Psychology in society, 1990, 13, 4-16

Psychotherapy with detainees: A theoretical basis

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INTRODUCTION

This article will examine various aspects relating to detention. Firstly, detention may be viewed as incorporating a systematised process of Assault, Invasion, and Deprivation (AID). It is aimed at undermining psychological resistance and the political resolve of detainees and may be designed to induce pliability and the extraction of information. A distinction is argued to exist between the characteristic process of AID and the notion of Dependency, Debility and Dread (DDD)(Farber, Harlow & West, 1957). The latter may rather be viewed as part of the consequence of the AID process.

Secondly, the article will present a brief review of empirical findings that demonstrate the role locus of control plays in mediating detention trauma. Those internal in their perceived locus of control appear to experience reduced post-detention trauma compared to those external in their perceived orientation.

Thirdly, the incorporation of the locus of control construct into psychotherapeutic strategies will be examined. Employing locus of control in pre-, and post-detention intervention is argued to improve the efficacy of treatment outcome by re-orienting the perceived internal-external dimension.

THE DETENTION PROCESS

The process of Assault, Invasion and Deprivation (AID) (Perkel, 1988) has been integral to the system of political detention in South Africa for decades.

The process of AID provides the framework whereby systematised abuse of various forms may flourish. Assault refers to the direct and indirect attack on the beliefs, moral principles, personality, spirituality, defences, and physicality of a detainee. Invasion refers to the invasion of body space, personal belongings and private boundaries whereby the control exerted over every aspect of a person (from reading and confiscating personal letters to dictating how someone may dress and toilet) is manifest. Deprivation refers to the process of sensory and social isolation, and intellectual, emotional and physical deprivation that characterises detention.

Such a process has reportedly included various facets, each of which has been documented to be potentially pathogenic. Indefinite confinement has been argued to be far more stressful than captivity where termination time is known (Zuckerman, 1964; Schultz, 1965; West, 1982). Solitary confinement has been argued to impose sensory deprivation conditions (Zuckerman, 1964; Gendreau, Wilde & Scott, 1972; West, 1982) as well as social isolation (Zubek and MacNeill, 1967), inducing of a range of psychological and psychiatric sequelae (for example, Smith and Lewty, 1959; Zuckerman, 1964). Psychological abuse has been reported in South African studies (Foster and Sandler, 1985; Foster, Davis & Sandler, 1987), creating conditions which may induce significant stress and a sense of loss of control (Ames, 1982). Finally, physical torture has been alleged by countless numbers of detainees (Davis, 1985; Marcus, 1985; DPSC, 1987; Foster, Davis & Sandler, 1987), the psychological consequences being well known.

It has been argued that each component of the AID process of detention, including indefinite solitary confinement, psychological and physical abuse, is pathogenic in itself. Some authors have explained the detention-interrogation-torture process as leading to a syndrome of Dependency, Debility and Dread (DDD)(Farber, Harlow & West, 1957). This model, although limited in the South African context since these mechanisms do not always occur, helps explain the consequences of the process incorporated by AID. AID, rather, refers to a systematised process that may affect different people in different ways and which does not presuppose a consistent pattern of response. It is this process that includes the elements outlined above.

Since the AID process of detention includes all these aspects, each of which has pathogenic potential, it may create psychological consequences that are severe. Reports of post-detention sequelae confirm this. Various reports derived from both South African detainees and others in various countries around the world exposed to the AID process, indicate a pattern of severe post-stress sequelae (Rasmussen and Marcussen, 1982; Foster and Sandler, 1985; Manson, 1986; DPSC, 1987). According to Davis (1985), some of these sequelae are characteristic of Post Traumatic Stress Disorder (PTSD)(APA, 1980).

PERCEIVED LOCUS OF CONTROL AS A MEDIATOR OF TRAUMA

It has been argued that personality variables may interact with a stressor in determining severity of its effects (Allodi, 1984; Somnier and Genefke, 1986). An important aspect of this, is the perception the victim has of his or her role in the experience and whether an active or passive self-perception in response to the stressor is exhibited. According to numerous research findings, perceived locus of control may mediate the consequential effects of stress with those internal in their perceived locus of control experiencing reduced post-stress effects compared to those external in their perceived locus of control (for example, Johnson and Sarason, 1978; Kobasa, 1979; Rotter, 1979). This notion of a perceived locus of control has been argued to apply in the detention situation as well (Tyson, 1982).

In a study designed to test the mediating capacity of perceived locus of control in detention (Perkel, 1988), post-detention scores from a Detention Locus of Control Scale (DLOC)(Perkel, 1988) were correlated with combined results from a variable PTSD Scale (Friedman, Schneiderman, West & Carson, 1986) and an Index of Well-Being Scale (IWB)(Ochse, 1984). The study was based on a sample of detainees varying in age, sex, race, educational level, length of detention, solitary confinement, assault, previous detentions and geographic location. Combining all subjects, the correlation was significant at a coefficient of 0,46 ($n=22$, $r=0,46$, $p<0,05$). Multiple regression also revealed that locus of control was the only significant predictor of traumatic "symptoms" over assault and length of detention ($F=6,18$, $df=1,24$, $p<0,05$).

