulu; and 2) comparisons of naturally occurring shame events in Bengkulu with reports of shame in California showed that shame is associated with guilt in California, and with shyness and subordination events in Bengkulu; and 3) in a synonym task guilt was again more prominent in California and subordination in Bengkulu. It is interesting to note that in this study, Westerners from individualistic cultures were more likely to conflate, merge or equate shame and guilt than non-Westerners from collectivistic societies (Fessler, 2004). This has been suggested by a number of authors, who draw attention to the close clustering and merging of self-conscious emotions among English-speakers, even those who were college educated (Edelstein & Shaver, 2007). However, it has not been consistently replicated: in Li et al.'s (2004) study, Chinese participants blurred the distinctions between shame and guilt.

Japanese people have been identified as particularly sensitive to exposure (a culturally rewarded or even prescribed attitude), with any kind of real or imagined exposure leading to *haji* (Lebra, 1983). The avoidance of *haji* comes with a great deal of pressure for perfectionism around the display of the self (Lebra, 1983). This sensitivity to exposure and pressure for perfectionism in display leads to anthropophobia (morbid fear of interpersonal contact) which is so characteristic of the Japanese (Lebra, 1983). Lebra (1983) argues that there is a great deal of cultural importance attached to the rules of formal display, which is particularly evident in rituals such as the tea ceremony – against the backdrop of *haji*, it is understandable that the Japanese find such ritualistic, rule-bound self-presentation as is demonstrated in the tea ceremony, calming, therapeutic, and tranquility-inducing. However, this drive towards formally flawless display inhibits self-expression, and consequently, Japanese people need to create occasions which allow for free, personal self-disclosure (Lebra, 1983). It is interesting to note that the formality and perfectionism so characteristic of Japanese social life is reserved for public or “on-stage” social performances, while when “off stage”, in the realm of the private, Japanese have been known to be uncharacteristically informal and display apparent shamelessness (Lebra, 1983). In Lebra's words (1983, p. 199), “It appears that the rhythm of the Japanese life represents cycles of alternation between on-stage inhibition and off-stage shamelessness or underexposure and overexposure.” The opposite extremes, in Lebra's (1983) view, are an intrinsic part of the shame complex in Japanese culture. Despite the ubiquitousness of shame in Japanese culture, Lebra (1983)

argues that guilt is more firmly entrenched in the Japanese moral system. Shame and guilt tend to be conflated, with shame exacerbating guilt reactions (Lebra, 1983). The shyness, exposure-avoidance, fear of eye-to-eye contact, and the culturally sanctioned self-denigration and humility in Japanese culture, then, should be reinterpreted and understood as the individual's attempt at thoughtfulness and avoiding hurting or offending others, in other words, pointing to the extreme other-oriented nature of the Japanese form of guilt (Lebra, 1983).

### **Guilt and Shame in Collectivistic and Individualistic Cultures**

The stark categorical distinction between Western cultures as wholly individualistic and non-Western cultures as wholly collectivistic has been criticised, from as early as the 1950's (Ausubel, 1955) – with authors claiming that the definition of any emotion needs to be general and flexible enough to encompass different culture-bound expressions thereof. Evidence against the simplistic categorisation of cultures into individualistic or collectivistic, or guilt or shame cultures, is that even in “we-self” cultures, there remains an “I-self” which can be shamed if standards, rules or goals are transgressed, for example, among Oriya Indians, a woman is “polluted” during her menstrual cycle and may not be touched (M. Lewis, 1992). Similarly, for Hindus there are a number of personal sins, such as being reborn, being born a woman, or having a lingering death (M. Lewis, 1992).

Having said this, however, there are discernible differences between collectivistic and individualistic cultures. The cultural values of independence, autonomy and equality are fostered in Western, individualistic or “I-cultures”, while the cultural values of conformity, interdependence, group solidarity and hierarchical authority are supported in non-Western, collectivistic or “we-cultures” (Li et al., 2004). The distinction between individualistic and collectivistic cultures is made on the basis of whether sanctions applied to normative behaviour are internal or external (Goldberg, 1991). If a particular context depends on the criticism, ridicule and ostracisation of others to ensure moral behaviour, it is shame oriented; alternatively, if a culture relies on an internalised conscience for adherence to moral behaviour, it is a guilt culture (Goldberg, 1991). A number of authors have made generalisations about the differences between individualistic and collectivistic cultures. For example, Kaufman (1993) argues that in Western cultures, compared to African or Asian

cultures, shame is centred around competition for success, being independent and self-sufficient, and being popular and conforming (Kaufman, 1993). Additional sources of shame in adulthood in Western culture identified by Kaufman (1993) are any situations in which the individual is powerless (reminiscent of his/her original helplessness in infancy), failed in vocation, failed in relationships, or has aged (great emphasis is placed on youthfulness).

M. Lewis (1992) maintains that I-cultures are focused on striving towards personal freedom, and have become more shame-driven and narcissistic (M. Lewis, 1992). This in part is caused by the achievement orientation of Western cultures; from infancy, children are encouraged to engage in academic, social and athletic competition, and are shamed when they fail to be as competent as others (Goldberg, 1991). Simultaneously, in such cultures, the influence of religious institutions has radically diminished over time, and consequently, there are fewer opportunities for absorbing shame (M. Lewis, 1992). In the past, religious institutions, whether guilt-oriented (e.g. in Judaism and Protestantism which focus on rewards for specific good deeds and punishment of specific transgressions in this life) or shame-oriented (e.g. Catholicism and fundamentalist Christian religions, which focus more on original sin and global forgiveness, in the hereafter for instance), played a central role in absorbing shame and forgiveness of sin (M. Lewis, 1992).

M. Lewis (1992) argues that in individualistic cultures, shame is present when the self violates central standards and accepts blame for failure; the focus remains on the self rather than reparation. However, the violation of group standards rather than the individual remains more shaming in collectivistic cultures (M. Lewis, 1992). In fact, Li et al. (2004) suggest that in China, individuals almost always belong to a closely knit group on which their honour and shame are reflected, which is why a network of people share an interest in each member's achievements and disappointments. So when, broadly speaking, individuals in collectivistic cultures fail, they not only lose face themselves, but also shame all who belong to the group (Li et al., 2004).

The distinction between shame and guilt may be less relevant in collectivistic cultures (Wong & Tsai, 2007). A number of studies have demonstrated that the differences between shame and guilt are far less pronounced in collectivistic cultures, and they are seldom considered entirely separate constructs (Wong & Tsai, 2007). On the few occasions when a distinction between shame and guilt has been drawn in collectivistic cultures, the underlying foundation of this distinction is different to most individualistic contexts (Wong & Tsai, 2007). For example, because Confucianism is the dominant philosophical framework in many East Asian

contexts, a tradition that is more focused on situations and relations, in Chinese culture guilt is experienced when an absolute standard is breached, while shame is experienced when a situation-specific standard is breached (Wong & Tsai, 2007).

Many scholars argue that the distinctions between shame and guilt are culturally constructed. Specifically, Wong and Tsai (2007) argue that the distinctions between shame and guilt vary cross-culturally, but also that the valuation, elicitors and behavioural consequences of these emotions vary according to individualistic or collectivistic culture. Of relevance here is the cultural construction of the self – in individualistic cultures, the self is considered bounded, separate from others, and independent, including stable personal attributes, whereas in collectivistic contexts the self is viewed as interdependent, including mutable and changeable personal characteristics, and consequently, external influences are as significant as internal influences (Wong & Tsai, 2007). The interdependent self is considered contextually and situationally dependent, and thus, changes in the self are both standard and common (Wong & Tsai, 2007). These changes in the self in collectivistic cultures – including feeling bad about the self - are normative and valued as a means of constantly improving the self (Wong & Tsai, 2007). This relates to the valuation of shame in collectivistic cultures – negatively valuating the self, which is typically associated with shame, is not traditionally seen as damaging to psychological well-being (Wong & Tsai, 2007). Instead, feeling negative about oneself is viewed as potentially informative and as motivating positive psychological change (Wong & Tsai, 2007). Consequently, shame is valued more in collectivistic contexts, and may very well play an important role in everyday life (Wong & Tsai, 2007). In individualistic cultures, however, shame is understood as an involuntary, very painful and incapacitating self-focused emotion that has a profoundly negative effect on individual outcomes and on interpersonal behaviour (Tangney & Dearing, 2002).

The elicitors of shame and guilt also vary according to culture. Because of the different construal of the self in individualistic and collectivistic cultures, those transgressing in individualistic contexts themselves feel the consequences of their wrongdoing (it is the individual who transgressed who feels the shame), while these consequences may be induced by others' behaviour in collectivistic contexts (Wong & Tsai, 2007). In terms of behavioural consequences, unlike individualistic cultures, which traditionally view shame as a negative emotion because of its psychological, social and physical consequences, in collectivistic cultures, shame may have positive and adaptive consequences (Wong & Tsai, 2007).

It has been shown that the expressions of traumatic memory, and associated experiences, including shame, differ across individual and collectivist societies (Elsass, 2001). Elsass (2001) found that in collectivist Peruvian villages, individuals did not respond to violence with standard DSM-IV criteria for PTSD. Participants mentioned “evil and bad thoughts”, “a burning head”, or having “cried the eyes out”, and suggested that their “souls are putrefied and destroyed by all dead persons”, or “we are as in a dream without thoughts” (Elsass, 2001, p. 309). A few participants described further difficulties that are not reflected in the diagnostic criteria of PTSD such as “insufferable homesickness” and “gnawing shame” (Elsass, 2001, p. 309). Peruvian participants also did not believe that traumatic memory needs to be treated with psychological interventions (Elsass, 2001). Instead, most psychosocial work is dedicated to strengthening the construction of local communities (Elsass, 2001). By contrast, people in the more individualistic villages in Colombia tend to be preoccupied with guilt and shame, and psychosocial work takes the form of individual psychological interventions, which are widely used and accepted (Elsass, 2001).

Another study found that shame mediated the relationship between personality (introversion, extroversion, neuroticism and psychoticism) and social anxiety among Chinese university students, whereas no such relationship could be found among American students, for whom there were direct relationships between personality and shame, and personality and social anxiety (Zhong et al., 2008). Contrary to previous findings, however, in this study the authors found that the American sample had higher shame and lower social anxiety scores than the Chinese sample, a difference that was attributed to Americans’ tendency to be more open about expressing their private feelings (Zhong et al., 2008).

Fischer et al. (1999) found important distinctions between collectivistic honour-related cultures (Spain) and individualistic cultures (Dutch). In their study, they found that honour-related values were more important in Spain, while values associated with individualism were more important in the Netherlands (Fischer et al., 1999). In a second, related study, the authors explored whether differences in values would be reflected in cultural conceptualisations of pride, shame and anger. As hypothesised, they found that there were more dissimilarities than similarities between how participants from the two different cultures described pride and shame episodes, compared to their descriptions of anger (which is not a self-conscious emotion). Results indicate that Spanish participants referred more to others and their relationships with them than Dutch participants, who were more self-focused (Fischer et al., 1999). Furthermore, Spanish participants mentioned negative feelings and consequences

to pride more often than their Dutch counterparts (Fischer et al., 1999). In addition, for Spanish respondents, shame was more likely to be associated with situations where their honour was publicly affected (Fischer et al., 1999).

A number of studies which have found differences in shame and guilt between individualistic and collectivistic societies have produced results which were unexpected. For example, in a recent study, guilt, not shame, was the most prevalent emotion in narratives generated by Japanese young people (Thonney, Kanachi, Sasaki, & Hatayama, 2006). In a study comparing Indian and Italian undergraduates' shame and guilt responses and shame and guilt proneness, results showed firstly, that shame and guilt are indeed separate constructs; and that secondly, Indian participants responded more intensely to shame while Italian participants reacted more intensely to guilt; and thirdly, and somewhat unexpectedly, that Indian respondents were prone to both more shame and guilt (Anolli & Pascucci, 2005). In a comparison between Chinese (collectivistic) and American (individualistic) students' shame reactions, the authors found that there were significant differences in levels of shame across imaginary scenarios, but in an unexpected direction – that US students had higher shame scores than their Chinese counterparts on the majority of scenarios (Tang, Wan, Qian, Gao, & Zhang, 2008). However, in both groups, intensity of shame decreased with social distance between the self and a related other (mother, partner, best friend and classmate) (Tang et al., 2008).

A comparison between German (individualistic) and Kurdish and Lebanese (collectivistic) individuals in reactions to violation of normative standards also revealed surprising results (Bierbrauer, 1992). The author found that individuals in the collectivistic group not only had higher shame scores, they also had higher guilt scores (however, their shame scores remained higher than their guilt scores). This unexpected finding was explained by the religion of participants – despite their collectivistic orientation, the Kurdish and Lebanese participants endorsed a monotheistic religious orientation (Islam, which, like Christianity, includes a personal God that is the highest form of authority, who regulates transgressions from normative standards by inducing feelings of guilt), which is associated with higher levels of guilt. Furthermore, although there were distinct differences between the individualistic and collectivistic cultural groups in terms of their belief in the legitimacy of tradition and religious norms (the collectivistic group endorsing these beliefs more), there was no difference between the groups in terms of perceived legitimacy of state laws. This result suggests that religion and tradition – as opposed to the Western reliance on state laws - may potentially play an

important role in regulating individual and social behaviour in some cultures (Bierbrauer, 1992).

Finally, in closing this section on individualistic and collectivistic cultures, it is worth reiterating that in some (usually collectivistic) contexts, shame may be positive and pride negative. For example, in their review of the literature, Goetz and Keltner (2007) describe that in Bedouin culture, the word *hasham* has positive connotations, and includes not only the concept shame, but also embarrassment, humility and modesty, and may even be experienced as a pleasurable sensation. Eid and Diener (2001) demonstrate that in individualistic cultures such as the U.S. and Australia, pride was considered positive, both acceptable and desirable, while in collectivistic cultures such as China and Taiwan participants were indifferent to, or had a negative orientation towards pride. In addition, guilt was considered highly undesirable in all participating countries (U.S., Australia, Taiwan and China), except for China (Eid & Diener, 2001). Furthermore, Wallbott and Scherer (1995) found, in their comparison of shame experiences across 37 countries, that shame had a much less negative impact on self-esteem and on relationships in collectivistic cultures, and was also associated with behaviours such as smiling and laughing, indicating pleasure.

In summary, it is clear from the number of studies that have produced unexpected findings, that there is no such thing as a pure shame culture, or pure guilt culture (corresponding with pure collectivistic and individualistic societies). Hong (2004) argues against such dichotomous thinking, suggesting a more nuanced approach that recognises diversity and complexity, and includes culturally sensitive methodologies and measurement tools. It is also important to note that societies are not static, but are continually changing. As an example of this, Lee (1999) describes the transition in Korean culture from a face-saving culture to a modern culture. The most important value in the face-saving culture was the safeguarding of honour in the family. However, influenced by Western culture, modern Korean culture has begun to value personal competence, particularly material prosperity (Lee, 1999).

Consequently, the major source of shame has changed from damage to the honour of the family in the face-saving culture to personal incompetence in modern Korean culture (Lee, 1999). It is likely that in a dynamic society such as South Africa, similar changes are happening. It is also highly likely that cultures of honour and shame permeate South African culture(s). Because of the established connections between shame and mental health, these changing conceptions of shame need to be captured and understood to ascertain their impact on the mental health of survivors of chronic trauma.

## CHAPTER 5

### **The Associations Between Trauma, Shame and Psychopathology**

Research on the associations between chronic trauma, shame and psychopathology is limited. This is despite the fact that individuals who have experienced multiple traumatic events, particularly if the traumas are interpersonal in nature, have higher levels of post-traumatic symptoms (which I will argue includes shame) than those who have been exposed to a single traumatic event (Green et al., 2000). The literature that does exist falls into two categories: the generally more dated theoretical literature on shame from a variety of perspectives, which tends to be based on single cases (which were discussed in chapter 2); and the more recent empirical literature, which includes large samples, and has a broader focus, linking shame to a full range of psychological difficulties. Thus, although the proposed study is qualitative in orientation, the literature reviewed in this chapter includes mostly medium to large-scale quantitative studies, so conclusions are drawn on the basis of data rather than clinical experience. Where this is not the case, attention will be drawn to it, as it has implications for the kinds of generalisations that can be made on the basis of findings. In some instances, theoretical work will be referred to, in which case, the reader's attention will once again be drawn to it.

The tone of this chapter is somewhat in conflict with an ethnographic study. This is because of the nature of the material I am reviewing. And since this chapter is the heart of my literature review, including all my main themes, it is critical that this literature is reviewed.

Due to the frequent association of shame to high-risk psychological outcomes, and a lack of research on the possible positive functions of shame, the following review also emphasises psychopathology. This reflects the focus of the vast majority of available research<sup>16</sup>.

However, it is worth noting that Mollon (2002) has recognised that shame also has adaptive functions. He argues that in evolutionary terms, shame protects a person from engaging in behaviour which is in conflict with (prosocial; advantageous) group norms and result in social exclusion, and thus the support and protection of the community and society.

---

<sup>16</sup> As will be seen in later chapters, this deficit will be addressed during the field work component of the current study, when participants will be given an opportunity to resist or challenge dominant biomedical discourses which tend to locate pathology within the individual. Participants will be encouraged to give voice to shameful, silenced and stigmatized experiences in a manner which generates alternative knowledges and meaning structures which will be used to inform future research.

In this chapter, I have foregrounded certain forms of trauma-related psychopathologies, because they are more common than others. It is beyond the scope of this chapter to cover all shame and trauma-related outcomes. Firstly, due to the overlap between child abuse and chronic trauma including IPV (Dunkle, Jewkes, Brown, Yoshihama et al., 2004) I focus on 1) the contributions of emotional, physical and sexual abuse to shame and psychopathology, and 2) the contributions of parenting and attachment patterns to shame and psychopathology. Then I turn to the consequences of trauma for shame reactions and selected psychopathologies. This is with the knowledge that chronic trauma often results in a complicated comorbid picture, which does not cohere into a simple, unified syndrome. As can be seen in the third section below, psychic splitting and fragmentation (aspects of dissociation) as a post-traumatic response frequently co-occurs with shame, which are both central to Complex PTSD (and DESNOS).

### **Trauma, Shame and Psychopathology**

Shame has been associated with a range of psychopathological outcomes, including depression, anxiety, eating disorders, Complex PTSD, and personality disorders such as BPD and narcissism, as well as to disorders of conduct, dissociative disorders and substance misuse (N. K. Morrison, 1987; Tangney, Wagner, & Gramzow, 1992; Tangney et al., 2007). As I have noted, reviewing all the literature on shame and psychopathology is beyond the scope of this review. Instead, the review will focus on the associations between shame and specific forms of trauma-related psychopathology.

#### **1. Causes and Correlates: The Contributions of Emotional, Physical and Sexual Abuse to Shame and Psychopathology**

Gilbert (1998) points out that trauma is both a categorical and dimensional construct, which implies that although certain social interactions do not constitute abuse, they may still be damaging for the child's developing personality or sense of self. In this chapter, I engage with trauma as a categorical concept (e.g. a child was sexually abused or not), as well as a dimensional one (e.g. occasional role reversal between child and primary caregiver [low on

the continuum], or the frequent or escalating experience of failed identification between infant and primary caregiver [higher on the continuum]).

Child abuse of various kinds has been implicated in the development of a shame-prone interpersonal style in a number of studies (Hoglund & Nicholas, 1995). In fact, some authors have named physical and sexual abuse shame-based syndromes, based on their clinical work (Kaufman, 1992). Individuals who have been abused tend to experience a great deal of shame because of feeling unvalued and worthless as a person (Hoglund & Nicholas, 1995).

One of the ways in which those who have been shamed through abuse counter their feelings of helplessness is to become abusers themselves (Goldberg, 1991). Based on his clinical experience, Kaufman (1993) argues that scenes of both physical and sexual abuse often compel re-enactment, but that they are recast – the previously abused individual is now in the role of the abuser, thus reversing roles. Goldberg (1991) estimates that one third to one half of those who have been physically abused become abusers themselves, as a means of taking back the power and potency which was taken from them during their own abuse. Oliver (1993) replicated this estimation in a study that included original research and a compilation of 60 studies, which were recent at the time, predominantly from the United States and the United Kingdom. The results indicate that one-third of child survivors of abuse grow up to engage in severely impaired, neglectful, or abusive rearing as caregivers (Oliver, 1993). One-third do not engage in abusive caregiving (Oliver 1993). The remaining one-third was classed as vulnerable to the effects of social stress on the likelihood of becoming abusive caregivers (Oliver, 1993). Kaufman and Zigler (1987) came up with similar estimates (approximately 30% of caregivers with a history of abuse perpetrate abuse against their offspring), but they emphasise the obvious point that the majority of maltreated children (two thirds) do not become abusive caregivers, and that there are a range of mediating factors that influence transmission.

Emotional abuse, as opposed to physical abuse, has been found to be a particularly important contributor to feelings of shame, as well as overt and covert hostility, and both unexpressed and expressed anger in a sample of 107 male and 101 female undergraduate psychology students (Hoglund & Nicholas, 1995). However, guilt, overall, was unrelated to abusiveness, anger or hostility. This was attributed to the fact that the individual's self-concept is a core component in both the experience of shame (but not guilt) and emotional abusiveness – in this kind of abusiveness the individual's basic sense of self is being undermined, criticised or belittled. In other words, emotional abuse involves the negative evaluation of who one "is"

(shame), rather than what one “does” (guilt). The lack of relationship between physical abuse and shame is more complex, and could involve the perception that physical abuse is the rightful punishment for actual or imagined transgressions; that exposure to physical abusiveness is dominated by emotions other than shame; or that these findings may be a function of the sample characteristics (low levels of exposure to abusiveness) or choice of measures (Hoglund & Nicholas, 1995).

Shame has been found to mediate the association between exposure to psychological abuse by a romantic partner and PTSD symptomatology (Street & Arias, 2001). Interestingly, once again, psychological abuse (in the absence of physical abuse), not physical abuse, was associated with shame-proneness, and shame-proneness was a significant predictor of PTSD (Street & Arias, 2001). Emotional abuse has been repeatedly isolated as an important predictor of pathological outcomes, not only in the case of PTSD, but also in depression (Cloitre et al., 2009; Webb, Heisler, Call, Chickering, & Colburn, 2007). For example, psychological maltreatment, whether open, direct hostility, neglect or social isolation, was found to be associated with shame-proneness (not guilt) and depression in a sample of 280 participants from a public community college and a private university (Webb et al., 2007).

Shame has also been found to account partially for the relationship between severe child sexual abuse and severity of depression in a sample of 105 psychiatric patients aged fifty years and over diagnosed with depression (Gamble et al., 2006). Specifically, a dimension of neuroticism known as self-consciousness (characterised by feelings of shame and embarrassment) mediated the association between severe child sexual abuse and severity of depressive symptoms (Gamble et al., 2006).

Emotional abuse and emotional neglect were found, in a recent study, to predict both anxiety and depression in a sample of 301 college students, and this association was mediated by schemas of shame (feeling that the whole self is defective and unworthy), vulnerability to harm (the belief that one is unable to prevent disasters and that disasters may occur at any time) and self-sacrifice (exaggerated focus on the needs, feelings and reactions of others, frequently at the cost of the individual's own needs) (O'Dougherty Wright, Crawford, & Castillo, 2009). In addition, emotional neglect was related to dissociation, and this relationship was once again mediated by schemas of shame and susceptibility to harm (O'Dougherty Wright et al., 2009). The relationship of these schemas to dissociation was explained by the authors as a result of resorting to hiding or escaping during a shame reaction; insulating oneself against this painful emotion.

A study including 373 psychology undergraduate students examining the impact of childhood psychological abuse and shame-proneness on adult outcomes found significant gender differences (Harper & Arias, 2004). Specifically, shame-proneness was a moderator of child psychological maltreatment and depressive symptoms in women, and for child psychological abuse and anger in men. Thus, for women, those who reacted with high levels of distress to child psychological abuse experience an increase in shame and are more likely to develop internalised symptoms. Contrary to women, men exhibited less shame-proneness and more anger, which is consistent with the proposition that in by-passed shame (an avoided or denied shame), externalising emotions such as anger are used to suppress the painful shame response (Harper & Arias, 2004).

Child sexual abuse has repeatedly been implicated in a range of pathological outcomes, and shame and guilt have been identified as particularly common post-traumatic reactions (Feiring, Taska, & Lewis, 1996; Feiring, Taska, & Lewis, 2002; Ginzburg et al., 2009; Uji, Shikai, Shono, & Kitamura, 2007). Factors which increase shame in survivors of sexual abuse include the offender blaming the survivor, sexual abuse by a parent or familial member (betrayal by a trusted person), more serious forms of sexual contact (which involve penetration and force), playing an active part in the abuse (complicity in a socially stigmatised and forbidden relationship), and being discovered as opposed to purposeful telling (Feiring et al., 1996). However, the most important variable in determining shame remains the cognitive evaluation of the event (internal, stable, global attributions for negative events) and the individual's (pessimistic) attributional style (Feiring et al., 1996).

Feiring, Taska and Chen (2002) conducted a study including 80 children and 50 adolescents who were seen within eight weeks of discovery of the abuse and one year later. Participants were asked to describe why they believed the abuse happened, rate the extent to which internal and external attributions for the abuse event applied to them, and complete measures of general attribution style for everyday events, shame for the abuse, and symptoms of depression, PTSD, and self-esteem. The authors found that shame was a key mediator in the association between sexual abuse-specific internal attributions (self-blame) and PTSD. Abuse-specific internal attributions were related to higher levels of psychopathology, including PTSD symptoms and internalising behaviour problems, such as depression. In another study, Feiring et al. (1996) presented a theoretical and testable model that specifies psychological processes related to stigmatisation in child and adolescent survivors of sexual abuse. The model proposes that sexual abuse leads to shame through the mediation of

cognitive attributions about the abuse, and shame, in turn, leads to poor psychological adjustment. Three factors, social support, gender, and developmental period are proposed to moderate the proposed stigmatisation process. These findings were largely replicated by Uji et al. (2007), who tested Feiring et al.'s (2002) model on a Japanese sample of 172 women with negative sexual experiences. Shame directly predicted PTSD, and mediated the associations between internal attribution and PTSD (Uji et al., 2007). This relationship was significant even though the reported sexual abuse was relatively mild (Uji et al., 2007). Interestingly, the closer the survivor of sexual abuse was to the perpetrator emotionally, the greater her shame (Uji et al., 2007).

In a study of 25 female survivors of sexual assault, a history of previous sexual victimisation, physical consequences (sexually transmitted infections, pregnancy, pelvic pain), self-blame, concealing the assault and being assaulted by a known attacker were all significantly related to characterological and body shame (Vidal & Petrak, 2007). These findings emphasise the importance of early and repeated sexual victimisation in the development of shame.

A recent study involving 195 survivors of childhood sexual abuse examined the moderating effect of hardiness on shame associated with childhood sexual abuse. In this study, hardiness, defined as “the learned ability to cope with a wide variety of stressful situations or events by creating a successful coping strategy”, was expected to decrease along with increases in shame in those who have experienced childhood sexual abuse (Feinauer, Hilton, & Callahan, 2003, p. 68). Results confirmed a potent negative relationship between internalised shame and hardiness. In addition, hardiness moderated the negative effect of internalised shame and severity of abuse on relationship intimacy. The authors argue that in clinical practice therapists should bear in mind that traumatic sexual abuse experiences inhibit children's capacity to gain mastery over themselves and their environments; they undermine their sense of competence; and they deprive them of the opportunity to learn positive ways of coping with their situations. However, many women do develop some hardiness skills despite their experiences, do not internalise shame and manage to create meaningful intimate relationships (Feinauer et al., 2003).

Shame and anger have been linked to self-harming in a sample of 89 offender women with a history of child sexual abuse (Milligan & Andrews, 2005). Bodily shame in particular (as opposed to characterological or behavioural shame) was isolated as an important direct determinant of self-harming (Milligan & Andrews, 2005). In this study, bodily shame also partially mediated the association between childhood sexual abuse and self-harming (Milligan

& Andrews, 2005). Bodily shame has also been shown to play an important role in mediating the association between childhood physical and sexual abuse and bulimia in a community sample of 69 teenagers and young women (Andrews, 1997).

Social support is hypothesised to moderate the impact of shame and adjustment in individuals who have experienced sexual abuse (Feiring et al., 1996). Furthermore, developmental period also plays a role. Some research has found that adolescents have poorer psychological adjustment than children in the aftermath of sexual abuse (Feiring et al., 2002), while other scholars argue that pre-pubescent children are the most vulnerable to poor outcomes (Feiring et al., 1996).

## **2. Causes and Correlates: The Contribution of Parenting and Attachment Patterns to Shame and Psychopathology**

According to the theoretical work of Mills (2005), the trauma of rejection by the primary attachment figure, as well as insecure attachment (characterised by a caregiver who is consistently emotionally inaccessible and does not promote affect regulation in the infant) has long-term implications for the individual's mental health (Mills, 2005). In Miller's (1985) theoretical work, she argues that ideally, there needs to be a bond of affection, protectiveness, and appreciation for the child, and the caregiver should encourage the child to experience intimacy and identification with the caregiver, and facilitate him or her to live up to realistic expectations. This protects the child's self-esteem and self-confidence (Miller, 1985). Actual or perceived sibling favouritism has been identified as a risk factor for a shame-prone emotional style (Mills, 2005). In her review of the developmental literature, Mills (2005) identifies parental overcontrol, through treating the child as weak and incapable, and through fostering a perception of uncontrollability and inefficacy in the child, as a contributor to shame-proneness (Mills, 2005). Certain types of family environments also contribute to dispositional shame. In Mills' (2003) empirical study, authoritarian parenting by both parents when the child was aged three years, for example, predicted shame in these children at five years.

Theoretical work by Patterson, DeBaryshe and Ramsey (1989) and Mills (2005) suggests that coercive interaction cycles, in which child and caregiver continually attack and counter-attack each other, may in part be determined by shame-rage. Mills (2005) argues that caregivers with

poor self-esteem may tend to feel vulnerable in difficult caregiving situations, and so inclined to respond harshly or coercively to the child in an attempt to regain control or power over the situation. Although there is no empirical support for this conjecture, Mills (2005) proposes that such parents may be vulnerable to feeling shame in situations where they feel a sense of low power, and they counter these feelings with interactions characterised by rage and hostility. In such family environments, it is also likely that hurtful caregiver messages will be communicated, including shaming messages, which are likely to engender a disposition towards shame (Mills, 2005). In addition, in families where children's failures are frequently attributed to their inner traits (global, stable, internal attributions), and successes to external events, they may develop a depressogenic, helpless and pessimistic emotional style that contributes to shame-proneness (Mills, 2005). Excessive praise may also elicit shame, particularly if it conveys either low expectations of capability or unreasonably high expectations, or when it implies that the child's value or worth is dependent on performance (Mills, 2005). According to Mills (2005), it undermines motivation, may facilitate a sense of contingent self-worth and helplessness, and evoke self-consciousness which can disrupt performance.

On the basis of his clinical experience, M. Lewis (1998) argues that children may also experience shame when being disciplined for failing to meet accepted standards, rules and goals. Problematic disciplinary styles include those which involve high levels of blame, where there is a great deal of anger, contempt and disgust, and punitive attitudes are upheld (M. Lewis, 1998). Facial expressions of disgust and contempt, which are used to humiliate or shame the child out of the behaviour s/he is engaging in, tends to communicate a rejection or dismissal of the whole self (communicating the message "you are disgusting/contemptible"), and so results in internal, global attributions, which produce shame (M. Lewis, 1992). Optimal disciplinary strategies (such as reasoning with the child about the cause of his/her problem), which do not contribute to a shame disposition, are those in which only mild negative affect is elicited that is short in duration due to effective interactive repair (M. Lewis, 1992; Mills, 2005). Those disciplinary techniques which involve power assertion and which are intensely negative not only contribute to the development of shame, but force children's attention away from the content of the message, and thus render them incapable of reparation (M. Lewis, 1992).

A recent large eight-year longitudinal study (n = 363 time 1; n = 286 time 2; n = 297 time 3) illuminated the relationships between harsh parenting, sexual abuse and exposure to domestic

violence in childhood and parental rejection and parental warmth during adolescence (Stuewig & McCloskey, 2005). These variables, in turn, were then expected to have associations with shame- and guilt-proneness, which was hypothesised to predict depression and delinquency in late adolescence. Results of the path models developed indicate that harsh parenting in childhood related to shame-proneness in adolescence, and that this association was mediated by parental rejection and lack of warmth in adolescence. Those young people who had cold, rejecting parents were more shame-prone and less guilt-prone than other youth. In addition, shame-proneness was related to higher levels of depression, and guilt-proneness was associated with lower levels of delinquency in late adolescence, a relationship that was attributed to the role played by heightened empathy in guilt-prone individuals. It is interesting that exposure to sexual abuse and domestic violence did not relate to shame- or guilt-proneness in adolescents. Stuewig and McCloskey (2005) speculate that perhaps it is because psychological maltreatment (implied in parental rejection and lack of warmth) plays a more significant role in the development of a shame-prone emotional style than other forms of abuse.

Poor parental bonding has also been associated with shame. Specifically, in Lutwak and Ferrari's (1997) study involving 264 women and 140 men (young adults), shame was associated with memories of parents being demanding, over-controlling and non-nurturing during childhood. In addition, in this study, fear of negative social evaluation, social anxiety and interpersonal avoidance were identified as significant predictors of shame in young adulthood (Lutwak & Ferrari, 1997).

In Bradshaw's (2005) theoretical formulations, he argues that shame within families is often intergenerational because it remains unconscious. The internalisation of shame as an identity involves at least three processes: 1) identification with unreliable and shame-based models which is the source of "carried" shame from one generation to another; 2) the trauma of abandonment, which severs the "interpersonal bridge" (Kaufman, 1993, p. 33) and the binding of feelings, needs and drives with shame; and 3) the interconnection of memory imprints, which forms collages of shame. Thus, one of the most significant determinants of shame is abandonment (Bradshaw, 2005). This may take the form of the actual physical absence of the caregiver, through emotional abandonment and narcissistic deprivation by the caregiver (which often leads to role reversal between caregiver and child), through the creation of a fantasy bond (enmeshment), abandonment through the neglect of developmental dependency needs, or abandonment through abuse (Bradshaw, 2005). These processes all lead

to disorganised attachment styles, which persist from childhood to adulthood (Fonagy, 2011; Steele, 2011).

On the basis of Mills' (2005) theoretical review of the developmental literature on the role of families in the lives of children, she argues that families' socialisation of emotions is important in the development of shame. In particular, children of caregivers who face and validate emotions (as opposed to ignoring or denying them) in themselves and their children, and view their child's negative emotions as an opportunity for learning how to label emotions and tackle and solve the problems that arise from them, are less likely to develop a disposition to shame. She argues that it has repeatedly been demonstrated in the recent literature that discussion of emotions plays an important role in developing emotional awareness and affect regulation (Mills, 2005).

Based on M. Lewis' clinical experience, and Mills' (2005) theoretical work, these authors postulate that shaming family environments, which include those in which caregivers themselves are prone to shame and children chronically experience "empathic shame" and model self-blaming attributions, may facilitate the development of a disposition to shame (M. Lewis, 1992; Mills, 2005). M. Lewis' (1992) clinical work suggests that early trauma, such as parental depression, addictions, or conflict tend to produce more empathic behaviour in children because of the child's attempts to help his/her parents – s/he typically blames him/herself globally for failure, which leads to shame. He also suggests that in general, individuals who tend to make internal attributions also tend to be more shame-prone (M. Lewis, 1992). Thus, any family environment which encourages internal, global attributions for failure, are likely to foster a shame-prone emotional style (M. Lewis, 1992). This has been shown in Mills, Arbeau, Lall and De Jaeger's (2010) empirical study, in which child shame responding, parental shaming, and child temperamental inhibition were assessed at time 1 (n = 225, aged 3-4 years), shame responding was reassessed at time 2 (n = 199, aged 5-7 years), and shame-proneness was assessed at time 3 (n = 162, aged 7-9 years). Results indicated that higher mother shaming, and associated promotion of internal, global negative self-attributions, predicted increased shame in low inhibition girls between pre-school and school-going age, and high inhibition boys at the same age (although father shaming only contributed to boys' shame in preschool). Interestingly, there are also notable gender differences in parents' socialisation practices. This may be why some studies have found that girls show more shame than boys (Mills et al., 2010).

Parentification (the reversal of parent and child roles which occurs because the parent's own needs for acceptance, nurturance and support were not met during childhood) also plays a role in the development of shame. Parentified children develop a false self in response to unreasonable parental demands and conditional love, and become split off from their true needs, values and wishes, and begin to value themselves only for their abilities to be intuitive and meet others' needs (Wells & Jones, 2000). On the basis of a large-scale study involving 197 undergraduate students, Wells and Jones (2000) found that parentification demands a premature identification with the parental expectations and needs, at the expense of the development of the child's own strengths and talents, tending to leave the child feeling ashamed of the true or authentic self's unrewarded strivings. In this study, parentification was related to shame-proneness, but not guilt-proneness, supporting the notion that parentification involves the internalisation of unreasonable parental expectations which is accompanied by shame about the "real" or true self (Wells & Jones, 2000).

Finally, it is important to consider the theoretical work by N. K. Morrison. Although the role played by biological factors in schizophrenia is significant, the trauma of early rejection by parents has been associated with the pervasive experience of shame that is characteristic of schizophrenia (N. K. Morrison, 1987). These individuals are excessively prone to shame; a reaction that is traced back to repeated shame experiences perpetrated by important parental figures. Early rejection is thought to facilitate repeated rejections in later life, which leads to individuals with schizophrenia avoiding social interaction and affectionate feelings. It is the habitual nature of early shaming that is considered most damaging. People with schizophrenia are prone to emotional engulfment, which is attributed to extreme sensitivity to interpersonal interactions. Individuals with schizophrenia also tend to be particularly sensitive to fears of exposure. They typically fail to achieve psychological differentiation and integration – this failure at integration in particular leads to the feeling that aspects of the individual's character or personality are unacceptable, and s/he tends to feel intense shame about them. These aspects of the self are often projected onto others. Paradoxically, individuals with schizophrenia also tend to experience an exaggerated sense of responsibility, and tend to see themselves as to blame for situations which are not objectively their fault, which leads to intense feelings of shame (N. K. Morrison, 1987).

It is interesting to note that people with schizophrenia may either have a paranoid or schizoid personality organisation (N. K. Morrison, 1987). Schizoid individuals are aloof, often unaware of their emotions, avoidant of interpersonal interaction, and frequently engage in

fantasy, particularly fantasies of omnipotence which can be understood as an escape from experience of shame. It is argued that they desire attachments, but tend towards detachment as a defense against extreme sensitivity to shame. Unlike paranoid individuals, the schizoid person takes on the experience of shame (and personal responsibility for it) without question. In paranoia the individual reacts to shame as if it is a premeditated assault on the integrity of the self, and consequently s/he feels indignant, righteous anger. It is relevant to draw attention to the split typically experienced in the shame reaction (the vicarious experience of the shaming other, and the [shamed] experience of the self) that makes the paranoid individual's frequent belief that others are watching him/her, and that others are attempting to control him/her by putting thoughts in his/her head, more understandable (N. K. Morrison, 1987).

### **3. The Aftermath of Trauma: Shame and Complex PTSD**

It is a great pity that there are no studies on chronic trauma, shame and DESNOS. This seems to be an incomprehensible gap in the literature. However, in the absence of this literature, the relationship between shame and Complex PTSD needs to be foregrounded. Individuals rarely only experience one traumatic event; it is much more likely that a traumatised individual would have experienced several episodes of traumatic exposure (Cloitre et al., 2009; Herman, 1997; Kaminer & Eagle, 2010). One of the most common outcomes of repeated exposure is Complex PTSD, which involves impaired self-regulatory capacities (hyperarousal and hypervigilance or emotional numbing), problems with anger and aggression, dissociative symptoms, and avoidant behaviours (Cloitre et al., 2009). Cloitre et al. (2009) conducted a study examining the relationship between accumulated exposure to different types of traumatic events and total number of different types of symptoms (symptom complexity) in an adult clinical sample (n = 582) and a child clinical sample (n = 152). The results of Cloitre et al.'s (2009) study suggests that lifetime cumulative exposure to maltreatment and trauma can lead to both increased complexity and severity of symptoms – affecting multiple affective and interpersonal domains of functioning (Cloitre et al., 2009). One of the affective dimensions of functioning which is influenced by trauma exposure is shame. In fact, shame has been identified as a significant predictor of Complex PTSD independent of fear, helplessness, and horror, and is a determinant of impaired recovery among childhood abuse survivors who experience adult-onset trauma (Cloitre et al., 2009). *It is viewed by these*

*authors as the “core” emotion resulting from trauma.* Other features associated with prolonged trauma are loss and grief – of all the positive events and experiences the survivor was entitled to (Cloitre et al., 2009).

Wenzel, Griengl, Stompe, Mirzaei and Kieffer (2000) conducted a study focusing on psychiatric impairment in survivors of torture presenting to an out-patient department for psychiatry. A DSM-III-R-based psychiatric interview, including the general assessment of functioning scale, an open list of symptoms and the Vienna diagnostic criteria for depression were used to evaluate psychological functioning (Wenzel et al., 2000). The most frequent current diagnosis in 44 patients assessed over three years was PTSD (n = 40), but criteria for a present diagnosis of other disorders were met in 34 patients, even years after torture, mainly depression or dysthymia (n = 26) (Wenzel et al., 2000). Criteria for functional psychosis were fulfilled in four patients (Wenzel et al., 2000). However, these authors emphasise that the majority of their sample reported symptoms that fall outside of the DSM-III-R criteria for PTSD, mostly, and notably, feelings of shame and guilt, excessive rumination and existential fears, which are typically associated with Complex PTSD (Wenzel et al., 2000). Another more recent study involving 598 college students from North Texas also found that feelings of shame, guilt, disgust and sadness were more frequently reported than fear in those with chronic PTSD symptomatology (Hathaway, Boals, & Banks, 2010).

In Ebert and Dyck's (2004) theoretical work, which has important clinical implications, “mental death” has been associated with Complex PTSD. This concept is defined as the destruction of an individual's identity, including the loss of perceptions of consistency and continuity of self, which is frequently reported in the torture literature. Survivors of torture frequently fit the anticipated diagnostic criteria for Complex PTSD, characterised, among other symptoms, by existential dilemmas, guilt, shame (for having survived events that caused the death of others; their “shameful” maltreatment; as well as their unwanted participation in atrocities, often to protect the self; or their inaction during the traumas), distrust, attachment problems, damage to beliefs about safety and justice, and somatisation. This results in enduring personality changes, changes in fundamental beliefs and assumptions, and the ability to interact with, and attach to others (Ebert & Dyck, 2004).

Ebert and Dyck (2004) argue that torture situations, like other multiple, severe, prolonged interpersonal traumas, are characterised by the individual being caught in an extremely aversive situation which is of human construction rather than as an outcome of natural causes; the harm done to the individual is intentional; and dehumanising means are used to

deconstruct the victim's identity, including good guy/bad guy and impossible choice techniques. These techniques affect the extent to which the individual feels able to anticipate and control situations and their outcomes, and to depend on past life experiences to effectively guide behaviours (previous knowledge and new beliefs are irreconcilable) (Ebert & Dyck, 2004). These factors are associated with high levels of anxiety and distress, as well as learned helplessness, which is associated with shame (Ebert & Dyck, 2004). It is the total subjugation that comes with torture that diminishes self-respect, which evokes shame (Shapiro, 2003).

Features of Complex PTSD according to the American Psychiatric Association include:

Impaired affect regulation, **dissociative symptoms**, somatic complaints, feelings of ineffectiveness, **shame**, despair or hopelessness, feeling permanently damaged, a loss of previously sustained beliefs, hostility, social withdrawal, feeling constantly threatened, impaired relationships with others, and change from the individual's previous personality characteristics. (American Psychiatric Association, as cited in Ebert & Dyck, 2004)

A new category was introduced in the ICD-10 (International Classification of Diseases), called *enduring personality change after catastrophic experience*, which captures the essence of mental death, while the DSM-III-R and DSM-IV have not included criteria which adequately distinguish the symptoms associated with complex trauma from those that characterise individuals who have experienced acute trauma (Complex PTSD is seen as a syndrome based on PTSD, only with a few additional features, rather than two qualitatively different syndromes) (Ebert & Dyck, 2004). An important feature of a chronic post-trauma syndrome includes changed functioning across five dimensions: safety, justice, attachment, identity role, and existential meaning; and the individual has to adapt to compromised comprehensibility, manageability and meaningfulness of actions (Ebert & Dyck, 2004).

#### **4. The Aftermath of Trauma: Shame and PTSD**

PTSD is likely to occur as a result of acute trauma, however it is included here because it is often comorbid with other disorders when a chronic-trauma related diagnosis of Complex PTSD (or DESNOS) has not been made (Ford & Courtois, 2009). It is also included because more recent research acknowledges the co-occurrence of PTSD and shame, which is a

function of a lack of awareness of more appropriate chronic-trauma related diagnoses which acknowledge shame as a central feature of the diagnosed syndrome.

Three assumptions about the self and world are destroyed by traumatic events: that the self is invulnerable; that the world is ordered, understandable and meaningful; and that the self is positive and autonomous (Ebert & Dyck, 2004). When these core assumptions are broken down through trauma, the basis for the individual's sense of control is undermined, and s/he loses the belief in his/her ability to comprehend and predict events. As such, the individual has to adapt to the experience of alienation, which is a correlate of shame, destruction of identity, altered relationships, and existing in an uncontrollable, unpredictable world (Ebert & Dyck, 2004).

Lee, Scragg and Turner (2001) present a clinical model of shame-based and guilt-based PTSD. In this model, there are two pathways to the development of shame-based PTSD – one is through schema congruence, and the other is through schema incongruence. For schema congruence to occur, the shame evoked by the meaning of the traumatic event (feelings of loss of status, social attractiveness and a sense of the self being attacked) must “match” or be congruent with underlying “shame schemas”. These “shame schemas” are determined by previous experience (of family, community, culture, etc.). Thus, the process the individual goes through on the schema congruence path involves dormant beliefs about the self (as devalued) being reactivated by the traumatic event. This reactivation influences the receipt of information as well as thinking processes. Consequently, the individual continually evaluates the traumatic event from the perspective of maladaptive schemas, making the experience of shame pervasive. This pervasive experience of shame results in shame-charged intrusions (flashbacks, intrusive thoughts) which in turn contribute to withdrawal, avoidance and concealment (Lee et al., 2001).

The second pathway proposed by these authors is the schema incongruence pathway. In this pathway, there is a mismatch between pre-existing schemas and the experience and interpretation of the meaning of the traumatic event (Lee et al., 2001). It is argued that when the meaning of the traumatic event does not match a deeper negative evaluation about the self, humiliation frequently occurs (instead of shame) (Lee et al., 2001). Humiliation differs from shame in that when humiliated, the individual feels it is the perpetrator who is bad, not the self, and there is likely to be a great deal of rumination, replay and revenge fantasies (D. Morrison & Gilbert, 2001; Lee et al., 2001). However, the self remains robust and unimpaired (Lee et al., 2001). So, in the schema incongruent pathway, dominant feelings and behaviours

include anger and aggression, whilst in the schema congruent pathway, the pervasive feelings are of shame and defeat, and the resultant behaviour avoidant (of triggers or exposing the defective self) (Lee et al., 2001).

Maladaptive schemas have demonstrated a significant relationship with PTSD symptoms, dissociation and suicide risk in 137 chronically traumatised individuals seeking outpatient psychiatric treatment (Dutra, Callhan, Forman, Mendelsohn, & Herman, 2008). In Dutra et al.'s study, maladaptive schemas are defined as:

Extremely stable and enduring themes, comprised of memories, emotions, cognitions, and bodily sensations, regarding oneself and one's relationship with others, that develop during childhood and are elaborated upon throughout the individual's lifetime, and that are dysfunctional to a significant degree. (Young et al. as cited in Dutra et al., 2008, p. 71)

This study shows that the maladaptive schemas of emotional deprivation, abandonment, mistrust/abuse, social isolation/alienation, defectiveness/shame, failure, subjugation of needs, self-sacrifice, emotional inhibition and unrelenting standards were associated with PTSD symptoms. Furthermore, the strongest correlations were found between the maladaptive schemas of social isolation, alienation, shame and defectiveness and dissociation (Dutra et al., 2008). Finally, a number of maladaptive schemas, including social isolation, alienation, failure, shame and defectiveness, had a relationship with suicidal ideation and the existence of a suicide plan (Dutra et al., 2008).

Shame has been shown in another study to relate to rumination more than to intrusive memories in a sample of 31 patients diagnosed with PTSD referred for cognitive behavioural therapy to specialist services; a finding which has significant implications for the effectiveness of traditional psychotherapeutic interventions (Speckens, Ehlers, Hackmann, Ruths, & Clark, 2007). In this study, intrusive memories were described as predominantly sensory experiences of mostly short duration, while rumination was described as a thought process, which is typically longer in duration, has more pathological consequences, and is more difficult to treat (Speckens et al., 2007).

A recent study on the relationship between shame- and guilt-proneness and PTSD in 107 prisoner of war veterans has indicated that shame-proneness is positively related to PTSD symptom severity, whereas guilt-proneness is unrelated to PTSD symptom severity (Leskela, Dieperink, & Thuras, 2002). These authors question whether shame-proneness is a risk factor

that pre-exists the trauma, or whether it is, in fact, a post-traumatic reaction. Although most research points to shame as a post-traumatic reaction, further longitudinal research needs to be conducted.

Another study with 47 hospitalised US Vietnam war veterans has demonstrated that veterans who were diagnosed with PTSD scored significantly higher on internalised shame, alienation, inferiority and depression (than participants in the comparison groups diagnosed with depression and substance abuse), and found a marked overlap between shame and self-esteem, suggesting that shame might be the emotional experience underlying self-esteem (Wong & Cook, 1992). Shame memories (assessed through autobiographical narratives) have been shown to predict both depression and PTSD, while guilt predicted neither condition in a sample of 140 young people in the Boston area (119 were students) (Robinaugh & McNally, 2010). Centrality of the shameful event to the participant predicted the severity of depression and PTSD symptoms (Robinaugh & McNally, 2010). This study demonstrated that when memories charged with a great deal of negative emotion are remembered as congruent with the self (viewed from a field perspective), central to one's life story (high centrality), and related to global appraisals of the self (high levels of shame and low levels of guilt), these memories are linked to greater distress (Robinaugh & McNally, 2010).

## **5. The Aftermath of Trauma: Shame and Dissociation**

One of the most pathological aspects of complex post-traumatic shame is its relationship with dissociation, which is central to this study. Dissociation is understood as involving four distinct, but inter-related phenomena: the sensory and emotional fragmentation of experience; depersonalisation and derealisation at the moment of the trauma; ongoing depersonalisation in everyday life; and containing the traumatic memories within distinct ego-states (Van der Kolk & Fisler, 1995).

A great number of studies have demonstrated an association between trauma and dissociation (Van der Kolk et al., 1996). However, there are far fewer texts which take into account the central role of shame in the aetiology of dissociation, particularly DID. PTSD and dissociation are strongly associated, and a study conducted in the 1990's showed that PTSD was not only associated with dissociation, but also with affect regulation, somatisation and permanent personality changes, suggesting the inadequacy of this diagnosis as it stands for

survivors of chronic trauma (Van der Kolk, 1994). Dissociation is often selected as a defense because it assists in avoiding the profound and debilitating negative self-evaluation that accompanies trauma-related shame (Talbot, Talbot, & Tu, 2004).

Findings from a recent study show that greater shame-proneness (a propensity to experience shame across a range of situations) was related to elevated levels of dissociation, particularly in women who had experienced early sexual trauma ( $n = 99$ ; the sample included hospitalised women who had, and who had not been sexually abused) (Talbot et al., 2004). In another study, lifetime shame (in a two-wave study, wave 1:  $n = 81$ ; study 2:  $n = 21$ ) and dissociation have been shown to cause disconnection in interpersonal relationships among chronically traumatised individuals, with dissociation having the most disruptive impact (Dorahy, 2010). Another study including the completed self-report measures of 103 Australian students found that proneness to shame contributed significantly to dissociative tendencies, although guilt and age also played significant roles, however, the role of trauma was not taken into account (Irwin, 1998). This is despite the fact that dissociation has been theorised as a key feature of the so-called trauma induced “shame syndrome”, along with severe and consistent depersonalisation, eating disturbances, depression and thought disturbances such as concretisation and over-generalisation (Wurmser, 1995).

According to the experts in the field, on the basis of their research and clinical experience, in cases of extreme dissociation, as occurs when an individual has been exposed to severe and prolonged sexual abuse (usually of a ritual nature) in early childhood, DID may develop (M. Lewis, 1992; Putnam, 1989; Ross, 1997). Severe and prolonged trauma is likely to lead to the splitting of self (M. Lewis, 1992). M. Lewis (1992) argues that sexual abuse produces shame, which can become so powerful and debilitating that it needs to be transformed and/or avoided. It is during this shame-avoidance process that dissociation occurs (M. Lewis, 1992). It is only under conditions of both severely traumatic and prolonged shame that such an extreme form of dissociation, and an accompanying fragmentation of self, occurs (M. Lewis, 1992; Nathanson, 1992; Putnam, 1989).

## 6. The Aftermath of Trauma: Shame and BPD

It is important to emphasise that PTSD may be accompanied by other psychopathologies, which increases symptom severity. Comorbid PTSD particularly aggravates the symptoms, course of illness and social functioning of individuals diagnosed with BPD (Rusch et al., 2007). Interestingly, results of a recent study indicate that self-reported guilt-proneness and general psychopathology, but not shame-proneness or trait anxiety, were significantly higher in women with BPD and PTSD than in women with BPD alone. Contrary to expectations, self-reported shame, anxiety and anger were not significantly associated with comorbid PTSD (Rusch et al., 2007).

BPD, however, has been associated with shame in a number of other studies (Brown, Linehan, Comtois, Murray, & Chapman, 2009; Chan, Hess, Whelton, & Yong, 2005). It is possible that this association is mediated by the experience of trauma. On the basis of his clinically relevant theoretical work, Kaufman (1993) argues that borderline pathology only develops in individuals who have experienced trauma-related damage to their self-esteem, and narcissistic injury. In addition, he suggests that borderline tendencies are associated with an amplified, or exaggerated, need for fusion or merging, borne out of the trauma of inadequate identification in infancy. Others – also on the basis of clinical experience and theoretical principles – argue that shame is caused by the trauma of fusion with a shame-filled primary caregiver, which leads to devastating polarised fears that being loved will lead to engulfment and obliteration, and being unloved (because of being shameful and “bad”) will inevitably lead to abandonment (Fisher, 1985). It is interesting to note that some scholars argue that the diagnosis of BPD should be amended to include the crucial contribution of past trauma and shame, emphasising the diagnosis’ lack of stability, and its similarity to Complex PTSD (Crowe, 2004).

In Chan et al.’s (2005) study, 36 women with BPD were compared with 49 university women to investigate possible reasons for differences in the BPD women’s ability to function effectively. Participants with BPD had experienced significantly higher levels of trauma, internalised shame and psychiatric symptoms than those included in the non-clinical comparison group. It was demonstrated that the experience of trauma and internalised shame

were positively associated; the greater the level of trauma, the greater the experience of internalised shame (Chan et al., 2005).

Higher levels of non-verbal shame (lowering head and avoiding eye contact) have additionally been found to predict a higher likelihood of future self-inflicted injuries, as well as shorter time to the next incidence of self-inflicted injury in women with BPD who were enrolled in a clinical trial (N = 77) (Brown et al., 2009). Furthermore, in this study, self-reported shame and assessor ratings of shame were related to future self-inflicted injuries, although not after controlling for other negative emotions, such as fear (Brown et al., 2009).

## **7. The Aftermath of Trauma: Shame, Depression and Anxiety**

Both depression and anxiety are common responses to the experience of trauma, are often comorbid with PTSD, and have repeatedly been associated with shame reactions. Depression in particular has been associated with shame from the earliest theoretical and clinical writings on shame, and is associated with blaming the whole self or character for perceived failings or deficiencies (H. B. Lewis, 1986). In particular, depression often emerges as a product of humiliated fury being “turned back upon the self” (H. B. Lewis, 1987b). H. B. Lewis (1986, p. 334) and Mollon (2002) maintain that depressives tend to self-denigrate, however, this self-denigration is unconsciously meant for a significant other whose love s/he has lost (hostility towards the self is directed outwards, then through shame re-directed inwards), thus locating depression in the “lost social tie”. As we have seen, many scholars believe that shame is a key social emotion, designed to alert us to threats to significant social bonds. The destruction of these bonds seems to be integral to depression (H. B. Lewis, 1986). Rejection leads to shame, which in turn is associated with rage, self-hatred, falling self-esteem and further shame – a relentless spiral (Mollon, 2002). These individuals are aware that their deteriorating mental state makes them socially unattractive which leads to additional shame (Mollon, 2002). The deliberate self-destructiveness manifested by some depressive clients is an attempt at preventing feelings of helplessness and shame in response to rejection (Mollon, 2002).

Based on her clinical experience, H. B. Lewis (1987b) suggests that women are more likely to experience depression (a view supported by epidemiological evidence – see for example Tomlinson, Swartz, Kruger, & Gureje, 2007), and it has been argued that this is because of their greater sociability and lesser aggression, and their greater tendency to feel shame. This is

reversed in pre-pubertal children – boys are more likely to experience depression until they reach puberty (H. B. Lewis, 1987b). Learned helplessness, low self-esteem, as well as field dependence, all of which are well-known associates of shame, have been associated with depression repeatedly (H. B. Lewis, 1987b). In addition, the tendency to make internal, stable, global attributions for failure, as is the case with shame, has a strong relationship to depression (H. B. Lewis, 1987b).

In a recent two-wave longitudinal study including 221 non-referred adolescents, shame, guilt, behavioural blame and characterological blame were associated with making internal attributions about negative events (Tilghman-Osborne et al., 2008). Characterological blame, shame-proneness and state shame were more strongly related to depressive cognitions (attributing negative events to stable and global causes, inferring that negative events will have serious negative consequences and a tendency to perceive oneself as fundamentally flawed) and symptoms than were behavioural blame and guilt. Longitudinal analyses demonstrated that depressive symptoms predicted later shame-proneness, state shame and characterological blame. In addition, these authors' results support the convergence of shame and characterological blame into a single underlying construct. This suggests that the cognitions associated with shame are comparable with those that characterise characterological blame. Interestingly, the loading of the two different measures of guilt in this study onto separate factors suggests that there are two types of guilt, one positive and restorative, and the other damaging and maladaptive (Tilghman-Osborne et al., 2008).

The distinction between characterological and behavioural self-blame has been previously made in relation to shame (Andrews & Brewin, 1990). The former is associated with shame, and considered the most pathological because it is associated with feelings of responsibility, personal deservedness and attributions to a non-modifiable source (one's character) in situations where abuse has taken place. In a study conducted by Andrews and Brewin (1990), women (n = 407) who were experiencing marital violence, and who had also experienced either physical or sexual abuse in childhood, were most likely to report characterological self-blame, and were more likely than other woman survivors of domestic violence to suffer from persistent depression. As previously noted, characterological self-blame is also associated with learned helplessness (a well-established correlate of depression), which has been identified as closely associated with shame, although whether it is a precursor or an integral part of shame is yet to be established. Shame, characterological self-blame, and learned helplessness often co-occur with feelings of powerlessness, betrayal, and

subordination/submissiveness or inferiority in survivors of child sexual and physical abuse. There is evidence that defeat and subordinate status are associated with particular biochemical changes that evoke depressive states. Thus, experiences of either physical or sexual abuse which are accompanied by subordinate status may be associated with depression through feelings of submission and shame. It is important to note that the negative self-perceptions that accompany depression may be as a result of the guilt and hatred experienced by the perpetrator, which is introjected by the innocent child (Andrews & Brewin, 1990).

Andrews (1998) has made assertions based on reviewed research and theoretical work on symptoms of depression in those who had experienced childhood physical and sexual abuse and those who had not. Reviewed findings indicate that the women who had experienced childhood abuse differed on two dimensions: feelings of pathological guilt, and suicidal plans and actions (with guilt more strongly related to physical abuse) (Andrews, 1998). Pathological guilt involves high levels of self-blame, and the anticipation and deservedness of retribution and punishment from others (Andrews, 1998), distinguishing it from shame, which involves the anticipation of others' rejection, scorn and abandonment (Andrews, 1998). However, overall, Andrews (1998) concludes that abusive experiences from early childhood contribute to a tendency to feel both shame and pathological guilt in adulthood, and that shame may play a mediating role in the association between early abuse and depression in particular.

Although there are a multitude of studies on the relationships between shame and anxiety, there are very few studies which focus specifically on the inter-relationships between trauma, shame and anxiety. The findings of one of the studies that could be found indicated not only that those veterans with PTSD were more likely to have social phobias than those without PTSD, but that the post-trauma environment (e.g. an adverse home environment) and war-related shame were more important in determining social anxiety disorder than pre-military anxiety or the seriousness or severity of exposure to combat in 41 Vietnam war veterans (Orsillo, Heimberg, Juster, & Garrett, 1996). This suggests that shame may play a key role in the relationship between PTSD and social anxiety disorder (Collimore, Carleton, Hofmann, & Asmundson, 2010).

Although no further empirical studies could be found linking trauma, shame and anxiety, theoretical (psychoanalytic) work done by Wurmser (1995) suggests that two of the three types of shame identified (shame anxiety and shame as a preventive attitude) are linked to trauma. In fact, he argues that these types of shame are always determined by the anticipation or experience of a traumatic situation. His definition of "trauma" in this instance is the

helplessness of being unloved; the sense of being unlovable (expressed through rejection and abandonment). In this theoretical work, the typical sequence to shame is through exposure of the (shameful) self, contempt from others, the revealing of essential unlovability, and corrective efforts aimed at ameliorating the situation. This trauma unfolds in the structural components of shame, consisting of the self's failure to meet expectations (the ego ideal), the self's judgment of the self in relation to the ego ideal, comparison of expectations for the self against judged aspects (self-evaluation), criticism (originally from a significant other, but later introjected, becoming the self-critical part of the superego), and punishment from an external censor (in the form of contempt) (Wurmser, 1995).

Despite the lack of empirical research, theoretical and clinical work suggests that shame and anxiety and particular types of traumas are related in important ways. Fear of shame is a powerful motivator for anxiety; individuals with generalised anxiety disorder tend to dread finding themselves in situations where they may be depreciated, ridiculed, rejected, or feel out of control, and situations which are conducive to shame (Emery, 1985). In Gilbert's (1998, p. 6) words, social anxiety in particular arises from fear of exposure and "the prospect or presence of interpersonal evaluation in real or imagined social settings". Social anxiety, shame and depression have previously been linked to feeling inferior and to submissive behaviour (Gilbert, 2000). Interestingly, a recent study also demonstrated that individuals ( $n = 79$  with first episode psychosis) with high social anxiety scores were more likely to feel shame attached to a diagnosis of psychosis (feeling that the diagnosis made them socially marginalised, stigmatised) than a low social anxiety comparison group (Birchwood et al., 2006). Beck (1985) theorises that much of the anxiety around shame-filled situations is around the wish to avoid the trauma of being negatively evaluated, potentially rejected, and having one's public image depreciated, or occupying a position of low social status.

## **8. The Aftermath of Trauma: Shame, the Body and Eating Disorders**

I include a discussion on eating disorders in this chapter because of the overlap between child abuse and its association with eating disorders, and chronic trauma later in life (Dunkle, Jewkes, Brown, Yoshihama et al., 2004), as well as the complex comorbidity associated with trauma-related eating disorders.

Based on their clinical work, some scholars have theorised that the majority of Western women experience a difference between their actual self and their internalised ideal body weight (Silberstein, Striegel-Moore, & Rodlin, 1987). It is this discrepancy that leads to shame (Fodor, 1996; Silberstein et al., 1987). This kind of shame affects Western women disproportionately because current societal standards equate thinness with feminine beauty, and because of the constant traumatising scrutiny of women's bodies by both men and women (Silberstein et al., 1987). Women measure themselves against this societal standard, and inevitably they fail to measure up to this ideal, leading to the pervasive experience of shame (Silberstein et al., 1987). Fodor (1996) argues that self-objectification and body shame is common in Western women as a result of introjected societal messages. A vast number of women are chronic dieters, attempting to counter this shame, but any failure to implement the diet as directed, or to lose weight, may exacerbate feelings of inadequacy and shame (Silberstein et al., 1987). Furthermore, the effect of shortcomings in one area on the individual's self-esteem is determined by the importance of that area in the person's self-definition (Silberstein et al., 1987). Given the emphasis by society on attractiveness, a large number of women view weight as important, and consequently it is likely that there is a positive relationship between this construct and poor self-esteem (Silberstein et al., 1987). However, it is not only shaming cultural expectations that create poor body images and eating disorders, but also the experience of (often) intra-familial trauma.

Trauma increases the likelihood of developing an eating disorder (Corstorphine, Waller, Lawson, & Ganis, 2007). Child sexual abuse in particular, but also physical abuse and neglect, have all been implicated in the aetiology of eating disorders (Brewerton, 2007; Corstorphine et al., 2007; Kong & Bernstein, 2009; Meltzer-Brody et al., 2011; Sansone & Sansone, 2007; Tobin, 1995; Vanderlinden, Vandereycken, Van Dyck, & Vertommen, 1993). Bulimia nervosa has been associated with more extensive exposure to trauma, more severe depression and sexual and physical abuse than women with anorexia nervosa (Meltzer Brody et al., 2011). In one study, depression fully mediated the association between some forms of childhood trauma and eating psychopathology (Kong & Bernstein, 2009). There is also complex comorbidity to take into account: for example, there appears to be inter-relationships between trauma, BPD and eating disorders (Sansone & Sansone, 2007), as well as between eating disorders and PTSD (Brewerton, 2007), impulsive disorders (Corstorphine et al., 2007), and dissociative disorders (Tobin, 1995; Vanderlinden et al., 1993). Those with eating

disorders are also more likely to have suffered controlling mothers who devalued their fathers (Mollon, 2002).

Central to eating disorders is the issue of control. Survivors of trauma have typically suffered a great deal of loss of control at the hands of the perpetrator(s) and often experience persistent feelings of helplessness. As a result, some survivors seek to control at least one basic and fundamental aspect of their lives, their food intake, their basic means of survival, as a means of countering that helplessness and the feelings of loss of control associated with the traumatic experience(s) (and the terror that accompanies it/them). It is possible that such attempts at control may be unconscious attempts to “fix” or undo the trauma of the past, when the survivor had no control. Depriving the self of food, a basic requirement for living, dramatically and explicitly expresses self-hatred. In later chapters, I will discuss how feeling “bad” about the self is a means of reclaiming control from the perpetrator(s) or bad object(s) (Fairbairn, 1943; Ferenczi as cited in Orange, 2011).

In cases of sexual abuse, the perpetrator’s relationship to the survivor may be an important factor in determining psychological functioning in the aftermath of the trauma(s). A nonclinical sample of female undergraduates ( $n = 214$ ) completed standardised measures of experiences of sexual abuse, internalised shame, and bulimic psychopathology to test this assumption (Miller & Waller, 2002). The results of Miller and Waller’s (2002) study show that shame accounts entirely for the association between intra-familial sexual abuse and bulimic attitudes, whereas it only partially accounts for the link between sexual abuse from any adult and bulimic attitudes.

Based on his clinical experience, Kaufman (1993) argues that shame about eating, which leads to eating in secret, constitutes a displacement of shame away from the self. Similar to addictions, the eating patterns associated with bulimia in particular are a substitute for shame-bound interpersonal needs, specifically, the trauma of having emotional needs unmet, a means of “filling up” the internal emptiness and placating intense longing (Kaufman, 1992). Binging may also serve the function of anaesthetising feelings, or for some, may be an aggressive outlet, and for others, an expression of self-hatred (Silberstein et al., 1987). Similarly, purging may constitute an expression of anger or a release of tension in general (Silberstein et al., 1987). Purging may either be experienced as reinforcing (leading to feelings of thinness and control) or punishing (for the transgression of a binge) (Silberstein et al., 1987). Kaufman (1992) explains the purge part of the binge-purge cycle as a product of affect magnification,

which accelerates shame, bringing it to peak intensity before the purging, after which it is released – a process that usually stimulates feelings of relief and cleansing.

As can be seen, interpersonal trauma and shame play an important part in the aetiology of binge eating. Sanftner and Crowther (1998) conducted a study including a sample of 78 female university students, 37 who binge and 41 who do not binge, and demonstrated that women who binge eat experience higher levels of both state shame and guilt, greater fluctuations in social and performance self-esteem, and lower positive affect (defined as pleasurable engagement and high energy) than controls. Contrary to expectations, state self-esteem and positive affect increased significantly before bingeing episodes, but could be explained when considering the comforting, self-nurturant function of bingeing (Sanftner & Crowther, 1998).

Although the following two studies do not address trauma, they demonstrate that shame is associated with body image and that it has also been associated with particular psychopathologies. A recent study found connections between trait self-objectification and maladaptive eating attitudes and depressive symptoms (Choma, Shove, Busseri, Sadava, & Hosker, 2009). Undergraduate women from southern Ontario, Canada (Sample 1,  $n = 104$ ; Sample 2,  $n = 314$ ) completed measures of depression, disordered eating attitudes, subjective well-being, and body-image coping (Choma et al., 2009). Trait self-objectification was associated with lower subjective well-being, suggesting that this trait extends beyond depressive symptoms and body-related distress to women's global life evaluations, including her emotional reactions to, and satisfaction with her life (Choma et al., 2009). In addition, body shame significantly predicted depression, disordered eating attitudes and subjective well-being (Choma et al., 2009). Furthermore, the results of this study support a mediational model, where trait self-objectification predicted greater body shame, which was related to an increase in the use of appearance fixing (changing physical appearance) and avoidance coping (avoiding body image-related information) rather than using a more adaptive rational acceptance strategy (Choma et al., 2009). In particular, body shame and appearance fixing coping fully mediated the association between trait self-objectification and disordered eating attitudes, while appearance fixing coping partially mediated the association between body shame and disordered eating attitudes (Choma et al., 2009). In contrast, body shame and avoidance coping completely mediated the association between trait self-objectification and depression, while avoidance coping partially mediated the association between body shame and depression (Choma et al., 2009). The authors argue that appearance fixing involves active

attempts at controlling and changing one's appearance, including for example extreme exercise and plastic surgery, to combat distressing feelings about the body, all of which is characteristic of disordered eating attitudes. Some of the behaviours characteristic of avoidance, such as withdrawal, is also characteristic of depression, and represents an escape from the cause of distress or trauma, rather than actively searching for a resolution to the disturbing feelings (Choma et al., 2009). In Silberstein et al.'s (1987) clinically relevant theorising, they emphasise that other research also points to the relationship between eating disorders and depression – specifically, it is argued that the high levels of shame experienced by individuals with eating disorders contribute to depressive symptoms.

Self-objectification has been associated with poor outcomes in another study (Tiggemann & Boundy, 2008). Participants were 96 female undergraduate students who completed questionnaire measures and cognitive tasks in a 2 (a subtle objectifying environment versus a standard environment)  $\times$  2 (an appearance compliment versus no comment)  $\times$  2 (high versus low trait self-objectification) design. Results indicate that for women scoring high on trait self-objectification, an objectifying physical environment (including mirrors, scales and fashion magazines) increased state self-objectification, and a compliment on appearance (focusing attention on the body) significantly enhanced body shame (Tiggemann & Boundy, 2008).

Patterns of parental care and protection have demonstrated direct and indirect relationships with bulimic attitudes through shame-proneness and internalised shame (defined as perceptions about the self resulting from prolonged exposure to shameful situations) (Murray, Waller, & Legg, 2000). The participants in this study were 139 nonclinical undergraduate women (Murray et al., 2000). Each completed measures of perceived family function, shame-proneness, internalised shame, and bulimic psychopathology. Specifically, results indicate that perceptions of low paternal protection led to internalised shame, while perceiving one's father as overprotective led to greater internalised shame if the participant was already shame-prone. In the family care and protection-shame-bulimia model presented in this study, shame-proneness acts as a moderator, while internalised shame mediates the association between paternal overprotection and bulimic attitudes (Murray et al., 2000). The authors argue that the mechanism which activates internalised shame is the belief that one is either someone who needs to be firmly controlled, or someone not worthy of paternal attention.

Bodily shame has been demonstrated as having an association with childhood abuse and also has a relationship to chronic or recurrent depression in adulthood (Andrews, 1995).

Furthermore, bodily shame has also been shown to mediate the relationship between early abuse and depression in adulthood (Andrews, 1995). These findings are based on a study conducted by Andrews (1995) on the role of bodily shame as a mediator between sexual or physical abuse and depression in a community sample of 101 women who had been followed for eight years. Findings from another study reported in Andrews (1998) indicate that both bodily shame and characterological shame are related to early abusive experiences.

Finally, in a recent study on childhood experiences of being bullied and teased and eating disorders, 92 eating-disordered women completed measures of social anxiety, shame, eating pathology and childhood experiences of being bullied and teased about their appearance (by peers and family) (Sweetingham & Waller, 2008). Being teased by peers about appearance, and being verbally bullied by family members demonstrated a negative association with body satisfaction in adulthood (Sweetingham & Waller, 2008). In addition, results indicate that social anxiety and bodily, characterological and behavioural shame were related to body satisfaction. However, in this study, a composite of bodily, characterological and behavioural shame, and not social anxiety, was a perfect mediator between teasing about appearance by peers and body dissatisfaction (Sweetingham & Waller, 2008).

### **9. The Aftermath of Trauma: Excluded Syndromes and Symptoms, Including Trauma-related Shame and Narcissism, Externalising Disorders, Psychosis and Substance Abuse**

There are very few empirical studies on the relationship between trauma, shame and narcissism. However, there is a vast amount of theoretical work on the association between shame and narcissism, which bears little relevance to the focus of my research. The interested reader can refer to the largely theoretical work of Besser & Priel (2009); Broucek (1991); Kaufman (1993); Kinston (1987); H. B. Lewis (1987c); M. Lewis (1992); A. P. Morrison, 1989; Schimmenti, 2012; Thomaes, Bushman, Stegge, & Olthof, 2008; and Wurmser (1987).

I have not included any literature on externalising disorders (e.g. Conduct Disorder) as they typically affect children and adolescents, and my participants were adults. I have also not reviewed any material on trauma-related psychosis other than the theory I discussed earlier by N. K. Morrison in relation to parenting and attachment (schizophrenia). This is due to the paucity of literature on chronic trauma, shame and psychotic disorders which suggests that this and other psychopathologies are a much rarer occurrence than the post-traumatic

responses I have reviewed above, and so do not warrant further consideration. This is, however, with the knowledge that trauma-related dissociative disorders are frequently misdiagnosed as schizophrenia, and that schizophrenia, (and on occasion, schizotypal and antisocial personality disorders) are often comorbidly associated with PTSD. Finally, I consider substance abuse a secondary symptom of the syndromes discussed in this chapter – a means to numb the pain associated with trauma-related syndromes – and thus I do not dedicate a separate section to this phenomenon.

