A contribution to a theory of the dynamic mechanisms of Post-traumatic Stress Disorder in South African detainees

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INTRODUCTION

The theoretical formulations in this paper are derived from clinical experience in the Detainees Counselling Service in Johannesburg. This service is provided voluntarily by trained psychotherapists for people who have been detained on political grounds. The service emerged as a result of the growing realization that a significant proportion of ex-detainees suffered from debilitating and serious psychological sequelae which could be attributed directly to their detention experience. (Rasmussen, 1982; Lunde, 1982). This experience often included both physical and psychological forms of torture (Katz, 1982; Foster & Sandler, 1985). Over the past three years, the service has offered counselling to over 500 affected people. Increasing numbers of people are presenting as a result of traumas sustained outside the prisons and in their communities at the hands of security forces, rival political groupings, or both. This is part of the pattern of escalating political and social violence that has gripped the country.

The paper will examine the following:

(a) the necessary preconditions for the development of PTSD;
(b) the impact on the ego of serious trauma;
(c) the ego transformations induced by the trauma.

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Necessary Preconditions

The American Psychiatric Association's criterion for PTSD is a stressor that would evoke significant symptoms of distress in almost anyone (DSM III 1980). For Freud the element of surprise and a state of unpreparedness were essential factors in the development of a traumatic neurosis (Freud, 1920). Bluhme describes the density of the trauma and its degree of unexpectedness as determining the power of the trauma to cause effects (Bluhme, 1948). While these are no doubt accurate, local experience has shown that additional qualities of the stressor are invariably present among the ex-detainees with PTSD we encounter.

(a) In virtually all cases, ex-detainees reported feeling and thinking that the traumatic stressor was going to kill or severely and permanently damage and maim them. This sense of impending death was experienced at some point during the traumatic episode and not necessarily during the peak of pain.

In one young man who alleged to have been savagely beaten, the moment when he felt his imminent death came after the beatings. He was lying on the floor of the interrogation room, recovering from the beatings. He overhead a casual conversation between two of his interrogators in which they were discussing the pros and cons of killing him and disposing of his body. One interrogator was arguing in favour of killing him, the other was disagreeing and pointing out the inconvenience of an inquiry and the resultant publicity. It was overhearing this casual polite discussion that evoked in the detainee the sense of not just a significant stress but of his own imminent death. He realized how easy it would be for him to be killed and how close he was to that state (of his death). In his account of his experiences, this was the single most traumatic and affect-evoking episode, even more so that the multiple beatings that had resulted in breakage and loss of teeth, and severe bruisings and swellings on the rest of his body.

In another instance a detainee was allegedly immobilized by means of leg-chains. His interrogators placed a metal object in his hands, told him it was a bomb, then flicked a switch on the object and left the room saying the "bomb" would soon explode. The detainee thought that his end had come, that the bomb would explode and that he would be suffocated to death by toxic gases. This moment when he realised that he was about to die haunted him more than any other of his detention. A further instance is of a middle aged truck driver (the "truck driver") who was attacked by heavy gunfire while driving on business. While lying under his truck in terror he noticed a stream of blood on the road ahead of him. The blood was running off onto the side of the road. Although he had not been shot and had no physical

injuries, he felt as though it were his blood on the road, that he had been shot and that he was dying.

In a smaller number of cases the fear is not of death but of serious permanent physical damage and disablement. One detainee was allegedly suspended in an upside-down position and assaulted repeatedly about his head and face. He had the sensation that all the blows to his head together with all the blood rushing to and accumulating in his brain would cause permanent brain damage and mental retardation.

(b) A second precondition has been found operative from observations of this affected population. In all cases, the phenomenon of anticipating pending death has been accompanied by a deep and reality-based sense of impotence to avert the massive threat. Ex-detainees have described feeling completely unable to influence the course of events which threaten them, that matters have passed beyond their control, and that they are powerless to avert or avoid the danger. This state of impotence arises from the reality of their situation whereby they are often physically weak and weakened by a combination of sleep and food deprivation, excessive exercise, physical beatings and other exhausting torture techniques. They are cut off from all sources of support, regeneration and help. They are at the mercy of torturers who exercise massive and sometimes unrestrained power over them. They are often humiliated and always outnumbered. They have no means of, and are cut off from any possibility of escape.