Translated, those internal in their perceived locus of control appeared to suffer reduced post-detention effects compared to those external in their perceived locus of control in the detention specific situation. The apparent role of locus of control in determining stress effects following detention suggests that its capacity to mediate and thereby reduce such stress may have important implications.

It is a construct that is not typological in form (Rotter, 1975; Phares, 1978) and can vary across different contexts so that a person external in one situation may be internal in another. This implies that it is not a static variable that cannot be altered. Objective external circumstances also do not dictate perceived control experienced. A person **objectively** out of control (such as when in detention), may still perceive him or herself to retain control (Glass and Singer, 1972). Thus, although objectively out of control, the internally oriented subject may, for example, re-interpret events as contingent upon his or her mediation, thereby engendering the subjective perception of control.

According to attribution theorists, however, locus of control is only one dimension of perceived causality (Weiner, 1985). Other dimensions

investigated in research have been controllability, stability, globality and intentionality. Whilst a more nuanced investigation into these dimensions would enhance the discussion around mediational variables, space only permits the extraction of the most potent ones in perceived causality around the specific detention context. Nevertheless, a cursory glance at some of these concepts appears to indicate that control remains central. "Stability", for example, is engendered through re-attributing events as enduring or transient. Perceived capability to alter this dimension rests on cognitive attributions which may be derived from perceptions of empowerment to change (perceived internal locus) or helplessness to change (external locus). Perceived "stability", like other concepts such as controllability and globality may, therefore, be subject to causal attributions derived from an internal or external perception of control. In addition, proposed personality constructs such as "hardiness" (Kobasa, Maddi & Courington, 1981) despite arguing for the inclusion of a component of "control" have been criticised on methodological grounds (Funk & Kent Houston, 1987). Hull, van Treuren & Virnelli (1987) further argue that "hardiness" should not be considered a unitary construct and that research should examine the independent contributions of the hypothesised components. A major factor in this regard is control.

Central to the AID process of detention is control. In this sense, despite the possibility that other dimensions of causal attribution may play a more prominent role in other contexts, perceived locus of control appears to weigh more heavily in detention. This may occur because cognitive attribution of capacity to adapt and survive depends on one's ability to control even minor events.

If perceived locus of control can mediate stress effects, and it is a variable that is not typological or unchangeable, its usefulness as an intervention construct requires examination. Applied as a thread that is woven through the post-detention psychotherapeutic process, re-orienting a detainee's perception of his or her experience at different levels in an internal direction may serve to reduce the consequent traumatisation. In this way, detainees may be better equipped to deal both with their "symptoms" and their functional capacity to re-invest in their organisational structures - an energy that may be affected by the psychological complications induced by
detention experiences.

Clearly, this would vary from individual to individual as with any therapeutic process. Some individuals may be strengthened by detention, or may experience "symptoms" that are uncomfortable but not incapacitating. Nevertheless, whatever the level of traumatisation experienced, it may be assumed that most people will benefit to varying degrees from intervention in this regard. Such intervention may also be applied in both the pre- and post-

detention phase either in anticipation of detention or following release.

In anticipation of detention, orienting a person's locus of control in an internal direction may help reduce the stress of the AID process. After detention, although the trauma itself may have ceased, its effects may remain psychologically active. This may have conscious and unconscious effects. Therapeutic intervention that re-orientates locus of control, despite applying it retroactively, may still provide a major factor in reducing detention effects. This is so because the perception and meaning of the trauma, as with any memory, can be internally changed and resolved even when the external factors that induced them are no longer operative.

ASPECTS OF PSYCHOTHERAPY

It is worth noting that research does not appear to exist which demonstrates that interventions aimed at changing locus of control perceptions have therapeutic efficacy. Studies have simply demonstrated its mediational function. The present article, drawing on these findings, has aimed to replicate this link in the South African detention situation. Showing the mediational capacity of perceived locus of control in detention, does not in itself, however, provide conclusive evidence for its efficacy as a **psychotherapeutic** construct. Further, beyond evidence drawn from existential and other psychotherapeutic models, and from psychotherapeutic intervention in South Africa, no empirical evidence can be claimed which demonstrates that this construct does or does not work therapeutically. Nevertheless, at the theoretical level a foundation can be argued to exist for employing it in psychotherapy.