### **Summary of Key Points**

- Emotional abuse has been isolated repeatedly as an important predictor of shame-related pathological outcomes, especially PTSD, anxiety and depression (Cloitre et al., 2009; Street & Arias, 2001; Webb et al., 2007).
- Child sexual abuse has been implicated repeatedly in a range of shame-related pathological outcomes through its association with negative cognitive evaluation of the abuse event(s) and a pessimistic attributional style (Feiring et al., 1996, 2002).
- The trauma of rejection by the primary attachment figure, as well as disorganised and insecure attachment, and actual or perceived sibling favouritism have been identified as risk factors for a shame-prone emotional style (Mills, 2005). Certain types of family environments also contribute to dispositional shame, like for example parental over-control or coercive interactional styles (Mills, 2005).
- Individuals rarely experience only one traumatic event. One of the most common outcomes of repeated exposure is Complex PTSD (Kaminer & Eagle, 2010). This disorder involves multiple affective and interpersonal domains in functioning, including among other symptoms, impaired self-regulatory capacities, anger and aggression, dissociative symptoms and avoidant behaviours (Cloitre et al., 2009; Kaminer & Eagle, 2010)
- PTSD is generally understood as an anxiety disorder in which fear is the most dominant emotion (Lee et al., 2001). Similarly, anxiety is a central emotion in shame (Gilbert, 1998). Shame and guilt play prominent roles in the development and maintenance of the disorder (Lee et al., 2001). When a person has experienced chronic trauma s/he may be diagnosed with PTSD and one or more other

psychopathologies because of the complex comorbid picture created by chronic trauma.

- BPD is often comorbid with PTSD, and has been associated with shame in a number of studies (Brown et al., 2009; Chan et al., 2005). Some research shows that it is likely that this association is mediated by the experience of trauma. The pattern of research work suggests that there are strong relationships between various forms of shame, trauma and borderline psychopathology.
- Both depression and anxiety are common responses to the experience of trauma, often accompany a diagnosis of PTSD, and have repeatedly been associated with shame reactions. Learned helplessness, the tendency to make internal, stable global attributions for failure, low self-esteem, as well as field dependence, are all well-known correlates of shame, and are associated with depression (H. B. Lewis, 1987b). Very few studies focus specifically on the inter-relationships between trauma, shame and anxiety.
- One of the most pathological aspects of post-traumatic shame is its relationship with dissociation (Talbot et al., 2004). Severe and prolonged trauma is likely to lead to the splitting of self (M. Lewis, 1992). M. Lewis (1992) argues that sexual abuse produces shame, which can become so powerful and debilitating that it needs to be transformed and/or avoided. It is during this shame-avoidance process that dissociation occurs (M. Lewis, 1992).
- There are very few empirical studies on the relationship between trauma, shame and narcissism. However, there is a vast amount of theoretical work explaining this association.
- Shame has been implicated in the aetiology of a range of eating disorders, including binge eating and bulimia (Sanftner & Crowther, 1998). Child abuse, particularly sexual abuse, plays an important role in the development of these disorders (Miller & Waller, 2002). Regaining control of a central part of livelihood (countering the helplessness associated with trauma) is an important motivator for eating disorders.
- Externalising disorders, substance misuse and psychotic disorders are not discussed in the review for a range of reasons specific to each syndrome.

In the past five chapters, we have looked at violence and trauma in South Africa, theories on shame, the differences between shame and other self-conscious or related emotions, shame

and culture, and the associations between shame, trauma and selected psychopathologies. In the chapter that follows, the methodology of the study presented in this thesis is described.

## **CHAPTER 6**

### **Method**

#### **Overall Aim**

To explore experiences of chronic trauma, shame, and specific post-traumatic reactions in South African survivors of IPV.

#### **Objectives**

- 1) To conduct a categorical content analysis of women's experiences of chronic trauma, shame and related constructs (post-traumatic reactions and coping mechanisms) where they emerge as prominent themes in the data.
- 2) To examine the theme of the split self from a phenomenological perspective, and explore how it manifests on individual, organisational and cultural levels. I analyse the split self at an organisational level by using an informal form of narrative analysis from a social constructivist point of view.
- 3) To conduct a formal linguistic (categorical form) analysis of both long and complex and short, compressed trauma narratives with the aim of exploring whether psychic fragmentation manifests at linguistic level.

My theoretical positioning, and how I plan to achieve my aims and objectives through employing the social constructivist strand of narrative analysis, and how it complements a phenomenological interpretation of the data, is discussed under the heading "Theoretical Positioning" below.

## Research Design

### Procedure and Research Participants

The participants were drawn from the Saartjie Baartman Centre for Women and Children in Manenberg, Cape Town. The Centre is a 24-hour emergency shelter for women and children who are survivors of IPV. Services include short and medium term residential care, childcare services, counselling, mental health support, legal and economic empowerment services, research into gender-based violence, job skills training, and legal advice. The ethos of the Centre is important in the context of my study. The vision and the mission of the Centre is advocacy and human rights orientated and promotes a strong message of personal empowerment and agency. In some of the feedback given by women who have been resident at the shelter shown in the Centre's website, empowerment and new-found strength were emphasised, e.g. "I really found myself and became strong. I feel I can fight the world", and "During the course of my stay you motivated me to better myself by sending me on valuable courses, which has empower[ed] me as an individual. You gave me new vision and made me realise that I can make my own dreams come true". As will be demonstrated in the results and discussion chapters, this discourse or ethos had important implications for the construction of self and identity in my participants.

The director of the Centre was approached during the beginning of 2011, and permission to conduct the interviews was granted during this initial meeting, after I had described my research proposal. It was agreed that I would use a convenience sampling strategy, and invite all women resident at the Saartjie Baartman Centre to participate in my study. Field work began in August 2011. The first two months of field work involved doing voluntary work twice a week at the Centre to build rapport with the resident women (which I will elaborate on in chapter 7). I organised with the manager of the shelter to meet with all the women in the shelter on four occasions to explain my research and request their participation in my study. Four recruitment sessions were held, each lasting no more than fifteen minutes. All resident women attended the recruitment sessions. During these sessions, the women were informed about the nature and purposes of the research: that I was conducting a study about experiences of trauma, how people felt about it, how people felt about themselves, and how they coped. I

asked whether any women were interested, and in three out of four sessions, all women agreed to participate. I provided all information both in Afrikaans and English. The women who did not agree to participate did not give reasons for their refusal.

Inclusion criteria included being over 18 years of age (since the emotional and behavioural manifestations of trauma differ for adults and children/adolescents), and exposure to more than one violent event, including emotional, physical and sexual trauma. Interviews commenced in October 2011, and were completed in December 2011. Twenty interviews were conducted; however, one was lost due to poor recording quality, leaving a total of 19 completed interviews. Twelve participants were Coloured, while seven were Black. The youngest participant was 22 years old, and the oldest participant was 54 years old. The participants included eight Afrikaans participants, while the rest were English-speaking. The participants did not speak any other languages (see table 1 below).

Table 6.1  
*Demographics*

<i>Demographics</i>				
<b>Ethnicity</b>		<b>Language</b>		<b>Age range</b>
<i>Black</i>	<i>Coloured</i>	<i>Afrikaans</i>	<i>English</i>	
7	12	8	11	22-54

There was a wide range in the length of interviews. The shortest interview was 25 minutes long, while the longest interview was an hour-and-a-half. Most lasted approximately an hour. The longest interview's word count was 11658 words, while the shortest interview had a word count of 2257. Most interviews had a word count of between 5830 and 11443. Although follow-up interviews were offered to all interviewees for debriefing purposes, and I offered to speak to their counsellors if they wished, only one interviewee requested that I speak to her counsellor. Although some women expressed a need for a second interview, none of the women followed up with me. I believe it would have been re-traumatising for some of the women to engage in a second interview. I understood their reluctance as a product of the material which emerged in the interviews which was both traumatic and shameful. As I discuss later at length, women were reluctant to engage with me after the interview, but not after encountering me in a casual and less intimate context during rapport-building, which is significant. I believe this is due to the surprising degree of disclosure of extremely personal,

highly shaming material during the interviews. I strongly believe that it is the shame associated with the urgency to disclose intimate, traumatic material that caused a shame-filled avoidance of me, which resulted in no follow-up interviews. It cannot be co-incidental that not one of the interviewees requested a follow-up interview, and that each time I encountered a participant post-interview, she displayed typical bodily indicators of shame, particularly gaze avoidance and turning the head to face downwards. This has implications for controversial issues such as re-traumatisation of the interviewee and the co-construction of pain, which I will discuss in the final chapter.

### **Data Collection Instrument**

A semi-structured interview schedule consisting of eighteen questions was developed, providing a flexible guide for questioning. The questions focused on traumatic experiences, post-traumatic reactions and change, shame, and support and coping mechanisms, and is included as Appendix A.

I chose semi-structured interviews as my data analytic method because I was interested in capturing participants' subjective experiences and constructions of themselves, consistent with a phenomenological approach. I felt that a one-on-one approach to collecting data of such a personal, sensitive nature would be less threatening for participants than focus groups for instance, and I believed I would gain richer data if the participant felt safe. Narrative analysis is suited to exploring individuals' experiences phenomenologically – to examine how the subjective self manifests itself in language.

The interview schedule consisted mostly of open-ended questions, which is suited to the chosen analytic approach, narrative analysis. Compared to closed-ended questions, open-ended questions encourage greater disclosure by participants, and are more likely to facilitate disclosure in narrative form. However, a number of closed-ended questions eliciting information about emotional and psychological phenomena were included in the second half of the interview. In designing my interview schedule in this way I followed the suggestions of a study which recommended starting the interview with open-ended questions that allow the interviewee to relate her experiences freely, becoming more structured towards the end of the interview (Carlson, 1997).

The interview schedule was translated from English to Afrikaans by a senior member of staff at the Afrikaans Department, University of Cape Town. I am bilingual, so no interpreter was necessary during the interview process. The design of the interview schedule was informed by recent research (Spangaro, Zwi, & Poulos, 2011). Their study shows that women who have been exposed to IPV disclose abuse only when they feel safe, when asked by a trusted or trustworthy person (a perception I attempted through rapport building before I conducted the interviews, which involved doing volunteer work at the Centre), when they are directly asked, and when they are given a choice as to the level and extent of their disclosure. The safety dimension was divided into safety from the abuser, which the Centre could ensure, safety from shame (I actively tried to assume a non-judgmental and accepting attitude during the interviews), and safety from institutional control (like for example statutory child protection agencies) (Spangaro et al., 2011). It is possible that women may have perceived me as affiliated with management, which could have led to withholding certain information, for example around child abuse or substance misuse. I attempted to ask women questions as directly and as unambiguously as possible and I also told women at the outset only to share what they felt comfortable sharing. Because shame is so often an unconscious and unarticulated response to trauma, I also looked for the emotional and behavioural indicators of shame, as well as bypassed shame, emerging during the interviews.

The interviews were transcribed by an experienced bilingual transcriber recommended by my supervisor, and extensive notes were taken after each interview to record important or noteworthy aspects of the interview.

### **Using a Narrative Approach: Theory and Analysis**

The stories we tell about our lives are not necessarily those lives as they were lived, but these stories become our experience of those lives (Frank, 1995, p. 22).

It struck him that when one is overburdened and dreams of simplifying one's life...the law one longs for is nothing other than that of narrative order, the simple order that enables one to say: 'First this happened, and then that happened...'. Lucky the man who can say 'when', 'before' and 'after'! Terrible things may have happened to him, he may have writhed in pain, but as soon as he can tell what happened in

chronological order he feels as contented as if the sun were warming his belly (Etlin as cited in Ochs & Capps, 2001, p. 45).

Narrative analysis will be used to analyse the data. Narratives are distinguished from other textual modes such as description or argumentation; the essence of narrative is that something happens, that something changes as time progresses (Kleres, 2010). There is no single definition of narrative research, and there is no single way to do narrative research (Riessman, 2008). Elliott (2005) argues that all definitions of narrative research illustrate one or more of the following: An interest in people's lived experience and appreciation of the temporal nature of that experience; a desire to empower research participants and allow them to contribute to determining what are the most salient themes in an area of research; an interest in process and change over time; an interest in the self and representations of the self; and an awareness that the researcher him- or herself is also a narrator.

For the purposes of this study, narratives can be defined as deeply situated and contextual accounts of events that happen over time (temporality; Bruner, 1991), which involve specific events, episodes or experiences as their reference point (emplotment<sup>17</sup> and particularity; Bruner, 1991; Squire, 2005). As such, narratives can be described as "talk, organized around consequential events" (Riessman, 1993, p. 3). In many autobiographical narratives, the plot is organised around a turning point at which the protagonist experiences a transformation of identity (Ochs & Capps, 2001). Narrators may hyperpersonalise a cultural template, fully identifying with the collective, or s/he may hypopersonalise a cultural template, feeling uncomfortable in identifying with a social group or its worldview (Ochs & Capps, 2001). Many of my participants demonstrated a heightened sense of identification with the community of IPV survivors.

Narratives contain some or all of the following discourse components: description, chronology, evaluation and explanation (Ochs & Capps, 2001). Narrative analysis has to do with how narrators interpret their experience – in personal narratives "it is precisely because of their subjectivity – their rootedness in time, place and personal experience, in their perspective-ridden character – that we value them" (Personal Narratives Group in Riessman, 1993, p. 5). Narrative analysis focuses on how people construct their self-accounts through drawing on a range of societal genres (Burck, 2005).

---

<sup>17</sup> Plots have been described by a number of scholars as a combination of temporality (sequencing or succession) and causality because the plot links prior decisions, choices or events to subsequent happenings (Elliott, 2005).

People are natural storytellers; stories provide coherence and continuity to individuals' experience, and play a central role in communication with others (Lieblich, Tuval-Mashiach, & Zilber, 1998). Despite the universality of story-telling, some experiences are initially too difficult to speak about (Riessman, 1993). In trauma narratives, there is a constant tension between the yearning for coherence of life experience, and for authenticity (Ochs & Capps, 2001). In such cases, the task of the researcher is two-fold: firstly, to guide the narrator in making sense of her experiences through casting it in narrative form; and secondly, to bear witness to the event(s) in question (Riessman, 1993). As Dinesan (cited in Riessman, 1993, p. 4) put it, "all sorrows can be borne if we can put it into a story". However, there remains a tension between the need to authentically share personal experiences and express them in a way that aligns with, and is familiar and acceptable to, others (Ochs & Capps, 2001). Despite this, developing a story is particularly important in trauma narratives, as it represents an attempt to create some form of unity and coherence from fractured, disordered or chaotic experience (Riessman, 1993). As such, narratives can be understood as "meaning-making structures" which researchers must preserve in their analyses, so demonstrating respect for the narrator's subjective interpretations (Riessman, 1993, p. 4). For this reason, it is very important that researchers do not suppress narratives by asking standardised questions. Without such interruption, interviewees are free to organise their replies in long, personally meaningful stories (Riessman, 1993). Emotion is a key component of trauma narratives. Emotions are inextricably interlinked with the meaning dimension of texts to the extent that the distinction between cognition and emotion appears false – they are not separate, isolated and autonomous phenomena, they are both dimensions of human experience (Kleres, 2010). Developing coherent narratives enhances psychological well-being (Ochs & Capps, 2001). Because of how traumatic experiences are remembered, trauma survivors struggle to piece together traumatic events into a meaningful sequence – because of flashbacks of remembered sights, sounds, smells and other sensations, and because trauma often defies language, survivors have trouble articulating their experiences (Ochs & Capps, 2001). Trauma overwhelms the capacity to organise the traumatic event/s, and so survivors have great difficulty conceptualising them, and integrating them with other memories to link narrative episodes to form a lengthy narrative sequence (Ochs & Capps, 2001). This is not the same as the occasional ebb back and forth between time zones characterising some personal narratives – a kind of elasticity and flexibility characterising most oral narratives. In trauma narratives the non-linearity is far more distinctive and dramatic.

There is no single narrative method, no standard approach or list of procedures which is understood as representing the method of narrative analysis; in fact, in Elliott's words (2005, p. 36), there is a "state of near anarchy in the field." Similarly, Chase (2011, p. 430) asserts that narrative analysis is a "field in the making". It may involve the use of multiple sources of data (e.g. interviews, letters, films, ethnography, self-portraits, diaries, maps etc.) which emphasises that every view is partial and incomplete, and that narrative environments are multiple and layered (Chase, 2011). The challenge with narrative research is that it offers no rules about the materials or modes of exploration, nor does it offer information about the best level at which to study narratives (Squire, Andrews, & Tamboukou, 2008). It also does not tell the researcher whether s/he should aim for objectivity or involvement, or whether to analyse narratives in terms of their particularity or generality; and what epistemological significance should be brought to bear on stories (Squire et al., 2008). Thus there is a wide array of perspectives on how to conduct narrative analysis, which may range from micro-level analysis of single segments or a focus on the entire narrative or large sections of it (Kleres, 2010).

### **Theoretical Positioning**

In a thesis which is somewhat theoretically eclectic, it is important to state explicitly my theoretical positionings, which I believe are complementary. As I have stated elsewhere, phenomenology, with its focus on subjective experience and consciousness, is compatible with narrative analysis' interest in the subjective construction of self through stories.

Phenomenology's intrapsychic, individual approach is complemented by narrative analysis from a social constructivist point of view's assertion that the self as socially determined and determining, multiple, incoherent and fragmented. It is clear how each of these theories shed light on my research aims and objectives in their complementary ways; aims which centre around the lived experience of the splitting of the self (multiplicity) and associated memory and language fragmentation, and the possible presence of trauma-related shame.

The multiplicity characterising narrative research is due not only to its divergent beginnings, but also to the multitude of theoretical perspectives which are relevant to it (Squire et al., 2008). For example, current perspectives locate narrative analysis in humanist terms, which conceives a singular unified subject, while social constructivist interpretations promote the

concept of the self and narrative as multiple, socially constructed and constructing, and also reinterpretable (Squire et al., 2008). Scholars have argued for some time over unity versus multiplicity of identity (McAdams, Josselson, & Lieblich, 2006). Life stories can be understood as functioning to create a coherent life; a synthesis; one which would otherwise be fragmented and scattered – in McAdams et al.'s (2006, p. 5) words, “life stories, therefore, may be seen as bringing different aspects of the self together into a unifying and purpose-giving whole”. Life story construction is considered an “interpretive process of self-making that operates to produce coherence through the formation of meaningful connections between past experiences and the self” (Pals, 2006, p. 177). The idea that there is some kind of integrated identity reflected in a unified, coherent story provides the individual with a comforting sense of sameness and continuity (Raggatt, 2006).

I believe this unified, coherent story and self is an illusion. Other researchers, much more convincingly in my view, have argued that life stories articulate multiple, conflicting, contradictory parts of the self, and that any given person will have many different selves, each with their own distinctive voice (McAdams et al., 2006). They believe that a singular and integrated life story or narrative identity does not exist; instead there is a dialogical self based on the assumption that there are multiple I positions which may “agree, disagree, understand, misunderstand, oppose, contradict, question and even ridicule the I in another position” (Hermans as cited in Halbertal & Koren, 2006, p. 41). These various positionalities often reflect multiple agendas (Maynes, Pierce, & Laslett, 2008). A middle ground is probably most appropriate: personalities and life stories are characterised by some stability, but also by change, development and growth (McAdams et al., 2006). Pals (2006) argues that this growth takes place through the acknowledgement of the emotional impact of a negative experience; actively analysing the impact and meaning of the negative event, and achieving a resolved ending which promotes transformation of the negative to the positive.

The meaning of narrative and narrative analysis has changed significantly over time (Brockmeier & Carbaugh, 2001). This change is characterised by a movement away from classical structuralism and “its adamant positivistic claims, reductionistic formalist explanations, reliance on generative causal mechanisms, and not least, an inaccessible idiosyncratic vocabulary, its jargon of technical ‘scientificity’” towards what has been variously dubbed “the interpretive turn”, “discursive turn”, “cultural turn” and “post-structuralist turn” (Brockmeier & Carbaugh, 2001, p. 4, 9). It is this “turn” in which I locate myself theoretically.

From a constructivist paradigm, one which I believe is complementary to phenomenology, the narratives we construct cannot be separated from our experiences of our lives - narratives inform and determine our lived experience, just as these lives determine the way we construct the stories or narratives of our lives (although some scholars disagree, and understand narratives as subjective accounts of varying degrees of historical accuracy, see Craib, 2009 and Wengraf, 2009<sup>18</sup>). Subjective experience and emotions are deeply embedded in our narratives and are acquired through stories; narratives are the antecedents of our subjective emotional experiences (Kleres, 2010). So too, narrative and identity cannot be separated – narrative is constitutive of self and identity, and the way we subjectively perceive ourselves shapes the stories we tell (Chase, 2011). Narratives are used to make claims about our experience of ourselves and our identities (Bamberg, 2004). Like mine, a few psychological studies incorporating narrative analysis focus on whether individuals' subjective identity constructions through narration indicate the self's unity, multiplicity or both; how the self and society work together to determine individuals' lived experience of constructing narrative identity; and how individuals' narratives display (and can be experienced as demonstrating) stability, growth, or both in their identities (Chase, 2011).

In constructivist, post-modernist terms, individuals cannot be seen to have a fixed identity that is:

...ontologically prior to their position in the social world. Identity is not to be found inside a person (like a kernel within a nut shell) but rather it is relational and inheres in the interactions a person has with others (Elliott, 2005, p. 124).

The self of autobiographical narratives does not necessarily precede its constitution in narrative (Charon, 2006). Furthermore, the way in which the past and the present are constructed in narratives, constructs the future (Charon, 2006). The self, and language, is relationally, socially constructed; it is an interactional achievement (Gergen, 1994). For theorists like Foucault and Derrida, the self is multiple and continually under construction and does not contain any fixed characteristics (Elliott, 2005). Identity is not seen as some kind of "static essence", but instead as a "dynamic accomplishment" (Elliott, 2005, p. 130). In other words, there is no essential, pre-existing self or life that is independent of the process of constructing it (Bruner, 2001). The audience for whom the narrative is being performed or produced is pertinent here. Freeman (2001) argues that each person has a repertoire of

---

<sup>18</sup> It is important to note that some scholars have argued that the denial of the existence of any subjectivity outside of discourse or narrative constitutes "discourse determinism" (Hollway & Jefferson, 2009, p. 136).

autobiographies which are suited to different cultural settings and different target audiences; that there is no singularity of self or story, but instead, remarkable multiplicity. Ochs and Capps (2001) add that although memory affects how events are narrated, narrative practices in turn affect how experiences are later encoded, retained and revised in memory. Thus, identity is malleable, and is changed as we narratively reflect on our experiences – as such, autobiographical memory informs and is guided by narrative. Both are changeable, mutable and constantly subject to reformulation (Ochs & Capps, 2001).

From a constructivist, post-modernist point of view, the belief that there is a story “out there” waiting to be discovered, prior to the narrative process and removed from its analytical construction, is known as the ontological fallacy (Brockmeier & Harré, 2001). An associated illusion is the “metalinguistic illusion” (Brockmeier & Harré, 2001, p. 48), which arises when philosophers and linguists examine words and sentences, or propositions and meanings, which it is argued are all imposed (theoretical) categories. These “metalinguistic shadows” have taken on a “stable, real existence...have materialized into real beings” (Brockmeier & Harré, 2001, p. 48). This criticism can be directed at certain structural methods of narrative analysis. A related fallacy, the representation fallacy, concerns the error of assuming that there is one human reality to which all narratives must conform (Brockmeier & Harré, 2001). From these authors’ perspective, narratives are constitutive of a highly variable and fleeting human reality (Brockmeier & Harré, 2001).

### **Types and Modes of Narrative Analysis**

There are a number of different modes of narrative analysis (Phoenix, 2008). Some emphasise temporal ordering and emplotment, some emphasise themes, some focus on episodes and drama, and still others on narratives as an interactional or co-accomplishment (Phoenix, 2008). The researcher may categorise the narrative using a typology or genre borrowed from literature, for example, comedy or tragedy or satire, or may focus on the direction of the plot – whether it is progressive, regressive or stable (Elliott, 2005). Because I will be focusing on oral narratives, however, I will not be discussing the work of scholars such as Propp and Barthes who focus on the structural aspects of literary texts here. Instead, my analysis will focus on the breakdown of temporal ordering or plots, which also applies to oral narratives. According to Toolan (2001, p. 6, p. 8) a narrative is a “perceived sequence of non-randomly

connected events”, which includes “foregrounded individuals”, and “crisis resolution progression”, and if there is not non-random connection, it does not constitute a narrative. I do not concur with this rather extreme view, and still consider fragmented narratives as recognizable stories. In my analysis I will also consider the narrative as an interactional or co-accomplishment. Analyses have tended to shift from the first wave of narrative analysis which focused on narrative as text, to the second wave of narrative analysis that focuses on the study of narrative-in-context (Phoenix, 2008). My analysis will incorporate aspects of both waves of analysis – including a structural/linguistic analysis of sections of text, and the identification of themes and discourses which are context-dependent.

Contemporary approaches to narrative analysis emphasise the connection between the individual and the social or cultural and historical collectivity (Maynes et al., 2008). These authors call for narrative researchers to focus on the links between the individual and social realms of experience – on how individual life stories are embedded in historical and social relationships and structures and articulated in culturally specific forms (Maynes et al., 2008). From these authors’ perspective, stories can be seen as reflections of lived experiences over time in specific social, cultural, and historical settings (Maynes et al., 2008). This is something I will discuss in chapter 8. This does not necessarily exclude the possibility for human agency. Maynes et al. (2008) argue in favour of locating individual motivations, feelings and meanings in a broader social and historical context and as changing and developing over time. They see the subject as constructed through social relationships, embodied in individuals with both histories and psyches, growing and changing over time (Maynes et al., 2008). In Maynes et al.’s (2008, p. 67) words, “individuals are shaped by their contexts but never reducible to them”. This will be further explored in participants’ master gendered narratives and counter narratives.

Researchers may be interested in the content of the narrative (the “what” of the narrative), while others will focus on the structure or form of the narrative; how the content is conveyed and how the narrative is put together (Elliott, 2005). Some may be interested in the performance of narratives, the interactional and institutional settings in which narratives are produced and received (Elliott, 2005). What these researchers look for is what the functions of the narrative are, what the narrative does through the use of rhetoric, particularly with regards the target audience (Freeman, 2001). Some researchers attempt a holistic analysis which preserves the narrative in its entirety, while others extract short sections of text, and place them in categories for analysis (Elliott, 2005). I will use short sections of text for my

linguistic and categorical analysis and will be paying attention to the interactional and institutional contexts which determine language (the social construction of language and self, see Gergen, 1994).

As noted, narrative researchers are interested both in the form or structure and content of the stories they analyse (Lieblich et al., 1998). Some authors argue that analysis of form is preferable because it provides greater depth of information on the narrator's identity, and that the form of the story is often more difficult to manipulate or influence than the content (Lieblich et al., 1998). In a similar vein, Hollway and Jefferson (2009) suggest looking for unconscious material in the text, which may be illustrated at a structural level. Riessman (1993) recommends starting with an analysis of form or structure; focusing on how the narrative is organised, and then moving on to focus on content. I agree that both form and content are important aspects to examine, but in no particular order.

Narrative analysis has also not been untouched by positivism. According to the positivistic Labov (as cited in Riessman, 1993; Toolan, 2001), fully formed narratives include six common structural elements: an abstract (summary of the substance of the narrative), orientation (time, place, situation, participants), complicating action (sequence of events), evaluation (significance and meaning of the action, attitude of the narrator), resolution (what finally happened), and coda (returns the perspective to the present). Another influential theory for analysing narratives was developed by Burke (as cited in Riessman, 1993), who identified five common dramatic structural elements: act (what was done), scene (when or where it was done), agent (who did it), how s/he did it (agency), and why (purpose). Labov is an important theorist in narrative research, although his work has been widely criticised in recent years due to "the interpretive turn", "discursive turn", "cultural turn" and "post-structuralist turn".

Labovian analysis is event-centred as well as text-centred, meaning that it tends not to take context into account (Patterson, 2008). Labov's approach assumes that there is an objective reality, and that what is being portrayed is the what of narrated experience; there is limited acknowledgement that the individual may be reconstructing the past for the purposes of the current interaction (Patterson, 2008). The danger of Labov's model is that it assumes that a "good" narrative is one that will neatly fit with the model, and that those which do not fit neatly have somehow been told by less competent narrators (Patterson, 2008). Using Labov's model may involve treating a narrative as if it has an orderly structure and reducing it to one type of text just so that it can fit with a particular paradigmatic model (Patterson, 2008).

Another danger of this approach is that some types of (unfitting) data may be lost (Patterson,

2008). A third danger is that according to Labov, the definition of a minimal narrative is a neat “sequence of two clauses which are temporally ordered”, which would render the majority of stories as non-narratives (Patterson, 2008, p. 33). In Patterson’s (2008, p. 32) words:

Focusing solely on chronologically ordered past tense clauses, analysing them in isolation from the rest of the transcript, and taking no account of the context in which the narrative was produced, can only produce an overly simplistic, reductive analysis and interpretation.

Elliott (2005) furthermore argues that narratives do not follow a strict sequence of event clauses, and that interviews typically include a range of different narratives leading to difficulties in finding the boundaries between them. She notes that Labov’s structural model may be more appropriate for analysing short sections of narratives, rather than examining the narrative more holistically. Labov’s event-centricity does not fit my phenomenological, experiential data and approach. As noted by Patterson (2008), using alternative approaches allows for more comprehensive analyses, which take into account the complexity and subtlety of the narration of experience. A final reason for not using Labov’s approach in my analysis is cited in Toolan (2001 p. 144), who describes how Labov argues that “crisis” oral narratives of personal experience are “invariably recounted chronologically”, and that he has no interest in the complexity of temporal reordering, which runs counter to my clinical and research knowledge (e.g. the fragmentation and the loss of chronology that accompanies trauma).

Nonetheless, Squire (2005) includes Labov, along with Ricoeur and cultural understandings of narratives as important ways of interpreting certain types of stories. All three of these methods of analysis have their strengths and drawbacks. Ricoeur’s work is relevant to narrative analysis in many ways, although it is most suited to literary texts, both historical writings and fiction (Simms, 2003). Ricoeur’s work is centred around time, and how both the subject and the narrative are bound by the inevitable movement through time (Simms, 2003). As such, emplotment is central in Ricoeur’s work. For him, the plot “integrates into one whole and complete story multiple and scattered events” (Ricoeur cited in Simms, 2003). Thus, a sequence develops, which is established by causal relationships between events (Simms, 2003). Two features of narratives are important to Ricoeur: firstly, mimesis, which refers to the representation of human reality; and secondly, the type of reality which narrative is mimetic of is human action (Simms, 2003). Accordingly, Ricoeur proposes that key aspects of narrative are Mimesis (1), Mimesis (2) and Mimesis (3) (Simms, 2003). These refer

respectively to the preconfiguration, configuration (emplotment) and refiguration of the text (Simms, 2003). Preconfiguration refers to prior knowledge or expectations that we bring to the narrative; configuration refers ordering of events into a plot (implying a temporal and causal sequence), and reconfiguration refers to the revised understanding of the real world we have as a result of engaging with the narrative (Simms, 2003). Although there are important differences between the autobiographical nature of the narratives I collected and historical texts, there is also a significant overlap between these texts. Of particular interest is the concept of configuration, specifically the breakdown of expected story or plot lines.

Ricoeur stresses that the term 'identity' can be understood on the one hand as exactly the same, equivalent or identical (*idem*), or identity can refer a sense of identity that has permanence through time without sameness through time (*ipse*) (Elliott, 2005). Narrative psychology fits with *ipse* as it presents a means of understanding individuals as living through time; a person with a past, present and future "made whole by the coherence of the narrative plot with a beginning, middle, and end." (in the absence of trauma) (Elliott, 2005, p. 125). This kind of understanding of identity avoids the extremes of both essentialist and constructivist approaches to the self (Elliott, 2005).

Three key features of narratives, which have relevance for my study, are that they incorporate chronology (or lack thereof), that they are meaningful, and that they are social in the sense that they are determined by, and produced for a specific audience (Elliott, 2005). These features are not separable and are associated in complex ways (Elliott, 2005). Although causality has not been determined as a universal and necessary dimension of narratives, the audience is likely to infer causal links between events (Elliott, 2005). In the fragmented narratives I examine in chapter 9, there is a breakdown in chronology or sequence, and meaning is lost in a number of the narratives. However, as some of the participants' narratives show, I interpret and extrapolate meaning from their narratives, and conclude that their stories are deeply reflective and constitutive of their social realities.

As has been noted, a key feature of narrative psychology is that it includes the concepts of time and sequence – for any individual to make sense of something that has happened, the sequence of events is crucial, and thus, there is a close connection between time and identity (Crossley, 2000). Alternative temporalities have also been identified, including unconscious as well as lived realities (Squire et al., 2008). Narrative researchers interested in temporal gaps and reinterpretations may focus on conscious or unconscious state, social, historical or spatial succession and change (Squire et al., 2008).

Central principles of narrative enquiry include emplotment, character, scene, place, time and point-of-view (Clandinin & Connelly, 2000). The purpose of narrative analysis is to identify patterns, narrative threads, tensions and themes within and across individual experience in their particular social setting (Clandinin & Connelly, 2000). The tension here is being able to honour the participants' experience, while trying to create a generalizable theory (Clandinin & Connelly, 2000). No set of stories is homogenous; there will always be variation even when the topic is the same (Gubrium & Holstein, 2009). My focus is on the breakdown of emplotment and on fractured points-of-view.

Some scholars have distinguished between narratives that are focused on particular past events, and those that are focused on emotional experience – in the latter case, stories may involve many hours of life histories, include general or imagined phenomena, events that occurred in the interviewee's life, or things they have simply heard about (Squire et al., 2008). This kind of narrative may also include varying types of media. A third type of narrative has also been identified. This type is co-constructed, for example in conversations or email exchanges (Squire et al. 2008). The narratives produced by my participants reflected an interest in both past events and emotional experience, and were at least partly a product of our joint construction (although perhaps less so than during less formal conversations).

Storytelling is seen as taking place in a sequential, collaborative and interactional environment (Gubrium & Holstein, 2009). Any conversation is a collaborative endeavour between researcher and participant, and analysis might focus on how stories are collaboratively told (emphasising analytic insights and techniques), or focus on what is accomplished through collaborative story telling (Gubrium & Holstein, 2009). This brings up the problem of authorship (Brockmeier & Harré, 2001). Narratives are constructed co-operatively, and every story is multi-voiced, its meaning determined by the numerous uses in previous contexts (Brockmeier & Harré, 2001). It has been called the “dialogical principle” of discourse “emphasising its inherent interindividuality: every word, expression, utterance or narrative bear the traces of all subjects, possible and real, who ever used or will use this word, expression, utterance, or narrative” (Brockmeier & Harré, 2001, p. 46). Narratives are also performative in the context of the collaborative relationship, to varying degrees (Toolan, 2001). The narratives of the women I interviewed were highly performative, including most of the criteria developed by Wolfson, including: direct speech, asides, repetition, expressive sounds, sound effects, motions and gestures, conversational historic present, alternating with narrative past tense (Toolan, 2001).

Linkage refers to the manner in which experiences are linked to other items in particular ways; in essence, the process of meaning making (Gubrium & Holstein, 2009). The meaning of stories may change as the particulars of the story are linked together in different ways for different audiences (Gubrium & Holstein, 2009). As noted, stories may be performative, and always involve consideration of the audience (Gubrium & Holstein, 2009). Specifically, performative particulars may include not only audiences, but also roles, purposes, modes of expression and emphases, which reflexively influence stories over and above their texts (Gubrium & Holstein, 2009). It is important to remain cognizant that stories are performed for particular audiences and that different kinds of situations call for different kinds of stories (McAdams et al., 2006). Different societies also privilege particular types of stories and storytellers; history and culture influence how people narrate their lives (McAdams et al., 2006).

A relevant concept, which is not limited to literary texts, is intertextuality, which means that texts or interactional accounts draw their meanings from other texts or accounts, “in an ongoing interplay of readings and interpretations” (Gubrium & Holstein, 2009, p. 186). Narratives need not be in written form to be intertextually shaped; all forms of accounts can be influenced and related to prior narratives, both written and unwritten (Gubrium & Holstein, 2009). These authors refer to narratives as “nodes within networks”, where any narrative could share the empirical stage with other narratives (Gubrium & Holstein, 2009, p. 187). Decisions and narratives or accounts made in one set of circumstances thus consider prior decisions, accounts and actions from other settings, for instance organisational histories – decisions and accounts are therefore “both retrospectively and prospectively composed” (Gubrium & Holstein, 2009, p. 187). The importance of understanding intertextuality in narrative analysis is for the researcher to pay attention to the influence of other narratives and other narrative environments, in making sense of present accounts (Gubrium & Holstein, 2009). As Gubrium and Holstein (2009, p. 197) argue, “Meaning is constructed at the confluence of sites of narrative production and the work of situated storytellers, listeners and readers. Accordingly, it would be analytically naïve to think of personal accounts or records as merely ‘their own stories’”. Once again, as I found, women’s narratives were influenced by previous narratives which were embedded in local discourse and context, which is explored in chapter 8.

Conversational narratives can be evaluated according to five dimensions (Ochs & Capps, 2001). 1) Tellership refers to the level and nature of involvement of conversational partners in

the recollection of a narrative. Conversational participants such as researchers facilitate the nature of quality of narrative construction by vocal and non-verbal displays of attention. 2) Tellability refers to the extent to which narratives describe remarkable, interesting or unexpected events, and describe them in a rhetorically effective manner. 3) Embeddedness refers to the extent to which a narrative is embedded in the surrounding discourse and social context – it describes whether a narrative is relatively self-contained, an entity in itself, separate from earlier, current or subsequent discourse, and is associated with turn-taking organisation, thematic content and rhetorical structuring. For example, embedded narratives vary in the length of turns, are thematically relevant to a topic being discussed or a social activity. They make a point, make comparisons, support an argument or focus on a central concern. Rhetorically, embedded narratives assume discourse features of the surrounding discourse. These narratives are often embedded in prayers, explanations, and disagreement (Ochs & Capps, 2001). The narratives I will be analysing reflect the features of the surrounding discourse. 4) Another dimension structuring personal narratives is linearity. This concerns the extent to which the narrative orders events in a single, closed, temporal and causal path. Many of the narratives I analysed did not display linearity. Non-linear narratives open the text to multiple truths and perspectives, and remind the listener or reader that particular life experiences resist simple, neat and tidy interpretive frameworks. In non-linear narratives, the plot structure breaks down, and the ordering, logic and meaning of experienced events are irregular and ambiguous. 5) Finally, personal narratives present perspectives on events – thus, a core dimension of personal narratives is the moral stance assumed by the teller. Personal narratives in the field of trauma usually contain a recollection of a social violation, and involves taking a moral stance in order to clarify, reinforce, or revise what the teller believes and values. Much like the narratives I analysed, women affirmed their own moral stance (as survivors) in opposition to rival moral perspectives (patriarchal beliefs in the legitimacy of the subjugation of women). However, where there is moral uncertainty, or a lack of firm belief in the justification of the teller's moral stance, it may become indeterminate and unstable, and the teller's moral stance may unravel as the telling proceeds (Ochs & Capps, 2001). Narrative competence is usually viewed as the capacity to describe a narrative by oneself (one active teller), in a rhetorically effective manner (high tellability), which is fairly self-contained (not embedded), with a coherent beginning, middle and end (linearity), and a consistent moral stance (Ochs & Capps, 2001). Obviously, these criteria cannot be applied to evaluate the typical trauma narrative.

## Reflexivity

It is recommended that all narrative inquirers remain intensely conscious of their own responses to the lived experiences of others (Clandinin & Connelly, 2000). Clandinin and Connelly (2000) emphasise the need for wakefulness – a quality characterising inquiries that necessitate ongoing reflection. As noted by Clandinin and Connelly (2000, p. 46):

We all, novice and experienced researchers alike, come to inquiry with views, attitudes, and ways of thinking about inquiry. These histories, these personal narratives of inquiry, may coincide with or cross a boundary to varying degrees with the actual inquiries that we undertake.

Dialogic listening to three voices is required when working with narratives: the voice of the narrator; the theoretical framework which provides the concepts and tools for interpreting; and a reflexive monitoring of the reading and interpreting of materials - a self-awareness of the decision process of drawing conclusions from the text (Lieblich et al., 1998). As such, I pay particular attention to self-reflexivity in the next chapter. Reflexivity is essential in narrative analysis. This refers to the researcher's awareness of his/her identity in the research process (Elliott, 2005). It does not simply involve providing personal information about the researcher, but rather involves providing an analytic account of how his/her personal and professional history and his/her theoretical orientation has lead him/her to approach the data in a specific way (Elliott, 2005). The researcher needs to engage in the significance and implications of his/her position and how it relates to the research (Elliott, 2005). As noted by Elliott (2005, p. 154):

Once we become aware that when the subjects of our research provide us with narratives, they are not merely reporting their experiences but rather are engaged in an activity that makes sense of those experiences, we are obliged to admit that our own research narratives are also constructed.

Where reflexivity becomes challenging is when researchers admit to the intuitive nature of much of the analysis that is invested in the hermeneutic perspective – some might question whether it is possible to document this intuitive process; to be fully reflexive about this part of research and so making it transparent and open to others' scrutiny (Elliott, 2005).

There is relatively little literature on reflexivity in the analysis and writing up of data (compared to the collection of data) (Elliott, 2005). However, Van Maanen (as cited in Elliott, 2005) identifies three types of writers: the realist writer, the confessional writer and the impressionist writer. The impressionist writer is closest to what we understand by a narrative approach to analysis and writing up. Unlike the realist or confessional tale, the impressionist tale does not focus exclusively on the researcher (confessional) or respondent (realist), but instead focuses on the doing of fieldwork – and aims to draw the reader in and encourage his/her participation through providing a vibrant account filled with concrete details (Elliott, 2005). This gives the write up an open-ended character, and leaves it feeling unfinished, so that with each re-telling or re-reading the individual is given the opportunity to make new interpretations and learn more from the data (Elliott, 2005). The impressionist writer does not situate the researcher as central character, but instead occupies the space of one of the key protagonists alongside his/her respondents (Elliott, 2005).

Two types of reflexivity, self-control (or disengagement) and self-exploration, are relevant to narrative psychology (Crossley, 2000). In Crossley's (2000, p. 20) words:

‘Self-exploration’ constitutes a total contrast to that involved in ‘disengagement’. Rather than standing back from our bodies, thoughts, feelings and desires, ‘objectifying’ them in the pursuit of self control, the stand of ‘self-exploration’ encourages us to explore these dimensions in order to establish our identity; we have to ‘search for ourselves’.

Clandinin and Connelly (2000, p. 61) eloquently emphasise the importance of recognising our own role in the work that we do with others:

As inquirers we, too, are part of the parade. We have helped make the world in which we find ourselves. We are not merely objective inquirers, people on the high road, who study a world lesser in quality than our moral temperament would have it, people who study a world we did not help create. On the contrary, we are complicit in the world we study. Being in this world, we need to remake ourselves as well as offer up research understandings that could lead to a better world.

What this quote indicates is that as narrative inquirers, we work not only with our participants but also with ourselves; our own experiences and lived and told narratives which unfold in our interactions (Clandinin & Connelly, 2000). Clandinin and Connelly (2000) stress the importance of the researcher's own experience; his or her own livings, telling, retellings, and

relivings. Consequently, the starting point for any narrative analysis is the researcher's own autobiography. One of the most important things narrative inquirers do is to place themselves "in the midst", which involves writing one's own stories (Clandinin & Connelly, 2000, p. 100).

Clandinin and Connelly (2000) believe that narrative inquiry boundaries are permeable, that they expand and contract, with researchers' personal and professional lives flowing across the boundaries into the research setting, with the participants' lives and experiences flowing the other way. Some feel that if researchers do not become fully involved in the inquiry, they can never fully understand the lives of others, whereas others feel that becoming fully involved leads to a loss of objectivity (Clandinin & Connelly, 2000). Clandinin and Connelly (2000) suggest that narrative inquirers must experience this tension, because all narrative analysis is relational. The inquirer needs to be aware of a great deal of things at once: the details of place or situation, the nuanced distortions in time, and the complicated shifts between personal and social observations and their relations (Clandinin & Connelly, 2000). How experiences are conveyed and how and what is said in what circumstances is very important (Gubrium & Holstein, 2009). They argue that inquirers must become fully involved, "fall in love" with their participants, yet they must also have the ability to take a step back and recognise their own stories or narratives at work in the inquiry, the stories of the participants, as well as the broader social landscape in which we all exist (Clandinin & Connelly, 2000, p. 81).

It is important to note that heard experiences and stories get modified in retelling and reliving them – consequently, critics of narrative analysis frequently speak of "co-optation of voice", suggesting that researchers run the risk of drowning out participants' voices, or speaking on their behalf, so losing participants' voices (Clandinin & Connelly, 2000, p. 75). This is closely tied to the notion of signature – too strong or lively a signature runs the risk of obscuring the field and participants, and too weak a signature runs the risk of speaking only from the perspective of the participant (Clandinin & Connelly, 2000). There will always be a tension between voice, signature, and audience, just like there will always be tension between the experiences of the researcher and the participant, and the broader social context that surrounds what is being addressed in the inquiry (Clandinin & Connelly, 2000). Narratives operate both within society and are about society (Gubrium & Holstein, 2009). They also reflect inner life (Gubrium & Holstein, 2009). In other words, stories have personal and social purposes and consequences, which shape their accounts (Gubrium & Holstein, 2009).

Gubrium and Holstein (2009, p. 16) argue that "stories are not just conveyed, but they are

given shape in the course of social interaction. How things are put or unfold is as important as what is said and in what circumstances". In this context it is easy to see why researchers need to pay attention to the fact that there may be preferred tellings of stories in particular circumstances (Gubrium & Holstein, 2009).

In reality, what should happen in narrative inquiries is that there is a progressive mingling of voices, a boundary crossing where there is a combination of researchers' and participants' narratives of experience (Clandinin & Connelly, 2000). This is what Gubrium and Holstein (2009) call the interactional terrain, whereas the situational terrain is about meaning-making preferences; local understandings and expectations for how a story should be constructed and its preferred results. Participants and researchers actively take part in discursive exchanges (Gubrium & Holstein, 2009, p. 42). They stress that:

Narratives emerge in context - interactionally, situationally, and organisationally. In practice, narrators are the architects and builders of their stories, but they accomplish their craft interacting with other storytellers and listeners. The narrative process - from start to finish - yields an ever-emergent, pliant product that should be treated as something more dynamic than a more or less accurate, waiting-to-be-told text.

Analysis needs to orient to the interactions and circumstances of narrative production as well as to the story that is produced. In practice, narratives are social to the core.

Researchers also need to be alert to how power and control may influence narrative collaboration (Gubrium & Holstein, 2009). Inequalities in status and power between the interviewer and interviewee can complicate the research process (Maynes et al., 2008). Although in my interviews participants could be described as the main storytellers, my input cannot be discounted. I had considerable power in the interview situation. The questions I asked determined the stories that were told; I activated the stories, and my prompts served to encourage women to elaborate on aspects of their stories that I felt were interesting or noteworthy.

McLean and Thorne (2006) argue that in thinking about how life stories are constructed, listeners play a very important role, as their responses determine whether the speaker's story is suppressed, revised or solidified. These authors emphasise that the listener and the context in which the story is told are central to which kinds of meanings are produced. It is important to note that I was considered as staff at the Centre, and that because of this women might have felt that there was a power differential between us, and although it was not so intended, they

may have felt that they were compelled to answer my questions. In this sense, I did hold some control over narrative construction. However unintentionally, I believe that the stories that emerged were at least partly a product of how I was viewed (as a member of the Centre staff), and that because of that, in some instances accounts which would be preferred by the Centre, were put forward. The issue of status is relevant here too. Gubrium and Holstein (2009) question the narrative agency of people who have low social status (such as a severely cognitively impaired young girl and people with Alzheimer's Disease). The women I interviewed occupied a similarly subjugated position, and consequently, in some instances, they were reluctant to admitting to shame, with all its associations not only of self-blame, but also of vulnerability and disempowerment.

The audience collaborates in storytelling by taking on roles that influence the final remembering in some way (Pasupathi, 2006). The roles available to both speaker and listener are historically and culturally bound, and they reflect the nature and structure of society and the identity options they allow (Cohler & Hammack, 2006). It cannot be denied that I entered the field as a privileged White woman, and all the women I interviewed were of lower socio-economic status and were Black or Coloured. These demographic differences are likely to influence the roles we played in relation to each other, and what the women felt comfortable disclosing to me (how much filtering or editing took place).

What most narrative researchers need to come to terms with is that they need to be ready to engage with “surprisingly abbreviated accounts, convoluted storying, remarkably repetitive narratives, and the less-than-unified commentaries that commonly inhabit this terrain – all of which have good practical reasons for taking the forms they do” (Gubrium & Holstein, 2009, p. 38). It is the researcher's responsibility to explore how external factors may affect the narrative, what conditions may make narrative emerge, flourish and thrive, and which achieve the opposite – this is closely related to the nature of cultural or organisational resources and preferences, which influence the interactional production or avoidance of particular narratives (Gubrium & Holstein, 2009). This is particularly relevant for the construction of counter-narratives, which resist master or hegemonic narratives (Andrews, 2004).

As noted by Gubrium and Holstein (2009, p. 174), “Organizations establish general parameters for how narratives may be produced and who is authorized to produce them. They establish the foundation for what might pass in their purview as recognizable, legitimate accounts”. These authors stress how the “big stories” of organisations or agencies (socio-cultural aspects) affect how the “little stories” (individuals' stories) are articulated.

Researchers should pay attention to individual accounts and listen carefully to how they reflect organisational principles and groundings (Gubrium & Holstein, 2009). Simultaneously, it is important to take heed of individual variations in talk and interactions (Gubrium & Holstein, 2009). Organisations influence and shape, but do not determine, locally and individually articulated narratives (Gubrium & Holstein, 2009). The importance of local and wider societal contexts cannot be emphasised enough in the construction of personal narratives (Phoenix, 2008). It may be worth examining, as Phoenix (2008) does, how canonical narratives around wider societal issues such as sexism are interwoven in personal narratives.

### **Discourses, Narratives, and Counter-narratives**

It is worth pausing for a moment to consider the distinctions between discourses and narratives. Narratives are considered a subtype of discourses (which is defined as a framework, articulated in language, for understanding things, people, events and relationships) (Brockmeier & Harré, 2001; Day Sclater, 2009). Within narrative enquiry, individuals are considered embodiments of lived stories; as living individual lives which are influenced by social and cultural narratives (Clandinin & Connelly, 2000). Self-making and life-making is highly dependent on the constraints and opportunities presented by the cultural or social system in which it is conducted (Bruner, 2001). Specifically, Brockmeier and Harré (2001) argue that stories are always told according to certain cultural conventions. In fact, narratives can be understood as a condensed set of rules and instructions, which capture what is coherent and plausible in any culture (Brockmeier & Harré, 2001). Thus, a narrative should consist of “a sequence of events over time, structured comprehensibly in terms of cultural canonicity, it must also contain something that endows it with exceptionality” (Bruner, 2001, p. 29). What makes a story interesting is the violation of canonical expectancy, but in a way that is culturally acceptable (Bruner, 2001). Bruner (2001) argues that narrative “turning points” are crucial to attempts to individualise a life, to resist automatic, folk-psychological or cultural canonicity, and it is what makes the ordinary and expectable, idiosyncratic and agentive. Thus, narratives are not culturally deterministic, individuals are active agents who accept, negotiate, challenge or resist the positionings that are offered to them by dominant or master narratives and discourses (Bradbury & Day Sclater, 2009). This brings me to counter-

narratives. Counter-narratives are by definition agentive and emancipatory. I shall try to demonstrate that the women I interviewed constructed counter-narratives which violated canonical or cultural master narratives and discourses but in a way that was culturally comprehensible (consistent with the predominant discourse or ethos of the Centre).

It is the researcher's responsibility to provide an analysis of narratives which makes transparent what has gone without saying, and to make linkages between specific narratives and underlying social conditions (Elliott, 2005). The researcher's main task is to identify taken-for-granted or hegemonic cultural processes which are embedded in social practice within personal narratives. However, s/he needs to do so ethically and bear in mind that the way in which s/he interprets and analyses the narratives produced may also influence the interviewee (Elliott, 2005). In Smythe and Murray's words (as cited in Elliott, 2005, p. 141):

The problem is that, once the researcher's account is taken as the authoritative interpretation of an individual's experience, the individual's own understanding of their experience inevitably is compromised. Narrative research in this way can become intrusive and subtly damaging, even when participants respond positively to the researcher's account.

### **Evaluating Narratives**

It is important to consider how the quality of narrative analyses is evaluated. Generalizability is determined on the basis of trustworthiness or plausibility (Emerson & Frosh, 2009). The trustworthiness of narrative research can be evaluated through its persuasiveness, its correspondence (with interviewees' interpretation of their stories), its coherence, and its pragmatic use (the extent to which it becomes the basis for other researchers' work) (Riessman, 1993). It has been emphasised that a persuasive analysis includes a detailed presentation of narrators' stories (Maynes et al., 2008). Emerson and Frosh (2009) argue, however, that narrative continuity or coherence has been too central in the process of demonstrating trustworthiness, particularly when considering the fractured accounts of trauma survivors, as I will be doing. Narrative research does not require replicability as a criterion in its evaluation. Instead, the quality of the research is dependent on the researcher's personal wisdom, skill and integrity (Lieblich et al., 1998). This does not imply absolute freedom of interpretation, but instead, requires self-awareness and self-discipline in the continuous

examination of the text against interpretation (Lieblich et al., 1998). The analyst is expected to make his/her interpretation and logic apparent through honesty, transparency and clarity (Maynes et al., 2008).

Clandinin and Connelly (2000) describe a good narrative as having explanatory, invitational quality, as being authentic, and as being adequate and plausible. Narrative analysis should also be self-reflective, particularly in relation to co-construction; it should be cognizant of the interplay between individual self-construction and social, historical and cultural context; and it should be transparent about the approach to interpretation (Maynes et al., 2008).

There has been some debate about the internal validity of narrative interviews. Emerson and Frosh (2009) argue that the validity of narrative research is assessed by the extent to which the primary text is displayed, the analytic categories are specified in terms of discernible features of the texts, and theoretical interpretations are focused on these structures. Some argue that the kinds of interviews described by Clandinin and Connelly (2000) are more likely to produce accurate, truthful or trustworthy data than structured interviews that limit the interviewee to a standardised list of questions (Elliott, 2005). Others argue that narratives are never an objective reflection of reality, but rather a subjective interpretation, thus, they are concerned that narratives may always obscure a clear description of the aspects of life that are narrated (Elliott, 2005). In fact, in Elliott's (2005, p. 24) words:

Narratives do not transparently reflect experience, rather they give meaning to it. ... In order to provide the details of life experience in the form of a story, individuals are forced to reflect on those experiences, to select the salient aspects, and order them into a coherent whole.

In thinking about internal validity, and whether the interviewee is telling the "truth", it is important to consider what questions are being focused on in the research, and what kinds of information the researcher is hoping to glean from the interview (Elliott, 2005). It is worth distinguishing between historical and narrative truth here. The former involves the belief that factual information can be discovered and articulated, while the latter emphasises the role that stories play in creating meaning about the self and others (Maynes et al., 2008). Maynes et al. (2008, p. 148) state that "any rendition of the past has to be seen in the context of its motives in the present (i.e. at the time of telling), its symbolic power, and its contextual framing".

In terms of external validity, many researchers opt for either depth or breadth (Elliott, 2005). Qualitative research, in Elliott's (2005, p. 26) view might require a "common sense" view of

generalizability in that the reader is allowed to decide for him or herself how far the evidence that has been gathered in a particular study can be transferred and offer information about the same research area in similar settings.

The most persuasive analyses acknowledge and take advantage of the most influential, cogent and specific features of personal narratives as evidence (Maynes et al., 2008). These kinds of studies make appropriate generalisations, including sociological generalisation (narratives that reflect a specific social position or social process), ethnographic generalisation (narratives that illuminate culture, including transactions, conventions, mythologies, meanings and motivations) and historical generalisation (narratives help to explain historical events or processes). Analyses should be transparent in describing the research process. They should provide enough narrative detail to facilitate the audience's understanding and buy-in. The best analyses acknowledge that narrative research involves a great deal of uncertainty, and that "truths" which emerge are complex, contingent and subject to revision and reinterpretation. Narrative analyses may be based on a single, detailed narrative, or on a group of narratives that are interconnected in some way. A group of narratives may be selected because they shed light on the research question, or serve particular methodological purposes (Maynes et al., 2008).

Friedman (1993) examines spatialisation as a strategy for reading narratives. Specifically, she identifies horizontal and vertical narrative co-ordinates. Although this applies mainly to written narratives, it can also usefully be applied to oral narratives. The horizontal narrative involves the sequence of events, the setting, character, action, initiating problem, progression and closure. It is the horizontal movement or linearity of the plot from beginning, middle to end. The vertical axis of the narrative does not exist at the level of the sequential plot; unlike the horizontal narrative which has a single textual surface, the vertical narrative has layers of superimposed surfaces, much like the human psyche. Simplistically, the horizontal narrative can be equated with consciousness, and the vertical narrative with the unconscious. Although interconnected, three strands of the vertical narrative can be usefully separated for analysis: the literary; the historical; and the psychic. The literary and historical strands have to do with intertextuality, but here the focus is on the psyche. Friedman (1993) argues that reading the vertical narrative involves the realisation that the text, as linguistic entity, mimics the structure of the psyche, particularly the multi-layered unconscious. In some of the narrative analysis I will conduct, I will examine the vertical axis which demonstrates how language mimics psychic processes, for example, fragmentation.

## **The Use of Narrative Analysis in this Study**

A constructivist take on narrative analysis will be used in the proposed study for a number of reasons. Firstly, the approach to understanding the analytic outcomes of the data is focused on subjective experience and personal interpretations; how the self and experience are constructed through stories, which is consistent with narrative analysis coming from a social constructivist point of view (Bruner, 1994; Widdershoven, 1993). Secondly, this type of narrative analysis is particularly suited to the exploration of disruptions in expected story- or plot-lines, as occurs with trauma (Burck, 2005; for an eloquent example of narrative analysis of a case of sexual abuse, see Crossley, 2000). Furthermore, the act of narrating experience may restore order and coherence to the frequently disordered and fragmented experience of traumatised individuals. Ochs and Capps (2001) argue that traumatic recollections will remain fragmented until they are heard in a supportive environment and are co-narrated into a coherent sequence of events and responses. This may be particularly helpful for narrators who split off the emotion associated with the setting and events being narrated – this is often associated with trauma-related discontinuities in an individual’s identity, memory and consciousness, such as appears in those with disorganised attachment experiences in childhood, dissociative personality disorders, and post-traumatic stress (Ochs & Capps, 2001). This study will explore how trauma leads to narrative breakdown, which in turn, often leads to a revision of personal beliefs and values. Crossley (2000) argues that such narrative disruption occurs when one element in a chain of events, people, plans, aims, objectives, values and beliefs disappears or is damaged irreparably. In such situations, we literally “lose the plot”, and temporal sequences which were meaningful before the moment of rupture (consisting of a beginning which informs the middle, which informs the end of the narrative) are experienced as “the senseless progression of one thing after another” (Crossley, 2000, p. 56). The disconnection and disorientation associated with this “mere sequence” (lack of meaningful temporal order or structure) is described by Carr (as cited in Crossley, 2000, p. 57) as:

The dark and looming outer limit of experience, the chaos which stands opposed to order...this is a threat which is, admittedly, in varying degrees, permanently present at the periphery of our consciousness, the very threat and possibility of madness.

I will analyse examples of narrative disruption or breakdown using Gee's (1991) linguistic approach to narrative, which, unlike Labov's approach, is more suited to lengthier oral narratives. This analysis is not meant to be an exercise in formalism, in which the structure and content of texts are analysed apart from their social, cultural, political and intertextual contexts. Gee (1991) argues that all discourse genres are socially situated and constituted, and that interpretive reading should take into account wider social contexts, including organising discourses and canonical narratives, in addition to the spoken linguistic co-construction of texts. In this manner, Gee (1991) largely avoids being criticised for performing the error of metalinguistic illusion, where language is viewed as a pre-existing, mechanical structure divorced from its social and cultural roots. Gee's (1991) method of analysis is particularly sensitive to narrative and linguistic disruption, and so seemed most appropriate for the detailed examination of the text as it fragments and loses coherence as a result of its traumatic content. Although Wengraf's (2004) biographic-interpretive method of analysing narrative life-stories, including centrally a comparison of stories of lives as lived with stories as told, seems intuitively a sensible approach to analysing my data, I selected Gee's (1991) method because firstly, unlike Wengraf (2004), I was not able to verify the "truth" or "factual" nature of interviewees' accounts (by accessing supplementary data), making a comparison between narratives of lives as lived with stories as told impossible. Secondly, Gee's (1991) method can be applied to short and specific sections of narrative, whereas Wengraf's (2004) method is better suited to lengthy biographical narratives. Thirdly, Wengraf's (2004) method is overly technical and cumbersome to execute. Finally, an important focal area of Wengraf's (2004) method is the generation of multiple hypotheses (counter-hypotheses and tangential hypotheses) at each turning point in the narrative, which was not a focus in my work. My focus was on proving or disproving the existence of narrative fragmentation, as a metaphor for psychic fragmentation.

The narratives I have collected will be divided into Parts, Strophes, Stanzas and Main lines. "Idea units" are the smallest component of narratives. Each Main line is made up of one or more than one idea units (indicated with a slash or / in the narratives that follow). Each idea unit contains a piece of new information which is called the focus, and it has a unitary intonation contour consisting of one pitch disruption (the pitch glide) (Gee, 1991). Thus, the focus of the idea unit is determined by the pitch glide, which is the change in the pitch of the voice, including falling, rising, rising-and-falling, or falling-and-rising in relation to the base pitch level of the sentence (Gee, 1991). The foci are in bold print. A Main line often

corresponds with a sentence, including complex sentences, and is about one central argument (Gee, 1991). Main lines form Stanzas, which are the “building blocks” of discursive language, which cluster into groups according to a topic, known as Strophes (Gee, 1991). These Strophes fall into larger units or themes, known as parts (Gee, 1991). In coherent texts, different components of the text are fairly uniform in length and structure (Gee, 1991).

Gee (1991) argues that narrative texts are structured at five hierarchical levels, each of which is connected to the Main line and Stanza structure of the text. Each level plays a role in interpretation. Levels include Main line and Stanza structure (level 1); syntax and cohesion (level 2), Main line/non-main line (level 3); psychological subjects (level 4) and the focusing system (level 5). Corresponding with each of these levels is a particular role in interpretation, respectively including ideas and perspectives on characters, events, states and information (level 1); logic and connections (level 2); plot (level 3); point of view (level 4); and images or themes which build an overall interpretation of the narrative (level 5) (Gee, 1991). The interpretive questions raised include: how has the text been organised as speech? (Main line and Stanza structure). Why has the speaker made particular connections at this point? How does this connection make sense within the logic of particular narrative sections and within the overall interview? (syntax and cohesion). What is the main point or significance of the plot? (Main line/non-main line). Who or what is the psychological subject of this Stanza: why does the narrator change subjects or shift perspectives? Are there patterns in these changes? (psychological subjects). Why is this focus so important? How does it fit with other focused material? (focusing system) (Emerson & Frosh, 2009).

Lieblich et al. (1998) make the useful distinction within narrative research between holistic-content analysis, holistic-form analysis, categorical-content analysis and categorical-form analysis. Respectively, these forms of analysis include taking into consideration the whole narrative and focusing on the content; taking into consideration the entire narrative and focusing on its form or structure; focusing on content as manifested in different parts or categories of the narrative; and finally, focusing on the form or structure of separate sections or categories of a narrative (Lieblich et al., 1998). These authors warn that researchers should not see these four modes of analysis as separate cells, but rather as occurring along a continuum. My analysis incorporates aspects of both categorical-content analysis and categorical-form analysis. The first descriptive results chapter based on the initial categorical-content analysis is based on all 19 narratives, and I make thematic claims on the basis of comparisons across the full set of narratives. In the process of reading and analysing

narratives when conducting categorical-content analysis, the research becomes an interactive process as the narrative becomes open to the researcher's interpretations. Hypotheses and theories are generated while the researcher is reading and analysing the narratives, as in grounded theory (Charmaz, 2005), and these inform and enhance future reading of the material, which generates further hypotheses and theories in a continuously developing circle of understanding (Lieblich et al., 1998). Interestingly, the themes that emerged tended to reflect the responses to the open-ended questions, where women were allowed to speak freely. There was considerable overlap in their responses, given the variety of ways in which they could have responded to the open-ended questions.

The presentation of results which follows in the next three chapters is divided into three sections. The first section (presented in chapter 7) is the descriptive categorical content analysis, and the second (presented in chapter 8) is an examination of the split self at individual, institutional and cultural level based on a dominant theme emerging from the initial categorical content analysis presented in chapter 9. For the categorical-form analysis (using Gee's framework), I have selected 5 long, complex narratives for analysis, and 3 short, compressed narratives for analysis. The reason I have ordered the analysis in this way is to firstly provide the reader with a broad overview of the data; a crucial narrative context for the subsequent more detailed analysis of the split self, and finally, the complex, in depth linguistic analysis which follows. I believe that this way of structuring the results demonstrates that categorical content analysis, and categorical form analysis (linguistic analysis) can complement one another, supplement the findings that each method is able to produce, and if ordered as I have suggested, provide the reader with a progressively in-depth and comprehensive analysis of the findings.

The categorical content analysis is based on the data provided by all the participants, while the analysis of the split self is based on 10 narratives, and the categorical form analysis is based on 8 women's trauma narratives. I selected the narratives focusing on fragmentation exclusively on the basis of evidence of non-linearity in the text (e.g. circularity, repetition etc.). The short narratives I chose to present were chosen on the basis of narrative length (they were the shortest narratives), to illustrate the effects of narrative compression, and the associated bodily encoding of unspeakable emotional pain.

## Research Ethics

When the story is about pain, trauma, and injustice, listening itself can be painful. Listening requires the willingness to put the other's story at the centre of one's attention, to resist defensive reactions, and to acknowledge the limits of one's ability to put oneself in another's shoes. (Chase, 2011, p. 428)

Three types of participant reactions have been isolated in trauma-focused studies – those who are positive about the experience, those who experience participation as effortful and time-consuming, and those who find it negative, intrusive, burdensome and painful (Seedat, Pienaar, Williams, & Stein, 2004). With survivors of IPV in particular, it was women with better mental health that experienced positive gain, while women with higher levels of depression and PTSD and poorer coping mechanisms were more likely to feel regret and distress (Seedat et al., 2004). Despite claims about the positive effects of disclosing trauma, past traumas can bring up a great deal of painful emotion, including fear, shame and anger (Seedat et al., 2004). It is inevitable that trauma studies will elicit some distressing emotion.

The re-traumatisation of participants is a major ethical concern. Lieblich (as cited in Elliott, 2005, p. 137) talks about her concern about “opening a Pandora's box” and confesses that she was “constantly tormented with the sense of opening my interviewee's wounds and (as I thought then) leaving them with the pain.” It must be remembered on the other hand that people may benefit from being able to talk about the difficult aspects of their lives to a skilled and interested listener (Elliott, 2005). Studies have shown that interviewees valued being able to contribute and be part of a worthwhile project, and enjoyed the unusual experience of talking to someone at some length about their lives (Elliott, 2005).

Elliott (2005) argues that the narrative interview includes aspects of research and therapy. However, researchers do not always consider the ethical implications of the therapeutic potential of interviews. As I discuss in a later chapter, most of the women in my study said that their interviews had been an emotional unburdening for them, implying a therapeutic dimension to the interaction. Elliott (2005) advises that in such situations, the effects of interviewing on the experience of both the interviewer and interviewee needs to be considered.

One of the purposes of the use of personal narratives is to introduce previously marginalised voices into the record, to give voice to previously unheard stories (Maynes et al., 2008). In such instances, the researcher is interested in revealing hidden histories to develop new understandings of phenomena (Maynes et al., 2008). However, this is likely to give rise to sensitive material. Topics are considered “sensitive” if the research “intrudes into the private sphere or delves into some deeply personal experience; where the study is concerned with deviance and social control; where it impinges on the vested interests of powerful persons or the exercise of coercion or domination; and where it deals with things sacred to those being studied that they do not wish profaned” (Renzetti & Lee as cited in Phoenix, 2008, p. 124). What makes a topic sensitive is not its personal nature, but rather has to do with relational circumstances – it is in the relationship that interviewees’ feel content-related shame and vulnerability (Phoenix, 2008). It is important to note that in any research focused on sensitive topics, there is always the risk that interviewees will consider the researcher as superior to them. This may be because they are expected to tell stories about things that they are ashamed of, issues that are considered culturally inappropriate and events that have left them feeling vulnerable (Hyden, 2005). This may result in all manner of resistances which can seriously compromise data. Another danger is what bell hooks (as cited in Hyden, 2005, p. 128) calls “conceal(ing) your woman into her suffering” by focusing only on the difficult side of the interviewee’s life, which may cause secondary traumatisation. In my study, I attempted to avoid this danger by focusing on positive aspects of interviewees’ lives at the end of the interview. One danger that I did encounter which is discussed by Hyden (2005) is some interviewees’ difficulty in knowing when to stop a conversation that is becoming too painful; in other words, how to disclose appropriately.

One of the primary concerns put forward in relation to narrative research is that interviewees who are marginalised and subjugated have little or no control over the representation, interpretation and dissemination of their accounts (Gready, 2008). Interviewees may also feel deceived if they assumed that the purpose of the interview was to glean “facts” and information, and the analysis and interpretation focuses not on content but on the structure or form of the narrative (Elliott, 2005). It may also be difficult to explain in sufficient detail what the research is about if a social constructivist approach is to be taken, as in my case (Elliott, 2005).

Many scholars argue that the use of narrative in research gives respondents more of a chance to become active agents within the research process, selecting what they believe is the most

important or relevant information in expressing the complexity of their lives, than more structured methods like structured interview schedules or questionnaires or surveys which limit the nature of response the individual may engage in (Elliott, 2005). However, because the narrative interview can take on the character of an intimate conversation between friends, there is a danger that respondents “have often revealed very private parts of their lives in return for what must be, in the last resort, very flimsy guarantees of confidentiality” (Elliott, 2005, p. 136). The telling of life stories means that it is likely that interviewees may be identifiable to others who know them (Elliott, 2005). Elliott’s (2005) recommendation is that the researcher focuses on material that is already in the public domain, or that s/he produces fictional ‘composite’ characters, (the danger in this is that the researcher may unconsciously or deliberately choose aspects of different life stories that support his/her theory). As such, I decided to safeguard my participants by changing their names, and presenting only parts of the text.

A number of ethical issues were carefully considered before conducting the study. Since the focus of the research was on examining traumatic experience, shame and narrative breakdown, I was aware that the interviews might provoke a great deal of painful emotion, which I needed to be skilled enough to contain. Although I have not trained as a clinical psychologist, I have recently completed both the Basic Counselling Skills and Advanced Counselling Skills programmes at the South African College of Applied Psychology (SACAP), which prepared me to some extent for responding sensitively and empathically to interviewees’ experiences, and to provide the necessary containment.

It is very important in trauma studies to be guided by the principal of beneficence. Studies should only be conducted if it can be clearly shown that the importance and significance of obtaining sensitive and painful material justifies the psychological distress it may evoke, or if there is not another, less distressing way of obtaining the data (Seedat et al., 2004). The necessity of my study has been previously outlined, and there was no less upsetting alternative method of obtaining the data. To protect participants, I ensured that there were mechanisms in place to assist participants in the case of harmful outcomes (Seedat et al., 2004).

Three precautionary measures were taken to protect the welfare of the interviewees. Firstly, I ensured that interviewees were in a relationship with a counsellor at the Centre whom they could consult after the interview should they wish to. I made myself available to talk to the counsellor about any difficult emotional material that emerged in the interview, which may

have needed to be processed during the next session (with the permission of the participant). Secondly, I offered each participant a follow-up interview should she wish to discuss any aspect of the previous interview. Thirdly, I sought supervision, both in preparation for the interviews, and during the process of conducting them, from a mental health professional who is very experienced in trauma-related therapeutic work.

As I have described, I conducted a number of recruitment sessions about the research at the Centre, during which I described my research and invited women to participate. I handed out informed consent forms to the women who agreed to participate, and all the women completed them; in only one instance did a woman need clarification about the meaning of something written in the form. The consent forms outlined the nature and purposes of my study and what participation would entail, as well as giving assurances of anonymity and confidentiality, and were handed out during recruitment sessions (Appendix B). Although there is some debate about how much information potential participants in trauma studies should be provided with (due to concerns around bias and discouraging participation) (Seedat et al., 2004), I opted to tell women that I would ask them about the traumatic experiences in their childhood and adulthood, and how they felt about their experiences, in the spirit of full disclosure. The consent forms were available in both Afrikaans and English to ensure that the participants could read about the nature and implications of their participation in their first language. Informed consent was provided by all 19 participants during the recruitment sessions. The interviews were also conducted in the language preferred by the participant so that she could communicate in their first language.

Participants were offered a R50 gift voucher from a chain of grocery stores (Pick 'n Pay) as a token of my gratitude for their participation.

Permission to conduct the study was granted by the Research Ethics Committee of the Faculty for Health Sciences, Stellenbosch University, prior to the commencement of the study. The Institutional Review Board (IRB) number is IRB0005239.

## CHAPTER 7

### Results and Discussion I

The following two chapters are not results chapters in the traditional sense. They include substantial discussion, which contextualises and provides some interpretation for the evidence I present. In this chapter, which focuses on the results and some discussion of them, I present a background and context to the study. Then I present the results of the categorical content analysis of the data, supported by quotes from the interviews with 19 women resident at the Saartjie Baartman Centre for survivors of IPV. I begin with the categorical content analysis because it gives the reader a broad and global picture of the women's experiences of trauma and shame. Its function is purely descriptive. In the second results and discussion chapter (chapter 8), I present a phenomenologically informed and social constructivist narrative analysis of cases where there is evidence of the split self, which is analysed at individual, organisational and cultural levels. In chapter 9, I conduct a more formal, in depth and complex categorical form analysis (using Gee's 1991 model) of single cases where there is evidence of linguistic fracturing, representing the trauma-related disintegration of self. As is evident, I am interested both in what women's stories were about (categorical content analysis, which will be presented in this, the first results and discussion chapter, and expanded upon in the next chapter), as well as how they narrated their experiences (categorical form analysis, which will be presented in the third results and discussion chapter; Chase, 2011). As such, I will: 1) identify themes across narratives (categorical content analysis) in pursuit of providing a detailed description of participants, 2) provide a more theoretically situated analysis of a specific and predominant theme emerging from this chapter (the trauma-related split self), and finally, 3) conduct a complex, in depth categorical form analysis of single cases where there is evidence of linguistic fragmentation. After providing background and contextual information, I begin with the categorical content analysis below.

