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Short Dissertation

Title:

Therapist countertransference experiences of clients' violent crime narratives in the South African context.

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Declaration for the Masters Dissertation:

I hereby declare under oath that this Masters dissertation is the product of my own independent work. All content and ideas drawn directly or indirectly from external sources are indicated as such. The dissertation has not been submitted to any other examining body and has not been published.

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Dedication:

To Duncan, Doug and Michael – for your wisdom and patience.

After great pain, a formal feeling comes —
The Nerves sit ceremonious, like Tombs —
The stiff Heart questions was it He, that bore,
And Yesterday, or Centuries before?

The Feet, mechanical, go round —
Of Ground, or Air, or Ought —
A Wooden way
Regardless grown,
A Quartz contentment, like a stone —

This is the hour of Lead —
Remembered, if outlived
As Freezing persons, recollect the Snow —
First — Chill — then Stupor — then the letting go —

(Emily Dickenson)

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Abstract:

AIM: This study endeavoured to explore and understand countertransference reactions that occur when the therapist is exposed to clients' stories of violent crime. The study focused on the therapist's experiential responses resulting from exposure to traumatic stories and the subsequent consequences thereof. This was contextualized from the particular perspective of South African therapists and their above average exposure to crime related trauma.

METHODOLOGY: A qualitative research design was used with Smith's Interpretive Phenomenological Analysis (IPA) as the methodology of choice. This included a double hermeneutic approach of analysing firstly the perceptions and secondly the meaning of such perceptions within the context of current literature. Nine South African psychologists were purposively selected and interviewed to provide the required data.

CONCLUSION: The results of this study show that both concordant and complementary countertransference play a large role in the therapist's experience of 'identification with suffering' and feelings of avoidance whilst listening to stories of violent crime. Such concordant identification with the client, if not mediated through awareness of one's internal dynamics, can result in the therapist's over-identification with the client which may be associated with features of vicarious trauma. One way in which such vicarious trauma states may be resolved by the therapist is through the concordant mimicking of the client's need to purge and be contained. Experiences linked to vicarious trauma, however, are not a certainty when working with trauma but rather an outcome that depends greatly on a therapist's level of experience, self-awareness and ability to implement coping strategies. Through these mediating factors, what may usually be experienced as vicariously traumatic may be transformed into resilience and self-growth. It appears that the implementation of coping strategies (such as normalization and reframing) are also what allow South African therapists to manage in the context of high crime rates and caseloads. Despite the barriers that the public sector poses, the tenacity and hopefulness demonstrated by some of the participants allowed them to overcome some of the difficulties linked to working with trauma.

Chapter one:

1. Introduction

The following study seeks to explore how South African therapists experience hearing narratives about violent crime within the South African context, the impact this experience has on both the therapist and the therapeutic alliance (from the therapists perspective) and how the therapist processes this information in real-time and post-session. The study has been conducted using an Interpretive Phenomenological Approach (IPA) as theorized by J.A. Smith (2004) which aims to understand the above phenomenon, and describe the therapist's interpretation of their experience.

There is much available information on theories of countertransference and vicarious traumatisation as a response to trauma-related psychotherapy, but very little research considers these issues from the perspective of the therapist's experience and even less from within a South African context. This study therefore aims to focus on the perceptions of South African psychotherapists as they reflect on their experience of hearing crime and/or trauma narratives in therapy. In this way this study attempts to gain an understanding of how therapists perceive the manner in which they make sense of and respond to countertransference, and whether such experiences affect their ability to treat trauma effectively.

It is anticipated that the findings described below regarding how therapists react to and process the hearing of crime stories may help to normalize the anxieties that therapists have when dealing with clients traumatized by crime, as well as heighten their awareness to their own feelings. If therapists are aware of their feelings they may be less likely to "act out" during the session or disrupt the therapeutic process in some way. They are also probably more likely to engage in self-care and other preventative strategies, which in turn will assist in the planning and success of future treatment strategies.

Chapter Two

2. Literature Review - Part One: Violent Crime and Trauma

2.1 Psychotherapy with Victims of Crime

Psychotherapy with victims of violent crime in the South African context is an area fraught with complications and difficulties. For example, if one is to first establish a sense of safety with the client before any further work may proceed (Herman, 1992), how is this to be achieved when the country's high crime rate poses a constant threat to both client and therapist? It is likely that the high crime rate translates into South African therapists having a higher 'trauma' case load than those in other countries. It is likely, too, that compassion fatigue and vicarious traumatization are a possible result of such exposure and thus a serious concern. The following sections explore both the current state of South African crime and the manner in which therapists conceptualize trauma and treat trauma clients in more detail. This serves to shed some light on the context within which the below study takes place, as well as to better understand the possible impact of crime and trauma on the therapist.

2.1.1 The State of Crime in South Africa

It is a commonly held perception, both nationally and internationally, that South Africa is rife with violent crime. The Nedcor Project on Crime (1996), as cited in Williams et al (2007) refers to the "culture of violence" (p. 846) left behind by Apartheid, a propensity of the South African population to engage in violence as a means to solve problems and effect (usually political) change. Williams also referred to the fact that of the almost 75% of South Africans that experience trauma during their lifetimes, approximately 24.6% are crime-related. In 2008, a survey by Synovate showed that approximately twenty percent of South Africans have considered immigration, eighty-two percent of which reason that this was due to the level of "violent crime and corruption" in the country (Marchetti-Mercer, 2012). This perception of violent crime is validated by the statistics released by the South African

government and the state police in particular; the official South African Police Service website details the following statistics for April 2010 to March 2011:

- 247 630 reported cases of burglary at residential premises
- 198 602 reported cases of assault with intent to inflict grievous bodily harm
- 18 5891 reported cases of common assault
- 66 196 reported cases of sexual offenses
- 15 940 reported cases of murder
- 15 493 reported cases of attempted murder
- 10 627 reported cases of carjacking
- 1 226 reported cases of public violence

The crime report for 2010/2011, found on the same website, explains that a total of 2 071 487 serious crimes were reported in South Africa during this time. This compared to the USA, a country much larger than South Africa, which reported just under half (1 246 248) the amount of violent crimes in 2010 (Federal Bureau of Investigation's official website).

A recent study showed that victims of crime who most need therapy tend to seek it out, many of them motivated by symptoms related to a normal trauma reaction or the psychiatric conditions of Acute Stress Disorder and Post Traumatic Stress Disorder (Semb, Fransson, Henningsson & Sundbom, 2011). It therefore stands to reason that the exceedingly high crime rate referred to above translates to an equally high trauma case-load for South African psychologists and counsellors (Edwards, 2005; MacRitchie & Leibowitz, 2010).

2.1.2 The Implications and Treatment of Trauma

The research of Williams, Williams, Stein, Seedat, Jackson and Moomal (2007) on Interpersonal Trauma shows a strong link between interpersonal trauma (such as violent crime) and mental health conditions in South Africa. Considering the above

argument on the high levels of crime in this country, the chances of a client experiencing more than one traumatic event is also quite probable, although the exact prevalence of multiple traumas in South Africa is difficult to determine due to lack of research in this area and under-reporting on both the victim and police's part (Williams et al, 2007). South African psychotherapists, therefore, need to be adept in both diagnosing and treating trauma-associated psychiatric conditions. The following section will begin by defining trauma and its outcomes, followed by an exploration of the common models of treatment used by South African Psychologists. As explained above, this serves to provide the context in which psychologists (treating trauma) work and thus provide some insight as to the impact that trauma has on said therapists.

2.1.2.1 Trauma Defined

Trauma, as defined by the DSMIV-TR (2000, p. 467) involves a situation where:

1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
2) the person's response involved intense fear, helplessness or horror

Such an experience often alters the way in which one's memories of the event – particularly those that are steeped in high emotion – are processed (Landre et al, 2012) and it is due to this 'altered processing' that trauma is often difficult to treat. Depending on the trauma's severity, intensity and longevity as well as the individual's vulnerability or resilience to such situations (Allen, 2005), the outcome may include a spectrum of reactions ranging from 'normal' traumatic symptomology to Post Traumatic Stress Disorder.

Abraham and Torok (as cited in Braga, Fiks, Mari & Mello, 2008) view trauma as "an unspeakable experience, not elaborated, not signified, that was incorporated but could not be introjected" (p. 3/8), and went on to explain that it is in fact this "barrier to symbolic elaboration [that] assigns the traumatic quality to experiences" (p. 3/8). Put

differently, clients often have no words or meaning to explain their trauma, they cannot make sense of it and recent studies show that sometimes rehashing the event (a technique frequently applied in traditional trauma debriefing) may serve to make the client feel more traumatised and even worsen their symptoms rather than prevent the onset of PTSD (Allen, 2005; Rose & Bisson, 1998; van Wyk & Edwards, 2005).

Lifton (as cited in Stocks, 2007) explains that:

> … extreme trauma creates a second self [. . .] in extreme involvements, as in extreme trauma, one's sense of self is radically altered. And there is a traumatized self that is created. Of course, it's not a totally new self, it's what one brought into the trauma as affected significantly and painfully, confusedly, but in a very primal way, by that trauma. And recovery from post-traumatic effects, or from survivor conflicts, cannot really occur until that traumatized self is reintegrated. (p. 74)

According to this proposition, trauma involves a transformation of the client's sense of self. They (the client) feel that the person they are now is vastly different from the person they were prior to the trauma in the most significant ways: their identity, their sense of safety, their relationships. It is the therapist's job then to bring together the 'before' and 'after' self in order to show the client that they are the same person, to assist them in processing the trauma and the psychological changes that occurred as a result. Without this process, clients often struggle through a myriad of challenges as a result of the unresolved trauma.

2.1.2.2 Results of Unresolved Trauma

Contrary to popular belief, trauma does not always result in psychiatric disorders such as PTSD or Depression. In their exploration of the concepts of resiliency and vulnerability to PTSD, Edwards, Sakasa and Van Wyk (2005, p. 149) explain that factors such as "temperament and personality, age and gender, the degree of adversity to which the individuals have been subjected and how well they coped with that adversity in the past" all affect whether the outcome of trauma will result in some

kind of psychiatric condition. There are, however, certain traumatic incidences which predispose one to trauma-related disorders more than others. For instance, interpersonal violence (as mentioned above) is strongly associated with PTSD symptoms, especially if it involved "significant injury" or the use of "deadly weapons", such as is common in instances of violent crime (Edwards et al, 2005). Allen (2005) explains that trauma affects an individual's memory, emotions, relationships and sense of self in a profound way, and may result in not only the expected Acute Stress Disorder (ASD), PTSD or Depression, but also Dissociative Disorders and self-destructive behaviour such as substance abuse, self-harm or suicide.

The outcome of trauma is often dependent on the type of trauma experienced, for example the greater the intensity, viciousness and duration (including repetitive trauma), the worse the outcome. In the South African context, the threat or likelihood of a person experiencing more than one traumatic event, as well as the violent nature of such events, seem to make trauma that much more difficult to resolve, as the fear the client may harbour of a repeat event may be a realistic one. Terr and Herman (as cited in Bacciagaluppi, 2011) identify two types of trauma: a single trauma and prolonged/repeated trauma, otherwise known as complex trauma. Courtois (2008, p. 86) describes complex trauma as "a type of trauma that occurs repeatedly and cumulatively, usually over a period of time and within specific relationships and contexts". In this context, the term usually refers to situations of child abuse, domestic violence and torture or war, but can also include a vicious gang rape, or repeated episodes of, or exposure to violent crime and death. The results of such trauma are expectedly more intense and more difficult to treat. In fact Borderline Personality-type symptoms such as "emotional liability, relational instability, impulsivity and an unstable self-structure" (p. 89) are often associated with complex trauma, to the point that many theorists are now beginning to recognise Borderline Personality Disorder as "a diagnosis that has come to be understood as a post-traumatic adaptation to severe childhood abuse and attachment trauma" (Briere, 1984; Herman, Perry, & van der Kolk, 1989; Van der Kolk, Perry, & Herman, 1991; Zanarini, 1997, as cited in Courtois, 2008, p. 89).

Most trauma interventions have the aim of preventing the onset of Post Traumatic Stress Disorder, emotional dysregulation or other deficiencies in the functioning of the affected individual. More recent studies have elaborated on some unexpected and serious psychological and biological results of trauma. For example, recent advances in the field of traumatology research, as described by Bacciagaluppi (2011), include neurobiological insights such as those that show how early trauma/lack of attachment may lead to disruption in connections between hemispheres and cortex/subcortical areas, which results in a form of brain damage. Bacciagaluppi also mentions research presented at the 2010 AAPDP/OPIFER Joint Meeting which exposes the developmental pathways of trauma which lead to dissociation and even psychosis. He mentions affect dysregulation and even somatic conditions such as "vascular accidents and malignant tumors" (p. 535) as being a result of traumatic experience (Bacciagaluppi, 2011).

What has been covered thus far - the definition of trauma and its impact on the client, especially when left unresolved for a certain amount of time - supplies the reader with a picture of the trauma client and their psychological/emotional state upon entering the therapy room. The following section will explore the process of trauma treatment that follows, with an aim of understanding what the therapist is exposed to during such a session, i.e.: the context in which countertransference often takes place.

2.1.2.3 Common Models of Treatment

Both past and current literature (as presented above) suggest that unresolved trauma often leads to a myriad of difficulties on the client's part, depending on their degree of resiliency. With the link between South Africa's high crime rate and South African mental health workers' increased trauma caseloads having already been established in a previous section, the following section attempts to explore what modalities South African psychotherapists use to manage and treat the high caseloads of trauma and what elements these treatment modalities have in common in order to understand their impact on the therapist.

A particularly popular trauma model commonly used by mental health practitioners in South Africa is the WITS Trauma Intervention Model (Eagle, 1998). This model begins with the client telling and retelling the story, first outlining only the facts, and later bringing in the thoughts and feelings attached to the facts. The next step, according to the model, is to assist the client in normalising their symptoms as the flashbacks, nightmares/sleep deficits, heightened startle response, irritability and feelings of dissociation that often accompany post-traumatic behaviour can make a client feel as though they are losing their minds. Step three in the model involves self-blame or survivor guilt. This involves reframing possible behaviours viewed as negative or selfish as life-saving and necessary in such a difficult circumstance. Encouraging mastery is the fourth step of the model, which hopes to “restor[e] the person to previous levels of functioning” (p. 142) through means of anxiety management, learning how to self-soothe, desensitisation to provocative stimuli etc. (Eagle, 1998). The therapist’s final step is to then facilitate creation of meaning by assisting the client in figuring out why this traumatic event happened to them. Perhaps they feel it was a test from God, perhaps it was a life-lesson so that they are better equipped to help others in a similar situation? The key here is to engage with the client beliefs, values and internal world so as not to impose your meaning of them, but allow them to formulate their own, as part of the healing process.

Although the WITS model is frequently used in many clinic settings in and around South Africa (Eagle, 1998), it is to be noted that the model is designed for use in brief, short-term intervention where the trauma being treated is fairly straight-forward and uncomplicated, and as such, would not be suitable for continuous and complex trauma cases (Eagle, 1998). Also, as mentioned above, short-term debriefing interventions – such as the WITS trauma model - have been criticised for possibly re-traumatising the client if it is not undertaken in a meticulously careful manner (van Wyk & Edwards, 2005). Short-term interventions most certainly have their place, especially in the South African context where, due to limited finances and resources, a therapist may only have a single session with a client, but this, still leaves the therapist in a bind as to how to approach therapeutic intervention without traumatising the client further? Wallin (2007) highlights this dilemma by explaining that:

> … the patient's attachment relationship to the therapist is foundational and primary. It supplies the secure base that is the sine qua non for exploration, development and change" and that "[b]y virtue of the felt security generated through such affect-regulating interactions, the therapeutic relationship can provide a context for accessing disavowed or disassociated experiences within the patient that have not – and perhaps cannot – be put into words. (p. 2 – 3)

As mentioned in the introduction to this section, the therapist therefore has to establish a sense of safety through initiating a "secure base" or attachment with the client prior to starting any sort of exploration of their trauma. The focus here would also then be on reflecting on the trauma rather than re-experiencing it per se.

An example of the above may be seen in Judith Herman's 3-Stage Trauma Recovery Model which begins with the first stage of **Establishing Safety** (Herman, 1992). This involves the client being physically moved to a place of safety, assistance with emotional containment and guidance towards self-soothing, followed by an establishment of trust within the therapeutic relationship. Only then does the second stage, **Remembrance and Mourning**, commence, which encourages the client to start engaging with trauma content by connecting to their body and felt/lived experience during the processing of the trauma. The client is to engage with their feelings, thoughts and bodily sensations before, during and after the trauma. And finally, the client is guided towards the third and final stage of **Reconnection to Ordinary Life**. This stage requires a shift from the past to the present, and how the trauma has impacted on relationships, work/academic settings and everyday life in general (Herman, 1992; Rappaport, 2010).