Torture may continue beyond the tortured person's supply of information. This then becomes gratuitous torture, the course of which the detainee is unable to even marginally influence since s/he has nothing more with which to co-operate. Torture may also be primarily gratuitous and intimidatory, again removing any possibility of influencing the course of the torture from the detainee, increasing the sense of helplessness.

A further quality of this impotence is passivity. The detainees are restrained and confined by the traumatizing environment with no outlet for actively dealing with it, withdrawing from or avoiding the dangers to their integrity. Their range of movement and activity is severely curtailed. This inability to act upon the environment leads to a passivity in the face of danger which consolidates the pervading sense of impotence. This combination of passivity and impotence, hopelessness and helplessness, contributes to the state of deep despair in which the possibility of being overwhelmed by death becomes a tangible reality. This thereby reinforces the sense of

inevitable and pending death or damage.

An example of impotence and passivity which occurred outside prison concerns a man who heard the screams of his friend who was being hacked to death by vigilantes. He was unarmed, outnumbered and unable to help his friend. He felt that he too was going to be killed and overhead the vigilantes talking of finding him next and doing the same to him. He felt unable to prevent that except by remaining out of the vigilantes' sight. His impotence to help his friend and himself when his own person, family and property was later threatened, attacked and partially destroyed, played a major conditioning role in the onset and evolution of his symptoms.

All the affected people reported on described in similar terms their feelings of powerlessness to alter the situation which confronted them and their passive impotence in the face of death-evoking dangers.

Impact on the Ego

Two stages appear to be involved in the manner by which the trauma acts upon the internal world and affects the ego.

(a) In the first place, the trauma itself leads to a withdrawal of libido from the object world and a redistribution of libido into the self. This process of libidinal retraction into the ego is something that probably begins before a life-threatening traumata are experienced due to circumstances preceding torture such as the arrest itself. This is reinforced by the degrading and often violent nature of the arrest and subsequent events which precede the interrogation. Detainees are sometimes pushed around, humiliated and beaten, even in front of their families, at the start of their detention experience. They are often arrested in the small hours of morning. Their experience of deprivation and restricted freedom may be initiated by their being refused opportunity to dress, take a change of clothing and or toiletries. This mistreatment in association with anticipated further discomfort, pain and threat to physical and emotional integrity, usually starts the process of libidinal retraction. It is primarily into the narcissistic core that the libido is withdrawn.

The process of retraction and re-allocation may occur either rapidly, or in a slowly progressive manner, depending on the circumstances which evoke the process of retraction. The process may or may not be complete by the time the life-threatening experience is confronted. In the case of the "truck driver", the libidinal redistribution occurred over the short space of time between his realising that he was under fire and his noticing the stream of blood on the road adjacent to him

and interpreting it as his own. In the case of many detainees, there may be a period of varying delay between the original detention and the subsequent life-threatening interrogation. S/he may then retain his or her libidinal attachments to the object world, although perhaps at a reduced level, depending on the intensity of the pre-interrogation experiences.

The mechanism of libidinal retraction into the self-preserving narcissistic core has been described by clinicians who worked with concentration camp survivors from the Second World War. It is viewed as an early adaptive defence against real threats from the external world, and therefore a normal response to an abnormally threatening situation or environment (de Wind, 1968); Bluhme, 1948). In the traumatic neurosis the libido is withdrawn from the objects in the object world with the objects remaining in the object world. This libidinal shift liberates the libido to concentrate its activities in the service of ego- or self-preservation by freeing it from other activities in the object world that have become superfluous under the new circumstances of danger.

(b) The next step towards the evolution of the PTSD after confronting the events which threaten destruction under the conditions of passive impotence is that the ego, into which the libido is condensed in the narcissistic core, is overwhelmed, and the defences surrounding the narcissistic core are ruptured. The rupture of the narcissistic defences leads to a deeply painful and often intolerable narcissistic injury (Freud, 1926). This injury constitutes the crux of the psychological damage which is central to the traumatic neurosis syndrome. The possibility of it occurring at all rests with the emergence of all the other preconditioning factors discussed earlier.