#### **Contextualising the Study: Impressions Before and During the Interviews**

The ever-presence of violence in and around the Saartjie Baartman Centre provided a backdrop to this study. For example, one of the women residents at the Centre went out for

the weekend, and was gang raped by the brother of one of the other residents, and his associates. The women's treatment of their children is also a testimony to the ubiquity of violence – their apparent abuse in particular, as well as their apparent physical abuse and neglect. During the time I was working at the Centre, one woman had her four children removed for physical abuse, and many others had been warned for similar behaviour. The threat of perpetrators, the ex-partners of the women, was additionally a constant feature. Men often threatened to come to the Centre when they found out that their ex-partners were there, and at times, threatened those in charge of security, and those in management. On occasion, they would arrive at the Centre and threaten violence. One woman's ex-partner abducted one of her children who was only found a few days later. This provides a context to the high levels of fear and anxiety reported by so many of the women I interviewed.

I had agreed with management to work at the Centre twice a week for two months before commencing recruitment, to get to know the women before I invited them to participate in my study. The purpose of this exercise was to encourage participation – if women were familiar with me, and felt comfortable with me, it was more likely that they would not only participate in an interview, but disclose deeply personal information. In the first few sessions, I simply helped staff and the women volunteers to sort out rooms filled with donations. After this, I spent a number of sessions in the on-site crèche. The level of neglect and deprivation that was evident in the children was startling. This was compounded by the number of children (between 20 and 30) in the crèche, and staff shortages. Even with volunteers assisting in the crèche, there were just not enough hands to go round, especially with children so emotionally needy. As an illustration of this level of emotional need, whenever I arrived at the crèche, a handful of children would run up to me and throw their arms around me, all desperately wanting to be held. This happened repeatedly, and often children would become aggressive with one another when they felt that they were not being given adequate attention. The level of attention seeking behaviour was striking, including negative attention seeking (antisocial behaviour) - at times it was as if some of the children would deliberately behave badly as a means of testing whether they would be rejected or abandoned; they were constantly testing boundaries. I found the experience in the crèche exhausting for that reason – so many children who were in need of basic care, all grappling; grasping for a bit of it.

Another feature of the Centre was the fluidity of the population of women resident there. Women were constantly coming and going, changing the landscape of the Centre. I found that, for this reason, I needed to be flexible in my approach to recruitment. For example, I

recruited eight women during my first recruitment session, and a week later, half of those women were expelled from the Centre for substance misuse. What was particularly problematic about these changes in the population was its effect on my rapport-building with the women. When women left the Centre, this rapport-building was largely wasted, since women with whom I had developed a relationship were replaced by new, unknown women. These changes also meant that I had to do multiple recruitment sessions, to accommodate new residents. I felt complicit in a web of circumstances which through no obvious fault of my own or that of the Centre exacerbated rather than ameliorated the situation of all these women and their need for stable and reliable attachments, an issue to which I shall return towards the end of the thesis.

The women who did not leave the Centre during my rapport-building quickly got to know me. Within a couple of sessions, they were familiar enough to greet me and talk to me during our organising sessions. This can be contrasted to the women's behaviour after the interviews, a point to which I shall return. What I found particularly striking was that despite only knowing me for a relatively short while, women were very open about their experiences with me during the interviews. They sometimes described in excruciating detail what they had survived, particularly sexual humiliation and rape. Almost without exception, I felt that women over-disclosed during interviews. The women I interviewed had a history of having their rights violated by a more powerful other, and this may be one of the reasons why they over-disclosed to me, an outsider who was affiliated with Centre management, and also occupied a higher social position (middle-class, White, educated, etc.). It is very possible that women felt compelled – because of this power differential – to comply with my request for participation and disclosure.

Perhaps in the context of this power differential, women struggled to assert their right to a reasonable degree of privacy, even within an emotionally evocative interview. Another interpretation is that, like their children, these women appeared to attach indiscriminately (a disorganised attachment pattern), characterised by transitioning from having a limited, or no relationship with me, to a sudden and surprising sense of familiarity and intimacy between us. This is likely to be the product of their own deprived backgrounds, and lack in adequate, consistent care from attachment figures.

The perception that I was affiliated with management and its relationship to women's compliance needs to be explored further. Women were very dependent on the management of the Centre, literally for basics such as food and shelter, so it was important to them to be seen

in a positive light by these staff members. This meant that women were highly compliant with requests or instructions from management. This compliance became apparent, for example, during a random drug testing procedure. It is Centre policy that there may be no drugs or alcohol on the premises, and consequently, the staff do spot checks to test for the presence of substances. My daunting task, the second time I volunteered at the Centre, was to watch the women urinate to ensure that they did not swap urine samples to avoid testing positive for substances. At no point did any of the women question a virtual stranger watching them urinate, and no women questioned the process generally and the possibility that their right to privacy was being violated (although the necessity of such testing is not denied). This level of compliance may very well be a result of having experienced chronic abuse, and the associated struggle or inability to safeguard personal rights and choices. In my view, it is this same compliance that determined women's high response rate to my invitations to participate in my study, and their willingness to disclose deeply personal material.

### **Categorical Content Analysis**

The themes extracted include the following:

#### **Exposure to IPV**

##### *Physical Violence*

##### *Sexual Violence*

##### *Emotional Violence*

Verbal abuse and threats

Sexual humiliation

Jealous and controlling behaviour

Financial deprivation

##### *Most Traumatic Experience*

Physical violence

Emotional violence

Children witnessing violence

##### *Most Difficult Feelings*

Helplessness

Fear

Memories or flashbacks

Ambivalent or mixed feelings towards the perpetrator

***Post-traumatic Changes in Perceptions of the Self and Functioning***

Positive changes

Negative changes

Positive and negative changes

***Feelings About Others***

Fear

Mistrust

Hate

Anger

***Feelings Towards Perpetrator***

Hate

Anger

Fear

Numbness

Love

***Health and Psychopathology***

Symptoms of depression

Symptoms of anxiety

History of suicidality and/or current suicidal thoughts and actions

Dissociation

Stress-related illnesses and somatic complaints

***Descriptions of Shame***

Social shame or stigma

Bodily expressions or descriptions of shame

Hiding behaviours

Overlapping concepts: humiliation and embarrassment

***Supports and Coping Mechanisms***

Spirituality/religion

Social support

- Centre staff (counselling and management)
- Friends
- Children

#### Defenses

- Smiling as a “mask”
- Avoidance (keeping occupied)

### Transgenerational Trauma

Direct exposure to physical violence

Indirect exposure to physical violence (witnessing)

Direct exposure to sexual violence

Emotional violence

Table 7.1 below provides an overview of the number of themes extracted by means of categorical content analysis; thereafter each theme will be discussed in turn. Although almost all women experienced more than one form of violence, categories were considered mutually exclusive, and participants were counted accordingly. Table 7.1, by providing counts, is in its nature a reduction of the complexity of the qualitative data obtained, but it does give a useful overview and context for the discussion that follows.

Table 7.1

#### *Categorical content analysis: Findings*

<b><i>Intimate partner violence</i></b>				
<i>Physical violence</i>		<i>Sexual violence</i>		
18		5		
<i>Emotional violence</i>				
<i>Verbal abuse</i>	<i>Jealous/controlling behaviour</i>	<i>Sexual humiliation</i>	<i>Financial deprivation</i>	
11	10	3	3	
<b>Health and psychopathology</b>				
<i>Depression</i>	<i>Anxiety</i>	<i>Suicidality</i>	<i>Dissociation</i>	<i>Somatisation</i>
9	3	10	3	4
<b>Splitting of self</b>				
<b>Descriptions of self (other perspective)</b>				
<i>Inner strength</i>		<i>Positive other</i>		
11		7		

<b>Shame-based self-perceptions</b>		
<i>Worthless/useless/inadequate</i>	<i>Dirty and contaminated</i>	<i>Blame and deservedness</i>
11	3	10
<b>Transgenerational trauma</b>		
12		

### **Exposure to IPV<sup>19</sup>**

All the women interviewed had experienced intimate partner violence. Cheryl describes the ubiquity of IPV in her community:

“Die omgewing wat ek uit kom is dit amper so, ek sal amper sê dis tradisie. Dis tradisie vir die mans om hulle vrouens te slaan of hulle meisies te slaan. Vir hulle is dit sort van om te bewys ek is in beheer en ek is baas... Vir ons is dit amper so, as jy nie jou vrou kan klap nie dan is jy ‘n moffie.” - Cheryl

*[Where I come from it is almost, I'll almost say it's tradition. The tradition is for the men to beat their wives or to beat their girlfriends. For them it's kind of proving I am in control and I am the boss... For us it is almost like, if you can't slap your woman then you're a pansy.]*

### **Physical Violence**

All but one woman reported a history of physical violence perpetrated by her ex-partner. This included slapping, kicking, beating with implements and single or multiple stabbings. In one instance, an interviewee (Irene) reported that her ex-boyfriend set fire to her wendy house (a small wooden house), believing she was inside. This woman described multiple stabbings over an extended period of time:

“He stabbed me, not last year, but the year before, and that's besides other occasions where he also stabbed me. And then when it came to court dates, I withdrew all cases. I tell you, he stabbed me 12 times. Last year, just before Easter, I was stabbed 12 times. And believe you me, I withdrew the case, in the sense of, ag (*oh well*), give him another chance, maybe he will

<sup>19</sup> To distinguish participants' quotes from published authors' quotes, they will not be indented. Where translation is necessary, the translations will be italicised.

change. And then this year he stabbed me 15 times. I can show you the marks. My stab wounds were all five to six-and-a-half centimetres wide.”

Cheryl described the beatings she received:

“Hy het my geslaan met 'n spyker in 'n plank. Dit het 'n spyker voor in gehad. Maar die seer het ek nie gevoel nie. Vir my was dit net, kom, maak net klaar, maak nie saak wat gebeur nie, maak net klaar dat dit oor en verby kan wees. Of hy my nou dood slaan, vir my was dit net, maak net klaar. Hy het my seker so vir 'n uur-en-'n-half aanhoudend geslaan met daai plank.”

*[He beat me with a nail in a plank. It had a nail at the front. But I didn't feel the pain. To me it was just, come, finish it off, doesn't matter what happens, just finish it off that it can be over and done with. If he kills me, to me it was just, finish it off. He must have hit me with that plank for an hour and a half without stopping.]*

### **Sexual Violence**

Women relatively commonly reported experiencing sexual violence at the hands of their perpetrators. These women described regular demands for sex, always against their wishes.

Annabelle described her terror at night:

“As hy inkom in die aande dan bid ek dat dit kan dag raak want in die aande vat hy baie drugs dan klap hy my sommer wakker of force vir my om seks te hê”.

*[In the evenings when he comes in, I pray for the day to break, because in the evenings he takes a lot of drugs and then he just slaps me awake or forces me to have sex with him.]*

The violence and brutality of sexual attacks against her was described by Jeanine:

“Daar was tye wat ek nie saam met hom wou geslaap het nie, en dan forseer hy my om by hom te slaap. Daar was tye gewees wat hy my klere van my liggaam afgeskeur het.”

*[There were times that I didn't want to sleep with him, and then he forces me to sleep with him. There were times when he tore the clothes off my body.]*

Irene explained to a police officer how she initially did not think that sex against her will was rape, as she knew her perpetrator:

“He [the police officer] asked me a few questions, and he asked me, did he [perpetrator] have sex with you? I said yes. And he did ask me, was it against your will? I said, but I did tell him no. I said, I wanted to go to the police station and lay a charge of rape. Then I also said, no, but he didn’t rape me, I know the guy!”

### ***Emotional Violence***

Emotional violence among these participants included verbal abuse and threats, jealous and controlling behaviour, sexual humiliation and financial deprivation.

Most of the participants reported that their perpetrators were verbally abusive towards them. This kind of abuse mainly consisted of belittling and undermining women, often in front of their children; using intimate details shared by women against them; and threatening women to prevent them from leaving the abusive situation.

Perpetrators were described as verbally attacking roles and capacities women valued:

“Daar was 'n stadium wat ek bereid was dat hy my kind kan vat, want ek het al begin glo ek is 'n slegte ma. Hy het dit elke dag in my kop in gepraat, jy's 'n slegte ma, jy's 'n slegte ma”.

(Cheryl)

*[There was a stage when I was prepared for him to take my child, because I started to believe that I'm a bad mother. Every day he drummed it into my head, you're a bad mother, you're a bad mother.]*

Patricia described the betrayal of her trust:

“En om te dink, nadat hy in 'n relationship gegaan het sou hy vir my beter verstaan het because hy weet waarvandaan ek kom en so, but hy het dit actually gebruik; hy het dit aanmekaar in my gesig gegooi”.

*[And to think, after he went into a relationship he would understand me better because he knows where I come from and so on, but he actually used it, he kept on throwing it into my face.]*

Felicia described a similar situation:

“Then when I met him, because we were trying to have a relationship, I opened up and I told him everything about my past. So because he knows all the things that I did in the past, then he keeps on bringing it up and he keeps on trying to push me down because of that.”

Mandy described her perpetrator’s terrifying threats:

“Then he threatened me and he said if I’m going to leave him, one of us is going to die. He is going to kill me or he is going to kill himself.”

Cheryl described her perpetrator’s threat to kill her and have her raped by members of a local gang:

“Hy het eenkeer vir my gesê dat hy gaan my vrek skiet, en dan gaan hy dat die hele JCY’s by my om gaan en so.”

*[Once he said to me that he would shoot and kill me, and then he would let all the JCY’s (name of a gang) rape me and so on.]*

Most of the participants’ perpetrators engaged in jealous and controlling behaviour. These men were described as insecure and obsessive in their relationships, and often falsely accused women of having sexual relationships with other men.

Chantal described the following humiliation:

“[Hy] vat my onderklere en dan sit hy dit in 'n plastic sak, dan sê hy vir my ons moet hospitaal toe stap dat die dokter nou vir hom sê met wat se mans ek mee geloop het”.

*[He] would take my underwear and put it in a plastic bag, then he would say we must walk to the hospital so that the doctor can tell him with which men I have been]*

Mandy described her perpetrator’s intrusive behaviour:

“Everything was fine for a while, but there were hints of some sort of obsession or something, that he always wanted to be where I am. Like if I’m at work...I used to work at a movie shop, so everybody can come in, so he used to like hang around there a lot when I was on duty”.

Patricia explained that her perpetrator’s jealous behaviour prevented her from taking care of her appearance:

“Ek het nooit eers my hare geblow nie; ek gaan nie eers buitekant toe nie; ek trek my nie eers aan nie. Want nou kom Zavier se pa uit die werk uit as ek nou my hare miskien eendag gewas het, en dan is dit: is dit ‘n man?’”.

*[I never even blow-dried my hair; I don't even go outside; I don't even dress myself. Because just now Xavier's father comes from work and if I perhaps washed my hair one day, and then it is: is this for a man?]*

It is worth noting here that my participants, almost without exception, did not take adequate care of their physical appearance. This could either be a function of continued or residual fear of their perpetrators' jealous and controlling behaviour, as illustrated in Patricia's quote above, and/or an indicator of depression. Despite the likely effect of poverty on how women presented themselves, the lack of care of physical appearance seemed amplified among the women I interviewed.

Some participants reported sexual humiliation. This took the form of perpetrators' bringing other women home and having sex with them in the home women shared with them.

Veronica described the following:

“He used to bring women in the house, then he will have sex with the women. I had to stand there and look at them.”

Denise said:

“The situation with my child's father, and catching him in my bed with his ex-girlfriend, that was very difficult. I'm not a violent type of person, and I had to pretend to be violent at that moment. I still told him, if you want to sleep with this woman, just get out of my house. I'm not interested in you any more. Just get out. Don't do your things in my house and in my bed. But she just kept on coming back; everyday she comes there to him and he locks the bedroom door and they do their thing in the room. I must still hear all the sounds and all that.”

Financial deprivation was experienced by a few women. This took the form of perpetrators not financially supporting women or their children during and/or after the relationship, and of men taking money from women or selling their possessions. The latter was accompanied by an expectation that women should financially support their perpetrators, including covering the cost of their substance misuse.

Isabelle described how her perpetrator used to abuse her financially:

“So sometimes I would buy something like a TV set for the house, and when I would go to work he would sell that TV for a silly price, maybe R200 or maybe R500. Then he drinks up that money.”

Some women reported that their perpetrators' substance misuse problems contributed to, or exacerbated their capacity for violence. These substances included dagga (cannabis), Mandrax ("buttons") and Tik (crystal methamphetamine).

Annabelle described the reason for her perpetrator's violence as follows:

"My boyfriend het eintlik begin drugs gebruik, die Tik. Hy raak deurmekaar, hy sien goeters en hoor goeters wat nie is nie... Dan kom hy sommer kwaad in, dan klap hy my."

*[My boyfriend actually started using drugs, the Tik [crystal methamphetamine]. He gets confused, he sees things and hears things that don't exist... Then he just comes in angrily, and slaps me.]*

### ***Most Traumatic Experience***

A number of women described their most traumatic experience as involving emotional abuse. Some women cited physical abuse as their most traumatic experience, while others described how difficult it was for them when their children witnessed violence between them and their perpetrators. The rest of the participants reported that the death of a loved one (a family member) and separation from children were the most painful experiences for them.

Cheryl describes how painful the emotional abuse by her perpetrator was for her:

"Ek sal altyd sê, vir my is dit wat hy my geslaan het, ek sal nie sê dit was swaar nie. Maar die woorde wat hy nou daarby gesê het en goed, dit bly altyd vas sit."

*[I'll always say, to me that he hit me, I won't say that was hard. But the words that he said with it and so on, that will always stick.]*

Chantal describes her worst experience as involving an unexpected and life-threatening physical assault:

"Dit was Christmas gewees laas jaar, wat ek saam met my oukie by sy ouma-hulle gewees het. Want ons is oppad na sy vriende toe; ons gaan mos nou daar by hulle gaan sit. Toe ons nou oor die heuwel kom...nou, daar's 'n dam daar by hulle, en nou lê daar 'n klomp van daai harde berg klippe, toe het hy van die klippe beginne op tel en vir my gegooi. En ek moet vir hom soebat...en hy gooi nie om te speel nie - hy gooi ernstig om my dood te gooi. Ek het nie geweet wat moet ek maak nie."

*[It was Christmas last year that I went with my guy to his granny and family. Because we're on our way to his friends; we're going to go and sit with them, not so? When we got over the hill...now, there's a dam there at their place, and now a lot of those hard mountain stones are lying there, then he started picking up the stones and throwing them at me. And I must plead with him...he is not throwing as if it's a game – he throws seriously, to kill me. I didn't know what to do.]*

Children witnessing the violence between parents evoked a great deal of guilt among women, and in all three cases, prompted them to leave the relationship. Cheryl describes her guilt as follows:

“En laterhand...hy slaan my en hy slaan my, maar vir hom is dit net, so lank daar nou net bloed uit of whatever. En hy slaan my toe oor die kop agterna, en die spyker maak toe 'n gat in my kop en die bloed spuit uit, en hy slaan toe weer op my kop en daar's nog 'n gat. En ek het vir my dogtertjie op my arm soos wat hy my toe slaan, en toe spuit die bloed toe op haar. Sy is onder bloed en sy is histeries. Ek voel niks vir dit wat hy vir my doen nie, dis net die feit dat my dogter daaronder moet ly.”

*[And later on...he hits me and he hits me, but for him it is just, as long as there's blood coming out or whatever. And after that he hits me on the head, and the nail makes a hole in my head and the blood spurts out, and then he hits me on the head again and there's another hole. And I have my little daughter on my arm while he is hitting me, and then the blood spurts onto her. She is covered with blood and she is hysterical. I don't care what he is doing to me, it's just the fact that it causes my daughter to suffer.]*

### ***Most Difficult Feelings***

Women described a range of feelings as being the most difficult for them, but responses clustered around helplessness, ambivalence towards their perpetrators, fear, and the experience of nightmares and flashbacks. Mandy describes how painful her helplessness in the context of her abusive relationship was:

“When something happens to you, if you are able to defend yourself, you feel at least better that you tried to defend yourself. But if you can't do anything, then it's just a terrible feeling.”

Irene described her mixed feelings towards her perpetrator as most distressing:

“You know, the thoughts and the feelings that I can’t cope with is where I think, I still love this man. And then it suddenly comes to me, how can you love him if he did this to you? Then I hate him again. I think that is what I call...they say it’s mixed feelings that I have.”

Fear was cited as the most difficult feeling by other women. In Cheryl’s words, “vir my die swaarste was om in vrees te lewe”. [*For me, the most difficult thing was to fear for my life.*]

Fear sometimes impeded women’s sleep:

“There are many nights when I cannot sleep. Then, to me, it’s like he’s [perpetrator] at the window. The thought comes to me, but he cannot be at the window because we are upstairs.”  
(Irene)

Patricia described her vivid nightmares as the source of most distress:

“Sometimes kry ek nog nightmares, like as ek nou slaap, dan skrik ek wakker en ek het miskien gedroom Zavier se pa staan voor my. Hy choke vir my. Nou die nag toe skrik ek weer wakker, like struggle en daai, en toe dink ek Zavier se pa staan voor my.”

[*Sometimes I still get nightmares, so when I am sleeping, then I wake up frightened and perhaps I dreamt that Zavier’s father was standing in front of me. He chokes me. The other night I woke up again, struggling and so on, then I thought Zavier’s father was standing in front of me.*]

### ***Post-traumatic Changes in Perception of the Self and Functioning***

The majority of the women I interviewed reported post-traumatic changes in their feelings about themselves and functioning. Changes were either positive or negative, although some women reported both positive and negative changes. Negative changes were those that endured as a result of the abusive relationship, while positive changes were more recent changes facilitated by the separation from the perpetrator. Irene described the negative shift in her feelings about herself as a function of her abusive relationship:

“Before I met David, I felt like a lady... I know he is trying to get me down, man. You see, I feel filthy. I feel dirty. I feel messed up.”

Linda describes a positive post-traumatic change in her perceptions about herself:

“I was always just surrounded in that bubble where I thought nothing of myself and that I’m worthless, and I can never achieve something because I’m not good enough; I’m not beautiful enough. I was living in that bubble all this time, and now I see things so totally differently (in a different perspective), that I know I can still achieve something if I just work and try to make that first step and start wanting to do something to make a change.”

A similar change is described by Chantal:

“Ja, en ek kan nou vir myself kyk in 'n spieël en sê, nee, maar jy's regtig 'n mooi meisie. En ek wil nooit vir my sommer gekyk het in 'n spieël nie want vir my was dit altyd...hoe kan ek nou sê...ek het net gedink, nee, ek is nie 'n mooi meisie nie. Ek is nou eerlik, ek het altyd so gedink, maar vandag kan ek vir my in 'n spieël kyk en vir myself sê, nee, maar Chantal, jy's rêrig 'n mooi meisie. Jy verdien nie dit wat jy gehad het nie.”

*[Yes, I can now look at myself in a mirror and say, no but you are really a beautiful girl. And I never wanted just to look in a mirror because for me it was always...how can I put it... I just thought, no, I'm not a beautiful girl. I am honest now, I always thought that, but today I can look at myself in a mirror and say to myself, no but Chantal, you're really a beautiful girl. You don't deserve what you got.]*

Other positive post-traumatic changes included increased perspective-taking and empathy, and reduced anger.

### ***Feelings About Others***

The traumatic experiences that the participants had experienced resulted in a range of negative feelings towards others, including mistrust, fear, anger and hate.

Cheryl explains:

“Daar op Worcester kan ek niemand vertrou nie. En sake wat ek gemaak het teen hom en goeters, val sommer net so deur die mat want daar's nie getuies nie en daar's nie mense wat my kan bystaan nie.”

*[There in Worcester I cannot trust anybody. And when I tried to have him prosecuted and things, it just came to nothing because there are no witnesses and there aren't any people who can support me.]*

She adds:

“Dis hoekom ek is op 'n punt waar dit vir my baie moeilik is om mense té naby my te laat, vir seer maak en vir teleurstellings. Ek praat met almal - ek het 'n verhouding met almal - maar ek gee hulle nie kans om té na aan my te kom nie.”

*[That's why I am at a point where it's very difficult for me to allow people too close to me, because of being hurt and disappointments. I talk to everyone – I have a relationship with them all – but I don't give them the chance to get too close to me.]*

Fear of others was characteristic of a number of women's narratives:

“Dis amper so, soos nou bang. Ek voel eintlik bang om te meng met mense.” (Christine)

*[It's almost like, like fear. I actually feel afraid to mix with people.]*

Mandy described both her mistrust and fear:

“I also find it quite difficult to trust people, but I still know that there are good people. There are good people out there, but it's just a bit difficult, ja (yes), it's difficult. I'm afraid that somebody might try to hurt me as well, like I have been through already. It's something that I don't want to go through ever again.”

Irene explains her anger and need for revenge:

“That's why I say, I don't want to be involved with another man. I'll never think of it because I will seker (*probably*) take my rage...my revenge, I will seker take it out on this next man that I must ever get involved with. Because the way he abused me and Harold abused me, I think I will abuse that man. Honestly, so I'm not interested. I'm not interested in another man.”

Cheryl explained that people who reminded her of her abuser evoked her hatred:

“Ek haat 'n persoon wat ander mense se lewe moeiliker maak, of wat 'n ander persoon in die gesig vat, of in beheer wil wees van daardie persoon se lewe. Want vir my is dit maar net, jy doen dieselfde wat daardie abuser doen, of jy is dieselfde.”

*[I hate a person who makes life difficult for other people, or one who insults another person, or tries to control that person's life. Because for me it is just, you do the same that that abuser does, or you are the same.]*

### *Feelings Towards Perpetrator*

Strong feelings were expressed towards perpetrators of IPV, as indicated in this comment:

“I hate the man”. (Thobeka)

Women felt a variety of feelings towards their perpetrators, including fear, anger, hate, numbness and love.

Some women expressed intense fear of their partners. Her reason for experiencing anxiety-related insomnia is chillingly articulated by Jeanine:

“En dan lê hy nou so vir my en aankyk in die nag in as die ligte af is. Dan sit hy weer regop. Nou in daardie stadium het ek altyd gedink, wat gaan deur jou mind? Ek kan enige iets... 'n mens kan expect dat so 'n persoon jou gaan wil dood maak in jou slaap.”

*[And then, lying down, he looks at me in the night when the lights are off. Then he sits up again. Now in that stage I always thought, what is going through your mind? Anything can...one can expect that such a person will kill you in your sleep.]*

Although women expressed a great deal of anger about their abuse, reasons for anger varied. Chloe describes the reasons for her anger as follows:

“Daar is baie kere wat ek kwaad voel. Because baie kere dan try ek nie om daaraan te dink nie, because why, dan begin ek kwaad te raak because ek het baie, baie, baie ingesit in die verhouding. Ek het my ma-hulle afgestaan en so om vir hom te satisfy, en to think back, hy het nie dieselfde gedoen vir my nie.”

*[There are many times that I feel angry. Because there are many times that I try not to think about it, because then I get angry because I put a lot, a lot, a lot into the relationship. I gave up my mother and them to satisfy him, and to think back, he didn't do the same for me.]*

Three women described feeling numbness in relation to the perpetrator. Numbness has been described as a pervasive feature in the lives of Holocaust survivors (Kraft, 2004). Mandy described her total lack of feeling towards her perpetrator in the following way:

“I just feel numb towards him. I don't feel anything”.

Isabelle expressed love for her perpetrator. Disturbingly, she described her feelings towards her perpetrator in the following way:

“My husband, honestly, I love him. I love him. At some point I was thinking, it’s better I go back there and take the abuse. It’s better being abused by someone who loves you.”

### ***Health and Psychopathology***

A number of women reported symptoms of depression (persistent sadness/depressed mood, loss of interest in personal appearance, and/or excessive sleeping/hypersomnia), generalised anxiety, a history of suicidality or current suicidal thoughts or actions and/or dissociation. Some women also reported stress-related illnesses and somatic complaints.

Chantal described her depression, which persists in her current life, as follows:

“Ek het gevoel...van die abuse besigheid...ek het gevoel eintlik laat ek ook suicide wou commit het. Ek het gevoel niemand gee om vir my nie en niemand is lief vir my nie, en daar gaan nie iemand wees wat my kan help nie. Die gevolg sal wees dat ek alleen wees, en ek huil en whatever, of ek loop sommer weg van die huis af, somtye. En daar was tye wat ek nie wil geëet het nie; bly sommer vir weke sonder kos want ek voel depressed. En ek het baie maer geraak - ek wou nie eet nie. Ek het depressed geword. Daar was ook tye wat ek net wou slaap.”

*[I felt...from the abuse business...I felt that I actually also wanted to commit suicide. I felt that no one cared about me and no one loves me, and there will be no one to help me. The result will be that I will be alone, and I cry and whatever, or I just walk away from home, sometimes. And there were times that I did not want to eat; stay without food for weeks because I feel depressed. And I got very thin – I didn’t want to eat. I became depressed. There were also times that I just wanted to sleep.]*

Felicia describes sleep as an escape from challenging feelings:

“I can’t cope, sometimes I’ll just sleep the whole day and wish things would go away. And yes, I wake up, then I’m still in the same place.”

Suicide attempts and suicidal thoughts were common among my participants, and were always understood as the results of their trauma exposure. Jeanine described the relentlessness of her thoughts of suicide:

“Maar daar was tye, ek het al probeer selfmoord...ek het dit al baie kere oorweeg, en dan het ek dit weer gelos, en dan kom dit weer op en dan los ek dit weer.”

*[But there were times, I have tried to commit suicide...I have often considered it, and then I left it again, and then it comes up again and then I leave it again.]*

The intrusiveness of her suicidal feelings is expressed by Denise:

“Because while I was still at home, I sit down and I start thinking about what happened, and I just start crying or I think of taking my own life – and things like that.”

Some women expressed a great deal of generalised anxiety, which was attributed to their abusive relationships. Cheryl described her continued apprehensive expectation that she is going to be hurt as a result of her perpetrator’s unpredictability:

“Ek was baie lief vir boeke lees, maar sodra ek té lank lees, die stilte beginne raak vir my krielrig. Vir my het die stilte altyd iets beteken: wat kom nou weer na die stilte? So ek het nou al beginne gewoon raak aan, ek moet nou iets verwag ashy was nou heeltemal stil of hy was nou gister heeldag reg, en nou as hy nou inkom dan moet ek heeltyd sy houding en sy gesig en alles dop hou vir enige iets wat hom nou kan laat snap - klein dingetjies.”

*[I was very fond of reading books, but as soos as I read for too long, the silence makes me fidgety. For me silence always meant: what will follow the silence? So I have become accustomed to, I must expect something when... yesterday he was completely quiet, or yesterday he was fine the whole day, and now when he comes in then I must always watch his body language and his face and everything that can make him snap – small things.]*

Dissociation is a common defense to trauma (Putnam, 1989). Irene describes how she experiences a brutal attack by her perpetrator in the third person, as if looking at something unreal unfold:

“I don’t know what happened, and he just took that knife and he put it into my leg, into my knee here. I’ll show you that mark. And here this knife is standing upright in my leg. I think that was the most...oooh, my god. I looked at the knife. I grabbed it, but it wouldn’t come out. I tried to get up, I couldn’t get up. Eventually, when I got up, I couldn’t walk. I actually did this with my leg, and once I did, I had to pull that knife out of my leg. And I think, that to me, pulling out his knife that he planted in my knee...he planted that knife there. I had to pull it out. It’s like watching a movie... A horrible movie.”

Women framed their physical illnesses and symptoms in particular ways, stressing the role played by trauma in their ill-health. Stress-related illnesses and somatic complaints included heart conditions, high blood pressure, nausea, headaches and infections such as pneumonia.

### *Descriptions of Shame*

“In the beginning, was the relation” (Buber, 1958, p. 31).

Understandings of shame differed in this study from previous research. Among these participants, shame was either denied outright or it manifested as another emotion. H. B. Lewis (1971) argues that one of the most powerful defenses against shame is denial. Even if they admitted to feeling shame, the women I interviewed generally struggled to articulate what shame felt like, and what it meant to them. Many had limited vocabularies, and found it difficult to describe their emotional lives. When present, however, shame was often described in social or relational terms. So the shame described by the women who experienced it was external shame, which overlaps significantly with humiliation.

A number of women referred to humiliation when asked about shame. Irene described her humiliation when her friends saw her injuries, emphasising the role of a hostile, mocking audience:

“If Steve hits me now, he will walk with me, with that blue eye or that stab wound, wherever it is on my body, and it’s like nothing happened. But me, walking with him...we go to town Centre, say, we’re going to Cape Town now and we’re going shopping...and I will now walk past Maureen or one of my friends, I would feel so ashamed of myself, thinking, they know why my eye is blue... I would feel so ashamed of myself, look what I look like!”

Veronica describes how she lied about the cause of her injuries because of her humiliation:

“I said, jinne (*goodness*), man, I don’t want my family to see this. I always hid, and I always lied to them. Even my boss and my friends, they see me with blue eyes or a broken arm, I always lie. I would say, no, I got hurt, and that and that.”

The perception that she is surrounded by a hostile or mocking audience also emerges from Christine’s narrative:

“Daar by ons is dit mos nou amper so, dis mos 'n klein dorpie, nou daar's mos nou baie wat nou al weet watter dinge ek nou al deurgemaak het en so aan. Ek voel skaam as ek partykeers loop in die straat.”

*[There with us it is almost so, isn't it, it's a small little town, isn't it, now there are many who know by now what things I have gone through and so on. I feel ashamed when I sometimes walk in the street. ]*

Feelings about the self are intricately implicated in the experience of shame and humiliation. Mandy expresses this relationship well:

“When he used to tell me that I'm useless, I'm going to be a nobody and I'm good for nothing and all that, I used to feel that's maybe how I am, and I used to be ashamed of myself.”

Finally, shame included feelings of being at fault; something for which the survivor was to blame. Patricia describes this feeling:

“Vir my, iets soos abuse, is iets om skaam te wees oor.”

*[For me, something like abuse, is something to be ashamed of.]*

For Chloe, shame is judgement by others (which is characteristic of both humiliation and stigma); she says “ek is bang mense vind uit en hulle judge my.”

*[I am afraid people find out and they judge me].*

A number of women talked about the stigmatised status of survivors of IPV, for example:

“Because the stuff that I hear from staying in a shelter, people are going to classify you as...you are like...how can I say...you are useless, that's why you had to go and stay in a shelter. You can't look after yourself... The stigma of having to stay in a shelter.”

Shame was also confused with embarrassment. Embarrassment is a less intense emotion than shame, and it may be evaluative or non-evaluative in nature. It emerges in the context of relatively trivial or amusing transgressions, and is associated with a great deal of physiological arousal (e.g. blushing) (Tangney et al., 1996). Considering the gravity and intensity of IPV experiences, this choice of word seems at odds with the lived experience of IPV. In the following quote, Denise responds to my asking her what shame felt like, by describing both embarrassment and humiliation (hostile and mocking audience):

“I was just embarrassed... I was also hurt. And I couldn't go to anyone to ask them advice or to get help from them, because in that area everybody just sees for themselves. If they see

anything going on, then they are there first to see what's going on, and then they laugh behind your back – you know, things like that.”

Six women expressed shame in bodily terms, either verbally or through body language. Irene described her bodily shame:

“It's like I'm not a woman anymore; being a woman has been taken away from me. I just feel like I'm just there because I must be there. I cannot tell you how I feel, but sometimes I feel I can't feel like a woman any more. How can a woman feel if her body looks like this? I don't know if I'm explaining myself and if you can understand me, but the reason why also I don't want to get involved or be involved with another man, I don't want to answer his questions when he asks me questions: what happened there? What happened there? That's why my body is like a map. It's for me to...that is also one reason why I don't want to get involved with another man, because I'm too conscious about my body at the moment, very, very, conscious about my body.”

As mentioned earlier, a number of women displayed bodily shame during the interviews, including covering their faces with their hands, bending or curling over, or pulling clothes over their faces as they talked about their traumatic experiences (bodily expression of the wish to hide, which is so typical of shame). Many whispered, and their narratives were peppered with pauses and hesitations, also verbal indicators of shame.

Lisa verbalised her understanding of shame in bodily terms, indicating its depth and pervasiveness:

“It's like something that crawls under your skin and you can't get rid of it.”

Among these participants, shame was also described using vague and diffuse emotional terms such as “hurt”, “pain” and “sore”. These words do illustrate, however, that shame is a negatively charged emotion for these women, which is consistent with the literature. Other words indicating shame were evaluations women made about themselves, like “stupid”, “worthless”, “empty”, “less than a person”.

Shame was additionally associated with hiding behaviour in two of the women's narratives. When asked what shame felt like, these women described that it felt like they had to avoid others, and hide from them. As Mandy said, “Maybe I must just keep myself from people”. This understanding of shame clearly overlaps with fear and mistrust of others.

A number of women felt that their financial dependence was a source of shame for them.

Veronica responded to my question of how shame felt in the following way:

“It’s like, being here I don’t have nothing. I don’t have an income... I don’t have a weekly income; not a monthly income; not a fourth-monthly income; I don’t have child support; I don’t have a grant. I thank the Lord that at Saartjie Baartman I eat every day. But I’m not talking about that. What I’m trying to say is, being here is not like being at home. I was very dependent upon where ...the salary came in every Friday and it was given to me. I had money in my pocket. Here I don’t have money”

### ***Supports and Coping Mechanisms***

Religion played an important protective function in the lives of participants, as indicated in this comment from Veronica:

“I’m very religious and I love my religion.” (Veronica)

A number of women cited spirituality or religion as a primary support in their lives. They also described a range of social supports. Other coping mechanisms included specific defenses and substance misuse.

Mandy described her supports in the following way:

“I think just praying to God for strength, and also just talking to friends. Counselling helps also. And just the urge to go on and try and survive, try to provide for your kids, try to look after them.”

The role of religion in calming and consoling her is described by Isabelle:

“I’m a Christian, and the one thing that takes me through all of this, it’s praying. If it weren’t for God...Ja (yes), so when I’m hurt, I always...when I pray, and after praying, I feel like I have this comfort in me; somebody tells me it’s okay and somebody is with me.”

Denise describes the powerful protective role played by the church and praying:

“I go to church and I listen to what they have to say there. You know, all these negative thoughts, praying and asking God for help, that helped me a lot. It helped me a lot to stop thinking all these negative thoughts. And afterwards, I couldn’t blame myself. I mean, I didn’t ask for that [the abuse].”

A few of the women's narratives were shaped by a broader religious discourse that emphasised the role of forgiveness. These women stressed that they would "forgive, but not forget" the trauma they had experienced. For Denise, the role of God was central in her decision to forgive her perpetrator:

"I still forgive him, because if God forgives, why can't I forgive?"

Many of the women felt that their counselling sessions were the most significant support in their lives. Chantal described how helpful the interventions offered at the Centre are to her:

"Hier by Saartjie Baartman, hulle help jou lekker. Daar is baie bystand van die staff. Hulle laat jou nie voel asof jy alleen is met daardie probleem nie, en jy sit alleen hier in die wêreld met jou probleem nie en daar's niemand wat jou kan help nie. Hulle laat jou sommer verstaan, maar ons is daar om vir jou te help, en hulle bied baie support groups... Jy het jou support group en jou eie counsellor. Dan het jy 'n sessie met jou eie counsellor wat jy praat nou van wat gebeur het, met jou counsellor en so, en dit help jou baie."

*[Here at Saartjie Baartman, they help you nicely. There's a lot of support from the staff. They don't make you feel as if you are alone with that problem, and that you are sitting alone in the world with your problem and there is no one who can help you. They let you understand, but we are there to help you, and they offer many support groups... You've got your support group and your own counsellor. Then you have a session with your own counsellor that you talk to about what happened, and that helps you a lot.]*

Family did not feature as a significant support to all but two of the women I interviewed. Many women described conflictual and rejecting relationships with family members. Often, however, women severed contact with their families to protect them from the perpetrator, as described by Irene:

"Before you (the perpetrator) go that far, rather stab me and rather hit me, but leave my family. I protected them on so many occasions; then I just walk back with him and there we go again, like nothing ever happened. But knowing deep in my heart, I know what I am going in for now, but rather kill me than hurt my family who doesn't deserve this. Because they cannot be blamed for what is happening between the two of us."

A few women cited friends as supports, while other women felt that their children helped provide meaning in their lives. Cheryl describes the role of her daughter in her life in the following way:

“Al wat my aan die gang hou is die feit dat ek 'n wonderlike dogtertjie het, en ek wil vir haar die beste gee.”

*[All that keeps me going is the fact that I have a wonderful little daughter, and I want to give her the best.]*

A number of women reported that they wore a smile as a “mask” to conceal difficult feelings from others. This seemed to help women feel less vulnerable and exposed. When trauma survivors speak of “masks” they are talking of concealing their authentic, shameful selves (Kraft, 2004). One survivor in Kraft’s (2004, p. 380) study says: “Beatrice S. admits in her testimony that her children do not know the ‘real’ me, conceding that she is playing the part that is expected of her: ‘You put on a smile and you go. You just become an *actress*.’”

Linda describes this coping mechanism as follows:

“I always carry a smile on my face, no matter what the circumstances or what position I might find myself in. I always can...because that is the way I think...it’s more like a mask. So that is my mask: I always have a smile on my face.”

Veronica said:

“I won’t come to you and tell you this is my problem and that is my problem. I’ll keep it to myself. I’ve always got a smile on my face.”

Another coping mechanism employed by women was keeping occupied in order to avoid confronting and dealing with difficult emotions. Distraction can have enormous therapeutic value for people trying to escape unbearable pain, albeit temporarily (Kraft, 2004). In response to being asked how she copes with challenging feelings, one woman replied:

“I tried not to think. I just blocked it out. And keep busy, at all times keep busy... I would do anything just to avoid it.”

Cheryl said:

“Vir my depressie, ek gebruik my medikasie. En ek hou my besig.”

*[For my depression, I take my medication. And I keep myself busy.]*

Finally, both women who abused substances as a method of coping reported using alcohol. I sensed that more than just the two women who admitted to using substances did in fact rely on this method of coping, however the Centre policy was zero tolerance of any kind of

substance use. It is possible that my affiliation with Centre staff meant that women withheld this kind of information from me.

### **Transgenerational Trauma**

The majority of the participants were exposed to some form of trauma during their childhoods. The types of trauma they were exposed to include direct exposure to physical violence, witnessing physical violence between caregivers, direct exposure to sexual violence, and emotional violence. Often this exposure was more traumatic and distressing for the women I interviewed than the adult-onset IPV. In addition, in agreement with much of the literature in this field, my participants who had suffered both child abuse and adult onset abuse tended to have poorer mental health outcomes than those who had only endured adult onset abuse (serious histories of depression, suicidality and dissociation for example).

Many of my participants experienced beatings during their childhoods. Mandy described her abuse as follows:

“She [mother] would hit us for any silly thing you did. We were at boarding school... I was at boarding school since I was about maybe nine years old, and if I lost a pair of socks, she would hit me. She would let me lie on the bed, naked, and hit me with an electricity cord. It was just normal now, but it was very, very painful.”

A few of the participants reported witnessing their fathers physically assaulting their mothers. One of these women (Irene) describes being exposed to such violence, but fails to link this kind of exposure to her own abusive relationship later in life:

“I was never abused, really, honestly. I was raised not very rich. We were poor. Daddy and mommy never had much money, but we survived. We ate every night. There was never abuse. My daddy, ja (*yes*), he used to hit mommy at times, but where I was concerned, I don't know, I was never abused, not by my daddy and not by my mommy. We were reared very strictly, that is just to be married properly and to have manners. Where the house was concerned, it must be clean. But never abuse, never abuse. I don't know where this abuse comes from.”

Women also described experiencing sexual abuse during their childhoods. This kind of abuse was shrouded in secrecy, and the women described being reluctant to disclose their abuse, mainly due to feelings of guilt towards their caregivers (mothers).

One of these women (Felicia) explains how isolated she was in her suffering; how she felt she had no option but to endure the abuse:

“When I was five years old, my mom’s cousin close by was expecting a baby, so she asked to look after me so that the baby could have someone to play with. I was five, and then the baby was still-born, so I went to go and stay with my aunt. Her reason really to ask me to come and stay with her, was so that she could get the grant money. So she took me and she got the grant money<sup>20</sup>. I stayed with her, and at the age of six or seven, her son was roundabout fourteen or fifteen, he [her son] started sexually abusing me at that age of six or seven. And it went on and it went on, and I wanted to tell my mother, but at the very same time this woman is trying to help me, and if I tell my mother I’ll be trying to create...that’s what I thought when I was still a child...that I’ll be trying to create a fight and I won’t have the future that my mother wants me to have. Like if I stay with my aunt, I’ll go to good schools and I’ll have a proper life. Then, if I stay with my mom, things were hard for her. She was kind of suffering, and she had me at an early age, and she just couldn’t take care of me and she had a life of her own.”

Patricia described similarly protecting her mother:

“My pa het tronk toe gegaan omdat hy my suster verkrag het. Toe was sy 14 jaar oud. But wat my ma tot vandag toe nie weet nie, dieselfde het met my ook gebeur, en nie een van hulle weet nie. Ek is altyd die sterk een in ons se familie. Hulle het altyd op my skouer gehuil, nou ek kan nie myself gebring het om my ma nog...want toe sy uitvind daarvoor, toe is dit amper soos, sy is ook gebruik al, ek kan nie nog vir haar verder oor die edge gestuur het nie. Ek kan dit nie oor my hart gekry het nie.”

*[My father went to jail because he raped my sister. She was 14 years old then. But what my mother doesn’t know up to this day, is that the same happened to me, none of them know. I am always the strong one in the family. They have always cried on my shoulder, now I cannot bring myself to...my mother...because when she found out about that, it was almost, she has also been used, I could not send her further over the edge. I couldn’t bring myself to do it.]*

Felicia reported emotional abuse during her childhood. She described being broken down and made to feel she deserved suffering, as well as ridiculed by her family:

---

<sup>20</sup> The narrator is referring here to a Foster Care grant, part of the social security provision in South Africa.

“And also, my family telling me...not all of them, but some of them...telling me that I won't get anywhere in life. I was born to suffer – those kind of things. Now they rejoice because they know that I'm suffering, and now I'm calling them to ask them for help. Those kind of things, it hurts when you are picking up that phone and calling that person, and you know even if that person helps you or not, but you know that you have the problem that you always have. Around my family, when I'm going to places and they see me, I'm a joke. That kind of thing, it hurts.”

Quite a number of the participants were raised by their grandmothers. These women reported being well cared for during their childhoods, and although some felt rejected by their parents' absence, they were grateful for the substitute care their grandmothers provided.

In summary, the categorical content analysis revealed themes broadly centred around experiences of chronic trauma, post-traumatic reactions and functioning, understandings of shame, and supports and coping. Women were exposed to a great deal of violence, including physical, sexual and emotional violence. Women reported trauma-related depression, anxiety, a history of suicidality or current suicidal thoughts or actions, and/or dissociation. Some women also reported stress-related illnesses and somatic complaints. Some of the most difficult experiences women reported were emotional abuse and having their children witness the abuse between them and their ex-partner. Women used religion and counselling to help them cope. They also kept busy to keep themselves distracted, and spoke of wearing a smiling “mask” to cover painful feelings. Women described a range of negative feelings towards others, including mistrust, fear, anger and hate. They described fear, numbness, anger, hate and love towards the perpetrator. Women expressed both very positive beliefs about themselves, particularly that they are strong survivors, and very negative self-perceptions, which centred around shame. Shame was viewed as a social emotion (external shame), and often described as humiliation (and sometimes embarrassment), which required the presence of a mocking, hostile audience. This was interpreted in socio-cultural terms.

Transgenerational violence was common, and was more distressing than adult-onset IPV.

In this chapter there was a striking co-occurrence between chronic trauma, and shame and psychopathology. One of the most significant findings emerging from the categorical content analysis was the presence of a very particular form of trauma-related psychopathology, the split self amongst participating women (which is not reported here) – the authentic self who admitted to a great deal of shame when asked indirectly (which is related to the internalisation of the bad object), and the false self who was described in surprisingly positive terms (when

asked directly). Ten of the nineteen women presented with a split self. Due to the predominance of this theme, I have selected it as the focus of its own chapter, which follows.

## CHAPTER 8

### Results and Discussion II

“In adult life, forced competence may lead to considerable success. None of her achievements in the world redound to her credit, however, for she usually perceives her performing self as inauthentic and false. Rather, the appreciation of others simply confirms her conviction that no one can truly know her and that, if her secret and true self were recognised, she would be shunned and reviled” (Herman, 1997, p. 105).

This chapter forms a theoretical “bridge” between chapter 7 (categorical content analysis) and chapter 9 (categorical form analysis), by situating the discussion in both phenomenological terms (women’s subjective perceptions of themselves), and paying attention to social constructivist-determined linguistic features of the women’s (counter) narratives.

Phenomenologically, there are four aspects which are essential to the subjective experience of shame. Before discussing these features below, it is worth noting that shame was described earlier as the inevitable response to loss of love; the loss of an important intimate relationship (H. B. Lewis, 1987a, 1987b, 1987c). This is consistent with the experience of my participants.

My analysis of the authentic and the false self is based on Herman’s (1997) understanding of the terms. She argues that the development of a malevolent, shameful authentic identity is concealed by a socially conforming and valued false self (Herman, 1997). She diverges from Winnicott in that she does not focus mostly on the parenting context, and in that she understands this split to occur as a result of a multitude of different traumas. For Winnicott, the true self is who we are in the truest sense; it is when we feel alive and energised and stimulated; and only the true self can be creative and can be real (Anderson & Winer, 2003). When acting from the false self, the individual feels s/he is denying him/herself, s/he feels hollow, empty or unreal, that s/he is doing what is expected or necessary, rather than what is personally meaningful (Anderson & Winer, 2003). These authors argue that the false self develops when the child responds to the caregivers, rather than when the child is responded to by the caregiver, and the manifestation of the false self is an act of compliance and an expression of a wish to be loved.

Mollon (2002) argues that shame arises when the self expresses authentic feelings and aspirations which s/he feels are not recognised, understood or accepted. He argues that it is “akin to emerging from behind a mask, or taking off a costume, or exposing oneself as having been a fraud or imposter” (Mollon, 2002, p. 17). The fear accompanying the shame of the emergence of the authentic self is that the self will embarrass the other, and that this always involves disruptions in the expectations the person or observer had of the self (Mollon, 2002). This leads to a continual monitoring of the presentation of the self, ensuring it fits in with the expectations of the other, which is the basis of self-consciousness (Mollon, 2002). Thus, shame emerges when there are discrepancies between the expectations of the other and the real emotions and behaviours of the self (Mollon, 2002).

Although all selves are constructed and fictional to some extent insofar as they are based on the roles, standards, rules, values and images available in the pre-existing culture into which the self is born, this process can become pathological when a loved other’s narcissism and grandiosity takes precedence over recognising, understanding and accepting the self (Mollon, 2002). Mollon (2002) observes that the self fears being discovered that s/he is not what the loved other assume s/he is; that this knowledge will be met with shock and rejection, and that this possibility is so shame-filled that the self has to make absolutely sure that the authentic self remains concealed.

### **Shame From a Phenomenological Perspective: A Brief Overview**

Firstly, to recap shame is an internal, stable and global emotion (H. B. Lewis, 1971). Secondly, shame involves feeling that the self as a whole is inadequate, flawed, useless, defective and unworthy. Thirdly, shame involves wanting to hide or disappear, which is often encoded in bodily form. Fourthly, shame is associated with intense and painful emotions such as sadness or anger. Fifthly, in shame states, there is a split between affect and cognition – there is restricted cognitive activity and a great deal of affective (and autonomic) activity. How this manifests is that in these shame states, the self is unable to think clearly, rationally, logically and coherently, and terminates all activity; it is accompanied by a kind of paralysis that involves the inability to talk and the inability to take any action. Simultaneously, there a great deal of sensory activity and intense emotional experience. Shame also involves the integration of subject and object. There is a peculiar kind of fusion that occurs in shame

reactions, once the negative evaluation of the real or imagined audience has been internalised and has fused with the self. Thus, the self is divided in shame reactions in two ways – cognition and emotion are split, and the self is determined by the internalisation of the condemning and disparaging other, while it is simultaneously intensely aware of itself (H. B. Lewis, 1971). This divided activity of the self makes it very challenging for the self to function optimally.

### **Theorising the Split Self**

Individuals who have been abused often feel inferior because they did not, or could not, help themselves (Cloitre, Cohen, & Koenen, 2006). Often, these survivors answer the question of why the abuse happens, particularly when at the hands of a loved one, with the belief that they deserved it (Cloitre et al., 2006). Messages that the self is worthless, and that their lives are of no value leaves the self feeling annihilated (Cloitre et al., 2006). Frequently survivors are identified as causing the abuse, because they are inherently “bad”, “defective” (Cloitre et al., 2006). These feelings are amplified when the survivor betrays herself by keeping secret the abuse s/he is enduring, so conspiring with the perpetrator (Cloitre et al., 2006). Feelings of “badness”, self-blame and deservedness of abuse were rife amongst my participants. Negative self-perceptions, by definition, mimic shame (global negative emotional evaluation of the self). There is a great deal of overlap between constructing the self as “bad” and shame; these two constructs co-occur, and mutually influence each other. As has been noted, feelings of “badness” or “deservedness” are a typical defense among survivors of chronic trauma (Fairbairn, 1943). This overlaps with the process of identification with the aggressor, which links to feelings of shame-based rage (Ferenczi as cited in Orange, 2011). As I have previously pointed out, these survivors tend to identify with and internalise unbearably bad objects and bear the burden of shame because it is more tolerable to believe that the self is bad and so remain in control, than it is to accept that the loved perpetrator, whose abuse is random and unpredictable, is bad (Fairbairn, 1943).

The characteristics about themselves that women reported included being worthless, useless and inadequate, dirty or contaminated, and as deserving the abuse they endured. However, they also reported being caring, being communicative, being sensitive or soft-hearted, being helpful and being friendly. But inner strength was the most common and most important

positive quality reported by the participants. Women's descriptions of themselves as strong and as survivors are agentic, resistance narratives – rejecting the construction of women as helpless, subjugated, and disempowered. Bamberg (2004) argues that counter-narratives such as these are often characterised by inconsistencies and contradictions; a vacillation between complicity with master narratives, and active opposition. These discrepancies and contradictions are also indicative of multiplicity – of a plurality or split in identity (Halbertal & Koren, 2006). Individuals who have been traumatised, and feel a great deal of shame, often develop a split between the idealised projected self (the strong and proud survivor), and the inherently faulty or deficient (shameful) authentic self which s/he believes underlies her inauthentic projected persona (Herman, 1997). It is the hidden authentic self which is so “bad”, so shamed, that it deserves to be punished. This split has been described by Holocaust survivors as “a double existence” or “double lives” (Kraft, 2004, p. 379). This links to the emphasis that women I interviewed put on the presence of a hostile or mocking audience in shame (or more accurately, humiliation) – perhaps shame is most acutely felt when there is a danger of the hidden authentic self being exposed.

Below I provide extracts from 10 interviews, where I ask women two questions – how they would describe themselves, and how they feel about themselves. These questions often elicited quite different responses, with women describing themselves in positive terms, and perceiving themselves in negative terms (feeling a great deal of shame and in some cases, humiliation). To me this suggests that when asked about feelings, which go deeper than mere descriptions, one is more likely to tap into the concealed authentic self situated beneath the projected false self.

### **Extracts From Cases Which Demonstrate the Split Self<sup>21</sup>**

#### **Linda**

**“I’m starting to build up more confidence. I feel more confident than ever before. And for me, that is strange because I don’t really think anything of myself. I was always just surrounded in that bubble where I thought nothing of myself and that I’m worthless, and I can never achieve something because I’m not good enough; I’m not beautiful enough. I was living in that bubble all this time.**

---

<sup>21</sup> I will highlight in bold words or phrases indicative of shame and positive descriptions of the self to draw attention to psychic splitting in the narratives.

...I see now that **I've got ability and that I'm capable of doing a lot of things**, but...that's hard.

I would describe myself as...**I'm a good person**. I used to be closed up, but I'm starting to open up. **I love being around people. I'm very forgiving**, that's the sort of person I am. **I always carry a smile on my face**, no matter what the circumstances or what position I might find myself in. I always can...because that is the way I think...it's more like a mask. **So that is my mask: I always have a smile on my face. .... The true me is really a sensitive person; very much sensitive; very childish** – I can say that. I have a lot of love to give, a lot of love to give. So I don't see myself ever being bitter, but letting go of the past is hard.

And me, I was born with a talent and nobody...with me\*\*<sup>22</sup> to go to university to do anything. You know, to stay for whatever with...people approached me and asked me: "Linda, how do you do this? Because here I am a professor or here I am this, and you know how to do it exactly, but I had to go to college to go and study for it - and here you have it. You were born with it." **I don't know, my given talent is to perform \*\***. **I was born with that. I was born with that**...Because I've seen how people get...how people are touched by my music and by my singing. I have never seen people sit with a dry eye. A person told me they get goose bumps whenever I sing.

But I feel like I want to **hide where nobody could ever find me**. I feel like just being in the woods, all by myself and not being surrounded with the people, just all by myself **where I know I won't be harmed any more**".

### *Interpretation*

This is a very interesting narrative because it contains so many contradictions, most notably for instance, the shame words, "I don't really think anything of myself. I was always just surrounded in that bubble where I thought nothing of myself and that I'm worthless" are contrasted by the realisation that she is able, that she is capable, at the end of the paragraph, and that "I am a good person", including loving being with people and being forgiving, in the next paragraph. What I find particularly thought-provoking is the evidence of the split self – the false, projected persona who wears a smile as a "mask", and who is so talented, and the

---

<sup>22</sup> The stars indicate a break in the text – what the narrator says is inaudible.

“true” self that does not realise her talents, is sensitive and child-like (suggesting her inner vulnerability and defencelessness). Perhaps it is this inner child that wants to hide from others, a typical shame response – the urge to sink through the ground and cease to exist; become invisible. It is also interesting to note that the narrator refers to existing in a “bubble” more than once, suggestive of being split off or separated from others, isolation, and on a clinical level, perhaps even dissociation.

### **Chantal**

“Hoe kan ek nou sê...okay, ek sien 'n verandering in my. Ek was 'n baie skraal mens gewees. My ma is ook 'n skraal mens. Ek en my ma was ewe skraal. Maar ek kon sien ek het darem 'n bietjie vetjies op getel. Ja, en ek kan nou vir myself kyk in 'n spieël en sê, nee, maar **jy's regtig 'n mooi meisie**. En ek wil nooit vir my sommer gekyk het in 'n spieël nie want vir my was dit altyd...hoe kan ek nou sê...**ek het net gedink, nee, ek is nie 'n mooi meisie nie**. Ek is nou eerlik, ek het altyd so gedink, maar vandag kan ek vir my in 'n spieël kyk en vir myself sê, nee, maar Chantal, jy's rêrig 'n mooi meisie. Jy verdien nie dit wat jy gehad het nie...

**Chantal is 'n baie grapperige mens, en Chantal is nie bakleierig nie. Nie lief om mense in te doen nie. Ek skel nie soos 'n straat-lêer nie.** Ek dink dis nou omdat ek weet ek is nie daai persoon nie, ek jok nou nie vir my auntie nie. **Chantal is 'n baie lieflike mens.** Okay, wat is daar nog...ek kan veel dinge...maar ek onthou dit nie... **Okay, 'n mens wat baie lief is vir kommunikeer.** Al ken ek nie mense nie, dan kommunikeer ek so dat dit lyk ons ken mekaar jare. Ek was altyd skaam gewees om met mense te praat, maar ek het daai skaamgeit eenkant gesit want skaamgeit bring 'n mens nêrens nie. En wat is daar nog...maar dit is soos ek is. **Ek is 'n baie sagte mens. As iemand vir my in doen of beledig of so, baie gou vir huil.**

Okay, ek vat dit as my skuld dat ek voor die tyd 'n kêrel gevat het en so. **Ek vat dit as my skuld dat ek my skool loopbaan net so gelos het; nie meer geworry het van my ouma en so nie. ... Laterhand, was ek so skaam gewees.**

Ek het al so gevoel. **Niemand dink niks van my nie. Ek voel minderwaardig. Hoe kan ek sê...almal wat met my kommunikeer en so, dink niks van my nie. Ek voel net baie minderwaardig - so, baie minderwaardig... Die omstandighede waarin ek was, dit het my altyd so laat voel.**

**Hulle sê so ek lag vir als. Ek kan nie help nie, maar ek is baie lief daarvoor. Nou sê hulle, iemand kan my slaan, seer maak of wat ook al, dan lag ek ook.** Die vroue sê hierbo, jy's so lief vir lag, Chantal, iemand kan jou slaan of wat ook al, maar dan lag jy ook daaroor. Nou sê hulle vir my, hoe gaan jy maak die dag as jy op die hof gaan staan?<sup>23</sup> Dan gaan jy seker ook staan en lag. Ek sê, nee, daai dag moet ek ernstig wees. Maar ek kan nie help nie, ek is té lief vir lag”.

*Translation*

*“How shall I put it...ok, I see a change in me. I was a very thin person. My mother was also a very thin person. My mother and I were equally thin. But I can see that I put on a little bit of weight. Yes, I can now look at myself in the mirror and say, no really, you are a beautiful girl. And I never wanted to look at myself in the mirror because for me it was always...how shall I put it...I just thought, no, I am not a beautiful girl. I am honest now, I have always thought that, but today I can look at myself in the mirror and say to myself, no really Chantal, you are really a beautiful girl. You don't deserve what you got... **Chantal likes to joke, and Chantal doesn't like to fight. Doesn't want to do people in. I don't shout at others like the people living on the streets.** I think it's because I know I am not that kind of a person, I don't lie to you, my aunty. **Chantal is a very lovely person.** Ok, what else is there...there are many things I can...but I don't remember them... **Ok, someone who likes to communicate.** Even when I don't know people, then I communicate as if we have known each other for years. I was always shy to talk to people, but I put that shyness aside because shyness brings you nowhere. And what else is there...but that is how I am. **I am a very soft person. If someone does me in or insults me or so, very quick to cry.***

*Ok, I take it as my fault that I took a boyfriend too soon and so on. I take it as my fault that I left my school career just like that; didn't worry about my grandmother and so on... Later on, I felt so ashamed.*

*I have felt like that. Nobody thinks nothing of me. I feel inferior. How shall I put it...everyone who communicates with me, thinks nothing of me. I just feel very inferior – so, very inferior... The circumstances in which I found myself, it always made me feel like that.*

---

<sup>23</sup> This narrator was gang raped a few weeks prior to the interview and was going to face her rapists in court in a few weeks time.

*They say everything makes me laugh. I cannot help it, but I like it very much. Now they say, someone can hit me, hurt me or whatever, then I also laugh. The women up there say, you like laughing so much, Chantal, someone can hit you or whatever, but then you laugh about it. Now they say to me, what are you going to do the day when you have to stand up in court? Surely then you are also going to laugh. I reply, no, that day I must be serious. But I cannot help it, I love laughing too much”.*

### *Interpretation*

Perhaps the most disturbing aspect of this narrative is the evidence of by-passed shame in the form of laughing. Chantal says that no matter how she is hurt, she cannot help but laugh; that she is afraid that when she goes to court to testify against her rapists, she will just laugh. By-passed shame is unacknowledged, unconscious and repressed shame, which manifests as another cognition or emotion when the shame feeling is so unbearable that it has to be replaced by another, more bearable emotional reaction (H. B. Lewis, 1971). It is interesting that this laughing stands in stark opposition to her claim at the beginning of the narrative that “as iemand vir my in doen of beledig of so, baie gou vir huil.” (*if someone does me in or insults me or something, [I] will cry very easily*).

Her narrative is also rife with contradictions: she describes herself as a “*lieflike mens*” (*lovely person*), and a “*mooi meisie*” (*beautiful girl*), as someone who likes to make jokes, who communicates readily, who is soft-hearted and sensitive, and well-mannered. These are features of her projected, false self or persona. She then counters these positive qualities with starkly different ones: she says that no one thinks anything of her, that she is inferior, so terribly inferior (“*minderwaardig*”), and that her abusive circumstances had made her feel that way. Her narrative also demonstrates a great deal of self-blame. She blames herself for choosing the boyfriend she did, and for leaving school and not worrying about her grandmother (her caregiver). She ends her narrative by saying that she continues to experience profound by-passed shame; the foundation of her mostly hidden, authentic self.

### **Denise**

**“I’m a very caring person. I like to give as well. And I’m very emotional: if I see someone else crying, then I will also start crying – that’s how I am. So very soft-hearted, and I will give my last to someone.**

And many people say, the things that I have been through, they are very much amazed because they say **I'm a very strong person compared to what I went through**. If they knew what I went through...I should have been dead by now, honestly, the way that man abused me. But with sore body, full of blood, I ran to the police station, I ran to the day hospital, on my own. **No one helped me. I did it all on my own. I had to be strong for my child's sake**. And me having heart disease and high blood, I had to take care of myself (my body) for her because there's no one else, no other family for her, besides my son. And he's also got a baby now, so I can't expect him to take care of my child. **So I must be strong for her**.

Sometimes I think, **why was I so stupid**. We were at high school together, but afterwards we never worried to talk to one another – we just knew one another. But after all the years we met up again, and it was just too quick, man. I was...everything happened so quickly, **but I also blame myself for that, in a way**.

**I couldn't blame myself. I mean, I didn't ask for that...I didn't ask for that**".

### *Interpretation*

The most striking part of this narrative is its ending. The narrator berates herself for being “so stupid” for having been in an abusive relationship, and says “I also blame myself for that”, when very shortly afterwards she says, “I couldn't blame myself. I mean, I didn't ask for that...I didn't ask for that”. This is evidence of a stark split between the false self (“I didn't ask for that”) and the self-blaming, shamed authentic self (“I also blame myself for that”). There are also conspicuous contradictions in her descriptions of her personality – she describes herself as caring, generous, emotional and soft-hearted (some of which can be read as illustrative of a striking sense of emotional frailty, for instance, in the phrase, “I see someone else crying, then I will also start crying”, indicative of the vulnerability of the authentic self. She then contrasts this description with an explanation of how strong she has been capable of being for herself, and for the sake of her child, indicative of the false self.

### **Veronica**

“I just ask myself, do I deserve...because my other sisters, they don't allow things like I do in their lives. My one sister's husband had an affair, and the minute she heard about it, she went

straightaway to his work, grabbed him and told him, come, take me to that woman. And I asked her, Jolene, why did you do it? She said, Veronica, if I do it to him it's okay, then he can help me. I don't hurt him. I respect him. I expect him to respect me also. And he had to choose between the two of them, between my sister and the other woman. Because he also lied to the woman and told her he's not married and all that. And I said to her, but how do you feel? She said, no, I feel like a woman. He must respect me as a woman, or he must leave me. **But, Amelia, me, I just looked and said nothing. I kept it to myself.**

Oh, **(I feel like) less than the person.** Certain times...like if you hit me now I'll think, **jesus, huh-uh, I'm nothing. I'm zero. And then afterwards it was like a voice came: no, Veronica.** And I believe when you see two roads or footsteps, it's **when god walks with you**, but when you only see one, it's when he carries you. I believe in that. **I'm strong with him**, and that pulled me through.

I won't come to you and tell you this is my problem and that is my problem. **I'll keep it to myself. I've always got a smile on my face. I dress well, clean and everything. I will respect you. That's me.**

**I used to think it's (abuse) my fault by dressing...**he used to tell me, why must your scarf go with your top? Why must your shoes go with your bag? You don't have brains. I said, ah, it's all right, only you've got brains. Just because of that, a broken arm and a blue eye.

No, huh-uh, no. **I'm proud of what I am. I'm proud I'm a human, and I'm proud I'm on my own.**

**I don't think there's the word shame in my vocabulary. I'm honest with you, no, I don't feel shame. I personally feel that God has a reason why he put me through all of this... Yes. But as I've said, hate is not in my vocabulary, and to be rude, no. It's not in my vocabulary.**

(The counselling has) made me stronger, really, really, because I kept a lot of things in me. I usually tell them that there are a lot of rooms in my heart; **my heart is divided up into a lot of rooms.** And the only thing that I can remember – what were the happy times in my life?''

*Interpretation*

This is an extremely interesting and unusual narrative. It is narrated by the same woman who tells the “parrot story” in the next chapter. A persistent theme in this narrative is lack of self-respect, particularly in the first paragraph where she listens intently to how her sister confronts her unfaithful husband, but “I kept it (her own unfaithful husband) to myself”. Shame is known to silence, to debilitate, to paralyse and inhibit action. The next paragraphs are a somewhat chaotic mix of good and shameful qualities the narrator sees in herself – she uses highly descriptive shame words, like “I’m zero”, “less than a person”, “I’m nothing”. The issue of blame is complicated in this narrative, because it is difficult to ascertain whether the narrator blames herself or her perpetrator for the abuse when she refers to the way she dresses as a reason for being abused. Although she is both flippant and angry about it, there was something in her tone that suggested that her exposure of the shame-based authentic self was compounded to some extent by self-blame for the violence directed against her. The level of investment in the belief that it was she that provoked the violence directed at her, though, I would not venture to guess at.

There is evidence of an internal struggle in this narrative, when she describes herself in shame terms: she says “it was like a voice came: no Veronica”. She does, like many other narrators, refer to strength, but it is strength that she draws from God, it is strength she draws from an external source, it is not strength that she owns. Her false self is much weaker than the shame-based authentic self – it is limited to her always wearing a smile on her face, dressing well, being clean, and respecting others, fairly superficial qualities. Yet paradoxically, and somewhat inauthentically, she says: “I’m proud of what I am. I’m proud I’m a human, and I’m proud I’m on my own.” What struck me in this final quote is that being proud of who one is, and being proud of being independent are virtues worthy of being proud of, but that being “human” somehow does not fit in this category; it does not feel meaningful or heartfelt. This contributes to the sense of inauthenticity of some of her statements – in this case they seem clichéd and forced.

Despite the consistent thread of shame through this narrator’s narrative, she says, “I don’t think there’s the word shame in my vocabulary. I’m honest with you, no, I don’t feel shame.” Shame, particularly when felt acutely, is commonly denied (H. B. Lewis, 1971). However, one of the most fascinating aspects of this narrative is that the narrator unconsciously equates shame with hate. She says, “But as I’ve said, hate is not in my vocabulary, and to be rude, no.

It's not in my vocabulary." There are many possible reasons for this slip of the tongue, but one of my educated guesses would be an unconscious recognition of the relationship between shame, and self-hate or loathing (the being "bad" Fairbairn [1943] talks about; the assumption of the perpetrator-defined identity).

The final paragraph in this remarkable narrative points to fragmentation and selective memory loss, both reactions to chronic trauma. The narrator points to the volume of traumatic emotional material she has had to contain (which has been repeated in this narrative), and how she does so, by compartmentalising and forgetting what is painful. This is highly indicative of dissociation. In her words, "I kept a lot of things in me. I usually tell them that there are a lot of rooms in my heart; my heart is divided up into a lot of rooms. And the only thing that I can remember – what were the happy times in my life".

### **Isabelle**

"If someone were to describe me, a lot of people just say that **I'm a strong person.**

Ja, because really, **I'm not put down that easily.** I'm not that. I always try to find a solution for the situation. **I don't let the situation get the best of me.** So I always tell the situation, you know what, I'm going to get over you. You might be like you are winning for now, but then I'm going to get over you. So I'm that kind of person. Generally, **I'm a hard labourer: I just love working,** which is one of the things that is stressing me, it's that I'm not working. I love being at something, at least I know I'm actually doing something.

At certain places, ja, **I feel shame.** Like when I used to work, you know, **eventually everyone had to find out what had happened to me, and there are all these false stories around each and everything,** so ja, at some places or around some people I do feel that way.

**It (shame) feels like...it is hurting because people are believing what they don't really know about you.** I believe in the wrong story about you, so you feel like it's something that is... I cannot really take everyone and put them together and tell them, no, this is not the right story, this is what happened and this is why this happened. **But I can't change everyone, and I can't change what they think about me now. So it's painful to know that people have the wrong things about you – but you can't do anything about it. Shame is what other people think about you and what they say about you".**

*Interpretation*

“Shame” in this narrative is actually humiliation. It is worth pausing here for a moment to recap on the differences between shame and humiliation. As discussed in chapter 3, humiliation is an intense and unpleasant emotion involving lowering in the eyes of others; loss of esteem, social status or dignity (Elison & Harter, 2007; Miller, 1985). Gilbert (1998) argues that humiliation is similar to shame in that it is experienced when an individual is subordinated; put in a debased or powerless position by someone more powerful. Humiliation thus usually occurs at the hands of another, and in most cases, there is a broader audience that observes the humiliating event; a hostile and contemptuous audience is a key predictor of humiliation (Elison & Harter, 2007). Critically, as I pointed out in earlier, in humiliation the victim is seen as undeserving, the event tends to be viewed as an unprovoked attack (Elison & Harter, 2007). In other words, there is no acceptance that the negative judgment from another is justified (as in shame). So, unlike shame, humiliation does not involve the negative evaluation of the self by the self; instead it involves a focus on the other as bad (Elison & Harter, 2007; Gilbert, 1998).

This narrator describes her false, projected self as strong and as able to make the best of a situation, and as a hard worker. So the good qualities that she can use to describe herself are limited. She describes the source of her “shame” or vulnerability in different terms to other narrators: she says: “Shame is what other people think about you and what they say about you”. It constitutes the spreading of “false stories” by others, producing a loss of esteem, social status or dignity. So, just as described above, her pain is caused by the negative evaluation of the self by a hostile and malicious audience. For this narrator, the audience is also ignorant: “it is hurting because people are believing what they don’t really know about you”. Here I believe she is referring to the hidden authentic self, which holds the truth not only about emotional reactions to her traumatic experiences, but also the pain related to her humiliation. Where the narrator diverges from understanding shame in terms of humiliation is in her response to this emotion. She says, “So it’s painful to know that people have the wrong things about you – but you can’t do anything about it” suggesting a great deal of helplessness and inaction, which is associated with shame, not humiliation. Humiliation is usually characterised by potent, agentive emotions such as anger or rage – typically expressed as a desire for revenge and retaliation (Elison & Harter, 2007; Gilbert, 1998). Thus, there is evidence that the two emotions overlap in this narrative.

**Janine**

“Ek het gevoel...van die abuse besigheid...ek het gevoel eintlik laat **ek ook suicide wou commit het. Ek het gevoel niemand gee om vir my nie en niemand is lief vir my nie, en daar gaat nie iemand wees wat my kan help nie. Die gevolg sal wees dat ek alleen wees, en ek huil en whatever, of ek loop sommer weg van die huis af, somtye. En daar was tye wat ek nie wil geëet het nie; bly sommer vir weke sonder kos want ek voel depressed. En ek het baie maer geraak - ek wou nie eet nie. Ek het depressed geword. Daar was ook tye wat ek net wou slaap...**

Daar is baie tye wat mense sal sê, **ag, jy's nie worth...jy's nie iets werd nie.**

Ander mense sal altyd vir my sê, **jy is 'n baie goeie mens. Jy's baie sag. Jy is baie bestaanbaar. Jy's 'n mooi mens; kyk mooi na jouself. Moenie laat daai dinge vir jou beweeg nie**”.