Table 2.1: Common Models of Trauma Intervention

Herman's 3 Stage Model :	**WITS Trauma Model**:
1. ***Establishing Safety*** (Physical, emotional, relational)	1. Telling/retelling the story
2. ***Remembrance and Mourning*** (Working with trauma whilst being cognisant of body and experience)	2. Normalising the symptoms
3. ***Reconnection to Ordinary Life*** (Moving from the past to the present)	3. Addressing self- blame /survivor guilt
	4. Encouraging Mastery
	5. Facilitating creation of meaning

Although the above models, particularly the WITS model, incorporate a certain amount of Cognitive Behavioural Therapy elements in order to make it amenable to the short-term, "problem orientated" context (Eagle, 1998, p. 137), they also make use of many Psychodynamic principles regarding trauma, which generally aims to achieve the following during consultation with a traumatised client:

- *"bringing unconscious material into awareness;*
- *establishing a sense of meaning, purpose, and safety;*
- *examining affects such as guilt and shame;*
- *fostering insights into how threatening thoughts and feelings are kept from awareness in order to reduce hyperarousal;*
- *examining the therapeutic relationship for symbolic re-enactments of past trauma* (Krupnick, 2002, as cited in D'Andrea & Pole, 2011, p.1)

In keeping with the focus of this study, one needs to consider what the above requirements mean for the therapist. Both the WITS and Herman's models seem to require that the therapist perform the role of "container" while the client works

through and processes their intense emotions related to the traumatic experience. Bion (1955) sees the therapist–client relationship as a parallel of the mother-child relationship in terms of the 'container-contained' model. Under this assumption, the client/child projects unbearable emotions onto the therapist/mother who models the ability to 'contain' and 'detoxify' them, and returns them to the client/child in a more manageable form (Gabbard, 2001). Cartwright (2010) elaborates on how a therapist applies Bion's concept within the clinical setting:

> Because unbearable mental states remain separated, split off, from the patient's core self, the therapist's containing function relies on attending to thoughts and feelings on the periphery of his awareness. For this reason, the therapist's reverie, his dream thoughts, become a gateway to accessing unprocessed experience that requires further psychic work. In this way the therapists containing function becomes part of a broader psychic processing system, picking up on and attending to parts of the patient's internal world that for various reasons cannot be tolerated or given meaning. (p. 1-2)

The expectation therefore is that the therapist 'contains and detoxifies' the 'intolerable affects' of their client, and in doing so, models for their client the ability to tolerate intense emotion. Thus the therapist's ability to contain uncontainable emotions is of utmost importance to the healing process of the client. Delvey (1985) elaborates further by explaining that:

> [t]he goal of the therapist in containing the patient's feelings is maturation. Properly containing the feelings of developmental arrested patients helps to modulate their feelings, shifting them into a range that minimizes disruptive and paralyzing levels, and thereby frees the patient to begin to mature again. Also, the patient learns how to manage difficult feelings by watching the therapist successfully manage the same or similar feelings. By not becoming emotionally disrupted, by staying calm and reasonable in the presence of strong emotions, the therapist becomes a healthy model and eventually a healthy introject for the patient. (p.584)

Bion (as cited in Vaslamatzis, 2005) goes on to explain that if the therapist fails in their ability to contain, the client has to deal with their unbearable emotion on their own and the opportunity for modelling the ability to contain is lost. One can imagine how a client may feel overwhelmed by his emotion if not even his therapist can bear it. The therapist, therefore, has to engage in and tolerate thoughts/affects that are intolerable to the client. But how does the act of containing such intense emotion impact the therapist? As mentioned above, when clients cannot bear their own affect or internal objects (such as during times of trauma) they split them off and project them into the therapist (Bion, 1955). How does the therapist manage such a dynamic without reacting themselves? They cannot become overwrought with emotion as well, particularly if establishing emotional and relational safety is a must (according to Herman's model). The lived experience of the therapist during such a process will be explored in detail during the course of the following chapter.

Chapter 3

3. Literature Review - Part Two: Countertransference and Trauma States

The following section moves away from the general context in which trauma therapists work (as reviewed above) towards a more specific and in-depth look at their experiences of and reactions to hearing narratives of violent crime-associated trauma (ie: countertransference experiences) both in real time and post session. There will also be a discussion around how South African psychotherapist's countertransference experiences are influenced by the context (country) in which they work as well as the possible outcomes of trauma-related countertransference exposure, but first, an accurate definition and understanding of countertransference.

3.1 Defining Countertransference

According to Blagys and Hilsenroth (2000, as cited in McWilliams, 2004) Psychodynamic therapies are characterized by:

1. Focus on affect and expression of emotion
2. Exploration of the patient's efforts to avoid certain topics or engage in activities that retard therapeutic progress (i.e., work with resistance)
3. Identification of patterns in the patient's actions, thoughts, feelings, experiences and relationships (object relations)
4. Emphasis on past experiences
5. Focus on interpersonal experience
6. Emphasis on the therapeutic relationship (transference and the working alliance)
7. Exploration of wishes, dreams and fantasies (intrapsychic dynamics) (p. 3)

Psychodynamic therapy therefore aims to bring a client's unconscious internal conflicts (dynamics and defenses) into awareness through the fostering of a strong therapeutic/working alliance with the client. In working with the above, transference and countertransference are privileged as core concepts in therapeutic interventions and

understanding the client's experience. Chodorow (1999, as cited in Redman, 2009) explains transference as "the process, largely unconscious in character, by which our experience of 'external' reality (prototypically, the patient's experience of the analyst) is imbued with feeling and takes on subjective texture, colour and shape" and countertransference as "what is happening in the analyst, primarily to what the transference is itself said to stir up in his or her unconscious" (p. 53). The issues of what experiences are stirred up in that analyst, and in what way, however, has led to considerable debate in psychoanalysis. Both the Classical/Freudian view and more contemporary understanding of countertransference will be explored below, with particular focus on the model of countertransference upon which this study is based.

The Freudian or Classical view of countertransference understands it to be a negative "rupture" in the working alliance, reflective of the therapist's "desires to make clients objects of gratification of their own infantile impulses" (Prochaska & Norcross, 2007, p. 44). Theorists of this perspective feel that unresolved conflicts from the therapist's childhood emerge when triggered by related transference, which causes the therapist to be become defensive, regressive and no longer able to maintain the objectivity (analytic position) required for a successful reflective therapeutic interaction. It purports that countertransference is based on an unconscious acting out of unresolved conflicts on the therapists part, in reaction to the client's transference. It thus was (and still is by some) viewed as "a disturbance of and a deviation from analytic neutrality" (Zachrisson, 2009, p.180) and as such is unhelpful and problematic to the therapeutic alliance, only to be resolved through the therapists own analysis and deeper understanding of their own unconscious conflicts (Hayes, Gelso & Hummel, 2011). Countertransference under this assumption therefore refers to the thoughts, feelings and behaviours of the therapist as influenced in reaction to the client. Zachrisson (2009) describes the "wide spectrum of reactions" that are classified or considered as countertransference:

> … something happening in the analyst ... Something takes place in the analyst threatening to bring him or her out of analytic position. This something can be a feeling of emptiness, irritation or anxiety. It can be tendencies to be a bit too pleasing to a patient, a tendency not to stick to frames and agreements as we usually do – for example, we stretch the session some minutes in an atypical way, as if we have to go a bit out of the way not to hurt or irritate the patient. It can be

> a question of thoughts, fantasies or pictures which, sometimes quite unexpectedly, pop up in the analyst (Zachrisson, 2006). It can be a question of shifting moods, variations in alertness and interest, boredom, drowsiness, and so on, appearing as signs of unconscious reactions in the analyst. (p. 178)

According to this perspective, if the countertransference is not resolved, it may result in a rupture – "a tension or breakdown in the collaborative relationship between patient and therapist" (Safran & Muran, 2006, as cited in Safran, Muran, & Eubanks-Carter, 2011, p. 80). Nowadays, it is generally acknowledged that the reparation of such ruptures through open and honest communication with one's client may eventually result in a deepening of the therapeutic alliance; however this is not always the case and sometimes the result is a breakdown of the therapeutic process altogether (Safran et al, 2011).

More contemporary understandings of countertransference tend to adhere to the premise that the countertransference one experiences during a therapeutic interaction is also indicative of what the client is experiencing and may in fact be an unconscious clue to what the linchpin of their concern is (Mitchell, 1997; Safran, 2003). If the therapist is attuned to such experiences he or she may bring the countertransference back into the therapeutic dialogue in a well-timed and tactful manner, and may use it as a tool to deepen his/her understanding of the clients experience. Done correctly, this may result in the client feeling both heard and understood which will in turn deepen the therapeutic alliance. Here, countertransference is viewed as a form of unconscious communication between client and therapist rather than a personal reaction on the therapist's part. Such theories, however, are still divided on the point of whether countertransference is elicited by the client, or co-constructed by both the client and therapist.

Kernberg's "Totalistic" definition, for example, sees countertransference as every possible reaction of the therapist to the client, both good and bad (Shubs, 2008). This was a significant epistemological shift from the common Freudian view of the time (1950's) and both allowed and encouraged therapists to begin working with their countertransference experiences with a view to better understanding the patient (Hayes et al, 2011). This was achieved through acknowledging the countertransference experience, becoming aware of it and its possible roots in one's unconscious, and then making an informed decision as to whether it was the client's unconscious internal conflicts or the

therapists. An example of one of the first shifts from the classical view include Winnicott's theory of Objective Countertransference which distinguishes between countertransference which stems from the client and that which stems from the therapist:

> [W]hen objective CT occurs, a large percentage of the variance in a therapist's feelings toward a patient is attributed to the recurrent evocative pattern of the patient's maladaptive behaviour during the therapy sessions. In contrast, when subjective CT occurs, a large percentage of the variance in a therapist's feelings toward a patient is attributed to the therapist's own residual maladaptive tendencies. (Hafkenscheid & Kiesler, 2007, p. 393)

The author, here, acknowledges that although the therapist's unconscious internal conflicts may have a role in producing the countertransference experience, so too does the client's unconscious internal conflicts (although the responsibility of the discernment between the two lies squarely on the shoulders of the therapist).

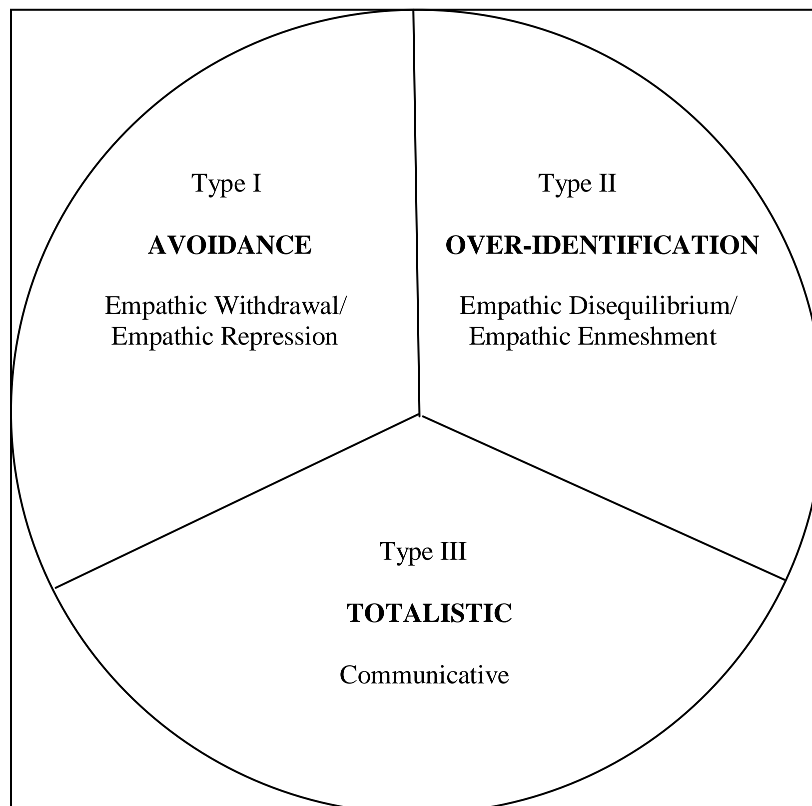
Around the 1950's other prominent psychoanalysts began to voice alternative opinions of countertransference – such as Heimann, Money-Kyrle, Eromm-Reichman, Little, Sullivan and Racker (Keisler, 2001, p. 1057) – as shown by Heimann's paper, "On Countertransference", which viewed countertransference as "something desirable" as long as awareness was maintained (Zachrisson, 2009). Racker (1957) made a particularly useful contribution with his differentiation between Concordant and Complementary countertransference. According to his theory, concordant countertransference involves the therapist's identification with the projected "concordant" part of their client's projected external object, for example, the therapist's Id (victim) identifying with the projected Id (victim) of the client. Complementary countertransference on the other hand involves the therapist identifying with a "complementary" part of the client's projected internal object, for example the client's Id (child-like) with the therapist's Superego (punitive parent) (Carveth, 2011). Here, the client is thought to bring out countertransference experiences in the therapist, and if the therapist is sufficiently aware of this dynamic, rather than reacting to them, they interpret reactions and use this process to engage more meaningfully in the alliance. Hayes et al (2011) views this as the client "exerting certain "pulls" on the therapists" (p.89), which draw out a certain countertransference response; for example: a child-like way of relating by the client may draw out a parental

countertransference in the therapist, or a variety of other dyadic relationships such as victim/aggressor. This concept, however, is slightly different to Anna Freud's (1936) concept of 'identifying with the aggressor' as here the therapist appears to be intersubjectively mirroring an unconscious part of the dynamic, which results in the therapist identifying with the aggressor, or the fear thereof. Racker emphasizes the point that such countertransference experiences can only be judged as negative or positive depending on the level of awareness of the therapist. If the therapist is aware of the dynamics, they may bring them usefully back into therapy, however if they are unaware, it may lead to a disconnect or rupture of some sort (Carveth, 2011).

A somewhat more recent and overlapping definition, that displays the longevity of this school of thought, is provided by Shubs (2008) who feels that transference and countertransference are "bi-directional" in that they each encourage or promote the emergence of the other. He coins this as a "form of unconscious communication" (p. 161) which allows the therapist to gain a deeper understanding of the client's thoughts, behaviours and experience. Shubs based his work on Wilson and Lindy's (1994) concepts of 'type I' (avoidant, counterphobic, detachment) and 'type II' (overidentification) countertransference response - constructs which were based on the premise of Freud's classical or "impediment" theory (Shubs, 2008, p. 160), and as such focus on the role of empathy and empathic-strain on the relationship when considering containment of traumatic countertransference. Shubs, however, found such explanations limiting as they did not account for those therapists who were neither hindered nor vicariously traumatized by exposure to trauma work and so went on to suggest a 'type III' countertransference which espouses a typically totalistic perspective. Type III countertransference takes into account the "*intersubjectivity* of the psychotherapeutic dyad of patient and therapist" and the "*object relations* view of countertransference [which] incorporates an understanding and examination of such notions as projection, externalization, identification, concordant identification, complementary identification, introjection, projective identification, and projective counter-identification" (Shubs, 2008, p. 161). He calls this "communicative countertransference" which is based on the process that takes place between the client and the therapist (a two-person model), unlike type I and II which are based on content. In fact, Shubs feels that Type III countertransference allows us to become aware of and understand content-based reactions (like type I and II countertransference) better (p. 163).

This concept of an unspoken dialogue into which one may carefully and tactfully tap for further enrichment and better understanding, is a far cry from Freud's classical views of countertransference as hindrance to the therapeutic alliance, and thus aids us in viewing countertransference as potentially helpful. It is this tripartite model of totalistic countertransference upon which the present study is based.

Table 3.1: Shubs' (2009) Tripartite Model of Countertransference (p. 163)



Despite the fact that countertransference is more recently viewed by contemporary theories as a tool which may positively influence the therapeutic context, it is only through an awareness of countertransference that it becomes useful and the therapist is able to avoid destructive 'acting out' and subsequent ruptures in the therapeutic alliance (Carveth, 2011; Gelso, Latts, Gomez & Fassinger, 2002).

3.2 Countertransference and Violent Crime-Related Trauma

Even though psychotherapy "should ideally include the ability of the therapist to empathize with what the patient is unable to tolerate within him- or herself" (Kernberg,

1975, as cited in Goldfeld et al, 2008, p. 524), oftentimes therapists are unable to avoid countertransference reactions, particularly when faced with the intense emotions elicited by trauma work. Within the definition of countertransference in general, as discussed above, there are certain types or subtypes of countertransference which may be associated with instances of trauma. For example, Pearlman and Saakvitne (1995, as cited in Rasmussen, 2005), discuss various types of countertransference that therapists experience during psychotherapy with incest survivors, such as "parental countertransference, voyeuristic countertransference, body-centered countertransference and the wish not to know" (p. 25). Such experiences may be overwhelming for the therapist, and often forces the therapist into implementing some kind of coping mechanism which can be detrimental to the therapeutic alliance. Rasmussen (2005) explains the implications of such responses: "[t]he therapist's defenses against strong affects may, for example, make one vulnerable to VT responses, or conversely, lead to an overprotective detachment" (p. 21). So it seems in order to avoid vicarious trauma commonly associated with trauma (see discussion below), the therapist may detach themselves empathically. Similar use of avoidance as a coping mechanism is evidenced in Fox and Carey's (1999) examination of the concept of 'collusive resistance' with particular reference to rape survivors. This is similar to what Danieli (1984) calls the "conspiracy of silence", both of which speak of the therapist "collusively" avoiding difficult subjects/topics along with the client. This seems to serve the purpose of both protecting the therapist against the overwhelming exposure of intense affect as well as the fears they (the therapist) may have of re-traumatising the client (Fox & Carey, 1999). According to Lindy and Wilson (cited in Shubs, 2008, p. 164/5), the experience of hearing a client retell a traumatic incident associated with violent crime has the tendency to bring out the "*protector, rescuer, comforter, perpetrator, or significant figure involved in the traumatic event*" in the therapist. This is likely to be related to the felt anguish and assumed victim-role of the client.