In the normal course of developmental events, the narcissistic defence is built up from the normal maternal (and/or paternal) nurturing behaviour (Freud, 1914). At the same time as meeting the infant's specific physical needs, this maternal nurturance conveys to the infant, by the very meeting of his needs, that s/he will not be abandoned to the terrifying inner impulses which threaten to destroy and annihilate him/her. It thus develops as a defence against infantile experience of annihilatory vulnerability. The infant thus builds up a defence against the inevitability of his/her own destruction and death. Initially the infant uses maternal or paternal supplies of narcissism to defend against vulnerability. S/he uses this until s/he has incorporated and internalized sufficient supplies for him/herself that s/he can maintain this death-defiance on his/her own. The defence modifies the unbearable reality of inevitable death

into a tolerable one and frees libidinal energy for other tasks of normal living into the world of objects which also, and in turn, feedback onto the narcissistic core by facilitating and enhancing its preservation. The trauma and ensuing narcissistic insult evokes a regression to this state that precedes the emergence of defence mechanisms against narcissistic anxiety.

The pertinence of these theoretical constructs was evident in the case of the "truck driver". Having noticed the stream of someone else's blood and sensing that it was his own and that he was bleeding to death (the pretraumatic events with the libidinal retraction into his narcissistic core), he was unable to restrain his growing anxiety and emerged from under the vehicle. As he fled off into the bush, a shot was fired at him which missed him, but something, perhaps the force of the bullet, caused him to fall to the ground. He fell and lay down for a long time, thinking that he was dead. When night fell, he stood up but still felt that he was dead. He described an extreme state of depersonalization and derealization. This state persisted over the next few days that it took him to rejoin his family and remained with him even then. He continued to feel depersonalized and that he was dead. This was so disturbing to his wife and children that friends went to fetch his mother from the town where she lived and brought her to him. When he saw her, which was ten days after the ambush, he instantly realized that he was not dead. His depersonalization and derealization lifted dramatically. This episode suggests the links between external danger, threat of annihilation and death, the narcissistic insult and defence and the origins of the latter in early maternal nurturing relationships.

Consequences of the Ego Effects

(a) The Emergence of Anxiety

The major consequence of the rupture of the narcissistic defence is the release of large amounts of anxiety. Anxiety is a response to danger (Freud, 1926). The danger under these conditions is one that threatens to destroy the detainee and threatens his/her very survival. This danger, implicit in the deep narcissistic insult is therefore of a primitive kind. It generates a primitive form of anxiety which can be regarded as narcissistic anxiety. The immediate fate of this narcissistic anxiety is unclear since in the subsequent evolution of events in the PTSD, its manifestation is usually delayed until the detainee is released from prison or the traumatising environment. What happens to this anxiety in the interim remains unclear. It has been suggested that while traumatised people remain in an actively traumatising environment, their psychic resources are mobilized fully

in the service of warding off the dangers, protecting the self from the continuing threats and of preserving the self. This necessitates an adaptive restructuring of the ego function with a restricted, distorted, deformed, weakened and impoverished ego state that focuses exclusively on survival in the immediate present (de Wind, 1968). This may well be the immediate consequences of narcissistic injury under these conditions with no functional or adaptive role for manifest anxiety.

Since the detainee is still engaged in the traumatizing environment, there is no purpose to be served by the signal function of anxiety as anticipation of future trauma is meaningless in a situation of acute and ongoing traumatic insults. Similarly the function of mitigating the trauma is also meaningless in a situation where the detainee has lost control over his ability to influence the traumatic events which are ongoing (Freud, 1926).

In contrast to the in-prison situation, as in the case of the "truck driver", narcissistic anxiety erupted immediately after the traumatic event and manifested as profound depersonalization and derealization.

(b) The Mobilization of Defence Mechanisms

Once the detainee is released from prison, the narcissistic anxiety emerges from whatever psychic structures that have been employed to contain it. This release of anxiety may be immediate or delayed. On emerging it mobilizes a number of different defence mechanisms as a way of dealing with the traumas and the memory residues of these traumas that provoked its emergence initially. Two particular defence mechanisms have been noted to be operative by authors writing of the PTSD in Vietnam veterans, namely the repetition-compulsion and the denial mechanisms (Horowitz, 1986). Experience with ex-detainees in the local setting has pointed to the activity of a third mechanism, namely the conversion-somatization defence.