*Translation*

*“I felt...about the abuse business...I actually felt that I also wanted to commit suicide. I felt that no one cared about me and no one loves me, and nobody will be there to help me. The result will be that I will be alone, and I cry and whatever, or I just walk away from the house, sometimes. And there were times that I didn't want to eat, just stay without food for weeks because I feel depressed. And I got very thin – I didn't want to eat. I became depressed. There were also times that I just wanted to sleep...*

*There are times that people will say, oh, you're not worth...you're not worth anything.*

*Other people will always say to me, you're a very good person. You are very soft. You are very considerate. You are a beautiful person; look well after yourself. Don't let those things move you”.*

*Interpretation*

In this short narrative there is a great deal of evidence of the split self. The narrator describes in the first paragraph a combination of depression and shame reactions (which overlap), and ends this part of the narrative by saying she is worth nothing. These self-perceptions are consistent with Janine's appearance. She takes very poor care of herself physically and

outwardly it appears as if she lacks self-esteem and confidence. Yet in the next paragraph it is as if she is describing an entirely different person. She says she is a “mooi” (*beautiful*) person; a “goeie” (*good*) person, who should look after herself well (in stark contrast with the suicidality – which is commonly linked to shame - expressed at the beginning of the narrative), and who should stay steady, not get swayed by challenges. It is interesting, however, that these positive qualities are spoken by others, not owned by the narrator. In this narrator’s case, in her speech as well as her body language and dress sense, the authentic self was far more exposed than with other narrators, the false self only thinly veiling this very vulnerable, shamed part of the self.

### **Mandy**

“I still feel like **I’m strong. I can survive**, but I have been through quite a lot. It’s always going to be there – my past – but I also try and not make myself maybe abusive to my children. That’s what I’m scared of, that maybe I might be that monster like my mother was.

I think they (others) will tell you **I am a fighter**. I’ll try and try to make things better for me and for my kids.

(I felt shame) when he used to tell me that **I’m useless, I’m going to be a nobody and I’m good for nothing and all that, I used to feel that’s maybe how I am, and I used to be ashamed of myself.**

**If you keep on hearing the same thing over and over, and this person you are staying with, almost every week you hear that, you are bound to start thinking, maybe it’s true. And also coming from an abusive childhood, I was just ashamed. I never really wanted to tell anybody about what was happening because I was scared that maybe my friends would laugh at me or something.**

I think it’s (shame) painful. **It’s painful to be ashamed of yourself.**

(When I am ashamed) I just thought that maybe I don’t fit in. **I don’t fit in, maybe I must just keep myself from people. I mustn’t talk too much with people. I mustn’t be friendly with people.**

**It's almost like hiding away".***Interpretation*

This narrator's shame is amplified by the transgenerational nature of her abuse. The depth of her shame is palpable, and like the previous narrator, her shame-based authentic self is thinly veiled by a false self that is described simply as "strong" and as a "fighter", who is able to ensure her survival. The rest of the narrative revolves around shame. She uses common shame terms, such as "I'm useless, I'm going to be a nobody and I'm good for nothing"; "I used to feel that's maybe how I am, and I used to be ashamed of myself". She also makes reference to the damaging effects of the chronicity of shaming messages: "Because if you keep on hearing the same thing over and over, and this person you are staying with, almost every week you hear that, you are bound to start thinking, maybe it's true. And also coming from an abusive childhood, I was just ashamed".

What I find interesting about this narrative is that although Mandy is very articulate, her description of how shame feels is vague at best ("painful"). This is consistent with the literature which emphasises the speechlessness associated with shame, and the difficulty of expressing it concisely in language (H. B. Lewis, 1971; M. Lewis, 1992).

Finally, the narrator's response to feeling shame is a common one which we have encountered before, the need to hide, to protect the self from further hurt. It is interesting that she says that the feeling of "not fitting in" pre-empts this, since it can be partially explained by evolutionary theory. Once a person is perceived as an outcast, or has lost SAHP, s/he can choose to engage in defensive, reparative or retaliatory action (Gilbert, 1998), and hiding is a defensive action.

**Lilly**

"Oh, this place helped me a lot, because even the time I came here, me and my children had huge things. So now in this place, I can say that, no matter what, I can go outside. The things to dress, ja, most of them I got from here. So it was nice to me. I experienced that the people here, **they have patience and support, ja. I was so empowered about that. When I am here, I feel strong.**

The only thing I used to feel, **it's like maybe it was a mistake that I'm alive.**

It's just the feeling that I have, maybe if I can be successful in life. But the problem is, if you are maybe going to look for a job, then they want experience or what-what. Most of the time they are looking for those who have matric, and then me, **I don't have matric. So I just blame myself**".

### *Interpretation*

In this very short narrative, there are some indications of splitting, although I would argue that the self is essentially shame-based. There was more evidence of shame at a bodily level than can be demonstrated in the written narrative, and much of the excluded narrative revolved around suicidality. Shame has previously been associated with suicidality (Brown et al., 2009; Chan et al., 2005), so perhaps this feeling that "it was a mistake that I am alive" is at least partially an expression of the authentic, shame-based self. The narrator also seems to feel shame for specific reasons, like not having a higher education, leading to her blaming herself for not having employment, which is likely to further feed into a shame-based self-esteem. Although the narrator speaks about feeling supported and "empowered", and describes how she has become "strong", she does not own this power or strength, she hands it over to the Centre. These positive characteristics are so flimsy, and so poorly "owned", I am not sure they constitute a false self at all. The shame-based authentic self is definitely clearly exposed and predominant in Lilly's case.

### **Christine**

**"Ek kan nie sê ek is sterk nie. Ek is maar baie saggeaard.** Dis hoekom, as ek altyd 'n prent op die TV kyk, en dis miskien 'n hartseer storie, dan as daai een nou huil op die TV, dan huil ek ook. Dis amper so. Dit is mos nou nie werklikheid nie; party stories is die waarheid, maar nie altyd nie. Maar ek bedoel, mens weet mos nou nie wat is die waarheid nie, maar dan huil ek ook maar saam. Ek voel vir daai ene - so is ek.

**Ja, ek het dit (skaamte) baie keer al gevoel al.** Ek het baie keer al daai gevoel gekry van so...amper so, jy is...hoe kan 'n mens sê...**jy is maar vir niks hier op aarde nie.**

**Daar by ons is dit mos nou amper so, dis mos 'n klein dorpie, nou daar's mos nou baie wat nou al weet watter dinge ek nou al deur gemaak het en so aan. Ek voel skaam as ek partykeers loop in die straat. Mens weet mos, jy kry dan die gevoel iemand hou jou dop en so aan.**

Dit (skaamte) het altyd seer gevoel. **Eerlik, dit het altyd seer gevoel.**

Is amper so, **ek is amper soos sy vloerlap**: hy kan maak met my wat hy wil. So is hy. Ek moet nou net klein speel, klein speel. Maar ek het al die pad so klein gespeel, maar nou van ek so kerk geloop het, toe laat ek nie meer hy vir my sê nie. Hy's amper soos 'n hondjie nou gewees onder my. **Hy's amper so, hy's nou bang om my te slaan. Daai man is bang vir gaat tronk toe.** Hy is bang. Hy ken die tronk. Ja, hy ken die tronk en hy is bang. **Maar ek dink dis meeste die wat hy wil hê ek moet nou af kom huis toe want hy wil hê ek moet die saak terug trek. Nee, ek gaan dit nie doen nie”.**

*Translation*

*“I can't say that I'm strong. I'm quite gentle. That's why, whenever I watch a film on TV, and if it's perhaps a sad story, then whenever that one cries on TV, then I also cry. It's more or less like that. It's not real, is it? Some stories are true, but not always. But I mean, one doesn't know what's the truth, but then I cry with that one. I feel for that one – that's what I'm like.*

*Yes, I have often felt it (shame). I have often had that feeling of...almost like, you are...you are just nothing here on earth.*

*There at our place it's almost so, isn't it, it's a small little town, isn't it, there are many people, aren't there, who know about the things which I have experienced and so on. I feel ashamed when I sometimes walk in the street. You know, don't you, you then get the feeling someone is watching you and so on.*

*It (shame) always hurt me. Truly, it always hurts.*

*It's almost like, I am almost like a doormat to him: he can do with me what he wants. That's what he's like. I must just play the little one, the little one. But I have played the little one all the way, but since I have gone to church, I don't let him tell me what to do. He has almost been like a puppy with me. He's almost so, he's now afraid to beat me. That man is afraid of going to jail. He is afraid. He knows the jail. Yes, he knows the jail and he is afraid. But I think he mostly wants me to come back home because he wants me to withdraw the case.*

***No, I'm not going to do that***.

*Interpretation*

The narrator starts by saying that she is not strong (a striking exception), but that she is very soft-hearted, and empathic, qualities she seems to value. But she immediately admits to feeling shame; to feeling like she isn't on earth for any reason ("jy is maar vir niks hier of aarde nie".) Then, very much like in Mandy's narrative, this narrator describes shame in terms of humiliation. She talks about how she lives in a small village where everybody knows what happened to her and she describes how ashamed/"skaam" (*humiliated*) she feels when she is walking out in the open, in the street. The hostility and contemptuousness of the audience is captured in the phrase "Mens weet mos, jy kry dan die gevoel iemand hou jou dop en so aan" (*You know, don't you, you then get the feeling someone is watching you and so on*). Like Mandy, she also describes shame in vague and diffuse terms – as "seer" (*painful*) once again pointing to the difficulty with which to accurately and precisely articulate the emotional meaning of shame in language.

The last paragraph is a beautiful illustration of the juxtaposed authentic and false self. She speaks of herself as his "vloerlap" (a cloth to clean the floor with – a shameful, insulting Afrikaans term indicating a state of servitude) and immediately follows this description with an account of a process requiring immense inner strength - "hy wil hê ek moet die saak terug trek. Nee, ek gaan dit nie doen nie" (*He wants me to withdraw the case. No, I am not going to do it*).

**Annabelle**

**"Ek het baie mooi maniere, en ek is baie stil en so.** Is nie eintlik iemand om eerste met 'n mens praat of so nie. **Ek dink ook baie.** Ek try om nie te dink nie, maar dit gaan net aan en aan.

As hy so vir my geforce het in die aande om seks te hê en as ek sê nee, sê hy vir my is daar 'n ander man; hy vra vir my of ek met 'n ander man gelê het of so. Hy ruk my sommer \*\* doen wat hy wil doen \*\* ek kan maar huil ook of sê nee \*\*

**Soos 'n vuil hond het ek gevoel.**

*Translation*

*I also have very good manners, and I am very quiet and so on. Not really someone to talk to a person first or so. I also think a lot. I try not to think, but it just goes on and on.*

*When he forced me in the evenings to have sex and I say no, he tells me there's another man; he asks me if I lay with another man or so. He just pulls me \*\* do what he wants to do \*\* even if I cry or say no \*\**

*Like a dirty dog I felt”.*

*Interpretation*

I include this very short narrative purely for the last sentence, which as my title indicates, is a metaphor which I believe captures the essence of shame, an emotion, as we have established, which is so difficult to accurately, precisely articulate or express. This young woman describes herself as a quiet person with mild manners who thinks deeply, a woman with a relatively strong false self. Yet when she describes the horror of her rapes, and the more expressive reaction to this profound violation: “Soos ‘n vuil hond het ek gevoel” (*like a dirty dog I felt*), she gives voice to a deeper, concealed, shame-based authentic self.

**Patricia**

“My pa het tronk toe gegaan omdat hy my suster verkrag het. Toe was sy veertien jaar oud. But wat my ma tot vandag toe nie weet nie, dieselfde het met my ook gebeur, en nie een van hulle weet nie. Ek is altyd die sterk een in ons se familie. **Hulle het altyd op my skouer gehuil, nou ek kan nie myself gebring het om my ma nog...**want toe sy uit vinne van daai, toe is dit amper soos, sy is ook gebruik al, ek kan nie nog vir haar verder oor die edge gestuur het nie. Ek kan dit nie oor my hart gekry het nie. **Ek is altyd die sterk ene, tot vandag toe, maak nie saak wat ek deur gaan nie, ek hou my nog altyd sterk. En hulle weet nie eers...ek is besig om in stukkies op te breek**, en ek kan nie vir myself bring om dit vir hulle te sê nie.

Even toe sy pa ook hier gekom het, dan staan ek agter 'n hek en dan sê ek, ek is nie bang vir jou nie want jy kan my niks maak nie. Want as ek my voete in sit hier, dan voel ek gerus want die is huis vir my. Mense kyk my aan...like **ek is 'n baie harde person en daai, but ek break mos nie down voor mense nie.**

Hy (partner) het my laat voel like ek is **laer as die dirt op die grond. Worthless. Ek sal nooit goed genoeg wees ook nie.**

**Ek voel nou nog skaam, like even oor Sarie se pa wat vir my geabuse het. Om te dink, ander tyd het ek geloop met blou oë in die pad in en daai. Hy het my al geslaat in public, in ons se court en voor mense.** Toe kom leer ek vir Agnes ken, die intern counsellor wat ek by is, sy bly in dieselfde court wat ek bly in Mannenberg. Mense in die court het al gesien al hoe slaat Sarie se pa vir my in public. Dan loop ek met blou oë in public en ek is nou skaam. Al even is dit weg ook nou, dan loop ek nog altyd skaam buitekant. Even tot nou toe, hy was gewees but nog altyd, **ek is skaam want ek voel like...hy maak dit amper soos, is jou skuld laat ek vir jou geslaat het. Even tot vandag toe, as ek hom sê is deur jou, dan sê hy my is my eie skuld gewees - dit was deur my. Is my skuld dat hy so gereact het. Dat hy vir my geslaat het.**

**No. 1, ek is 'n sterk person. Ek is ook 'n baie helpful person.** Ek is at all times willing to help, waarever. So iemand wat my goed ken sal my so describe: sterk, helpful, **en ek is friendly** - nie baie nie - but ek is friendly. As ek nou nie vir jou ken nie, ek gaan nou smile en jou groet, but ek gaat nie like 'n conversation hou met jou nie. As ek jou miskien leer ken, ja, dan sal jy sien ek is meer sagtere, sal ek sê. But ek is nie like overfriendly nie. Ek lag nie met almal of met enige een in die pad nie. En vir my is dit 'n bietjie baie \*\* om te smile. \*\* wat Ashley gevat het, **dan sê sy my altyd, Patricia, not a fake smile, please, a real one. Dan sê ek vir haar, ek het nie vir jou 'n real smile nie, actually, then my face is going to hurt because ek is nie gewoond aan smile nie.**

**Vir my, iets soos abuse, is iets om skaam te wees oor. Even toe ek gekom het hier, toe was ek like skaam. Want soos mense vir my aan kyk, hulle sal nie sê the way ek hard is, ek was abuse nie. But die eerste twee maande wat ek hier was, toe voel ek skaam even om verby die mense te loop. Dis like ek bly in 'n shelter vir abused women, en dis vir my iets om skaam te wees oor.**

(Ek voel worthless) Ook net 'n bietjie nog omdat ek nou **nie financially independent is nie**".

*Translation*

*“My father went to jail because he raped my sister. She was fourteen years old then. But what my mother doesn’t know, up to this day, is that the same happened to me, and none of them know. I am always the strong one in our family. **They always cried on my shoulder, now I cannot bring myself to...my mother...**because when she found out about that, then it was almost like, she has also been used, I could not push her even further over the edge. I could not find it in myself to do it. **I am always the strong one, up to this day, doesn’t matter what I go through, I still pretend to be strong. And they don’t even know...I am breaking into pieces, and I cannot bring myself to tell them that.***

*Even when his father came here, then I stand behind a gate and then I say, I’m not afraid of you because you can do nothing to me. Because when I put my feet here, then I feel at peace because the house is for me. People look at me...as if **I am a very hard person and all that, but I don’t break down in front of other people, not so?***

*He (partner) made me feel I am lower than the dirt on the ground. Worthless. **I will also never be good enough.***

***I still feel ashamed, like even about Sarie’s father who abused me. To think, that other time I walked with blue eyes in the road and all that. He beat me in public, in our quarters and in front of others.** Then I came to know Agnes, the intern counsellor with whom I am, she stays in the same quarters where I stay in Manenberg. People in the quarters have seen how Sarie’s father beats me in public. Then I walk with blue eyes in public and then I am ashamed. Even when it is gone, then I still walk ashamed outside. Even up till now, he was but still...**I’m ashamed because I feel like...he almost makes as if, it’s your fault that I beat you. Even till today, when I tell him it’s through you, then he tells me it was my fault – it was through me. Is my fault that he reacted like that. That he beat me.***

***No. 1, I am a strong person. I am also a very helpful person.** I am at all times willing to help, wherever. So someone who knows me well will describe me like this: strong, helpful, **and I am friendly** – not very much - but I am friendly. If I now don’t know you, I will now smile and greet you, but I’m not like going to have a conversation with you. If I perhaps learn to know you, yes, then you will see that I am more softer, I’ll say. But I’m not like overfriendly. I don’t laugh with all people or with anyone in the street. And for me it’s a bit*

very \*\* to smile. \*\* that Ashley took, *then she always says to me, Patricia, not a fake smile, please, a real one. Then I say to her, I don't have a real smile for you, actually, then my face is going to hurt because I'm not used to smiling.*

*For me, something like abuse, it's something to be ashamed of. Even when I came here, then I was like ashamed. Because how people look at me, they won't say the way I am hard, I was abused. But the first two months that I was here, then I even felt ashamed to walk past the people. It's like I am staying in a shelter for abused women, and that is for me something to be ashamed of.*

*(I feel worthless) Also a little bit because I'm not financially independent”.*

#### *Interpretation*

Patricia repeatedly emphasises that she is “sterk” (*strong*), hard and tough (“ek is ‘n baie harde persoon en daai, but ek break mos nie down voor mense nie”/ *I am a very hard person and so, but I don't break down in front of people*), but the very first paragraph ends with the dramatic phrase indicative of dissociation: “ek is besig om in stukkies op te breek” (*I am breaking into pieces*). The secret of her abuse as a child, that she keeps from her family to protect them, because she believes she must be the “strong” for them is literally breaking her apart, causing internal disintegration, fragmentation. The narrator's strength, her ability to be hard and tough - these qualities that should be positive in high-risk environments, the ones she projects as her false self, are in fact tragic for her, and have heart-breaking consequences – years of silence that lead to this unconcealed, conscious fragmentation.

There is a great deal of humiliation (which the narrator calls “skaam” or shame) and self-blame in this narrative. Again, like in previous narratives, Patricia explains that she experiences “shame” when she has to walk in public with blue eyes or when her partner hits her in public. The underlying assumption is that those who witness this will evaluate her (not her partner) negatively; that her pain will be perceived by a hostile and contemptuous audience. The self-blame reactions are fuelled by her shame-based authentic self. Her narrative suggests that she buys into her perpetrator's projection that it her own fault that she was abused; that she somehow provoked the attacks: “...ek is skaam want ek voel like...hy maak dit amper soos, is jou skuld laat ek vir jou geslaat het. Even tot vandag toe, as ek hom sê is deur jou, dan sê hy my is my eie skuld gewees - dit was deur my. Is my skuld dat hy so

gereact het. Dat hy vir my geslaat het” (*I’m ashamed because I feel like...he almost makes as if, it’s your fault that I beat you. Even till today, when I tell him it’s through you, then he tells me it was my fault – it was through me. Is my fault that he reacted like that. That he beat me*). In the next part of the narrative, Patricia returns to the false self, and emphasises her strength, and other good qualities, such as being friendly and helpful. But unlike many other participants, Patricia does not wear a smile as a mask. Interestingly, there is a greater authenticity in her interactions with others. Not surprisingly, given her history, she says, “my face is going to hurt because ek is nie gewoond aan smile nie” (*...because I’m not used to smiling*).

The narrative has a fragmented quality, mirroring the narrator’s fractured self. In the final parts of her narrative, she returns to the theme of shame, and she says quite simply that abuse is something to be ashamed about. Then she slips into humiliation when describing living in a shelter for abused women, expressing a concern for what outsiders might think; how she will be humiliated, negatively evaluated by that mocking, hostile imaginary audience. This narrator covers many aspects of shame, and ends with another source of shame, her lack of financial independence, which is particularly shaming in individualistic, Western cultures. I believe that this participant’s shame-based authentic self is so pervasive because of the chronicity of her exposure to abuse.

### **Overall Interpretation from a Phenomenological and Social Constructivist Narrative Analysis Point of View**

I am going to begin the overall analysis by discussing the sources of psychic splitting at an individual/clinical level. I will then move on to examine how the split might have been unintentionally exacerbated by the organisational context in which the women were embedded. I will end this section with brief commentary on how psychic splitting is reinforced at cultural level.

#### **Psychic Splitting at Individual Level**

Severe and sustained trauma, like my participants experienced, is likely to lead to the splitting of self (M. Lewis, 1992). The purpose of splitting is to protect the traumatised, shamed and concealed authentic self from being exposed to further harm by producing another part of the

psyche which conceals and compensates for the often unconscious pain experienced by this vulnerable part. As I outlined above, shame itself is subjectively experienced as a split emotion – it is experienced as the internalised negative evaluation of a real or imagined other, while the self remains acutely aware of itself; it is self-reflective. Shame-proneness has also demonstrated a negative relationship with self-esteem, stability of the self, and a positive association with self-consciousness, fear of negative evaluation, and splitting (Tangney, Burggraf, & Wagner, 1995).

At an individual clinical level, psychic splitting and fragmentation as a post-traumatic response often co-occurs with shame, which are both central to Complex PTSD and DESNOS, both syndromes that are a response to prolonged or chronic trauma, like the women I interviewed had been exposed to (Ford & Courtois, 2009). Furthermore, as discussed earlier in the thesis, PTSD has three key features – hyperarousal, intrusion and constriction (Herman, 1997). Each of these symptoms is exaggerated (in intensity and duration) in survivors of chronic trauma, particularly constriction (Herman, 1997). In constriction, the self is defeated, in a state of surrender – the survivor escapes from an unbearable situation by altering his/her state of consciousness. One of the aspects of life that constriction interferes with are plans for the future (e.g. a sense of foreshortened future), forcing survivors to live in an endless present, the past becoming split off into dissociated fragments, which are often difficult to access (Herman, 1997).

Finally, in terms of understanding the phenomenon of splitting at individual level, it is worth mentioning that in a number of cases, women kept their abuse hidden or secret for long periods of time. This silencing and secrecy causes a second injury or betrayal trauma (Ford & Courtois, 2009). It has been argued that it can lead to splitting in the personality, where the individual maintains a front of an “ostensibly normal” personality which is functional and effective in the world and, critically, gives the survivor a role in protecting the public from being exposed to the inconceivable and unspeakable. This façade may be split off or disconnected from the underlying “emotional” personality which is debilitated psychosocially by the subjective knowledge of the trauma (Ford & Courtois, 2009, p. 18). These authors’ description is in complete agreement with Herman (1997) and Kraft’s (2004) understanding of the false self and the authentic “emotional” self.

### **Psychic Splitting at Organisational Level**

Individuals may use their talk to develop self-views they would like to hold but which are not yet in existence (Pasupathi, 2006). Individuals engage in this kind of talk to embed them in a life story in the hope of creating supportive evidence and coherence, and also with the hope of social confirmation (Pasupathi, 2006). It is relevant here that the ethos of the Centre, and the discourse driving counselling was an empowering one; one that emphasised the women's role as survivors (as opposed to victims), and women were keen to embed this characteristic in their narratives both implicitly and explicitly, and have this validated.

It is worth pausing here a moment to consider counter-narratives. As Bruner (2001) has pointed out, a story is made interesting by the violation of canonical expectancy, but in a way that is culturally acceptable. Bruner (2001) argues that narrative "turning points" are crucial to attempts to individualise a life, to resist automatic, folk-psychological or cultural canonicity, and it is what makes the ordinary and expectable, idiosyncratic and agentic. Women's descriptions of themselves as strong and as survivors are agentic, resistance narratives – challenging and violating the canonical or master narrative that constructs women as subjugated, disempowered. These counter-narratives not only reflected a change or "turning point" for women in how they viewed themselves, but were made micro-culturally acceptable by their consistency with a broader discourse of survival and empowerment promoted by the Saartjie Baartman Centre. Identity cannot be separated from the local discursive context (Freeman, 2001). Women often attributed feeling strong to the interventions they had been exposed to at the Centre, particularly counselling. As Lisa said: "that's what my counsellor first told me. She would always try to encourage me: I know you are strong."

Women's counter-narratives were informed by this discourse. In these cases, counter-narratives were filled with emotional references to women's empowerment process and survivor status. Sarbin (1989) argues that such emotions or "passions" are rhetorical acts performed not only in attempts to maintain or enhance moral identity, but constitute the reconstructed plots of narratives encountered during the process of enculturation, in this case, through the predominant ethos of the Centre.

It is important to notice, however, that these claims of inner strength are at odds with the anxiety and fear that so many women reported feeling; the sense of imminent threat, reported in the previous chapter. There is a tension between these feelings, interviewees' shame and associated vulnerability, and their overt descriptions of themselves as active, strong survivors.

It is possible that for these reasons, and because women had typically only been exposed to counter-narratives for a short period of time, I felt the articulated constructions of the self as strong, as survivors, were often thinly-veiled and inauthentic.

There is another point worth considering. Counter-narratives by definition are resistance narratives; they imply authority, potency, agency. Although women's attempts at constructing themselves as strong, proud survivors did resist the broader patriarchal culture from where they came, one which normalises and socially sanctions violence against women, it is not in opposition to the ethos of the Centre (and I am not suggesting here that it should be). The identity that women are expected to internalise is – however well-intentioned – one which is imposed upon them. It is not one that emanates from the women themselves, perhaps making them less agentive than I had initially claimed. This may be another reason why the constructions of themselves which were consistent with the ethos of the Centre felt unconvincing and lacked psychological depth.

Bamberg (2004) argues that individuals' counter-narratives are often characterised by inconsistencies and contradictions; an oscillation between complicity with master narratives, and active resistance. These inconsistencies and contradictions are also indicative of multiplicity – of a splitting or plurality of identity (Halbertal & Koren, 2006). Gregg (2006) similarly maintains that counter-narratives construct identities which are organised according to a deep structure founded on binary oppositions. These oscillations between complicity and resistance against master narratives, when analysed using a social constructivist approach to narrative analysis, demonstrate psychic splitting unconsciously exacerbated by the well-intentioned master narrative or ethos at organisational level.

### **External and Psychic Splitting at Cultural Level**

All selves are illusory “false selves” – no matter how vigorously and sometimes violently they might be defended – formed out of this plastic and elusive substance that pre-exists us and yet continually evolves. The threat of shame in its social function binds us to the ground, to the culture – and to the illusion. But there is always the threat – a barely perceptible dread – that the illusion will unravel. (Mollon, 2002, p. 49).

I include three quotes to begin this section of the discussion of findings:

### **Cheryl**

Ja, en so het dit basically erger en erger geraak. Maar vir my was dit nie so snaaks nie, want die omgewing wat ek uit kom is dit amper so, ek sal amper sê is tradisie. Dis tradisie vir die mans om hulle vrouens te slaan of hulle meisies te slaan. Vir hulle is dit soort van om te bewys ek is in beheer en ek is baas. Maar ek het dit nie beseft nie, totdat ek vier-en-'n-half jaar vas gevang gewees het in dit. ... En in die posisie wat ek vir my bevind het, dink ek is omdat in ons omgewing is daar te min bewusmakings en veldtogte teen vroue mishandeling. Soos ek sal nou \*\* geslaan, maar ek gaan niks maak nie want vir my is dit net, ag, dan gebeur dit maar net weer. Dit gebeur miskien vir elke... dit gebeur in agtien huise in een straat miskien, so dit is nie snaaks nie. Die kinders groei so op en dit moet so wees.

### *Translation*

*Yes, so it basically got worse and worse. But to me it wasn't so strange, because the environment out of which I come, it is almost like, I could almost say it is a tradition. It's a tradition for men to beat their wives or girlfriends. But I did not realise it, till I was caught in it for four-and-a-half years. ... And the position that I found myself in, I think is because in our environment there is too little awareness-raising and resistance against the abuse of women. Like I will now \*\* beaten, but I am not going to do anything because for me it is just, oh, then it just happens again. It happens perhaps for each...it happens in eighteen houses in one street perhaps, so it isn't strange. The children grow up and believe that it should be so.*

### **Irene**

Actually, I'm Irene. I've been a married woman for 28 years. I'm married to a Harry Isaacs, and in our marriage we had two children. The first year of marriage, it was like rosy. Going into my second year, he was my first abuser. He used to drink a lot and hit me. And I just thought, ag, everybody says when you get married, that is just how life is. You must just make the best of it.

### **Felicia**

Because in their (Xhosa) culture, beating a woman is fine.

Women said more frequently than I expected that they felt stigmatised by their status as an IPV survivor, both in this and the previous chapter. They described acute humiliation reactions as a result of being resident at a shelter such as the Saartjie Baartman Centre. This seems to contradict the routine character of IPV in many of the communities the women came from. IPV was described as a “tradition” by one interviewee in the quote above (an expanded version of the quote provided in chapter 7), suggesting that it was the norm rather than the exception in her community. It is interesting, as this suggests that these women were familiar with cultures of honour, “where living is hard” (Patricia said: “ekke kom al klaar uit 'n harde lewe uit.” [*“I already come from a hard life”*]), where there are strong and oppressive patriarchal values among men (Cohen et al., 1998, p. 277). I would argue that these cultures undoubtedly contribute to IPV and facilitate the (presumably unconscious or by-passed) development of cultures of shame among women (Cohen et al., 1998). In fact, I would further argue that men’s particular form of masculinity in these contexts is maintained by the reactive shame that women feel and that this is a shame-based response pattern that is cyclically repeated at cultural level. In such a culture where patriarchal structures such as male strength and power are highly valued and deeply embedded in the social system, and where poverty is pervasive and consequently social status is held in high esteem, one can only expect the existence of binary oppositions – alongside this patriarchal self (perhaps symbolic of the false self) must be the shame-based self (perhaps symbolic of the authentic self), who has lost dignity, power, and control. Yet a strange dynamic creeps in here. In these cultures, as in many South African communities, wrongs are not only indiscretions against the (male) individual, but also to the (male) individual’s reputation, which includes those with whom he is intimate, particularly females for whom men are considered responsible (Cohen et al., 1998). It is likely that they are held responsible for “their” women, and that these women accept this to varying extents because they have been so subjugated and disempowered by occupying a gendered position that facilitates cultures of honour’s particular brand of patriarchy. It is perhaps this process which causes the ambivalence that some of my participants felt towards their partners – although their partners literally beat them down, they also took care of them, took possession of them, a pattern of attachment that is likely to be seductive for those who have grown up in abusive homes and have established disorganised attachment patterns. Self-sufficiency, especially at an economic level, may have helped

interrupt the dependency characteristic of these attachment styles, and facilitated an (at the very least partial) escape of the shame felt by the authentic self.

So what I have argued so far is that highly patriarchal (male) selves are represented by cultures of honour, and highly subjugated, disempowered (female) selves are represented by cultures of shame. So, this is external, not internal or psychic splitting. As I have noted, I believe cultures of honour and shame are two sides of the same coin; they are cyclical reactions to one another. This may be why, then, IPV occupied such an apparent normative status.

At an individual level, I would argue that IPV paradoxically still evoked shame, humiliation and embarrassment among my participants despite IPV's normative status, because of individual self-blame. For women who have internalised a perpetrator-defined identity; accepted the "bad" self (Fairbairn, 1943), and who have taken responsibility for their abuse; who feel deserving of their abuse (as most do), will feel all these challenging emotions despite the prevalence of this form of violence in their cultures. This self-blame is compatible with my earlier theory that women are unconsciously complicit in maintaining the gender-based status quo – they protect the supremacy, strength and power of men in cultures of honour, and the "right" of these men to own or possess them at the cost of valued parts of themselves, which is an undeniably painful process, however unconscious (e.g. their own dignity, sense of self-worth and self-respect).

The concern with social status and respect was prominent among the women I interviewed, especially in chapter 7 and this chapter. Women's narratives indicated that they valued being respected by others a great deal, which may be exaggerated by their gendered subjugation at cultural level. These women displayed a great deal of stigma consciousness, which does not only involve an individual's awareness that s/he has a stereotyped, or diminished status, but involves his/her focus on, or preoccupation with, his/her stigmatised status (Mosley & Rosenberg, 2007). As will be shown, many of the women's descriptions of shame actually point to the experience and awareness of stigma. Stigma is closely aligned with (lack of) respect. Hollway and Jefferson (2009) competently demonstrate how important respect is, particularly in disempowered, working class communities where there tends to be preoccupation with social status, a phenomenon known as status anxiety (a term coined by De Botton, 2005). Status anxiety occurs when an individual feels in danger of not conforming to the ideals of success determined by society, and that s/he will be stripped of dignity and respect, just as the women I interviewed had been by their marginalised, subjugated and

powerless position in the communities they came from. It is often accompanied by worrying that the self is occupying a low and stigmatised rung, or that s/he is about to descend to one (signalling the loss of SAHP). One of the reasons for status anxiety is dependence, and these women were highly dependent (often emotionally and financially) on their perpetrators, and were particularly resentful that they struggled to achieve financial independence or self-sufficiency. Perhaps this preoccupation with status and financial independence was because, having escaped the interdependent, gendered cultures of honour and shame, women were seeking freedom, and were in the process of reclaiming the parts of themselves that they had unconsciously sacrificed to maintain the gender-based power differential; attempting, as we saw in the counter narratives, to shed their own subjugation, disempowerment and shame, and regain (or gain for the first time) their pride, independence, self-respect, dignity and an elevated social status at cultural level. As I argued when discussing the counter-narratives, the process of assuming a new identity of this kind, however, is a lengthy one. It cannot simply be acquired in a few sessions; it requires long-term and sustained psychological intervention.

Kaufman (1993) argues that in Western or individualistic cultures, compared to African or Asian cultures, shame is centred around competition for success, being independent and self-sufficient, being popular and conforming, and being in a successful relationship, all strivings my participants would struggle to meet (Kaufman, 1993). Although South Africa is a complex, multi-cultural context, it appears that the majority of my participants identified with Western or individualistic cultures, and the ideals and values propagated by this cultural system. I believe the numerous references to seeking financial security in both chapter 7 and this chapter is a culturally compatible compensatory effort made by the individual false self for the culturally-determined shame felt by the authentic self.

In the next chapter I go into greater depth on the topic of trauma-related splitting, but I focus on a more dramatic form thereof using a different method of analysis. I focus on psychic fragmentation as it is represented in language, where the self has disintegrated. Severe and chronic trauma and prolonged shame can become so potent and incapacitating that it needs to be altered and/or avoided (M. Lewis, 1992). It is during this shame-avoidance process that fragmentation of self, and dissociation, occurs (M. Lewis, 1992; Nathanson, 1992; Putnam, 1989). Although I have loosely referred to narratives and counter-narratives in this chapter from a social constructivist point of view, the next chapter will use a more formal type of narrative or categorical form analysis (Gee's, 1991 model) to analyse this chronic shame and trauma-related fragmentation.



## CHAPTER 9

### Results and Discussion III

The 'wild country of time' is a place where things only ever go missing; planting our narrative flags in its inhospitable soil and claiming a piece of its ground as our own, though perhaps ultimately a futile gesture, is nonetheless what we need to do to survive the pain of this life, to get to the 'there' that must follow the 'gone'. (Schnell, 2008, p. 181)

In this chapter, I comment on the structure of women's narratives using Gee's (1991) linguistic approach to narratives. This method was considered the most appropriate for assessing narrative fragmentation. Other current measures of narrative organisation, like those assessing sentence length in words and average number of syllables per word, lack face validity and are not empirically supported measures of the cohesiveness of a text (some argue that these measures are proxy measures for cognitive ability) (Gray & Lombardo, 2001; O'Kearney & Perrott, 2006). I also considered Gee's (1991) approach more appropriate and suited to the linguistic or structural analysis of narratives than Stein and Glenn's (1979) episodic analysis system, and Labov and Waletzky's (1967) high point analysis system (as cited in Riessman, 1993), as I have discussed in chapter 6.

It is important to know that verbatim memory is the original representation of the traumatic event(s), whereas gist memory organises and structures verbatim memory and its linguistic form (Kraft, 2004). The distortions, the ellipses, the repetitions, the errors and the intrusions that we will encounter in the narratives that follow, occur within gist memory; verbatim memory persists and endures, and remains resistant to distortion and assimilation (Kraft, 2004).

Most, but not all, of my participants told their stories in vivid and great detail; telling their stories about their abuse at great length. Five examples of longer narratives, which will be subject to linguistic analysis, and three shorter, compressed narratives, will be presented. Another important consideration is that for most of the women I interviewed, it is likely that the traumas they endured shattered their assumptions about the world; the world as safe, as benevolent. This is common in individuals who have been traumatised (Brewin & Holmes,

2003). Perhaps this sense of shattering is what is reflected in the fragmentation of women's trauma narratives, to which I will turn shortly.

It is important at the outset for those intervening with shamed individuals to be able to identify the variants and correlates of shame (H. B. Lewis, 1971). As I have previously noted, signs of overt shame include acute, painful self-consciousness, depression (which can be understood as a product of self-directed hostility), soft self-boundaries (including fusion of self and other), feeling the contagiousness of shame, shyness (defined as acute dread and chronic tension), wordlessness, obsessive rumination, disgust, and autonomic arousal (H. B. Lewis, 1971). In therapy, shame may additionally manifest as feelings of numbness and depersonalisation, possibly as a reactions against feelings of "badness", contamination and filthiness (Wurmser, 1987). Finally, shame may also be masked as haughtiness – cold arrogance and withdrawal; as envy; as paranoia of being watched, spied on or controlled; or in the grandiose claims characterising narcissism and states of apparent shamelessness (Wurmser, 1987).

An important defense that therapists should look out for is by-passed shame, which refers to unacknowledged, unconscious and repressed shame, which typically manifests as another cognition or emotion (H. B. Lewis, 1971). To recap, by-passed shame occurs when the feeling of shame is so aversive that it is intolerable, so it is pushed from awareness and substituted with a less painful emotion, like sadness or anger or rage at either oneself or another (H. B. Lewis, 1971; M. Lewis, 1992). This sadness is often transformed into depression, which is often understood as anger turned inward (H. B. Lewis, 1987b; M. Lewis, 1992). Anger may develop in response to a specific event, while rage is a response to prolonged shaming; to an injury to the self (M. Lewis, 1992). Substitution may involve focusing on a single feature of the entire emotional state, or on a new emotion (M. Lewis, 1992). By-passed shame can be recognised by the fact that it evokes a "wince" or a "jolt" to the self, followed by negative thoughts about the self (H. B. Lewis, 1987a). Unlike by-passed shame, when shame is acknowledged and experienced, it may be dispelled by allowing the emotion to dissipate by itself, shifting one's attention to something different, denial, forgetting, using humour and laughter or confession to distance the emotion (M. Lewis, 1992; Mills, 2005; Tomkins, 1963). Other ways of diffusing shame is through affirmation (of non-shamed aspects) of the self (Izard, 1977).

In addition to signs of overt shame, a number of these veiled indicators of shame manifested themselves in the interviews I conducted with the women. Wherever they appear, I will draw the attention of the reader to the substitute emotion.

Scholars as early as Janet claimed:

Forgetting the event which precipitated the emotion...has frequently been found to accompany intense emotional experiences in the form of continuous and retrograde amnesia... If people become too upset to tell their story, memories cannot be transformed into a neutral narrative: A person is unable to make the recital which we call narrative memory, and yet he remains confronted by (the) difficult situation. This results in a phobia of memory that prevents the integration ("synthesis") of traumatic events and splits the traumatic memories from ordinary consciousness: The memory traces of the trauma linger as unconscious fixed ideas that cannot be "liquidated" as long as they have not been translated into a personal narrative and instead continue to intrude as terrifying perceptions, obsessional preoccupations and somatic re-experiences such as anxiety reactions (as cited in Van der Kolk, 1994, p. 585).

It is worth noting at the outset that definitions of narrative fragmentation are imprecise and sometimes distinctions are made between narrative disorganisation and narrative fragmentation, and sometimes the terms are used interchangeably (O'Kearney & Perrott, 2006). In this thesis, the term fragmentation will be used interchangeably with disorganisation, and will be defined as addressing both narrative cohesion (connectedness) and narrative coherence (conceptual organisation) (O'Kearney & Perrott, 2006). Although these two concepts are related, they describe different ways in which the narrative can be organised or fragmented, with very different implications for conclusions drawn about memory fragmentation in individuals who have been traumatised (O'Kearney & Perrott, 2006). Cohesion refers to the additive, comparative, temporal and causal connections between sentences or clauses, while coherence refers to connections between goals, actions, outcomes, topics, themes or event sequences irrespective of their cohesiveness (O'Kearney & Perrott, 2006). It has been argued that recovery from Complex PTSD should be tested by narrative coherence of personal memories (Brown, 2009).

Baerger and McAdams (1999) argue that a substantial body of research indicates that narratives which adhere to a recognizable or canonical story structure are more easily remembered than those that deviate from the structure. Story quality is frequently based on its

coherence (Baerger & McAdams, 1999). The first basic requirement for life story coherence is that the narrative starts with an orientation that provides the audience with pertinent background information to enable understanding (Baerger & McAdams, 1999). This includes providing the life story, including the central characters, locating the narrative in time, and describing the events that precede this particular moment (Baerger & McAdams, 1999). The second basic requirement for life story coherence is that there is temporal or sequential ordering, facilitating the construction of a linear, chronological or causal structure (Baerger & McAdams, 1999). The third essential component of life story coherence revolves around the emotional aspects of the storytelling (Baerger & McAdams, 1999). A narrative will not be coherent if there is not a consistent affective tone, one which imbues the narrative with an evaluative stance (Baerger & McAdams, 1999). The final basic requirement of life story coherence is integration, which involves the narrator being able to synthesise the separated pieces of his/her life into a story (Baerger & McAdams, 1999). None of the trauma or shame narratives generated by my participants adhered to all these criteria, particularly the ability to develop a linear or sequential story or plot, and having an appropriate and consistent affective tone – in fact, one of the participants laughed throughout her verbal recollection of being gang-raped, another typical example of by-passed shame (H. B. Lewis, 1971).

Ochs and Schieffelin (1989) focus on the relationship between linguistic structure and emotion – how linguistic features intensify or subdue affect functions - and drawing on their work, it is interesting to look at the use of personal pronouns in the trauma and shame narratives of my participants. Fourteen of the 19 interviewees often used personal pronouns other than “I” when talking about events and experiences that had happened to them – they often used the word “you”, or sometimes even spoke in the third person. This can be read as a symptom of dissociation, which functions to decrease the proximity of the trauma from the person who has experienced it. Fear, dissociation and depression/suicidality were common responses to the traumas my participants were exposed to, as was explored in the categorical content analysis. Unlike in Klein and Janoff-Bulman’s (1996) interesting study, however, there were no consistent differences amongst my participants between child abuse survivors and those who had not been victimised during childhood in terms of narrative length, whether their narratives focused more on the past or the present (they focused mostly on the past, with some discussion of current practical worries, usually of a legal or financial nature) and their narratives did not consistently de-emphasise the self and emphasise the perpetrator – women

tended to talk both about themselves (their feelings and actions) and their experience of the perpetrator.

Baerger and McAdams (1999) found that the most significant correlation was between affect and integration, suggesting that the transmission of factual information during narration is less important than the subjective communication of meaning, and that these two constructs are dependent upon one another to make the narrative's central evaluative point. By contrast, the least important association was between orientation and integration, suggesting that setting the scene or contextualising the narrative is less important than expected (Baerger & McAdams, 1999). Finally, mental health was found to be associated with a coherent life story (Baerger & McAdams, 1999). Specifically, there were significant correlations between life story coherence and depression, happiness and satisfaction with life (Baerger & McAdams, 1999). Depression was negatively related to life story coherence, while happiness and satisfaction with life were only modestly related to life story coherence (Baerger & McAdams, 1999). As previously noted, depression was identified as a significant mental health problem among my participants.

Baerger and McAdams (1999) argue that psychological problems result from participation in an unsatisfying, oppressive or incoherent story, or alternatively, occur when the narrator lives out stories that others have about his or her life, preventing the narrator from developing his/her own dominant life narrative. Narrative interviewing, like narrative therapy, is likely to facilitate narrative revision – a means of reconstructing “the unstoried chaos of the unconscious...under conscious narrative control” (McAdams as cited in Baerger & McAdams, 1999, p. 75). In their study of the relationship between life story coherence and psychopathology, participants' narrative coherence was scored according to orientation, structure, affect and integration (Baerger & McAdams, 1999).

The results of Baerger and McAdam's study are fascinating, and it is worth pausing briefly to consider integration. Narratives that scored high on the integration index were those that synthesised distinct narrative elements into a unified life story, linking the narrative to larger life themes (Baerger & McAdams, 1999). Life stories that scored low on the integration index were those that did not resolve or reconcile contradiction or ambiguity, or did not make links to the larger life context that surrounded them (Baerger & McAdams, 1999). Most women I interviewed tended to see the world in polarised terms, perhaps because their traumatic pasts had been so complex and confusing. Very few of my participants were able to link their past and current experiences to the larger life context that surrounded them, which is

understandable given that so many of them were still in crisis situations. Although women's identities were shaped by the discursive context that surrounded them, most women were focused on past traumas, and only on occasion on the here and now – their present context – which usually involved concentrating on how to solve legal battles with the perpetrators, find employment, and take care of their children, while struggling with their own post-traumatic reactions. But their focus was on emotional and physical survival.

In a recent study conducted by Freer, Whitt-Woosley and Sprang (2010) survivors of repetitive traumatic exposure produced narratives with greater awareness and perception of trauma severity and greater emotionality than survivors of a single traumatic event, pointing to a “dose-response relationship”. Like in my participants, in this study, exposure to trauma during childhood resulted in narratives with higher levels of emotionality than traumas which occurred during adulthood – the women I interviewed were often much more emotional and distressed about childhood abuse than they were about IPV in adulthood. Consequently, in this study, focusing on the more distant past seemed the most distressing.

The majority of the trauma narratives were long, vivid and detailed in my study; only five were short and compressed. Some scholars have suggested that greater arousal, personal salience, and rehearsal lead to longer and more detailed narratives about a traumatic incident compared to other kinds of narratives (Beaudreau, 2007). Furthermore, some researchers argue that personal salience and extreme arousal associated with trauma impairs the capacity to produce a cohesive narrative. The speechlessness associated with trauma, as a result of unconscious repression of memories and the presence of implicit memory associations, however, especially affective and somatosensory information, can render trauma narratives shorter than other life narratives. A number of other factors can affect narrative length, including conscious avoidance of painful or shameful memories, the willingness to discuss a trauma, and the time that has passed since the trauma took place (Beaudreau, 2007).

These narratives also illustrate some key points made by Orange et al. (1997). They argue that psychic fragmentation, somatic fragmentation and psychosomatic fragmentation leads to the experience of self-loss, which includes the loss of inner cohesion, subjectivity, affectivity, authenticity, agency, temporal continuity, and self-differentiation. This chaos calls into question or even destroys parts of ourselves which we take for granted. For example, the individual may disintegrate into unrelated parts, dissolve into others or diffuse into the physical environment. S/he may feel an inner deadness or numbness, lose the sense of being a subject and become an inert physical object, being inauthentic and false, a simulation lacking

substance, lose possession of him/herself as his/her thoughts are usurped by a foreign will, and feel such extreme discontinuity in who one is that fragmentation takes place along the axis of time (Orange et al., 1997). Note how these experiences overlap with the dissociation found in my participants. This feeling of self-loss is understood as the product of an intersubjective catastrophe, as occurs in IPV.

When using narrative analysis, it is important to look at narrative structure or form as well as content. In many of the interviews, particularly when interviewees were talking about traumatic experiences, the narrative structure was disrupted. Sometimes the trauma is so overwhelming that meaning is lost (Simon, 2008). The fragmented nature of these narratives is evidence of how narrative coherence is disturbed by trauma; interviewees literally “lost the plot” (Van der Merwe & Gobodo-Madikisela, 2008). Because trauma often represents a crisis in meaning, in these narratives, the chronology or order of events which connects experiences in a meaningful sequence with a beginning, middle and end, is lost. The chronicity of trauma that my participants had been exposed to meant multiple disruptions to the coherence in the narrative, resulting in non-linearity due to the often chaotic piecing together of traumatic memories and associated thoughts and feelings. Five examples follow. In these examples, it is clear that the self, splintered and fragmented from trauma (Putnam, 1989) is reflected in the quality of the narratives. In other words, narrative form mirrors narrative content. It is worth pausing here for a moment. From a social constructivist point of view, lack of coherence, multiplicity, contradiction, conflict and fragmentation are thought to characterise identity and narrative, and the kind of disorganisation I report on below would thus not be interpreted as a sign of pathology (Raggatt, 2006). This is a point I consider next.

### **Theoretical Positioning**

The self and narratives are not only socially and culturally constructed, but also historically determined (Freeman, 2001). Personal identity, and the stories we tell, are changeable across time, space and the discursive contexts within which identity is negotiated and produced (Freeman, 2001). Personal identity and the narrativisation of experiences are configured in particular ways across the course of history, and currently, post-modernist and social constructivist understandings of self and narrativisation are predominant in certain contexts.

Some may say I have analysed the data from what may be termed a clinical point of view – I have understood the fragmentation in narratives as a post-traumatic response. There is however, another theoretical way in which these narratives could be interpreted. From a social constructivist point of view, life narratives are discontinuous, heterogeneous, random and fragmented. From this point of view, any narrative coherence or order is imposed on a life which is essentially meaningless and formless (Freeman & Brockmeier, 2001). It is a distinctly modernist point of view to see life, and autobiographical memory, as characterised by narrative coherence, temporal linearity and as reflective of a singular, unified self (Freeman & Brockmeier, 2001). In fact, Freeman (2001) argues that narrative order and coherence are fictional, defensive strategies for convincing ourselves that our lives are meaningful. From this point of view, narratives can be seen as stifling, constricting and delimiting meaning (Freeman, 2009). So, from a structural analysis of language it is to be expected that such fragmented, socially constructed identities would emerge. I would argue, however, that the trauma narratives which follow are more fractured and disrupted than other narratives, narratives not focused on trauma. Although very few of the narratives were as ordered and coherent as the typical modernist narrative ought to be, the trauma narratives were distinctly more fractured than a typical social constructivist text, suggesting the validity of a clinical approach. It is further worth noting that oral narratives – whether about trauma or not - are less likely to constitute well-made stories with central subjects, clear beginnings, middles and ends; they are less linear and coherent than written texts (Ochs & Capps, 2001). I do believe that the clinical approach does not invalidate the social constructivist approach; I would argue that awareness of the clinical sequelae of trauma simply amplifies the socially constructed non-linearity, incoherence and fragmentation that characterise all texts to varying extents.

As noted in the previous chapter, Hollway and Jefferson (2009) suggest looking for unconscious material in the text, which may be illustrated at a structural level. It is worth pointing out once again that, from a narrative analytical point of view, language is not considered a transparent communication medium; it is seen as socially, culturally and historically constructed. Although I have used a structural linguistic approach for analysing narratives, I do not view language in modernist terms. Instead, I used Gee's (1991) approach to uncover unconscious material reflected in language. In other words, I view language as unconsciously constructed. Specifically, in my analysis, I aimed to demonstrate how (unconscious) fragmentation of self is made visible in the fractured usage of language. A

related, somewhat controversial observation is that, unlike Gergen (1994) and other postmodernists' argument, in the case of the five fragmented narratives I have analysed, language is remarkably representational – but in agreement with Gergen (1994), it is descriptive and indicative of an underlying psychological structure.

### **The Analysis**

Two of the narrators were selected to illustrate the fragmentation of the narrative due to the pervasiveness of the trauma-related shame-based self. It is important to note at the outset, that prior to the interview, Narrator 2 disclosed to me that her husband suffered from paranoid schizophrenia, which is the “madness” referred to in the text. As will be seen, what is interesting about her recollection of her experiences, is the delusional nature of some of her narrative. I was left wondering in this interview if it was not in fact the narrator who suffered from a psychotic illness, but I confirmed with her counsellor that this was not the case. She did disclose to me that her mental health deteriorated as a result of her abuse, but that it was depression that she tended to struggle with, not a psychotic illness. I chose her narrative for its remarkable emphasis on the importance of bearing witness to traumas the survivor cannot believe or articulate herself. Other narratives include fracturing around important trauma-related themes such as humiliation, dissociation, disorganised attachment patterns and abandonment, and were chosen for that reason. But the main reason any of these narratives were selected was for their length, complexity and non-linearity, and each and every one of these narratives have a particular non-linear structure, and a fracture which occurs at a significant or traumatic point of the narrative.

To review, following Gee's (1991) approach, the narratives below will be divided into Parts, Strophes, Stanzas and Main lines. “Idea units” are the smallest component of narratives. Each Main line is made up of one or more than one idea unit (indicated with a slash or / in the narratives that follow). Each idea unit contains a piece of new information which is called the focus, and it has a unitary intonation contour consisting of one pitch disruption (the pitch glide) (Gee, 1991). Thus, the focus of the idea unit is determined by the pitch glide, which is the change in the pitch of the voice, including falling, rising, rising-and-falling, or falling-and-rising in relation to the base pitch level of the sentence (Gee, 1991). The foci are in bold print below. A Main line often corresponds with a sentence, including complex sentences, and is

about one central argument (Gee, 1991). Main lines form Stanzas, which are the “building blocks” of discursive language, which cluster into groups according to a topic, known as Strophes (Gee, 1991). These Strophes fall into larger units or themes, known as Parts (Gee, 1991).

As I have described, Gee (1991) argues that narrative texts are structured at five hierarchical levels, each of which is connected to the Main line and Stanza structure of the text. Each level plays a role in interpretation. Levels include Main line and Stanza structure; syntax and cohesion, Main line/non-main line; psychological subjects and the focusing system. Corresponding with each of these levels is a particular role in interpretation, respectively including ideas and perspectives on characters, events, states and information; logic and connections; plot; point of view; and image/theme (Gee, 1991).

## Narrative 1

### PART 1: (Changes in the relationship)

#### Strophe 1: (Rosy)

##### Stanza 1 (In the beginning it was rosy)

1. To me...in **the beginning**/, everything was...like in the relationship everything **was rosy**/.

#### Strophe 2: (Start of violence)

##### Stanza 2: (Slapping and kicking and hit with implements)

2. And then the part came where the **slapping began**/ and the **kicking began**/
3. And the more **everything started**/, the more...the harder I got **beaten up**/
4. Then it was **spoons, axes, knives**/ – whatever object he **should get**/, he would start **an attack**/.

### PART 2: (Deservedness)

#### Strophe 3: (Bad child)

##### Stanza 3: (Disobedience and punishment)

5. And, **for me**/, in a sense, I felt that **I deserved it**/

6. The reason why is because I haven't been the best of children for **my parents/** And...that I lived **being disobedient/**, to me, I felt like **I deserved that/**. That's how **I felt/**.
7. I was just taking **my punishment/**. But I didn't think of **anything else/**, because I just felt that **I deserved it/**, although I never did **anything wrong/**.

## PART 3: (His mommy)

Strophe 4: (His mommy's sickness)

Stanza 4: (Wanting to look after his mommy)

8. Because **I looked up** to his mommy/: his mommy **had arthritis/**
9. She had arthritis in her **whole body/** so she was in **a wheelchair, paralysed**, so to speak/
10. She couldn't do **anything for herself/**
11. And with the hard **I had/**, I wanted to **look after her/**.

## PART 4: (My son)

Strophe 5: (My son and I were separated)

Stanza 5: (Separation at the shelter)

12. Because me and my son **were separated** that time/
13. Also because **I left him/** in **the shelter/**.

## PART 5: (Worthless and alone)

Strophe 6: (A rightful burden<sup>24</sup>)

Stanza 6: (Nobody can help, this is my situation)

14. And, **to me/**, the way **I felt/**, I felt then that **I was worthless/**
15. Everything I thought of **myself then/**, I just thought, **hey, Linda/**, this is **just it/**. This is **yours**. This is **your package/** that you have to take to **the market/**
16. And nobody **can help me/**, although I never wanted to reach out and **ask for help/**

---

<sup>24</sup> In discussing whether the burden referred to here was "rightful" or not, there was some debate around whether this interviewee felt that her burden was deserved. However, the term was retained because from my (the interviewer's) point of view, from my felt sense of the woman's emotional experience and from her paralinguistic cues, there was a strong sense of deservedness.

17. I always thought, **hey**/, this is **my situation**/, I have to deal with it **myself**/

PART 6: (Help)

Strophe 7: (Availability of help)

Stanza 7: (Help will be available if there is need and sacrifice)

18. But **it wasn't so**./ Now **I see it**/: there are people out there that **can help us**/, if you really want to **be helped**/

19. And not mess around and **play around**/

20. You really, really **need help**/

21. And you are willing to sacrifice **everything to get help**/.

PART 7: (Blame and responsibility)

Strophe 8: (I wasn't wrong)

Stanza 8: (I didn't provoke him)

22. That was **him really**/ ...I allowed myself to be **torn apart**/ with all the things that he **had done to me**/ and all the things he **had said to me**/

23. Although I knew it **wasn't wrong**./ It **wasn't right** for him to say those things/ because I knew **how innocent** I was/ in the **whole situation**/.

24. Sometimes people – the other party – **provokes** that person/ to **abuse them**/. But coming from **my way**/, I **see myself**/ where I never **provoked him/ to abuse me**/.

Strophe 9: (He took it out on me)

Stanza 9: (I let him take it out on me)

25. Because it's always like **his thing**/ that's going on in **his mind**/, and if his friends didn't arrive at **the party**/, then he would take it out **on me**/

26. When he didn't **have money**/ or he didn't have what **he wanted**/, he would like force me to get what **he wanted**/, and when I didn't want **to do it**/, then he would take it out on me **at all times**/

27. I was the one who had to look **for food**/ and see that he **had cigarettes**/, and he would just **lie there**/. I was the one who had to **do everything**/

28. And I allowed him **to do that** to me/.

PART 8: (Unconsciousness)

Strophe 10: (Denial)

Stanza 10: (Blindness)

29. But **yet again**, I was **blinded**/

30. I was **in denial**/ and I was **blinded**/.

The Main line, Stanza, Strophe and Part structure of the text (level 1) divides the narrative into related and hierarchically ordered information, ideas, events, characters and states which comprise the narrative (Gee, 1991). Unlike the example that Gee (1991) uses in his analysis, the narrative's form is not uniform across Stanzas and Strophes and Parts (they are not equal in length or complexity); which compromises the coherence and unity of the narrative. It is noteworthy that Gee (1991) has two Stanzas per Strophe in his analysis, but that the Stanzas in Narrative 1 vary in content; most of the Strophes consist of only one Stanza.

The next level of narrative structure is syntax and cohesion, a level which is dramatically affected in the above narrative. Gee (1991) argues that the syntactic system consists of cohesive devices that link Main lines to each other within Stanzas, and Stanzas to each other across the entire narrative in a logical manner. Cohesion is achieved by a range of linguistic devices, such as conjunctions, pronouns, demonstratives, ellipsis, adverbs, repeated words and phrases (Gee, 1991). Aside from the use of the word "and" (which at times is used to link idea units of Main lines that are quite distinct in their meaning), there is a virtual absence of connecting words and phrases in this narrative. In some instances, connecting words such as "because" are used, but they do not link Main lines, they are used to signal the beginning of a new idea unit (see Stanza 3, Main line 1, Stanza 5, Main line 1 and Stanza 9, Main line 1). In fact, the word "because" in all three instances is phatic because it does not follow on from the previous Main line, explaining its contents. It is used to facilitate ongoing social contact rather than to convey specific meaning. What is interesting here is that although the narrator uses linguistic devices which superficially suggest a narrative order or coherence (connecting words), they are not used to convey content; they are used for interpersonal purposes. Connecting words are used in this text both to signal fragmentation at a semantic level, and attempts to facilitate interpersonal connection.

Despite the linking phrase "But it wasn't so" (Stanza 7, Main line 1), the themes covered in Part 5 and Part 6 are also divergent, and on the surface, seem contradictory. In Part 5 the narrator says that nobody can help her, while in Part 6 she states that there are people willing to help her. This suggests an internal struggle around whether help is really available, and

whether it can be used to her benefit. This struggle is a product of whether she feels she is worthy of help. The most significant inner conflict is about whether she deserves the abuse (Part 2, Strophe 3, Stanza 3) or whether she was underserving of the violence directed against her (Part 7, Strophe 8, Stanza 8). This internal struggle is based on the split self we examined in the previous chapter - the authentic self defined by shame and self-blame, and the false self that resists.

The narrative is rife with contradictions, which is consistent with the theme of the split self, and there are clear points of fracturing (look, for example, at the breakdown in coherence and meaning from Part 2 to Part 3 and Part 3 to Part 4). As soon as the trauma of physical violence is uttered in Strophe 2, Stanza 2, the narrative begins to fragment. It is worth pausing here for a moment to consider the significance of repetition. Foa, Molnar and Cashman (1995) argue that repetition in trauma narratives is the most direct index of fragmentation. In this narrative, there is a pattern of themes being revisited at odd intervals from the point of trauma onwards (look for example how the theme expressed by Part 2 is brought up again in Part 5). This repetition is significant, because it demonstrates what is important to the narrator; what she wants to emphasise, and here it is her deservedness and worthlessness. I would like to go into further detail about the contradiction in meaning between Parts 2 and 5, and Part 7. In Parts 2 and 5 the narrator states that she deserved her abuse, that she is worthless and brought her abuse on herself. This is radically contested in Part 7, where she states that she was innocent in her abusive situation, and that she did not do anything to provoke her perpetrator. This contradiction is re-iterated in Main line 4 of Stanza 3, where she says “I just felt that I deserved it, although I never did anything wrong”. As I have noted, these repetitive contradictions are the product of an internal struggle around blame and responsibility; a conflict between the shame-based authentic self and the resisting false self. Although there is an internal struggle, this narrator leans towards evaluating herself negatively (illustrated by her more frequent emphasis on deservedness and worthlessness compared to innocence), locating the blame and shame in herself, rather than her perpetrator, indicating that her shame-based authentic self is more prominent than the false self (three Stanzas are devoted to the authentic self, and two to the split self).

Another repetition occurs in Part 8 (Main lines 1 and 2). Here the narrator emphasises her “blindness”. Her emphasis once again suggests what is important to her, and it is interesting that this blindness may be a reference to her own inability to see that she is not to blame or responsible for her abuse; that the shame should be located outside her, in the perpetrator.

What is striking is the surprising reference to the narrator's son in Part 4, which links to another emotion related to shame, guilt. To contextualise, at the time of the interview, the narrator had been warned by the staff at the Centre that if she did not look after her son better, he would be removed by social services. She had received her last warning the day of the interview, after leaving her son unsupervised for a night at the shelter. She showed extreme remorse about this, and it came up multiple times during the interview. She felt that because she had been rejected and abandoned by her own parents as a child, she was doing the same to her son. Like we will see many times in this chapter, history repeats itself.

This affects the Main line/off Main line of the plot (Gee, 1991). There are noteworthy disruptions at this level of the narrative. Gee (1991) argues that in past tense narratives, the Main line events of the plot are built up from main clauses (non-subordinate, non-embedded) and expressed in perfective aspect (simple past tense and the historical present). That is not to say that the subordinate clauses are unimportant. As Gee (1991) argues, the plot needs to be interpreted in light of off Main line material. Below are the main clauses of the narrative which establish plot.

### **Narrative 1: Main line/off Main line of the plot**

PART 1: (Changes in the relationship)

Strophe 2: (Start of violence)

Stanza 2: (Slapping and kicking and hit with implements)

1. The slapping began and the kicking began.
2. I got beaten up.

PART 2: (Deservedness)

Strophe 3: (Bad child)

Stanza 3: (Disobedience and punishment)

3. I felt. I deserved it.

PART 5: (Worthless and alone)

Strophe 6: (A rightful burden)

Stanza 6: (Nobody can help, this is my situation)

4. I felt. I was worthless.
5. Nobody can help me.

PART 6: (Help)

Strophe 7: (Availability of help)

Stanza 7: (Help will be available if there is need and sacrifice)

6. It wasn't so. I see it. There are people out there that can help us.

PART 7: (Blame and responsibility)

Strophe 8: (I wasn't wrong)

Stanza 8: (I didn't provoke him)

7. I knew how innocent I was. I see myself I never provoked him to abuse me.

Strophe 9: (He took it out on me)

Stanza 9: (I let him take it out on me)

8. It's his thing. He would take it out on me.

In the whole narrative earlier, the themes expressed in parts diverge from one another in content. It was difficult to discern a plot at first reading as there was no clear narrative progression. There is no clear beginning, middle and end in the full narrative. In its entirety, the narrative is characterised by loosely strung together, often disconnected subordinate clauses, and somewhat haphazardly placed main clauses. Again, it is as if the narrator is trying to use structural or linguistic means (numerous subordinate clauses) to create the illusion of coherence or a sense of plot (chronological and/or logical linking of characters, events, and states). When the Main line material is presented, what is immediately striking is the abundance of (removed) subordinate clauses. This suggests that the narrator felt the need for a great deal of supporting or qualifying information to tell her story. However, I would argue that in this case, it is less challenging for the reader to discern the underlying theme, an internal struggle. This is because, even in the absence of chronological or logical progression in the Main line narrative, it is more clearly focused on particular themes and contradictions without the distraction or interference from non-essential information in terms of plot (e.g. "his mommy" or her "son"). What can be said is that the Main line or main point or significance of the plot, paradoxically, through its contradictions, emphasises the central theme of the split self: violence (Part 1, Strophe 2, Stanza 2) and deservedness (Part 2, Strophe 3, Stanzas 3 and Part 5, Strophe 6, Stanza 6), the availability of help (Part 6, Strophe 7, Stanza 7) and resisting self-blame (Part 7, Strophe 8, Stanza 8; Strophe 9, Stanza 9). Note the perfect balance in terms of Main line material devoted to deservedness and worthlessness, and resisting self-blame.

There is some surprising consistency in the psychological subjects of this narrative. The psychological subject represents the points of view from which the material in the Stanza is

viewed; so they are the entities with whom/which the narrator is empathising (Gee, 1991). The psychological subject helps the reader ascertain something about the narrator's stance and how it changes across the narrative (Gee, 1991). "I/me" is the psychological subject of every Stanza except Stanza 3 Main line 2 ("my parents") and Stanza 4 Main line 2 and 3 ("his mommy"). The narrator expresses a great deal of her own feeling in this narrative. It is interesting to note that when the psychological subject changes, in each instance, the narrator is expressing feelings of duty and deservedness. The change in psychological subject suggests that the content of the Main lines comes from a changed perspective – that the narrator feels that from their (her parents and his "mommy") perspective she needs to compensate somehow for her "disobedience" and for her "hard" life.

Finally, level five of the system, the focusing system, refers to the pitch used to signal the focus of a particular idea unit. The change in pitch shows that the information that is being shared is new, salient or important, that it is the information the reader should focus his/her attention on (Gee, 1991)<sup>25</sup>. I argue that there is a series of disruptions in the articulation of focal areas, after the disclosure of abuse in Strophe 2. The major shifts in focus occur between Part 2 and Part 3, and Part 3 and Part 4. The focus abruptly changes from *slapping began; kicking began; everything started; beaten up; spoons, axes, knives; should get; an attack; for me; I deserved it; my parents; being disobedient; I deserved that; I felt; my punishment; anything else; I deserved it; anything wrong to looked up; arthritis; whole body; a wheelchair; paralysed; anything for herself; I had; and look after her*. The next Stanza's focus also changes radically, to *separated; I left him; shelter*. There is another significant shift in focus from Part 6 to Part 7, where focal areas such as *it wasn't so, I see it, can help us, want to be helped, play around, need help, everything to get help, to him really, torn apart, had done to me, had said to me, wasn't wrong, wasn't right, how innocent, whole situation, I've seen, people, the other party, to abuse them, see myself, provoked him*.

What is interesting here, in addition to the shifts, is the frequent focus on violence and shame/deservedness.

## Narrative 2

### PART 1: (Isolation)

#### Strophe 1: (Limited contact with friends and family)

---

<sup>25</sup> I use italics at this level of analysis to make it easier for the reader to distinguish different foci.

Stanza 1: (No friends and seeing family twice a year for an hour)

1. He never allowed me to **have friends/**
2. He only took me **twice/** to my **own family/**, and **my family/** stays in **Stellenbosch/**
3. He took me **twice/** to **my family/**, **twice per year**, and that was only for **an hour./**

Stanza 2: (Excuses and lies)

4. And whenever they want **to come/**, then I had to come up with **an excuse/** like, no, we are not **at home/**; we are going out for **the weekend/**
5. Then I **must lie/**. We are going out for **the weekend/** or **I'm working/**

Stanza 3: (Mommy wants to help)

6. And my mommy **said/**, that was **before/** she **passed away/**, but, no, it's **mos** (*not so/isn't it?*) **nothing/**, then I can **cook for you/** or do **something for you/**. Because I used to work from **nine o'clock till nine o'clock/** at night in **a shop/**.

PART 2: (Shame and stigma)

Strophe 2: (Lies about abuse)

Stanza 4: (Lied to boss and friends)

7. Then I would say, **no, mommy/**, we are not going to be **at home/**
8. Then my children would ask me, **mommy, why?/** I said, **jinne** (*goodness*), **man/**, I don't want my family **to see this/**
9. I **always hid/**, and I always **lied to them/**
10. Even my boss and my friends, they see me with blue eyes or **a broken arm/**, I **always lie/** I would say, no, I **got hurt**, and that and that/.

PART 3: (The parrot)

Strophe 3: (The parrot can talk)

Stanza 5: (So excited about Grysie)

11. And then, Amelia, my boss gave me **a parrot/**
12. I never knew a parrot **could talk/**, that was **so interesting/**
13. She gave me **a parrot/**, **a little one/**, and I gave him the **name Grysie/**

14. She gave it to me as a **birthday present**/
15. It was in **its cage**/, and a big bag **of mealies**/. I was **so excited** about this bird/.

Strophe 4: (The parrot tells the truth)

Stanza 6: (The parrot opens my eyes to his madness)

16. The first night he **was sitting**/ in **the cage**/, just **looking at us**/
17. The second night when I **got home**/ he told me, **hey, you vark (pig)**/, you are **fast asleep!**/ He is bringing in a lot **of girlfriends**/
18. And then he clawed my **fokken face**/. I said, **huh?!**/
19. He said, ja (*yes*), and **he told me**/, you know **what**/, and that bloody thing **is mad**/
20. And that **opened my eyes**/. That was on the 16<sup>th</sup> of **March 1990**/, and that bird **opened my eyes**/
21. I won't **lie to you**/, that bird **told me**/, you know, he took a lot **of tablets**/.

PART 4: (Madness)

Strophe 4: (He is mad)

Stanza 7: (He is a mad donkey, a monkey, not human)

22. And his sister came this morning with a **big bag**/, a lot of packets and packets **of tablets**/, **he's mad!**/
23. That is why he's going on like a **mad donkey**/. He acts like a **monkey**; he's **not human**/.

PART 5: (The parrot is not dead)

Strophe 5: (The parrot is used to this)

Stanza 8: (The parrot told me not to worry)

24. And then he went to **the cage**/, took the **bird out**/ and...I thought the bird **was dead**/
25. And then Gysie said in Afrikaans: **naai (no), don't worry!**/ I'm used to **this**/.

PART 6: (Abuse)

Strophe 6: (You don't talk about the abuse)

Stanza 9: (Something wrong and bruises)

26. I phoned **my boss/** and I said, **auntie Asma/**, why did you give me this  
thing **that talks?/**

27. She said, you **know why/**, because you **don't talk,** my child/

28. And I know there is **something wrong/** because I see **the bruises** on you/

29. And I don't **feel lekker (nice)/** to see you in pain **every day./**

PART 7: (The parrot is needed)

Strophe 7: (The parrot is needed by somebody special)

Stanza 10: (Someone special)

30. And **she told me/** the bird was eight **years old/** and it belonged to **her  
brother/**

31. She asked **her brother,** give that bird,/ **I need that bird/**

32. I want to give that bird to **someone special./**

PART 8: (The parrot tells the truth)

Strophe 8: (The parrot talks to the policeman)

Stanza 11: (The parrot tells the policeman everything)

33. The first time I laid a charge **against him/** and the policeman **walked in/**,  
the bird told the policeman every **single thing/**

34. **Everything./**

PART 9: (I ran out)

Strophe 9: (I ran out because he killed the bird)

Stanza 12: (He wrung his neck)

35. He **killed the bird/** a day before I left **the house./** He **killed the bird/**

36. He **took him/** and he wrung **his neck/**

37. And that was **in 2009/** when **I left./** That is when I **ran out./**

Again, the narrative's form is not uniform across Stanzas and Strophes and Parts and there is some variation in the length and complexity of these components of the text. The Parts, Strophes and Stanzas are either quite elaborate and detailed, or are relatively short and end abruptly to give way to a dramatically new and different theme. Only one Strophe consists of more than one Stanza. This gives the narrative a disrupted, fragmented quality.

There are insufficient connections between Parts, Strophes, Stanzas and Main lines. However, the connecting words “and” and “then” do function to link different components of the text (see Stanzas 2, 3, 4, 5, 7, 8, 9). However, as in Narrative 1, these words sometimes do not carry any meaning, and their function is solely structural. It is worth paying attention to Main line 3 of Stanza 6 in particular. The surprising content of Main line 3, which bears no direct relevance to preceding or following Main lines, disrupts the flow of this Stanza. This is despite the use of the words “and then”. The meaningless use of connecting words (once again, “and then”) recurs in Stanza 8 (Main lines 1 and 2) where the theme changes from madness (Stanza 7) to the parrot not being dead (Stanza 8).

As has been noted, the point at which the plot is “lost” is Part 3 (the parrot). Up until this point there had been a loose but logical progression from social isolation (Part 1) to shame and stigma (Part 2). The narrator’s abuse is brought up again in Part 6, but she returns to the theme of the parrot in Parts 7, 8 and 9. What is striking about this “plot” is the disconnected repetition of particular themes or topics, most notably, lies and truth. This is a tension that characterises the whole narrative. Part 1, Stanza 2, Part 2, Stanza 4 and Part 6, Stanza 9, which all focus on excuses and lies about the abuse and the madness that evokes it (see Part 4), can be starkly contrasted with the “truth” of her perpetrator’s madness told by the parrot in Part 3. In this Part, the parrot becomes a witness to the perpetrator’s indiscretions (girlfriends) and his madness (for which he takes tablets); his function is to validate the narrator’s (unspoken) knowledge. The narrator’s silence (see Stanza 9, Main line 1) is also contrasted with the parrot’s outspoken disclosure of “everything” (Stanza 11). Where she conceals, the parrot tells. The juxtaposition of lies and truth is most dramatic in Main line 6 of Stanza 6, where the narrator says: “I won’t lie to you, that bird told me, you know, he took a lot of tablets”. Thus, in this narrative, the main points of the plot are lies (Stanzas 2 and 4) and the parrot/truth (Stanzas 5, 6, 8, 10, 12). The presence of the parrot indicates multiplicity; the existence of oppositional, contradictory voices within the self (Raggatt, 2006).