Such impediment theory-based views of countertransference purport that psychotherapy is fraught with prospective negative countertransference experiences associated with trauma that one has to navigate extremely carefully in order to understand and manage instances of rescuing, collusion, avoidance, over-identification and a number of other therapeutic landmines. Danieli (1984) in a study of Nazi Holocaust Survivors moves away from this school of thought with the introduction of 'event countertransference'. In his paper he argues that countertransference reactions such as "bystander guilt, dread and

horror, and shame” on the therapist’s part is a response to hearing the Holocaust-related story rather than “unresolved neurotic conflicts of the therapist” (Hafkenscheid, 2005, p.160), but still views countertransference as a potential barrier to therapy as well as an occurrence which leaves the therapist vulnerable to vicarious trauma. Shubs (2008), on the other hand, shed some light on how therapists may avoid the therapeutic difficulties mentioned above through maintaining awareness of these dynamic processes. He purports that by viewing countertransference from a Totalistic perspective one is more able to identify, interpret and mediate negative countertransference experiences rather than react to them. The Totalistic perspective, as Shubs goes on to elaborate, includes “content-based as well as process-based reactions of the therapist, emanates from a two-person psychotherapy model, and is rooted in intersubjective and communicative understandings of the therapeutic interaction” (p. 177). This is because countertransference experiences are viewed as being an ‘interactional product’ of patient-therapist interaction. This helps therapists understand their intense reactions without overly personalizing them. Shubs explains that if such a view is not held, intense emotions often expressed by trauma clients, such as homicidal revenge/rage or anguish, can frequently result in the therapist experiencing uncontained fear, anxiety, guilt, disillusionment and other overwhelming emotions. As mentioned above, such countertransference responses can lead to the therapist “colluding” with the client in order to avoid difficult topics or over-identifying with his/her own life experiences which result in therapy revolving around the therapists needs and not the clients. This is especially so if the therapist has experienced something similar to that of the client (Shubs, 2008).

More so than any other class of disorders, trauma seems to have the propensity to elicit negative or particularly strong countertransference experiences that are often difficult to identify and manage. Boulanger (2005) argues that such experiences are often necessary for the healing of the client:

> Survivors of massive psychic trauma frequently experience deficits in symbolic functioning affecting the capacity to dream and to think productively. Clinicians working with survivors also find themselves struck thoughtless, unable to reflect on the horrors their patients describe. The writer argues that experiencing an initial state of incoherence might be a necessary condition of the healing process when analysts work with this population. It is in the struggle to overcome this

> state and to become thinking professionals again that they can start to bear witness to the patient's experience. And it is through this work with the analyst's containing presence that the survivor ceases to be a mute observer to her own loss, starts to recapture her thinking self, and begins the process of witnessing her own survival. (p. 21)

However, as Carveth (2011) maintains, such countertransference may only be viewed as useful if the therapist is aware of it. For example, in order to become 'thinking professionals' again and model to the client a way out of their muteness, the therapist needs to understand the dynamics behind why they felt mute in the first place. If the therapist is not alert to such dynamics, they may fall prey to acting out what has been projected on to them by the client, as in the above case, a feeling of being stuck or mute. Pick (1985) and Steiner (2000) explain that "enactment represents the patient's attempts to actualize wishes and evade frustrating feelings rather than thinking about and tolerating them. Similarly, from the analyst's perspective, the pain of tolerating uncomfortable feelings evoked by the patient is avoided if these feelings are enacted rather than thought about" (as cited in Ivey, 2008, p. 28). To elaborate on the above example, the therapist may become frustrated in their 'stuckness' and may not know how to move forward with therapy, thus being unable to give a voice to the muted client. Self-awareness on the therapist's part is therefore essential in order to ensure the constructive use of countertransference and the avoidance of enactment.

3.3 Countertransference and the South African Context

As evidenced above, a particularly difficult area in which to manage ones countertransference reactions is whilst listening to the narratives of violent crime and its associated trauma. This is especially so within the South African context, where violent crime is so prevalent and there is a general heightened awareness of issues around personal safety. Evans and Swartz (2000, p. 49 – 51) explain the difficulty of South African mental health workers having to "[work] in a situation of ubiquitous, ongoing violence" and that due to the lack of resources available to assist the plethora of victims, "[f]eelings of inadequacy and helplessness are close at hand" for mental health workers.

If the therapist enters a therapeutic relationship already feeling inadequate and helpless, how are they supposed to adequately contain the clients affect?

Other than the high levels of crime, there are also particular aspects of the broader South African context – such as multicultural/multilingual aspects, political and socioeconomic difficulties – that make it difficult to use western psychological in reference to adequately understand trauma in context (Long, 2012). What applies in Europe and the USA, does not necessarily translate well in the South African context. Long (2012) explains that:

> intellectuals have been arguing since the late 1970s that psychological theories [used by South African therapists] remain beholden to American and European (especially Germanic) explanations of human functioning (Holdstock, 1981a; Turton, 1986) and that the paradigmatic inclinations of psychology are in keeping with "the worldview of the colonizer (Ahmed & Pillay, 2004). (p.4)

For example, a large part of the South African population do not conceptualize trauma, or pathology in general, in the manner which is presented by the DSM. The isiZulu culture, for instance, traditionally sees pathology as the result of having angered their ancestors or "mthakathi" (black magic). What can be considered borderline psychotic from a Western perspective is a completely understandable and logical reaction within certain cultural views. These traditions are strong and revered, and any attempt to challenge them may likely spur defensiveness rather than insight. Hayes (1998) reminds us that "psychoanalysis tries to ensure that our speech, our words, our stories are revealed in a holding environment which facilitates the comprehension and integration of our 'unbearable truths'" (p. 39). However, if there is a cultural or linguistic disconnect between therapist and client, how is this to be achieved? Long (2012) makes reference to the dearth of indigenous language-speaking psychologists available in South Africa, a country with 11 official languages, 10 of which are indigenous. Surely this must affect therapist perceptions of their effectiveness in treating clients from different cultural and linguistic backgrounds?

The economic position of the country also dictates who is able to receive psychological intervention and who is not. Van't Hof, Stein, Marks, Tomlinson and Cuijpers (2011) showed that even though "psychiatric disorders were ranked as the third most disabling

condition, after HIV/AIDS and other infectious diseases" many people were still not receiving treatment because of "the fact that resources are inadequate and unevenly distributed across the country" (p. 1). Practicing therapists are therefore often left with dilemmas about charging for sessions that most of the population cannot afford, which brings up the ethical questions of turning clients away who cannot afford to pay, which does not bode well for the secure relationship required for trauma work.

The above issues appear to point to a number of concerns that South African therapists may face and are continuously required to balance whilst remaining present during the counselling process. Considering the helplessness that therapists experience regarding both their and their clients continual exposure to crime and the disconnect between the application of western ideology to an African people, one wonders as to the impact this has on the immediate therapeutic alliance and whether such concerns distract from the therapists ability to empathise. Unfortunately, much of the therapist's experiences with these dilemmas remain largely unknown due to lack of research in this area. It can be assumed, however, that these dilemmas so intrinsic to the South African context must have some sort of effect on the therapists that work within its context.

3.4 Vicarious Traumatisation vs. Resiliency in Therapists

One of the possible effects of high crime rates and large 'trauma' caseloads is vicarious traumatization or the experiences that are associated with vicarious trauma, i.e., trauma states. Vicarious traumatization involves "the transformation that occurs within the therapist (or other trauma workers) as a result of empathic engagement with clients' trauma experiences and their sequelae" (Pearlman & Mac Ian, 1995, p. 558), a process which "resembles those experienced by trauma victims" and "results in disruptions in the therapists' sense of identity, worldview, spirituality, ability to tolerate strong affect, and central cognitive schemas (e.g., core beliefs about safety, trust, esteem, control, and intimacy" (Neumann & Gamble, 1995, p. 344). This transformation or change, Pearlman and Mac Ian (1995) suggest, is a far reaching and extremely negative one, as a cumulative imprint of trauma is left with the therapist each time a client walks out of their door. Although merely hearing detailed, traumatic accounts of assault, rape, hijacking and murder, for instance, could be a traumatic and highly emotional event itself, "empathic

engagement with survivor's trauma material" (p. 169) is known to frequently lead to symptoms of vicarious trauma (Pearlman & Saakvitne cited in Salston and Figley, 2003). The more the therapist engages empathically with the client (attempts to place themselves in their client's shoes), the more susceptible they become to being affected by the instances of trauma they hear. Such exposure can result in PTSD-like symptoms in the therapist, including changes in their belief systems, intrusive thoughts, inadequate coping skills and even burnout (Pearlman & Mac Ian, 1995).

Killian (2008), MacCann and Pearlman (1990), Neumann and Gamble (1995) and Salston and Figley (2003), all discuss vicarious trauma and compassion fatigue as possible outcomes of secondary exposure to trauma and violence. However, they do not assume this to be the only outcome. Weingarten (2003, as cited in Hernandez et al, 2007), for instance, suggests mediating factors which may influence a therapist's susceptibility to vicarious trauma. This includes the therapist's awareness of the implications of the trauma and whether they feel empowered to take action. The less awareness and ability to take action, the greater the susceptibility to vicarious trauma. Conversely, the more awareness and ability to take action, the more resilient the therapist. Masten and Coatsworth (1998, as cited in Hernandez et al, 2007) describe resiliency as "a pattern of positive adaptation to challenges" (p. 231). It is encouraged by unconditional familial and communal support, flexibility and reflection and, similarly to trauma, can also be vicariously experienced by therapists through their clients (Hernandez et al, 2007). Resiliency, therefore, allows a therapist to 'role with the punches' by placing the stories of violent crime-related trauma into perspective and maintaining strong therapeutic boundaries. McCann and Pearlman (1990, as cited in Harrison & Westwood, 2009) elaborate on the thought that certain attitudes and coping strategies implemented by the therapist allow them to transform vicarious trauma into something more positive and useful. These include:

> advocacy, enjoyment, realistic expectations of self in the work, a realistic worldview (that includes the darker sides of humanity), acknowledging and affirming the ways in which trauma work had enriched lives (of others and their own), maintaining a sense of hope and optimism, and a belief in the ability of humans to endure and transform pain (p. 206).

Hernandez's research showed that "therapists who work in extremely traumatic social contexts learn about coping with adversity from their clients, that their work does have a positive effect on the therapists, and that this effect can be strengthened by bringing conscious attention to it" (p. 237). Trauma, therefore, sometimes serves to strengthen therapist's ability to cope, particularly when they are open to learning from their clients. As Carmel and Friedlander (2009) explain: "therapists gain comfort from knowing of the importance of their work and, as they become more experienced, learn how to cope with symptoms of burnout and vicarious traumatisation" (as cited in Hunter, 2012, p. 181).

Chapter Four

4. Research Context, Rationale and Aims

4.1 Psychodynamic Framework and Key Questions

The objective of this research was to engage the phenomenon of "countertransference experiences in response to hearing client's violent crime stories in the South African context" using an Interpretive Phenomenological Approach. This entailed an exploration of the phenomenon from the experiential perspective of the chosen sample without assuming a particular standpoint or proving/falsifying a hypothesis. Countertransference is a psychodynamic concept which can only be understood in the framework of Psychodynamic Theory. In order to achieve this, some key questions were formulated in order to set the psychodynamic frame without assuming a particular outcome. These questions were guided by both the research and the formulation of the interview schedule:

1. How does the therapist understand or process hearing about crime-related stories (a highly emotional therapeutic context) in real-time and after the session?

2. Do therapists notice interruptions or changes in the therapeutic process whilst listening to such stories and how do they manage or recover from such changes?

3. How do therapists process their countertransference experiences within the South African context (considering the prevalent issues of race and gender disparities, socioeconomic inequalities, and extremely high crime-rates and low prosecution rates)?

4. What limitations or difficulties are therapists aware of (regarding both themselves and their clients) in dealing with traumatic crime-related incidences?

4.2 Rationale

As shown above in the review of recent and related literature, there is relatively little research and understanding of the "lived experience" of psychotherapists with regards to how they process hearing stories of violent crime-associated trauma. Of the studies that are available in the field, most assume symptoms associated with vicarious traumatization as the end result or hypothesized outcome of exposure to such trauma, yet few seem to explore alternative concepts such as resiliency. South Africa, being known for its high prevalence of violent crime, social inequalities and cultural diversity, also does not fit neatly into the theories and techniques espoused by the western world and thus requires context-specific research to better understand the situation on the ground. Given the above, there seems to be a need for phenomenological research from a South African perspective on the therapist's experience of hearing traumatic crime-related stories.

4.3 Research Aims

1. To gain an understanding of South African psychotherapist's lived experience of hearing narratives of violent crime from their clients.

2. To understand how they manage and deal with information and emotions related to crime-related stories during the session and post-session.

3. To understand how the South African context affects how therapists process trauma-related countertransference.

Chapter Five

5. Methodology

5.1 Interpretive Phenomenological Analysis

The topic of countertransference experiences lends itself to qualitative-type research as it aims to investigate the "lived experience" of the participants and as such relies heavily on their opinion, feelings and thoughts about their experience of countertransference related to hearing traumatic stories about violent crime. The following study is based on J.A Smith's (2004) Interpretive Phenomenological Analysis (IPA), a qualitative method which serves to capture the participant's point of view, rather than the researchers. Although initially viewed as a methodological choice for research in the area of Health Care, many prominent researchers are now using IPA for their research into Applied Psychology (Biggerstaff & Thompson, 2008).

According to Smith (2004), the aim of IPA is "to explore in detail participants' personal lived experience and how participants make sense of that personal experience" (p. 40). This means that no hypotheses are formulated regarding the "research problem" and there are no expectations of proving or falsifying any previously assumed outcomes or inferences. One does not go into such research with a particular end result in mind. Rather, the researcher seeks to find out how a participant or participants make meaning of their particular experience. In addition, IPA embraces the idea that the researcher also interprets the data as he/she attempts to expose it's meaning, a "double hermeneutic" or "second order" interpretation if you will (Larkin et al, 2006; Smith, 2004). Larkin et al (2006) explains this as the "two complementary commitments of interpretative phenomenological analysis (IPA): the phenomenological requirement to understand and 'give voice' to the concerns of participants; and the interpretative requirement to contextualize and 'make sense' of these claims and concerns from a psychological perspective" (p. 102). Larkin goes on to explain that certain aspects of such interpretation has to be "informed by direct engagement with existing theoretical constructs (something which distinguishes IPA from grounded theory approaches)" (p. 106). It aims not to establish or generate new theory but rather to understand existing one's from the

perspective of the participant. Following this, although this particular study had no specific hypotheses in mind, the study in its entirety is situated within the context of other theories and research regarding countertransference (a construct of psychoanalytic/dynamic theory), trauma, violent crime and the South African context.

5.2 Data Collection Technique

IPA studies usually choose a sample group of 10 or less participants and are also known to focus on a single case study (Smith, 2004). Each of the 9 selected participants for this study were contacted and invited for a 60 – 90 minute interview in order to explore the phenomenon of experiencing narratives about violent crime within the context of South Africa. Each interview was audio-recorded (with the consent of the participant) and transcribed for analysis, thus ensuring that an accurate account of the experience of the participant was captured.

A semi-structured interview was designed and reviewed by the research participants (myself and my supervisor, Duncan Cartwright) to ensure each prospective interview was conducted along similar guidelines. Room was left for probing and/or exploring ideas or themes which emerged (See Appendix 2). As per the IPA guidelines, the questions within the semi-structure interview were designed to be open-ended and the interview itself as non-directive as possible. This was to ensure that I wasn't presupposing the outcome of the research. For example, the idea that negative countertransference responses or vicarious trauma states resulted from hearing narratives of violent crime could not be assumed.

During the interviewing process I realized this to be an important issue when I reflected on my own assumptions about expecting a negative response to trauma. These reflections made it possible to explore positive responses to trauma as they emerged which were deepened through the use of probing questions or reflections to encourage discussion. Such responsive questioning included:

- "It sounds like it was accompanied by a lot of self-growth?"

- "… faith seems to be a strong part of coping with the intensity of [listening to trauma stories], and it tends to be the people who deal with trauma as well, which is interesting."
- "So you feel, just to recap, that you kind of bring yourself back and you put your focus on the client?"
- "Do you think that makes a difference to how you process trauma?"
- "So having a … really good solid relationship with your partner … helps you level that out a bit?"
- "How exactly do you detach, if you can just elaborate on that…?"
- "Okay, and by "different" do you mean … a stronger constitution, or?"
- "So they're quite introspective at that time themselves?"
- "…these kind of thoughts stay in your head – how would I cope here?"

5.3 Participants

The sample of this study was chosen purposively (Terre Blanche & Durheim, 2002) and was dependent on the participant's expertise in the field of study. Each participant was required to have experience in dealing with trauma cases, particularly those that involved violent crime. Participants were also asked to think of a particular case whilst answering the questions in the semi-structured interview. An attempt was made to include varying gender and race, as well as a representation of both the private and public sectors. The sample consisted of 9 practicing clinical and counselling psychologists (who had been in practice for more than 3 years).

Table 5.1: Details of Participants

No.	Public Sector/Private Practice	Counselling/Clinical Psychologist	Pseudonyms
1	Private	Clinical	Colin
2	Public	Clinical	Meagan
3	Public/Private	Counselling	Rhonwyn
4	Public/Private	Counselling	Sarah
5	Private	Counselling	Tracey
6	Private	Clinical	Christa
7	Private	Clinical	Jonathan
8	Private	Clinical	Rowan
9	Private	Clinical	Sherry-Lee

5.4 Data Analysis

Due to the fact that IPA is an idiographic method (Smith, 2004), each transcript was analysed until a saturation point was reached before moving on to the next transcript or beginning to cross-reference themes across transcripts. This was made easier by virtue of the small sample group, as advocated by Smith, who was concerned with various levels of analysis and "examining the divergence and convergence of [these] smaller samples", (cited in Brocki & Wearden, 2006, p. 95). Unexpected themes both at the stage of interview and at the stage of analysis were explored and analysed (Inductive IPA Analysis). A certain amount of interpretation on the researcher's side at this stage is embraced by IPA and is viewed as a necessary part of the analysis as opposed to Giorgi's theory of bracketed phenomenology (Brocki & Wearden, 2006; Larkin, 2006). As such, any themes or categories that emerged during the analysis of the individual transcripts were recorded in the margins for the purposes of cross referencing at a later point.