The repetition-compulsion is a primitive defence structure which operates by repeating the traumatic events over and over again in the same format as they originally occurred. Its functional value in diminishing the intensity of the anxiety has been suggested to occur mainly by transforming the person from a passive to an active participant in the traumatic events. The victim of the trauma in this internal way regains some control over the circumstances that induced the trauma. There is also an innoculation effect whereby with each repetition the noxious effect is diminished as the person learns to anticipate the trauma, defuse it and become progressively

more immune from its traumatizing effects. In these ways, the original trauma loses much of its dangerous overwhelming qualities. It can then become incorporated into the ego as an integrated part of the personality (Freud, 1920).

The second defence mechanism of denial is also a primitive defensive function (Freud, A., 1936). Denial of a threatening external reality at the time is non-adaptive and may not be compatible with survival. Once the external danger has passed or become internalized, the denial defence becomes a convenient way for the ego to deal with overwhelming threats and impulses. Its more frequent application can be detected in relation to serious illness or sudden loss as a normal and early part of the process which precedes acceptance of the unpleasant reality or narcissistic injury. The force with which the trauma is denied is gradually lessened and the ego is slowly able to integrate the trauma. The more complete entrenchment of denial is usually incompatible with healthy integration of the trauma. Instead, this may lead to the person becoming detached from both the trauma and other areas of normal psychic functioning.

The third defence mechanism of somatization has impressed itself by the frequency with which ex-detainees point to its activity. In this mechanism, narcissistic anxiety is converted into certain body parts. The body parts affected are usually those which were significantly associated with events at the time of the trauma. By displacing the anxiety from the psychic structures, the ego is relieved from inner tension to alleviate what is felt to be overwhelming danger and threat. Conversion into somatic structures helps to externalize the stress which becomes less threatening to the ego. This affords the ego the opportunity to work through the stress at more of a distance and at less risk to itself (Hoppe, 1968; Eitinger, 1969).

(c) Symptom Production

The next step in the evolution of the PTSD is the transformation of narcissistic anxiety by the above defence mechanisms into symptoms.

The major symptom of the disorder is the recurrent intrusive recollections of the traumatic event. This distressing symptom in which the narcissistic injury is relived in full detail of both event and affect occurs either in clear consciousness or in dreams where it often takes the form of nightmares. It can be provoked by stimuli that either resemble closely an aspect of the trauma, or only remotely and innocuously so. The combination of relived events and affects constitute the painful nature of the symptom. The neurotic, distressing or symptomatic part of this process is that these

recollections occur unconsciously, unbidden and beyond the control of the sufferer and cause significant distress. It is the frequent reliving of the traumatic experiences that is the clue to the repetition-compulsion being the implicated mechanism.

In some cases, the intrusive memories may dissipate over a relatively short period of time, the dissipation then coinciding with the person's coming to terms with the trauma. In this respect the ego-syntonic nature of the defence is demonstrated. It is when the person is plagued by these memories for a long period of time with no apparent defusing of the emotional impact, reduction of intensity or integration of the experience that these memories become disabling symptoms. Even here the attempt of the ego to work through the trauma can be detected. Its inability to achieve integration can be seen either as a result of the intensity of the original injury, unfavourable underlying narcissistic and ego organizations, an absence of other favourable and supportive factors or any combination of the above. In all cases of PTSD seen to date, each person has reported being plagued by recurrent intrusive memories of a particularly damaging moment during their traumatic experience. This moment has invariably been the one at which they experience their proximity to death and their helplessness in the face of this, the "traumatic moment". A number of additional symptoms typical of the PTSD flow secondarily from this. The states of hypervigilance, hyperalertness and the exaggerated startle response can be understood as conditions of heightened anticipation for the activity of the repetition-compulsion and the re-experiencing of the trauma. The characteristic sleep disturbance may be due to difficulty falling asleep after awakening from distressing nightmares. It may also be an avoidance of the loss of control inherent in sleeping and the fear of not waking up again or surviving this loss of control, all of which are so reminiscent of the original trauma.

The other major symptom characteristic of the disorder is the psychic numbing or state of emotional detachment. This is associated with impoverishment of and estrangement from previously healthy emotional, personal, social and occupational relationships, weakening of cognitive functions such as concentration and memory, constriction and numbing of affect, lowering of mood with concomitant increase in mood lability and diminished interest in previously significant activities. In this cluster of typical symptoms, the denial defence can be traced as the dynamically active factor since the cutting off from the surrounding environment implicit in the symptoms parallels the attempts by the ego to cut itself off from painful events and recollections of the precipitating trauma.