Many trauma survivors struggle to believe that the traumas they survived occurred in reality – a phenomenon which is at least partly caused by dissociation and loss of traumatic memory (Putnam, 1989). This is why it is often important for trauma survivors to have someone who can bear witness to the traumas they have survived; to validate their experiences. Ferenczi (as cited in Orange, 2011, p. 92) argues that when traumatised the individual may feel “split – innocent and culpable at the same time – and his [sic] confidence in the testimony of his own senses is broken”. It is very important to this narrator that she is believed (Stanza 6, Main line

6), perhaps because she struggles to believe herself. The formulation of the kind of delusions this narrator has developed in relation to the parrot takes place in contexts of radical invalidation, where the individual's sense that his or her feelings have any validity whatsoever are lost (Orange et al., 1997). What is ironic is that the parrot fails at his task as validator; as "objective" witness. It is not his own words that he is using, but the narrator's forbidden ones; the ones she is too ashamed to utter. There is a merging between the bird and the voiceless narrator; the bird, who in Strophe 5, Stanza 8, symbolises the narrator who is already emotionally deadened against the continual onslaught of abuse from the perpetrator. The projection of her own feelings onto the bird is most dramatic in the following scene: "And then he went to the cage/, took the bird out and...I thought the bird was dead. And then Grysie said in Afrikaans: naai (no), don't worry! I'm used to this". This is the narrator's experience; a flippant expression of her own familiarity with the experience of near death. The bird expresses everything the narrator knows, but cannot say. She puts words in the bird's mouth, and in so doing, destroys her validation, her "objective" witness. Although it is the perpetrator that ultimately kills the bird (Stanza 12), at a symbolic level, she has already destroyed him (i.e. his functions).

There are other parts of the text where repetition occurs. As we have seen, repetition illustrates what is important to the narrator, what she wants to emphasise. This repetition occurs for the first time in Stanza 1, when she talks about how seldom the narrator saw her family during the abusive relationship. This emphasis tells the reader that social isolation was clearly very painful for her. The importance of uncovering the "truth" of the madness of her perpetrator in the narrative is demonstrated in Stanza 6, where the narrator repeats how the parrot opened her eyes, an expression that suggests that it was the first time the narrator could see clearly. The last repetition occurs in Stanza 12, where the narrator tells the reader how her perpetrator killed the bird (she repeats it three times in this Stanza). This death symbolises the death of self, truth, validation, support. It is perhaps this that leads the narrator to leave her abusive relationship for the last time.

In order to analyse the plot, or the breakdown of the plot, I list the Main line material in the text below.

## **Narrative 2: Main line/off Main line of the plot**

PART 2: (Shame and stigma)

Strophe 2: (Lies about abuse)

Stanza 4: (Lied to boss and friends)

1. I always hid, and I always lied to them.

PART 3: (The parrot)

Strophe 3: (The parrot can talk)

Stanza 5: (So excited about Grysie)

2. My boss gave me a parrot.

3. I never knew a parrot could talk. That was so interesting.

4. She gave me a parrot. I gave him the name Grysie.

Strophe 4: (The parrot tells the truth)

Stanza 6: (The parrot opens my eyes to his madness)

5. That bird opened my eyes.

6. I won't lie. That bird told me.

PART 4: (Madness)

Strophe 4: (He is mad)

Stanza 7: (He takes tablets; he is a mad donkey, a monkey, not human)

7. He's mad!

8. He's going on like a mad donkey. He acts like a monkey. He's not human.

PART 8: (The parrot tells the truth)

Strophe 8: (The parrot talks to the policeman)

Stanza 11: (The parrot tells the policeman everything)

9. The bird told the policeman.

10. Everything.

The Main line material demonstrates the tension between the predominant theme of lies (the perpetrator and the perpetrator-defined identity) and truth (the parrot). From the point that the parrot is introduced into the narrative (Part 3), the full narrative loses its structure and becomes somewhat chaotic, but at Main line plot level, the partial narrative above quite clearly illustrates the main theme, and although I would not call the Main line plot linear, it is not as fractured as the full narrative; it includes less disruptions and diversions. What is interesting is that even at Main line level, there is overlap between Stanzas which borders on repetition - truth is referred to in three Stanzas, which is unusual and draws particular attention to the importance to the construct that is being emphasised. For this narrator, it is vitally important that the (her) truth is heard and validated. The centrality of this process in

the healing of individuals who have been exposed to chronic trauma has already been pointed out.

What is interesting in this narrative with regard to the psychological subject is that it varies substantially across different components of the text, and that psychological subjects even change within one Stanza. This shifting of perspectives fits with the chaotic structure of the narrative. In Stanza 1, the psychological subject is “he”, while in Stanza 2 it is “I” and in Stanza 3 it is “mommy”. In Stanza 4 however, the psychological subject changes from “I” to “boss and friends” to “I”, and in Stanza 5, it shifts from “my boss” to “I” to “she” to “I” to “she” to “parrot” to “I”. The chaotic shifting continues in Stanza 6 (“parrot” to “I” to parrot [“he”] to “I” to parrot [“that bird”]), but abates again in Stanza 7 (“his sister” to “he”). In Stanza 8 the psychological subject changes from “he” to “I” to parrot (“Grysie”), and in Stanza 9 it shifts from “I” to “she” to “I”. In Stanza 10, this pattern is reversed and the changes are from “she” to “I” to “she”. In Stanza 11, the shift is from “I” to the parrot (“that bird”). Stanza 12 closes with a more chaotic shifting from “he” to “I” to “he” to “I”. Note that the most dramatic shifting takes place in Stanzas 5 and 6, which are all centred around the parrot, and mark the most irrational (if not delusional) part of the narrative in terms of content. It is significant that the psychological subject is so unstable in this, the most fragmented, section of the text.

There are dramatic shifts in foci in this narrative. What can be seen when studying the narrative is that there is some coherence in the focal areas in Parts 1 and 2. The focus, however, completely changes in Part 3; Part 4 shows another radical shift, and Part 5 returns the focus to the parrot. Part 6 is once again a shift in focus from the parrot, but the narrator returns once again to the parrot in Parts 7, 8 and 9. Key examples of the changes in foci include: *Family; friends; lying (repeated 3 times in up to Part 3) to could talk; so interesting; a parrot; a little one; name Grysie; birthday present; its cage; of mealies; so excited to opened my eyes; March 1990; opened my eyes to the cage; bird out; was dead; naai (no), don't worry! (I'm used) to this to someone special to everything; killed the bird; took him; his neck; in 2009; I left; ran out.* The chaotic shifts in psychological perspectives in the narrative, the disorganised changes in focus reflect an incoherent, fragmented narrative; a narrative representative of significant psychic fracturing.

### Narrative 3

#### PART 1: (Dissociation)

Strophe 1: (A horrible movie)

Stanza 1: (The knife)

1. A **horrible movie**/. He planted the knife **here**/; I had to **pull it out**/ before I **could walk**/.

Stanza 2: (The stones, the rocks)

2. And I eventually came **out by the door**/ and I went to **the neighbour**/, and whilst lying **by the neighbour's door**/, he was throwing me **with stones**/, believe **you me**.
3. I think that was the worst experience **I've ever had**/ because...I'll never forget **that day**!/  
 4. And they removed **the fence**/ and the old stuff that was **in there** - /the pigs - and the pieces of stone **were lying there**/, he actually stood in the driveway and picked up those rocks and **threw it at me**.

Stanza 3: (The knife)

5. And he had stabbed me in my **knee already**/, I don't know **what for**/. We were just **sitting and talking**/. Oh yes, I remember, my daughter or my son phoned me, and he wouldn't believe **it's them**/. Then he stabbed me **just like that**/. He took the knife and planted it **in my knee**/.
6. I think why I will never **forget it**/, it's because we were chatting so lekker (*nicely*) **with one another**/, and all of a sudden he just grabbed **the knife**/, planted it **in my knee here**/ and **walked out**.

Stanza 4: (The knife, the stones, the rocks)

7. And I'm like, **oh, my god**/, I couldn't believe this thing is standing up **in my knee**!/  
 You know, with both hands **I had to**/ ...picture **it**/ ...*jô*, I didn't know what was going **to happen**/, I just pulled and **it wouldn't come out**/, because it's got **that raffle on**/. I had **to do this**!

8. And eventually I **got it out**/, and I limped out of **the house**/. I went to the neighbour and I fell there **on the stoep (verandah)**/.
9. Then he took the bricks and **he threw it at me**.

Stanza 5: (The worst part of the abuse: out of the blue)

10. I thought to myself, **ooh**/ ...I think that was the worst part **of his abuse**/, besides the other parts **where he like**/ ...but that, to me, because **I saw everything**/. Okay, the other stabbings **I also saw**/, but I was like **more careful**/. It was **out of the blue**/.
11. Just now here the knife is standing **inside of my leg**/, and I couldn't **get it out**/. It was so **deep in**/ ...I mean, this part was **out of my leg**/ and the rest was **all in**/. I had to struggle **to get it out**/ because I **couldn't get up**/. I couldn't push **my leg straight**/. I had to remove this thing first before I **could get up**/.

PART 2: (The crucifixion)

Strophe 2: (Humiliation)

Stanza 6: (Redemption of the shame-based self)

12. And the other time **he crucified me**/ ...I said, jinne (*goodness*), I **saw the movie**, The Crucifixion of Jesus Christ/ ...he **crucified me once**/.
13. I will never forget **that day also**/.
14. Whilst standing on the stoep there where **we stayed**/, you know, when I looked up I saw **the whole street**/ ...to me, it was **like Jerusalem**/ and I'm there **on the stage**/, and the people are **standing there**/ ...because we lived on a **high hill**/, our house was **very high**/ and you can stand there and **look down**/ ...and as I was looking **down**/, all the people were **standing there** in the road/.
15. And he's **like performing**/, as he is shouting and stabbing me **like that**/, and the people are like, oh, Petrus, **don't do that**/, and he's just **doing this**/, and in my arms and **here and here**/.
16. I said, **jô**, this cannot **be true**/. Believe **you me**/, and I withdrew **all those cases**/, meaning I'll give him **a second chance**/ – he might **change**/. And he **never changed**/, until today he **never changed**/. I said, **enough is**

**enough** where withdrawing cases is also concerned:/ I'm not withdrawing **any more cases**/.

Like the previous narratives, the narrative's length and complexity across Stanzas, Strophes and Parts varies, indicating some structural instability, however, what is most striking is the cyclical repetition in this narrative. As I noted earlier, Foa et al (1995) argue that repetition in trauma narratives is the most direct demonstration of linguistic and psychic fragmentation. This narrative is fascinating because of its particular form of non-linearity – its undeniable spiral structure. More accurately, it forms a *fractured* spiral structure through its significant repetitions – it is a typical example of a chaos narrative. It is interesting that although there is a great deal of use of connecting words such as “and”, and on occasion, “then” at the beginning of lines, suggesting progress and linearity, these words are used to hold together a structure comprised of circular reiteration of the central trauma. Unlike the other narratives, the theme does not change, the narrative is a description of a single incident; the theme is not what indicates fragmentation. The detailed repetition, particularly of phrases around never forgetting (Part 1, Strophe 1, Stanza 2; Part 1, Strophe 1, Stanza 3; Part 2, Strophe 2, Stanza 6), suggests hypermnesia rather than the amnesia we encounter in other women's narratives in this chapter (please note that hypermnesia can co-occur or alternate with the emotional numbness or paralysis of dissociation, although dissociation is more typically associated with amnesia [Payne, Nadel, Britton, & Jacobs, 2004]). The randomness of the cyclical repetition, however, does suggest that the narrative does not function as a cohesive whole, with a beginning, middle and an end. Although there is a great deal of thematic repetition across Stanzas, they are not calculated, they are choked out in panic, shock, without any regard to narrative order. For example, Stanza one is focused on the knife, Stanza two is focused on the rocks and stones, Stanza three returns to the knife and Stanza four includes both the knife, and the rocks and stones. This narrator returns to describe the same unbelievable scene, over and over. She repeats that the knife is in her knee no less than five times. Survivors like Irene become immersed in visualising the traumatic event, the outside world “dissolves”, and the survivors convey the traumatic images “in raw form, unstructured, and testimony can seem incoherent to the listener” (Kraft, 2004, p. 354). There is some significant contradiction in the narrative. The narrator says on two occasions that she will never forget that day, but then says she cannot believe it happened.

This leads me to the theme of dissociation (Part 1). There are several indicators in this narrative of dissociation; of the narrator emotionally distancing herself from an experience

that is too traumatic for her to metabolise. She says repeatedly that what is happening cannot be real, cannot be true (Part 1, Strophe 1, Stanza 2; Part 2, Strophe 2, Stanza 6). In fact, that is how the narrative starts, the narrator refers to the event as “a horrible movie” – so disowning the emotional experience, projecting it onto an imaginary screen. It almost sounds like she is experiencing an out of body experience. Part 1 links to Part 2 in fascinating ways. Again, there is the theme of performance, most dramatically demonstrated in the reference to the film “The Crucifixion of Christ”, and on a lesser scale when describing Petrus’ behaviour (see Part 2, Strophe 2, Stanza 6 - Petrus is described as “performing”). She also describes herself as “there on the stage”, again emphasising a performative element; the pervasive non-reality of the nightmarish unfolding events. Something very interesting is happening here in the identification with this film. In surrounding narratives not reported here, Irene expressed very high levels of shame and humiliation. The image of her up on the hill, with a frozen audience watching her hideous trauma from below (her symbolic “crucifixion”), but who does not make any real effective attempt at intervening, is one of profound, shameful exposure and humiliation. But Irene turns this theme around, and identifies with Christ, the archetypal figure of both shame and humiliation; and one of absolution and redemption. She transforms her fractured, dissociated self; her broken body, into a heroic figure who suffered for sacred reasons. This is where a thematic and structural split occurs between Part 1 and Part 2. In Part 1 she is undeniably the victim; helpless, passive. In Part 2 she is making a vivid statement about her identification with a holy figure, which can be interpreted in several ways. I believe that this identification is a dramatic shame-based compensatory effort on her part. I would argue, based on the rest of the lengthy interview I conducted with Irene, that she suffered from a great deal of self-loathing and self-hatred, and was seeking any means to reduce her self-blame (evidence of which was her continual withdrawal of cases against Petrus, see the final Stanza), to forgive herself and feel absolution and redemption from self-blame for her abuse; to no longer identify with a victim status. I do not think that it was co-incidental that Irene had attempted suicide three days before I interviewed her, just after the incident she describes here had taken place; this act is consistent with the death of Christ. I believe that her identification with Christ was an exaggerated, if somewhat deluded attempt in keeping with compensating for a profound shame-based self. I also believe that in escaping death, she was attempting at creating and embracing a kind of symbolically “resurrected” self based on freedom; an identity based on redemption; one that was strong and persevering, illustrated in the statement in the final Stanza: “I’m not withdrawing anymore cases”.

This is the major fracture in the narrative. However, there are many more “micro-fractures” in this dramatically non-linear narrative. The narrative has a raw, immediate quality about it, and the narrator uses several devices to hook the reader in, particularly at points where she finds her experience particularly disturbing and unbelievable. We have established that many trauma survivors find it difficult to believe that the traumas they endured took place in reality – this is partly caused by dissociation, which is a major theme in this narrative, and loss of traumatic memory (Putnam, 1989). As I have noted, repetition is a significant feature of this narrative; one which signals fragmentation, and being believed is a persistent theme, which is consistent with dissociation. This is perhaps why the narrator tries so hard to draw my attention to particularly ghastly parts of her narrative – she needs me to hear; to believe; to bear witness for her, for whom this narrative is intolerable. This narrator draws my attention to the unbelievable, unbearable horror that she is going through by using exclamations like “With both hands I had to/ ...picture it/ ...**jô**, I didn’t know what was going to happen” (Part 1, Strophe 1, Stanza 4). This sentence was uttered in the context of the horror of: I couldn’t believe this thing is standing up in my knee! Another example includes: And the other time he crucified me ...I said, **jinne (goodness)** (Part 2, Strophe 2, Stanza 6).

A number of Main lines show dramatic fracturing, as we will see, and once again, they occur at points of intolerable trauma. The first sentence I described above in the context of exclamations shows significant fragmentation; all the strings of words before the exclamation are incomplete fragments that do not constitute clauses. Another set of examples follows:

“I thought to myself” (incomplete sentence, there is no object)

“I think that was the worst part of his abuse” (“that” is unspecified),

“besides the other parts” (“other parts” is also unspecified)

“where he like...but that, to me, **because**” (incomplete, incoherent, fractured sentence).

“I saw everything”. (What did she see?)

“Okay, the other stabbings I also saw, but I was like more careful”.

“**It was out of the blue**”. (This is the only part of the narrative that is coherent). (Part 1, Strophe 1, Stanza 5).

It is clear from this example that when the narrator talks about what was “worst”, most painful for her, her narrative collapses. There are several ellipses, a great deal is implied, she is vague, unspecific and implicit about what she means, and at certain points, her “sentences”

are incomplete, fractured and non-sensical. Even the use of the linking word “because” does not make this part of the narrative coherent. It ends an incomprehensible, fragmented phrase. My interpretation of this excerpt is that when the narrator attempts to speak about the most agonising aspects of her abuse, her total helplessness associated with the unpredictability of the attack, she communicates it through the structural breakdown in language and what she leaves out; what is absent in the narrative. One of the reasons that so much remains unspoken, other than that it is just too painful to be uttered, is that she is ashamed that she could be treated this way; her identification with the Christ figure certainly suggests this. Further examples follow:

“And he’s like performing as” (incomplete sentence – “as” should be followed by “then”)

“He is shouting and stabbing me like that. And the people are like, oh, Petrus, don’t do that.

And he’s just doing this (implied meaning). And in my arms and here and here”. (incoherent sentence)

“I said, **jô**, This cannot be true”. (dissociation)

“Believe you me”. (split self) (Part 2, Strophe 2, Stanza 6)

This excerpt also has prominent features of the narrative as a whole: the exclamation, drawing my attention once again to the juxtaposition between the contradictory “This cannot be true” AND “Believe you me” which are indicative of clinical features (dissociation and the split self); ellipses, implied meanings, and at certain points, her “sentences” are incomplete, and difficult to comprehend. This “micro-fracturing” also occurs at a highly significant point in the narrative, when she has experienced humiliation, the inefficiency of the observing crowd, the compensatory identification with the archetypal figure of both shame and humiliation; and of absolution and redemption – a point that pre-empts her final defiance against her perpetrator; her taking legal action against him.

In order to analyse the plot, or the fracturing of the plot in greater detail, the Main line material (main clauses) are included below.

### **Narrative 3: Main line/off Main line of the plot**

PART 1: (Dissociation)

Strophe 1: (A horrible movie)

Stanza 1: (The knife)

1. (It was like) A horrible movie. He planted the knife here. I had to pull it out.

Stanza 2: (The stones, the rocks)

2. I went to the neighbour. He was throwing me with stones. Believe you me.

PART 2: (The crucifixion)

Strophe 2: (Humiliation)

Stanza 6: (Redemption of the shame-based self)

3. I saw the movie. (I saw) The Crucifixion of Jesus Christ. He crucified me once.

4. It was like Jerusalem. I'm there on the stage. We lived on a high hill. You can stand there and look down. All the people were standing there in the road.

5. This cannot be true. Believe you me. I'm not withdrawing any more cases.

The plot of this narrative consists mainly of main clauses, there is not a great deal of “padding” or use of subordinate clauses to draw the reader’s attention away from the central trauma. However, paradoxically, the narrative is dense with repetition, and there are many main clauses, and some adjectival phrases, which have been excluded in this narrative as Gee (1991) suggests. As a whole, the narrative has a fractured spiral structure, which is peppered by the excluded cyclical repetitions; the tone of the narrative is increasingly urgent; catastrophic, until the disconnected revisiting of the scene of abuse (the knife, the stones, the rocks) gives way to her symbolic crucifixion, the associated shame and humiliation, and her absolution of her self-blame through the redemptive identification with the Christ figure. One theme adds to the chaotic (non) structure of the “plot”: the shift in the narrator’s identity from Part 1 to Part 2. In Part 1 she is undeniably the victim, helpless, passive, under attack. In Part 2 she takes a peculiar kind of humiliated, shame-based control, and through her particular identification, transforms herself into an archetypal figure who survives; resurrects, and re-invents herself (will not withdraw anymore cases). However, two themes give this dramatically non-linear narrative some coherence: the theme of dissociation which runs throughout Part 1 and Part 2 and the associated tension between believing and not believing the horror this narrator survived (see for example the juxtaposition in Part 2, Strophe 2, Stanza 6, final Main line), which have significant links with shame (and convincing me of the truth of her experiences).

The patterning of who constitutes the psychological subject of aspects of the narrative mirrors the fractured spiral structure of the narrative as a whole. There is a to-and-froing between the narrator (“I”) as psychological subject, and her perpetrator as psychological subject (“he”) – a cyclical alternation. Although the narrator’s daughter or son is introduced in Part 1, Strophe 1, Stanza 3, they are mere characters, they do not “speak” in the narrative, and do not share any point of view. Part 2, Strophe 1, Stanza 6, demonstrates the same alternation, but the perspective of the frozen, passive audience is introduced. This is consistent with the major fracture in the narrative. However, overall, even where her perpetrator is the psychological subject, it is from the narrator’s own disbelieving, dissociated “I” perspective.

As I have noted, the focusing system refers to the pitch used to signal the focus of a particular idea unit. The change in pitch demonstrates the importance of the information, and in this narrative, I argue that there is remarkable consistency in the focal areas in Part 1 (centred around violence: stabbing, throwing; the knee, the knife, the rocks, the stones). There is a disruption in the focal areas when the fracture in the narrative takes place in Part 2. Here the focus shifts to words and phrases such as *crucified; the stage; the whole street; Jerusalem; standing there; high hill; stand there; and look down; standing there; like performing*. There is repetition here too, focused on the audience, the passive audience, whose attempts to intervene are weak and ineffective. The narrator is alone, helpless, watching with horror, as if from a distance, how she is brutally, publically attacked. It is this intolerable helplessness and humiliation which is perhaps the motivation for her use of the dramatic metaphor to describe her shameful experience – the Crucifixion of Christ – and the dissociative, (shame) compensatory identification with the Christ figure.

## Narrative 4

PART 1: (Ons gaan kuier)

Strophe 1: (Ek was dronk)

Stanza 1: (Hulle los my net so)

1. Toe het ek saam met haar gaan kuier **die Vrydag**/. En ons kom toe die Vrydag **aand daar**/ ...toe **die hokkies**/, net soos **die huise s'n**/, so aan **die agterkant**/ ...ek meen, **hierso is die huis**/ wat ons **kuier**/, en hier agter waar die huise is **is daar die hokkie**/. Is mos nou **nie ver nie**/.

2. Toe **los hulle vir my net so/**.
3. Want ek het **ook gedrink/**, ek is **eerlik/**, ek het **ook gedrink/**, maar ek weet ek is **nie 'n drinker nie/**. En toe is ek nou seker maar **té dronk/**, en toe **los hulle vir my net so/**.

PART 2: (Die groepsverkragting)

Strophe 2: (Hulle verkrag en slaan my)

Stanza 2: (Carel bly by my)

4. Toe vat drie ouens **vir my uit/** en neem **my daar af/**. Hulle al drie neem vir my **\*\* sex toe/**.
5. Ek kan nog baie mooi **sy naam onthou/**. Dit was **Carel/**. Al drie **het sex met my/**. Hoe sê **'n mens nou/** ...in my anus het hulle ook **sex gehad met my/**. Hulle het my **geslaan/**.
6. Die **heel nag/** ...nee, **nie heel nag nie/** ...seker hier by die **oggend ure/** toe gaan die twee **huis toe/**.
7. Toe hou Carel vir my **daar by hom/**.

PART 3: (Liefde uit skaamte)

Strophe 3: (Carel bly by my)

Stanza 3: (Verlief)

8. Sy ma-hulle het geslaap **daai tyd toe/**. Maar dit was **nou seker so/**, die twee het nou **huis toe gegaan/** en Carel hou vir my **daar by hulle huis/**. Die Saterdag oggend toe kom loer die twee nou **weer in/**, maar hulle het nou nie verder aan **geworry nie/**.
9. Toe is ek **so skaam/**: ek het nog nooit in my lewe **so iets oor gekom nie/**. Toe's ek **so skaam/**.
10. Ek sit net daar **op die bed/**. Toe sit en **kyk ek vir hulle so/**.
11. Hulle maak nou jokes **onder mekaar en so/**. Nou drink hulle **nou weer/**.
12. Die Saterdag toe vra die twee nou vir Carel, maar **gaan hulle nie weer kan \*\*/**, die twee nou vir **die Saterdag aand/**. Hulle sing mos en **dit gaan mos so/**. Dit was net 'n naweek **of so gewees/**, maar toe kom ek mos **nou dit oor/**.
13. Toe sê hy, nee, maar hy **gaan nêrens heen nie/**. Hy gaan heel tyd **by my wees/**.

14. Nou sê Chriska, lyk my hy het toe nog **verlief ook geraak op jou**/. Want hy het my die heel naweek **by hom gehou**/. Hy het nie **rond geloop nie**/. Hy het net **gesit daar by my**/. Hy het my ook nie **lelik getreat of wat nie**/. Nou sê hulle mos nou, dit lyk my hy het **nog verlief ook geraak**/.

PART 4: (Transformasie)

Strophe 4: (Verwarring oor die verlede en die teenwoordige)

Stanza 4: (Carel = Ricardo [oorsponklike IPV mishandelaar], and skuiling = Ouma [haar versorger, haar huis/tuiste])

15. Toe sê hy, nee, maar hy **gaan nie worry nie**/. Toe gaan hulle seker **ook nou na \*\***/. Hulle het my die Vrydag aand daar gehad en die Saterdag aand, en dis eers die Sondag oggend, **toe sê** / ...as ek ook nie vir hom **gesê het nie**/, sou hy seker nog altyd vir my **daar gehou het**/.
16. Toe sê ek vir Ricardo, "maar Ricardo, ek moet **nou huis toe gaan**./ Jy weet mos ek bly nie hier nie - ek **kom kuier net**."/ Want ek dink, ek wil ook **nie lelik wees nie**/, want ek weet mos nou nie wat is **sy reaction nie**/.
17. Toe sê ek vir hom, ek wil nou **nie lelik wees nie**/, maar ek moet **huis toe gaan**/. Toe sê hy, **ja, okay**/, ek gaan 'n endjie **saam met jou stap**/. Hy het 'n endjie **saam met my gestap**/, en toe gaan ek nou na die **huis toe**/ waar ons gekuier het **daar waar ouma is**/.

Stanza 5: (Versmelting van verlede en teenwoordige tyd: Ouma/skuiling gee nie om nie)

18. Maar ouma het nie eenkeer gebel of rond gekyk **waar ek is nie**/, so dit wil vir my sê hulle was nie eers **geworried waar ek is nie**/. Die tyd wat ek **by die huis kom**/, toe sal **hulle vir my sê**/, ons was bekommerd oor jou, maar hulle **sit en drink**/. Nie eenkeer het sy gesê sy het uit gebel om te luister of ek miskien by die shelter terug gekom het **of enige iets nie**/. So dit wil mos nou sê hulle **was nie geworried van my nie**/.
19. Toe het ek net vir hulle gesê, okay, **is all right**/, ek gaan nie nog worry om **te eet nie**/. Dis die Sondag **mos nou**/, ek gaan nie nog wag **om te eet nie**/. Ek gaan nou my **sak vat**/ en dan gaan **ek huis toe**/.
20. Nee, maar Chantal, jy kan nie sonder my **huis toe gaan nie**/ - en al die **klomp goed**/. Toe sê ek, **nee**/, maar **ek gaan huis toe**/ want **ek voel**

**ongemaklik./**

## PART 5: (Terug in die teenwoordige)

Strophe 5: (Stilte uit skaamte en uitwissing van die verkragting)

Stanza 6: (Skaamtevolle erkenning)

21. Toe het ek my **nou eers gewas/**. Want hulle mos nou die Maandag \*\* en toe neem sy my mos **nou hospitaal toe/**, toe sê hulle ek **moes nie gewas het nie/**. Maar ek het mos nou **nie geweet nie/**, want ek het ongemaklik gevoel van die Vrydag aand af **tot die Sondag/**. Toe het ek mos nou **vir my gewas/**. Ek het **net klaar gewas/**, en nou pak ek nou **my sak uit/**.
22. Toe sê ek vir hulle, maar **ek gaan nou stap/**. Toe kom ek **op gestap/**.
23. Toe ek hier **by die huis kom/**, my lyf was vol bommels soos die vlooië en goed **my gebyt het/**. Dele van die bommels was **tot op my voete/**.
24. Toe ek **hier kom/**, toe sê ek net vir my auntie Labia **ek is honger/**, want toe het ek mos nou **nie daar geëet nie/**. En die mense het sommer gesien ek **lyk nie lekker nie/**, alhoewel ek wil gepretend het dat daar **niks verkeerd is nie/**, het hulle klaar agter gekom **ek lyk nie lekker nie/**. En die Maandag toe sou ek 'n \*\* **duty gedoen het/**.
25. Ek het net **beginne werk/**, maar toe kan ek nie meer dit **vir myself hou nie/**. Toe dink ek, ek kan nie, **ek moet praat/**. Ek gaan dit nie vir ewig **vir myself hou nie/**.
26. En toe het ek nou met iemand gesels **in die office/**, en ek **vertel toe daarvan/**. Sy was eintlik so \*\* en sy sê, Chantal, hoekom het jy nie al **gister gepraat nie?/** Hoekom het jy nie al gister vir my gesê toe ek hier **af gekom het nie?/**
27. Toe sê ek, **nee/**, ek was nog eerste **te skaam om te praat/**.
28. Toe sê ek nou die Maandag **ook vir Chriska/**, en toe het Chriska mos nou vir Dorothea **in die counselling/**, toe vertel **ek nou vir hulle/** en toe vat hulle my sommer dadelik hier na \*\* se **hospitaal toe/**. Toe het hulle nou weer bloed getrek **en als daai/**. Die Vrydag, toe gaan ek **vir my uitslag/**. Toe sê hulle ek moet **Vrydag kom/**. Die Maandag het hulle **my uitslag \*\*/** bloed en so **gevat/**. En vir die aande was dit sulke stokkietjies en goete mos nou vir ...dat ek **nie AIDS sal kry nie/**. Toe het hulle vir my pille gegee wat ek vir drie weke moes gedrink het vir die Aids en vir die

infeksie - en **als daai**./

PART 6: (Terug in die verlede)

Strophe 6: (Stockholm Syndrome)

Stanza 7: (Obsessie met Ricardo)

29. Ek weet nie of ek dit **kan hanteer**/ ...ek voel **all right**/, maar die dag is daar wanneer dit vir my '**n bietjie pla**./

30. En as ek met **iemand praat**/, dan noem ek **gedurig Ricardo se naam**/. Ek weet nie, dit begin nou al van die **weke wat dit net so**/ ...as ek met **iemand praat**/, dan noem ek **Ricardo se naam**/, ek weet nie **hoekom nie**/. Want sy naam kom **net so**/ ...nie dat ek dink aan hom **of wat nie**/, want ek wil nie eers **dink aan hom nie**/ ...maar noem net '**n naam**/, dan noem ek **altyd sy naam**/. Dan sê ek, ag, man, Ricardo, want dan **maal dit weer by my**/. Dan dink ek **net die aand daaraan**./

*Translation*

PART 1: (We go visiting)

Strophe 1: (I was drunk)

Stanza 1: (They leave me just like that)

1. Then I went visiting with her **that Friday**/. And we came **there** the Friday **night**/ ...then **the sheds**/, just like **those of the houses**/, so **at the back**/ ...I mean, **here is the house**/ where we **visit**/, and here at the back where the houses are **there is the little shed**. /. Now it's **not so far**, is it?
2. Then **they left me just like that** /.
3. Because I **also drank**/, I'm **honest**/, I **also drank**/, but I know I'm **not a drinker**/. And then I suppose I must have been **too drunk**/, and then **they left me just like that** /.

PART 2: (The gang rape)

Strophe 2: (They rape and beat me)

Stanza 2: (Carel stays with me)

4. Then the three guys **took me out**/ and they take **me down there**/. All three of them take me **\*\* to sex**/.

5. I can still **remember his name** very well. / It was **Carel**/. All three of them **had sex with me**/. How does **one say it now**/ ...in my anus they also **had sex with me**/. They **beat** me/.
6. The **whole night**/ ...no, **not the whole night**/ ...I think towards the **morning hours**/ then the two **went home**/.
7. Then Carel kept me **there with him**/.

## PART 3: (Shame-based love)

Strophe 3: (Carel stays with me)

Stanza 3: (In love)

8. My mother and them slept **that time**/. But I **suppose it was like this** /, the two now **went home** / and Carel keeps me **there at their home** /. Now the Saturday morning the two popped **in again** /, but they didn't **worry** any further /.
9. Then I'm **so ashamed**/: never in my life has **something like that happened to me**/. Then I'm **so ashamed**/.
10. I just sit there **on the bed**/. Then I sit and **watch them and so on**/.
11. They are joking **among themselves and so on**/. Now they are drinking **once again** /.
12. The Saturday then the two ask Carel, but **can't they again go and \*\***/, the two now for **the Saturday night**/. They sing, don't they, and **it goes like that, doesn't it**/. It was only **a weekend or so** /, but then **this happened to me, didn't it** /.
13. Then he said, no, he is **not going anywhere** /. He's going to **be with me** all the time /.
14. Now Chriska says, it seems to me he **then also fell in love with you** /. Because he **kept me with him** the whole weekend. He did **not wander around** /. He just **sat there with me** /. He also **didn't treat my in a nasty way** or anything /. Now they say, don't they, it seems to me that he **also fell in love** /.

## PART 4: (Transformation)

Strophe 4: (Past and present confusion)

Stanza 4: (Carel = Ricardo [original IPV perpetrator], and shelter = Ouma [her

caregiver, her home])

15. Then he said, no, but he's **not going to worry** /. Then I suppose **they also went to\*\***/. They had me there the Friday night and the Saturday night, and it's only the Sunday morning, **then he said** / ...if I **didn't tell him** /, he would probably still have **kept me there**.
16. Then I said to Ricardo, "but Ricardo, I must **go home now**./ You know, don't you, that I do not live here – I'm **only visiting**."/ Because I think, I **don't want to be rude** /, because I don't know what **his reaction** will be, not so?
17. Then I said to him, I **don't want to be rude** /, but I have to **go home** /.  
Then he said, **yes ok**, I will **walk a little way with you**/. He **walked a little way with me** /, and then I **went home** / where we visited, there **where my granny is** /.

Stanza 5: (Past and present fuse: Ouma/shelter doesn't care)

18. But granny didn't phone once or look around **where I was** /, so that tells me they **weren't even worried where I was** /. At the time when I **came home** /, then **they would tell me** /, we were worried about you, but they **sit and drink** /. Not once did she say that she phoned out to hear if I maybe had come back to the shelter **or anything** /. So it tells me, doesn't it, that they **were not worried about me** /.
19. Then I said to them, **okay, it's all right**/, I am not going to worry **about eating** /. It's Sunday **now, isn't it** /, I'm not going to wait **to eat** /. I'm going to **take my bags** / and then **I'm going home** /.
20. No but Chantal, you **cannot go home** without me / - and **a lot of such things** /. Then I said, **no**, / but **I'm going home** / because **I feel uncomfortable**./

PART 5: (Back in the present)

Strophe 5: (Shame-filled silence and obliteration of rape)

Stanza 6: (Shameful admission)

21. Then I first **washed myself** /. Because the Monday they **\*\* didn't** they and then she takes me **to the hospital**, didn't she /, and then they say **I shouldn't have washed** /. But **I didn't know**, did I /, because I felt

uncomfortable from the Friday evening **until the Sunday** /. Then I washed myself, didn't I /. I have **just finished washing** /, and now I **unpack my bag** /.

22. Then I said to them, but **I am going to walk now** /. Then I came **walking up** /.
23. When I came here **at the house** /, my body was full of bumps where the fleas and thing **bit me** /. Some of the bumps went **down to my feet** /.
24. When I **came here** /, then I just said to my auntie Labia **I'm hungry** /, because I had **nothing to eat** there, not so? /. And the people could just see that I **didn't look well** /, although I tried to pretend that **nothing was wrong** /, they had already realised that **I didn't look well** /. And the Monday I would have **\*\* done a duty**/.
25. I had just **started working** /, but then I couldn't **keep it to myself** any more /. Then I thought, I cannot, **I must talk** /. I'm not **keeping this to myself** forever /.
26. And then I spoke to someone **in the office** /, and then I **tell what happened** /. She was actually so **\*\*** and she says, Chantal, why didn't you **talk yesterday already?** / Why didn't you tell me yesterday already when I **came down here?**/
27. Then I say, **no** /, at first I was **too ashamed to talk** /.
28. Then I told **Chriska** on Monday **too** /, and then Chriska has Dorothea **in the counselling**, doesn't she /, then I **now told them** / and then they just took me straight away here to **\*\* hospital** /. Then they took my blood **and all that** /. The Friday, then I went for **my results** /. Then they said I must **come on Friday** /. The Monday they have **my results\*\*** /, **took my blood** and so on /. And in the evenings it was little sticks and things like that you know for...that **I won't get AIDS** /. Then they gave me tablets that I had to drink for three weeks for the AIDS and the infection – and **all that** /.

#### PART 6: (Back in the past)

##### Strophe 6: (Stockholm Syndrome)

##### Stanza 7: (Obsession with Ricardo)

29. I don't know if I **can handle it** / ...I feel **all right** /, but the day comes when it **bothers me a bit** /.

30. And when I **talk to someone** /, then I say **Ricardo's name all the time** /. I don't know, it started from **the weeks that it just** / ...when I **talk to someone** /, then I mention **Ricardo's name** /, I **don't know why** /. Because his name comes **just like that** / ...it's not that I think about him **or so** /, because I **don't** even want **to think about him** / ...but just **mention a name** /, then I **always mention his name** /. Then I say, oh man, Ricardo, because then it just **mills in my head again** /. Then I just think about it **in the evening**.

Purely structurally, the narrative's form is not even, with Stanzas in particular differing in length and complexity. Only one part consists of more than one Stanza, and significantly, it is the Part where the narrative breaks down (Part 4). Some Stanzas are particularly long and detailed. Note that the Stanzas focused on shame and staying/abandonment, are the lengthiest. As I have noted previously, chaos narratives are characterised by a proximity, by a "and then, and then" present tense style (Frank, 1995). The narrator uses the connecting word "toe" (*then*) (which are mostly reflected in the subordinate clauses, not indicated here) frequently during all Parts in the narrative, barring the last one, where the tone changes and reflects a bewildered sense of confusion, disorientation and loss.

Part 1, Strophe 1, Stanza 1 begins with the narrator's short tale of going to a visit at a house nearby the shelter. However, significantly, a split is immediately introduced between self-blame for what happened (she had been drinking), and her blaming her friends, who left her at the mercy of her rapists. This is the basis of the shame-based self. The relatively short Stanza 2 describes the gang-rape, and what is immediately striking here is that there is no description of what happened; the central trauma is absent from the narrative, and the audience does not know if this is an amnesiac response which links later to a profound disorientation in time. The only mention of what happened during the rape is the reference made to anal rape, to which I will return later. Certain survivors protect themselves by omitting details, and by talking about the traumatic event(s) in cryptic terms (Kraft, 2004). In this Stanza, the reader also first hears about Carel, one of the rapists. Carel is different from the other rapists, he stays with her throughout her three day ordeal, whereas everyone else in her life leaves (other sections of the interview indicated significant abandonment in childhood, and in this scenario her friends leave her to be raped). Carel stays; he never leaves her, even in her most shameful state: "Toe is ek so skaam: ek het nog nooit in my lewe so iets oor gekom nie. Toe's ek so

skaam.” (*Then I’m so ashamed: never in my life has something like that happened to me. Then I’m so ashamed*).

Carel introduces important themes in the narrative: once again, the shame-based self, the narrator’s significant abandonment terror, which relates to her disorganised attachment patterns. For example, what is particularly striking about this narrative is what the narrator considers being “lelik getreat” (*treat me in a nasty way*) (Part 3, Strophe 3, Stanza 3). Carel raped her and beat her, yet she says he did not treat her badly. It is as if his refusal to abandon her obscures all else. This is evidence of the themes I have mentioned: a tremendously shame-based sense of self, the internalisation of a perpetrator-defined identity (being “bad” and so deserving of punishment that it is not even acknowledged or noticed) and a highly disorientated, conflicted, disorganised pattern of attachment based on deep-seated fears of abandonment.

In this Stanza, this deep appreciation of Carel not leaving her alone after her acute trauma, develops into a kind of shame-based infatuation. Note the disturbing repetition in this Stanza of the word “verlief” (*in love*) indicating its centrality in the narrative. It demonstrates to the reader the distorted understanding the narrator has about love, perhaps only as a result of this trauma, but it could be a long-standing pattern that facilitated her experience of IPV.

In the brief Part 4, Strophe 4, Stanza 4, the past and present begin to merge. It appears as if the narrator is confusing the present and the original adult trauma, for which she sought shelter at the Centre in the first place (IPV). Confusion in thought can be caused by both trauma and shame. Levendosky et al. (2011) suggest that trauma, particularly among those with a history of IPV, can lead to dissociation which impairs cognitive capacities through intrusions of disorganisation, disorientation and confusion. Shame, in turn, is a global negative self perception associated with confusion in thought, interruptions in current behaviour, and speechlessness (M. Lewis, 1992). I will further elaborate on possible reasons for this mergence in the section where I analyse the plot.

Part 4, Strophe 4, Stanza 5 amplifies this confusion between past and present. The reader is entirely unable to distinguish between “ouma” (*grandmother/granny*) and “hulle” (*them, her friends*), and the “huis” (*home*) and the shelter. The personal and proper pronouns do not correspond with any linear chronology. A coherent timeline is indiscernible from this part of the narrative. The reader is left wondering from where the narrator is leaving and where she is going. The narrator is highly disorientated and this manifests in the non-sensical way

language is used in this Stanza – it is difficult to understand or extract any linear micro-narrative from this Stanza.

The reader is returned to the future in Part 5, and it lends some coherence to the narrative, however short-lived. Stanza 6 is a long Stanza that revolves around shameful disclosure, but also physical needs, and the practicalities of preventing sexually transmitted diseases. The physical realities of her gang-rapes seem to ground the narrator, and bring her back into the present, making her more lucid and the narrative more coherent. The reader knows she is aware that she is back at the shelter because she names staff members at the Centre. So, a post-traumatic transition to the present appears to have been made. The speechlessness of shame comes up once again in this Stanza, as it takes the narrator considerable time to confess what happened to her (H. B. Lewis, 1971; M. Lewis, 1992): “ek was nog eerste te skaam om te praat.” (*at first I was too ashamed to talk*).

In the concluding Part 6, the reader is taken back into the past, back to Ricardo. One is unsure whether this Stockholm Syndrome-like obsession with the man she cannot stop thinking about is her ex-partner, Ricardo, or her rapist, Carel. The narrator is aware that something is “wrong” (*maar die dag is daar wanneer dit vir my 'n bietjie pla/but the day comes when it bothers me a bit*), but she has a compulsion to return to any form of “love”, which she interprets as the opposite of abandonment, a life-long theme for her, despite the consistent care she insists her primary caregiver during childhood, “ouma” provided. Thus, this narrative begins and ends with abandonment. As I have noted before, the urgent need for love and acceptance in survivors of chronic trauma may lead to trusting others indiscriminately or becoming very compliant with others in an attempt to prevent abandonment from them, typical of disorganised attachment styles (Herman, 1997; Kaminer & Eagle, 2010). This increases the chance that chronically traumatised individuals will be emotionally or physically or sexually abused by others again, as was the case with this narrator.

This narrative has a number of linguistic features which point to the psychic reality of Chantal, the narrator. Like other narrators in this chapter, there are ellipses, and there are incomplete sentences, and they do not occur randomly, they occur at particularly painful or significant points of the narrative. For example, in Part 2, Strophe 2, Stanza 2, the narrator includes the incomplete fragments of sentences relating to the length of her captivity and the gang-rapes: “Die heel nag...nee, nie die heel nag nie...seker hier by die oggend ure” (*The whole night...no, not the whole night...I think towards the morning hours*). These phrases do not constitute clauses (they do not include verbs), and they are also indicative of trauma-

related disruptions in time, which become a feature of this narrative. Another example occurs in Part 6, Strophe 6, Stanza 7 where she talks about her obsessive thoughts about Ricardo: “Ek weet nie, dit begin nou al van die weke wat net so...” (*I don't know, it started from the weeks that it just...*) and the sentence trails off.

I now turn to analyse the Main line text or plot of this complex narrative.

#### **Narrative 4: Main line/off Main line of the plot**

PART 1: (Ons gaan kuier)

Strophe 1: (Ek was dronk)

Stanza 1: (Hulle los my net so)

1. Ek het saam met haar gaan kuier die Vrydag. Hier agter is daar die hokkie.
2. Hulle los vir my net so.
3. Ek het ook gedrink. Ek is eerlik. Ek het ook gedrink. Ek weet ek is nie 'n drinker nie. Ek is nou seker maar té dronk.

PART 2: (Die groepsverkragting)

Strophe 2: (Hulle verkrag en slaan my)

Stanza 2: (Carel bly by my)

4. Drie ouens vat vir my uit.
5. Ek kan nog baie mooi sy naam onthou. Dit was Carel. Al drie het sex met my. Hoe sê 'n mens nou. ...In my anus het hulle ook sex gehad met my. Hulle het my geslaan.
6. Die twee gaan huis toe.
7. Carel hou vir my daar by hom.

PART 3: (Liefde uit skaamte)

Strophe 3: (Carel bly by my)

Stanza 3: (Verlief)

8. Ek is so skaam. Ek het nog nooit in my lewe so iets oor gekom nie.
9. Hy sê, nee. Hy gaan nêrens heen nie. Hy gaan heel tyd by my wees.
10. Lyk my hy het ook verlief geraak op jou.

PART 4: (Transformasie)

Strophe 4: (Verwarring oor die verlede en die teenwoordige)

Stanza 4: (Carel = Ricardo [oorspronklike IPV mishandelaar], and skuilings = Ouma [haar versorger, haar huise/tuiste])

11. "Maar Ricardo, ek moet nou huis toe gaan. Jy weet mos ek bly nie hier nie. Ek kom kuier net."
12. Ek wil nou nie lelik wees nie. Ek moet huis toe gaan.

Stanza 5: (Versmelting van verlede en teenwoordige tyd: Ouma/skuilings gee nie om nie)

13. Ouma het nie eenkeer gebel nie. (Ouma het nie) rond gekyk nie. Hulle was nie eers geworried nie. Hulle sal vir my sê. Ons was bekommerd oor jou. Maar hulle sit en drink.
14. Ek gaan nou my sak vat. Ek gaan huis toe.
15. Ek voel ongemaklik.

PART 5: (Terug in die teenwoordige)

Strophe 5: (Stilte uit skaamte and uitwissing van die verkragting)

Stanza 6: (Skaamtevolle erkenning)

16. Toe het ek my nou eers gewas.
17. Sy neem my mos nou hospitaal toe.
18. Hulle sê ek moes nie gewas het nie.
19. Ek is honger. Ek het mos nou nie daar geëet nie. Ek lyk nie lekker nie.
20. Ek nie meer dit vir myself hou nie. Ek moet praat.
21. Ek vertel toe daarvan. Sy sê, Chantal. Hoekom het jy nie al gister gepraat nie?
22. Ek sê, nee. Ek was nog eerste te skaam om te praat.
23. Hulle vat my sommer dadelik hier na \*\* se hospitaal toe.

PART 6: (Terug in die verlede)

Strophe 6: (Stockholm Syndrome)

Stanza 7: (Obsessie met Ricardo)

24. Ek noem gedurig Ricardo se naam. Ek weet nie hoekom nie. Ek wil nie eers dink aan hom nie. Dit maal weer by my.

*Translation*

PART 1: (We go visiting)

Strophe 1: (I was drunk)

## Stanza 1: (They leave me just like that)

1. I went visiting with her that Friday. Here at the back is the little shed.
2. They leave me just like that.
3. I also drank. I am honest. I also drank. I know I'm not a drinker. I suppose I must have been too drunk.

## PART 2: (The gang rape)

## Strophe 2: (They rape and beat me)

## Stanza 2: (Carel stays with me)

4. Three guys took me out.
5. I can still remember his name very well. It was Carel. All three of them had sex with me. In my anus they also had sex with me. They beat me.
6. The two went home.
7. Carel kept me there with him.

## PART 3: (Shame-based love)

## Strophe 3: (Carel stays with me)

## Stanza 3: (In love)

8. I am so ashamed. Never in my life has something like that happened to me.
9. He says no. He is not going anywhere. He is going to be with me all the time.
10. It seems to me he also fell in love with you.

## PART 4: (Transformation)

## Strophe 4: (Past and present fuse)

Stanza 4: (Carel = Ricardo [original IPV perpetrator], and shelter = Ouma [her caregiver, her home])

11. "But Ricardo, I must go home now. You know, don't you, that I do not live here. I am only visiting."
12. I don't want to be rude. I have to go home.

## Stanza 5: (Past and present fuse: Ouma/shelter doesn't care)

13. Granny didn't phone once. (Granny didn't) look around. They weren't even worried. They would tell me. We were worried about you. They sit and drink.

14. I'm going to take my bag. I'm going home.

15. I feel uncomfortable.

PART 5: (Back in the present)

Strophe 5: (Shame-filled silence and obliteration of rape)

Stanza 6: (Shameful admission)

16. I first washed myself.

17. She takes me to the hospital, didn't she.

18. They say. I shouldn't have washed.

19. I'm hungry. I had nothing to eat there, not so? I didn't look well.

20. I couldn't keep it to myself anymore. I must talk.

21. Then I tell what happened. She says, Chantal. Why didn't you talk yesterday?

22. I say, no. At first I was too ashamed to talk.

23. They just took me straight away here to \*\* hospital.

PART 6: (Back in the past)

Strophe 6: (Stockholm Syndrome)

Stanza 7: (Obsession with Ricardo)

24. I say Ricardo's name all the time. I don't know why. I don't even want to think about him. Then it just mills in my head again.

There is significant circularity and repetition in the full narrative (excluded above). This Main line text has no linearity and disintegrates entirely at a number of points. This disintegration is both trauma- and shame-related and involves not only non-linearity or a total break-down of plot, but fractures in temporality and identity. Up until Part 3 the reader is able to discern some kind of structure – the initial context or background described in the first Part, and very significantly, the introduction of a major theme, abandonment. Part 2 is dramatic in its (lack of) description of the gang rape and beatings, but in stark opposition to the abandonment by her friends in Part 1, Carel, the rapist, is introduced, the abuser who stays. The abuser who does not abandon, the very worst pain of all. The narrator describes Carel's "care" of her as a protective presence (an inversion of what truly happened, which was an invasive violation); almost as a kind of fatherly love in the face of what she sees as **her** most shameful moment (as opposed to his). Her "love" for him is fear-based, shame-based and includes a great deal of dependence, but when speaking to the narrator in the interview, she seemed delighted that

the deputy manager of the shelter suggested that Carel had fallen in love with her in the next Part. Part 4 and 5 constitute a complete rupturing of the plot. As I have already noted, there is a complete fusion of past and present and different identities which represent similar (perpetrators) and different (*ouma* and friends/*hulle*) experiences to her. Part 5 returns the narrator to the present, and centres around shame-filled hesitations, silences; feelings of contamination and the final admission of the gang rape. The plot does not conclude as one would expect, in the present, or looking towards the future – instead the reader is cyclically taken in and out of the present and the past, and the end of this text does not constitute an end at all; the narrator is back in the past, pining for a past perpetrator.

There is a great deal of contradiction in this narrative as a whole. This occurs in the very first Stanza, where the narrator admits twice that she had been drinking (admission of guilt; self-blame), and once that she was drunk, but then contradicts herself and says she is not a drinker and shifts the blame for what happened to her onto her friends, who abandoned her. So there is a circular shifting of blame in this Stanza. The words “seker maar” (*[I] suppose*) in the second last main clause in Stanza 1 suggests that a reluctant admission of guilt and self-blame, which links so painfully with shame.

The narrator chooses somewhat formal wording in the Stanza 2 (after a significant hesitation) to describe her anal rapes. She has no formal education, and I was surprised at her use of the word “anus”. I wondered whether she was trying to formalise, even medicalise, the experience, to emotionally distance the experience and make it more palatable for herself, and perhaps also for my sake, this “ordentlike” (*decent*) White middle class woman. Irrespective of the reason, her description was remarkably emotionally blunted. Part 3, Strophe 3, Stanza 3 revolves around the narrator’s search for love. She persistently repeats that Carel stays with her. There is a perfect balance in this Stanza, which begins with the two other rapists (*wat nou nie verder aan geworry nie* (*[who] didn’t worry any further*); followed by the shame associated with her trauma (*Ek is so skaam. Ek is so skaam/I am so ashamed. I am so ashamed*) as well as humiliation (*Hulle maak nou jokes onder mekaar en so/They are joking among themselves and so on*) – indicating a hostile, dismissive audience as occurs in humiliation). The Stanza ends with the opposite of abandonment. In the last paragraph, the narrator says four times, in four different ways, how Carel did not leave her. This is a very dramatic emphasis, showing its significance to her. The Stanza ends with the suggestion that Carel had fallen in love with her. It is interesting, however, that this repetition introduces a total fragmentation and breakdown in the narrative in Part 4.

As I have already noted, the past and the present begin to fuse in this section of the narrative. There could be many reasons for this. Perhaps the original adult trauma (IPV) was less traumatic than the gang-rape, and functioned as a form of displacement. Perhaps the fusion was further facilitated by similarities between Carel and Ricardo. In this context it is helpful to reflect on certain clinical features associated with severe trauma. Diagnostic criteria for DESNOS include among other things, disruptions in attention or consciousness, distorted perceptions of the perpetrator/s, profound shame and guilt, and disorganised attachment patterns (Ford & Courtois, 2009). Dissociative disorders are commonly associated with disruptions in chronology and “lost time” (Putnam, 1989). Furthermore, acute shame has also been associated with forgetting (M. Lewis, 1992; Mills, 2005; Tomkins, 1963).

However, one can also explain such “lost time” or amnesia-like behaviour biopsychologically. Payne et al. (2004) argue that there is a difference between episodic and semantic memories. What is of interest for us, is episodic memory, which involves remembering the particular context of an experienced event, including the time and place of its occurrence (Payne et al., 2004). The literature suggests that chronic glucocorticoid elevation and loss of hippocampal volume disrupts the storage of information about place, time and context of the traumatic experience, as well as the connecting process that binds aspects of the experience to the context and to one another (Payne et al., 2004). Thus, trauma memories are encoded without a well-developed spatio-temporal frame to organise them (Payne et al., 2004). So, memories created when stressed, and under the influence of elevated levels of glucocorticoids, are likely to be fractured and fragmented, lack spatial and temporal contexts and so produce deficits in episodic memory (Payne et al., 2004). In a sample of individuals with PTSD, these authors found that participants tended to struggle to report contextually specific memories with a specific source, including time and place. They also report that those who have been exposed to prolonged trauma, like war veterans, may struggle with remembering recent events, but have detailed memories of previous traumas that occurred a long time ago (Payne et al., 2004). This is consistent with Chantal’s experience. It is also worth noting that Chantal had been drinking alcohol, which is associated with memory impairment.

One of the most fascinating aspects of this part of the narrative is that the narrator hesitates before telling “Ricardo” that she has to go home, as if to soften the possible pain of her departure, because in her mind, since he did not leave her, and he was good to her, loved her, her departure may hurt him. She struggles to utter the words that she has to leave – she

repeats twice: “ek wil nie lelik wees nie”. (*I don't want to be rude*). Once she has told the audience that if she had not asked to leave **he would still have kept her there**, she is able to speak what needs to be spoken without hesitation, without pauses. So once again, she is emphasising: “hy sou seker nog altyd vir my daar gehou het” (*he would probably still have kept me there*) if she had not asked to leave (Part 4, Strophe 4, Stanza 4). It is this sentence (which indicates for her that she is wanted) that allows her to speak, and to take action to leave.

From Part 4, the narrator talks about home, when in fact she has no home. There are two observations of importance here. Later, when I present the compressed narrative, I will present more material produced by Chantal, about her mother. She makes a point of telling me that her “real” mother “swerwe” (*wanders aimlessly*), and hence has no home. Here is an uncomfortable repetition of the past. In this narrative, I believe that in her confusion, Chantal is looking for her primary caregiver during childhood, her “ouma”, because she represents the only home she has ever known, the only comfort she has ever known. But “ouma” is in Worcester, quite inaccessible. Perhaps this is what Carel offers her, a substitute, temporary home; one where she is not alone, where she feels protected and loved, however distorted that perception of love may be.

Another interesting contradiction characterises this narrative. As I have noted, there are major disruptions in place and time. However, the narrator is quite capable of maintaining a particular kind of chronology. She frequently speaks of Friday, Saturday, Sunday and Monday, and what happened on these days. But this is dramatically undermined by the complete mergence of past and present that occurs in Part 4, Strophe 4, Stanza 5. At a linguistic level, this Stanza makes no sense. She juxtaposes “huis” (*house*) (as opposed to the reality of the shelter), with the plural pronoun “hulle”, which would be consistent with the shelter, but not with “ouma”, since she lived alone with her “ouma”. Furthermore, her “ouma” did not drink, but the people described in this Stanza do drink, like at the party the narrator went to. She keeps repeating that she is going “huis” toe, but that no one “geworried is nie”, which again is incongruent with her description, provided during the interview, of the home her “ouma” created for her. It is her friends who aren't “geworried” (*worried*), not her “ouma”, who in any case is oblivious of what has happened to the narrator. The reader asks him/herself, where is she? Who is she talking to? The over-riding theme again is one of angry, disorientated and confused abandonment.

It seems that in Part 5, Strophe 5, Stanza 6, the narrator's story becomes more lucid, perhaps due to the time that has passed since the trauma. Again, the theme of this Stanza is around shame. Many rape survivors feel contaminated and dirty after their experiences, and this can be accompanied by self-blame and shame. The narrator emphasises this filth by describing the "bommels" (*insect bites*) on her body. One concrete way of addressing these feelings is to engage in the purging and cleansing symbolised by the act of washing. The first part of the Stanza is about physical needs. Washing, and hunger; the narrator repeatedly says she is hungry. It is tragic that the narrator continues to feel that Carel took such good care of her, but he did not feed her for three days. Although Chantal repeatedly says she is hungry, it is stated in an almost flippant, emotionally blunted way. This is either a function of dissociation, or constitutes familiarity with a profound experience of deprivation. Simply being there with her; not abandoning her, is enough for this narrator; love is stripped down to its most basic (and inadequate) components. It does make one wonder whether the upbringing with "ouma" was idealised by the narrator, if these conditions of deprivation are what she is accustomed to at some level, but one can only hazard a guess since the narrator insisted that she was well cared for as a child.

The second part of the Stanza is about overcoming shame, a central theme in the narrative ("Ek was nog eerste te skaam om te praat"/*At first I was too ashamed to talk*) and breaking the silence of what happened to her. The Stanza ends as it started, by addressing her physical needs; the use of preventative medicine. Again, where the content of the narrative becomes especially distressing, the language breaks down. The narrator describes (in subordinate clauses) the treatments she has to use to prevent the development of HIV/AIDS, but before she can utter this terrible potential outcome, she says: "mos nou vir..." (*You know now for...*). She hesitates for a great length of time before she can consider what she is being treated for; what possibilities lie ahead for her.

Part 6, Strophe 6, Stanza 7 includes far more subordinate clauses than any of the other Parts. Perhaps these clauses help conceal, or "pad" some of the most painful truths. The repetition in this Stanza is striking: "Ek noem gedurig Ricardo se naam. Ek weet nie, dit begin nou al (wat dit net so...). Ek noem dan Ricardo se naam. Ek weet nie hoekom nie. Want sy naam kom net so. Ek wil nie eers dink aan hom nie. Dan noem ek altyd sy naam. Dan sê ek, ag, man, Ricardo. Want dan maal dit weer by my. Dan dink ek net die aand daaraan". [*I say Ricardo's name all the time. I don't know, it started from the weeks (that it just...). I mention Ricardo's name. I don't know why. I don't even want to think about him. Then I always mention his*

*name. Then I say, oh man, Ricardo. Then it just mills in my head again. Then I just think about it in the evening.]*

Whether the narrator is talking about Ricardo or Carel cannot be determined. All that is clear is that there is evidence of significant regression, displacement, amnesia or forgetting, dissociative disruptions in time and place, and overt and by-passed shame. Overall, I would argue that this narrator represents a self that has been overwhelmed by trauma, and has clinical features of Complex PTSD, DESNOS and dissociative disorders.

In Part 1 the narrator is the psychological subject, although the focus shifts to her abandoning friends twice in Strophe 1, Stanza 1. As we have established, abandonment is a significant issue for the narrator, which, as noted, is indicated by the repetitive shifts in the psychological subjects in this Stanza.

In Part 2 the rapists are the psychological subjects, with a special focus on Carel, who becomes her focus, her obsession, the one who stays with her. He stands in radical opposition to her abandoning friends in Part 1.

There are a number of psychological subjects post- gang-rape described in Part 3. Carel's mother, the other two rapists (casual, mocking, indifferent), the narrator and her shame, and Chriska, the shelter deputy manager, who expresses a central theme in the narrative (in love). The chaotic inclusion of so many psychological subjects may be expressive of the peri-traumatic chaos characterising traumatic experiences such as rape.

Part 4, Strophe 4, Stanza 4 consists of a confusing alternation between the narrator and Carel/Ricardo. This is the moment where the narrative fractures, and it is interesting that it follows the somewhat chaotic Part 3 from a psychological subject point of view. In the second Stanza, "ouma" is introduced as a psychological subject, but the reader does not know if she is "real". The reader also does not know who, in fact, the narrator is talking to. There is no indication who the "hulle" (*they*) are who she is speaking of. She remains the psychological subject throughout – almost all lines begin from the "ek"/ "I" position - but one who is disintegrating, fracturing, splitting into a form of co-consciousness in which past and present are indistinguishable.

Part 5 is more coherent, and the narrator ("I") remains the psychological subject until she reaches psychological breaking point and cannot keep her experience a secret any longer. Briefly, Chriska becomes the psychological subject, but the narrator quickly returns to hold

the main perspective, and tells, however, matter-of-factly, of her frightening experiences at the hospital; the real-life consequences of her traumatic experiences.

The narrative fractures again in Part 6. Here the narrator is the sole psychological subject, who is immersed in the past. There is no conflict or tension between the past and present, there is total regression.

The foci in this narrative are numerous and diverse. Part 1; Strophe 1; Stanza 1 describes the context within which the trauma occurs, with words such as *die Vrydag; hierso is die huis; wat ons kuier; en hier agter waar die huise is is daar die hokkie (the Friday; here is the house; and here at the back where the houses are there is the little shed)*. But the theme of abandonment is immediately introduced, and repeated twice: *los hulle (her friends) vir my net so (they [her friends] left me just like that)*.

Part 2, Strophe 2, Stanza 2 focus on *die drie ouens/the three guys (the rapists); sy naam onthou/remember his name; Carel; daar by hom/there with him*. Part 3 foci are the results of the rape: *ek is so skaam/I am so ashamed; (yet Carel) gaan nêrens heen nie/he is not going anywhere; by my wees/be with me; verlief ook geraak op jou/also fell in love with you; by hom gehou/kept me with him; (nie) rond geloop nie/ did not wander around; gesit daar by my/sat there with me; (nie) lelik getreat of wat nie/he didn't treat me in a nasty way or anything; nog verlief ook geraak/fell in love also*. These foci point to shame-based love; to a self that has been so profoundly abandoned (in childhood and in adulthood) that any consistent figure, any figure who stays, becomes an attachment object.

Part 4 is the part of the narrative that breaks down, where there is present and past confusion. In Strophe 4, Stanza 4, the foci are centred around (maar Ricardo), *ek moet nou huis toe gaan ("I must go home now")*. Here again, the term "huis" is meaningless. The reader is not sure what home means to the narrator in her post-traumatic state. In Stanza 5 the foci point to the narrator's distress that "ouma" or "hulle" *(nie) geworried waar ek is nie/weren't even worried where I was*; she repeats this twice, perhaps experiencing it as yet another rejection; abandonment. Before the end of the Stanza, the narrator again repeats twice that *ek gaan huis toe (want) ek voel ongemaklik ("I'm going home [because] I feel uncomfortable")*. The reader wonders whether she herself knows where home is, where she is longing to be in order to stop feeling "ongemaklik" ("uncomfortable").

The foci in Part 5 brings the reader back to the present. The narrator repeats the term "gewas" ("wash") four times during this Part, indicating the depth of her feelings of filth and

contamination, despite the negative consequences thereof for her examination at the hospital. As I have already described, at this level of analysis, this sense of dirtiness is also amplified by her description of the marks on her body where fleas *my gebyt het* (“bit me”) during her captivity. The foci direct us to a picture not only of dirt and pain, but of deprivation, the narrator frequently mentioning that she is *honger/hungry* and *eet/eat* or *geëet/eaten* (three times) (this despite Carel’s “care”). The temporary break in the captivation with Carel is when she admits she knows (ek) *lyk nie lekker nie* (repeated twice), and makes her disclosure: (*ek kon nie*) *vir myself hou nie; ek moet praat; ek gaan dit nie vir ewig vir myself hou nie; vertel toe daarvan* (“I couldn’t keep it to myself; I must talk; I’m not keeping this to myself forever; then I tell what happened”). Yet we return to an old focal area; her silence up until this point was that she was: *te skaam om te praat* (“too ashamed to talk”). This Part ends with a return to the focus on the *hospitaal/hospital* and the terrifying possible physical consequences of her gang rape.

Part 6 is a unsettling end to this narrative. The initial foci are on the narrator’s ability to recognise that she is feeling pain (*bietjie pla/bothers [me] a bit*) but that she can cope (*kan hanteer[can handle]/all right*), suggesting that she has some capacity to understand that what Carel and the others did to her was wrong, but her claim that she is coping is flimsy and unconvincing. The focus remains on Ricardo, whose name is repeated twice. As she says in the concluding sentences: *altyd sy naam/always his name; maal dit weer by my/it just mills in my head again*. As a whole, given this narrative, it is difficult to imagine Chantal escaping from a lifetime of shame-based violence.

## Narrative 5

### PART 1: (Ambivalence)

#### Strophe 1: (Running away)

##### Stanza 1: (Running away and returning)

1. Because in their culture, beating a woman **is fine**/. So that’s how it started, and I thought it would be like an **on-and-off thing**/.
2. But at the **very same time**/, from my **past also**/, at home when they started **to beat me**/, I’ve had this thing of **running away**/. I didn’t like **that tension of** / ...if you start to **beat me**/, I don’t know, I think I get **scared**

**inside/** and then I start **running away/**, but I'll come **back home/** when they have forgotten **about everything/**. Then I'll **apologise/** and I'll stay **at home/**.

3. With him, I also did **the same/**: I ran **away/** and I went to a children's home **in Blouberg/**, the first time **it happened/**.

Stanza 2: Escape

4. I know **the owner/** I used to be in **that home, \*\*\*/** I used to stay there from 2006 till 2008, when I **was eighteen/** So I went to her **for help/** She was willing **to help me/** She asked me if I had anyone **to go to/** and I said my cousin **in Joburg/**
5. The younger cousin **called me/** she asked me how am I doing **and everything/**, and I told her **what had happened/** She went to speak to her **older sister/** then her older sister said why don't I **come down to Joburg/** She offered me education **and everything/** And mainly **for him/** they would welcome me **in their home/**
6. So I told my partner that I was moving **to Joburg/** He didn't like **the idea/** but he ended up **letting it go/**

PART 2: (Running away and returning)

Strophe 2: (Co-dependence)

Stanza 3: (Love/hate relationship)

7. But he tried to fetch us **at their home/** he **pulled tantrums there/** and then the police chased **him away/**.
8. Then he **called me/**, and because I **still love him/**, then he asked me to **come back/** and help me to further **my studies/** Then he made **empty promises/**
9. I did **come back/** and within two weeks **it started again/** It **started again/** He started **shouting/**
10. When it was time for him to come **back home/** it was always...I don't know...I won't **be free/** I'll start **getting scared/**, wondering what is he going to be angry **about today/** and what are we going to argue **about today/** – because everyday we **would argue/** Everyday we **would argue/**

11. And he'll get **phone calls**/, and if I ask him why don't you **answer your phone**/, now he'll get angry **at me**/ and start shouting **at me**/. He'll get **mysterious calls**;/ he'll go to the bathroom and talk **in the bathroom**/. He'll actually speak to **these women**/, and say that he's not staying with his **girlfriend and the baby**/. He's not staying with the mother of the baby **and the baby**./
12. You know, he'll start saying it's not mine **and all that**/, and then when I actually confront him about **these things**/, he says that he **didn't say it**/. I said, but I **heard you speaking**/, then he'll **start getting angry**/\*\* - those kind **of things**/. I'm **lying**/, he never said **such things**./
13. Then we'll also argue **about that**/, and then he'll also start beating me **because of that**/. So he's got also a temper problem, **I think**./
14. But he doesn't **admit it**/, so it will **never stop**/. I always pray and hope that **he'll change**/, but he'll **never change**/. I didn't finally decide, enough, **to really say**./

### PART 3: (Intergenerational abandonment)

#### Strophe 3: (Giving my child up)

#### Stanza 4: (Guilt and longing)

15. I went to **my cousin**/ ...that day we had **a fight**/ ...I went to my cousin and **I gave my child up**/. I left him at a **children's home**/ and asked them to keep him **for me**/ until I'm finished with **my studies**/ or **finished with working**/ ...until I could **afford him**./
16. But then later on in my life my cousin **said that, no**/, go and **fetch your child**/, because once your child is there he'll never have an opportunity **to know**/\*\* the way he would if he was staying **with you**./
17. Your mother **never left you**/, but your mother **couldn't afford you**/. That child living **at that home**/, he will **never forgive you**/ when **he's older**./
18. And ja, I couldn't live **without him**/: I would **cry**/ and **get emotional**/. I could **visit him**/, but sometimes I couldn't do things because **he's not around**./
19. I'll just sit down **at home**/, and instead of trying to go and **find a job**/, I'm sitting down and thinking about **my child**/, wishing that he **was here**/ – and those **kind of things**/. So I went to **go and fetch him**./

## PART 4: Return

## Strophe 4: (Co-dependence)

## Stanza 5: (Fear of abandonment by partner)

20. And when I went to go and fetch him his father called and said can you please **come back home**./ And I went **back again!**/ Then we stayed with him for **a week**./ We started to **argue again**./
21. He asked us **to leave**./, and that's when I didn't have **anywhere to go**./
22. And I said, actually, this person **really, really, really loved**/ ...the kid **really loved him**./ even though I stayed in **an abusive home**./
23. But the fact that he's asking us **to leave**./ and then tomorrow he'll call us and ask us **to come back**./ it's time to **actually really leave**./ He's asking me to **leave now**./ let me **just leave**/ and **never come back**./
24. Because he'll ask me to leave because he **needs space**./, but then how long am I going **to do that?**/ Every time he **needs space**./, must I go **on the street**/ and stay with **the child?**/
25. Because he does **need space**/ – he needs time with **those women**./ So I said **to myself**./ let me not **fool myself**./ he doesn't **love us at all**./ if he can ask us **to leave**./ And I'll tell him **to his face**./ we do know that **you have no \*\***./ You do know that I'm carrying the child **on my back**/ and then you still say, I need **some space**./

## PART 5: (All my fault)

## Strophe 5: (Conflict over child)

## Stanza 6: (Fear of abandonment by the child)

26. That I broke his heart **and everything**/ ...you know, he'll turn stories around and I'll be **the bad guy**./ Everything that happens is **because of me**./
27. He did this **because of me**./ and I don't want him to **see his child**/ – that's **a lie**./
28. I said, if you want to see **your child**./, you are more **than welcome**./ but it will mean for you to take **the responsibility**/ to come and fetch **your child**./ where your child **is at**./, and then you bring **the child back**./

29. And he said the child must stay **with him permanently**,/ and I'm only allowed to see the **child once a month**,/ What are you trying **to do**?/
30. You are trying to make my child **forget me**/ and then be used to the **new women**,/ There's not just **one woman**/ – it's **different women**,/ in-and-out of **his place**,/ so I don't want my child to be also surrounded by that **kind of environment**,/

This narrative, like all the others, consists of Parts, Strophes and Stanzas of different lengths, levels of detail and complexity, suggesting structural instability, and demonstrating points of significance in the narrative. This narrative has a funnel shape, starting with painful but present-based, easily recalled and immediate personal experiences, which gradually deepen after a central fracture in the narrative to reflect deep-seated, unconscious material being played out in the narrator's life. Both the "top" and the "bottom" of the funnel reflect the over-riding theme of leave-return. Like in all the other narratives, repetition, an important sign of narrative fragmentation, occurs in this narrative at a number of points, and includes not only leave-return, but related constructs such as ambivalence, co-dependence and fear of abandonment. Thus, more accurately, this narrative has a *fractured* funnel shape. There are few linking or connecting words or phrases in this narrative, so without the repetition, it would be very difficult to follow. The Main lines and Stanzas and Strophes and Parts would feel somewhat disconnected if it were not for the significant repetition which deepens our understanding of what is important to the narrator on each occurrence.

In Part 1, Strophe 1, Stanza 1, the tension between abuse and running away which characterises the majority of the narrative is immediately introduced, a tension which parallels the split self, the shame-based self that stays and "apologises" for her abuse and thinks it is acceptable if the abuse is an "on-off thing", and the false self that tries to escape because unconsciously she believes she deserves better.

Part 1, Strophe 1, Stanza 2 which centres around the narrator moving to Joburg to escape her abusive situation is the only coherent Stanza, the only Stanza not characterised by conflict, confusion and ambivalence. It is the only Stanza characterised by leaving, and (as yet) no returning to the abusive situation. It is also the shortest Stanza. At a semantic level, this structural feature suggests that its content is the most unusual or infrequent.