After each transcript had been analysed to a reasonable saturation point, the texts were cross-referenced in order to identify themes which traversed all nine transcripts. The initial themes that emerged from reading and re-reading the transcripts, as well as my annotations, included:

Table 5.2: Initial Themes

No.	Initial Themes
1	The extent to which the therapist is aware of their countertransference
2	Countertransference responses
A	Negative or positive?
B	Thoughts, emotions or behaviours (real-time or post session)
3	Techniques used for trauma counselling, particularly high emotion
4	Techniques for prevention of compassion fatigue/burnout
5	Therapeutic ruptures during trauma counselling
A	Techniques for recovering from a therapeutic rupture
6	Bringing countertransference back into therapy to deepen the process
7	Stories of personal trauma or effects
8	Working within the South African context – negative or positive?
9	Opinion's about South Africa and it's high crime rate
10	Any important points the participant wanted to make

Further analysis and comparison of the transcripts lead to the emergence of four overarching themes and their subthemes, all of which shall be discussed at length in chapter six.

Table 5.3: Final Themes/Subthemes

No.	Details of Final Themes and Sub-themes
1	HOW HAS THE THERAPIST INTERPRETED THEIR REACTIVE STATE?
A	Identification with Suffering
B	Avoidance
2	PURGING AND CONTAINING
A	Containing the Purge
B	Purging the Contained: the "need to tell"
3	THE THERAPISTS PERCEIVED LASTING IMPACTS
A	Signs of Compassion Fatigue and Vicarious Trauma States
B	Hope and Resiliency
4	THE SOUTH AFRICAN CONTEXT
A	Normalising and Reframing as Coping Mechanisms
B	Public Sector Barriers

Due to the "double hermeneutic" stance of IPA, an attempt was first made to understand how the therapists perceived the various themes and concepts that emerged in the text. A second level of interpretation was then attempted in order to view these interpretations in context and derive meaning from them. The results were then viewed in the context of current literature on countertransference and trauma, and evaluated in terms of their possible contribution to the field of psychology.

5.5 Reliability and Validity

With regards to reliability and validity in qualitative research, Terre Blanche and Durheim (2002) suggest the following as their standard to ensure "defensible knowledge claims (p. 428)":

1. Good Qualitative Practice
    - Keep close to the cases when labelling and interpreting phenomena
    - Seek disconfirming cases and rival opinions
    - Take into account the researchers impact

2. Triangulation
    - The use of multiple sources of data, theory, methodology or researchers against which to "check one's own position"

3. Generalisibility and Transferability
    - The extent to which one's findings/interpretations can be applied or transferred to other contexts

4. Communicative Validity
    - Testing the "truthfulness" or "veracity" of one's findings with both professionals in the related field and lay persons with a view to attending to any possible criticisms

5. Pragmatic Proof
    - The ability of one's research to achieve a "socio-political agenda" or effect change in practice

(Terre Blanche & Durheim (2002, p 429 - 433)

The present study took all these points into account. A supervisor as a second researcher assisted with the continuous questioning of results, theory and veracity of the analysis and findings throughout the process. Further, a fairly large and varied sample (for IPA) was used and an accurate transcription of the texts was recorded. An attempt was made to record all versions of analysis, annotations and notes in order to leave an "audit trail" as suggested by Smith (2004). Care was also taken to ensure that I was not imposing my presuppositions (for example, my views about vicarious trauma states) onto the participants and emphasis was placed on understanding the phenomenon from the participants' perspective. When an interesting finding arose (e.g., positive responses to trauma stories), care was taken to view such findings as objectively as possible, and to look at any possible rival findings and bring those into the discussion to ensure an unbiased view of the participants experience. Where any such bias was identified, these findings where re-analysed and re-written. Limitations of this approach have been discussed in the Conclusion chapter.

Generalisibility and transferability was established through positioning the findings within the context of current literature. Including 9 participants in the sample and close interpretation of direct quotes also contributed to meeting the criteria, as it was more likely to cover a range of different perceptions of South African psychologists. Lastly, in terms of a socio-political agenda, it was hoped that, whatever the outcome of the participant's experiences, both the participants and the future readers of this dissertation would become more aware of the impact that trauma has on them, as well as the necessity for an awareness of one's own internal dynamics and the usefulness of countertransference experiences.

5.6 Ethical Considerations

Each participant was contacted regarding their interest in the subject and participation of the study. After acquiring written or telephonic permission, each participant was sent a detailed explanation of the intended research as well as a consent form (Appendix 1). They were advised that any participation was completely voluntary, that their details were to remain strictly confidential to all except the researchers. They were also advised that they could withdraw from the study at any stage without any recourse. Any forms that were signed have been stored in a lock up facility and will be kept for the requisite 5 years with all other research data.

The participants were contacted for a 60-90 minute on-site interview at a time that was convenient for them. During the interview the confidentiality clause was discussed again and the interview was recorded with the use of an audio-recorder, with their permission. The participants were requested to not refer to themselves at all by their first or last name so that each transcript remained anonymous and pseudonyms were later allocated to each for the purposes of the report. Participants were asked to keep a particular case of traumatic violent crime in mind during the interview. It was explained to each participant that case material (patients they may discuss) would only be used to help focus their thoughts about the subject matter and would not be mentioned in the study report in any way. The interview was concluded by notifying the participants that they could contact me at any time for further information or to add anything to their interview that they thought was pertinent.

The recorded interviews were then transcribed with particular care taken to ensure that all names and identifying attributes had been purposely left out to safe guard the identity of any cases being referred to during the course of the interview. Both the recordings (on disk) and the 9 transcripts have been and will continue to be kept in a lock up facility together with the consent forms.

Throughout the interview process, care was taken to ensure that any sensitive or emotional issues that arose where dealt with in a careful manner so that none of the participants were caused any psychological distress. Although a few of the participants chose to bring up issues of a fairly personal nature, they seemed comfortable to discuss

such concerns and were not coerced in any way. Were they to have become distressed for any reason, the interview would have been stopped/post-poned and the issue addressed. None of the participants required the interview to be prematurely terminated.

5.7 Reflections on the Process

My experience of this study as primary researcher has been both negative and positive. I found IPA as my chosen methodology deceivingly challenging as one does not anticipate how difficult it is to put aside one's own perceptions and write interpretively about someone else's experience. This led to much re-analysing and re-writing in order to achieve a standard that was acceptable to both myself and my supervisor. I found this process to be a mixed labour of love, patience and humility. However, the opportunity of interviewing South African Psychologists has been an invaluable experience and my understanding of trauma, countertransference and my own internal dynamics has increased exponentially throughout the research process. The analyses of the transcripts lead to some very interesting themes which challenged me and my preconceptions around the following topics:

- Many psychologists are not terribly affected by such narratives of violent crime, but rather choose to focus on the resiliency of their clients who were most often able to overcome such terrible atrocities. This is a particularly surprising finding given the South African context in which therapists are likely to encounter such crimes themselves during their lifetime.

- Despite the fact that I had attempted to remain "objective" during the {construction} of the interview questions and only record the "lived experience" of each interviewed therapist, further reflection has shown that even my line of questioning had anticipated a negative outcome. I was surprised that therapists could contain their own emotions whilst 'holding' the client and allowing them to express theirs. This also spoke to my inexperience and fears as a new therapist.

- Personal experience seems to affect the way in which one hears a story of crime. One has to be particularly mindful of red-flags – areas which, due to personal experience, you are particularly sensitive to or may have experienced yourself, eg: substance abuse or rape - as these seem to pull one's attention away from the client and/or move one towards expecting the client to feel as we would/did in that situation. This seems often to lead to a

rupture of sorts as your experience of how you felt in that situation is not necessarily how the client is feeling.

- A large part of trauma intervention seems to be assisting the client in tolerating their trauma and its related symptoms while it is being processed. Clients want to get rid of their feelings and thoughts in the very first session, they 'vomit' it out as quickly as possible (purge) and want to leave it with you.

- Are psychologists 'emotional prostitutes' of sorts – using oneself (one's emotions and lived experience) as a tool to ameliorate the suffering of others, for which we are paid? Psychologists are required to make themselves vulnerable through empathic engagement with trauma victims and are continually exposed to the process of containing, which requires one to "detoxify" clients' unbearable affect. When one considers our willingness to expose ourselves to vicarious trauma states in the effort to alleviate others of theirs, we begin to seem somewhat masochistic.

Not all of these thoughts or questions could be resolved within the scope of this study but it has spurred an enthusiasm for taking such thoughts further by way of a PhD, and the hope that other researchers may pick up where I left off.

Chapter Six

6. Findings: Perceptions of Trauma States and their Consequences

As mentioned in the preceding chapter, four themes emerged from the individual analysis and cross-analyses of the nine transcripts. These themes, as well as their subthemes, will be explained below, and discussed as a whole in the following chapter.

6.1 How has the Therapist Interpreted their Reactive State?

Each participant was asked to think of a specific trauma case associated with violent crime and was then prompted to discuss any countertransference they experienced during or post the session. The below subthemes contain the most poignant countertransference experiences as described by the participants.

6.1.1 Identification with suffering:

"I couldn't bring it to an end. It held us all in for a while – I don't know how long..." (Rhonwyn)

Most of the countertransference experiences recorded in the 9 transcripts seemed to be examples of some form of concordant countertransference (Racker, 1968) (particularly those which were expressed as emotions), where the therapist identified with the suffering of their client. Participants reported to have frequently felt helpless, trapped, tired, frightened, overwhelmed, horrified, lost, vulnerable, sad, angry, and shocked; all feelings which seem to mimic how the client felt at the time of their trauma. Interestingly, therapist's counselling sexual assault survivors, especially in cases with children, reported to have felt guilty (for pushing too far for information/procedures), and enraged at the destructive and erosive nature of this crime. Some found themselves visualizing the look on their own child's face if they had undergone such a trauma.

Other participants found that trauma cases in general felt very chaotic and fragmented. They understood this to be a ‘mirroring’ of how the client felt at the time of the trauma or in the therapy room. They were able to bring this countertransference back into the therapeutic context with a careful and well-timed explanation of how they, as the therapist, felt and what they thought it may mean for the client. This often resulted in the benefit of deepening the client’s experience of “being heard”. Identifying with the client’s suffering (concordant identification) is a core element of establishing empathy, but only so far as the therapist is aware of their countertransference reactions. The following quote illustrates this point by showing how Tracey identifies with her client’s intense emotion and existential questions brought on by the impact of trauma exposure:

> Trauma, grief and bereavement are the cases that I find tend to impact with me far more intensely than … sort of assertiveness stuff, or some personal development stuff … [It’s] interesting, because I haven’t thought about why it might be that way. I think the level of emotion of my client is obviously very much more intense. The personal growth thing, they’re kind of neutral, you know, the conversation, if I can call it that, just kind of flows, my client just talks. Whereas when its grief, bereavement or trauma or if there’s intense emotion related, usually tears, usually very graphic descriptions of what they’re thinking and experiencing, usually lots of real deep grappling on their part of trying to get some meaning. And that’s what I would be trying to help them to do, is to get a sense of meaning for themselves… Also possibly because when people are grappling with the meaning of life issues, it makes me think about the meaning of life, whereas personal development stuff just doesn’t have that intensity... (Tracey, pg 3, line 7 – 3)

Here this participant, who initially felt that she was not affected by the trauma case she brought to the interview, began to process how some of her trauma cases do affect her and why. Perhaps there was a certain amount of denial about intense emotions because they are felt to be overwhelming? In the above quote she seems to perceive the processing of intense emotion as leading to a “grappling” of meaning on both her and the client’s part, with the end result of being left with existential questions/concerns. Another participant, who also connected with the idea of existential issues being at the core of her countertransference experiences, reflected further on the fundamentally “human topic[s]” that she identifies within her client:

> …I think what's especially difficult [about trauma] is the almost existential questions about that, so: "What if this had happened?" or "What does this mean about life?", "What does this mean about trust?" And those sort of questions are human, you can't just leave that in a therapy room. So it's sometimes difficult to leave, sort of, crime stories. I think we are trained on how to leave those behind but all the existential questions round, "Well, I'm not in control of everything", goes on and it's quite difficult to realistically deal with that, but also not to ruminate over your client's stories. So it's hard to know where your thinking stops, you know, whether its client specific or you personally because it's such a human topic, you can't totally separate it. (Christa, pg 2, line 2 – 10)

There seems to be an element of identification here, where the therapist is struggling to separate out what belongs to her and what belongs to the client in terms of countertransference. The therapist understands this as being caused by the innate 'humanness' of trying to find meaning in suffering. She seems to link these existential issues with a difficulty in leaving the trauma case in the therapy room, highlighting a potential boundary breach. She seems to feel that although identifying with the client is healthy and allows her to connect empathically, it makes it that much more difficult to leave the trauma in the therapy room post session. The difficulty seems to lie in the 'humanness' of the topic which bridges the gap between her sessions and everyday life. The distinction, and thus the boundary, becomes unclear when the topic at hand is so innately human, for example: what does this mean about life and trust?

Two key aspects highlighted here are the level of the therapist's awareness and their ability to strike a balance between healthy empathy and identification, and unhealthy over-identification. One of the participants showed a distinct awareness of this process, where empathizing with a traumatised client can lead to fusion and unhealthy over-identification:

> …[E]mpathy and then sort of reclaiming one's sense of self and a little bit of separateness, occurs all the way in therapy. There's that pendulum between sort of fusing with someone and being able to empathise with them, then the danger of merging too much and, you know, the purpose of the merge and fusion, temporary as they are, are for empathy, but one has to then regain [the] self. Because traumatized people especially are boundary sensitive, and I'm more conscious of not overdoing it than in fact undoing… Going from empathy to over-identification to obviously merger and fusion are what I'm

> aware of in my head. To locate myself in that, some different things are obviously necessary, it's about the balance. But at times, you know, when people have been really neglected and abused it actually helps to come up with a huge dollop of surprise empathy, you know, and it's got to be genuinely and authentically given. I have no problem demonstrating horror, exclaiming, "That really is just absolutely awful." You know, I'm saying it on behalf of them and at times I'm aware I'm saying it on behalf of society… It re-establishes some level of humanity. (Rowan, pg 9, line 22 – 37)

Here Rowan feels it a necessary step in showing empathy to merge with a client temporarily and then be able to detach. He feels that if a balance is not struck between merging and detaching then a therapist may fall prey to over-identification. As Rowan explains above, empathy "re-establishes some level of humanity" and when dealing with the innately human topic of creating meaning out of suffering, it seems difficult for therapists to remain objective and detached. Rowan, however, appears to have managed the process in an enlightened and helpful way by giving voice to the client's feelings and expressing empathy without blurring boundaries. He achieves this through making a distinction between a 'passive' kind of empathy which results in fusion (not necessarily pathological) and sometimes over-identification; and the 'communication of empathy' which uses the countertransference to emerge from 'identification with suffering'. This emergence or separation allows the therapist to notice the client's suffering and is an act of care on 'behalf of society'. This, however, is a double-edged sword as his advocation on behalf of society may further emphasize the 'human' dimension of trauma, as discussed above, which can make one more vulnerable to experiences associated with vicarious traumatisation – further highlighting that what is good for the client is not always so for the therapist.

6.1.2 Avoidance

"… I stepped out of that, because it seemed like just too fearful a thought for me and I just refused to go there" (Colin).

Avoidance was a common countertransference response described by participants, which links in closely with the above idea of identification. The below quote

highlights an instance of complementary identification (the therapist as rescuer to the client's victim) as a result of experiencing a certain detached helplessness:

> And that's very difficult – you've got this absolutely traumatised, grieving family and it's almost overwhelming, it's almost nicer to have a debriefing session with 2 psychologists and I remember thinking: "I cannot contain this distress myself – I cannot in my own strength contain this distress that I am seeing in front of me". You've got these... faces looking at you as if you are going to deliver them from their pain… So basically you do rely on what you know works which is: "Just tell me what happened?", and in the middle of it the mother just breaks down, wails... and the little girl looks up at her granny, so perturbed and I kept on looking at this little girl thinking "is this good for her to be here?" ... and the strange part, at the end of it they were joking... and they actually got themselves out of their, sort of, stress and the traumatised distress feeling and then it was all over. As a psychologist, you don't know what to offer them thereafter, you almost want to rescue them but you can't because the people have died and there's nothing you can do about that… (Rhonwyn, pg 1, line 20 - 36)

Here the participant seems continually concerned about whether she would be able to contain the family's distress and how the little girl in particular may be affected by the process. She seems to want to rescue them from the awfulness of the debriefing that she is imposing on them. It is her experience of knowing "what works" which allows her to almost float through the remainder of the session without being consumed by the fear that she is re-traumatising them through the very process (debriefing) that is supposed to bring them amelioration. In the end, she seems somewhat in awe that they managed to resolve their own crisis, almost as if it had happened without her, which speaks of a certain detachment. This detachment seems to stem from a fear and thus an avoidance of being viewed by the client as someone who is traumatizing them further. Rhonwyn is left feeling helpless and vulnerable ("I cannot in my own strength contain this distress that I am seeing in front of me"), which then results in her wanting to rescue the client. The link between feelings of detachment, helplessness and rescuing are important because they show how they allow the therapist to disengage from the intense affect in the room. This avoidance seems to serve two purposes: to protect Rhonwyn from being overwhelmed by her client's intense affect and to protect her from feeling like she is re-traumatising her client through the process of debriefing, a feeling to which she is particularly sensitized and which

seems to set off the above reaction. Rhonwyn recognises this "floating" sense of detachment as a self-defense mechanism which she automatically/unconsciously employs when she is feeling overwrought. She later elaborated on this feeling:

> And when I have clients, I think I do that – I almost become numb, it's so horrific sometimes – you almost numb yourself and you think you cannot believe what you are hearing but it protects you. And then afterwards you're almost shocked and numbed but you are not too distressed and overwrought because you've almost numbed yourself… In actual fact, I even come out of the sessions at home and I don't want my child to say: 'Well let's go straight away mum" because I'm still in the session. I'm floating in the session and I think we sort of float around the person but we don't get like too hectically upset. (Rhonwyn, pg 7, line 1 - 8)

Here Rhonwyn explains how a certain level of distance, particularly during times of heightened emotion (which frequently accompanies trauma), enables her to manage the intensity of her client's emotions without her becoming too "overwrought" herself. The image of "floating around the client" seems to be an unconscious effort not to engage too deeply for reasons of self-preservation. It has an almost autonomic quality (which she referred to earlier in the transcript as an "auto-hypnotic state"), an unconscious defense in reaction to feeling overwhelmed. Post interview, the same participant went on to explain that people often find her quite frivolous, because she does not want to discuss heavy, in-depth topics in a social context. She tells me that she needs to be lighter and 'happier' outside of therapy and does not want to hear negative stories. This seems to show a continuation of the avoidance of traumatic stories. Although it is difficult to ascertain, such continued avoidance is often suggestive of experiences associated with vicarious trauma.