Denial occurs in relation to both the originally traumatic event as well as to these events being repeatedly relived via the activity of the repetition compulsion. It seems that when these other aspects of the person's life are affected in a symptomatic way, the energy required to dissociate from the original trauma and subsequent recollections is of such an intensity that it spills over into a denial of a detachment from the rest of their affective life. In addition, denial may function as a secondary suppression of affect so as to deprive any anticipated intrusive recollections of affective force, thereby preserving the depleted ego from further narcissistic injury. In the sense that denial shields the deformed and weakened ego from both the initial and repeated narcissistic injury, its function can be seen as protective and contributing towards the preservation of the self. With time it may weaken its hold over the narcissistic anxiety, releasing it in quanta for other psychic mechanisms to work through more productively. It may by the same token outstrip its utility as a protective device and become entrenched as a permanent defensive structure which gives rise to the persistent disabling symptoms outlined above.

In practice it is not uncommon to find that the two defence mechanisms of repetition compulsion and denial alternate in intensity in the struggle to control and contain the narcissistic anxiety. This manifests in a fluctuation of symptoms.

There is not yet sufficient clinical evidence to support an early and very tentative observation that when these two defences do not seem to occur simultaneously and that one or the other predominates, that the repetition compulsion seems to occur in people with a more integrated underlying narcissistic structure. Denial on the other hand then appears as the preferred mechanism where the underlying narcissistic core is less well developed. This tentative distinction will have to await further observation and elaboration.

Clinical experience has shown that the conversion somatization defence has been responsible for generating a number of other frequently encountered symptoms. Numerous ex-detainees suffer from headaches, often ill-defined and non-specific, and a host of other vague body aches, visual complaints, pains, paraesthesias and other unusual and uncomfortable physical sensations. In most cases, repeated medical examinations have excluded specific physical causes.

Therapy has sometimes then been able to reveal the psychological nature of the symptom. An example of this is the case of the young

man who feared becoming brain damaged and retarded whilst being physically assaulted whilst suspended in an upside down position. He complained of a vague, burning, hot, headache-like sensation over the side of his face, scalp and head. this was found to be associated with anxiety, awareness of his continuing state of vulnerability and memories of his detention experiences. Therapy was able to reveal that the headache sensation reproduced for him the fear of becoming retarded. The fear was associated with the physical sensation of his blood collecting in his brain during his forced inverted suspension and the pain in his head and face from the simultaneous beatings. The sensation of his presenting complaint was the same as that which had occurred at the time of his torture except that it was less intensely and painfully felt. Uncovering the association in therapy held him gain relief from the symptom. Not all somatic symptoms have been or can be so readily traced back to a particular moment during the traumatic experience.

It has also been found that the traumatic experience is not necessarily attached directly to the somatic symptom that develops. Instead, the trauma may merely mobilize an underlying conflict indirectly. This may then become entrenched as a somatic symptom under conditions of ego weakness and distortions set up by the narcissistic injury. A particular case which substantiates this observation is of a teenager who was pursued and shot at by the security forces. This persecutory situation evoked in him associations of his own neglectful, competitive and persecuting father who the teenager blamed directly for amongst other things, a serious and incapacitating illness in the teenager's young sibling. Soon after being pursued by the security forces, he broke down with visual hallucinations of his sick sibling, and concomitant seizures, both of which were conversion in origin and which responded well to therapy.

CONCLUSION

This model proposes that under conditions of significant external threat to life, when the threatened person anticipates his/her own destruction actively in thought and in physical circumstances where s/he is restrained and unable to alter the threatening environment, a regressive libidinal shift occurs from the world of objects back into the self-preserving narcissistic core. The threat to and anticipation of destruction is sufficiently severe to overwhelm the narcissistic defence and this gives rise to the liberation of free-floating narcissistic anxiety. Three defence mechanisms are mobilized to bind this anxiety, namely the repetition compulsion, denial and the conversion somatization mechanisms. Where these defences are unable to adequately defuse the intensity of the anxiety, they transform it into symptoms as a

further attempt at accepting and integrating the trauma. It is the symptoms produced by these defences that characterize the classical post-traumatic stress disorder or traumatic neurosis syndrome. These are the symptoms that are encountered clinically so frequently among ex-detainees who have presented for counselling at the service. This theoretical formulation has implications for an approach to treatment, which will be dealt with in a separate article.

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