The next Stanza (Part 2, Strophe 2, Stanza 3) returns to the tension between leaving and returning. This Stanza is the longest Stanza, and it centres around the narrator's partner, suggesting his prominence and importance in her life; in this Stanza she admits that she still loves him. Her partner's disowning of the narrator and their son is acutely shaming for her, as is his sexual humiliation of her. This Stanza is rife with many forms of violence; as we have seen, there is a great deal of emotional violence, but there is also physical violence. The narrator underplays this dramatically, stating "So he's got also a temper problem, I think". This kind of understatement suggests she is not acknowledging the seriousness of the violence perpetrated against her, possibly because she wants to justify her continual returns to him, suggesting "it's not so bad". The continual return to him suggests she is highly dependent on him, and he on her dependence on him. They are stuck in a spiral of leave-return; leave-return, which reflects their love-hate relationship. This is reflected at linguistic level – the narrative guides the reader to the perpetrator, and then away from him again. There is no commitment here on the narrator's part, to leave and not to return, but the situation is not sustainable for her, as is demonstrated later in the narrative (see Part 4). This eternal return suggests the prominence of a shame-based sense of self. Like so many of the participants, but even more strikingly in this narrative, this leave-return cycle represents a disorganised attachment pattern; a pattern of seeking intimacy with a partner whose abuse is familiar, known to her, and then, out of fear, running from and escaping an emotional intimacy which is so dangerous for her, a pattern acquired during her neglectful and abusive childhood (Fonagy, 2011).

Part 3 is the most significant point of narrative fragmentation. This narrative fracture from the previous Parts, Strophes and Stanzas, I believe, is the thematic heart of the narrative. It is from this Stanza onwards that the narrative gains psychological depth. The reason for the narrator's cyclical leave-return, leave-return is fear of abandonment, which, like the previous narrator, was a constant feature during her childhood. From other interview material not reported here, the narrator tells of severe abuse for which she was blamed as a child, and being abandoned by her mother (unlike her cousin claims), and two of her aunts who were substitute caregivers, until she left home at sixteen. She had no consistent caregiver, and was passed from one adult to the other, all of whom eventually left her. Abandonment is intolerable for her. Yet this is also unconscious for the narrator, and so she repeats the past, and abandons her own child, until the guilt and longing is too great for her. It is unbearable for her to have lost both her partner and her child.

What is interesting here is that high levels of shame and personal distress are not associated with empathy (Lindsay-Hartz et al., 1995; Tangney et al., 2007). The narrator does not empathise with how her child may experience this abandonment, perhaps because she has not processed her own feelings about her abandonment as a child. However, she does cry and get “emotional” about leaving him; I wonder if perhaps she is crying out of longing for him as much as for her own unprocessed, unarticulated childhood of abandonment. She seems emotionally disconnected, even naïve – the belief that she can drop her child at a children’s home and pick him up again at her convenience seems out of touch with reality. Here again, the tension between the leave-return, leave-return emerges (leaving her child, and periodically returning), but it has far greater psychological depth and significance because it more closely mirrors the cause of her adult behaviour, which is rooted in her experience of her own childhood.

A great deal of her motivation for actions appear to be unconscious, and the narrative reflects this – it starts with the most immediate, easily accessible and repetitive theme in her life, her relationship with her partner and her pattern of leave-return, which deepens and gains unconscious significance through the same intergenerational pattern of repetition with her child from the point of narrative fracture (Part 3).

In the penultimate Part 4, the refrain of co-dependence recurs, but Stanza 5 is filled with more fear, and more anger than previous Stanzas. It is as if the previous Stanza, which brought about the rupture and the theme of abandonment, unleashed these strong emotions. These feelings are centred around being left, around her partner wanting “space”; about tolerating being shamed in this way. In Part 2, Strophe 2, Stanza 3, the narrator talks about the other women, but the tone is quite different, and there is no conviction that she will leave as a result of their presence in her partner’s life, as there is here. Longer narratives have been associated with progress and psychological recovery (Gray & Lombardo, 2001) – perhaps this long and complex narrative has helped make conscious for the narrator what was unconscious before, and helped instill some self-respect, some potency and agency, in a predominantly shame-based self.

The final Part 5, Strophe 5, Stanza 6 is reminiscent of Part 3, Strophe 3, Stanza 4, where the narrator experiences a dreadful fear that she has lost, or is in the process of losing both her (ex) partner and her son, and the blame is located in the narrator, which causes a great deal of internal conflict. The acute experience of the possibility of abandonment from her son is articulated in “You are trying to make my child forget me”. This, however, is a far more

conscious statement of fear of abandonment than would have appeared at the beginning of the narrative, perhaps suggestive of some progression despite the significant fracturing which occurs. The narrative ends with a chilling sense of isolation; a sense that the narrator feels quite alone, trying to negotiate her way through a hostile, abandoning, loss-filled world in which she has to fight unaided, unloved, for her emotional survival.

There are a number of unusual linguistic tools used by the narrator, for different reasons. Besides the major fracture that takes place in Part 3, the most interesting aspect of this narrative is the frequency of “micro-fracturing”, at which particular points in the narrative they occur, and how they manifest. The “micro-fracturing” starts in Part 2. There are examples of 1) incomplete sentences (for example: “Then he called me. **And because I still love him** (incomplete sentence). Then he asked me to come back” (Part 2, Strophe 2, Stanza 3). At points there is no logical sentence structure, like for example: “When it was time for him to come back home, it was always...I don’t know...” (subordinate clauses). What is evident here too, is the presence of ellipses. In this sentence, she is concealing, or at the very least, not explicitly stating, that she allowed herself back into the abusive situation. This narrator makes use of ellipses a number of times when the content of what she is uttering is too emotionally painful. At the end of Part 2, she makes the ambiguous statement: “I didn’t finally decide, enough, to really say”. What she means is very difficult to interpret here. I would argue that what she is leaving out is that she knows she cannot help herself from returning, and that this is too shameful for her to utter.

Like most of the narratives, there is significant repetition – I have already mentioned the repetition of the theme of leave-return, but at a micro-level there is parallel or related repetition about “the women” her ex-partner sees. She repeatedly mentions them and openly resents being disowned because of them: “He’ll actually speak to these women. And say that he’s not staying with his girlfriend and the baby. He’s not staying with the mother of the baby and the baby” (Part 2, Strophe 2, Stanza 3). These kinds of statements would simply fuel the narrator’s abandonment terror, her shame, and her disorganised attachment patterns.

A final example of “micro-fracturing” is how the broader theme of conflict between the narrator and her ex-partner manifests in Part 4, Strophe 4, Stanza 5 and 6. The cyclical alternation; the conflict between the narrator and her ex-partner also mirrors the major leave-return theme, and adds to the non-linearity of the narrative:

He’s asking us to leave. Then tomorrow he’ll call us and ask us to come back. It’s time to actually really leave. He’s asking me to leave now. Let me just leave and never come back.

He'll ask me to leave. He needs space. How long am I going to do that? Must I go on the street and stay with the child? Because he does need space. He needs time with those women. So I said to myself, let me not fool myself, he doesn't love us at all. And I'll tell him to his face. You do know. And then you still say, I need some space. (Stanza 5).

Lastly, the narrator uses inversion a number of times, for example: "mainly for him (the narrator's son), they would welcome me in their home" (Part 1, Strophe 1, Stanza 1), which should read, "they would welcome me in their home, mainly for him". Another example is: *So he's got also a temper problem, I think* (Part 2, Strophe 2, Stanza 3). Finally, in Part 4, Strophe 4, Stanza 5, the narrator says: "Every time he needs space (subordinate clause), must I go on the street and stay with the child?" This inversion, for whatever reason (perhaps lack of grammatical proficiency) adds to the disorganised quality of the narrative.

I now turn to the analysis of the Main line/off Main line of the plot.

### **Narrative 5: Main line/off Main line of the plot**

#### PART 1: (Ambivalence)

##### Strophe 1: (Running away)

##### Stanza 1: (Running away and returning)

1. Beating a woman is fine.
2. I've had this thing of running away. I think I get scared inside.  
Then I start running away. I'll come back home. Then I'll apologise. I'll stay at home.

#### PART 2: (Running away and returning)

##### Strophe 2: (Co-dependence)

##### Stanza 3: (Love/hate relationship)

3. He called me. He asked me to come back.
4. I did come back. It started again.
5. He'll speak to these women. (He'll) say that he's not staying with his girlfriend and the baby. He's not staying with the mother of the baby and the baby.
6. He'll never change.

#### PART 3: (Intergenerational abandonment)

##### Strophe 3: (Giving my child up)

## Stanza 4: (Guilt and longing)

7. I gave my child up. I left him at a children's home. (I) asked them to keep him for me.
8. My cousin said no. (My cousin said) go and fetch your child. Your mother never left you. Your mother couldn't afford you. That child will never forgive you.
9. I went to go and fetch him.

## PART 4: Return

## Strophe 4: (Co-dependence)

## Stanza 5: (Fear of abandonment by partner)

10. His father called. (He) said can you please come back home. I went back again!
11. He asked us to leave. That's when I didn't have anywhere to go.
12. The kid really loved him. Even though I stayed in an abusive home.

## PART 5: (All my fault)

## Strophe 5: (Conflict over child)

## Stanza 6: (Fear of abandonment by the child)

13. He said the child must stay with him permanently. I'm only allowed to see the child once a month. What are you trying to do?
14. You are trying to make my child forget me.

Firstly, this narrative has a great deal more subordinate clauses than the previous two narratives, qualifying the main clauses. Thus, more descriptive context is given to the narrative, and it also gives it a less raw, immediate and dazed quality than Irene's narrative, for instance. The narrator additionally frequently included long descriptions of the object, which could almost constitute a whole new sentence, which I have excluded as Gee (1991) suggests, even where I feel it adds to the meaning of the narrative. So this narrator's Main line text was complex to analyse at a linguistic level. The linguistic and thematic patterning of this Main line material is fascinating. The Main line text starts with Part 1: (Ambivalence); Strophe 1: (Running away); Stanza 1: (Running away and returning) to Part 2: (Running away and returning); Strophe 2: (Co-dependence); Stanza 3: (Love/hate relationship) to Part 3: (Intergenerational abandonment); Strophe 3: (Giving my child up); Stanza 4: (Guilt and

longing) to Part 5: (All my fault); Strophe 5: (Conflict over child); Stanza 6: (Fear of abandonment by the child). The non-linearity of the plot is not only due to the excluded cyclical repetitions of leave-return, but due to the emotional enmeshment between the narrator and her partner, and the narrator and her son, which presents at linguistic level. As I have noted, the disclosures of leave-return, leave-return cycles manifest at linguistic level by appearing and disappearing. The emotional enmeshment can be observed most clearly at heading level; headings (representing themes) melt or fuse into each other, and equally apply to both partner and child at different moments in the text. The narrative opens with the theme of ambivalence about vacillations; instability, the narrator's desperate quest to be loved. Right from the outset, she tells us that she runs away from some situations when she becomes afraid. Yet she is drawn to situations that are likely to make her afraid, and this is due to her own abusive past (repetition compulsion). She does not feel she deserves any better. When she does stay with her partner, it is a relationship of co-dependence. This co-dependence elicits complex feelings of love (dependence) and resentment (about being "owned" or "possessed" and so feeling demeaned and helpless), but are typical of disorganised attachment patterns such as this narrator is clearly displaying. These kinds of patterns of attachment are typically characterised by an inability to regulate emotional closeness – a running towards intimacy, and then a fearful backing away. So what the narrator is doing in a concrete way represents her emotional/attachment life. This is transferred onto her child, whom she abandons, then returns to again.

Part 3 is where the narrative deepens. At linguistic level, the lie told by the cousin (about the narrator's mother not abandoning her), who continues not to believe the experiences of the narrator, cannot be identified. What is interesting, knowing the narrator's history, is that the story she tells in Part 3, Strophe 3, Stanza 4, is not the story of the narrator's son, but the story of the narrator. This is the beginning of the past and present merging. In Part 4, Strophe 4, Stanza 5, she says: "The kid really loved him. **Even though I stayed in an abusive home**". Note here how she slips from "the kid" to her own abusive home. I would argue that she fears a repetition of her own childhood despite her enacting parts of it (hence her distress when abandoning her child, the point where the narrative deepens). The disconnected Stanza 6 of the final Part centres entirely around self-blame (for all that has gone wrong in her life – see excluded subordinate clauses in the full narrative) and abandonment, and her fear of the loss of her child, just as her own mother abandoned her. The past and the present have fully merged (see Payne et al., 2004).

It is interesting that the first Part (Strophe 1, Stanza 1) and the final Part are characterised by

the narrator as psychological subject, suggesting she has the most to say about the themes coming up in these parts, pointing to their importance in the narrative. Part 1 introduces the theme of leave-return, and Part 5 centers around a related or subtheme, abandonment.

In Part 1, Strophe 1, Stanza 2, the psychological subject is initially the owner of the children's home in Blouberg, then shifts to the cousin in Joburg, first the younger sister, then the older sister, and then to her (ex)partner. At this point in the narrative, all the psychological subjects are intricately involved in the narrator's intention to escape her abusive situation.

In Part 2 there is an intermingling of psychological subjects: the narrator and her (ex) partner, suggestive of their enmeshed relationship/leave-return relationship. But the perpetrator's voice is predominant, and the narrator's point of view is disregarded (e.g. "when I actually confront him about these things, he says that he didn't say it"). The intervening voice of the narrator is dependent, helpless, captive, tragic, including such statements as: "I still love him. I did come back, and within two weeks it started again. I won't be free. I'll start getting scared. So he's got also a temper problem, I think. I always pray and hope that he'll change, but he'll never change. I didn't finally decide, enough, to really say".

Part 3 is where a rupture in the narrative occurs; where the deepening in the narrative takes place. At a structural level, this is not reflected in the perfect alternation between the narrator and her cousin in terms of who constitutes the psychological subject. However, the content of the perspectives of these psychological subjects reflect the deep-seated reasons for Felicia's repetition compulsion, acted out here in her relationship with her child.

Like Part 1, Part 5 is entirely from the perspective of the narrator. In this case, an anxious, angry narrator, who fears losing her child. Although she enacts it, it is also her greatest fear. The tip of the funnel, from the perspective of this psychological subject is: *You are trying to make my child forget me*, just like the narrator was herself as a child.

The foci in this narrative are relatively repetitive until Part 3 where the first deepening or fracturing of the narrative takes place, and they center around running away and returning, asking for *help*, and returning. In Part 2, the focus is on the consequences of the narrator returning, for example, foci include typical IPV phenomena: *Would argue, phone calls heard you speaking; start getting angry; lying; never stop; never change*. In Part 3 the theme of leaving (and then returning) continues, but the narrator's reactions include sadness and grief, she cries and feels "*emotional*". She feels guilt because her cousin says (*Your mother*) *never*

*left you, (but your mother) couldn't afford you* (although this is not factually true). The foci in Part 4 center around a repeated return of another kind, the return to her partner, and once again, the catastrophic consequences thereof (typical foci include: *Back again, argue again, needs space, those women, (and I) must go on the street; (with) the child*. In the final Part, the focus is on the heart of the narrative, the angry terror of abandonment, and the foci are the other women, and the child she fears losing (*with him permanently; once a month; child forget me; new women; different women*).

To conclude this section, I would like to argue that although Gee's (1991) model is an excellent tool with which to illustrate linguistic fracturing, its focus is less on semantics, or on the interpretation of the subjective meaning of the fracturing; the phenomenology of what lies beneath this broken narrative. This is quite appropriate since this model focuses on narrative form rather than content. Nonetheless, I would like to take a moment to draw the reader's attention to something that could supplement the findings facilitated by Gee's (1991) model. If the reader looks closely at these narratives, at a semantic level; at a phenomenological level, there is some consistency: coherence. There are overarching trauma- and shame-related themes that run throughout the narratives – that remain intact - despite their linguistic fracturing. They are, in order of narratives, 1) shame/self-blame and deservedness; 2) truth/lies and bearing witness; 3) shame, humiliation and dissociation; 4) the concealed, shame-based self, including amnesiac-like disorientation of place and time; and 5) patterns of cyclical leave-return reflecting perpetrator-instilled abandonment terror, including disorientation of time. Although language remains representative – narrative structure mirrors narrative content (these narratives are fractured, and represent fractured selves) – there is also the intriguing possibility of a disjuncture between form and content; and that thematic coherence and narrative fracturing can co-exist.

I would argue that from these five narratives we can detect both a linguistic and semantic pattern. At linguistic level, the narrators produce non-linear, fractured narratives through the use of repetition, connecting words such as “and”, “then” and “because” that do not fulfil linking functions, ellipses, incomplete “sentences”, and non-sensical phrases. These linguistic features happen at particularly significant or painful parts of the narrative. There is also evidence of both “macro-fracturing” and “micro-fracturing” in some of the narratives. In terms of the thematic coherence or consistency I referred to above, the theme of shame is pervasive in at least two of the narratives (Irene and Chantal), and is a central feature in a third narrative (Felicia). Four dimensions of chronic trauma also emerge from the narratives –

firstly, the related themes of disorganised attachment patterns, and abandonment terror; secondly, the issue of credibility/being believed and the need for survivors to have someone bear witness to their trauma, and thirdly, the belief in the perpetrator-defined identity – the self as “bad” and as to blame, which overlaps with shame. As I have emphasised, most trauma survivors have difficulty believing that the traumas they experienced occurred in reality – this is often associated with loss of traumatic memory and dissociation (Putnam, 1989). Fourthly, there is evidence of significant disorientation; disruptions in space and time which occur when trauma memories are encoded without an adequate spatio-temporal frame to organise them (Payne et al., 2004). Consequently, trauma memories created when stressed are likely to be disjointed and fragmented, lack spatial and temporal contexts and so produce deficits in episodic memory (Payne et al., 2004). These dimensions are either associated with, or constitute diagnostic criteria of chronic trauma syndromes such as chronic PTSD and DESNOS, and overlap with shame themes in the narratives analysed above (e.g. particularly with Irene and Chantal, but also with Felicia and her shameful perpetrator-defined identity, and to some extent Linda through her self-blame). Thus, I would suggest that there is a significant overlap or co-occurrence between exposure to chronic trauma, and trauma-related clinical symptoms, including shame, which occur in narratives, which without exception, show prominent linguistic fracturing.

### **Urgency to Talk vs. Narrative Compression**

We do not talk about our inner meaning using conversation as an instrument, but rather we exist in it (Ferenczi as cited in Orange, 2011, p. 103).

An important goal of narrative research is that subordinated individuals are given a voice – there is an urgency to speak, to be heard, to develop collective narratives and to create public dialogue (Chase, 2011). The trauma narratives of my participants are more than individual stories: they link to a collective story of a marginalised social group (Chase, 2011). It is important when such narrativisation takes place – the narrative will vary in structure and content according to the interviewee’s proximity to the traumatic event (Chase, 2011). Not much time had elapsed since the women I interviewed had left their abusive partners (a few months at most), so many women were still in a crisis situation.

Due to this proximity, there was an urgency to share traumatic experiences. In many instances, these women's stories about their traumatic experiences persisted throughout the interview to its conclusion, and questions not directly relevant to these experiences were largely left unanswered. Among the women whose narratives were the most incoherent, it seemed like the urgency to talk about what had happened to them was most acute. It is likely that women who had the most incoherent and fragmented narratives experienced their traumas most intensely (perhaps due to its proximity), and consequently felt more pressure to talk. It is likely, in such instances, that the plot would be "lost", because the interview would consist of pieces or fragments of urgently expressed trauma, which may bear little relation to one another.

It is interesting that the women who felt the most pressing need to talk about their traumatic experiences tended to rush out of the interview room after the interview, as if wanting to escape what had been disclosed. These women, as I noted in the methods section, when encountering me on occasion after the interview, avoided eye-contact with me, turned their faces away from me, and did not greet me or engage in conversation with me as they had prior to the interviews. This kind of avoidance is an expression of shame associated with over-disclosure. I do not intend to use the term "over-disclosure" in a judgmental way. What I mean, is that for some, but not all, people who have experience significant trauma, there is an urgency to talk incessantly and without discretion about their experiences because the pressure of trauma-related emotions is so great (Payne et al., 2004).

The apparent opposite of the urgency to talk is silence. Silences suggest the presence of the unspeakable, the incommunicable – these untellable events make the narrative skewed, erratic, interrupted and compressed (Scarry, 1985; Simon, 2008). This is why traumatic memory is so often encoded in bodily form (Simon, 2008). Van der Kolk (1994) suggests that traumatic memories are not semantic memories at all but somatosensory memory fragments related to overwhelming previous experiences. Charon (2008) argues that the body is the portal that allows the doctor into the psyche of the patient; our bodies are our humanity, they house our selves – our bodies are constantly telling, if only the telling is heard. Recent work on autobiographical narratives have focused on and emphasised the body – Descartes' belief in the separation of body from mind has been long left behind (Charon, 2006). The body attests to the singularity of the self, it is corporeal evidence of the individuality, the authenticity of the experience of the self (Charon, 2006). Charon (2006) argues that to fail to recognise and acknowledge the body is to fail to recognise and acknowledge the self,

including its traumatic experience. As noted by Hartman (as cited in Schnell, 2008, p. 169), “Perhaps the only way to overcome a traumatic severance of body and mind is to come back to mind through the body. We recall how the voice dries up, and chokes its way out again”.

Chaos narratives are always embodied and always beyond speech (Frank, 1995). The chaotic body is “contingent, nomadic, lacking desire, and dissociated” (Frank, 1995, p. 104). Chaos narratives are characterised by an immediacy, by a self-interrupted “and then, and then” present tense style (see Narrative 2) and are told without being able to reflect on the self; these narratives are necessarily lived through the body (Frank, 1995). Scarry’s (1985) work on the body in pain also has important implications for this study. Like Frank (1995), one of her main points is that pain resists, if not destroys, objectification in language (Scarry, 1985). This is what Frank (1995, p. 109) has called the “claustrophobic terror of muteness”. Scarry (1985) argues that pain destroys or negates the contents of consciousness; that it obliterates all psychological content, and so renders the subject silent (Scarry, 1985). This means that the self, which would be expressed and projected through language, disintegrates (Scarry, 1985), much like the language and selves captured in the first narrative which follows.

All bodily manifestations of shame are designed to conceal the self; make the self smaller, less significant, less conspicuous. M. Lewis (1992) calls such bodily indicators of shame, the self “imploding”, which is associated with the body curved in on itself, head bowed and eyes closed (M. Lewis, 1992). As the reader may remember, Retzinger (1987, p. 171) states that the external bodily expressions of shame may also include: 1) the hand covering all or certain parts of the face; 2) turning in, biting, or licking the lips, or biting the tongue; 3) gaze avoidance, eyes lowered or glancing; 4) blushing; 5) forehead wrinkled; and 6) false smiling and masking behaviours. Nonverbal markers of shame also include shame phrases (e.g. It was sore, it hurt; I am nothing; I am dirty), repetitious speech, and fragmented speech (Retzinger, 1987).

Five of the 19 interviews contained short life narratives. I present three here. It is interesting that in the shorter narratives, women expressed more emotion through their bodies. It is as if in the absence of words, the body expressed what could not be spoken in a more elaborate or detailed fashion. What is striking in the narrative which follows is not only its surprising brevity, but that the interviewee sat hunched up with her hands over her eyes, crying, throughout the interview. Sometimes she pulled her shirt over her face, gestures typical of shame (making the body smaller as if to disappear). Sadness is an important indicator of by-passed shame (H. B. Lewis, 1971). In addition, her sentences were punctuated by long

silences, as if what she was talking about was unspeakable to her. The narrative below is all she could manage to tell me (in verbal form) about her experience of IPV:

Amelia: Can you tell me a bit about that relationship?

Lilly: He used to hit me... And when he hit me, I've got the other child, so the other child is not his child... So I've got two children. So when he hit me...my child is the first child that is not his child, so he asked, why you hit my mom, and then he started to hit him also... And then he got hold of things and hit me... The last time I got the feeling that I must come here, it was the time he liked to point at me with a big knife, so I said he has almost killed me now and then I left, because I was staying at his home with him.

In the next short narrative, it is clear that the speaker has “lost the plot”. The actual narrative has no storyline. It is a random collection of disconnected traumatic memories, interspersed with nonsensical phrases like “Hy loop al in die rondte in die huis” (*he walks in circles all round the house*), a phrase which is repeated in different form (“Dan draai hy in die rondte”/*he turns round and round*) later in the short narrative. What makes her narrative interesting is its amorphousness, its lack of structure, and the extreme anxiety and shame that she expressed at a bodily level while she was telling me her story. She was also extremely shy, which is characteristic of by-passed shame; something that was not common among other women, who tended to be outspoken (H. B. Lewis, 1971). She was rocking back and forth, curled forward, biting the sleeves of her shirt, looking down and avoiding eye contact with me, and periodically covering her mouth with her hands, which made her already soft voice inaudible at times. She whispered her story, as if she did not want it to be heard, and stammered and paused and hesitated throughout her short narrative. These are all manifestations of shame (H. B. Lewis, 1971; Retzinger, 1998). What she was unable to say, her body was communicating for her. The narrative follows below:

Amelia: Vertel vir my ‘n bietjie van die verhouding waarin jy was, en hoekom jy na die sentrum toe gekom het. [*Tell me a little bit about the relationship you were in, and why you came to the Centre*].

Annabelle: My boyfriend het eintlik beginne drugs gebruik, die Tik, hy raak hy deurmekaar, hy sien goeters en hoor goeters wat nie is nie. Hy loop al in die rondte in die huis. Ek sit in die huis maar...(inaudible). Senoumaar ek gaan na die winkel dan se hy sommer mans kyk vir my of ek kyk vir hulle, maar dan is dit nie so nie. Dan draai hy in die rondte, en ek moet in die huis sit dan hoor hy mense buite dan maak dit hom kwaad, dan kom hy sommer kwaad in dan

klap hy my. Hy se ek lieg altyd vir hom dan is dit nie so nie. Dit is (inaudible) tyd wat dit nou so aangaan (inaudible) na ander mense toe (inaudible) dan kan die mense niks maak of doen nie. Een aand was ek nog pregnant met hom, dit was in die nag in gewees, maar dit was rustig gewees, toe kom haal hy vir my uit die mense se huis uit, hy het so ‘n dun rooi pypie gehad, toe klap hy my daarmee. Toe ek my ander een gedra het van twee jaar oud.

*[My boyfriend actually started using drugs, Tik (crystal methamphetamine), he got confused, he saw things and heard things that weren't there. He walks in circles all around the house. I sit in the house but...(inaudible). Imagine I go to the shop then he will say men are looking at me or I am looking at them, and then it isn't so. Then he turns round and round, and I must sit in the house and he hears people outside and it makes him angry, and then he comes in angry and hits me. He says I always lie to him and then it isn't so. It is (inaudible) time that it is going on like this (inaudible) going to other people (inaudible) then there is nothing that people can do. One night I was still pregnant with him, it was in the night, but it was calm, then he came to fetch me from other people's house, he had a thin red pipe, and he hit me with it. When I was pregnant with my other one of two years old.]*

In this final short narrative, I explore the notion of the fragmented mother – the substitute mother, the real mother and the ideal mother. I include this narrative because it is an extremely striking example of a particular form of by-passed shame, expressed at bodily level. Specifically, the most disturbing part of this narrative is that Chantal, the same woman who had suffered the gang rape in the lengthier narrative above, smiled and laughed throughout the narrative that follows. She sat close to me, straight-backed, leaned into me, making the interview both emotionally and physically intimate. Her body language communicated the opposite of shame, yet I knew she felt significant shame. This was both defensive, and she had no means of negotiating boundaries, so I found her emotional material immensely contagious. Whereas shame conceals and tries to be contained by the imploding body, her body reached out to me, laughingly. This discrepancy between her mood and demeanour, and the trauma she had experienced, was a function of suppression and denial, but I could feel the weight of the experience she dismissed with a smile or laugh transferred onto me – the false smiling and masking behaviours referred to by Retzinger (1987). I felt that there had just been too much trauma in her short life, and that confronting it would destroy her. Perhaps her denial and suppression in such circumstances was not only adaptive, but also resilient? Whether that is the case or not, I felt burdened and weighed down by her avoidance for days afterwards, leaving me feeling depleted and depressed, while as Chantal says “ek lag

vir als” (“*everything makes me laugh*”). In this narrative, I will indicate material about the substitute mother by underlining the relevant text, text about the real mother is in bold print, and the idealised mother is indicated by the use of bold italics. The translation, as is the convention in this thesis, is in italics. What is evident from presenting the short narrative this way, is that the narrator is searching for a stable maternal figure, but the tragedy is that she cannot find this in her real mother, so she turns to substitutes and idealised versions of her. A predominant part of the (underlined) text is dedicated to the stable substitute maternal figure, suggesting that in reality, she plays the most significant caregiving role in her life; that it is she who cares for her the most frequently, and consistently. She is the most “real” and the most immediate. Yet despite this, the narrator continues to search for her real mother in the narrative. This real mother is no mother at all, the narrator admits she hardly knows her (“My ma ken ek ook nie eintlik rêrig nie”/My mother I also don’t really know), but the further her mother “swerwe” (*travels aimlessly*), the more her daughter longs for her and feels compelled to find her. The narrator becomes increasingly preoccupied about her real mother’s well-being towards the end of the narrative; expressing enormous worry about her; where she sleeps, where she eats, as if there is a real relationship between them. The real mother is slippery, forever disappearing, ungraspable, while her daughter longs for emotional connection which she cannot express. Her ideal mother, the one who takes up the least space in the narrative, can be found; she is traceable, tangible: she goes to work every day. It is that mother – the imaginary, illusory, longed for mother of whom she is the only cherished child - whom the narrator misses so terribly. It is a tragic narrative, filled with loss and abandonment-related shame, which the narrator attempts to dismiss with her bizarrely incongruent bodily reactions.

“Daar was dae wat daar nooit 'n stukkie brood in die huis was nie. Daar was een vrou, sy is 26 en haar man is 28, hulle tweetjies is getroud en hulle het drie kinders, maar hulle is nog 'n jong paartjie, en was dit nie vir daai vrou nie wat in die yard is nie, dan weet ek nie. Sy het vir my altyd gesê ek is soos 'n kind vir haar. Dis omdat ek mos nie rêrig eintlik my ma... en my pa is nou vier jaar oorlede. Ek het maar net vir 'n kort tydjie my pa geken, en toe het hulle hom ook dood gesteek en hy's ook maar net weg. **En my ma is nie al die tyd op Worcester nie. My ma ken ek ook nie eintlik rêrig nie: my ma swerwe ook maar dan hier en dan daar.** Ja, was dit nou nie vir haar nie, dan het ek nooit...daar was dae wat ek honger gelê het...maar was dit nie vir haar nie, weet ek nie. Sy het elke dag vir my... sy het tot vir my klere en toiletries altyd gekoop, tot skoene het sy ook altyd vir my gekoop. Sy was soos 'n ma vir my, want ek het mos nou by my ouma al die tyd gebly. Nou sy was net soos 'n ma en haar

man was soos 'n pa vir my, want my pa is mos nou nie meer daar nie. Ek weier om weer terug te gaan Worcester toe, regtigwaar. Want ek kan nie sê ek gaan na my ma toe nie, **want ek is bekommerd oor my ma.** Hier's baie aande wanneer ek ook nie...dan sê ek vir \*\* of vir Chriska...dan is daar baie aande wat ek nie kan slaap nie want dan is my gedagte nou net by my ma: **wat eet sy elke dag? Een ding van my ma, sy het nie 'n regte blyplek nie, maar sy's elke dag in haar werk, al moet sy ook sonder 'n stukkie brood gaan werk. Nou dis waarom ek baie bekommerd is, wat eet my ma elke dag? Waar slaap sy elke dag? Is nie lekker om elke dag, dan vanaand by die een en dan vanaand by daai een nie.** Die mense is snaaks. Die mense is baie snaaks. Ek is baie geworry oor my ma want vir my voel dit net, ek kan nie lekker lewe die kant en dan is ek nie geworried van haar daai kant nie, as ek weet dat **my ma nie 'n blyplek het daai kant nie.** Ek sê baie \*\* nie elke keer van my ma nie, maar ek kan nie help nie. Dit hennervir my. **Ek mis my ma,** en ek is al kind van my ma - my ma het nie nog kinders nie”.

#### Translation

*“There were days when there was not a morsel of bread in the house. There was one woman, she is 26 and her husband is 28, the two of them are married and they have three children, but they are still a young couple, and if it wasn't for that woman who is in the yard, then I don't know. She always told me that I was like a child to her. It's because I actually didn't really... my mother...and my father died four years ago. I only knew my father for a short while, and then they stabbed him and he died and he was also just gone. And my mother is not in Worcester all the time. My mother I also don't really know: my mother also wanders about, now here, then there. Yes, if it wasn't for her, then I would never...there were days that I lay hungry...but if it wasn't for her, I don't know. Every day she...she even always bought me clothes and toiletries, even shoes she always bought me. She was like a mother to me, because I stayed with my granny all the time, not so? Now she was just like a mother and her husband was like a father to me, because my father isn't there anymore, not so? I refuse to go back to Worcester, really. Because I cannot say that I'm going to my mother, because I am worried about my mother. There are many evenings when I also don't...then I say to \*\* or Chriska...then there are evenings when I cannot sleep because then my thoughts are just with my mother: what does she eat every day? One thing about my mother, she doesn't have a real place to stay, but she's at her work every day, even if she has to go and work without a piece of bread. Now that's why I am very worried, what does my mother eat every day? Where does she sleep every day? It's not nice, every day, this night with this one, the*

*next night with another one. People are funny. People are very funny. I'm very worried about my mother because it just feels to me, I cannot enjoy life this side and then I'm worried about her on that side, if I don't know that **my mother has a place to stay that side**. I don't often say \*\* every time about my mother, but I cannot help it. It troubles me. **I miss my mother**, and I am my mother's only child – my mother has no other children”.*

## Conclusion

The past three chapters have been dedicated to presenting the themes emerging from the interviews and the structure and fragmentation of selected trauma narratives. In the concluding chapter, the main findings will be reviewed, particularly the complex and surprising shame-related findings, and self-reflexivity. The South African socio-cultural setting will be considered, and the limitations and recommendations for future research and practice will be presented.

## CHAPTER 10

### Review of Findings and Conclusions

I began this thesis with a review of exposure to chronic violence, self and memory fragmentation and IPV, focusing on South Africa in chapter 1. I have located the study in terms of a particularly psychological shame theory (phenomenology), and pointed to specific features of other theories which were of relevance in the context of my study. I have drawn distinctions between shame and related (self-conscious) emotions and associated constructs to provide the reader with a complete and detailed understanding of shame, which, as a complex construct, is not effortlessly defined. In my penultimate literature review chapter I focused on shame and culture, paying particular attention to the international literature on cultures of honour and shame which so closely correspond with poor, urban, patriarchal South African communities. I also describe guilt and shame as they manifest in individualistic and collectivistic cultures, and universalist and cultural understandings of shame. In my final literature review chapter, I investigate the relationships between exposure to trauma, shame and a range of psychopathologies. I then describe my method, focusing on my choice of analytic method, narrative analysis, from a social constructivist point of view.

Chapter 7 begins by providing a background to my establishment of a relationship with my interviewees, and describes the rapport-building process with them. Then I use categorical content analysis to describe my participants' accounts of their traumatic experiences, reactions, and coping mechanisms. The next chapter is clearly located within phenomenological theory and uses a social constructivist narrative approach to the informal narrative analysis conducted in one part of this chapter (the organisational split self). Using categorical content analysis, it describes the participants' conflicting descriptions of themselves, indicative of a split between the authentic self and the false self; a typical post-traumatic response. I analyse this split at individual, organisational and cultural levels. It is this theoretically eclectic chapter that introduces the final, most complex results chapter. Chapter 9 presents a categorical form analysis that expands, deepens and formalises the narrative analysis used in chapter 8. This chapter includes a more complex linguistic analysis of trauma and/or shame narratives to demonstrate the relationship between narrative and

psychic fragmentation. It also explores the role played by the body in communicating the unspeakable; the trauma or shame which is too unbearable to utter.

My detailed plan for this final chapter is to describe the findings emerging from the categorical content analysis of 19 whole interviews (chapter 7), then follow with a description of the results of the trauma and shame-based split from 10 narratives, based on categorical content analysis as well as a social constructivist approach to narrative analysis in chapter 8. I conclude with an in-depth, complex and comprehensive formal linguistic analysis of 5 long, complex trauma and shame narratives, and an informal narrative analysis of 3 short, compressed trauma/shame narratives.

The chapters have been ordered in this way for a reason. As I have previously noted, I begin with a broad, descriptive account of a wide array of women's trauma-related experiences to introduce the reader to the data. I then narrow my focus to one particular, highly significant theme, the split self, which emerged from this initial categorical content analysis, and focus my next chapter on this dimension. I conclude with the most complex, most intricate, and most detailed data analysis, which, once again, is a sub-theme of the split self. I use a highly formalised categorical form analysis/linguistic analysis to demonstrate the association between psychic and linguistic fragmentation. All results are discussed in the context of the theory and the empirical literature presented in the extensive literature review chapters. Finally, I discuss the limitations to my study, and conclude by presenting the reader with recommendations for future research.

## **Trauma and Shame Related Findings: Categorical Content Analysis**

### **Exposure to Trauma**

IPV is one of the leading causes of morbidity and mortality for South African women (Gass et al., 2010). All but one of my participants reported a history of physical violence perpetrated by her intimate partner. This included slapping, kicking, beating with implements and single or multiple stabbings. Unlike the South African literature indicates (Abrahams et al., 2010) guns were not used in the violence directed against the women I interviewed. Five women reported experiencing sexual violence at the hands of their perpetrators. These women

described regular demands for sex, always against their will. Rape and sexual coercion are rife in South Africa, and high-risk ages are between 17 and 48 years, which is similar to the age range among my participants (Jewkes & Abrahams, 2002). It is important to note that non-consensual sex (sex agreed upon after blackmail, threats, trickery or pleading) occurring within marriages or dating relationships – due to self-blame or shame – is often under-reported (Jewkes & Abrahams, 2002), so it is possible that this kind of sexual behaviour occurred more often than was disclosed. Verbal abuse and threats, sexual humiliation, jealous and controlling behaviour, and financial deprivation – all types of emotional abuse – were also reported by the vast majority of my participants, and as noted by Dunkle, Jewkes, Brown, Yoshihama et al. (2004) constitutes part of a more general pattern of dominant and controlling behaviour. Emotional abuse was often cited by women as the most painful part of the abusive relationship.

In keeping with the literature, transgenerational trauma was common in my participants. The majority of my participants were directly exposed to physical violence, witnessed physical violence between caregivers, and/or were directly exposed to sexual and emotional violence as children. Child abuse is a significant risk factor for IPV (Dunkle, Jewkes, Brown, Yoshihama et al., 2004). Typically childhood exposure was more traumatic for the women I interviewed than the adult-onset IPV. Furthermore, similar to the majority of research findings in the area, the women I interviewed who had suffered both child abuse and adult onset abuse tended to experience greater shame and have poorer mental health outcomes than those who had only endured adult-onset abuse (Cloitre et al., 2009; Kim, Talbot, & Cicchetti, 2009). Andrews (1998) found that women who had experienced childhood abuse felt pathological guilt, and had suicidal plans and actions. In Andrew's (1998) study, abusive experiences from early childhood contributed to a tendency to feel both shame and pathological guilt in adulthood, and shame played a mediating role in the association between early abuse and depression.

Violent or abusive caregivers (often because they have histories of abuse themselves and have complex attachment patterns) produce (often lifelong) disorganised, unpredictable attachment behaviour in their children (De Zulueta, 2011). Disorganised attachment patterns were evident in both the women and children I encountered during my research, and during the time I spent at the Centre, there were movements towards and away from emotional intimacy with me. Lutwak, Panish and Ferrari (2003) found that individuals who tend towards self-derogating thoughts, and those who tend to blame both the self and others, fear intimacy and create

conditions that are not conducive to its experience. Although not measured in my study, this pattern of attachment has been associated with BPD and dissociative disorders in adulthood (De Zulueta, 2011).

### **Post-traumatic Reactions and Psychopathology**

The feelings women described as being most difficult for them to cope with were helplessness, fear, nightmares, flashbacks, and ambivalence towards their perpetrators. Feelings towards the perpetrators ranged (in order of frequency) from fear, numbness, anger, and hate, to love. Because of the traumas these women had been through, they also felt a range of negative feelings towards others in general, including mistrust, fear, anger and hate. Women openly expressed finding it difficult to trust others, and that they often felt suspicious about others' intentions towards them, a feeling which sometimes bordered on paranoia. But the more striking emotion reported by women was anger (and hate), which were important features in their lives. However, there was also a grave reluctance to talk about anger; there was far more emotional investment in the discourse of "forgive and forget", which may have to do with the high level of religiosity among these participants. But their rage was real, it was palpable, even when turned inward, despite the explicit investment in this discourse. Despite their reluctance to engage at any length or in depth with their anger, anger is a natural response to intense injury to the self when exposed to repeated shaming experiences (Mills, 2005). The literature tells us that the shame-rage which develops in abusive situations results in aggression targeting the individual who induced abuse and associated shame, or sometimes, it is displaced onto safer targets (Mills, 2005). I wondered whether that could be the reason why there was so much conflict between the women living in the shelter; why there was so much anger and aggression between them. Over time, this shame-rage cycle begins to foster a hostile interpersonal style, which is characterised by distrust of others, hostile attributions, and hostile solutions to interpersonal problems, all features of these women's lives (Mills, 2005). However, anger also has an adaptive function. Because anger is a potent, authoritative emotion, it counteracts some of the helplessness and paralysis of shame, giving the individual back their sense of power and agency, although it is less effective in this regard when turned inward against the self (Tangney & Dearing, 2002).

A number of women described symptoms of depression (persistent sadness/depressed mood, loss of interest in personal appearance, and/or excessive sleeping/hypersomnia), generalised anxiety, a history of suicidality or current suicidal thoughts or actions and/or dissociation. Some women also reported stress-related illnesses and somatic complaints, including heart conditions, high blood pressure, nausea, headaches and infections such as pneumonia. Somatic complaints, particularly complaints for which no medical explanation could be found, have repeatedly been associated with exposure to trauma (Van der Kolk et al., 1996). My findings are consistent with the literature on PTSD and Complex PTSD, although since my study was a small-scale qualitative study, the association between IPV and these clinical outcomes were not measured. However, shame was an important feature in both chronic trauma exposure and psychopathology in these participants. It is clear that fear and anxiety was a predominant feature in the lives of these women. They spoke freely and frequently about persistent feelings of fear. PTSD is generally understood as an anxiety disorder in which fear is the most dominant emotion (Lee et al., 2001). Similarly, anxiety is a central emotion in shame (Gilbert, 1998). Shame and guilt play prominent roles in the development and maintenance of PTSD (Lee et al., 2001).

PTSD and depression frequently co-occur – anxiety and depression are common responses to trauma (H. B. Lewis, 1987b; Kaminer & Eagle, 2010). Women tend to be more vulnerable to PTSD, anxiety and depression, across cultures, even when the severity of the trauma is taken into account (Seedat, Stein, & Carey, 2005; Suliman et al., 2009). The literature tells us that women who were sexually abused as children are in the highest risk group for depression (Feiring et al., 1996, 2002), and a number of my participants had been abused in this way. The chronic hyperarousal and intrusive memories of post-traumatic stress amplify the vegetative symptoms of depression, leading to insomnia, nightmares, and somatic complaints, all of which were reported by my participants (Herman, 1997). The numbing of initiative associated with chronic trauma combines with the lethargy and helplessness of depression, symptoms which were both frequently reported by my participants (particularly helplessness), and clearly visible to the observer (particularly lethargy) (Herman, 1997). The pervasiveness of depression is perhaps accountable for the suicidality and the high suicide rate among survivors of IPV, as was evident in my participants (the frequently reported histories of suicidality and suicide attempts) (Herman, 1997).

One of the most dramatic and challenging aspects of post-traumatic shame is its links with dissociation (Talbot et al., 2004). Women frequently complained of feeling numb, like they

were “living in a bubble”, that they felt emotionally deadened and as if they were watching their lives unfold before them from a distance. It is important to note the increased likelihood of dissociative disorders in patients with sexual abuse histories, and as I have noted, a number of my participants reported histories of this kind of abuse (Ford & Courtois, 2009; Putnam, 1989). The dissociation evident in my participants is concerning yet unsurprising. It is a central aspect of Complex PTSD, which, as commented on earlier, although not measured, is likely to be highly prevalent amongst the women I interviewed. One of the most common outcomes of chronic trauma exposure is Complex PTSD (Kaminer & Eagle, 2010). This disorder involves multiple affective and interpersonal domains in functioning, including among other symptoms, impaired self-regulatory capacities, anger and aggression, avoidant behaviours, and significantly, as noted, dissociative symptoms (Cloitre et al., 2009; Kaminer & Eagle, 2010). This was also true for PTSD: According to Van der Kolk et al., (1996), PTSD rarely occurs in isolation. In Van der Kolk et al.’s (1996) study, participants who met criteria for current PTSD had significantly higher levels of dissociation, somatisation and affect dysregulation (all of which were highly interrelated) than those who did not meet criteria for lifetime PTSD, who in turn had fewer symptoms than those who did not meet criteria for PTSD at all. Again, although not measured, my participants displayed considerable dissociation and somatisation.

Disorganised attachment patterns have been associated with dissociation and the ability to mentalise (make sense of one’s own and other’s mental states) (Fonagy, 2011; Schimmenti, 2012; Steele, 2011). As described in the background to my study, the over-disclosure, and then shame-filled avoidance of me after the interviews I attributed to transgenerational disorganised attachment patterns. Research has shown that rejection by the primary attachment figure, or his/her having a disorganised attachment style him/herself are risk factors for dissociation and a shame-prone emotional style (Fonagy, 2011; Mills, 2005). Certain types of family environments also contribute to dispositional shame, for example, parental over-control or coercive interactional styles (Mills, 2005). Abusive and abandoning family environments encourage the development of disorientated, conflicted, disorganised attachment patterns that are remarkably stable from childhood into adulthood (Fonagy, 2011). Mothers experiencing IPV are likely to be in a fearful and overwhelmed state, and may react to the child with either projective identification or projection – the child is likely to be perceived as either helpless and vulnerable like the mother or like the abusive perpetrator, and may be treated (and behave) accordingly (Levendosky, Bogat, & Huth-Bocks, 2011). These

authors suggest that the trauma of IPV is likely to cause dissociation which impairs the mother's cognitive capacities through intrusions of disorganisation, disorientation and confusion, impeding her parenting and making it challenging for her to focus on her child's needs and mental states. These kinds of relationships may also be characterised by role-reversal and emotional loss of boundaries and identity fusion, which contributes to the transgenerational transmission of violence (Levendosky et al., 2011).

As noted earlier, many women reported that the experience of emotional abuse was the most difficult for them. Emotional abuse has been identified as an important determinant of shame-related pathological outcomes, especially PTSD, anxiety and depression (Cloitre et al., 2009; Street & Arias, 2001; Webb et al., 2007). A number of women described their worst experience as involving situations where their children witnessed their abuse. In all reported cases, women's guilt enabled them to leave the abusive situation. This leads me to important differences between shame and guilt – shame which debilitates, and guilt which motivates amendment of the specific guilt-inducing situation. Because the self is not debilitated with guilt, and because it involves focusing on specific and controllable behaviours, it is more likely to be accompanied by reparative action, hence the demonstrated association between guilt and prosocial feelings and behaviour (H. B. Lewis, 1971; Lazarus, 1991; Tangney, 1991). Shame incapacitates and is accompanied by a wish to die or disappear; it is an intense negative state in which the whole self is seen as defective, flawed, inferior; a global perception that results in an interruption of current behaviour, confusion in thought, helplessness and speechlessness; it is comparative to the self “imploding”, accompanied by the body curved in on itself, head bowed and eyes closed (M. Lewis, 1992). Shame is an involuntary, devastating self-focused emotion that has severely negative effects on psychological outcomes and on interpersonal behaviour (Tangney & Dearing, 2002). Thus, it was guilt that stimulated the women who could not bear seeing their children witness their abuse, to leave. They were not incapacitated, and were able to take corrective action.

### **Post-traumatic Changes and Coping Mechanisms**

Most of my participants described post-traumatic changes in their feelings about themselves. Changes were either positive or negative, although some women experienced both positive and negative changes. Negative changes were described as shame reactions, such as feeling

“dirty”, “worthless”, like “nothing”, as never being able to “achieve anything”, while positive changes included feeling less cut off or dissociated, and feeling more confident about physical appearance, decreased anger, and increased empathy and perspective taking. These findings are congruent with the literature that demonstrates that although the majority of outcomes associated with trauma are negative, there may also be some positive outcomes associated with such exposure (Kaminer & Eagle, 2010; Kleim & Ehlers, 2009). It is possible that women’s increased confidence in their physical appearance is due to no longer experiencing abuse, particularly sexual humiliation, facilitating a new appreciation for their bodies. It is possible that reports of decreased anger are defensive (denied because they are incongruent with predominant discourses or the ethos of the Centre), or that the levels of anger women felt were relatively less than they felt while in the abusive situation. It is worth noting that shame-prone individuals are less likely to have an empathic disposition, are less likely to be able to take another person’s perspective, and that shame is more likely to be related to poor interpersonal relationships (Tangney & Dearing, 2002; Tangney et al., 2007). By contrast, the guilt-prone individual is much more likely to shift perspectives and engage in empathic concern (Tangney & Dearing, 2002). It has been demonstrated repeatedly that shame, low empathy, high self-preoccupation and high personal distress tend to co-occur (Lindsay-Hartz et al., 1995; Tangney et al., 2007). Perhaps those women who reported increased empathy and perspective taking were more guilt-prone than shame-prone.

Social support has been identified as an important protective factor in the lives of people with PTSD (Brewin & Holmes, 2003). A great number of participants cited spirituality or religion as a primary support in their lives. They also reported the supportive role of counselling, although many reported conflictual and unsupportive relationships with their families. Specific psychological defenses reported by the women included wearing a smile as a “mask” to disguise painful feelings from others. This protected women from feeling vulnerable and exposed. Women frequently reported that “keeping busy” to distract themselves from their emotional pain was an effective coping mechanism. Only two women reported using alcohol to cope. It is likely that a greater number of women abused substances in order to help them cope, but since I was affiliated with the Centre which had a zero tolerance policy to drugs and alcohol, it was unlikely that women would make this kind of admission to me.

## How Was Shame Described?

Manifestations and understandings of shame in this study were unexpected. Shame was often described as humiliation, embarrassment, and in one instance, shyness. In no instance was shame described as a positive emotion, as claimed by Bradshaw (2005). H. B. Lewis (1971) argues that one of the most powerful defenses against shame is outright denial, a finding that was replicated in this study. Even if the women admitted to feeling shame, they generally struggled to articulate what shame felt like, and what it meant to them. Perhaps due to limited education, some women with lower education levels had restricted vocabularies and found it difficult to describe their emotional lives. This is one possible explanation, although I believe there are many others, which will be discussed shortly. When present, however, shame was typically described in social or relational terms. So the shame described by the women who experienced it, was external shame. Gilbert (2007) defines external shame as the manner in which the self believes it exists in the minds of others. Gilbert (2007) argues that the core source of shame is the experience of lack of social safeness; a sense of heightened social threat and an uncertain sense of social positioning (Gilbert, 2007). High levels of external shame exist when individuals believe that because of possessing certain characteristics they will not be able to create positive or acceptable images of the self in the eyes of the other (Gilbert, 2007). This is why external shame may also be associated with humiliation (Gilbert, 2007).

As discussed in chapter 3, humiliation is an intense and unpleasant emotion involving lowering in the eyes of others; loss of esteem, social status or dignity (Elison & Harter, 2007; Miller, 1985). To recap, Gilbert (1998) argues that humiliation is similar to shame in that it is experienced when an individual is subordinated; put in a debased or powerless position by someone more powerful. As I outlined earlier, the most common causes of humiliation include 1) being harassed, teased, ridiculed, debased; 2) public behaviours or accidents that go against social norms; and 3) incompetence or mistakes seen by others (Elison & Harter, 2007). What is vital is the role played by the audience, who mock or laugh at the victim (Elison & Harter, 2007). As I have already noted, humiliation thus usually occurs at the hand of another, and in most cases, there is a broader audience that observes the humiliating event; a hostile and contemptuous audience is a key predictor of humiliation (Elison & Harter,

2007). Critically, in humiliation the victim is seen as undeserving, the event tending to be viewed as an unprovoked attack (Elison & Harter, 2007). In other words, as I have noted previously, there is no acceptance that the negative judgment from another is justified (as in shame), and no re-evaluation of the self takes place. Instead, the individual may feel motivated to make the other give up or take back his/her negative judgment (Tantam, 1998). So, unlike shame, humiliation does not involve the negative evaluation of the self by the self; instead it involves a focus on the other as bad; there is an external rather than internal attribution for negative events; a sense of injustice and unfairness; and a strong desire for revenge and retaliation (Elison & Harter, 2007; Gilbert, 1998).

From this description, it is obvious that humiliation also overlaps in important ways with stigma, which is also defined in external, social or relational terms. In M. Lewis' (1998, p. 126) understanding, as I pointed out in chapter 3, shame can be defined as "an intense negative emotion having to do with the self in relation to standards, responsibility, and such attributions as global self failure" (an internal experience) whereas stigma is a "public mark" or violation (an external experience), something that is noticeable to others and involves a "spoiled identity". Thus, the stigmatised person is publically marked by his/her deviation from the norm in appearance or in behaviour (M. Lewis, 1998; Nussbaum, 2004). A related construct is stigma consciousness. It refers to an individual's expectation that s/he will be prejudiced against or discriminated against on the basis of dispositional or situationally induced differences (Mosley & Rosenberg, 2007). Stigma consciousness refers both to an individual's awareness that s/he has a stereotyped status, and to the individual's focus on his/her stereotyped status (Mosley & Rosenberg, 2007). As will be shown, many of the women's descriptions of shame actually point to the experience and awareness of stigma. Stigma is closely aligned with (lack of) respect.

It is worth pausing here for a moment to consider the shame-related findings. There is considerable overlap between shame, humiliation and embarrassment, although, as I have pointed out, there are important theoretical and clinical differences between them. There is a social dimension to shame which permeated women's accounts of their experiences of shame. In their narratives, there was always a hostile and judging audience accompanying the experience of any of the shame variants. What is interesting here is that, in contrast to the literature, the experience of humiliation did not lead to the expression of rage and a strong desire for revenge in many women. Instead, the more typical pattern was that women turned that anger against themselves and took responsibility for the abuse perpetrated towards them;

perceiving themselves as deserving and as to blame<sup>26</sup>. Perhaps it is this process that exacerbated the development of post-traumatic and somatic symptoms. A theme to which I will return later in this chapter is the frequency with which women said that they felt stigmatised by their status as an IPV survivor; how humiliated they were to be a resident at a shelter like the Saartjie Baartman Centre. This seems to contradict the routine character of IPV in many of the communities the women came from. IPV was described as a “tradition” by one interviewee, suggesting that it was the norm rather than the exception in her community.

As I said at the outset of this thesis, current theories of shame focus on intimate attachment relationships and do not engage with broader experiences of discrimination and disempowerment which may also facilitate the development of shame and shame defenses (Kaminer, personal communication, May 24, 2012). Individual shame commonly co-occurs with group-level shame (Kaminer, personal communication, May 24, 2012), and reminds the reader not to make simple distinctions between individualistic and collectivistic cultures. Group or societal-level cultures of masculine or patriarchal honour are likely to be particularly pertinent to the individual women I interviewed, who are likely to have experienced individual trauma, historical trauma, and collective trauma, which will sensitise them to the experience of shame (either overt, or unconscious or by-passed) both as stigmatised individuals and individuals belonging to a stigmatised group. However, although their experience of shame was social, it was not experienced as reflecting on the group as a whole. Shame was also referred to as embarrassment. Embarrassment is a less intense emotion than shame, and it may be evaluative or non-evaluative in nature. It emerges in the context of relatively inconsequential or amusing wrongdoings, and is associated with a great deal of physiological arousal (e.g. blushing) (Tangney et al., 1996). Considering the seriousness and intensity of IPV experiences, this choice of term seems at odds with the experience of chronic trauma of the nature these women had been exposed to. The only reason to which I could attribute this finding was a lack of the necessary vocabulary – that in instances where women wanted to use words with a graver emotive tone, they could not find the words to express themselves appropriately.

---

<sup>26</sup> It is also worth noting that there has been a long history of victim blaming in psychiatry which may influence the tendency to self-blame. As noted by Herman (1997, p. 116): “*This tendency to blame the victim has strongly influenced the direction of psychological inquiry. It has led researchers and clinicians to seek an explanation for the perpetrator’s crimes in the character of the victim.*”

Consequently, another important issue has to do with language, and how shame is expressed. As described in chapter 4, it is important to note that in different cultures shame may be differently conceptualised, experienced and expressed (Bedford, 2004; Bedford & Hwang, 2003). Not only is shame not a negative or pathological construct in all (particularly collectivistic) cultures, but not all languages discriminate clearly between different dimensions of shame and shame and other self-conscious emotions. Some have argued that languages in which concepts are highly elaborated, and which are more discriminating, are likely to belong to cultures which are more sensitive to shame (Bedford & Hwang, 2003). Some scholars have suggested that because of the highly elaborated nature of the concept of shame in Chinese language, it might be worthwhile for Chinese researchers to work with Western, English-speaking researchers to achieve a more discriminating and precise conceptualisation of shame (Edelstein & Shaver, 2007). Furthermore, certain emotions, like shame, may occur with greater frequency in one culture than another, may be more focused on and conceptualised in greater detail, may be valued more highly, and may be captured in language with greater precision (Edelstein & Shaver, 2007).

Firstly, the emotion, shame, in English and Afrikaans, is not highly differentiated, specific and precise – it is a broad concept which includes a range of thoughts and feelings, hence the complexity of defining this construct. Secondly, there are potentially different interpretations of the word “shame” in Afrikaans and in English (C. N. van der Merwe, personal communication, June 11, 2012). Although, of course, both share the same etymological roots (to hide; to cover). In English, the word shame has connotations not only of exposure, but of woundedness. It is quite different in Afrikaans. In Afrikaans the word “skaamte” includes the dimensions of shyness, of scandal (“skande”), the latter of which carries or implies blame (C. N. van der Merwe, personal communication, June 11, 2012). Self-blame can be emotionally toxic. The reader might recall an earlier study referred to where characterological self-blame, shame, learned helplessness and depression often co-occur with feelings of powerlessness, betrayal, and subordination/submissiveness or inferiority in survivors of domestic violence, and child sexual and physical abuse (Andrews & Brewin, 1990). Another important point is that there is no separate word in Afrikaans for shyness. This is perhaps why the one woman who confused shame with shyness interpreted shame in the way she did. However, shyness is also a form of by-passed shame (H. B. Lewis, 1971). Women like those I interviewed, who have been made to feel weak and helpless through histories of such extreme subjugation, are likely to avoid admitting to feelings which are associated with culpability and fallibility, and

in some instances, imply blame. Particularly among the prouder and more defended women, it was as if *admitting to shame in itself was a shameful thing*. Admitting shame has previously been linked to individuals feeling defective and weak (Miller, 1985). Perhaps this is one of the reasons that many of my participants did not admit to feeling “skaamte” when asked directly, although they manifested significant levels of shame at bodily level and when asked about how they felt about themselves. The suggestion of blame is entirely inconsistent with the survivor ethos and (imposed) counter-narratives of the women I interviewed, and therefore unlikely to be admitted to when asked directly.

### **How Did Theoretical Understandings of Shame Fit Into My Study?**

For the women I interviewed, shame was a purely social emotion, although individual shame surprisingly did not reflect on the group as occurs in collectivistic cultures. The interviews were congruent with aspects of phenomenological, evolutionary, and self psychological approaches to understanding shame, because each of these theories has a social dimension. I have selected only particular parts of these shame theories to discuss, those that are relevant to shame as a social emotion, to indicate which theories are consistent with my shame-related findings and which are not. It is worth pointing out that no theory provides an explanation for individual (external, social) shame experiences, which do not reflect on the group as a whole, as I found.

#### ***Phenomenological Theory***

Shame is experienced as an unrestrained, immensely painful and debilitating self-focused emotion that has intensely negative consequences for individuals’ psychological well-being and interpersonal functioning (Tangney & Dearing, 2002). Shame has been described as an incapacitating emotion that is associated with a great deal of autonomic activity, virtually no cognitive activity, and speechlessness (H. B. Lewis, 1971). At a bodily level, shame reactions are characterised by a bowed head, closed eyes, and the body curled in itself, to make the person as small and as unobtrusive as possible (Izard, 1977; H. B. Lewis, 1971). What makes shame so painful is that it affects the entire self, which is experienced as inferior, defective,

flawed, contaminated or worthless; it is an undifferentiated emotion, where the whole self, not just a behaviour, is evaluated as “bad”, as contemptible (H. B. Lewis, 1971; Miller, 1985; Tangney, 1991). As I noted earlier in the thesis, “when guilty we feel ‘as if’ we are bad”, while with shame, this “as if” circumstance falls away, and the shamed individual becomes the “anti-ideal” (Lindsay-Hartz, Rivera, & Mascolo (1995, p. 295).

Phenomenological theory supports a social understanding of shame. What is relevant here is that in H. B. Lewis’ (1987a) phenomenological understanding, shame is constructed in relational terms - it is the unavoidable response to loss of love; the loss of an important social relationship, in the case of IPV, the perpetrator. H. B. Lewis (1987a) argues that shame, the result of the loss of the other, is inevitably accompanied by humiliated fury, and many of my participants expressed a great deal of both humiliation and rage towards their ex-partners. H. B. Lewis (1987a) argues that the purpose of humiliated fury is to protest the loss and demand restitution of the other’s positive feeling towards the self, which then leads to feelings of guilt. However, none of my participants expressed guilt towards the perpetrator. In order to preserve physical proximity to the love object the self may choose to avoid him/her, instead of reacting with aggression towards him/her (H. B. Lewis, 1987a). This seemed to be the pattern of most participants – most did not want to face their perpetrators again, and were intensely afraid of them. According to H. B. Lewis (1987a), the self may also repress rageful longings towards the other to protect the social tie (H. B. Lewis, 1987a).

### ***Evolutionary Theory***

As outlined in Chapter 2, in contrast, the core tenet of evolutionary theory is that human beings are social animals who are motivated to engage in behaviours which promote survival and reproduction. Gilbert (1998) argues that evolution has resulted in a range of biosocial goals and strategies (e.g. finding a sexual mate, caring for offspring) which enhance the likelihood of survival and reproduction of the species. Social signals are humans’ most important source of information, showing us whether our search for these evolutionary goals has been successful or not (Gilbert, 1998). These social signals are crucial in the maintenance of internal regulation and in indicating how attuned individuals are to their social roles (Gilbert, 1998). Shame signals misattunement, which leads to physiological dysregulation and indicates the need for defensive, reparative or retaliatory action (Gilbert, 1998). Shame

activates the need to hide from view what is considered worthy of rejection, attack or ostracism (Gilbert, 1998). It may also be accompanied by depression or anxiety associated with the perception that there has been a reduction or diminishment in social status, respect and social attractiveness (Gilbert, 1998). As explored earlier in the thesis, in order to avoid shame, and to ensure ongoing social attention holding power (SAHP), individuals may rely on attractiveness or aggression (Gilbert, 1998). Human shame is typically not focused on being physically attacked or injured, but rather on having SAHP damaged in some way. In modern societies, SAHP is associated with social standing rather than with dominance (Fessler, 2004).

This concern with social status and respect was very prominent in my participants. Women's narratives indicated that they valued being respected by others a great deal. Hollway and Jefferson (2009) emphasise how important respect is, particularly in subjugated, working class communities where there is often a concern with power and with status; where there is a great deal of status anxiety (De Botton, 2005). One of the reasons for status anxiety is dependence, and these women were highly dependent (often emotionally and financially) on their perpetrators, and were particularly resentful that they struggled to achieve financial independence. Kaufman (1993) argues that in Western or individualistic cultures, compared to African or Asian cultures, shame is centred around competition for success, being independent and self-sufficient, being popular and conforming, and being in a successful relationship (Kaufman, 1993). Although South Africa is a complex, multi-cultural context, it appears that the majority of my participants identified with Western or individualistic cultures, and the ideals and values propagated by this cultural system.

### *Psychoanalysis and Self-psychology*

As I have said from the outset, Freud had "no consistent theory of shame. Shame received relatively little attention in the Freudian corpus, especially as contrasted with anxiety and guilt" (Broucek, 1991, p. 12). Freud's limited attention to shame meant he understood it only as reactive, inhibitory, and prohibitive, opposing the pleasure principle and preventing engagement in natural but shameful behaviours, including sexual activities such as voyeurism and exhibitionism or activities centred around waste elimination (Broucek, 1991). Although the limited consideration of shame in psychoanalytic theory and practice was not entirely a-social, it did not, until recently, emphasise the social or relational dimension of shame.

Orange et al.'s (1997) thoughtful and thorough scrutiny of psychoanalytic theory and practice emphasises the relational over the intra-psychic and examines the possible sources of shame in the therapeutic relationship. Unlike Miller (1985) and other "purist" psychoanalytic colleagues' exclusive focus on sexual exhibitionistic impulses and genital inferiority as the (only) source of shame, Orange and colleagues broaden their focus to examine the intersubjective or relational origins of shame. Orange (2008) describes the therapeutic interchange as inherently shameful, for a number of reasons that have been described in an earlier chapter, and will be dealt with later in the current chapter. This kind of work humanises psychoanalysis, and makes it compatible with more contemporary theoretical work which focuses on the co-construction of social relationships.

Unlike the experience of my participants, who mainly described external shame, articulated by their fears of being judged, or being ridiculed or being mocked, self-psychologists like Kohut argued that the experience of shame is entirely internal, and as such, may develop in isolation (A. P. Morrison, 1987). However, there is a great deal of Kohut's work which is relevant to the women's experiences. Many women described neglectful, chaotic and abusive childhoods, with inadequate care from primary caregivers, which resulted in disorganised attachment patterns. Kohut emphasised the conditions needed for the self to achieve cohesion: firstly, through the empathic mirroring of the exhibitionistic grandiose self, usually by the mother, and secondly, the presence of an empathic, idealised selfobject later on, usually the father, who accepts the child's identification, idealisation and desire for merger (A. P. Morrison, 1989). For Kohut, a selfobject which is unresponsive to the self's need for mirroring and idealised merger contributes to vulnerability towards shame – in his understanding, as is evident, shame is a manifestation of weaknesses or deficiencies in the self with regards the ideal self (A. P. Morrison, 1987). Specifically, shame is understood as the consequence of overwhelming, unmirrored grandiosity and selfobject unresponsiveness. However, in my view, this reaction is based on an interaction with a selfobject, which does not make it entirely internal. Although the struggle is primarily internal, its consequences are partly social in nature: for example, in the search for the merger in adult selfobjects. This is often focused on intimate partners, and those who have not experienced mirroring and merging early on in life, an inability to endure any separation or difference between oneself and one's partner is likely to develop, which could lead to shame-rage spirals as are seen in domestic violence situations (Brown, 2004). Thus, although the experience of shame is

primarily understood as an internal battle, it does have a social dimension in the search for the external selfobject.

What is interesting in the context of the fragmentation of some of the women's trauma and shame narratives, is that Kohut described the consequence of the selfobject's failure to mirror and affirm age-appropriate exhibitionistic needs as fragmentation, disintegration; the opposite of cohesion (A. P. Morrison, 1989). Psychological depletion, on the other hand, is understood as a response to the absence of the needed, wished-for, omnipotent and idealised selfobject, which leads to emptiness, depression and shame (A. P. Morrison, 1989).

Before moving onto the results of chapter 8 on the split self, it is important to briefly recap on Fairbairn's (1943) important thesis. Feelings of "badness" are a typical defense among people who have been abused. Abuse survivors identify with and internalise insufferably bad objects and accept this "badness" and shame because it is more bearable to believe that the self is bad, than to admit to oneself that the loved perpetrator, whose abuse is unpredictable and erratic, is bad (Fairbairn, 1943). The main functions of this internalisation is to try to control these bad objects that have so much power over the person who is being abused; by splitting the internalised bad object into the exciting or needed object, and the rejecting object; and/or by splitting off from his/her central ego and repressing two secondary or subsidiary egos (Fairbairn, 1943). This theory overlaps to some extent with Herman's focus on the existence of the trauma-related, shame-based authentic self and the false self.

### **The Split Self: Categorical Content Analysis and Narrative Analysis**

In this section I review the the results from chapter 8. I analyse the authentic and false self as understood in Herman's (1997), not Winnott's terms, at individual, organisational and cultural levels. Herman (1997) suggests that the shameful authentic identity is obscured by a idealised false self that is defined by its socially conforming nature (Herman, 1997).

As outlined in the literature review, phenomenologically, when shame is experienced, there is a split between emotion and cognition – there is limited cognitive activity and an abundance of affective (and autonomic) activity. The result of this split is that the individual finds it difficult to think clearly, soundly, reasonably and rationally, and it ceases all activity; which results in total inaction (H. B. Lewis, 1971). In these shame states the individual also

experiences intense sensory activity and emotions (H. B. Lewis, 1971). In addition, shame also encompasses the fusion of subject and object. There is a unusual kind of mergence that takes place in shame reactions, once the negative appraisal of the real or imagined audience has been internalised and has united with the self. Consequently, the self is divided in shame response in two ways – cognition and emotion are divided, and the self is the product of the internalisation of the accusing and disapproving other, while it is concurrently profoundly aware of itself (H. B. Lewis, 1971).

The characteristics about themselves that women reported included being worthless, useless and inadequate, dirty or contaminated, and as deserving the abuse they endured. However, they also reported being caring, being communicative, being sensitive or soft-hearted, being helpful and being friendly. But inner strength was the most common and most important positive quality reported by the participants. The women seemed proud of the positive characteristics they reported. Pride is associated with dominance/superiority; believing in the importance of the standards one has upheld; maintaining good feelings about oneself; believing that others will think one is good; inclinations to show or tell others about one's achievement; the self as agent; moderately tense voice, flushed face and high heart rate (Barrett, 1995). Research suggests that pride can be an important motivator of altruistic behaviour (Hart & Matsuba, 2007). Pride motivates prosocial behaviour by helping individuals improve the image of the self that other people see and evaluate, or by helping individuals feel better about themselves (Hart & Matsuba, 2007). The ability to feel both pride and shame at the same time can be explained by the split in identity so common in those who have been traumatised (Halbertal & Koren, 2006). This split was plainly visible in all ten short narratives that I analysed.

Women's portrayals of themselves as strong and as survivors are agentive, oppositional narratives; denying the construction of women as weak, defeated, disempowered. Counter-narratives such as these are often comprise irregularities and incongruities; an alternation between collusion with master narratives, and dynamic resistance. These inconsistencies and contradictions also demonstrate multiplicity or a split in identity (Halbertal & Koren, 2006).

A brief summary of the interpretation of the results of the chapter are provided below, based on the narratives of eleven women.

### **Psychic Splitting at Individual Level**

Briefly, at individual level, the function of splitting is for the false self to protect (conceal, disguise) the traumatised, shamed authentic self from further exposure to potential harm. It is also, along with fragmentation, a post-traumatic response that can occur alongside shame, which are both core features of Complex PTSD and DESNOS, syndromes attributed to exposure to chronic trauma (Ford & Courtois, 2009). In addition, with one of PTSD's most important dimensions, constriction, the trauma survivor escapes an intolerable situation by changing his/her state of consciousness; however, it is also associated with the past being split off into dissociative fragments, which are often forgotten and difficult to access consciously (Herman, 1997).

Another point worth mentioning is that the frequent silencing and secrecy around chronic trauma causes a second injury or betrayal trauma, which can produce or enhance splitting (Ford & Courtois, 2009). In these cases, the individual develops a socially conforming or "normal" front which allows the survivor to protect the public from being exposed to the unthinkable and unspeakable. This façade becomes disconnected from the underlying authentic, shamed self which is incapacitated psychosocially by the personal knowledge of the trauma(s) (Ford & Courtois, 2009).

### **Psychic Splitting at Organisational Level**

Women's portrayals of themselves as strong and as survivors challenge and contest the canonical or master narrative that constructs women as dominated, subjugated, disempowered. These counter-narratives were made micro-culturally acceptable by their correspondence with a wider discourse of survival, enablement and empowerment promoted by the Saartjie Baartman Centre. Women frequently attributed feeling strong to the ethos underlying the interventions they had been exposed to at the Centre, especially counselling.

There is, however, a significant tension between women's powerful feelings of anxiety, fear and threat (see chapter 7), and their explicit descriptions of themselves as dynamic, strong survivors. As I suggested in chapter 8, I would argue that because women had only

encountered counter-narratives for a short period of time, I felt their expressed constructions of the self as active, strong, as survivors, were often forced and inauthentic.

Counter-narratives by definition suggest resistance, authority, potency, agency. Although women's counter-narratives did challenge the broader patriarchal culture they were familiar with, one which normalises and regulates violence against women, their counter-narratives are not in disagreement with the ethos of the Centre; not that I am implying it should be. The strong survivor identity that women were encouraged to own, to internalise, is – however well-meaning – one which has been selected for them. It is not one that is based on their own choice; it is not an alternative, empowered identity which they chose for themselves, which suggests that these counter-narratives may be less agentive or authoritative than I had originally believed.

### **External and Psychic Splitting at Cultural Level**

Despite the fact that IPV was considered routine (a “tradition”) in the communities my participants came from, they frequently reported feeling highly stigmatised by their status as an IPV survivor, and that they were extremely humiliated to be seen as a resident of a shelter such as the Saartjie Baartman Centre.

I believe that cultures of shame and honour contribute to IPV. Specifically, I believe that the type of patriarchy associated with cultures of honour produce cultures of shame among women; a shame-based reaction that is cyclically repeated at cultural level (Cohen et al., 1998). In cultures of honour, which are also characterised by poverty, hierarchies are important, so patriarchal structures such as male strength and power are highly valued and deeply entrenched in the cultural system. Social status is held in high esteem in these contexts, which contributes to the presence of binary oppositions – parallel to this patriarchal self (symbolic of the false self) is the shame-based self (symbolic of the authentic self), who has sacrificed dignity, power, and control to maintain the existing gender-based status quo.

In cultures of honour men are also held responsible for “their” women, and it is perhaps this process of ownership or possession which caused the ambivalence that some of my participants felt towards their partners – although these men abused them, they also took care

of them, “owned’ them, which signals a pattern of attachment that is likely to ensnare and entrap women who had never had the opportunity to established healthy attachment patterns. Although paradoxical, considering its normative status, IPV still produced shame, humiliation and embarrassment for my participants, which I would attribute to self-blame. Internalising a perpetrator-defined identity (Fairbairn, 1943), and taking responsibility for their abuse; and feeling deserving of their abuse continue to be painful emotions despite how common their causes are. Which brings me Foucault’s theory of self surveillance (1977), which is symbolically based on the design of the Panopticon, a circular building with an observation tower in the middle of an open space surrounded by an outer wall. In this theory, the outer wall of the Panopticon includes cells (for occupants like prisoners or mental patients for instance). The cells are flooded with light, so inhabitants are easily discernible and visible to an official invisibly positioned in the central tower/office. However, the concrete walls dividing the cells make the occupants invisible to each other. The ever-visible occupant, Foucault argues, is always “the object of information, never a subject in communication”. He goes on to suggest that,

"He [sic] who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection" (Foucault, 1977, p. 202-203).