As with the theme of identification, it seems that there may be both positive and negative implications for using avoidance strategies. On the one hand, if the therapist identifies too strongly with the client, avoidance serves the purpose of circumventing their own fears but doing so at the risk of leaving important client-material un-dealt with. On the other hand, it seems almost a normative attempt to prevent compassion/empathy-fatigue. It creates a 'necessary' distance to ensure that the therapist does not become "overwrought" with the emotion emanating from the client, a way of coping or managing intense feelings provoked by listening to stories of

trauma. It seems unrealistic to expect a therapist not to be moved at all by such intense presentation of emotion. As discussed above, those that felt unperturbed seemed to be expressing a certain amount of denial in this regard, which, upon further reflection, became more apparent.

Another participant conceptualised his tendency to identify with the aggressor as a combination of projection on the clients part and his own "primitive impulses". He felt that both the therapist and the client need to come to terms with such feelings, rather than fear them. Below he expands on how his understanding and acceptance of these dynamics was integral in moving the client forward in their therapeutic progress:

> ... sometimes I think "I would've shot them back and that would have been wonderful". You know, and so much for my compassion at that point. Yes, and it was through realising, you know, the very strong impulses of my own. Then I know that one of the things I have to do with trauma work, particularly with violence, so much affect and negativity and primitive stuff is projected into it that very often there is a fight-or-flight reaction, you know, murderous impulses... And people are very traumatised by that. Anna Freud speaks about this when she covers identification with the aggressor, you know – if you can't beat them, join them... I think it's only when people get in touch with that, and it's hard to expect traumatised people to do that. But to get to the point of saying: "I too could be like that", and then reclaim yourself. I think for me that is the final step, the symptoms are actually quite easy to manage in trauma. The return to humanity is the most difficult. So it's when people realise in themselves that they too, if perhaps very hungry, could murder. You know, that if they too were religiously offended or, you know, psychotically delusional enough that they would put a plan into action. I mean, I think that's there in all of us, you know, and if people accept that then I think we reclaim our humanity in some sense... (Rowan, pg 5, line 21 – 35)

Here, Rowan realises that it is through an acute awareness of his unconscious dynamics that he is able to accept the ways in which he (or his client) may be similar to the aggressor. Until such a point, one would only be reacting to such threatening fears which may result in avoidance, as shown in Rhonwyn's reaction above. He acknowledges, however, that it is extremely difficult for a traumatised person to engage in such introspection, and so the responsibility would therefore fall on the therapist to manage this process and guide the client back to a place where they can

"reclaim [their] humanity". This cannot be done, however, if the therapist is caught up in a countertransference state of avoiding their own unconscious fears.

6.2 Purging and Containing

6.2.1 Containing the Purge

"*... people when they come, they just want to leave everything with you, and you feel like you've been carrying almost about five loads" (Sarah).*

Considering the extent of crime and thus trauma in South Africa, another interesting finding was how the participants conceptualised their ability to hold traumatic material during the telling of the client's story and how they managed any effects post-session. It seems that a fairly large part of trauma intervention involves assisting the client in tolerating their trauma and its related symptoms whilst it is being processed. Clients seem to want to rid themselves of their feelings and thoughts in the very first session, it like a purging of emotions and they want to leave it with the therapist and continue on as normal:

> … when it's a trauma case… people kind of feel obliged to be with you, you know, to come and see you as a counsellor. They've been referred to you or been told: "This is a really good idea". So they're kind of there, not under duress because they've chosen to be there, but they wouldn't be there for any other reason. Whereas I find with some of the other work that I do, especially personal development work, they're there because they've absolutely chosen to be there and are wanting to be there long-term. And their intention is to really come to, you know, terms with whatever it is that they're grappling with… Ja, whereas with trauma, they want to get it out as quickly as possible or get the whole process, you know, in terms of a number of sessions, to keep it as short as possible. (Tracey, pg 3, line 24 – 34)

This quote highlights how trauma clients often come to therapy with an expectation of amelioration of symptoms within the first couple of sessions. There is no joint investment in the process of unearthing unconscious dynamics for example; these clients are in crisis and seem to view the therapist as a tool for purging and

containment. Whereas the participant above appears to see the purging as a rather frustrating part of the work, other participants saw it as a necessary part of trauma treatment. In the quote below, Rowan accepts that it is simply part of being a psychologist to be able to filter all the things that his clients "put into him" (purging) in order to give voice to their distress (containment), which he explains using the example of a client who had witnessed a shooting:

> …and I've been aware of somebody really battling not to throw their water glass against the window. And in a deep sense I knew the calmer I remained the less the person would do it. And maybe at that point I have to be numb and in a state of terror about something that was going to go off. And so, you know, I might, what I'll be doing is in order to contain it I'll be thinking a lot about probably what I'm going to say, hopefully at the right moment. So, you know, as soon as the person starts to de-simmer, I might well say: "Well done for not doing that, but while threatening to do it you gave me a flinch for a few moments of what it felt like for you for a gun to go off in a confined space. I knew you wouldn't do it. But you had no way of knowing that, did you?" You know, so I'll take them to a deeper fear. So, you know, they're putting things into me and I'm filtering it all the time... So, you know, I'm watching, I'm listening, but I'm also very aware of having to keep my own head and my own capacity to interpret. But to interpret into the feelings rather than away from the feelings... so like the example I gave... that can get a bit concordant or whatever kind of countertransference, I don't care, I don't divide it out. At that point I just simply give it back... (Rowan, pg 7, line 17 – 33)

Here the client seemed to have no words to express his terror and so could only enact his fears. Interestingly, in this case it was the client who identified with the aggressor, leaving the therapists feeling like a victim. Because the therapist was aware of the dynamics being played out, he was able to give voice to the client's fears. An important point here is that the therapist not only had to be aware of the process, but also had to allow himself to experience the "numbness" and "terror" of that moment without trying to placate the client and reduce the intensity in the room. In others words, the purging allowed the therapist to 'feel' the victims pain and eventually give voice to it. Being able to bear this intense emotion was perceived by some therapists as beneficial for the client, as Christa explains:

> … I think, especially when people are raw, I think we all become sort of childlike. You know how you can't fool children, you can't fool somebody who's really feeling something and... people can tell if you're not being genuine. And I think sometimes just a sheer communication of: "This is just so sad" or "You know it really feels sad to be hearing this", and: "You know, it feels quite overwhelming and its quite hard for us right now to know, you know, what to talk about"... And I find often somebody can pick up on that... Someone will say something or there'll be a bit of silence for a while and to just tolerate that. And I find so often that people don't feel awkward, they actually appreciate the space, that there's someone just sitting with them, bearing it and also normalising it. And to know that you're not this immune person because you're a therapist, you're someone who's helping them cope with the experience and to process it, but it doesn't mean you're immune to it. (Christa, pg 8, line 34 – 40 to pg 9, line 1 – 5)

"Bearing it and normalising it" seems to be an integral part of containment. From the above quote, it seems to require a balance between not being overwhelmed like the client but also not being "immune" to their distress and the 'childlike' honesty in the room. This seems an essential but taxing aspect of therapy as it demands a certain element of vulnerability on the therapist's part:

> ...it's also pretty draining to some degree to listen to an event like [a trauma story] and try and articulate what sort of feelings a person may have when you're going through that empathic response phase. That's pretty difficult in the sense that you obviously make yourself vulnerable. (Colin, pg 10, line 20 – 23)

Thus, from this point of view, therapists are constantly required to "use" themselves (their emotions, lived experiences etc.) as the main tool of their trade. The very concept of countertransference speaks to the therapist being used by the client as a receptacle for the projection of traumatic states; and the therapist using their understanding of their own dynamics/self to separate out what is theirs from their clients and bring it back into therapy. Although it seems that most participants perceive their ability to contain the client as unmistakably positive for the client, there is a parallel concern about the impact it has on the therapist. Many of the participants expressed the view that they struggled with the "impact" of their trauma cases –

especially if it spoke to a previous trauma or sensitive area in their own lives, as shown in the below quote:

> Let me go back to [an earlier date] because I think it affected me quite a lot...When I started working with trauma cases... I felt very overprotective of my kids... I was very negative about males, nothing was good and at some point [my child] said "But mum, you know all the time you speak about males, there's nothing good about men, you know. That makes me think negatively about men". And, well, I was defensive for quite some time... because I had proof, you know... I hear it every day so it was difficult for me to actually distance myself from that... it took quite a while for me to be able to say "But this is what's going on in reality and how much of this was affecting me?" And it not only affected my children, it affected my appetite. I would notice that when I go [to work] I ate more, that's the place where I ate more than anything... And I noticed that even when I ate I was more bilious, something that doesn't happen... at home. You know I sat down and said "But where does this come from?" Up until I realised that it's all these things that I get to hear and this food... comfort food... that I'm associating with it and hence it is not good for me. It's more poison than being good, you know. (Sarah, pg 5, line 28 – 33 to pg 6, line 1 – 26)

This quote shows how it took some time for the participant to realise just how affected she was by the trauma she was dealing with on a daily basis. In being a container for others without knowing how to manage her own internal processes, she appeared to over-identify with her clients and began to make generalisations about the perceived negative intentions of men in her own personal life. Seeing up to seven trauma clients in one day led her to feel completely overwhelmed, like a person who had been carrying "five loads", as she put it. She felt like it began to poison her, it began to turn the very food she ate for sustenance into what seemed like poison.

Although this participant makes a clear case for certain vicarious trauma symptoms as a result of all the trauma stories she had heard, it is worth noting that this participant felt that she was better able to manage this process through being more aware of her internal dynamics. She further felt that learning how to 'hand over' the load she had been carrying also help manage her countertransference. This is a concept which will be elaborated further in the next theme.

6.2.2 Purging the Contained: the "need to tell"

"There was a lull and I said to my husband and this friend of my daughters: "I had this case where this man's 16-year-old son hanged himself and he sat with me for one and three quarter hours telling me about it today". And then my husband and the friend and my daughter looked and said: "Do we have to hear this?" But I had a need to just talk about it – but that's where you introduce something inappropriate into your everyday life." (Rhonwyn)

As alluded to in the previous theme, some of the participants seemed to experience trauma as an acute and often draining process. They reported feeling like they had to be a lot more mentally prepared prior to the session than usual and post session were left with an 'emotional aura' which would sometimes takes a few days to fade. Such 'after effects' were also reported to affect their most intimate of relationships:

> Ja, I definitely find that I need longer after a trauma client, I can't book somebody soon after them... it takes a bit longer after those sessions to get that session out of my mind...Especially if it's been, you know, abuse or whatever it is and, you know, sometimes I find the thought of even having sex that night quite difficult... particularly if I haven't had the time to sort of transition from work to home. And now I've got this randy partner and you're just thinking, and, you know, an image will come to mind of a client in a position, or being forced to have sex, or whatever it is, and even though you're not in that position I will have to say: "You know, my minds not actually here, I'm actually thinking about something else and I need some time"… I find that communication quite important... even though you can't talk about what's happened... (Christa, pg 4, line 3 – 7 to pg 5, line 18 - 28)

This quote highlights how stories of violent crime are very difficult to leave in the therapy room and have the potential to contaminate personal space. It also highlights the difficulty that therapists have with not being able to tell friends or family why they may be feeling 'off' or not wanting to engage in intimate activities. This participant perceives communication with her spouse as extremely important, but due to the confines of confidentiality, what she is able to communicate it quite limited.

Therapists frequently espouse the benefits of the "talking cure" to their clients yet, aside from supervision, they are not entitled to such a luxury outside of personal therapy (which, interestingly, none of the participants mentioned as a potential coping mechanism). The above participant showed a high level of self-restraint in not divulging the details of her case to her husband to help explain a possibly very awkward and difficult moment. She also makes frequent use of supervision and the discussion of her cases with colleagues, which seems to satiate a certain amount of her "need to tell". However, other participants disclosed that the "need to tell" has the potential to spill over into conversations with family and friends, even though they understand that, strictly speaking, one should not discuss their cases in these situations. It seems, particularly with cases of violent trauma, that the need to tell is so overwhelming that sometimes therapists require someone to contain them while they purge, and that this cannot always be put aside for a scheduled supervision:

> What I actually find very violent is the effect it [crime-related trauma] might have on therapy with existing patients. Patients sometimes having to come back because something has happened to them. [It is like] I have been busy with clients [making] a tapestry and somebody has just gone and cut into it. And then they'll come back, I'll have to re-thread that... It's like a collision...
>
> …. I had to go to this event and fortunately I remember landing up sitting at a table with people I had known for a long time. And fully aware that I was breaching a boundary, I specifically said to a female friend next to me: "By the way, if I'm a little odd tonight and don't come across as my usual self it's because a patient of mine has been raped". And, you know at that point it's completely inappropriate, we're at a birthday party... And, you know she of course assisted me and then disassociated it because she said, "Oh, how absolutely awful" and then carried on with a different topic of conversation. So in some ways I sought a co-container and I think we both put it aside and then had a good evening... So that sense of, you know, in me kind of a rage felt: "Dammit, you know, this is not supposed to happen, you know, not while we're doing therapy, that's supposed to be a sacrosanct space". You know, all my fantasies about therapy as protective at that point underwent somewhat of a significant collapse... (Rowan, pg 1, line 10 – 14 to pg 2, line 16 - 31)

Interestingly, Rowan's need for containment during his moments of acting out/purging, mimics the need to purge and be contained evident in the client's process, a concept discussed earlier. It seems to be a form of concordant

countertransference, where the therapist has moved from empathy to fusion and over-identification, resulting in him acting out inappropriately outside of the therapy room as a way of managing his uncontained emotion. He perceives hearing the news about his client's rape as a "collision", a type of trauma in and of itself. He describes a moving image of the therapeutic process as a tapestry which both him and his client have worked on together to create, and views this trauma as 'somebody' who has 'just gone and cut into it'. He perceives this act as not only harmful to the victim, his client, but also to the work they have achieved thus far, which will now need to be 'rethreaded'. And despite his insight and awareness of his unconscious dynamics, his "need to tell" was overwhelming and he acted on it. He was the fragmented victim with spilling emotions in need of containment. Another interesting point was that as soon as he was allowed the space to tell, he felt contained and was able to continue with his evening relatively unperturbed. Christa provided some insight as to why the act of telling is experienced as cathartic and therapeutic:

> I am unfortunately aware of the fact that I talk sometimes about cases. And I won't obviously disclose names - that is not relevant to my family in any way. But you talk about a good session or you talk about a session where you feel a bit lost at times or you feel a little more vulnerable. I certainly talk about the criminals I've treated when you are feeling sometimes threatened in the session. But with this [client] – I did mention her. It almost felt as if ….If I say it, I acknowledge that it's real – that it's not just something I've experienced in my mind. That it actually happened. And it's an interesting perspective because you are aware of vicarious trauma and you don't want your family to go through that, and I didn't disclose the details to them… (Christa, pg 5, line 14 – 22)

The above quote shows how the act of the participant telling her partner/family about a particularly intense trauma case served to not only contain her but also to make the experience more concrete in her mind. Her statement: "If I say it, I acknowledge that it's real – that it's not just something I've experienced in my mind. That it actually happened", indicates that she may have experienced a certain amount of derealisation or depersonalisation, either during and/or post the session. The fact that one usually associates such symptoms with Acute Stress Disorder further emphasizes how indicative 'the need to tell' may be linked to risks regarding vicarious traumatisation.

It seems that the process of containing the client's purged emotions is a particularly difficult process to manage. It is often ameliorated through the concordant acting out of the therapists' purging along with their own need for containment. As Rhonwyn succinctly put it: "You can't be alone or without [support/supervision] because it makes you too serious about life – you get cabin bound with your patients! Thinking about them and living in their life stories" (pg 4, line 12 - 15). This quote echoes the difficulties in dealing with countertransference as discussed above and explains how without support and coping mechanisms, trauma work can become all too present, too real. This further highlights the necessity for therapists (particularly those who work with trauma) to engage in supervision and even their own counselling, as it allows them an appropriate space to 'tell' and a healthier way to manage their countertransference.

6.3 Therapists' Perceived Lasting Impacts:

6.3.1 Signs of Compassion Fatigue and Vicarious Trauma States

"But none of this is normal and you actually have the right to feel completely weird and off-beam…Accept [that] there's a lot that one cannot neutralize, you know, it's just far too toxic"(Rowan)

Aside from "the need to tell" as a consequence of trauma-induced countertransference exposure, there were other instances of vicarious trauma states/symptoms and compassion fatigue reported. Tracey, for example, shared how her current inability to counsel children was borne from traumatic sexual trauma cases with children as an intern:

> ... I do not work with children because when I first did it was as an intern that I realised I actually could not cope with it... Really the impact of children having been abused - it was, you know, sexual abuse, physical abuse – the impact on me was enormous and I couldn't let them go. I couldn't get them out of my mind... the last case that I worked with which decided it for me... was particularly traumatic and I just couldn't seem to let him go. And I still think of him, he must be [much older] now and I still think of this little kid.