Given these limitations, what follows is a framework for using the perceived locus of control construct in psychotherapeutic intervention. Including it in the psychotherapeutic process may involve various components at different levels. These include: i) "symptom" reduction and control; ii) normalisation; iii) cognitive reframing; and iv) experiential reorientation. Each component would serve the purpose of inducing a sense of perceived control where such control has been lost in the objective situation. By so doing, the helplessness engendered by detention would be reduced and control increased. In this endeavour, standard therapeutic approaches would not necessarily be discarded but rather enhanced by employing this construct.

It is important to note that several authors have written on the subject of detainees (for example, OASSSA, undated; OASSSA-DACOM, undated; Manson, 1986; Foster, Davis & Sandler, 1987; Friedman, 1987; Straker, 1987; Solomons, 1988). Solomons (1988), for example, has provided a psychodynamic account of the mechanisms related to PTSD in detainees, with Straker (1987) proposing specific guidelines for intervention with this population. In this regard, different aspects of the four component model proposed in this article are not new. Rather, the method attempts to make use

of an eclectic approach that synthesises different psychotherapeutic modalities in a structured way. According to various theorists, different models of therapy are not incompatible with each other at the practical level (despite being built upon different theoretical frameworks) and may be used to supplement one's overall strategy (McCaffrey and Fairbank, 1985; Fairbank and Nicholson, 1987).

It is also informed by the notion of locus of control as the foundation upon which the psychotherapeutic model is built. This construct, therefore, is used as a basis to deciding which techniques are employed and how they are applied.

Each stage will be discussed in turn:

i) "Symptom" reduction and control

Somnier and Genefke (1986), argue that even in totalitarian environments such as concentration camps, some choice and spaces for decision are left. They therefore propose that the subject needs to be brought out of his or her victim role. In this regard, Goldfried (1986) has argued that treatment interventions that emphasise training in self-control achieve greater anxiety reduction than those that rely on a more passive lessening of anxiety. Such changes are enhanced if the subject believes they have an active role in bringing about such change. Many of the PTSD "symptoms", such as sleep disturbance, intrusive recollections and hypervigilance, may create a spiral of further helplessness because the "symptoms" are experienced as beyond conscious control. Therefore, assisting the subject to "take control" of these "symptoms" may help reduce the spiral of increasing helplessness that is sometimes experienced.

It is important to avoid a therapeutic bias that insists on repeated catharsis without adequate "symptom" control as this may actually increase the intrusive "symptoms" and create depression or reactive numbing (Kinzie and Fleck, 1987). This arises because a victim of traumatic stress may have defences that are already acutely overwhelmed and the use of insight may be burdensome (Simon and Blum, 1987). In a similar vein, analysis of transference phenomena may exert a further regressive pull.

The initial object of psychotherapy should therefore be to restore the subject to a pre-trauma level of functioning through reduction of target "symptoms". Behavioural strategies that assist in stress management (such as with sleep disturbance, hypervigilance, re-experiencing of the trauma, etc), may include relaxation training, anger control training, cognitive restructuring, problem-solving, pleasant imaging, assertiveness training and other techniques that increase mastery. Since intrusive memories may play an adaptive psychological role in assimilating the trauma, techniques such as flooding may

be problematic. Management procedures therefore remain preferable in the initial phases of intervention.

ii) Normalisation

Normalisation may involve a dual role of a) controlled catharsis, and b) assisting in the realisation that the subject's response to the trauma is a common one. The function of catharsis, maintained in the subject's relative control (Kinzie and Fleck, 1987), needs little elaboration. Experiences in detention may lead to a build up of affect since there may be little opportunity for emotional outlet prior to release. Repressed affect and introjected feelings (such as anger), may increase a sense of helplessness and loss of control and make post-detention adaptation more difficult. Controled catharsis may assist the detainee to regain a sense of control over feelings and overcome possible fears of losing control of intense built-up affect.

The latter aspect allows the person to realise that their response remains a normal one to an abnormal situation (despite being unique in some respects)(Manson, 1986). This insight allows the unknown, unpredictable and often frightening "symptoms" to become more predictable and less overwhelming. Research has demonstrated that life stress may demand of a person to assess and predict chances of achieving acceptable levels of control (Fisher, 1984). Predictability and achieving perceived control therefore appear to be linked. Assisting a detainee to achieve greater predictability and insight into their response to detention, may help reduce the sense of helplessness that may otherwise be induced. In this way, a sense of control is increased as the person becomes able to grasp the "normality" of his or her "symptoms".

iii) Cognitive reframing

This aspect involves two components: a) explaining the process of AID, the procedures employed during interrogation and their purpose (such as how the person may have been placed in a "double-bind" situation where no choice was actually possible); and b) reorienting the person's cognitions of self as helpless victim to self as active participant who may be able to "find" meaning in the experience.