By constantly observing the occupants and positioning them in a state of constant visibility, the efficiency of the institution is optimised. Those who are constantly watched, adopt the identity that is thrust upon them by those who observe them, so it guarantees the continued function of power, even when there is no one actually asserting it. It is in this respect that the Panopticon functions routinely; automatically. It is not difficult to see how this metaphor extends to the often jealous, ever-surveilling perpetrator in cases of IPV, how it facilitates the perpetrator-defined identity, even in his absence, and how this leads to isolation, self-blame (and incidentally, victim-blaming), and shame.

Protecting the dominance, authority, strength and power of men in cultures of honour, and the duty or “right” of these men to own or possess women at the cost of prized parts of themselves, is an unquestioningly painful process, even if it does not occur on a conscious level (e.g. their own dignity, sense of self-worth and self-respect).

The gendered subjugation occurring on a cultural level had a number of interesting outcomes. Women were highly concerned with social status and respect (in chapter 7 as well as chapter 8), and were frequently preoccupied with their stigmatised status (stigma consciousness) (Mosley & Rosenberg, 2007). Descriptions of shame were often actually portrayals of the experience of stigma. This is not surprising - working class communities are often concerned with respect, social status or with status anxiety; these constructs are highly relevant in communities where poverty and associated disempowerment is pervasive (De Botton, 2005; Hollway & Jefferson, 2009)

One reason for my participants' preoccupations with economic independence and social status was that having removed themselves from subjugating, disempowering cultures of honour, women were in the process of creating new identities based on reclaimed parts of themselves that they had unconsciously surrendered to maintain the gender-based power differential. These women seemed to want to aspire to the valued cultural assets associated with Western individualism; pride in themselves as individuals, economic independence, self-sufficiency, being conforming and popular, having self-respect, and dignity, which are all associated with an elevated social status at cultural level. I would argue that these preoccupations and efforts are a culturally compatible compensatory effort made by the individual's false self for the culturally-determined shame long felt by the authentic self.

However, a shift in identity of this magnitude does not take place overnight, as I argued when discussing counter-narratives; it requires enduring and persistent psychological intervention.

### **Linguistic Analysis of Trauma and Shame Narratives**

I analysed examples of narrative disruption or breakdown using Gee's (1991) linguistic approach to narrative, which is suited to lengthier oral narratives. As the reader will recall, narratives are divided into Parts, Strophes, Stanzas and Main lines. Gee (1991) suggests that narrative texts are structured at five hierarchical levels, each of which is connected to the Main line and Stanza structure of the text. Each level plays a role in interpretation. Levels include Main line and Stanza structure; syntax and cohesion, Main line/non-main line; psychological subjects and the focusing system. Corresponding with each of these levels is a particular role in interpretation, respectively including ideas and perspectives on characters, events, states and information; logic and connections; plot; point of view; and image/theme

(Gee, 1991). I analysed five longer trauma narratives using this framework, and then examined three particularly short trauma narratives.

To review, Narrative 1 lacks coherence and unity because the narrative's form is not uniform across Stanzas and Strophes and Parts; they are not equal in length or complexity. Connecting words are used in this text both to signal fragmentation at a semantic level (they bear no meaning), but do constitute attempts to facilitate interpersonal connection. Stripped down to its main elements, it is clear that the themes expressed in Parts deviate from each other in content. As such, it is difficult to discern a plot at first reading. One set of Main line material does not lead up to the next set of Main line material, each Part has a quite distinct theme, which does not represent narrative progression. There is no clear beginning, middle and end here, which is compounded by the repetition of especially important parts of the narrative at odd intervals. Overall, the narrative is characterised by loosely strung together, often disconnected subordinate clauses, and somewhat haphazardly placed main clauses. Again, it is as if the narrator is trying to use structural or linguistic means (numerous subordinate clauses) to create the illusion of coherence or a sense of plot (chronological and/or logical linking of characters, events, and states). However, it is challenging for the reader to discern an underlying chronological or logical progression in this narrative.

The contradiction in meaning between parts where the narrator states that she deserved her abuse, that she is worthless and brought her abuse on herself, which is then radically contested, suggests the presence of a split self. There is some surprising consistency in the psychological subjects of this narrative despite this split. The psychological subject represent the points of view from which the material in the Stanza is viewed; so they are the entities with whom/which the narrator is empathising (Gee, 1991). The narrator frequently speaks of her feelings of deservedness – it is a fairly consistent theme in her narrative. Finally, the focusing system refers to the pitch used to signal the focus of a particular idea unit. The change in pitch shows that the information that is being shared is new, salient or important, that it is the information the reader should focus his/her attention on (Gee, 1991). I argue that there is a series of disruptions in the articulation of focal areas, after the disclosure of abuse.

In Narrative 2, it is striking that the narrative's form is not uniform across Stanzas and Strophes and Parts and there is some disparity in the length and complexity of these components of the text. The Parts, Strophes and Stanzas are either quite elaborate and detailed, or are relatively short and end abruptly to give way to a radically new and different theme. Like Narrative 1, most Strophes consist of only one Stanza. This gives the narrative a

disrupted, disconnected quality. However, the connecting words “and” and “then” do function to link different components of the text. But, as in Narrative 1, these words sometimes do not carry any meaning, and their function is solely structural. Like in the previous narrative, there is no clear narrative thread which connects components of the text from early on in the narrative, and the repetition does not contribute to connections between Parts, Strophes and Stanzas. Instead, the narrative feels like it contains a fairly random, disconnected revisiting of particular themes or topics.

The plot is “lost” when the parrot is introduced. There is some loose progression up until this point from social isolation to shame and stigma, then a return to the theme of abuse and then the focus shifts onto the parrot. What is interesting here is the tension between truth (the parrot/narrator) and lies (the perpetrator) that runs throughout the narrative, and the importance of bearing witness to the violence this narrator endured, perhaps because she cannot believe it herself (the role of the parrot). The narrator’s silence is compared with the parrot’s brazen disclosure of “everything”. Where she obscures, disguises, the parrot expresses. Once again, this tension is indicative of a trauma-related split in the self. The narrator’s repetition of the traumatic killing of the bird indicates its psychological significance to her. I would argue this bird symbolised truth, validation, support. This death is what prompts the narrator to finally leave her abusive husband. The psychological subject varies substantially across different components of the text, and that psychological subject even changes within one Stanza. This shifting of perspectives and dramatic changes in foci fits with the chaotic structure of the narrative.

Narrative 3 also varied in length and complexity across Stanzas, Strophes and Parts, demonstrating significant structural instability. However, what is most striking is the cyclical repetition in this narrative, its (fractured) spiral structure. Although the narrator frequently uses connecting words such as “and”, and sometimes, “then”, suggesting linear development, these words actually fulfil the function of linking together a structure consisting of a circular repetition of the central trauma. Unlike the other narratives, the narrative revolves around a single incident; the theme is not what produces fragmentation. The thematic recurrence, repetition in the first Part of the narrative, is unplanned, it is blurted out in horror, in panic, in shock, without any thought to narrative order; the narrator cannot stop herself from revisiting the same intolerable, unbelievable scene of trauma, repetitively, over and over.

In the second Part of the narrative the theme is dissociative identification and its implications. There are numerous signs in this narrative of dissociation. Firstly, she says a number of times

that what is happening cannot be real, cannot be true. Secondly, there is a strong performative aspect to the narrative; the narrative almost feels as if it is being projected onto a screen. At times the reader feels that she is having an out of body experience. The narrator presents the audience with the image of her up on the hill, with a passive, ineffectual audience watching her hideous trauma from below (her symbolic “crucifixion”), is one of intense, shameful exposure and humiliation. But Irene inverts this experience and identifies with Christ, the archetypal figure of both shame and humiliation; and one of absolution and redemption. It is clear that there is both a thematic and structural split between the first and second Parts of the narrative. In the first Part she plays the role of the dissociated victim; powerless, helpless, but in the second Part she transforms herself into a holy figure. This identification can be interpreted as a vivid shame-based compensatory effort on her part.

The plot includes mainly main clauses, with few subordinate clauses, giving the narrative a striking immediacy. However, there are numerous “micro-fractures” (which occur at particularly traumatic points in the narrative), especially when she finds her experience particularly distressing, traumatic and unbelievable. She uses repetition, exclamations, and ellipses, which cause sentences to collapse into non-sensical fragments.

There is a to- and froing between the narrator (“I”) as psychological subject, and her perpetrator as psychological subject (“he”). This cyclical alternation parallels the spiral structure of the narrative in its entirety.

In the first Part of the narrative the foci are consistently centered around the trauma, while in the second Part of the narrative, once the fracture has taken place, the foci shift to dissociative identification, humiliation, shame and redemption.

At a structural level, like all the other narratives, Narrative 4 has a disorganised form, with Stanzas specifically differing in length and complexity. Only one Part consists of more than one Stanza, and it is interesting to note that this is the part where the narrative breaks down (Part 4). The Stanzas that are especially long and detailed focus on shame and staying/abandonment, very significant themes in this narrative. This disintegration in the narrative which is mostly caused by circularity and repetition are both a product of trauma and shame and does not only point to non-linearity, but disruptions in temporality and identity. Other than circularity and repetition, other linguistic features which allow us to experience the psychic reality of the narrator, are ellipses, and incomplete sentences, which, as I have indicated in previous narratives, occur at especially painful, shameful or significant

points of the narrative. These incomplete sentences, or phrases also point to trauma-related fractures in time, which is an important aspect of this narrative.

The narrative centers around the gang-rape of the narrator, Chantal. What is immediately noticeable when she “talks” about her experience is that she provides barely any information about what happened. From this moment onwards, the attentive listener begins to wonder if this is due to trauma-related amnesia (a response which would be consistent with dramatic disorientation in time later in the narrative).

The second significant theme in this distressing narrative is Chantal’s experience of one of her rapists, Carel. In a Stockholm Syndrome-like manner, she attaches to him (and later believes he is in love with her), because whilst the other rapists left her, he stayed with her for the duration of her captivity. She forges a deeply appreciative relationship with him, one typical of someone who has Chantal’s history of abandonment and disorganised attachment pattern.

In the last paragraph before the narrative fractures (Part 4), the narrator says multiple times how Carel did not leave her, indicating the profound significance to her of his staying. It cannot be ignored, however, that this repetition is followed by a total fragmentation and collapse in the narrative in Part 4.

The past and the present begin to merge in this section of the narrative. There could be many reasons for this, which include psychological and psychobiological causes, described in the previous chapter. The most dramatic confusion is between Carel and her ex-partner or perpetrator, Ricardo. She starts to call Carel by Ricardo’s name, and asks him to walk her back home. The narrator appears to be looking for her childhood home. In her trauma-related confusion, Chantal is looking for her primary caregiver during childhood, her “ouma”; she is fully immersed in the past, searching for the woman who represents the only care she has ever known, the only security she has ever known. Perhaps Chantal’s attachment to Carel post her terrible trauma (despite his involvement) is because he offers her substitute “care”; he does not leave her alone in her most shameful state. She slips between “huis” (home) and “shelter” and “ouma” and those who drank (likely her “friends” at the party), and between those who weren’t “geworried nie” and the “ouma” who cares. Her tone is angry, disorientated, confused and abandoned. There is another surprising contradiction in this narrative. As we have seen, there are significant disruptions in place and time. However, the narrator is quite capable of managing another kind of chronology. For example, she often speaks of Friday, Saturday, Sunday and Monday, and she seems aware of what happened on these days.

In the next section of the narrative, the narrator seems to be more logical and lucid, and the focus is on the body. She is ashamed, deeply ashamed, describes feeling uncomfortable and dirty, as many rape survivors do, stressing her exposure to filth by describing the “bommels” (insect bites) on her body. Thus this part of the narrative is about physical needs – washing and hunger, both needs which are repeated several times. It appears as if concrete needs ground the narrator, and brings her back into the present.

The second part of the Stanza is again centred around shame, a significant theme in the narrative and the courage it took to speak about what had happened to her. As in other narratives, when the experience described becomes too traumatising, the language breaks down. The narrator describes (in subordinate clauses) the treatments she has to use to prevent the development of HIV/AIDS, but before she can speak this terrifying potential outcome, she says: *mos nou vir... (You know now for...)*. Considering what possibilities might lie ahead for her is peppered with anxiety-driven hesitations.

Never is the pattern of an abandonment-driven disorganised attachment pattern more clearly articulated in the tragically repetitive longing for Ricardo: *Ek noem gedurig Ricardo se naam. Ek weet nie, dit begin nou al (wat dit net so...)*. *Ek noem dan Ricardo se naam. Ek weet nie hoekom nie. Want sy naam kom net so. Ek wil nie eers dink aan hom nie. Dan noem ek altyd sy naam. Dan sê ek, ag, man, Ricardo. Want dan maal dit weer by my. Dan dink ek net die aand daaraan. (I don't know, it started from the weeks [that it just]. I don't know why. Because his name comes just like that. It's not that I think about him or so. I don't even want to think about him. But I just always his mention a name. Then I say, oh man, Ricardo. Because then it just mills in my head again. Then I just think about it in the evening).*

There is significant evidence of psychopathology in this narrative. Overall, I would suggest that this narrator has been overwhelmed by trauma, and has symptoms of Complex PTSD, DESNOS and/or dissociative disorders.

There is some shift in the psychological subjects. But the most important psychological subjects are the rapists, especially Carel, who stands in stark opposition to her abandoning friends in the first part of the narrative. There are several psychological subjects post- gang-rape described during and after the major fracture in the narrative. The foci in this narrative are copious and varied.

Narrative 5, like all the others, consists of Parts, Strophes and Stanzas which vary in length, levels of detail and complexity, suggesting some structural instability, while at the same time indicating points of significance in the narrative. The narrative has a funnel shape, starting with emotionally challenging but present-based, conscious and immediate personal experiences, which slowly deepen after a crucial disruption in the narrative to reflect entrenched, unconscious material being repetitively played out in the narrator's life. Thus, the structure of the narrative is actually a "fractured" funnel shape.

The narrative's main theme is of leave-return (to and from her perpetrator). Like in all the other narratives, repetition, an important sign of narrative fragmentation, appears in this narrative at significant moments, and does not only include a focus on leave-return, but on associated constructs such as ambivalence, co-dependence and fear of abandonment. There is a virtual absence of linking or connecting words or phrases in this narrative, so without the significant repetition, it would be a very difficult "plot" to follow.

Unlike most of the other narratives, this narrative has numerous subordinate clauses and there is a great deal of micro-fracturing, demonstrated by the use of ellipses, resulting in incomplete sentences. As we know, this occurs when the content of what is being uttered is too emotionally painful or shameful.

The reason for the narrator's cyclical leave-return, leave-return is fear of abandonment, which like the previous narrator, was a significant part of her childhood. Abandonment is unbearable for her, however unconscious it is. She unconsciously repeats the past, and abandons her own child, and then, because of her guilt, she returns to collect him. Thus, the leave-return cycle occurs on another, deeper level.

The narrative deepens when there is confusion between the story of the narrator's son and the story of the narrator. This is the beginning of the past and present fusing. In the quote: *The kid really loved him. Even though I stayed in an abusive home*, the audience's attention is drawn to how the narrator slips from "the kid" to her own abusive home (subordinate clause). The disconnected part of the narrative focuses exclusively on abandonment, and her fear of the loss of her child, just as her own mother abandoned her. Here, there is a complete fusion between past and present (see Payne et al., 2004).

In the final part of the narrative, which is reminiscent of earlier parts of the narrative, the narrator experiences an excruciating fear that she will lose, or has lost both her (ex) partner

and her son and she blames herself for it, which causes a significant internal struggle. The critical experience of the potential abandonment from her son is articulated in “*You are trying to make my child forget me*”. But this is a significantly more conscious statement of fear of abandonment than would have occurred at the beginning of the narrative, perhaps suggestive of some progression despite the significant disruption which occurs.

Lastly, the narrator uses inversion a number of times, which adds to the disorganised quality of the narrative.

The psychological subjects and foci are plentiful and diverse, and typical of the somewhat chaotic nature of the narrative.

I also examined three, short, compressed trauma narratives. These narratives were characterised by silences, pauses, and hesitations. Unlike the majority of women with longer trauma narratives, these women expressed no urgency to talk. Silences occur in the presence of the unspeakable, the incommunicable – these unutterable events make the narrative skewed, erratic, interrupted and compressed (Scarry, 1985; Simon, 2008). This is why traumatic memory is so often expressed through the body, which was starkly visible among my participants with shorter trauma narratives (Simon, 2008). It is as if, in the absence of words, the body expressed what could not be spoken. In the first narrative, the interviewee sat hunched over with her hands over her eyes, crying, throughout the interview. At times she pulled her shirt over her face, gestures typical of shame. Crying, which signals sadness, is an important sign of by-passed shame (H. B. Lewis, 1971). In addition, her sentences were characterised by long silences, as if what she was talking about was too horrific for her to speak about.

The next short narrative had no plot to speak of. What makes the narrator’s story interesting is its total lack of structure; its chaos and disconnection, and the extreme anxiety and shame that the narrator expressed at a bodily level while she was telling me her story. She was also tremendously shy, which is characteristic of by-passed shame (H. B. Lewis, 1971). She was rocking back and forth, biting the sleeves of her shirt. She looked down and avoided eye contact with me, and periodically covered her mouth with her hands, which made her already soft voice imperceptible at times. She whispered her story, as if she did not want it to be heard, and stammered and paused and hesitated throughout her short narrative. These are all manifestations of shame (H. B. Lewis, 1971; Retzinger, 1998). What she was unable to say, her body was expressing for her. As I described in an earlier chapter, some of the most

important indicators of bodily shame include hands covering all or certain parts of the face; avoidance of eye contact, eyes lowered or glancing; repetitious speech, and fragmented speech (Retzinger, 1987).

In the final short narrative I present, I focus on a particular type of unconscious or by-passed shame, which manifests at bodily level, namely, narrative-incongruent laughter. In the narrative, the narrator, Chantal, unconsciously explores the notion of the (her) fragmented mother – the substitute mother, the real mother and the ideal mother. The incongruency between the content of the narrative - which centred around the loss of, and the longing for the ideal mother, the desperate search for a substitute mother, and the significant distress evoked by the real mother - and the constant interruptions in the narrative due to unexpected bouts of laughter, was disturbing. The narrator's body language also denied all evidence of shame, when I knew from the lengthier interview with her that she felt a great deal of shame. In fact, her body language bordered on defiant, perhaps a defence against shame, and against the intrusive questions I was asking. She sat close to me, straight-backed, leaning towards me, particularly towards my face, making the interview both emotionally and physically intimate. The uncomfortable, somewhat bizarre disjuncture between the content of her narrative and her emotional and bodily reaction to it, combined with her inability to regulate physical and emotional boundaries, made her confusing emotional experience unusually contagious. Whereas shame disguises and tries to be contained by the imploding or hunched over body, her body reached out to me, laughingly.

Thus, this inconsistency between the narrator's mood and demeanour and the trauma she had experienced was a function of suppression and denial, but through the contagion I spoke of in the previous paragraph, I could feel the weight of the experiences she dismissed with a smile or laugh transferred onto me – the false smiling and masking behaviours referred to by Retzinger (1987). In my analysis, I suggest that perhaps her suppression and denial in circumstances where she has experienced chronic and severe trauma from a young age was not only adaptive, but also resilient. Whether that is the case or not, she had transferred her unconscious losses and longings onto me, as I felt depleted by her avoidance for days afterwards, while as Chantal says “ek lag vir als” (*I laugh about everything*).

To conclude this section, on the basis of the lengthy, complex trauma and shame narratives I analysed before the shorter, compressed narratives presented above, I would argue that from these five narratives, it is possible to note that on linguistic level, the narrators produced non-linear, fractured narratives mainly through the use of repetition, the meaningless use of

connecting words such as “and”, “then” and “because, ellipses, and incomplete sentences. These linguistic features happen at especially significant, painful or shameful parts of the narrative. There is also evidence of both “macro-fracturing” and “micro-fracturing” in some of the narratives.

However, shame is difficult to articulate concisely. For many, shame resists objectification in language (M. Lewis, 1992; Scarry, 1985), which is why it is often described in vague and diffuse terms, and is frequently encoded in bodily form. But it always carries associations that the self is bad. At bodily level, the most common response to this emotion is to conceal or disguise the self, make the self smaller, less significant, less conspicuous because the self wants to hide and disappear (to prevent judgment or attack). However, it can also manifest at by-passed or unconscious level; and/or manifest as a defensive reaction, as was the case with my final narrator. Shame is many-faced, and since its purpose is concealment, the prevention of exposure, it may be very difficult to detect.

### **Self-reflexivity and Intersubjectivity in Data Collection and Interpretation**

As historian Luisa Passerini writes in the first chapter of *Autobiography of a Generation*:

Italy, 1968: I conducted my first interviews with the protagonists of '68. The interviews plunge me into my own past: as I listen, the film of what I was doing at the time unreels. (as cited in Maynes et al., 2008, p. 100)

Often this work (with shame people) is both facilitated and impeded by the analyst's capacity and/or propensity for shame. (Orange, 2008, p. 96)

Trauma is contagious. In the role of witness to disaster or atrocity, the therapist at times is emotionally overwhelmed. She experiences, to a lesser degree, the same terror, rage, and despair as the patient. This phenomenon is known as ‘traumatic countertransference’ or ‘vicarious traumatization’. (Herman, 1997, p. 140)

Clandinin and Connelly (2000) suggest that the researcher starts the interpretation of results with a consideration of his/her autobiography. As such, I will give the reader some background to my interest in trauma, shame and associated psychopathology.

My interest in trauma in particular is long-standing. My Honours thesis focused on the association between community (chronic) violence and the development of aggression and

other antisocial behaviour in young people. My Masters studies were informed by this choice of subject and widened it to focus on the associations between community violence, antisocial and pro-social tendencies, parenting practices, social support and selected household and demographic variables. After my Masters studies, most of my work was focused on violence, trauma, resilience and children's rights.

But what I also brought to the interview situation was my personal history of physical, sexual and emotional violence, and my own feelings of shame. So I have both a long history of work in this field to inform my analytic decisions, as well as an experiential, intuitive understanding of both trauma and shame due to my personal history.

It is these experiences that brought me to the point of being ready to explore the associations between chronic trauma, shame and psychopathology. My personal familiarity with trauma and shame had both advantages and disadvantages. Because of my experiences, I believe I have a capacity for hearing and digesting traumatic material, and giving others the space to articulate them. As one participant said, she felt I was not "scared" of her trauma; she felt she did not have to edit or sanitise her account of her experiences to protect me. She felt she could "tell it as it is", and that I would accept, and not judge her by her experiences. This was not always easy, but I felt it facilitated the production of immensely rich data. The personal cost of collecting such data was that I was often struck by the contagiousness of shame (H. B. Lewis, 1971). Sometimes, especially when shame was expressed via the body, and accompanied by feelings of self-blame, dirtiness or filthiness, I would leave an interview feeling contaminated through identification, my own feelings of trauma-related shame amplified. Because of my specific vulnerabilities, I also experienced myself dissociating when particularly evocative material was brought up, material that reminded me of my own past. Inevitably, I would experience an out-of-body sensation, and be consumed by a sense of unreality.

Orange (2008, p. 21) suggests that "experiential worlds, I believe, are transformed only in an atmosphere of radical acceptance", something I believe I was able to provide, because of my own familiarity with exposure to violence. As Charon (2006, p. 180) argues, the process of bearing witness does not violate the narrator, instead allowing him/her:

...to tell their story in order to survive. There is, in each survivor, an imperative need to tell and thus to come to know one's story...to know one's buried truth in order to be able to live one's life.

Opportunities for sharing traumatic narratives allows survivors first to remember and then to forget, so that they can learn again how to be functional in the world, to work and love (Charon, 2006).

Interviewees without exception told me that the interviews had been an emotional unburdening for them, and that they felt lighter afterwards. Research seems to support the health and mental health benefits of sharing trauma narratives. For example, it has been demonstrated that imagined dialogues about trauma (as opposed to writing about the trauma in isolation) facilitated greater present-oriented, affective experiencing and cognitive processing (Burke & Bradley, 2006). Imaginal exposure to the trauma has also been associated with higher levels of narrative organisation, suggesting the therapeutic dimension to engaging with, and remembering the traumatic event (Van Minnen, Wessel, Dijkstra, & Roelofs, 2002). Finally, some scholars have emphasised the long-term benefits on health and immune system functioning of both written and verbal disclosure of traumatic experiences (Foa et al., 1995).

Many participants had had few opportunities to talk about their traumas. As Kraft (2004) argues, those with traumatised backgrounds learn the value of not talking about the past, and they learn not to reminisce; much remembering remains unspoken, they are not narrated or expressed. For example, one woman said: “You are the first person where I let it...at least I let it all out. At least, since I came here, I found someone to let it all out to”. Again, I think it was my own empathic familiarity with the kinds of violence the women described, that facilitated this kind of disclosure.

The work of Orange et al. (1997) – from an intersubjective, psychoanalytic point of view – is highly relevant to my interviews. Orange (2011) distinguishes between the hermeneutics of suspicion and the hermeneutics of trust. The former is represented by Marx, Nietzsche and Freud, who believed that their patients brought to them conscious material which was inevitably “false” and whose manifestations had to be deciphered by experts (which immediately exaggerates an existing power differential). Thus, for Freud, patients’ consciousness always disguised and concealed the truth, and always reached the analyst accompanied by a tangled mess of underlying hidden motives, made obvious to the analyst by dreams and neurotic symptoms only they could interpret (Orange, 2011). With this school of thought comes the “blank slate” therapist, who has little human-to-human contact, who aims to uncover unconscious or latent falsehoods and deception, and who considers transference and countertransference as merely a nuisance factor to be dismissed or ignored (Orange,

2011). This approach may be damaging because a suspicious, mistrustful, sceptical, cynical, deconstructive attitude creates a distance between the analyst (or in this case, interviewer), and his/her patient (or interviewee's) experience, devaluing and objectifying him/her (his or her experience is negated, because the analyst/interviewer believes in the *opposite* of what s/he is saying). Lastly and most importantly, commitment to this approach means that the analyst (interviewer) is afraid, distant and defensive of their own emotional experiences or processes, and therefore has no choice but to treat their patients (interviewees) with (perhaps unconscious) disdain and veiled superiority (Orange, 2011).

By contrast, the hermeneutics of trust creates a climate of trust and a participatory sense of inclusion and respect (Orange, 2011). The father of the hermeneutics of trust is Sándor Ferenczi, who “through embracing a hermeneutics of trauma, that is, by allowing the suffering of others to traumatise him, he began to trust the embodied voices of shattered people.” (Orange, 2011, p. 82). The hermeneutics of trust does not include the notion of the “expert” – by contrast, analysts (or interviewers) are encouraged to acknowledge openly how little they understand, their fears, confusions, frustrations and at times, exhaustion (Orange, 2011). This model requires the same sincerity from the analyst (or interviewer) as the authenticity or honesty expected of the patient, while maintaining appropriate boundaries (Orange, 2011). Centrally, supporters argue that phenomena which emerge in a particular psychological field are made up of the intersection of two subjectivities – that of the analyst and that of the patient. For them, intersubjectivity theory is the dialogic attempt of two people to make sense of one person's emotional experience by understanding together their intersubjectively configured experience. Unlike the hermeneutics of suspicion, transference or countertransference (or cotransference), the organising activity of both people within the analytic experience constitutes the intersubjective field of the analysis (Orange et al., 1997). Transference and countertransference create an intersubjective system of mutual influence – neutral analysts, pure, objective interpretations, uncontaminated transferences are mythological and cannot exist in this kind of system (Orange et al., 1997). This unfortunately means that the analyst's subjective world may facilitate or impede the analytic situation. But as Orange (2011, p. 109) concludes:

To explain the ‘therapeutic action’ in intersubjective systems or relational terms, I must describe what both parties bring to the field, how complex and interdependent are the processes of mutual influence and how asymmetric (Lévinasian) role

responsibility. I must relate how both of us have been changed by each other, and by the work/play/struggle we have done together.”

My approach supported the hermeneutics of trust, and I entered into my interviews with an openness to suffer with my interviewees. This, along with my first-hand familiarity with trauma, may have facilitated personal disclosure of immense pain, but as I have indicated, it may have (unconsciously) encouraged over-disclosure, and placed interviewees at psychological risk. Something I have not yet considered is how my dissociative responses may have affected the intersubjective interaction. I spoke earlier of how I was consumed by an out-of-body sensation when emotional material which was particularly provocative for me emerged in the interview situation. On reflection, despite my intention to remain psychologically open and undefended, I was using dissociation as a defense against trauma or shame contagion – it was a means of boundary management for me; a means of regulating the emotional distance between myself and the interviewee. Perhaps in some instances interviewees sensed this, although my felt sense was that it did not prohibit disclosure; in fact, as I have indicated, evidence suggests the opposite – as illustrated by the nature and length of the majority of the interviews and how women described their experiences of disclosure to me, the intersubjective interaction facilitated (perhaps overly so) rather than impeded intimate disclosure. This suggests that I may have been more successful in communicating the principles of the hermeneutics of trust than I thought when considering my dissociative responses.

I have mentioned the striking over-disclosure of intimate and personal information during interviews, and the deliberate, shame-filled avoidance of me after interviews. I think this is a very significant finding. Although I believe that the over-disclosure of interviewees was largely due to disorganised attachment patterns, I also wondered whether my attempts at creating a safe, accepting, empathic space for women to narrate traumas they had rarely (or never) spoken before may have allowed and encouraged an outpouring or flooding of more painful revelation than I (or the narrators) were able to contain, particularly in a single session. Most women felt an urgency to talk, but were understandably overwhelmed by the content of their narratives. In my view, they avoided me because I had become a receptacle of trauma and shame for them, and they did not want to confront that trauma and shame again. It was emotionally safer to suppress traumatic and shameful content, and defend against it with a smile and keeping busy.

Individuals who have been chronically traumatised form a very particular type of transference in the therapeutic relationship, which may be of relevance here. Their psychological responses to people in positions of power, as I was, have been affected by the experience of terror (Herman, 1997), which may have contributed to heightened levels of submission, and exaggerated compliance with requests for highly personal information in the interview, however committed I might have been to the hermeneutics of trust and equalising the relationship. This power differential between analyst or interviewer and patient or interviewee sets up an intrinsically shameful situation. Orange (2008) argues that the therapeutic situation is shaming for a number of reasons, some of which are applicable to the interview situation, including having a stigmatised or shameful status (as an IPV survivor), the painful revelations disclosed by the patient or interviewee, the shame felt by the analyst or interviewer through identification with the patient or interviewee, and the shameful power differential between analyst or interviewer and patient or interviewee as discussed in chapter 2. The only way shame can be held or healed in this kind of relationship is if the analyst or interviewer has acknowledged his/her own shame, and is willing to work with it; and if s/he is able to restore the “interpersonal bridge” between shamed self and other in the relationship over time, once power differentials have been addressed and processed, as one would if one was a supporter of the hermeneutics of trust (Kaufman, 1993, p. 33; Orange, 2011).

The trauma narratives women present are often chaotic. Chaos narratives, which do not constitute a “proper” story, where there is a lack of coherent sequence; a lack of control, are difficult to hear (Frank, 1995). Orange et al. (1997, p. 42) call this “the dread of structureless chaos”. They are difficult to hear because they are personally threatening (Frank, 1995). This is because what the listener hears becomes a possibility or a reality in the life of the listener; the listener often has to distance him/herself from the narrative to make it bearable (Frank, 1995). Frank (1995, p. 101) reflects on how interviewers directed Holocaust survivors towards alternative narratives that demonstrate “the resilience of the human spirit”, failing to bear witness to the real stories the survivors have to tell because of their own fears; their own emotional inadequacies. In a similar vein, therapists often make claims of neutrality when their patients’ transference attributions threaten or endanger central features of their sense of self (Orange et al., 1997). These authors talk about the “exquisite vulnerability that is inherent to an awareness of the embeddedness of human experience in relational systems” (Orange et al., 1997, p. 42). Interviewers who cannot bear their potential likeness to their traumatised interviewees tend to steer their interviewees towards a restitution narrative of progress, for

example, by encouraging them to focus on the liberation, when survivors, unlike their interviewers, did not experience liberation as the great dividing line that ordered and gave meaning to their experience (Frank, 1995). (Shapiro [2011, p. 69] calls believing in the inevitability and greater authenticity of these restitution narratives and quest narratives [where you are better off at the end of the story than the beginning], “comic”, in reference to the “comic plot” as opposed to the “tragic plot” in literary theory). In fact, for people about whom Frank (1995) writes, with liberation “the real trouble begins: the trouble of remaking a sense of purpose as the world demands” (Frank, 1995, p. 107). This calls to mind the horseman in Kluger’s (2001) tale, who feared crossing a lake covered by a thin layer of ice. Once he had made it to the other side, he looked back, and instead of feeling relief or joy, on realising what he had survived, he died of fright.

There are a number of challenges in interviewing severely traumatised individuals. Firstly, many complexly traumatised people exhibit insecure or disorganised attachment styles. They may have underdeveloped self-capacities reflected in emotional dysregulation that is manifest in intense and rapidly changing affect states, dissociation, aggression (including being abusive towards the interviewer) and self-injurious behaviours (Pearlman & Caringi, 2009). Chronic trauma affects survivors’ ability to remain connected to personal systems of meaning and hope, and impedes the development of satisfying interpersonal relationships, and their interactions may be characterised by a great deal of depleting cynicism and despair (Pearlman & Caringi, 2009). Memory disruptions may mean that interviewees re-enact their memories in ways that are unnerving and leave the interviewer feeling hopeless and de-skilled (Pearlman & Caringi, 2009). Somatic complaints for which the interviewee is unable to find effective treatment might evoke the same reaction in the interviewer (Pearlman & Caringi 2009). Finally, trauma is contagious, and interviewees are likely to experience secondary traumatisation (Pearlman & Caringi, 2009). Some of these factors affected my interviews, including changing affect states, emotional dysregulation, and despair amongst the interviewees, and I often felt hopeless and de-skilled, as well as traumatised by the content of the interviews.

Pearlman and Caringi (2009) argue that there are a range of contributing factors of the interviewer that affect the interaction between the interviewer and participant, including personal trauma history and avoidance of difficult emotional material. I do not believe that it was possible to avoid the effects of my own personal trauma history on the nature and intensity of traumatic disclosure by interviewees. Like Orange et al. (1997), I believe every

relationship is a co-construction. Pearlman and Caringi (2009) suggest that interviewers cope by seeking social support, consultation, engaging in a spiritual life, engaging in self-care, working within a particular theoretical framework, staying connected to personal experience, remaining aware of the present moment and the treatment frame, and accepting the inevitability of vicarious trauma and our own personal and professional limitations (Pearlman & Caringi, 2009). Furthermore, although this is more applicable to clinical settings, these authors emphasise the importance of focusing on the process rather than the outcome, focusing on the positive, reinforcing desired behaviour and outcomes rather than focusing on shortcomings and disappointments, and being aware of appropriate boundary management. Additionally, Pearlman and Caringi (2009) attend to the interviewer's bodily and emotional responses to the interviewee. I believe I was able to seek the appropriate support and supervision, and engaged in the necessary self-care to enable me to continue conducting supportive interviews, and remain conscious of the effects of traumatic (or shame) contagion. Despite these attempts to protect myself, as I have noted, sometimes it was emotionally complex to negotiate the interviews. I can only imagine how much more complex and exhausting the counselling sessions were for the social workers working at the Centre, given their ongoing nature. Tronto (2010, p. 167) argues that careworkers should find care rewarding, both on personal and economic grounds, so that they are not affected by the "opportunity cost" of caring. This translates to an organisational level. It is well known that organisations which provide crisis interventions are often in crisis themselves (financially, organisationally), mirroring at organisational level the chaos, exhaustion and depletion that is happening on individual client level. It is likely that staff at these organisations are suffering from vicarious trauma or trauma fatigue.

Wood (2012) found that in his study of staff working with young people with anorexia nervosa, that the majority of these staff found the trauma work involved "overwhelming, confusing, deskilling, exasperating and thankless task" (p. 84). This, Wood (2012) argues, may become manifest in the unconscious experience of an organisation in a number of destructive and damaging ways, one of which is incohesion or splitting, fragmentation among staff; incapable of sustaining co-operative work. It is also worth bearing in mind that in voluntary organisations, funding is seldom secure and the existence of the organisation is always fragile; precarious. Ironically, in such circumstances, it is particularly important that there is strong, bounded and containing leadership, to promote group cohesiveness and a supportive environment (Corbett, Cottis, & Lloyd, 2012). This can be facilitated by having a

regular, designated time to process the traumatic and toxic effects of working with trauma by an external, experienced facilitator – a time to think and process, reflect and consider the impact the work has on workers in the trauma field (Corbett et al., 2012). Without these protective processes in place, organisations, like people, may experience demoralisation; may stereotype and/or scapegoat their clients; staff may become emotionally numb or treat their clients' problems as routine; staff could develop paranoid feelings towards their managers, who are not helping them as they are helping their clients; splitting and fragmentation could occur in the team; and finally, individual worker reactions to the constant onslaught of trauma may occur which will interfere with their work - the so-called social defence system – and may leave workers feeling deskilled; finally and alternatively, they may engage in “anti-tasks” with their clients, tasks or processes which are easier and more rewarding to resolve than those that are more pressing but more difficult emotionally to tackle (Hinshelwood, 2012). It is also worth noting that individuals as well as organisations vary in their capacity to work with trauma; however, organisational resilience and hardiness are the outcomes of the decisions and behaviours of the staff and management of an organisation, it is within their control and good decisions and actions can be encouraged and fostered (Kleinberg, 2012). Staff hopefulness has been identified a central facet of work-group processes (Kleinberg, 2012).

Healthy organisations, according to Tronto (2010), are those that that adhere to three principles: *politics*: the recognition that there are relations of power within and outside the organisation and agreement of common purpose; *particularity and plurality*: attention to human activities as specific or particular and acknowledging that there are different ways of doing them, and that there are diverse individuals who have different ideas about how needs might be met; and *purposiveness*: awareness and discussion of the ends and functions of care. It is important to note, particularly when thinking about women's counter-narratives and the split self I spoke of earlier, that Tronto (2010) does not promote a standardised model of care – she recommends that the care each individual receives is tailored to their specific, unique needs. This potentially additionally avoids the significant and rapid leap promoted by the Centre from the felt sense of the self as victim, to the construction of self as survivor. Although this may be difficult to achieve in practice (the reality of staff members' typically narrow areas of expertise or way of working), I believe that individualised care constitutes a way of healing the trauma-related split between the authentic and the false self. It remains difficult, given the complexity of the issues at stake, for me to offer any “recommendations”

for improvement in care practices at the Centre, and in resisting offering clear “recommendations” I am aware that I am also resisting a convention common in many doctoral theses. The nature of the material I have collected and the analytic framework I use support my decision not to offer recommendations of the conventional type.

Orange et al. (1997) argue that analysts often have misguided beliefs that they can prevent their own personalities from being present in the analytic dialogue, which may be harmful, and produce transference artefacts that may be counter-therapeutic. Orange et al. (1997) go as far as to say that the notion of analytic neutrality is a grandiose defensive illusion which should be replaced by the principles organising the patient’s experience (empathy), the principles organising the analyst’s experience (introspection) and the ever-changing psychological field produced by the interplay between the two known as intersubjectivity. This has implications for the discussion of the co-construction of painful experiences which follows shortly – specifically, how interviewing traumatised individuals requires a great deal of introspection and self-awareness on the part of the interviewer (of both the beneficial and harmful effects of what s/he is evoking), and the importance of avoiding making use of grandiose defenses to protect the self from the reality of the pain that is emerging in the intersubjectively created psychological field.

Up until now, I have emphasised the therapeutic nature of sharing traumatic material, although I have given some consideration to the possible causes and risks of over-disclosure in my participants in particular. But I would like to explore in further detail the darker side of traumatic revelations. I would like to address next a complex issue that is relevant both self-reflexively and ethically. Any research which involves exploring sensitive and often painful experiences comes with emotional risks for the participant. What I think is of relevance to my research is the co-construction of painful experiences, which occurs when interviewers elicit traumatic material from the interviewee, facilitating the recollection and re-experiencing of emotionally charged memories. As noted by Orange (2011, p. 100), “we must accept responsibility for our current contribution to our patient’s suffering. We must be sincere.” As an interviewer doing research on a sensitive topic, asking explicitly about traumatic memories, it is perhaps inevitable that I felt complicit in my interviewees’ painful reliving of their experiences. But I think this tendency to feel complicit in others’ pain was exaggerated for me, because of my own experiences of trauma, and being involved in the injury and pain of others. This complicity, this co-construction of emotional pain evoked a great deal of shame in me. This was amplified not only by the contagiousness of (interviewees’) shame, but

by my knowledge that these women often had highly disorganised attachment styles, displaying a conflicted pattern of approaching then retreating/avoiding in fear, a pattern that has been attributed to early neglect, physical or sexual abuse and abandonment (Fonagy, 2011). And I was repeating a part of their early experience. I was eliciting and allowing the reliving of painful experience, and then abandoning them. And I was doing the same to their children, with whom I had formed relationships during the time I worked at the crèche, and then I left, once I had got what I came for. I dread standing accused of, as one social scientist commented to another about a keynote speaker at a conference, “She wears other people’s pain like jewellery” (Swartz, personal communication, August 6, 2012).

There is a deeper, more pervasive structural issue at stake here. The services that the Saartjie Baartman Centre offer are in my view outstanding, but out of necessity, in terms of resources and the pressure of need, limited in terms of the length of time they can be offered. This is not unique to Saartjie Baartman, but a function of the difficulty of balancing needs with available resources that affects most organisations like it. For women who have experienced transgenerational trauma in particular, developing relationships of trust which are short-term and unsustainable can be highly re-traumatising. There are no easy answers to dilemmas such as these. But it is important to be conscious of them, and to work against re-traumatising survivors of trauma wherever possible.

### **Limitations and Recommendations**

There is a far greater need for qualitative studies on shame than there is for quantitative studies. Although there is a vast quantitative literature on shame and psychopathology and a major theoretical literature on shame, there are virtually no qualitative studies on shame. Having said that, this study would have been stronger methodologically if I had triangulated methods; I would have been able to come up with firmer conclusions.

Firstly, considering the relative emphasis on psychopathology in my study, it would have been desirable to administer clinical scales assessing for the presence of chronic trauma- and/or shame-related disorders. For example, PTSD is often accompanied by other, comorbid disorders such as panic disorder, simple phobia, social phobia, substance misuse, and in women in particular, dissociation, eating disorders (bulimia and anorexia nervosa) and personality disorders (Carey et al., 2003; Ford & Courtois, 2009; Sanftner & Crowther, 1998;

Seedat, Stein, & Forde, 2005). BPD in particular has been associated with shame and suicidality in a number of studies (Brown et al., 2009; Chan et al., 2005). Observation and interviews alone could not assess for the presence of any of these disorders. Future South African research on chronic trauma and shame should triangulate methods and clinically assess for the presence of these disorders and relate them to chronic trauma exposure. The associations between exposure to chronic trauma, psychosomatic complaints and psychopathology also need to be tested quantitatively, with reliable and validated instruments. Secondly, qualitative constructions of shame could have been complemented by quantitative measures of shame, particularly since shame was so often unspoken. Scales such as the Test of Self Conscious Affect (TOSCA) (Tangney, Wagner, & Gramzow, 1989), its predecessor, the Self-Conscious Affect and Attribution Inventory (SCAAI; Tangney, 1990), and the Dimensions of Consciousness Questionnaire (DCQ; Johnson et al., 1987), the Adapted Shame and Guilt Scale (ASGS; Hobitzelle, 1987), the Internalized Shame Scale (ISS; Cook, 1988; 1996), and the Personal Feelings Questionnaire – 2 (PFQ-2; Harder & Zalma, 1990) are examples of quantitative measures of shame. The use of these measures would be valuable chiefly in studies triangulating qualitative and quantitative methods. Although counter-intuitive, some research suggests that the repeated telling of one's narrative leads to an increase in narrative length rather than a decrease in narrative length. Foa et al. (1995) found that narrative length increased from pre-exposure therapy to post-exposure therapy. Specifically, the percentage of thoughts and feelings increased, especially thoughts illustrative of attempts to organise the traumatic memory, while the percentage of action and dialogue (concrete details of the trauma) decreased. This was associated with an improvement in mental health outcomes (Foa et al., 1995). Similarly, in another study, level of simplicity or complexity of rape narratives was inversely associated to chronic PTSD, which is consistent with the idea that simpler, less developed trauma narratives impede recovery (Amir et al., 1998). It would have been useful to do a quantitative analysis of the relationship between trauma narrative length and mental health outcomes in my participants, to see if this relationship is applicable in the South African setting.

I believe my study could have been enriched by a more detailed and comprehensive study of the relationships between culture and shame. South Africa is characterised by a great deal of cultural diversity, but from observation of the women I interviewed, it appeared that they endorsed the values of a broadly individualistic culture, and that they reacted in shame against a culture of honour maintained by patriarchal, oppressive men in their communities. But these

are mere reflections. A more systematic and in-depth investigation of these associations would add to our understanding of why these women experienced shame in the way they did, as a thoroughly social (and stigmatising) emotion, which one would expect from more collectivistic cultures. But as noted in chapter 4, the distinction between individualistic and collectivistic cultures is not as simple as initially believed, which may account for this unexpected finding (Swartz, 1985, 1998). These women experienced shame on an individual level, but associated it with the authentic self being seen, exposed, by others, even others from the same social group as they came from themselves. And they saw all IPV survivors, as a group, as inherently shameful; stigmatised, but unlike one would expect in a collectivistic culture, they did not feel their own shame reflected badly on the social group they belonged to.

There is an acute lack of prevalence studies of chronic trauma and its correlates in South Africa. In addition, there is a dearth of longitudinal studies on chronic trauma, shame and psychological outcomes, both internationally and locally. But qualitative studies are just as rare. And the advantages of conducting a qualitative study is that you gain access to a fuller, in-depth verbal and non-verbal understanding of the topic at hand – in this case, shame - with all its complexities, intricacies, contradictions, ambiguities and nuances.

## **Conclusion**

In this final section I draw together the most striking findings emerging from this study. Most of these findings have been mentioned elsewhere, in different contexts, but this final section provides the reader with a convenient summary of key findings.

One of the most important findings involves (external) shame, often described or interpreted as humiliation (more so than embarrassment) in this study, which requires a hostile, mocking audience who sees the now exposed authentic self. This, as we have seen, is not a necessary precondition of (internal) shame. Unlike shame, humiliation does not involve the negative evaluation of the self by the self, instead it involves the self's negative evaluation (and blame) of the other whom s/he believes has behaved unjustly towards him/her (Elison & Harter, 2007; Gilbert, 1998). When experiencing humiliation, there is an audience who no longer respects the shamed self, the self who feels stigmatised and experiences status anxiety (the self, who in evolutionary terms, has lost SAHP). The self responds by feeling humiliated fury,

frequently turned inward, which leads to the fused construct I spoke of earlier – the experience of the global negative self-perceptions (including feelings of deservedness and “badness”) associated with a shame-prone emotional style. However socially defined, these emotional processes occur in an individualistic culture where individual shame does not reflect badly on the group as in collectivistic cultures, but in a culture that values certain types of status that these women do not have access to (for example, financial independence). It also manifests within a cultural/linguistic system where the word “shame” is poorly differentiated (e.g. the word “shame” includes embarrassment and shyness, for instance, in Oriya Brahmans [Shweder, 2003], in Bengkulu [Fessler, 2004] and in Japanese culture [Lebra, 1983]), and has negative connotations that emphasise blame, vulnerability and fallibility, and consequently do not facilitate its expression, and so, the possibility of freedom from its bondage.

Women I interviewed were exposed to a great deal of diverse and overlapping traumas. Transgenerational trauma, emotional abuse, and having children witness abuse between parents were cited as the most traumatic experiences for women. Research has demonstrated that earlier onset trauma (before the age of 14 years) is associated with significantly more dissociative symptoms, difficulties in modulating anger and self-destructive and suicidal behaviours than for older survivors of interpersonal traumas or acute traumas/disasters (Van der Kolk et al., 1996). As will be described, these are all symptoms that were evident in my participants, suggesting high rates of child abuse.

The most striking reported mental health outcomes (I did not formally assess levels of psychopathology) were persistent fear, depression and suicidality, dissociation and somatic complaints. Coping mechanisms included religion, support from family, counselling and substance misuse. Using smiling as a mask to conceal difficult feelings, and keeping occupied were cited as the most effective defenses.

One of the most significant findings emerging from the categorical content analysis and the narrative analysis from a social constructivist point of view, is the presence of the split self amongst participating women – the authentic self who admitted to a great deal of shame when asked indirectly, and the false self who was described in surprisingly positive terms when asked directly. Eleven women demonstrated a significant split between the false, socially conforming self, and the shame-based authentic self. I firstly analysed this split on an individual level, drawing attention to its manifestation in chronic trauma syndromes such as Complex PTSD and DESNOS, and how it is amplified by complicity with the perpetrator –

by remaining silent, and keeping the abuse secret. Secondly, I analysed the split at organisational level, and drew attention to women's counter-narratives, in which they constructed themselves as strong survivors, which was consistent with the ethos of the Saartjie Baartman Centre. I critically evaluated the authenticity of these counter-narratives, which are by definition meant to be resistance narratives, and came to the conclusion that they were not "true" counter narratives, because they were based on what had been micro-culturally (organisationally) – however well-intentioned - imposed upon them. They were not new identities that women had constructed for themselves, which is why these claims of inner strength and survivorhood often felt thinly-veiled and forced. Finally, I analysed the split at cultural level, and focused on cultures of shame and honour. I argued that cultures of honour develop where poverty is pervasive, and where, as a result, social status and patriarchy are held in high esteem (Cohen et al., 1998). Patriarchy in cultures of honour is maintained by the reactive shame that women feel, this being a shame-based response pattern which recurs cyclically at cultural level. This is why IPV was considered normative in these communities. However, paradoxically, considering its normative status, women also expressed a great deal of shame, humiliation and embarrassment about IPV. I argue that women are unconsciously complicit in preserving the gender-based status quo – they protect the dominance, strength and authority of men in cultures of honour, and the "right" of these men to own or possess them at the cost of valued parts of themselves, and that they blame themselves for their abuse, which is an undeniably painful process, however unconscious.

I believe the numerous references to social status, respect, and seeking financial security (representing a preoccupation with stigma, stigma consciousness, and status anxiety) in both chapters 7 and 8 is a compensatory effort made by the individual false self for the culturally-determined shame felt by the shame-based authentic self.

In the final results and discussion chapter, I explore trauma and shame narratives for significant signs of related pathology: psychic fragmentation. I analysed five long, complex narratives using Gee's (1991) method, and three short, compressed narratives, using a more informal method to demonstrate how the unspeakable manifests for some narrators in bodily form. The nature and length of trauma narratives have implications for narrators' mental health; shorter narratives are associated with poorer outcomes (Amir et al., 1998; Foa et al., 1995).

The structure of the short narratives tended to be circular, erratic, disjointed, and interrupted (Scarry, 1985; Simon, 2008). The three short, compressed trauma narratives were

characterised by long pauses or silences, hesitations, avoiding eye contact, hunching over, covering the face with clothes, whispering, so making the narrative almost inaudible, crying, and defensive leaning in towards me, and laughing. These women were exceptions – most women expressed an urgency to talk about their experiences. Yet these women did want to talk; their bodies were talking for them. This is why traumatic memory is so often communicated through the body (Simon, 2008).

Although the longer narratives are essentially fractured chaos narratives at linguistic level, they contain predominant trauma- and shame-related themes that are consistent throughout the narratives and that remain intact in spite of the signs of linguistic disruption and fragmentation. They are, in order of narratives, 1) shame/self-blame and deservedness; 2) truth/lies and bearing witness; 3) shame, humiliation and dissociation; 4) the concealed, shame-based self, including amnesiac-like disorientation of place and time; and 5) patterns of cyclical leave-return reflecting perpetrator-instilled abandonment terror, including disorientation of time. I have argued that although language, or narrative structure, continues to mimic and reflect narrative content (fractured narratives vs fractured selves) – there is also the fascinating possibility of a disconnection between form and content; and that thematic coherence or consistency and narrative fracturing can co-occur; co-exist.

I would argue that from the five narratives I analyse, a linguistic and semantic pattern emerges. At linguistic or structural level, the narrators produce non-linear, disrupted, fragmented narratives through the use of linguistic devices such as repetition; the meaningless use of connecting words such as “and”, “then” and “because”; ellipses, followed by incomplete “sentences”; and incomprehensible phrases. These linguistic features do not occur randomly – they occur, without exception, at particularly significant, painful or shameful parts of the narrative. Both “macro-fracturing” (major structural breakdowns) and “micro-fracturing” (minor structural ruptures) occur in some of the narratives.

The theme of shame is ubiquitous in at least three of the narratives. Four aspects of chronic trauma also feature in the narratives: firstly, disorganised attachment patterns, and abandonment terror; secondly, the issue of credibility/being believed and bearing witness to the trauma; and thirdly, the emotional investment in the perpetrator-defined identity (the “bad”, blamed, shamed self). Fourthly, in at least one of the narratives, there is evidence of substantial disorientation: disturbances in space and time which take place when trauma memories are encoded without a spatio-temporal frame to organise them, creating memories which are disjointed and fractured, which lack spatial and temporal orientation and can induce

deficits in episodic memory (Payne et al., 2004). These features are either related to, or comprise diagnostic criteria for chronic trauma syndromes such as chronic PTSD and DESNOS, and intersect with shame themes in the narratives I analysed. Consequently, I would argue that there is a substantial intersection or co-occurrence between exposure to chronic trauma, and trauma-related clinical symptoms, including shame, which emerge from the narratives, which without exception, demonstrate noteworthy linguistic fracturing.

To expand on this interpretation, firstly, I would argue that a global pattern of negative self-evaluative responses is the process underlying a shame-prone emotional style borne out of repeated exposure to trauma. Following this argument, chronically traumatised individuals are likely to have shame-based self-esteems, which I would argue should be included as a diagnostic criterion for all chronic trauma-based syndromes. Secondly, the linguistic fracturing referred to at the end of the last paragraph is representative of the fragmentation of self, which is the basis of dissociative and complex traumatic syndromes. Thus, in my view, both shame and fragmentation/dissociation link and underlie complex trauma-based syndromes. Van der Hart, Nijenhuis, & Steele (2006) have worked on a theoretical approach which supports this argument. They argue that trauma-related dissociation unifies psychiatric disorders with a traumatic stress source, and provide an associated treatment model. In essence, existing research and the outcomes of my study show that shame is embedded in chronic trauma, yet literature linking the two is limited. Shame (and linguistic fragmentation, as representative of the fractured self) has been associated with a range of trauma-related psychopathological outcomes, yet it is not included as a diagnostic criterion in most chronic trauma-based syndromes. Van der Kolk argues in his 1994 article that there has been debate about diagnostic criteria in the DSM system for PTSD in particular for (now) over three decades. This lack of attention to shame as a central contributor to psychopathology, combined with the complex comorbidity associated with chronic trauma undermines clinical efficiency and the effectiveness of treatments. In fact, shame has been described as a key predictor of Complex PTSD independent of fear, helplessness, and horror, and contributes to psychological recovery among childhood abuse survivors who experience adult-onset trauma (Cloitre et al., 2009). It is viewed by these authors as the “core” emotion resulting from chronic trauma (Cloitre et al., 2009).

In conclusion, women participating in this study were in what Wozniak and Allen (2012, p. 85) define as a “liminal space”. Liminality is characterised by a separation from one’s old life, and transition towards a time of ambiguity, rolelessness and danger, where individuals are no

longer who they were, but they have not yet become something personally and socially different (Wozniak & Allan, 2012). Women who continue to identify themselves as either victims or survivors of intimate partner violence, as these participants did, in their (imposed) counter-narratives, remain in liminality (Wozniak & Allan, 2012). The danger is that crisis intervention often ends at this point, leaving women to perpetuate their psychological investment in an identity blemished by deficit, stigma and shame (Wozniak & Allan, 2012). It was during this important time of transition that I collected my data. Most women had already attempted to alter their identity from victim to survivor, at least at a superficial level, but few could see beyond an identity defined through abuse. It is my sincere hope that through continued mental health interventions, for as long as is sustainable, these women will begin to construct narratives that will free them of the bondage of a shame-filled, perpetrator-defined identity. That they will construct narratives that free them from their persistent fear, their wishes to die, their numbness, and their sense of unreality, or dissociation; their descriptions of seeing the world through a “bubble”, a pane of glass. It reminds me of a quote by author Martha Beck (2005), who in her recent autobiography refers to her identification with Virginia Woolf, who was never able to free herself from such bondage, particularly the paralysis, the numbness, of dissociation. I wish for these women what Beck (2005, p. 220) says:

I am endlessly grateful for the fact that I was lucky enough to learn something Virginia Woolf never realized: glass can melt. It melted for me when I began allowing myself to know what I already knew, to feel consciously the pain I'd been ignoring almost all my life... Call it awakening, call it being born again, call it whatever you like; but the sensation of my disowned self moving back into my body was so strange and delicious that it occupied much of my attention for many months. In the words of another female writer, Emily Dickinson, 'to live is so startling it leaves little time for anything else.'

## REFERENCES

- Abrahams, N., Jewkes, R., Laubscher, R., & Hoffman, M. (2006). Intimate partner violence: Prevalence and risk factors for men in Cape Town, South Africa. *Violence and Victims, 21*(2), 247-264.
- Abrahams, N., Jewkes, R., & Mathews, S. (2010). Guns and gender-based violence in South Africa. *South African Medical Journal, 100*, 586-588.
- Abrahams, N., Martin, L. J., Mathews, S., Vetten, L., & Lombard, C. (2009). Mortality of women from intimate partner violence in South Africa: A national epidemiological study. *Violence and Victims, 24*(4), 546-556.
- Alessandri, S. M., & Lewis, M. (1996). Differences in pride and shame in maltreated and nonmaltreated preschoolers. *Child Development, 67*, 1857-1869.
- Amir, N., Stafford, J., Freshman, M. S., & Foa, E. B. (1998). Relationship between trauma narratives and trauma pathology. *Journal of Traumatic Stress, 11*(2), 385-392.
- Anderson, J. W., & Winer, J. A. (2003) Recent psychoanalytic theorists and their relevance to psychobiography: Winnicott, Kernberg, and Kohut. *Annual of Psychoanalysis, 31*, 79-94.
- Andrews, B. (1995). Bodily shame as a mediator between abusive experiences and depression. *Journal of Abnormal Psychology, 104*(2), 277-285.

- Andrews, B. (1997). Bodily shame in relation to abuse in childhood and bulimia: A preliminary investigation. *The British Journal of Clinical Psychology*, 36(1), 41-49.
- Andrews, B. (1998). Shame and childhood abuse. In P. Gilbert, & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 176-191). Oxford, UK: Oxford University Press.
- Andrews, B., & Brewin, C. R. (1990). Attributions of blame for marital violence: A study of antecedents and consequences. *Journal of Marriage & Family*, 52(3), 757-767.
- Andrews, B., Brewin, C. R., Rose, S., & Kirk, M. (2000). Predicting PTSD symptoms in victims of violent crime: The role of shame, anger, and childhood abuse. *Abnormal Psychology*, 109(1), 69-73.
- Andrews, M. (2004). Counter-narratives and the power to oppose. In M. Bamberg & M. Andrews (Eds.), *Considering counter-narratives: Narrating, resisting, making sense* (pp. 1-7). Amsterdam, Netherland: John Benjamins Publishing Company.
- Anolli, L., & Pascucci, P. (2005). Guilt and guilt-proneness, shame and shame-proneness in Indian and Italian young adults. *Personality and Individual Differences*, 39, 763-773.
- Ausubel, D. P. (1955). Relationships between shame and guilt in the socializing process. *Psychological Review*, 62(5), 387-390.
- Baerger, D. R., & McAdams, D. P. (1999). Life story coherence and its relation to psychological well-being. *Narrative Inquiry*, 9(1), 69-96.

- Bamberg, M. (2004). Considering counter narratives. In M. Bamberg, & M. Andrews (Eds.), *Considering counter-narratives: Narrating, resisting, making sense* (pp. 351-373). Amsterdam, Netherland: John Benjamins Publishing Company.
- Barbarin, O. A., & Richter, L. M. (2001). *Mandela's children: Growing up in post-apartheid South Africa*. New York, NY: Routledge.
- Barbarin, O. A., Richter, L., & De Wet, T. (2001). Exposure to violence, coping resources, and psychological adjustment in South African children. *American Journal of Orthopsychiatry*, 71(1), 16-25.
- Barrett, K. C. (1995). A functionalist approach to shame and guilt. In J. P. Tangney, & K. W. Fischer (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment and pride* (pp. 25-64). New York, NY: The Guilford Press.
- Beaudreau, S. A. (2007). Are trauma narratives unique and do they predict psychological adjustment? *Journal of Traumatic Stress*, 20(3), 353-357.
- Beck, A. T. (1985). The evaluation anxieties. In A. T. Beck, G. Emery, & R. L. Greenberg (Eds.), *Anxiety disorders and phobias: A cognitive perspective* (pp. 146-167). New York, NY: Basic Books, Inc.
- Beck, M. (2005). *Leaving the saints: How I lost the Mormons and found my faith*. New York, NY: Three Rivers Press.
- Bedford, O. (2004). The individual experience of guilt and shame in Chinese culture. *Culture Psychology*, 10(29), 29-52.

- Bedford, O., & Hwang, K. (2003). Guilt and shame in Chinese culture: A cross-cultural framework from the perspective of morality and identity. *Journal for the Theory of Social Behavior*, 33(2), 127-144.
- Benjamin, L., & Crawford-Browne, S. (2010, March). The psychological impact of continuous traumatic stress; limitations of existing diagnostic frameworks. Paper presented at Continuous Traumatic Stress in South Africa: Towards a Collaborative Research Agenda, Cape Town, South Africa.
- Berke, J. H. (1987). Shame and envy. In D. L. Nathanson (Ed.), *The many faces of shame* (pp. 318-335). New York, NY: The Guilford Press.
- Besser, A., & Priel, B. (2009). Emotional responses to a romantic partner's imaginary rejection: The roles of attachment anxiety, covert narcissism, and self-evaluation. *Journal of Personality*, 77(1), 287-325.
- Bierbrauer, G. (1992). Reactions to violation of normative standards: A cross-cultural analysis of shame and guilt. *International Journal of Psychology*, 27(2), 181-193.
- Birchwood, M., Trower, P., Brunet, K., Gilbert, K., Iqbal, Z., & Jackson, C. (2006). Social anxiety and the shame of psychosis: A study in first episode psychosis. *Behavior Research and Therapy*, 45, 1025-1037.
- Bouwer, C., & Stein, D. J. (1998). Survivors of torture presenting at an anxiety disorders clinic: Symptomatology and pharmacotherapy. *The Journal of Nervous and Mental Disease*, 186(5), 316-318.
- Bradbury, P., & Day Sclater, S. (2009). Narrative and discourse: Conclusion. In M. Andrews, S. Day Sclater, C. Squire, & A. Treacher (Eds.), *The uses of narrative: Explorations in*

- sociology, psychology, and cultural studies* (pp. 193-199). New Brunswick, NJ: Transaction Publishers.
- Bradshaw, J. (2005). *Healing the shame that binds you*. Florida, FL: Health Communications, Inc.
- Brewerton, T. D. (2007). Eating disorders, trauma, and comorbidity: Focus on PTSD. *Eating Disorders, 15*(4) 285-304.
- Breugelmans, S. M., & Poortinga, Y. H. (2006). Emotion without a word: Shame and guilt among Raramuri Indians and rural Javanese. *Journal of Personality and Social Psychology, 91*(6), 1111-1122.
- Brewin, C. R., Andrews, B., & Rose, S. (2000). Fear, helplessness, and horror in posttraumatic stress disorder: Investigating DSM-IV Criterion A2 in victims of violent crime. *Journal of Traumatic Stress, 13*(3), 499-509.
- Brewin, C. R., & Holmes, E. A. (2003). Psychological theories of posttraumatic stress disorder. *Clinical Psychology Review, 23*, 339-376.
- Brockmeier, J., & Carbaugh, D. (2001). Introduction. In J. Brockmeier, & D. Carbaugh (Eds.), *Narrative and identity: Studies in autobiography, self and culture* (pp.1-25). Amsterdam: John Benjamins Publishing Co.
- Brockmeier, J., & Harré, R. (2001). Problems and promises of an alternative paradigm. In J. Brockmeier, & D. Carbaugh (Eds.), *Narrative and identity: Studies in autobiography, self and culture* (pp. 39-59). Amsterdam: John Benjamins Publishing Co.
- Broucek, F. J. (1991). *Shame and the self*. New York, NY: The Guilford Press.

- Brown, D. (2009). Assessment of attachment and abuse history, and adult attachment style. In C. A. Courtois, & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 124-145). New York, NY: The Guilford Press.
- Brown, J. (2004). Shame and domestic violence: Treatment perspectives for perpetrators from self-psychology and affect theory. *Sexual and Relationship Therapy, 19*(1), 39-55.
- Brown, M. Z., Linehan, M. M., Comtois, K. A., Murray, A., & Chapman, A. L. (2009). Shame as a prospective predictor of self-inflicted injury in borderline personality disorder: A multi-modal analysis. *Behavior Research and Therapy, 47*, 815-822.
- Bruner, J. (1991). The narrative construction of reality. *Critical Inquiry, 18*, 1-21.
- Bruner, J. (1994). The remembered self. In U. Neisser, & R. Fivush (Eds.), *The remembering self: Construction and accuracy in the self-narrative* (pp. 41-53). Cambridge, UK: Cambridge University Press.
- Bruner, J. (2001). Self-making and world-making. In J. Brockmeier & D. Carbaugh (Eds.), *Narrative and identity: Studies in autobiography, self and culture* (pp. 25-39). Amsterdam: John Benjamins Publishing Co.
- Buber, M. (1958). *I and thou*. New York, NY: Charles Scribner's Sons.
- Burck, C. (2005). Comparing qualitative research methodologies for systemic research: The use of grounded theory, discourse analysis and narrative analysis. *Journal of Family Therapy, 27*, 237-262.

- Burke, P. A., & Bradley, R. G. (2006). Language use in imagined dialogue and narrative disclosures of trauma. *Journal of Traumatic Stress, 19*(1), 141-146.
- Bybee, J. A., & Zigler, E. (1991). Self-image and guilt: A further test of cognitive-developmental formulation. *Journal of Personality, 59*(4), 733-745.
- Campbell, J. C. (2002). Health consequences of intimate partner violence. *Lancet, 359*, 1331-1336.
- Carey, P. D., Stein, D. J., Zungu-Dirwayi, N., & Seedat, S. (2003). Trauma and posttraumatic stress disorder in an urban Xhosa primary care population: Prevalence, comorbidity, and service use patterns. *Journal of Nervous and Mental Disease, 191*(4), 230-236.
- Carey, P. D., Walker, J. L., Rossouw, W., Seedat, S., & Stein, D. J. (2008). Risk indicators and psychopathology in traumatized children and adolescents with a history of sexual abuse. *European Child and Adolescent Psychiatry, 17*, 93-98.
- Carlson, B. E. (1997). A stress and coping approach to intervention with abused women. *Family Relations, 46*(3), 291-298.
- Chan, M. A., Hess, G. C., Whelton, W. J., & Yonge, O. J. (2005). A comparison between female psychiatric outpatients with BPD and female university students in terms of trauma, internalized shame and psychiatric symptomatology. *Traumatology, 11*, 23-40.
- Charmaz, K. (2005). Grounded theory in the 21st century: Applications for advancing social justice studies. In N. K. Denzin, & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3<sup>rd</sup> ed.) (pp. 507-537). London, UK: Sage Publications.
- Charon, R. (2006). *Narrative medicine: Honouring the stories of illness*. Oxford, UK: Oxford University Press.

- Charon, R. (2008). Material and metaphor: Narrative treatment for the embodied self. In P. L. Rudnytsky, & R. Charon (Eds.), *Psychoanalysis and narrative medicine* (pp. 287-295). New York, NY: State University of New York Press.
- Chase, S. E. (2011). Narrative inquiry: A field in the making. In N. K. Denzin, & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (4<sup>th</sup> ed.) (pp. 421-435). California, CA: Sage Publications.
- Choma, B. K., Shove, C., Busseri, M. A., Sadava, S. W., & Hosker, A. (2009). Assessing the role of body image coping strategies as mediators or moderators of the links between self-objectification, body shame, and well-being. *Sex Roles, 61*(9-10), 699-713.
- Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry: Experience and story in qualitative research*. San Francisco, CA: Jossey-Bass.
- Cloitre, M., Cohen, L., & Koenen, K. (2006). *Treating survivors of childhood abuse: Psychotherapy for the interrupted life*. New York: The Guilford Press.
- Cloitre, M., Stolbach, B. C., Herman, J. L., Van der Kolk, B., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to Complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress, 22*(5), 399-408.
- Cohen, D., Vandello, J., & Rantilla, A. K. (1998). The sacred and the social: Cultures of honor and violence. In P. Gilbert, & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 261-283). New York, NY: Oxford University Press.

- Cohler, B., & Hammack, P. (2006). Making a gay identity: Life-story and the construction of a coherent self. In D.P. McAdams, R. Josselson, & A.Lieblich (Eds.), *Identity and story: Crafting self in narrative* (pp. 151-17). Washington DC: The American Psychological Association.
- Collimore, K. C., Carleton, R. N., Hofmann, S. G., & Asmundson, G. J. G. (2010). Posttraumatic stress and social anxiety: The interaction of traumatic events and interpersonal fears. *Depression and Anxiety, 27*, 1017-1026.
- Collings, S. J. (1995). The long-term effects of contact and noncontact forms of child sexual abuse in a sample of university men. *Child Abuse & Neglect, 19*(1), 1-6.
- Collings, S. J. (1997). Child sexual abuse in a sample of South African women students: Prevalence, characteristics, and long-term effects. *South African Journal of Psychology, 27*(1), 1-14.
- Cook, D. (1988). Measuring shame: The internalized shame scale. *Alcoholism Treatment Quarterly, 4*, 197-215.
- Cook, D. (1996). Empirical studies of shame and guilt: The Internalized Shame Scale. In D. L. Nathanson (Ed.), *Knowing feeling: Affect, script and psychotherapy* (pp. 132-165). New York, NY: Norton.
- Corbett, A., Cottis, T., & Lloyd, E. (2012). The survival and development of a traumatized clinic for psychotherapy for people with intellectual disabilities. In E. Hopper (Ed.), *Trauma and organizations* (pp. 111-129). London: Karnac.
- Corstorphine, E., Waller, G., Lawson, R., & Ganis, C. (2007). Trauma and multi-impulsivity in the eating disorders. *Eating Behaviors, 8*(1), 23-30.

- Craib, I. (2009). Narratives as bad faith. In M. Andrews, S. Day Sclater, C. Squire, & A. Treacher, (Eds.), *The uses of narrative: Explorations in sociology, psychology, and cultural studies* (pp. 64-75). New Brunswick, NJ: Transaction Publishers.
- Crossley, M. (2000). *Introducing narrative psychology: Self, trauma, and the construction of meaning*. Buckingham, UK: Open University Press.
- Crowe, M. (2004). Never good enough – part 1: Shame or borderline personality disorder? *Journal of Psychiatric and Mental Health Nursing*, 11, 327-334.
- Dawes, A., & Ward, C. (2008). Levels, trends, and determinants of child maltreatment in the Western Cape Province. In R. Marindo, C. Groenewald, & S. Gaisie (Eds.), *The state of population in the Western Cape province* (pp. 97-125). Cape Town, South Africa: HSRC Press.
- Day Sclater, S. (2009). Narrative and discourse: Introduction. In M. Andrews, S. Day Sclater, C. Squire, & A. Treacher (Eds.), *The uses of narrative: Explorations in sociology, psychology, and cultural studies* (pp. 129-131). New Brunswick, NJ: Transaction Publishers.
- De Botton, A. (2005). *Status anxiety*. London, UK: Penguin Books.
- De Zulueta, F. (2011). Post-traumatic stress disorder and dissociation: The traumatic stress service in the Maudsley hospital. In V. Sinason (Ed.), *Attachment, trauma and multiplicity* (pp. 96-110). London, UK: Routledge.

- Dearing, R. L., Stuewig, J., & Tangney, J. P. (2005). On the importance of distinguishing shame from guilt: Relations to problematic alcohol and drug use. *Addictive Behaviors, 30*, 1392-1404.
- Dorahy, M.J. (2010). The impact of dissociation, shame, and guilt on interpersonal relationships in chronically traumatized individuals: A pilot study. *Journal of Traumatic Stress, 23*, 653-656.
- Dost, A., & Yagmurlu, B. (2008). Are constructiveness and destructiveness essential features of guilt and shame feelings respectively? *Journal for the Theory of Social Behavior, 38*(2), 109-129.
- Dunkle, K. L., Jewkes, R. K., Brown, H. C., Gray, G. E., McIntyre, J. A., & Harlow, S. D. (2004a). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet, 363*, 1415-1421.
- Dunkle, K. L., Jewkes, R. K., Brown, H. C., Gray, G. E., McIntyre, J. A., & Harlow, S. D. (2004b). Transactional sex among women in Soweto, South Africa: Prevalence, risk factors and association with HIV infection. *Social Science & Medicine, 59*, 1581-1592.
- Dunkle, K. L., Jewkes, R. K., Brown, H. C., Yoshihama, M., Gray, G. E., McIntyre, J. A., & Harlow, S. D. (2004). Prevalence and patterns of gender-based violence and revictimization among women attending antenatal clinics in Soweto, South Africa. *American Journal of Epidemiology, 160*, 230-239.
- Dutra, L., Callhan, K., Forman, E., Mendelsohn, M., & Herman, J. (2008). Core schemas and suicidality in a chronically traumatized population. *The Journal of Nervous and Mental Disease, 196*(1), 71-74.

- Dutton, D. G., Van Ginkel, C., & Starzomski, A. (1995). The role of shame and guilt in the intergenerational transmission of abusiveness. *Violence and Victims, 10*(2), 121-131.
- Ebert, A., & Dyck, M. J. (2004). The experience of mental death: The core feature of complex posttraumatic stress disorder. *Clinical Psychology Review, 24*, 617-635.
- Edelstein, R. S., & Shaver, P. R. (2007). A cross-cultural examination of lexical studies of self-conscious emotions. In J. L. Tracy, R. W. Robins, & J. P. Tangney (Eds.), *The self-conscious emotions: Theory and research* (pp. 194 - 208). New York, NY: The Guilford Press.
- Edwards, D. (2005). Post-traumatic stress disorder as a public health concern in South Africa. *Journal of Psychology in Africa, 15*(2), 125-134.
- Eid, M., & Diener, E. (2001). Norms for experiencing emotions in different cultures: Inter- and intrainational differences. *Journal of Personality and Social Psychology, 81*, 869-885.
- Elison, J. (2005). Shame and guilt: A hundred years of apples and oranges. *New Ideas in Psychology, 23*, 5-32.
- Elison, J., & Harter, S. (2007). Humiliation: Causes, correlates, and consequences. In J. L. Tracy, R. W. Robins, & J. P. Tangney (Eds.), *The self-conscious emotions: Theory and research* (pp. 310-330). New York, NY: The Guilford Press.
- Elliott, J. (2005). *Using narrative in social research: Qualitative and quantitative approaches*. London: Sage Publications.