> And he kind of decided it for me that I'm not going to work with kids. I couldn't seem to remain objective... And it's interesting because I haven't now worked with children in trauma for many years, and I would be quite, I would wonder how I would react now, you now. I was still, I was an intern then and inexperienced. I wonder if it would be the same now, but I just don't want to put myself there in case... (Tracey, pg 6, line 1 – 26)

Although this participant had neither experienced any abuse herself nor did she have her own children, she appeared to be deeply affected by the children she was counselling at the time and could not "let them go" post session. She seems unsure as to why she was so traumatised by these cases, but understands that it is a red-flag area for her and has chosen not to work with children as a result. Perhaps there was an element of complementary identification leading to a need to rescue these children but could not, and so chose to avoid these situations altogether. She wonders now whether she has enough experience to cope with child clients again but was so traumatised in her internship that she is not even willing to try. Although she seems to lack some insight as to why she could not let these children's experiences go, she seems confident that her choice to avoid child cases is a good one because she feels she would not be an effective counsellor.

The same participant showed some insight into the possibilities of compassion fatigue as a result of the continuous empathy required for trauma clients. Although she said she does not think she is 'burning out' (or that perhaps she is not aware of it), she understands that certain behaviours of hers are clues that she needs a break or that she is not coping in some way:

> … you can be quite blasé sometimes about [trauma cases] and I think, especially if I'm quite, you know, if I'm needing a holiday, or something's happened, you know, you kind of go into a case as: "Well, okay, I need to contain, I need to explore this, we need to talk about the story telling and the re-integrating and whatever", and you actually forget, you know, well to remember that this is an individual that this has happened to and I think you can become a bit brazen. But I think that will show up in the session and you've got to keep that in check and actually stay with somebody… Ya, I suppose it's a defense mechanism… (Christa, pg 10, line 3 – 10)

Interestingly, Christa perceives this "blasé" attitude as a defense mechanism which defends against her becoming too distressed for her client, so as to avoid experiences associated with vicarious trauma. It also, however, seems indicative of a certain amount of compassion fatigue, as shown by her substantiation of "need[ing] a holiday" or "something [having] happened". Christa seems to be cognisant of these cues in her counselling and when she becomes aware of them she understands that she needs time to relax and recoup. The use of the word "defense mechanism" implies that she understands that it's possibly not the healthiest way of dealing with the situation but that it is necessary to help her cope at that time.

A few of the participants spoke of a similar experience where they may not exactly be sure of the unconscious dynamics that govern their inability to "let go" of a certain case or client but that they are still able to recognise the fact that they cannot let go and do something about it. As shown above, trauma cases seem to have the potential to affect therapists in a profound way and it takes some level of insight and certainly support and/or supervision to be able to discern when one is no longer functioning optimally. Rhonwyn reflected on this final thought and cautioned therapists against allowing their cases to direct their lives:

> I mean the fact that I can still tell you in detail, shows you how it sits with you – how these incidents sit and as I'm talking I'm thinking of other incidents. They do sit with you as a psychologist and you have to be careful that they don't direct your own life. (Rhonwyn, pg 2, line 1 – 4)

6.3.2 Hope and Resiliency

"Well, what stays with me is that life is fragile, and it actually makes me enjoy every day… life is just amazing" (Rhonwyn)

Despite the difficulties and challenges that accompany trauma intervention and its associated countertransference experiences (as described above) some of the participant's lasting impacts seemed partially, if not predominantly, positive. These particular participants seemed able to put the intensity of trauma into perspective by

not only seeing their client's pain, but also their resiliency and capacity for self-healing. They chose to learn from their client's stories and seem to be genuinely interested and fascinated with how the client is able to turn their situation around:

> I want to know what is happening – because everything that a patient tells you, every critical incident, teaches you about life. And I am fascinated to hear how people take an incident. I ask, you know, I want to know! What were they thinking, what did they say... I like to hear from my patients how they are taking it – and I quiz them. "How are you coping without antidepressants?" "How are you concentrating?" "What good is going to come of this?" It's funny what good comes – there's always some good that comes out of a bad experience. Because it instantly brings up in a person's life everything else, bad or good, that's happened before and they usually make a change in their life and it's usually for the good. And I mean that teaches you. I have got to that stage where I think I may change like this person or do this like that person. Your clients are your teachers – I must tell you... your clients start teaching you about life. (Rhonwyn, pg 6, line 2 – 23)

As shown above, the Rhonwyn's fascination with the trauma story and how the client is "taking it" allows her to manage the feelings and experiences associated with trauma discussed in previous themes. Sherry-Lee, in the quote below, elaborates on how this fascination allows her to see trauma in a more positive light:

> I think it's got to do with an interest in the extremes of human behaviour. So for me, you know, I'm interested in the writings of Viktor Frankl, I'm interested in what happened in concentration camps, the way people survived… I like to have an overview rather than just seeing a crime scene as bad and depressing. (Sherry-Lee, pg 5, line 28 – 34)

Perhaps there is an element of intellectualisation occurring here, that this fascination and interest allows the therapist to be slightly more distant and so better able to cope with the intense emotion? However, the therapists here do not perceive there to be any negative impact on their clients, and their process allows them to be more effective, less traumatised practitioners. Sarah also explained how she learns from both the victims and the perpetrators of child abuse and rape that she counsels:

> It makes me more alert. I think what I've learned is also understanding the victim's behaviour and understanding the perpetrator's behaviour… I am now able to look at a child and look at [their] behaviour and be able to tell… you start learning people's behaviour, you get a sense that this person is not stable… (Sarah, pg 12, line 1 – 6)

This participant went on to explain that she was even able to counsel the perpetrators of violent trauma through viewing them as somebody else's child who had undergone their own trauma to lead them to this place. For her, this was initially stimulated by a selfish motive for her to learn how perpetrators chose their victims in order to better protect her own children. However, with experience she was able to connect with the perpetrator's own trauma and work with them, which she felt would help protect possible future victims. She also felt that working with trauma had helped hone her skill: 'I am now able to look at a child and look at [their] behaviour and be able to tell'. She knows what signs and symptoms to looks for, and has learnt to interpret a certain feeling of 'instability' about the child as meaning something important.

Some participants displayed a particularly positive and resilient attitude (perhaps identifying with their client's ability to overcome their own challenges) in which they refused to be a victim and chose to let their client's stories remind them to treat each day as a gift rather than allowing them to imprison themselves in fear. This seemed particularly difficult considering the continuous negative media regarding the South African crime rate and the stories one hears from friends and family. In the below quote, Rhonwyn reflects on her thought process and behavioural reactions after counseling clients who have experienced violent crime:

> … I am determined to not become neurotic from hearing my patient's stories … I leave my gate open, I go to the shops and I leave my doors open, I leave my windows open, I purposefully don't lock my car sometimes because I'm not going to be pushed into a corner. I'm careful, but I like say: "I'm going to have faith, I'm going to trust God". I don't take my life into my hands – I won't drive in dangerous spots… What I mean is that I think we are brow beaten by the media and by [society]. And I'm not going to be brow beaten. And we so often limit our movements because we are living in fear (Rhonwyn, pg 2, line 40 – pg 3, line 1 – 6)

Interestingly, Rhonwyn separates her reaction to the crime rate as explained in isolated incidences by her clients to the way in which the South African media portrays high crime rate. She feels “brow beaten” by the media, which seems to emphasize or highlight the immediacy and danger of the South African crime rate more than her client’s stories do. Despite this fact, however, she makes a personal decision to not let either her client’s stories or the media impact her feeling’s of safety, and she refuses to become a prisoner behind locked doors and burglar guards. This was a surprising finding, but also one which needed to be understood in context, as although some of the therapist’s (such as Rhonwyn) had a positive outlook as a whole, they were often temporarily affected by trauma in more specific ways (as discussed above). It needs to be noted, however, that these negative thoughts, feelings and behaviours tended to wear off after a few hours or a few days and these experiences did not deter therapists in this study from wanting to work with trauma or sometimes even the perpetrators thereof.

6.4 The South African Context

Contrary to my initial expectations regarding the effects of the South African context on the countertransference experiences of therapists, culture and race were not mentioned by any of the participants as particularly problematic aspects. For the most part, participants seemed to be able to divorce trauma from the context of South Africa and rather focused on the process of such work. However, when probed, many had strong opinions about the high rates of crime in South Africa and how that did or did not affect them. Also, those that worked in the Public sector found that socioeconomic issues also impacted their ability to be present for the client. These concepts will be elaborated further in the below subthemes.

6.4.1 Normalising and Reframing as Coping Mechanisms

“I don’t know whether it’s our process of shutting out this unreal environment that we live in. In a sense that there’s always danger out there, hence we choose to move

away from being these paranoid individuals who live unproductive lives that are not fulfilling" (Colin)

As alluded to in the above theme, the attitude of the therapist and how they frame the crime and violence they see, seems to play a large part in how it affects them and their ability to work. This is particularly so within the South African context and it's high rates of crime. None of the participants disregarded the fact that the crime rate was unusually high, but they mostly seemed to cope using one of two techniques: normalization and reframing. Tracey, in the below quote, for example, acknowledges that the crime rate is 'unnecessarily high' but believes that crime is a concern of any country. Here she discusses South Africa's high crime rate in comparison to other countries she has visited:

> I've travelled a hell of a lot and I know it's a complete myth that it only happens in South Africa. Because I've got quite a few friends who've had, you know, worse stuff happing from overseas or whatever. So I absolutely don't buy into this thing that it only happens in South Africa. I know our stats are higher and certainly within our cities it's higher… but I know in any major city in the world this stuff is happening… So I don't know that I process it any differently here or anywhere else. Although I do know that as psychologists we deal with a lot more trauma on a daily basis of sort of high-jacking kind of stuff, you know, as opposed to natural accidents… (Tracey, pg 8, line 26 – 34)

Tracey's ability to normalize the trauma she deals with on a daily basis as something that happens 'in any major city in the world' allows her to accept as this context as something any psychologist would have to deal with – just 'part of the job'. Colin summarized this point of view by stating that: "my place of origin and practice is South Africa, so it's almost become like a normal state of receiving people who have [these] experiences" (Colin, pg 11, line 24 – 25). He perceives South African psychologist's ability to cope in such a context as being explained by the fact that they don't know any different. Although it may seem high to outsiders, it is what they have always been exposed to both privately and professionally and so it seems normal to them.

A surprising finding, described in the previous theme, was the resiliency and hopefulness which characterised many of the participants in the current study, despite the fact that they were working in an environment with such high crime rates and often limited resources. Sherry-Lee hypothesized that the reason for this is that those psychologists who were disillusioned with South Africa have largely already 'packed for Perth', resulting in a population of psychologists who are fairly tenacious and determined to stay in South Africa. She went on to describe how she perceived such psychologists are able to work in a context like South Africa:

> I think that you're (the researcher) getting tenacious people (the participants). I think tenacity is a big thing. And then I also think that there are therapists who retain, it doesn't matter for how long they have been working, a real interest in other people. And that's where you really get to enjoy your job. So you're getting that human interest, which you can still enjoy. And, you know, as long as you're enjoying people and interested in people then you're not burning out. So it's not so much: "My God, what a hideous thing to have happened to that person!" But how that person survived this hideous thing and what makes them unique? (Sherry-Lee, pg 11, line 3 – 9)

Trauma and crime are thus framed by Sherry-Lee as topics of interest due to her fascination with people and how they manage to survive their trauma. It's an attitude of choosing to see the positive and the resiliency of their clients rather than the crime and the violence. As mentioned above, some participants also viewed the high level of trauma as an opportunity to hone their skills rather than a negative aspect which leads to vicarious trauma states. The way in which they frame trauma work and South Africa as a whole seems to almost be a self-fulfilling prophesy – positivity begets positivity. Below, Rhonwyn expresses her view of South Africa and its people and how having 'an attitude of lighter living' is essential in order to cope in this context:

> Well I think it's the determination to have faith and have hope because I am not leaving this country. I love this country and most of the people in this country are the most wonderful, honest, versatile, interesting, multi-cultural bunch of people. So you don't want to be pulled down, you just are not going to be pulled down. You are going to look for the good all around you to counteract what your clients might tell you, and even in the sessions your clients still tell you a lot of good. So I think … that's the determination. You know, it's an attitude of lighter living in this country – you have to have it if you are going to stay… (Rhonwyn, pg 11, line 26 – 32)

6.4.2 Public Sector Barriers

"Private work and public work [are] completely different. I really believe that working in the private sector is easier – you can just be a psychologist. In the public sector you deal with so many incredibly poor patients that a lot of the way you do therapy changes" (Meagan).

Despite the tenacity and positivity of some of the participants (as described above) there were certain barriers that the South African context provided that were difficult to overcome. This seemed particularly prevalent for the therapists working in public or hospital settings as opposed to those who worked in private practice. The psychologists who worked in the public sector seemed frequently under pressure to "make a shift" in their clients symptomology due to the limited resources (human and otherwise) available at South African public hospitals. This was further emphasized by the fact that their clients often simply did not have money or time for repeat visits, despite sometimes debilitating symptoms, as shown by the below quote:

> … part of what you are thinking about when you are working with government is… can this patient afford to come this much? You are under a lot of pressure to shift children in particular because you are still reporting to parents very often and it is going through your mind: can they afford to come to this session? Even if they are not paying the hospital, they are paying transport costs. And patients travel from very far away to get to us – a lot of our patients stay overnight at their local hospital and then travel the next day to us… (Meagan, pg 6, line 21 – 26)

Poverty and the time-restraints it places on therapy is a concerning factor for Meagan which seems to affect her ability to be present in the session. She goes on to elaborate how thoughts about the above concerns, as well as other aspects related to limited resources, interrupted her sessions:

> So there is an incredible amount of pressure, and it has to be something you are working on as a team. If you don't have an actively involved social worker in the community then you are already on the back foot. No therapy can take place unless you've got some impact on a social context but we often have very scarce resources on that basis as well… So it's a battle, it's a substantial

> battle to deal with those issues… It definitely does interrupt the session. You're often working with translators as well so you are aware of the fact that you have a limited amount of time… it is going through your mind all the time, about where you stand, what you can do. Are you doing the best in the situation or just what can be done? All of that will go through your mind. You will be trying to shape how you can have some kind of impact. (Meagan pg 7, line 11 - 34)

Here it seems Meagan's thoughts about how she can better help the client seems to distance her from a certain helplessness that she experiences due to the lack of available resources and time. Perhaps there is a certain amount of intellectualization that takes place which protects her from the guilt that lies behind questions such as: 'Are you doing the best in the situation or just what can be done?' In the below quote, Tracey explains how she perceives that lack of control and the minimal time available to process post session are two factors which make working in the public sector particularly difficult:

> I also find the environment you are working in has a huge impact. I find that when I'm in my private practice I control the time, I control the bookings and how the day runs. In my environment, I decorate it how I want it to be decorated, I feel comfortable. Whereas when I'm in this high pressured "Right, you've got four people to see in this next hour-and-a-half. And so-and-so has just come in and he's in a totally different level of trauma and he's only just found out he's never going to walk again. And this person has no clue, and this one's still disoriented because of a head injury" or whatever. And I find there's no time to process while you're there… sometimes in a hospital setting there isn't that, it's very clinical and there isn't that space. (Tracey, pg 6, line 4 – 17)

Thus it seems that the resources that South African hospitals lack effect how therapists who work in the public sector are able to process trauma. As Jonathan succinctly puts it: "… in the hospitals you need to serve, I mean we see what comes through the door, you've got no choice" (pg 7, line 11 – 12). Thus there is no scope for 'red flag' areas that one would rather avoid or time to ready oneself prior to or process post the session. These psychologists are constantly trying to mediate and evaluate their role in the dynamic context of time-limitations, poverty, cultural differences and limited resources, and these factors interrupt their ability to be present for their clients. This finding, however, seemed particular to those in public settings

only. Those that worked within their own private practice seemed to be able to focus on their trauma work with little distraction caused by the fact that they were working in South Africa as opposed to anywhere else.

Chapter Seven

7. Discussion

The following chapter involves discussion and integration of the themes presented above. A summary of the main results of the study will be presented, followed by an interpretation of each identified theme in light of current literature. The significance and wider implications of the findings will also be considered.

7.1 Summary of Main Results

The aim of this study was to gain an understanding of the experience of countertransference (as related to violent crime) from a South African therapist's perspective. Through the processes of interviewing 9 South African psychologists on this topic, it became evident that two particular types of countertransference stood out as prevalent: identification with suffering (which may lead to over-identification) and avoidance (often linked to a fear of identification with the aggressor). Interestingly, as per the above literature review, over-identification and avoidance have been frequently identified as common countertransference responses to trauma in more Western settings (Wilson & Lindy, 1994), which shows the generalizability of these experiences in different contexts. Also, the constructs of identification and avoidance link in strongly with Racker's (1957) concepts of concordant and complementary countertransference respectively, which provides some insight into the internal dynamics of the therapist.

The second concept which stood out in the transcripts of the 9 interviews was the therapist's concordant mirroring of the client's need to purge and be contained as a result of trauma. Although it was shown that containment for the client is undoubtedly positive, the effects on the therapist often seem associated with features that may linked to potential vicarious trauma. This plays out with the therapist mimicking the client in their need to purge and be contained themselves, a process which they try and manage with supervision but frequently flows over to family and even friends. Although this was in part substantiated by literature on enactment in therapist's dealing with unbearable affect,

there was little available literature on the act of inappropriate purging and the need to be contained outside of the supervisory relationship.

Thirdly, it was found in the present study that although vicarious trauma states were certainly a problematic possible outcome of constant exposure to trauma through one's clients, a certain amount of hope and resiliency was also evidenced. Therapists found that the lasting impact of trauma work was not completely negative and they often experienced a positive attitude and openness to learning from their clients. This appeared to assist in transforming potential vicarious trauma into an opportunity for personal growth.

Lastly, the South African environment with its high crime rates does present challenges for the therapists working within its context, but none that the therapists in the current study seem unable to manage. Although those working in the public sector struggle with feelings of helplessness and loss of control, they have continued to see client's and have successfully negotiated such work for several years. The coping mechanisms of normalization and reframing seemed of particular use in this regard and allows South African therapists to see violent crime as 'part of the job' and view their high trauma case loads as an opportunity to hone their skills.