a) In this regard, it may be pointed out that whatever decision the detainee was forced to make, the outcome of the interrogation and torture would not have been altered. Impossible choices that induce the person to act or react against their ideology and ethics; attacks on the identity and dignity of the person that are linked with feelings of guilt, loss of self-esteem etc; false promises; the use of alternating friendly and hostile interrogators are amongst techniques that can be explained. This helps demonstrate how normal psychological mechanisms were distorted and manipulated. Mastery may thereby be increased over events that previously rendered the person helpless. Predictability may also be improved since given such particular

circumstances, the outcome remained predictable. Such "rationalisation" facilitates increased control.

b) Cognitive reorientation can also involve the process of encouraging a cognitive grasp of the meaning of the experience. This derives from an existentialist framework that aims to induce a sense of meaning and personal satisfaction with his or her role in the context of the traumatic experiences (Allodi, 1982). Kobasa and Maddi (1977) have made the point that "people tend, through the active use of their cognitive capabilities, to reflect on and invest perceived events with meanings" (p. 251). Perceiving detention as part of fulfilling one's political commitment is one way of achieving this. Further, by perceiving the fact that the detainee actually controlled the detention (such as length held, and even whether assaulted or not) by deciding at the time how, for example, he or she answered questions during interrogation, may be another. Thus by choosing to withhold information, the person can be shown to have been in control of that particular situation.

Deciding on the nature of events experienced, as well as infusing them with a sense of personal meaning, allows the ex-detainee to take the trauma in hand and develop a perception of control that is internally rather than externally located.

iv) Existential reorientation

This aspect may be included where warranted in terms of the level of functioning of the person and the depth of psychotherapy. It should, however, only be used if psychotherapy progresses over time and warrants in-depth work.

Some detainees appear to internalise a sense of helplessness derived from their experiences in detention where they may have felt powerless to affect change. Although the concrete conditions which induced this will no longer be operative, the sense of a state of helplessness may remain. Mastery over it may be increased by "acting out" elements of helplessness through "becoming" the feeling and exploring subjective experience of this state. Gestalt techniques may also be used. "Dialoguing" with interrogators for example, may allow the person to internalise control over the memory of interrogation and experientially alter the basis upon which the actual experience occured. Further, previously repressed hostility towards interrogators may be safely ventilated in role-play type situations. Through these procedures affect and the memories of detention experiences may be safely integrated.

Further, paradoxical approaches that exaggerate the state of helplessness may assist in evoking control over it. Prescribing exaggerated helplessness assists the person to actually begin to control the state since such exaggeration is under conscious volition.

A person having been through detention may carry with them memories of the power of interrogators and the capacity they had to control and manipulate. Regaining a normalised perception of these internalised "introjects" can assist in a deep sense of regained control. The techniques outlined above may go some way towards achieving a cognitive and affective change in this regard. In this way, an existential re-orientation towards the self and the environment generally can be gained.

CONCLUSION

In conclusion, I have explored the inherent stress integral to the AID process that characterises detention (in South Africa). Whilst each aspect remains stressful in itself, it is important to consider the fact that these various dimensions tend to operate together, thereby creating a situation that is potentially pathogenic. Findings indicate that this is indeed so with released detainees reporting between 80% and 100% of PTSD, as well as a range of other somatic and psychological "symptoms".

However, common sense indicates that not all people react the same way even where the stressor is similar. It can be assumed that amongst the variables mediating trauma, aspects of personality will play a role. In this regard, perceived locus of control has been found to mediate between different stressors and consequent sequelae, a finding that has been replicated on South African detainees. The implication of such a finding, is that perceived locus of control may be pliable in such a way that a person's orientation may be redirected in an internal direction to reduce the effects of the AID process. Whether applied pre- or post-detention, the potential of this construct to inform therapeutic intervention as a way of mediating stress effects, remains significant.

Perceived locus of control can be integrated into the psychotherapeutic process in order to induce a sense of perceived control in a situation where objective control has been stripped away. It is, therefore, the subjective perception of control that remains primary rather than the objective reality of control. Whilst other factors of causal attribution have been explored, control appears to remain a central factor in the detention context.

This in no way implies that all detainees are severely incapacitated by their experiences, or that detention is capable of weakening or destroying peoples' political commitment and trustworthiness. What it does imply, however, is that where psychotherapy is indicated, no matter the level of traumatisation, this component may be usefully employed to remedy the consequences and provide the impetus for re-empowerment. Used in anticipation of detention, the pathogenic potential of the situation may be markedly reduced.

Further research into this area is, however, necessary. Firstly, the mediating role of locus of control and other causal factors requires further empirical investigation. Although this article provides some preliminary results of such exploration, wider investigation would be useful. Secondly, this article provides some theoretical points regarding intervention strategies. Their clinical application has yet to be systematically tested and would benefit from an investigation in this regard.

Acknowledgements: Sincere thanks are due to Terri Broll and Anna Strebel for assistance and comments.

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