- Elsass, P. (2001). Individual and collective traumatic memories: A qualitative study of post-traumatic stress disorder symptoms in two Latin American localities. *Transcultural Psychiatry*, 38, 306-316.
- Emerson, P., & Frosh, S. (2009). *Critical narrative analysis in psychology. A guide to practice*. Basingstoke: Palgrave Macmillan.
- Emery, G. (1985). Modifying the affective component. In A.T. Beck, G. Emery, & R. L. Greenberg (Eds.), *Anxiety disorders and phobias: A cognitive perspective* (pp. 232-258). New York, NY: Basic Books, Inc.
- Erikson, E. (1950). *Childhood and society*. London, UK: W. W. Norton and Company.
- Fairbairn, W. (1943). The repression and return of bad objects. In D. E. Scharff, & E. F. Birtles (Eds.), *Psychoanalytic studies of the personality* (1952) (pp. 59-82). London, UK: Tavistock.
- Feinauer, L., Hilton, H. G., & Callahan, E. H. (2003). Hardiness as a moderator of shame associated with childhood sexual abuse. *The American Journal of Family Therapy*, 31, 65-78.
- Feiring, C., Taska, L., & Chen, K. (2002). Trying to understand why horrible things happen: Attribution, shame, and symptom development. *Child Maltreatment*, 7, 25-39.
- Feiring, C., Taska, L., & Lewis, M. (1996). A process model for understanding adaptation to sexual abuse: The role of shame in defining stigmatization. *Child Abuse & Neglect*, 20(8), 767-782.

- Feiring, C., Taska, L., & Lewis, M. (2002). Adjustment following sexual abuse discovery: The role of shame and attributional style. *Developmental Psychology, 38*(1), 79-92.
- Ferguson, T. J., Brugman, D., White, J., & Eyre, H. L. (2007). Shame and guilt as morally warranted experiences. In J. L. Tracy, R. W. Robins, & J. P. Tangney (Eds.), *The self-conscious emotions: Theory and research* (pp. 330-351). New York, NY: The Guilford Press.
- Ferguson, T. J., Stegge, H., & Damhuis, I. (1991). Children's understanding of guilt and shame. *Child Development, 62*, 827-839.
- Fessler, D. M. T. (2004). Shame in two cultures: Implications for evolutionary approaches. *Journal of Cognition and Culture, 4*(2), 207-262.
- Fessler, D. M. T. (2007). From appeasement to conformity: Evolutionary and cultural perspectives on shame, competition, and cooperation. In J. L. Tracy, R. W. Robins, & J. P. Tangney (Eds.), *The self-conscious emotions: Theory and research* (pp. 174 - 193). New York, NY: The Guilford Press.
- Fisher, S. F. (1985). Identity of two: The phenomenology of shame in borderline development and treatment. *Psychotherapy: Theory, Research, Practice, Training, 22*(1), 101-109.
- Fischer, A. H., Manstead, A. S. R., & Rodriguez Mosquera, P. M. (1999). The role of honour-related vs. individualist values in conceptualizing pride, shame, and anger: Spanish and Dutch cultural prototypes. *Cognition and Emotion, 13*, 149-179.
- Fischer, K. W., & Tangney, J. P. (1995). Self-conscious emotions and the affect revolution: Framework and overview. In J. P. Tangney, & K. W. Fischer (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride* (pp. 3-24). New York: Guilford.

- Foa, E. B., Molnar, C., & Cashman, L. (1995). Change in rape narratives during exposure therapy for posttraumatic stress disorder. *Journal of Traumatic Stress, 8*(4), 675-690.
- Fodor, I. (1996). A woman and her body: The cycles of pride and shame. In R. G. Lee, & G. Wheeler (Eds.), *The voice of shame: Silence and connection in psychotherapy* (pp. 229-269). San Francisco, CA: Jossey-Bass Publishers.
- Fonagy, P. (2011). Multiple voices versus meta-cognition: An attachment theory perspective. In V. Sinason (Ed.), *Attachment, trauma and multiplicity* (pp. 21-37). London, UK: Routledge.
- Ford, J. D., & Courtois, C. A. (2009). Defining and understanding complex trauma and complex traumatic stress disorders. In C. A. Courtois, & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 13-30). New York, NY: The Guilford Press.
- Foucault, M. (1977). *Discipline and punish: The birth of the prison*. Translated by Alan Sheridan, London: Allen Lane, Penguin. First published in French as *Surveiller et punir*, Gallimard, Paris, 1975.
- Frank, A. (1995). *The wounded storyteller: Body, illness and ethics*. Chicago, IL: The University of Chicago Press.
- Freeman, M. (2001). From substance to story: Narrative, identity and the reconstruction of self. In M. Andrews, S. Day Sclater, C. Squire, & A. Treacher (Eds.), *The uses of narrative: Explorations in sociology, psychology, and cultural studies* (pp. 283-299). New Brunswick, NJ: Transaction Publishers.

- Freeman, M. (2009). When the story's over: Narrative foreclosure and the possibility of self-renewal. In M. Andrews, S. Day Sclater, C. Squire, & A. Treacher (Eds.), *The uses of narrative: Explorations in sociology, psychology, and cultural studies* (pp. 81-92). New Brunswick, NJ: Transaction Publishers.
- Freeman, M., & Brockmeier, J. (2001). Narrative integrity: Autobiographical identity and the meaning of the "good life". In J. Brockmeier, & D. Carbaugh (Eds.), *Narrative and identity: Studies in autobiography, self and culture* (pp.75-103). Amsterdam: John Benjamins Publishing Co.
- Freer, B. D., Whitt-Woosley, A., & Sprang, G. (2010). Narrative coherence and the trauma experience: An exploratory mixed-method analysis. *Violence and Victims*, 25(6), 742-754.
- Freud, S. (1986). *On sexuality: Three essays on the theory of sexuality*. Middlesex, UK: Penguin Books.
- Friedman, S. S. (1993). A strategy for reading narrative. *Narrative*, 1(1), 12-23.
- Gamble, S. A., Talbot, N. L., Duberstein, P. R., Conner, K. R., Franus, N., Beckman, A., & Conwell, Y. (2006). Childhood sexual abuse and depressive symptom severity: The role of neuroticism. *The Journal of Nervous and Mental Disease*, 194(5), 382-385.
- Gass, J. D., Stein, D. J., Williams, D. R., & Seedat, S. (2010). Intimate partner violence, health behaviors, and chronic physical illness among South African women. *South African Medical Journal*, 100, 582-585.
- Gee, J. P. (1991). A linguistic approach to narrative. *Journal of Narrative and Life History*, 1(1), 15-39.

- Gergen, K. J. (1994). *Towards transformation in social knowledge* (2<sup>nd</sup> ed.). London, UK: Sage Publications.
- Gilbert, P. (1998). What is shame? Some core issues and controversies. In P. Gilbert, & B. Andrews (Eds.), *Shame: Interpersonal behaviors, psychopathology, and culture* (pp. 3-39). Oxford, UK: Oxford University Press.
- Gilbert, P. (2000). The relationship of shame, social anxiety and depression: The role of the evaluation of social rank. *Clinical Psychology and Psychotherapy*, 7, 174-189.
- Gilbert, P. (2007). The evolution of shame as a marker for relationship security: A biopsychosocial approach. In J. L. Tracy, R. W. Robins, & J. P. Tangney (Eds.), *The self-conscious emotions: Theory and research* (pp. 283-310). New York, NY: The Guilford Press.
- Gilbert, P., Allan, S., & Goss, K. (1996). Parental representations, shame, interpersonal problems, and vulnerability to psychopathology. *Clinical Psychology and Psychotherapy*, 3(1), 23-34.
- Gilbert, P., & Miles, J. N. V. (2000). Sensitivity to social put-down: Its relationship to perceptions of social rank, shame, social anxiety, depression, anger and self-other blame. *Personality and Individual Differences*, 29, 757-774.
- Ginzburg, K., Butler, L. D., Giese-Davis, J., Cavanaugh, C. E., Neri, E., Koopman, C., Classen, C. C., & Spiegel, D. (2009). Shame, guilt, and posttraumatic stress disorder in adult survivors of childhood sexual abuse at risk for human immunodeficiency virus: Outcomes of a randomized clinical trial of group psychotherapy treatment. *Nervous and Mental Disease*, 197(7), 536-42.

- Goetz, J. L., & Keltner, D. (2007). Shifting meanings of self-conscious emotions across cultures: A social-functional approach. In J. L. Tracy, R. W. Robins, & J. P. Tangney (Eds.), *The self-conscious emotions: Theory and research* (pp. 153-173). New York, NY: The Guilford Press.
- Goldberg, C. (1991). *Understanding shame*. Northvale, NJ: Jason Aronson Inc.
- Gray, M. J., & Lombardo, T. W. (2001). Complexity of trauma narratives as an index of fragmented memory in PTSD: A critical analysis. *Applied Cognitive Psychology, 15*, 171-186.
- Gready, P. (2008). The public life of narratives: Ethics, politics and methods. In C. Squire, M. Andrews, & M. Tamboukou (Eds.), *Doing narrative research* (pp. 137-151). London: Sage Publications.
- Green, B. L., Goodman, L. A., Krupnick, J. L., Corcoran, C. B., Petty, R. M., Stockton, P., & Stern, N. M. (2000). Outcomes of single versus multiple trauma exposure in a screening sample. *Journal of Traumatic Stress, 13*(2), 271-286.
- Greenwald, D. F., & Harder, D. W. (1998). Domains of shame: Evolutionary, cultural, and psychotherapeutic aspects. In P. Gilbert, & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 225-246). New York, NY: Oxford University Press.
- Gregg, G. S. (2006). The raw and the bland: A structural model of narrative identity. In D. P. McAdams, R. Josselson, & A. Lieblich (Eds.), *Identity and story: Creating self in narrative* (pp. 63-89). Washington, DC: American Psychological Association.
- Gubrium, J. F., & Holstein, J. A. (2009). *Analyzing narrative reality*. Los Angeles, CA: Sage.

- Halbertal, T. H., & Koren, I. (2006). Between “being” and “doing”: Conflict and coherence in the identity formation of gay and lesbian orthodox Jews. In D. P. McAdams, R. Josselson, & A. Lieblich (Eds.), *Identity and story: Creating self in narrative* (pp. 37-63). Washington, DC: American Psychological Association.
- Halligan, S. L., Michael, T., Clark, D. M., & Ehlers, A. (2003). Posttraumatic stress disorder following assault: The role of cognitive processing, trauma memory, and appraisals. *Journal of Consulting and Clinical Psychology, 71*(3), 419-431.
- Harder, D. W. (1995). Shame and guilt assessment, and relationships of shame- and guilt-proneness to psychopathology. In J. P. Tangney, & K. W. Fischer (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment and pride* (pp. 368-393). New York, NY: The Guilford Press.
- Harder, D. W., & Zalma, A. (1990). Two promising shame and guilt scales: A construct validity comparison. *Journal of Personality Assessment, 55*, 729-745.
- Harper, F. W. K., & Arias, I. (2004). The role of shame in predicting adult anger and depressive symptoms among victims of child psychological maltreatment. *Journal of Family Violence, 19*(6), 367-375.
- Hart, D., & Matsuba, M. K. (2007). The development of pride and moral life. In J. L. Tracy, R. W. Robins, & J. P. Tangney (Eds.), *The self-conscious emotions: Theory and research* (pp. 114-134). New York, NY: The Guilford Press.
- Hathaway, L. M., Boals, A., & Banks, J. B. (2010). PTSD symptoms and dominant emotional response to a traumatic event: An examination of DSM-IV Criterion A2. *Anxiety, Stress, & Coping, 23*(1), 119-126.

Hearn, J., & Morrell, R. (2012). Reviewing hegemonic masculinities and men in Sweden and South Africa. *Men and Masculinities*, 15(1), 3-10.

Heider, K. (1991). *Landscapes of emotion: Mapping three cultures of emotion in Indonesia*. New York, NY: Cambridge University Press.

Herman, J. (1997). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror*. New York, NY: Basic Books.

Hinshelwood, R. D. (2012). Personal trauma and collective disorder: The example of organisational psychodynamics in psychiatry. In E. Hopper (Ed.), *Trauma and organizations* (pp. 129-151). London: Karnac.

Hobitzelle, W. (1987). Differentiating and measuring shame and guilt: The relation between shame and depression. In H. B. Lewis (Ed.), *The role of shame in symptom formation* (pp. 207-236). Hillsdale, NJ: Erlbaum.

Hoffmann, W. A. (2002). The incidence of traumatic events and trauma-associated symptoms/experiences amongst tertiary students. *South African Journal of Psychology*, 32(4), 48-53.

Hoglund, C. L., & Nicholas, K. B. (1995). Shame, guilt, and anger in college students exposed to abusive family environments. *Journal of Family Violence*, 10(2), 141-157.

Hollway, W., & Jefferson, T. (2009). Narrative, discourse and the unconscious: The case of Tommy. In M. Andrews, S. Day Sclater, C. Squire, & A. Treacher (Eds.), *The uses of narrative: Explorations in sociology, psychology, and cultural studies* (pp. 136-150). New Brunswick, NJ: Transaction Publishers.

- Hong, G. (2004). Emotions in culturally-constituted relational worlds. *Culture Psychology, 10*(53), 53-62.
- Hyden, M. (2005). "I must have been an idiot to let it go on": Agency and positioning in battered women's narratives of leaving. *Feminism & Psychology, 15*, 169-188.
- Irwin, H. J. (1998). Affective predictors of dissociation II: Shame and guilt. *Journal of Clinical Psychology, 54*(2), 237-245.
- Izard, C. E. (1977). *Human emotions*. New York, NY: Plenum Press.
- Jewkes, R., & Abrahams, N. (2002). The epidemiology of rape and sexual coercion in South Africa: An overview. *Social Science & Medicine, 55*, 1231-1244.
- Jewkes, R., Levin, J., Mbananga, N., & Bradshaw, D. (2002). Rape of girls in South Africa. *Lancet, 359*, 319-320.
- Jewkes, R., Levin, J., & Penn-Kekana, L. (2002). Risk factors for domestic violence: Findings from a South African cross-sectional study. *Social Science & Medicine, 55*, 1603-1617.
- Jewkes, R. K., Levin, J. B., & Penn-Kekana, L. A. (2003). Gender inequalities, intimate partner violence and HIV preventive practices: Findings of a South African cross-sectional study. *Social Science & Medicine, 56*, 125-134.
- Johnson, R. D., Danko, G. P., Huang, Y. H., Park, J. Y., Johnson, S. B., & Nagoshi, C. T. (1987). Guilt, shame and adjustment in three cultures. *Personality and Individual Differences, 8*, 357-364.

- Joireman, J. (2004). Empathy and the self-absorption paradox II: Self-rumination and self-reflection as mediators between shame, guilt, and empathy. *Self and Identity*, 3, 225-238.
- Jones, R., & Kagee, A. (2005). Predictors of post-traumatic stress symptoms among South African police personnel. *South African Journal of Psychology*, 35(2), 209-224.
- Kaminer, D. (2010, March). Continuous traumatic stress in South Africa. Paper presented at Continuous Traumatic Stress in South Africa: Towards a Collaborative Research Agenda, Cape Town, South Africa.
- Kaminer, D., & Eagle, G. (2010). *Traumatic stress in South Africa*. Johannesburg, South Africa: Wits University Press.
- Kaminer, D., Grimsrud, A., Myer, L., Stein, D. J., & Williams, D. R. (2008). Risk for post-traumatic stress disorder associated with different forms of interpersonal violence in South Africa. *Social Science & Medicine*, 67, 1589-1595.
- Karen, R. (1992). Shame. *The Atlantic Monthly*, 40-70.
- Kaufman, G. (1992). *Shame: The power of caring* (3<sup>rd</sup> ed.). Rochester, NY: Schenkman Books, Inc.
- Kaufman, G. (1993). *The psychology of shame: Theory and treatment of shame-based syndromes*. London, UK: Routledge.
- Kaufman, J., & Zigler, E. (1987). Do abused children become abusive parents? *American Journal of Orthopsychiatry*, 57(2), 186-192.

- Kaysen, D., Morris, M. K., Rizvi, S. L., & Resick, P. A. (2005). Peritraumatic responses and their relationship to perceptions of threat in female crime victims. *Violence Against Women, 11*(12), 1515-1535.
- Keltner, D., & Harker, L. (1998). The forms and functions of the nonverbal signal of shame. In P. Gilbert, & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 78-99). Oxford, UK: Oxford University Press.
- Kim, J., Talbot, N. L., & Cicchetti, D. (2009). Childhood abuse and current interpersonal conflict: The role of shame. *Child Abuse & Neglect, 33*, 362-371.
- Kinston, W. (1987). The shame of narcissism. In Nathanson, D. L. (Ed.), *The many faces of shame* (pp. 214-246). New York, NY: The Guilford Press.
- Kleim, B., & Ehlers, A. (2009). Evidence for a curvilinear relationship between posttraumatic growth and posttrauma depression and PTSD in assault survivors. *Journal of Traumatic Stress, 22*(1), 45-52.
- Klein, I., & Janoff-Bulman, R. (1996). Trauma history and personal narratives: Some clues to coping among survivors of child abuse. *Child Abuse & Neglect, 20*(1), 45-54.
- Kleinberg, J. (2012). Building individual resilience and organisational hardiness: Addressing post-trauma worker's block. In E. Hopper (Ed.), *Trauma and organizations* (pp. 255-277). London: Karnac.
- Kleres, J. (2010). Emotions and narrative analysis: A methodological approach. *Journal for the Theory of Social Behavior, 41*(2), 182-202.

- Kluger, R. (2001). *Landscapes of memory: A holocaust girlhood remembered*. New York, NY: Bloomsbury.
- Kong, S., & Bernstein, K. (2009). Childhood trauma as a predictor of eating psychopathology and its mediating variables in patients with eating disorders. *Journal of Clinical Nursing, 18*(13), 1897-1907.
- Koss, M. P., Figueredo, A. J., Bell, I., Tharan, M., & Tromp, S. (1996). Traumatic memory characteristics: A cross-validated mediational model of response to rape among employed women. *Journal of Abnormal Psychology, 105*(3), 421-432.
- Kraft, R. (2004). Emotional memory in survivors of the Holocaust: A qualitative study of oral testimony. In D. Reisberg, & P. Hertel (Eds.), *Memory and emotion* (pp. 347-391). Oxford: Oxford University Press.
- Lazarus, R. S. (1991). *Emotion and adaptation*. New York, NY: Oxford University Press.
- Lazarus, R. S., & Folkman, S. (1987). Transactional theory and research on emotions and coping. *European Journal of Personality, 1*, 141-169.
- Lebra, T. S. (1983). Shame and guilt: A psychocultural view of the Japanese self. *Ethos, 11*(3), 192-209.
- Leith, K. P., & Baumeister, R. F. (1998). Empathy, shame, guilt, and narratives of interpersonal conflicts: Guilt-prone people are better at perspective taking. *Journal of Personality, 66*(1), 1-37.

- Lee, D. A., Scragg, P., & Turner, S. (2001). The role of shame and guilt in traumatic events: A clinical model of shame-based and guilt-based PTSD. *British Journal of Medical Psychology, 74*, 451-466.
- Lee, Z. (1999). Korean culture and sense of shame. *Transcultural Psychiatry, 36*(2), 181-194.
- Leskela, J., Dieperink, M., & Thuras, P. (2002). Shame and posttraumatic stress disorder. *Journal of Traumatic Stress, 15*(3), 223-226.
- Levendosky, A. A., Bogat, G. A., & Huth-Bocks, A. C. (2011). The influence of domestic violence on the development of the attachment relationship between mother and young child. *Psychoanalytic Psychology, 28*(4), 512-527.
- Lewis, H. B. (1971). *Shame and guilt in neurosis*. New York, NY: International Universities Press, Inc.
- Lewis, H. B. (1986). The role of shame in depression. In M. Rutter, C. E. Izard, & P. B. Read (Eds.), *Depression in young people: Developmental and clinical perspectives* (pp. 325-341). New York, NY: The Guilford Press.
- Lewis, H. B. (1987a). Introduction: Shame – the “sleeper in psychopathology”. In H. B. Lewis (Ed.), *The role of shame in symptom formation* (pp. 1-28). New Jersey, NJ: Lawrence Erlbaum Associates, Publishers.
- Lewis, H. B. (1987b). The role of shame in depression over the life span. In H. B. Lewis (Ed.), *The role of shame in symptom formation* (pp. 29-50). New Jersey, NJ: Lawrence Erlbaum Associates, Publishers.

- Lewis, H. B. (1987c). Shame and the narcissistic personality. In D. L. Nathanson (Ed.), *The many faces of shame* (pp. 93-133). New York, NY: The Guilford Press.
- Lewis, M. (1992). *Shame: The exposed self*. New York, NY: The Free Press.
- Lewis, M. (1993). Self-conscious emotions: Embarrassment, pride, shame and guilt. In M. Lewis, & J. Haviland (Eds.), *Handbook of emotions* (pp. 563-573). New York, NY: Guilford Press.
- Lewis, M. (1998). Shame and stigma. In P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 126-141). Oxford, UK: Oxford University Press.
- Lewis, M. (2003). The role of the self in shame. *Social Research*, 70(4), 1181-1204.
- Li, J., Wang, L., & Fischer, K. W. (2004). The organization of Chinese shame concepts. *Cognition and Emotion*, 18(6), 767-797.
- Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis & interpretation*. California, CA: Sage Publications.
- Lindsay-Hartz, J., De Rivera, J., & Mascolo, M. F. (1995). Differentiating guilt and shame and their effects on motivation. In J. P. Tangney, & K. W. Fischer (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment and pride* (pp. 274-301). New York, NY: The Guilford Press.
- Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: The Guilford Press.

- Lutwak, N., & Ferrari, J. R. (1997). Understanding shame in adults: Retrospective perceptions of parental-bonding during childhood. *Journal of Nervous and Mental Disease, 185*(10), 595-598.
- Lutwak, N., Panish, J., & Ferrari, J. (2003). Shame and guilt: Characterological vs. behavioral self-blame and their relationship to fear of intimacy. *Personality and Individual Differences, 35*, 909-916.
- Lynd, H. M. (1958). *On shame and the search for identity*. New York, NY: Harcourt, Brace and Company.
- Madu, S. N. (2001). The prevalence of patterns of childhood sexual abuse and victim-perpetrator relationship among a sample of university students. *South African Journal of Psychology, 31*(4), 32-37.
- Madu, S. N., & Peltzer, K. (2000). Risk factors and child sexual abuse among secondary school students in the Northern Province (South Africa). *Child Abuse & Neglect, 24*(2), 259-268.
- Maynes, M. J., Pierce, J. L., & Laslett, B. (2008). *Telling stories: The use of personal narratives in the social sciences and history*. Ithaca, NY: Cornell University Press.
- McAdams, D. P., Josselson, R., & Lieblich, A. (2006) *Identity and story: Creating self in narrative*. Washington, DC: American Psychological Association.
- McLean, K. C., & Thorne, A. (2006). Identity light: Entertainment stories as a vehicle for self-development. In D. McAdams, R. Josselson, & A. Lieblich (Eds.), *Identity and story: Creating self in narrative* (pp. 111–127). Washington, DC: American Psychological Association.

- Meltzer-Brody, S., Zerwas, S., Leserman, J., Von Holle, A., Regis, T., & Bulik, C. (2011). Eating disorders and trauma history in women with perinatal depression. *Journal of Women's Health* 20(6), 863-870.
- Menon, U., & Shweder, R. A. (1994). Kali's tongue: Cultural psychology and the power of shame in Orissa, India. In S. Kitayama, & H. R. Markus (Eds.), *Emotion and culture: Empirical studies of mutual influence* (pp. 241-284). Washington, DC: American Psychological Association.
- Miller, C., & Waller, G. (2002). Reported sexual abuse and bulimic psychopathology among nonclinical women: The mediating role of shame. *International Journal of Eating Disorders*, 32, 186-191.
- Miller, R. S. (2007). Is embarrassment a blessing or a curse? In J. L. Tracy, R. W. Robins, & J. P. Tangney (Eds.), *The self-conscious emotions: Theory and research* (pp. 245-263). New York, NY: The Guilford Press.
- Miller, S. (1985). *The shame experience*. Hillsdale, NJ: The Analytic Press.
- Milligan, R., & Andrews, B. (2005). Suicidal and other self-harming behavior in offender women: The role of shame, anger and childhood abuse. *Legal and Criminological Psychology*, 10, 13-25.
- Mills, R. S. L. (2003). Possible antecedents and developmental implications of shame in young girls. *Infant and Child Development*, 12, 329-349.
- Mills, R. S. L. (2005). Taking stock of the developmental literature on shame. *Developmental Review*, 25, 26-63.

- Mills, R. S. L., Arbeau, K. A., Lall, D. I. K., & De Jaeger, A. E. (2010). Parenting and child characteristics in the prediction of shame in early and middle childhood. *Merrill-Palmer Quarterly*, 56(4), 500-528.
- Mollon, P. (2012). *Shame and jealousy: The hidden turmoils*. London: Karnac.
- Morrison, A. P. (1987). The eye turned inward: Shame and the self. In D. L. Nathanson (Ed.), *The many faces of shame* (pp. 271-292). New York, NY: The Guilford Press.
- Morrison, A. P. (1989). *Shame: The underside of narcissism*. Hillsdale, NJ: The Analytic Press.
- Morrison, D., & Gilbert, P. (2001). Social rank, shame and anger in primary and secondary psychopaths. *Journal of Forensic Psychiatry*, 12(2), 330-356.
- Morrison, N. K. (1987). The role of shame in schizophrenia. In H. B. Lewis (Ed.), *The role of shame in symptom formation* (pp. 51-88). New Jersey, NJ: Lawrence Erlbaum Associates, Publishers.
- Mosley, T. M., & Rosenberg, J. (2007). Stigma consciousness and perceived stereotype threat and their effects on academic performance. *The University of Alabama McNair Journal*, 7, 85-114.
- Murray, C., Waller, G., & Legg, C. (2000). Family dysfunction and bulimic psychopathology: The mediating role of shame. *International Journal of Eating Disorders*, 28, 84-89.

- Nathanson, D. L. (1987a). The shame/pride axis. In H. B. Lewis (Ed.), *The role of shame in symptom formation* (pp. 183-206). New Jersey, NJ: Lawrence Erlbaum Associates, Publishers.
- Nathanson, D. L. (1987b). A timetable for shame. In D. L. Nathanson (Ed.), *The many faces of shame* (pp. 1-64). New York, NY: The Guilford Press.
- Nathanson, D. L. (1992). *Shame and pride: Affect, sex, and the birth of the self*. New York, NY: W. W. Norton & Company, Inc.
- Newman, E., Riggs, D. S., & Roth, S. (1997). Thematic resolution, PTSD, and Complex PTSD: The relationship between meaning and trauma-related diagnoses. *Journal of Traumatic Stress, 10*(2), 197-213.
- Norman, R., Matzopoulos, R., Groenewald, P., & Bradshaw, D. (2007). The high burden of injuries in South Africa. *Bulletin of the World Health Organization, 85*(9), 695-701.
- Nussbaum, M. (2004). *Hiding from humanity: disgust, shame, and the law*. Princeton: Princeton University Press.
- Ochs, E., & Capps, L. (2001). *Living narrative: Creating lives in everyday storytelling*. Harvard: President and Fellows of Harvard College.
- Ochs, E., & Schieffelin, B. (1989). Language has a heart. *Text, 9*(1), 7-25.
- O'Dougherty Wright, M., Crawford, E., & Costillo, D. (2009). Child emotional maltreatment and later psychological distress among college students: The mediating role of maladaptive schemas. *Child Abuse & Neglect, 33*(1), 59-68.

- Oliver, J.E. (1993). Intergenerational transmission of child abuse: Rates, research, and clinical implications. *The American Journal of Psychiatry*, *150*(9), 1315-1324.
- O’Kearney, R., & Perrott, K. (2006). Trauma narratives in posttraumatic stress disorder: A review. *Journal of Traumatic Stress*, *19*(1), 81-93.
- Orange, D. (2008). Whose shame is it anyway? Lifeworlds of humiliation and systems of restoration (or “the analyst’s shame”). *Contemporary Psychoanalysis*, *44*, 83-100.
- Orange, D. (2011). *The suffering stranger: Hermeneutics for everyday clinical practice*. New York/London: Routledge.
- Orange, D. M., Atwood, G. E., & Stolorow, R. D. (1997). *Working intersubjectively: Contextualism in psychoanalytic practice*. New York, NY: The Analytic Press.
- Orsillo, S. M., Heimberg, R. G., Juster, H. R., & Garrett, J. (1996). Social phobia and PTSD in Vietnam veterans. *Journal of Traumatic Stress*, *9*, 235-252.
- Pals, J. L. (2006). Authoring a second chance in life: Emotion and transformational processing within narrative identity. *Research in Human Development*, *3*(2-3), 101-120.
- Pasupathi, M. (2006). Silk from sows ears: Collaborative construction of everyday selves in everyday stories. In D. McAdams, R. Josselson, & A. Lieblich (Eds.), *Identity and story: Creating self in narrative* (pp. 129-150). Washington, DC: APA Press.
- Patterson, G. R., DeBaryshe, B. D., & Ramsey, E. (1989). A developmental perspective on antisocial behavior. *American Psychologist*, *44*(2), 329-335.

- Patterson, W. (2008). Narratives of events: Labovian narrative analysis and its limitations. In C. Squire, M. Andrews, & M. Tamboukou (Eds.), *Doing narrative research* (pp. 22-41). London: Sage Publications.
- Payne, J. D., Nadel, L., Britton, W. B., & Jacobs, W. J. (2004). The biopsychology of trauma and memory. In D. Reisberg, & P. Hertel (Eds.), *Memory and Emotion* (pp. 76-129). Oxford: Oxford University Press.
- Pearlman, L. A., & Caringi, J. (2009). Living and working self-reflectively to address vicarious trauma. In C. A. Courtois, & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 202-225). New York, NY: The Guilford Press.
- Peltzer, K. (1999). Posttraumatic stress symptoms in a population of rural children in South Africa. *Psychological Reports*, 85(2), 646-650.
- Phoenix, A. (2008). Analysing narrative contexts. In C. Squire, M. Andrews, & M. Tamboukou (Eds.), *Doing narrative research* (pp. 64-78). London: Sage Publications.
- Piers, G., & Singer, M. (1953). *Shame and guilt*. Springfield, IL: Charles C. Thomas.
- Putnam, F. W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York, NY: The Guilford Press.
- Pynoos, R. S., & Eth, S. (1987). Children traumatized by witnessing acts of personal violence: Homicide, rape, or suicide behavior. In R. S. Pynoos, & S. Eth (Eds.), *Posttraumatic stress disorder in children* (pp. 19-43). Washington, DC: American Psychiatric Association.

- Raggatt, P. T. F. (2006). Multiplicity and conflict in the dialogical self: A life-narrative approach. In D. P. McAdams, R. Josselson, & A. Lieblich (Eds.), *Identity and story: Creating self in narrative* (pp. 15-37). Washington, DC: American Psychological Association.
- Renn, P. (2012). *The silent past and the invisible present: Memory, trauma, and representation in psychotherapy*. New York & London: Routledge.
- Retzinger, S. M. (1987). Resentment and laughter: Video studies of the shame-rage spiral. In H. B. Lewis (Ed.), *The role of shame in symptom formation* (pp. 151-182). New Jersey, NJ: Lawrence Erlbaum Associates, Publishers.
- Retzinger, S. M. (1991). *Violent emotions: Shame and rage in marital quarrels*. London, UK: Sage Publications.
- Retzinger, S. M. (1998). Shame in the therapeutic relationship. In P. Gilbert, & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 206-225). Oxford, UK: Oxford University Press.
- Ricoeur, P. (1991). Life: A story in search of a narrator. In M. Valdes (Ed.), *A Ricoeur Reader: Reflection and imagination* (pp. 425-437). Toronto: University of Toronto Press.
- Riessman, C. (1993). *Narrative analysis*. London, UK: Sage Publications.
- Riessman, C. (2008). *Narrative methods for the human sciences*. CA, USA: SAGE Publications.

- Robinaugh, D. J., & McNally, R. J. (2010). Autobiographical memory for shame or guilt provoking events: Association with psychological symptoms. *Behavior Research and Therapy*, *48*, 646-652.
- Rodriguez Mosquera, P. M., Manstead, A. S. R., & Fischer, A. H. (2002). The role of honor concerns in emotional reactions to offences. *Cognition and Emotion*, *16*, 143-163.
- Ross, C. A. (1997). *Dissociative identity disorder: Diagnosis, clinical features, and treatment of multiple personality*. New York, NY: John Wiley & Sons, Inc.
- Rusch, N., Corrigan, P. W., Bohus, M., Kuhler, T., Jacob, G. A., & Lieb, K. (2007). The impact of posttraumatic stress disorder on dysfunctional implicit and explicit emotions among women with borderline personality disorder. *The Journal of Nervous and Mental Disease*, *195*(6), 537-539.
- Sanftner, J. L., & Crowther, J. H. (1998). Variability in self-esteem, moods, shame, and guilt in women who binge. *International Journal of Eating Disorders*, *23*(4), 390-397.
- Sansone, R. A., & Sansone, L. A. (2007). Childhood trauma, borderline personality, and eating disorders: A developmental cascade. *Eating Disorders*, *15*(4), 333-346.
- Sarbin, T. R. (1989). Emotions as narrative emplotments. In M. J. Packer, & Addison, R. B. (Eds.), *Entering the circle: Hermeneutic investigation in psychology* (pp. 185-205). Albany, NY: State University of New York.
- Sawyer, K. (2003). Coherence in discourse: Suggestions for future work. *Human Development*, *46*, 189-193.

- Scarry, E. (1985). *The body in pain: The making and unmaking of the world*. New York, NY: Oxford University Press.
- Scheff, T. J. (1988). Shame and conformity: The deference-emotion system. *American Sociological Review*, 53, 395-406.
- Schimmenti, A. (2012). Unveiling the hidden self: Developing trauma and pathological shame. *Psychodynamic Practice: Individuals, Groups and Organizations*, 18(2), 195-211.
- Schneider, C. D. (1987). A mature sense of shame. In D. L. Nathanson (Ed.), *The many faces of shame* (pp. 194-214). New York, NY: The Guilford Press.
- Schnell, L. J. (2008). Learning how to tell. In P. L. Rudnytsky, & R. Charon (Eds.), *Psychoanalysis and narrative medicine* (pp. 169-183). New York, NY: State University of New York Press.
- Schoeman, R., Carey, P., & Seedat, S. (2009). Trauma and posttraumatic stress disorder in South African adolescents. *The Journal of Nervous and Mental Disease*, 197(4), 244-250.
- Schore, A. N. (1998). Early shame experiences and infant brain development. In P. Gilbert, & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 57-78). Oxford, UK: Oxford University Press.
- Schore, A. (2003). *Affect dysregulation and disorders of the self*. New York, NY: W. W. Norton & Company.

- Seedat, S., Pienaar, W. P., Williams, D., & Stein, D. J. (2004). Ethics of research on survivors of trauma. *Current Psychiatry Reports*, 6, 262-267.
- Seedat, S., Stein, D. J., & Carey, P. D. (2005). Post-traumatic stress disorder in women: Epidemiological and treatment issues. *CNS Drugs*, 19(5), 411-427.
- Seedat, S., Stein, D. J., & Forde, D. R. (2005). Association between physical partner violence, posttraumatic stress, childhood trauma, and suicide attempts in a community sample of women. *Violence and Victims*, 20(1), 87-98.
- Shapiro, D. (2003). The tortured, not the torturers, are ashamed. *Social Research*, 70(4), 1131-1148.
- Shapiro, J. (2011). Illness narratives: Reliability, authenticity and the empathic witness. *Medical Humanities*, 37(2), 68-71.
- Shaver, P. R., Murdaya, U., & Fraley, R. C. (2001). Structure of the Indonesian emotional lexicon. *Asian Journal of Social Psychology*, 4, 201-224.
- Shaver, P. R., Wu, S., & Schwartz, J. C. (1992). Cross-cultural similarities and differences in emotion and its representation: A prototype approach. *Journal of Personality and Social Psychology*, 52, 1061-1086.
- Shefer, T, Ratele, K, Strebel, A, Shabalala, N., & Buikema, R. (Eds.). (2007). *From boys to men: Social constructions of masculinity in contemporary society*. Lansdowne, South Africa: University of Cape Town Press/Juta.
- Shields, N., Nadasen, K., & Pierce, L. (2008). The effects of community violence on children in Cape Town, South Africa. *Child Abuse & Neglect*, 32, 589-601.

- Shi-xu (2009). Continuing commentary: Emotions of guilt and shame: Towards historical and intercultural perspectives on cultural psychology. *Culture Psychology, 15*(3), 363-371.
- Shweder, R. A. (2003). Toward a deep cultural psychology of shame. *Social Research, 70*(4), 1109-1130.
- Silberstein, L. R., Striegel-Moore, R., & Rodlin, J. (1987). Feeling fat: A woman's shame. In H. B. Lewis (Ed.), *The role of shame in symptom formation* (pp. 89-108). New Jersey, NJ: Lawrence Erlbaum Associates, Publishers.
- Simms, K. (2003). *Paul Ricoeur*. London: Routledge.
- Simon, B. (2008). It's really more complicated than you imagine: Narratives of real and imagined trauma. In P. L. Rudnytsky, & R. Charon (Eds.), *Psychoanalysis and narrative medicine* (pp. 119-137). New York, NY: State University of New York Press.
- Smith, C. A. (1989). Dimensions of appraisal and physiological response in emotion. *Journal of Personality and Social Psychology, 56*(3), 339-353.
- Smythe, D., Artz, L., Combrinck, H., Doolan, K., & Martin, L. J. (2008). Caught between policy and practice: Health and justice response to gender-based violence. In A. van Niekerk, S. Suffla, & M. Seedat (Eds.), *Crime, violence and injury prevention in South Africa: Data to action* (pp. 150-172). Tygerberg, South Africa: MRC-UNISA.
- Spangaro, J. M., Zwi, A. B., & Poulos, R. G. (2011). "Persist. Persist": A qualitative study of women's decisions to disclose and their perceptions of the impact of routine screening for intimate partner violence. *Psychology of Violence, 1*(2), 150-162.

- Speckens, A. E. M., Ehlers, A., Hackmann, A., Ruths, F. A., & Clark, D. M. (2007). Intrusive memories and rumination in patients with post-traumatic stress disorder: A phenomenological comparison. *Memory, 15*(3), 249-257.
- South African Police Services (2009). *Services statistics*. Retrieved from <http://www.saps.org.za>
- Squire, C. (2005). Reading narratives. *Group Analysis, 38*, 91-107.
- Squire, C., Andrews, M., & Tamboukou, M. (2008). Introduction: What is narrative research? In C. Squire, M. Andrews, & M. Tamboukou (Eds.), *Doing narrative research* (pp. 64-78). London: Sage Publications.
- Steele, H. (2011). Multiplicity revealed in the Adult Attachment Interview: When integration and coherence means death. In V. Sinason (Ed.), *Attachment, trauma and multiplicity* (pp. 37-38). London, UK: Routledge.
- Stone, A. M. (1992). The role of shame in post-traumatic stress disorder. *American Journal of Orthopsychiatry, 62*(1), 131-136.
- Street, A. E., & Arias, I. (2001). Psychological abuse and posttraumatic stress disorder in battered women: Examining the roles of shame and guilt. *Violence and Victims, 16*(1), 65-78.
- Stuewig, J., & McCloskey, L. A. (2005). The relation of child maltreatment to shame and guilt among adolescents: Psychological routes to depression and delinquency. *Child Maltreatment, 10*(4), 324-336.

- Stuewig, J., & Tangney, J. P. (2007). Shame and guilt in antisocial and risky behaviors. In J. L. Tracy, R. W. Robins, & J. P. Tangney (Eds.), *The self-conscious emotions: Theory and research* (pp. 371-389). New York, NY: The Guilford Press.
- Stuewig, J., Tangney, J. P., Heigel, C., Harty, L., & McCloskey, L. (2010). Shaming, blaming, and maiming: Functional links between the moral emotions, externalization of blame, and aggression. *Journal of Research in Personality, 44*, 91-102.
- Suliman, S., Mkabile, S. G., Fincham, D. S., Ahmed, R., Stein, D. J., & Seedat, S. (2009). Cumulative effect of multiple trauma on symptoms of posttraumatic stress disorder, anxiety, and depression in adolescents. *Comprehensive Psychiatry, 50*, 121-127.
- Swartz, L. (1985). Issues for cross-cultural psychiatric research in South Africa. *Culture, Medicine and Psychiatry, 9*, 59-74.
- Swartz, L. (1998). *Culture and mental health: A Southern African view*. Cape Town, South Africa: Oxford University Press.
- Sweetingham, R., & Waller, G. (2008). Childhood experiences of being bullied and teased in eating disorders. *European Eating Disorders Review, 16*, 401-407.
- Talbot, J. A., Talbot, N. L., & Tu, X (2004). Shame-proneness as a diathesis for dissociation in women with histories of childhood sexual abuse. *Journal of Traumatic Stress, 17*, 445-448.
- Tang, M, Wang, Z, Qian, M, Gao, J., & Zhang, L. (2008). Transferred shame in the cultures of interdependent-self and independent self. *Journal of Cognition and Culture, 8*, 163-178.

- Tangney, J. P. (1990). Assessing individual differences in proneness to shame and guilt: Development of the Self-Conscious Affect and Attribution Inventory. *Journal of Personality and Social Psychology*, *59*, 102-111.
- Tangney, J. P. (1991). Moral affect: The good, the bad, and the ugly. *Journal of Personality and Social Psychology*, *61*(4), 598-607.
- Tangney, J. P. (2003). Self-relevant emotions. In M. R. Leary, & J. P. Tangney (Eds.), *Handbook of self and identity* (pp. 384-401). New York, NY: The Guilford Press.
- Tangney, J. P., Burggraf, S. A., & Wagner, P. E. (1995). Shame-proneness, guilt-proneness, and psychological symptoms. In J. P. Tangney, & K. W. Fischer (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment and pride* (pp. 343-368). New York, NY: The Guilford Press.
- Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt*. New York, NY: The Guilford Press.
- Tangney, J. P., Mashek, D., & Stuewig, J. (2005). Shame, guilt, and embarrassment: Will the real emotion please stand up? *Psychological Inquiry*, *16*(1), 44-48.
- Tangney, J. P., Miller, R. S., Flicker, L., & Hill-Barlow, D. (1996). Are shame, guilt, and embarrassment distinct emotions? *Journal of Personality and Social Psychology*, *70*(6), 1256-1269.
- Tangney, J. P., Niedenthal, P. M., Covert, M. V., & Barlow, D. H. (1998). Are shame and guilt related to distinct self-discrepancies? A test of Higgins's (1987) hypotheses. *Journal of Personality and Social Psychology*, *75*, 256-268.

- Tangney, J. P., Stuewig, J., & Mashek, D. J. (2007). Moral emotions and moral behavior. *Annual Review of Psychology, 58*, 345-372.
- Tangney, J. P., Wagner, P., Fletcher, C., & Gramzow, R. (1992). Shamed into anger? The relation of shame and guilt to anger and self-reported aggression. *Journal of Personality and Social Psychology, 62*(4), 669-675.
- Tangney, J. P., Wagner, P., & Gramzow, R. (1989). *The test of self-conscious affect*. Fairfax, VA: George Mason University.
- Tangney, J. P., Wagner, P., & Gramzow, R. (1992). Proneness to shame, proneness to guilt, and psychopathology. *Journal of Abnormal Psychology, 101*(3), 469-478.
- Tangney, J. P., Wagner, P. E., Hill-Barlow, D., Marschall, D. E., & Gramzow, R. (1996). Relation of shame and guilt to constructive versus destructive responses to anger across the lifespan. *Journal of Personality and Social Psychology, 70*(4), 797-809.
- Tantam, D. (1998) The emotional disorders of shame. In P. Gilbert, & B. Andrews (Eds.) *Shame: Interpersonal Behaviour, Psychopathology and culture*. UK: Oxford University Press.
- Terr, L. C. (1983). Chowchilla revisited: The effects of psychic trauma four years after a school-bus kidnapping. *American Journal of Psychiatry, 140*(2), 1543-1550.
- Terr, L. C. (1991). Childhood traumas: An outline and overview. *The American Journal of Psychiatry, 148*(1), 10-20.

- Thomaes, S., Bushman, B. J., Stegge, J., & Olthof, T. (2008). Trumping shame by blasts of noise: narcissism, self-esteem, shame, and aggression in young adolescents. *Child Development, 79*(6), 1792-1801.
- Thonney, J., Kanachi, M., Sasaki, H., & Hatayama, T. (2006). Guilt and shame in Japan: Data provided by the Thematic Apperception Test in experimental settings. *North American Journal of Psychology, 8*(1), 85-98.
- Tiggemann, M., & Boundy, M. (2008). Effects of environment and appearance compliment on college women's self-objectification, mood, body shame, and cognitive performance. *Psychology of Women Quarterly, 32*(4), 399-405.
- Tilghman-Osborne, C., Cole, D. A., Felton, J. W., & Ciesla, J. A. (2008). Relation of guilt, shame, behavioral and characterological self-blame to depressive symptoms in adolescents over time. *Journal of Social and Clinical Psychology, 27*(8), 809-842.
- Tobin, D. L. (1995). Treatment of early trauma and dissociation in eating disorders of late onset. *European Eating Disorders Review, 3*(3), 160-173.
- Tomkins, S. (1963). *Affect, imagery, consciousness. The negative affects (Vol. II)*. New York, NY: Springer Publishing Company.
- Tomkins, S. (1987). Shame. In D. L. Nathanson (Ed.), *The many faces of shame* (pp. 133-162). New York, NY: The Guilford Press.
- Tomlinson, M., Swartz, L., Kruger, L-M., & Gureje, O. (2007). Manifestations of affective disturbance in sub-Saharan Africa: Key themes. *Journal of Affective Disorders, 102*, 191-198.

- Toolan, M. (2001). *Narrative: A critical linguistic introduction*. New York, NY: Routledge.
- Tracy, J. L., & Robins, R. W. (2007). The nature of pride. In J. L. Tracy, R. W. Robins, & J. P. Tangney (Eds.), *The self-conscious emotions: Theory and research* (pp. 263-283). New York, NY: The Guilford Press.
- Tronto, J. (2010). Creating caring institution: Politics, plurality, and purpose. *Ethics and Social Welfare*, 4(2), 158-171.
- Uji, M., Shikai, N., Shono, M., & Kitamura, T. (2007). Contribution of shame and attribution style in developing PTSD among Japanese university women with negative sexual experiences. *Archives of Women's Mental Health*, 10, 111-120.
- Valente, SM, & Jensen, L. (2000). Evaluating and managing intimate partner violence. *Nurse Practitioner*, 25(5), 18-30.
- Van der Hart, O., Nijenhuis, E., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization*. New York: W.W. Norton & Cie.
- Van der Kolk, B. A. (1994). The history of trauma in psychiatry. *Psychiatric Clinics of North America*, 17(3), 583-600.
- Van der Kolk, B. A. (2005). Editorial introduction: Child abuse and victimization. *Psychiatric Annals*, 374-378.
- Van der Kolk, B., & Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memories: Overview and exploratory study. *Journal of Traumatic Stress*, 8(4), 505-525.

- Van der Kolk, B. A., Pelcovitz, D., Roth, S., Mandel, F. S., McFarlane, A., & Herman, J. (1996). Dissociation, somatization, and affect dysregulation: The complexity of adaptation to trauma. *American Journal of Psychiatry*, *153*(7), 83-93.
- Van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, *18*(5), 389-399.
- Van der Kolk, B. A., & Van der Hart, O. (1995). The intrusive past: The flexibility of memory and the engraving of trauma. In C. Caruth (Ed.), *Trauma: Explorations in memory* (pp. 158-183). Baltimore, MD: The Johns Hopkins University Press.
- Vanderlinden, J., Vandereycken, W., van Dyck, R., & Vertommen, H. (1993). Dissociative experiences and trauma in eating disorders. *International Journal of Eating Disorders*, *13*(2), 187-193.
- Van der Merwe, A. P., & Dawes, A. D. (2000). Prosocial and antisocial tendencies in children exposed to community violence. *Southern African Journal of Child and Adolescent Mental Health*, *12*, 19-37.
- Van der Merwe, C. N., & Gobodo-Madikisela, P. (2008). *Narrating our healing: Perspectives on working through trauma*. Newcastle, UK: Cambridge Scholars Publishing.
- Van Minnen, A., Wessel, I., Dijkstra, T., & Roelofs, K. (2002). Changes in PTSD patients' narratives during prolonged exposure therapy: A replication and extension. *Journal of Traumatic Stress*, *15*(3), 255-258.
- Van Niekerk, A., Suffla, S., & Seedat, M. (2008). *Crime, violence and injury prevention in South Africa: Data to action*. Bellville: Medical Research Council-University of South Africa, Crime, violence and injury lead programme.

- Vetten, L. (2005). "Show me the money": A review of budgets allocated towards the implementation of South Africa's Domestic Violence Act. *Politikon*, 32(2), 277-295.
- Vidal, M. E., & Petrak, J. (2007). Shame and adult sexual assault: A study with a group of female survivors recruited from an East London population. *Sexual and Relationship Therapy*, 22(2), 159-170.
- Wallbott, H. G., & Scherer, K. R. (1995). Cultural determinants in experiencing shame and guilt. In J. P. Tangney, & K. W. Fischer (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride* (pp. 465–487). New York, NY: Guilford Press.
- Ward, C. L., Flisher, A. J., Zissis, C., Muller, M., & Lombard, C. (2001). Exposure to violence and its relationship to psychopathology in adolescents. *Injury Prevention*, 7(4), 297-301.
- Webb, M., Heisler, D., Call, S., Chickering, S. A., & Colburn, T. A. (2007). Shame, guilt, symptoms of depression, and reported history of psychological maltreatment. *Child Abuse & Neglect*, 31, 1143-1153.
- Weiner, B. (1986). *An attributional theory of motivation and emotion*. New York, NY: Springer-Verlag.
- Wells, M., & Jones, R. (2000). Childhood parentification and shame-proneness: A preliminary study. *The American Journal of Family Therapy*, 28, 19-27.
- Wengraf, T. (2004). *Qualitative research interviewing: Biographic narrative and semi-structured methods*. London, UK: Sage Publications.

- Wengraf, T. (2009). Betrayals, trauma and self-redemption: The meanings of “closing of the mines” in two ex-miners’ narratives. In M. Andrews, S. Day Sclater, C. Squire, & A. Treacher (Eds.), *The uses of narrative: Explorations in sociology, psychology, and cultural studies* (pp. 117-129). New Brunswick, NJ: Transaction Publishers.
- Wenzel, T., Griengl, H., Stompe, T., Mirzaei, S., & Kieffer, W. (2000). Psychological disorders in survivors of torture: Exhaustion, impairment and depression. *Psychopathology*, 33(6), 292-296.
- Widdershoven, G. (1993). The story of life: Hermeneutic perspectives on the relationship between narrative and life history. In R. Josselson, & A. Lieblich (Eds.), *The narrative study of lives* (pp. 1-20). Newbury Park, CA: Sage.
- Will, O. A. (1987). The sense of shame in psychosis: Random comments on shame in the psychotic experience. In D. L. Nathanson (Ed.), *The many faces of shame* (pp. 308-318). New York, NY: The Guilford Press.
- Williams, S. L., Williams, D. R., Stein, D. J., Seedat, S., Jackson, P. B., & Moomal, H. (2007). Multiple traumatic events and psychological distress: The South Africa stress and health study. *Journal of Traumatic Stress*, 20(5), 845-855.
- Wilson, J. P., Drozdek, B., & Turkovic, S. (2006). Posttraumatic shame and guilt. *Trauma Violence Abuse*, 7, 122-141.
- Winnicott, D. W. (1964). *The child, the family and the outside world*. London, UK: Penguin Books.

- Winnicott, D. W. (1971). *Playing and reality*. New York, NY: Routledge/Tavistock Publishers Ltd.
- Woelz-Stirling, N. A., Kelaher, M., & Manderson, L. (1998). Power and the politics of abuse: Rethinking violence in Filipina-Australian marriages. *Health Care for Women International, 19*(4), 289-301.
- Wong, M. R., & Cook, D. (1992). Shame and its contribution to PTSD. *Journal of Traumatic Stress, 5*(4), 557-562.
- Wong, Y., & Tsai, J. (2007). Cultural models of shame and guilt. In J. L. Tracy, R. W. Robins, & J. P. Tangney (Eds.), *The self-conscious emotions: Theory and research* (pp. 209 - 223). New York, NY: The Guilford Press.
- Wood, D. (2012). Baked beans and mashed potato: The basic assumption of Incohesion: Aggression/Massification in organisations treating adolescents with eating disorders. In E. Hopper (Ed.), *Trauma and organizations* (pp. 65-89). London: Karnac.
- Wood, K., Lambert, H., & Jewkes, R. (2008). "Injuries are beyond love": Physical violence in young South Africans' sexual relationships. *Medical Anthropology, 27*(1), 43-69.
- Wozniak D. F., & Allen K. N. (2012). Ritual and performance in domestic violence healing: from survivor to thriver through rites of passage. *Cult Med Psychiatry, 36*(1), 80-101.
- Wurmser, L. (1987). Shame: The veiled companion of narcissism. In D. L. Nathanson (Ed.), *The many faces of shame* (pp. 64-93). New York, NY: The Guilford Press.
- Wurmser, L. (1995). *The mask of shame*. London, UK: Jason Aronson Inc.

- Yang, M., Yang, C., & Chiou, W. (2010). When guilt leads to other orientation and shame leads to egocentric self-focus: Effects of differential priming of negative affects on perspective-taking. *Social Behavior and Personality*, 38(5), 605-614.
- Yontef, G. (1996). Shame and guilt in Gestalt therapy: Theory and practice. In R. G. Lee, & G. Wheeler (Eds.), *The voice of shame: Silence and connection in psychotherapy* (pp. 351-387). San Francisco, CA: Jossey-Bass Publishers.
- Zembylas, M. (2008). The politics of shame in intercultural education. *Education, Citizenship and Social Justice*, 3, 263-280.
- Zhong, J., Wang, A., Qian, M., Zhang, L., Gao, J., Yang, J., Li, B., & Chen, P. (2008). Shame, personality, and social anxiety symptoms in Chinese and American nonclinical samples: A cross-cultural study. *Depression and Anxiety*, 25, 449-460.
- Zoellner, L. A., Alvarez-Conrad, J., & Foa, E. B. (2002). Peritraumatic dissociative experiences, trauma narratives, and trauma pathology. *Journal of Traumatic Stress*, 15(1), 49-57.

## APPENDICES

### Appendix A

#### Interview Schedule (English Version)

Thank you so much for agreeing to participate in my study. I know that some of the things that we will talk about will be very private and personal to you, and so I would like to remind you that everything you say here is confidential. I also wanted to remind you that although I will be recording our conversation, only I will have access to the recording.

#### 1. How long have you been at Saartjie Baartman?

2. How does being a resident in a shelter make you feel? [*tapping stigma and its relation to shame*]

3. Would you mind telling me about the experiences that brought you to Saartjie Baartman? [*gender-based violence exposure*]

#### 4. Tell me about your life before the abuse from your partner.

- **Prompt 1:** Tell me about your mother and father. What was your childhood like?

- **Prompt 2:** Have you experienced things like what brought you to the Centre earlier in your life? [*chronic trauma exposure*]

- **Prompt 3:** How was your childhood similar to what happened to you recently, and in what ways was it different? [*chronic trauma exposure*]

- **Prompt 4:** (if interviewee has experienced exposure to natural disasters). How was the experience of the earthquake/flood/fire different from the kind of difficult times you experienced with your partner (and/or in childhood) recently? [*drawing distinctions between acts of nature and other traumas*]

#### 5. How do you feel about yourself? [*self-esteem*]

- **Prompt 1:** Is this different from how you used to think and feel about yourself?

- **Prompt 2:** (if yes). What has changed?

- **Prompt 3:** (if yes). When do you think it changed?

**6. If I was to ask someone who knows you very well what kind of person you are, what would he or she say?** [*self-perception*]

- **Prompt 1:** What parts of what this person says to describe you, are the most important or most noticeable parts of you?

- **Prompt 2:** Have the parts in you that are most important or noticeable changed because of the difficult things you have gone through?

**7. How have your difficult times changed the way you feel about people (not the person/people who hurt you)?** [*shift towards shame-proneness in social interactions*]

- **Prompt 1:** Some people feel like it is difficult to trust people after they have been hurt the way you have been. Is this how you feel?

- **Prompt 2:** Some people feel very angry about what happened to them, and easily get angry. Is this something you feel?

- **Prompt 3:** Some people wrongly feel that it is their fault that they were hurt in the way you were, and feel ashamed and shy and embarrassed with other people. Sometimes they just feel like hiding away. Is this something that happens to you?

**8. What kinds of thoughts and feelings about the hard times you have been through are the most difficult for you?** [*assessing how prominent shame features are and whether they relate to aspects of psychopathology*]

**Prompt 1:** Why is this thought/feeling so difficult for you?

**9. Focus on the experience which has been the hardest for you. How did you feel while it was happening?**

- **Prompt 1:** How did you feel in your body during the attack/abuse?

- **Prompt 2:** What thoughts went through your mind?

- **Prompt 3:** What feelings did you feel? [*tapping potential shame responses*]

**10. What do you think causes the kind of violence you have been exposed to?**

**11. Can you tell me how you feel in relation to the people who hurt you this way?**

*[internalisation of blame, as well as anger and hostility]*

- **Prompt 1:** Some people feel very angry with the person or people who hurt them. Is this how you feel?

- **Prompt 2:** Some people wrongly blame themselves rather than those who hurt them for what happened to them. Is this something you feel?

**12. Many people feel shame after they have been hurt by other people. Does what your partner did to you make you feel ashamed?**

**13. What does the word “shame” mean to you?**

- **Prompt 1:** (if yes) Can you tell me how it felt for you?

- **Prompt 2:** (if yes) How did it feel in your body?

- **Prompt 3:** (if yes) What kinds of thoughts did you think when you felt ashamed?

**14. Some people feel bad about themselves, or don't feel good enough or worthless after they have been hurt like you have. Have you ever felt like this?**

**15. Do you experience psychological problems?**

- **Prompt 1:** (if yes) Can you tell me about these difficulties?

**16. Who or what supported you through your childhood and abusive relationship?**

**17. What do you do to cope with your difficult feelings?** *[the presence of coping strategies for shame reactions]*

- **Prompt 1:** (if shame is one of the difficult feelings). How do you cope with your shame?

Thank you very much for talking to me. I have learnt a lot from what you have told me. I hope that what you and other women have talked to me about, will allow me to do research that helps to teach people about gender-based violence. I also hope that my research will teach counsellors and therapists how to work with women like you, to help them.

**Interview Schedule (Afrikaans Version)**

Baie dankie dat jy ingestem het om deel te neem aan my navorsing. Ek beseft dat sommige van die dinge waaroor ons sal praat, vir jou baie privaat en persoonlik is, daarom wil ek net bevestig dat alles wat jy hier sê, vertroulik is. Ek wil jou ook daaraan herinner dat, hoewel ek ons gesprek op band opneem, net ek toegang tot die band sal hê.

**1. Vertel vir my van jou ervaring van Saartjie Baartman.****2. Hoe laat dit jou voel om in 'n skulping soos Saartjie Baartman te lewe?****3. Gee jy om om my te vertel watter ondervindings jou na Saartjie Baartman gebring het? [blootstelling aan gender-geweld]****4. Vertel my van jou lewe voordat jy deur jou man of kerel mishandel is.**

- **Vraag 1:** Het jy al vroeër in jou lewe dinge ervaar soos dit wat jou na die Sentrum gebring het? [*kroniese blootstelling aan trauma*]

- **Vraag 2:** Op watter maniere was jou kinderjare dieselfde as dit wat onlangs met jou gebeur het, en op watter maniere was dit verskillend? [*kroniese blootstelling aan trauma*]

- **Vraag 2** (indien persoon aan natuurrampe blootgestel was). Hoe was die ervaring van die aardbewing/vloed/vuur anders as die moeilike tye wat jy onlangs met jou man of kerel (en/of in jou kinderjare) beleef het? [*tref onderskeid tussen natuurrampe en ander traumas*]

**5. Hoe voel jy oor jouself? [selfbeeld]**

- **Vraag 1:** Is dit anders as wat jy vroeër oor jouself gedink en gevoel het?

- **Vraag 2:** (indien "ja"). Wat het verander?

- **Vraag 3:** (if yes). Wanneer, dink jy, het dit verander?

**6. As ek iemand wat jou baie goed ken, sou vra watter soort persoon jy is, wat sou hy of sy sê? [self-persepsie]**

- **Vraag 1:** Watter aspekte van wat daardie persoon sê om jou te beskryf, is die belangrikste of opvallendste aspekte van jou persoonlikheid?

- **Vraag 2:** Het hierdie belangrikste en opvallendste aspekte van jou verander as gevolg van die moeilike tye wat jy deurgemaak het?

**7. Hoe het hierdie moeilike tye jou gevoelens teenoor ander mense verander (nie teenoor die persoon wat jou seergemaak het nie)?** [*oorgang na geneigdheid tot skaamte in sosiale interaksie*]

- **Vraag 1:** Sommige mense voel dit is moeilik om ander mense te vertrou nadat hulle soos jy seergemaak is. Is dit hoe jy voel?

- **Vraag 2:** Sommige mense is baie kwaad oor wat met hulle gebeur het, en word maklik kwaad. Is dit iets wat jy voel?

- **Vraag 3:** Sommige mense voel, verkeerdelik, dat dit hulle skuld is dat hulle seergemaak is soos jy, en voel skaam, teruggetrokke en verleë voor ander mense. Somtyds voel hulle net lus om weg te kruip. Gebeur dit ook met jou?

**8. Watter tipe gedagtes en gevoelens oor die moeilike tye wat jy deurgemaak het, is vir jou die swaarste?** [*nagaan hoe prominent skaamte-kenmerke is en of hulle verband hou met aspekte van psigopatologie*]

**Vraag 1:** Waarom is hierdie gedagtes/gevoelens so moeilik vir jou?

**9. Fokus op die ervaring wat vir jou die swaarste was. Hoe het jy gevoel terwyl dit aan die gebeur was?**

- **Vraag 1:** Hoe het jou liggaam tydens die aanval/mishandeling gevoel?

- **Vraag 2:** Watter gedagtes het deur jou gegaan?

- **Vraag 3:** Watter emosies het jy ervaar? [*stimuleer potensiële skaamte-reaksies*]

**10. Wat dink jy lei tot die tipe geweld wat jy ervaar het?**

**11. Kan jy my vertel hoe jy voel teenoor die persoon of mense wat jou op hierdie manier seergemaak het?** [*internalisering van blaam, sowel as woede en vyandigheid*]

- **Vraag 1:** Sommige mense voel baie kwaad vir die persoon of persone wat hulle seergemaak het. Voel jy ook so?

- **Vraag 2:** Sommige mense blameer verkeerdelik hulleself, eerder as die mense wat hulle seergemaak het, vir wat met hulle gebeur het. Is dit iets wat jy voel?

## **12. Baie mense voel verkeerdelik skaam nadat hulle deur ander mense seergemaak is.**

- **Vraag 1:** Het jy gevoelens van skaamte gehad oor dit wat met jou gebeur het? [*subjektiewe interpretasies van skaamte*]

- **Vraag 2:** (indien “ja”) Kan jy my vertel hoe dit vir jou gevoel het?

- **Vraag 3:** (indien “ja”) Hoe het dit in jou liggaam gevoel?

- **Vraag 4:** (indien “ja”) Watter soort gedagtes het jy gehad toe jy skaam gevoel het?

## **13. Wat beteken die woord “skaamte” vir jou?**

**14. Sommige mense voel sleg oor hulle self, hulle voel hulle is nie goed genoeg nie, of het geen waarde nie nadat hulle soos jy seergemaak is. Het jy al ooit so gevoel?**

## **15. Ervaar jy sielkundige probleme?**

**Vraag 1:** Kan jy vir my vertel oor die sielkundige probleme?

**16. Wie of wat het jou ondersteun gedurende jou kinderjare en gedurende jou geweldadige verhouding?**

**17. Wat doen jy om jou pynlike gevoelens te hanteer?** [*aanwesigheid van strategieë om skaamte-reaksies te hanteer*]

- **Vraag 1:** (indien skaamte een van die pynlike gevoelens is) Hoe hanteer jy jou skaamte?

Baie dankie dat jy met my gesels het. Ek het baie van die gesprek met jou geleer. Ek hoop dat dit waaroor jy en die ander vroue met my gepraat het, my in staat sal stel om navorsing te doen wat mense oor gender-geweld kan leer. Ek hoop verder dat my navorsing vir raadgewers en terapeute sal leer hoe om met mense soos jy te werk, om hulle te help.

## Appendix B

### **Informed consent form (English version)**

Focus of the research project:

**Shame narratives in South African survivors of chronic trauma**

Institutional affiliation: Stellenbosch University, Cape Town, South Africa

Principal investigator: Amelia van der Merwe

Address: 129 Empire Avenue, Hout Bay, Cape Town, 7806, South Africa

Contact number: 021 7907567

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study me any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

The interviews will be audio-taped, with your permission, so that I can go back later and listen carefully to what you had to say. If you do not wish to be audio-taped, I will ask you to withdraw from the study.

It is also important for you to know that everything we talk about during this study will be kept **private and confidential**, and only I will have access to the information you give me. Once I have collected all the information from you and other people who visit Saartjie Baartman Centre, I will put it together in a way that ensures that no-one can find out what you told me.

This study has been approved by the **Health Research Ethics Committee at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

**What is this research study all about?**

- *The study will be conducted at the Saartjie Baartman Centre, and 20 individuals will take part in the study.*
- *South Africa has very high levels of violence of all kinds, which makes exposure to trauma and experiencing associated psychological difficulties, more likely. In many South African communities, people are exposed to violence on an ongoing basis. Despite this, there is a serious lack of research on exposure to chronic (ongoing) trauma, and how people respond emotionally to this kind of trauma. I would like to use the information I collect to produce research in this area, and to advise counsellors who work with people like you how to address the emotional experiences and difficulties you may be feeling as a result of being exposed to chronic trauma.*
- *I will conduct one interview of approximately 1 hour in duration with each of the participants.*

**Why have you been invited to participate?**

- *You have been selected because you are an adult (over 18 years of age) who has experienced chronic (ongoing) trauma. I have also asked you to participate because you indicated that you are willing to participate in research.*

**What will your responsibilities be?**

- *Your only responsibility is to participate in an interview focusing on your emotional responses to exposure to chronic trauma.*

**Will you benefit from taking part in this research?**

- *Your participation in this study will help me produce research which will enhance the kind of help that mental health professionals working with people who have been*

*exposed to chronic trauma are able to provide. This will hopefully benefit all those exposed to chronic trauma who seek mental health services.*

**Are there any risks involved in your taking part in this research?**

- *There is a risk that you may feel upset when recalling traumas you have been exposed to, and how they made you feel. This is why we are arranging that you can speak to your counsellor at the Saartjie Baartman Centre at any time after the interview. This means you will be able to discuss what came up in the interview with your counsellor shortly after completing the interview. I will also, with your permission, talk to your counsellor about any issue that came up in the interview that you feel would be helpful for your counsellor to know about.*

**Will you be paid to take part in this study and are there any costs involved?**

- *You will be paid R50 in food vouchers for your participation. There will be no costs involved for you, if you do take part.*

**Is there anything else that you should know or do?**

- *You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by the researcher.*
- *You will receive a copy of this information and consent form for your own records.*

**Declaration by participant**

**By signing below, I ..... agree to take part in a research study focusing on shame narratives in South African survivors of chronic trauma.**

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.

- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) ..... 2011.

.....  
**Signature of participant**

.....  
**Signature of witness**

**Declaration by investigator**

I (*name*) ..... declare that:

- I explained the information in this document to .....
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.

Signed at (*place*) ..... on (*date*) ..... 2011.

.....  
**Signature of investigator**

.....  
**Signature of witness**

*Toestemmingsvorm (Afrikaans version)*

Fokus van die navorsingsprojek:

**Verhale van skaamte deur Suid-Afrikaanse oorlewendes van chroniese trauma.**

Geaffilieerde instelling: Stellenbosch University, Kaapstad, South Africa

Hoofnavorser: Amelia van der Merwe

Adres: 129 Empire Avenue, Hout Bay, Cape Town, 7806, South Afrika

Kontak nommer: 021 7907567

Hiermee word u uitgenooi om aan 'n navorsingsprojek deel te neem. Gebruik asseblief voldoende tyd om die inligting te lees wat hier gegee word. Vra asseblief enige vrae aan enigiemand van die studiepersoneel oor enigiets wat nie vir u volkome duidelik is nie. Dit is baie belangrik dat u heeltemal seker is wat hierdie studie presies behels en op watter manier u betrokke sou kon raak. Wees verseker dat u deelname **volkome vrywillig** is en dat dit u vry staan om deelname te weier. As u nie u toestemming verleen nie, sal dit geen negatiewe gevolge vir u inhou nie. U is ook vry om u in enige stadium aan die studie te onttrek, selfs as u aanvanklik toegestem het om deel te neem.

Die onderhoude sal, met u toestemming, op oudioband opgeneem word, sodat ek later presies kan nagaan wat u gesê het. As u nie op oudioband opgeneem wil word nie, sal ek u versoek om u aan die studie te onttrek.

Dit is ook belangrik vir u om te weet dat alles waaroor ons tydens hierdie studie praat, **privaat en vertroulik** gehou sal word, en net ek sal toegang hê tot die inligting wat u aan my verskaf. As ek eenmaal al die inligting van u en van ander persone wat die Saartjie Baartmansentrum besoek, versamel het, sal ek dit op so 'n manier saamvoeg dat niemand sal kan weet wat u aan my vertel het nie.

Hierdie studie is goedgekeur deur die **Gesondheidsnavorsing Etiekkomitee aan die Universiteit van Stellenbosch**, en sal uitgevoer word volgens die etiese riglyne en beginsels

van die Internasionale Verklaring van Helsinki, die Suid-Afrikaanse Riglyne vir Goeie Kliniese Praktyk en die Mediese Navorsingsraad (MNR) se Etiese Riglyne vir Navorsing.

### **Waaroor handel hierdie studie?**

- *Die studie sal by die Saartjie Baartmansentrum onderneem word, en 20 individue sal daaraan deelneem.*
- *Suid-Afrika het baie hoë vlakke van geweld in verskeie vorme, wat die ervaring van trauma en die sielkundige probleme wat daarmee verband hou, vermeerder. In baie Suid-Afrikaanse gemeenskappe word mense voortdurend aan geweld blootgestel. Nogtans is daar 'n ernstige tekort aan navorsing oor chroniese (voortdurende) trauma en mense se emosionele reaksie daarop. Die inligting wat ek inwin, wil ek gebruik om navorsing op hierdie gebied te doen, en om raadgewers wat met mense soos u werk, te adviseer hoe om die emosionele ervaring en probleme van mense soos u, wat aan chroniese trauma blootgestel is, te hanteer.*
- *Ek sal met elkeen van die deelnemers 'n onderhoud van ongeveer 'n uur voer.*

### **Waarom is u uitgenooi om deel te neem?**

- *U is uitgenooi omdat u 'n volwassene is (ouer as 18 jaar) wat chroniese (voortdurende) trauma ervaar het. Ek het u ook uitgenooi omdat u aangedui het dat u gewillig is om aan navorsing deel te neem.*

### **Wat sal u verantwoordelikhede wees?**

- *U enigste verantwoordelikheid is om aan 'n onderhoud deel te neem wat fokus op u emosionele reaksie op die blootstelling aan chroniese trauma.*

### **Wat sal dit u baat as u aan hierdie navorsing deelneem?**

- *U deelname aan hierdie studie sal my help om navorsing te doen wat van waarde kan wees vir die professionele persone wat geestesgesondheidsdienste lewer en wat met mense soos u werk. Sodoende, hoop ek, sal almal wat aan chroniese trauma blootgestel is en wat die hulp van geestesgesondheidsdienste soek, direk of indirek daarby baat.*

**Is daar enige risiko's verbonde aan u deelname aan hierdie navorsing?**

- *Daar is die risiko dat u ontstel mag word as u praat oor die traumas waaraan u blootgestel was en hoe dit u laat voel het. Daarom sal ek organiseer dat u met u raadgewer (counsellor) oor die onderhoud kan gesels sodra dit moontlik is, en as dit vir u sal help, (en met u permissie) sal ek met u raadgewer (counsellor) praat oor die dinge wat jou onstel het in die gesprek met my.*

**Sal u betaal word vir u deelname aan hierdie studie, en is daar enige koste aan verbonde?**

- *U sal voedsel-geskenkbewyse ter waarde van R50 ontvang. Dit sal u niks kos om deel te neem nie.*

**Is daar enigiets anders wat u moet weet of doen?**

- *U kan die Etiese Komitee van Gesondheidsnavorsing by die Universiteit van Stellenbosch skakel by 021-938 9207 as u enige klagtes of bekommernisse het wat nie bevredigend deur die navorser opgelos is nie.*
- *U sal 'n kopie van hierdie inligting en toestemmingsvorm vir u eie rekords ontvang.*

**Verklaring deur die deelnemer**

Hiermee word verklaar dat ek ..... toestem om deel te neem aan 'n navorsingstudie wat fokus op verhale van skaamte deur Suid-Afrikaanse oorlewendes van chroniese trauma.

Ek verklaar dat:

- Ek hierdie inligting en die toesigvorm gelees het of dat iemand dit vir my gelees het. Dit is geskryf in 'n taal wat ek ken en waarmee ek met gemak omgaan.
- Ek die geleentheid gehad het om vrae te stel en dat al my vrae voldoende beantwoord is.
- Ek begryp dat deelname aan hierdie studie **vrywillig** is en dat ek onder geen druk geplaas is om daaraan deel te neem nie.

- Ek enige tyd mag besluit om nie meer aan die studie deel te neem nie en dat ek nie op enige wyse daardeur gestraf of benadeel sal word nie.
- Ek gevra mag word om deelname aan die studie te staak voordat dit voltooi is, indien die navorser van mening is dat dit in my beste belang is of indien ek nie die studieplan volg soos ooreengekom nie.

Geteken te (*plek*) ..... op (*datum*) ..... 2011.

.....  
**Handtekening van deelnemer**

.....  
**Handtekening van getuie**

### **Verklaring deur die ondersoeker**

Ek (*naam*) ..... verklaar dat:

- Ek die inligting in hierdie dokument duidelik gemaak het aan .....
- Ek hom/haar aangemoedig het om vrae te stel en voldoende tyd gebruik het om die vrae te beantwoord.
- Ek tevrede is dat hy/sy alle aspekte van die navorsing, soos hierbo uiteengesit, voldoende begryp.