7.2 Interpretation of Identified Themes:

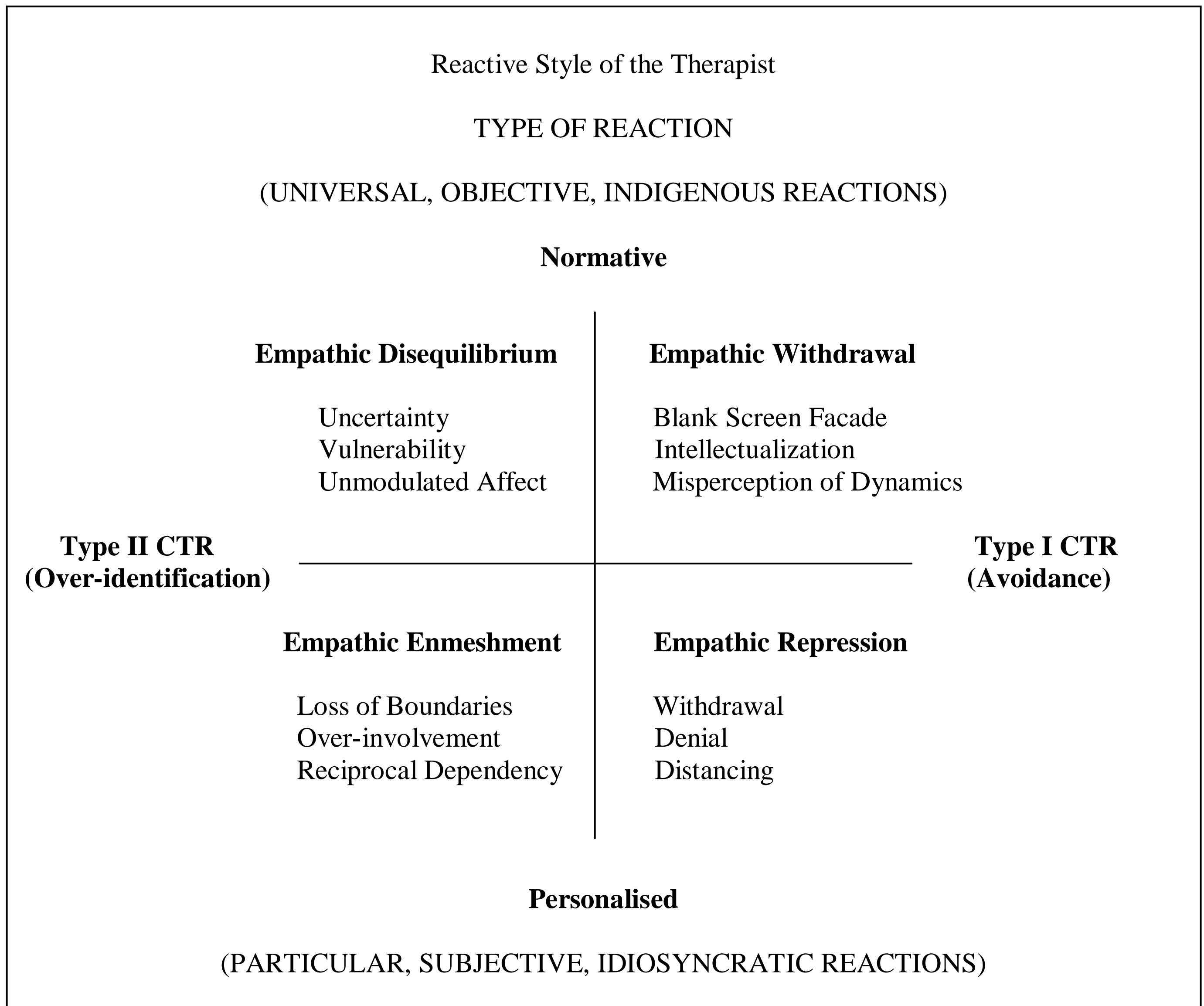
The below section attempts to interpret each of the three main identified themes in the context of current literature.

7.2.1 How the Therapist has Interpreted their Reactive State

It is well established in current literature that therapists exposed vicariously to trauma, through their clients, experience varying forms of countertransference both during and post session. These may range from avoidance, detachment and identifying with the perpetrator to over-identifying with the client and their suffering (feelings of rage, shame or mistrust), wanting to rescue and feeling like a victim themselves

(Hafkenscheid, 2005; Pearlman and Saakvitne, 1995; Rasmussen, 2005; Shubs, 2008; Wilson & Lindy, 1994). Interestingly, the findings of this theme link in closely to Wilson and Lindy's (1994) concepts of type 1 and type 2 countertransference, which views countertransference as shown in the below diagram (adapted from p 15):

Table 7.1: Wilson and Lindy's (1994) Type I and Type II Countertransference (p. 15)



Without delving too deeply into Wilson and Lindy's theory, it is evident from the above diagram that there are many sub-categories that fall under the umbrella of "avoidance" or "over identification". Avoidance for instance may be experienced as intellectualization, withdrawal or denial and over-identification as a loss of boundaries or a feeling of vulnerability. In this study, the majority of participant's

experiences of countertransference fell into two similar categories: identification with suffering (which frequently resulted in over-identification) and avoidance which linked either to a fear of re-traumatising the client or as a coping strategy to manage intense affect as elicited by the client. This not only speaks to the validity of this study's findings, but also to the generalizability of the countertransference experience in different contexts (and countries).

The propensity for the therapist to identify with the suffering of their clients serves as an example of Racker's (1957) Concordant Countertransference. Carveth (2011) elaborates on Racker's notion by distinguishing between concordant identification that is conscious or unconscious. He feels that conscious concordant identification may be likened to empathy because the therapist is aware that these dynamics are projected by the client, can separate and analyse them and bring them back into therapy, leaving the client feeling more understood/heard by the therapist. For example, the participants in this study reported to have felt "helpless, trapped, tired, frightened, overwhelmed, horrified, lost, vulnerable, sad, angry, and shocked", amoung others. Most of them were aware of the concordant countertransference at play, could frame these feelings as mirroring those felt by the client and could engage more empathically with that client without being overwhelmed by their emotions. However, when it came to the more inherently human experience of existential questioning as a result of trauma, not all therapists were aware of their existential conflicts and due to this did not appear to give much thought to their resolution. They were left with unresolved questions regarding the worth of human life, the reasons behind suffering and the inherent good and evil of mankind, which sometimes interrupted their ability to be present in the therapy session and often plagued them for days post session. Perhaps indentifying with the client's need to make meaning and the "humanness" of this process, gives the therapist permission to feel overwhelmed by the intensity of trauma, under the guise of "it's natural" to experience existential questioning after hearing about such atrocities? It seems to be employed, consciously or unconsciously, as a way to manage the intense emotion that accompanies hearing stories of violent crime/trauma, the outcome of which may be negative or positive. For instance, if the therapist identifies too closely with the client to a point where they are unable to separate their feelings from their clients, this form of over-identification would be more harmful to the process of therapy than helpful, and may even result in

certain vicarious trauma states on the therapist's part. Christa's question of "What does this mean about trust?" shows how her client's trust issues are now becoming her trust issues. However, if a therapist is aware of this identification and consciously and constructively uses it to give voice to both their and their clients feelings (by bringing the countertransference back into therapy), the result more likely will be an increase in empathy and depth of the therapeutic alliance.

Thus, as Carveth (2011) explains, unconscious concordant countertransference is not helpful to the progress of therapy as one has the potential to fall prey to over-identification with one's client. Wilson and Lindy (1994) view this state of unawareness as empathic disequilibrium or enmeshment, depending on whether the reaction has a universal or personal origin respectively. According to the above diagram, normative (or universal) reactions, such as the present study's example of existential crises, manifest in uncertainty, vulnerability and unmodulated affect. Personal (subjective) reactions, on the other hand, such as Tracey's inability to work with children because she could not "let them go", are displayed through loss of boundaries, over-involvement and reciprocal dependency. Rowan, however, makes use of what Shubs (2008) calls 'type III' or 'communicative' countertransference, a positive, totalistic view which involves the therapist's awareness of the intersubjective relationship between him and his client and the object relations at play. He thus separates passive empathy (such as that which leads to type I and II countertransference) from the process of actively communicating empathy (a process which entails much self-awareness of the therapists part). This allows him to emerge from his identification with his client's suffering and distance himself enough so as to notice the client and give voice to their affect, but not so far as to disengage or avoid. In order to achieve this, the therapist needs to maintain an acute awareness of the intersubjective dynamics at play, so as not to be caught up in unhealthy countertransference which may result in inappropriate enactment.

Avoidant countertransference states, as observed in this study, appeared to require a slightly more nuanced interpretation. They could be considered an example of either concordant or complementary countertransference (as defined by Racker) depending on the dynamics of the therapist. For instance, if the therapist was colluding with the client in avoiding difficult topics due to their potential for heightened emotion that

they as the therapist may experience, this identification with the client's suffering was concordant. However if the therapist felt that they wanted to rescue the client from their current or any further potential trauma, this would complementary countertransference.

According to Racker (1957) complementary countertransference involves the therapist "reacting" to a certain pull by the client who is projecting their internal objects onto them. Here, the therapist does not mirror the client's feelings but rather reacts as the complementary counterpart to their projection, for example: the rescuer to their victim. An example in the present study includes some participants who spoke about their fears of re-traumatising their clients and wanting to rescue them from the awfulness of the therapeutic process associated with trauma. Rhonwyn (p. 1) reported spending much of a session worrying about how she would contain the grief in front of her and what the impact would be on having a young child in the family therapy setting. Her worry seemed to disengage her from the session to a certain extent and she seemed surprised that they had managed to work through their grief almost on their own. Thus the therapist's worry appeared to serve as a defense mechanism which distanced her from the intensity of the room and focused her (albeit unconscious) fears on the possible traumatisation of the client through the debriefing process.

Interestingly, Racker (1957) also explains that "[t]he complementary identifications are closely connected with the destiny of the concordant identifications: it seems that to the degree to which the analyst fails in the concordant identifications and rejects them, certain complementary identifications become intensified" (p. 311). Therefore, because the therapist failed to concordantly identify with the client's suffering, it might be said that her fears of traumatizing the client (which lead to a sense of helplessness that resulted in the need to rescue) intensified. Rowan (p. 5) also provided an example of complementary identification when he spoke about his identification with the aggressor: "... sometimes I think "I would've shot them back and that would have been wonderful" (p. 5). He went on to explain that this countertransference keys into an innate fear of one having the potential to be an aggressor oneself. This participant, as a therapist, appeared to have processed this fear and so was able to identify such a state and analyse it accordingly. He was also able to

identify this state in his clients and acknowledges this as a difficult but key aspect to bring into awareness through the course of therapy.

Interestingly, it appears that if the therapist was not aware of the above dynamics, they would react in some way to defend against the threatening emotions associated with wanting to rescue or identify with the aggressor. In this study, this usually seemed to take the form of the therapist distancing themselves in some way from the client. Rhonwyn (p. 6 - 7), for example, experiences this distance as a kind of “numbness”, which does not seem to be an example of identifying with the aggressor, but rather a reaction to keeping away from the ‘aggressor’ countertransference state. In other words, it appeared to be a defense mechanism against feeling overwhelmed by emotions elicited by an unconscious identification with the aggressor. This caused the therapist to withdraw and become shut off from her feelings, a mechanism which is used to contain both herself and her client. This state still seems to fall under the umbrella of complementary countertransference as it allows the therapist to act as a container for the client’s emotional purge, a concept which will be discussed at length in the next theme. It also links in closely to Wilson and Lindy’s (1994) understanding of type 1 countertransference which “typically include[s] forms of denial, minimization, distortion, counterphobic reactions, avoidance, detachment and withdrawal from an empathic stance” (p 16).

As illuminated by Carveth (2011), concordant and complementary countertransference has the potential to be both negative and positive depending on the state of awareness of the therapist experiencing them. Rowan (p. 9), for instance, spoke of such an awareness in his explanation of a therapist’s need to find balance between fusing with someone temporarily for the purposes of empathy and then regaining one’s sense of self again. He felt this could be achieved without falling prey to either over-identification or avoidance (distance) only through an acute awareness of one’s own personal dynamics as well as the relational dynamics within the therapeutic setting (Shubs, 2008).

7.2.2 Purging and Containing

"The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma" (Herman, 1992, p. 1).

The necessity of secure attachment as the foundation for any effective trauma work has been well established (Allen, 2005; Herman, 1992 and Wallin, 2007– as cited in Dalenberg, 2004). Trauma patients come to therapy with an overwhelming urge to purge themselves of the intense affect that accompanies trauma experiences. Tracey (p. 3) for instance, explains how she had frequently experienced her trauma clients as usually having been advised to seek therapy and rather than looking to invest in self-growth, wanted to get the process over as soon as possible. These clients are often only motivated to attend therapy by the need for amelioration of the intolerable emotions they are experiencing. However, particularly with trauma associated with violent crime, trust is frequently an issue. Therapist's need to provide a literal and figurative (intrapsychic) place of safety in which the client may begin to process their experience. Part of this includes the ability to be a "container" for the clients "purge". This involves the therapist assimilating the client's unbearable emotion and helping them process it in a more manageable way. Allen (2005) explains that "[w]ith better containment, trauma can be processed gradually, in small doses" (p. 251). The client is not thrown to the wolves to be consumed by their overwhelming emotions, which they would have rather kept repressed, but are rather guided slowly, whilst being held in the safety of a secure attachment, through the treacherous minefield of traumatic memory.

Rowan (p.7) provided an exemplary example of containment in his vignette about a client threatening to smash their water glass. He was able to experience the feeling that the client had no words for but could only enact it. Being able to do so allowed him to process the unbearable state and feed it back into the therapeutic setting:

> So, you know, as soon as the person starts to de-simmer, I might well say: "Well done for not doing that, but while threatening to do it you gave me a flinch for a few moments of what it felt like for you for a gun to go off in a confined space. I knew you wouldn't do it. But you had no way of knowing

> that, did you?" You know, so I'll take them to a deeper fear. So, you know, they're putting things into me and I'm filtering it all the time... (Rowan, pg 7, line 23 - 28)

Thus, it seems the benefits of containment for the client are clear, but what does perpetual exposure to such a state mean for (and say about) the therapist? As stated by Pearlman and Saakvitne (as cited in Salston and Figley, 2003) in the literature review, vicarious trauma states are a frequent outcome of "empathic engagement with survivor's trauma material" (p. 169) and it is a commonly accepted truth that in order to be an effective therapist one has to engage empathically. Therefore, therapists in the business of trauma work are continuously and consciously situating themselves in a place of vulnerability for the sake of their clients. If the practice of effective psychotherapy dictates that one allows their "self" to be used for the betterment of others, it may be the case that it has certain consquences, especially in trauma work. The way in which one processes and manages the effects of being in a state of constant vulnerability is an important part of trauma work (reference?). This leads us to the next subtheme about the therapist's need to purge and be contained.

It is well known that many therapists do not come through the process of trauma work completely unscathed. A common occurrence is compassion fatigue/burnout or experiences associated with vicarious trauma (MacCann & Pearlman, 1990). Colin touches on these issues below:

> [T]here is a heightened sense of awareness of the potential acuteness of this trauma, in that the clear and present danger is there. [Your client] walks out and part of that danger gets superimposed on you. Whereas if you are talking about clients who have experienced contextualised aggression and that type of thing, I mean, you can deal with that affect in a very different way. But this kind of event creates a level of susceptibility… [which] leaves you with like a bit of a vulnerable feeling. (Colin, p 9, line 29 – 35)

Containment of the client, however, dictates that one cannot become overwrought with emotion during the session, thus any affect the trauma may have on the therapist needs to also be contained and processed post session. An interesting finding, in this study in particular, was the way in which many of the therapists mirrored their client's need to purge and be contained as a way of resolving vicariously imposed trauma.

This is shown through the participant's enactment of their "need to tell" others, sometimes in very inappropriate settings, about their trauma cases. Sarah (p. 7) explained that seeing trauma after trauma case left her feeling like she was carrying around "five loads". She was able to process this through mentally "handing over" the anguish that her clients had left with her to a higher being which she felt absolved her of her stress, while others found peer/supervision helpful in this regard.

However, many participants mentioned that particularly intense or difficult cases often sit with them post session, with the result of the therapists experiencing a need to purge (act out) and be contained themselves, sometimes even by family and friends. The 'need to tell', therefore, seems an enactment of the therapist's inability to tolerate uncomfortable feelings evoked by the client. Maroda (1998) explains that "enactment is universally defined as spontaneous, difficult if not impossible to control, unconscious, and affectively driven" (p. 519). This appears to explain the inappropriate contexts in which some of the participants acted out their need to tell. For example, Rhonwyn (p. 3) told her husband and child's friend about a client who hung themselves and Rowan (p. 2) told his friend at a birthday party about his client being raped. This concordant identification (the 'need to tell'), although somewhat problematic from a confidentiality perspective, appears to serve the purpose of allowing the therapist to cathart and move on, and thus seems to be an attempt to manage difficult internal processes related to continual exposure to vicarious trauma states. Also, the act of "acting out" seems to serves as a signal to the therapist that a particular case has affected them perhaps more than they realised (it being an unconscious process) and so helps them to become more aware of (by bringing into consciousness) these dynamics. Maroda (1998) emphasizes this point with her argument that "analysts need to develop a better appreciation of the value of acting and expressing, as part of the process of working through and understanding, rather than viewing these vital emotional expressions as alien to the analytic endeavour" (p. 531).

7.2.3 The Therapist's Perceived Lasting Impacts

As alluded to above, the impact of empathic engagement frequently results in compassion fatigue and vicarious trauma states (Killian, 2008; MacCann & Pearlman, 1990; Neumann & Gamble, 1995; Salston and Figley, 2003). Pearlman and Mc Ian (1995) tell us that a review of trauma-related literature showed that:

> …doing trauma therapy can affect therapists negatively and that its effects are different from those related to doing general psychotherapy. The research suggests that aspects of the therapist, such as personal trauma history, gender, and personal stress, may interact with exposure to trauma material to contribute to trauma-related symptoms in the therapist. (p. 559)

Neumann and Gamble (1995) explain that countertransference experiences are heightened in new therapists, particularly those including "rescuing" and preoccupation with their clients. Both Tracey and Rowan highlighted this point when they discussed how working with child-related trauma cases during their earlier practice affected them in a way that remains evident to this day. As Rowan put it: "I'll carry those children's feelings for the rest of my career, you know" *(*pg 5, line 15 – 16).

As discussed in the literature review, Neumann and Gamble (1995) posit that vicarious trauma states in therapists closely resemble the experience of their clients. This includes symptoms such as "disruptions in the therapists' sense of identity, worldview, spirituality, ability to tolerate strong affect, and central cognitive schemas (e.g., core beliefs about safety, trust, esteem, control, and intimacy)" (p. 344). Sarah (p. 5-6), for instance, spoke of feeling extremely negative about men in general during her early practice. She felt that she witnessed proof of their untrustworthiness on a daily basis and even conveyed this message, unconsciously, to her children. Pearlman and Mc Ian (1995) explain that:

> [it] is not difficult to understand the loss of esteem for others as individuals are exposed, perhaps for the first time, to the horrors of people's capacity for cruel

> behavior against others. That which formerly may have been defended against can no longer remain unknown, unseen. (p. 564)

Over and above the issue of vicarious trauma (and perhaps even the reason why experiences related to vicarious trauma occur), there seems to also be an element of concordant countertransference at play here. As discussed above, there is a fine balance between merging with the client for the purposes of engaging empathically, and becoming over-involved and over-identifying with the client. It seems this state is what creates a certain level of susceptibility (particularly in new therapists who sometimes lack an understanding of their internal dynamics) to vicarious trauma states. It highlights the necessity for a therapist's awareness of their unconscious conflicts, strengths and weaknesses. Such awareness allows them to identify certain behaviours or enactments as signs of vicarious trauma states or compassion fatigue and motivates them to do something about it. Christa (p. 10) highlights this point by explaining that when she notices a certain blasé or brazen response toward her clients she knows that it is time for a holiday. Although she acknowledges this attitude as a coping skill or defense mechanism (avoidance) against becoming too overwrought in the session, she realises that the cumulative impact of trauma can wear down one's empathic engagement with a client to a point where one is no longer effective. At that point a therapist needs a period of recuperation via debriefing (supervision) or a holiday. Both recent literature and the findings of this study emphasise the point that awareness through experience and introspection enables a therapist to better deal with the above challenges.

Interestingly, however, not all of the participants felt that the lasting impact of trauma work was negative. Some showed a certain amount of resiliency in the face of all the difficulties described above and felt that, rather than being traumatised by their client, they were able to learn both how to protect themselves from certain violent crimes and how to better appreciate their life and loved ones. Arnold, Calhoun, Tedeschi, and Cann (2005) argue for positive self-growth as a result of interacting with trauma cases, and even espouses that there are more positive than negative outcomes to working with trauma.

The above premise has also been evidenced in the study, for example, Rhonwyn (p. 6) mentioned how she felt that she was continually learning about life from her clients and was in awe of their ability to cope. Rather than identifying with the client's trauma and fear, she identified with their resiliency and strength, which seemed to culminate in a sense of hope. She explained that within the context of South Africa, with its exceedingly high crime rate, one has to have an attitude of 'lighter living' where one chooses not to be 'brow beaten" by the constant negativity from the media, but rather decides to see the good in people and understand their behaviour from a psychosocial and political perspective. Other participants felt that rather than deter them from taking trauma cases, the high level of trauma work provided by the South African context allowed them the opportunity to hone their skills, and thus enabled them to become more proficient at trauma counselling. They felt that they learnt how to better understand trauma clients in general and that it provided them with a certain sense of security in having information that could protect them and their families from future crime. There may be a certain amount of rationalisation or even denial in these explanations about the effects that trauma has on one's internal dynamics. However, one might argue that it seems to represent a relatively mature form of coping with exposure to trauma that has few destructive effects on the client.

This is not to say that the above therapists do not experience vicarious trauma at all as a result of their 'positive' attitude. To the contrary, most described at least one incident that seemed to have affected them either consciously or unconsciously. It appears to be rather an attitude of positivity and hope that allows them to transform their experiences associated with vicarious trauma into something good. Interestingly, a belief in the process and successful outcome of trauma counselling seemed to be particularly prevalent in the more experienced participants (or even from experienced therapists who compared how they were better able to deal with trauma on reflection in the interview as compared to when they first started), as they have had the time to witness the fruits of their labour. This knowledge, it seems, carries them over during times of overwhelming affect or 'distracting' countertransference states as they are able to "rely on what you know works..." (Rhonwyn, pg 1, line 25). Thus, openness to learning from one's clients, experience and a positive attitude seem to be what assists therapists in transforming experiences linked to vicarious trauma exposure into opportunities for becoming more resilient.

7.2.4 The South African Context

Interestingly, contrary to my initial thoughts, participants did not speak about the impact of the South African context in terms of culture or race (and the inability to apply Western concepts to an African population), but rather focused on the effects of crime and the barriers elicited by poverty and lack of resources in the public sector (for the few that currently worked there and those that referred back to their internships at public hospitals). This could possibly mean that culture is becoming less of a barrier for South African therapists (i.e., South African therapists are becoming more adept at working within various cultural groups). Although it is more likely that the clients that are able to afford psychologist fees tend to come from a more Westernised cultural background due to socio-political inequalities of South African's past. This is particularly so because most of the present study's population consisted of psychologists that work within the private sector. However, it also seems to suggest that trauma has the ability to cut across culture through its tendency to strike at our innate sense of humanness, as discussed in the first theme.

In a society where psychologists are faced daily with "continuous and therefore expected trauma" (Evans & Swartz, 2000, p. 50), practitioners are required to develop certain coping mechanism in order to deal with this bombardment of trauma exposure without developing symptoms of vicarious trauma. The participants seemed to do this through the implementation of 'normalisation' strategies related to the high South African crime rate. There is also a certain 'reframing' of the way in which participants appeared to view trauma and violence. For example, Colin (p. 11) and Tracey (p. 8) both speak about how there is also crime in many other countries, and that the crime rate in South Africa, although admittedly high, seems fairly normal to them as they have grown up being exposed to it on a daily basis. The findings also spoke to a certain tenacity perhaps present in South African therapists (Rhonwyn, p. 11 and Sherry-Lee, p. 11) who had resolved to stay in this country despite the fact that many of their colleagues were immigrating due to the crime rates. These therapist's displayed a certain resiliency (as mentioned above) which resulted from choosing to frame the high levels of crime and its associated trauma as something which enables them to hone their skills. They chose to see South African people as predominantly good and honest people, and showed a genuine fascination for how their clients were

able to overcome their hardships. These therapists chose to learn from their client's resiliency and be inspired by their ability to overcome trauma, rather than be traumatised by their misfortune. As highlighted by McCann and Pearlman (as cited in Harrison & Westwood, 2009) in the literature review, some therapist's make use of the following coping mechanisms in order to manage trauma exposure and its related symptomology:

> advocacy, enjoyment, realistic expectations of self in the work, a realistic worldview (that includes the darker sides of humanity), acknowledging and affirming the ways in which trauma work had enriched lives (of others and their own), maintaining a sense of hope and optimism, and a belief in the ability of humans to endure and transform pain. (p. 206)

This seems to reflect the present study's findings of how the therapist's attitude largely determines their ability to work in the context of South Africa without the certainty of compassion fatigue or vicarious trauma states. Thus, choosing to see South Africa's high crime rates as 'part of the job' (normalisation) and working within such a context as an opportunity to sharpen one's abilities (reframing) seems to be an effective coping strategy implemented by the participants in order to manage adequately.

Another area in which the South African context seemed to impact the way in which therapists think about and process trauma work is regarding the barriers of poverty and limited resources that psychologists working in the public sector face. Meagan (p. 6-7) highlighted the pressure she felt regarding her need to perform or "make a shift" in a limited amount of time due to the inability of her clients to attend more than a few sessions. She mentions how thoughts about whether she is giving adequate service interrupts her sessions and seems to leave her feeling helpless. Apart from being a realistic concern, these concerns may well become associated with concordant identifications with her trauma clients exacerbating feelings of helplessness as discussed earlier. Interestingly, Tracey (p. 6) felt that it was a certain loss of control (and inability to process post-session) that characterised the difficulty that therapists experienced with working in the public sector, which also seems reminiscent of the client's experience. However, although Meagan admittedly found the public sector

working environment challenging, she had nonetheless been managing for several years and counselled over 2000 different cases. She also spoke intermittently about working within a team environment and other positive aspects of the public sector, especially the joy she received from seeing patients again that had come back for a medical check-up and seemed to be coping far better (p. 9). Evans and Swartz (2008) explain that "traumatized persons must accommodate an experience of themselves as helpless" (p. 50). Perhaps the helplessness experienced by the therapist serves as an opportunity for them to model a way back to a sense of control for their clients. This would be reminiscent of how Rowan gave voice to his clients' feeling of muteness in the Findings above and thus modelled for his client a way out of their own muteness (Boulanger, 2005). The susceptibility to experiences associated with vicarious trauma due to such exposure and the stress of limited resources remains however, particularly for those therapist's that are unable to implement the coping mechanisms described above.

7.3 Importance of Findings

One of the more prominent findings of this study highlights the therapist's need for awareness of both their internal dynamics and the dynamics that play out in the therapeutic relationship. This appeared particularly important with regards to effects of trauma-related countertransference states. This was highlighted by the post-interview reflections from many of the participants who felt they had not given their responses as much thought as perhaps it deserved:

> Probably, this is the most that I've ever really thought about it and I will probably ponder over a lot now about these questions… I will probably think a lot more about what I do as a therapist and how I do it, and the meaning it has for me dealing with trauma cases. (Tracey, pg 10, line 39 - 40)

It is evident from the above findings that those therapists who seemed to have substantial insight into both themselves and their clients, appeared better able to contain their distress and less vulnerable to (although not immune) enactments and vicarious trauma states.

From a South African perspective, these results have also spoken volumes about the ability of therapists that work in the context of a third world country. There are often limited resources, great cultural diversity (which is seen as a positive aspect but can cause some challenges in counselling) and extremely high crime rates. These factors can compromise counselling, but some of the participants in this study demonstrate being able to function adequately despite these difficulties and do so with a positive attitude and hope for the future:

> Well I think it's the determination to have faith and have hope because I am not leaving this country. I love this country and most of the people in this country are the most wonderful, honest, versatile, interesting, multi-cultural bunch of people. So you don't want to be pulled down, you just are not going to be pulled down. You are going to look for the good all around you to counteract what your clients might tell you, and even in the sessions your clients still tell you a lot of good. So I think … that's the determination. You know, it's an attitude of lighter living in this country – you have to have it if you are going to stay… (Rhonwyn, pg 11, line 26 – 32)

This positive attitude signals a change from those therapist's that are *"pack[ing] for Perth"* (Sherry-Lee's reference to the many South African's who immigrate to Australia) due to the high crime rate. It demonstrates that through an awareness of one's internal dynamics and implementation of coping strategies, therapists are not necessarily traumatised by traumatic crime stories to which they are exposed. Rather, they perceive this as an opportunity to become more skilled, more experienced and more resilient. It seems that the deciding factor resides in the attitude of the individual.

Chapter Eight

8. Conclusion, Limitations and Future Research

In conclusion, the results of this study show that concordant and complementary countertransference play a large role in the therapist's experience of identification with suffering and feelings of avoidance whilst listening to stories of violent crime. Such concordant identification with the client, if not mediated through awareness of one's internal dynamics, can result in over-identification with the client which may expose the individual to experiences linked to vicarious trauma. One way in which vicarious trauma states are resolved by the therapist is through the concordant mimicking of the client's need to purge and be contained. Based on the therapists' reflections in this study, however, vicarious trauma is not a certainty when working with trauma but rather an outcome that depends quite heavily on a therapist's level of experience, self-awareness and ability to implement coping strategies. Through these mediating factors, what is usually experienced as vicarious trauma states may be transformed into resiliency and self-growth. Other coping mechanisms such as normalization and reframing seem to allow therapist's working within the context of high crime rates (and thus high trauma loads) to manage. South African therapists in the present study showed a certain amount of tenacity and resourcefulness born partly from being exposed to high rates of crime. Although trauma work in the public sector proved particularly challenging, these therapists continue to see clients and are fascinated and joyful when they bear witness to their healing capacity.

Although the consistency with which the above results match that of current literature speaks to the validity and reliability of these findings, a concern of mine is that part of the reason for this is that perhaps not a varied enough sample was included in the research. Only three of the nine participant's came from a non-Western based cultural background and this may have skewed the data slightly into seeming more in line with Western views on Psychology than perhaps it realistically is. However, this could also be accounted for by the fact that tertiary education in Psychology in South Africa tends to be largely based on Western ideology and theory and thus influences South African therapists substantially in their practice.

Another limitation of this study, as mentioned in the Methodology chapter, is the difficulty I had with setting aside my expectations of vicarious trauma or other negative outcomes related to hearing stories of violent crime. I felt that, upon further reflection, even the questions in the semi-structured questionnaire showed some bias in this regard. Despite this fact, some participants still discussed their feelings of hope and perceptions of resiliency which they felt were a result of their trauma work. I was, however, able to probe further on this matter in order to follow the outcomes of these unexpected findings. In retrospect, if I had made use of a focus group or pilot interview prior to conducting the remaining interviews, these concerns may have been ironed out earlier.

As mentioned in the section on self-reflection in the Methodology chapter, there were many other questions I could not answer within the scope of this study. Over and above these, it is hoped that the above results may initiate interest in other researchers to perhaps conduct similar studies from a particularly culturally-sensitive perspective as to how South African therapists experience hearing violent crime stories. It is hoped, however, that the findings of the present study will encourage psychologists, both South African and otherwise, to reflect on their level of self-awareness regarding the impact of trauma and what it means to their ability to treat trauma clients in the future.

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Appendix 1:

Informed Consent Form:

Researcher's details

Name:	Kelly Berry (nee Howard-Tripp)
Highest Qualification:	BA (Hons) Psychology / PGCE
Current Degree:	Psychology Masters Degree (Counselling)
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Supervisor's Details

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Project title:

Therapist countertransference experiences of clients' violent crime narratives in the South African context.

Objectives of and need for the study:

The proposed study seeks to explore how South African therapists experience hearing narratives about violent crime within the context of South Africa, the impact this experience has on the both the therapist and the therapeutic alliance (from the therapists perspective), and how the therapist processes this information in real-time and post-session.

The study will be conducted using an Interpretive Phenomenological Approach (IPA) which aims to understand the above phenomenon, and describe it from the perspective of the therapist population sample as it is experienced.

This study aims to fill in the gap between the theoretical understanding of countertransference responses to hearing crime stories (and the management and consequences thereof) and the actual experiences therapists who conduct such psychotherapy. It is anticipated that findings regarding how therapists react and process hearing crime stories may help to normalize the anxieties that therapists have when dealing with clients traumatized by crime, heighten their awareness to their own feelings and the consequences thereof, and be more likely to engage in self care and other preventative strategies.

Research Methodology

A semi-structured interview has been designed by the researchers to ensure each prospective interview is guided along similar lines but that room is left for probing and/or exploring ideas or themes which emerge. Each participant is invited for a 60 – 90 minute interview (either at the university or at the participant's offices) exploring the phenomenon of experiencing narratives about violent crime within the context of South Africa. Each interview will be recorded, with the consent of the participant, and later transcribed for analysis, to ensure that an accurate account of the experience of the participant (and not the interviewer) has been captured.

The population sample of the proposed study consists of 6 – 10 practicing Clinical and Counselling psychologists who have be chosen purposively due to their expertise and experience in the field of study. The 6 – 10 transcribed interviews will be analysed thematically and coded using the Nvivo8 program.

The study will take approximately 7 months to complete and the final product will be submitted to the university in October 2010. The only participation required by the research subjects is the interviews mentioned above and a possible phone conversation if any clarification is required.

Confidentiality and Voluntary Participation

Regarding participant confidentiality and anonymity, each research participant will be allocated a numerical code (known only to the researcher and their supervisor) and this code (not the participant's name) will be used from the point of data collection onward. At no stage will any record of the research participant's actual details appear in the finished dissertation, oral presentations or publications. Any of the author's notes that record participant's names and their allocated codes will be destroyed once the dissertation has been completed.

Participation in this study is completely voluntary. Research participants may decline to answer any particular question and are free to withdraw totally from the study at any stage should they feel compelled to do so.

I………………………………………………………………………… (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT ***DATE***

_____________________________ ____________________

Appendix 2:

Semi-structured Interview

1. What is the process of hearing about crime related stories? How is it experienced?

2. What exactly (thoughts/feelings/sensations) interrupts the therapist in their attending to the client?

3. How much of this interruption do they notice and how do they manage it?

4. Can this cause a therapeutic rupture and how do you recover from it?

5. What, if any, is the reaction from the client?

6. How does the therapist understand or process this information in real time and then after the session?

7. What is the "lived experience" of the therapist in the midst of a highly emotional therapeutic alliance (phenomenological perspective)?

8. How much of the therapist's response is considered a normative attempt to prevent compassion fatigue/burn out?

9. What is different about processing this information within the South African context as opposed to a country with a lower crime rate?

10. What are the therapist's feelings about crime in South Africa in general?

11. How honest are the therapists (with themselves and their clients) about their limitations (personal history/anxiety or concerns) in dealing with traumatic crime-related incidences?