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The torture goes on: The psychology of restrictions

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INTRODUCTION: REPRESSION AND RESTRICTION ORDERS

In South Africa, many psychotherapists have been working with released detainees over a number of years. More recently we have had to broaden our treatment to include people suffering under the latest form of repression: restriction orders.

In this paper, we aim to describe some of the problems encountered by restrictees in South Africa, and the psychic damage visible to psychotherapists working with this population. To clarify the origins and nature of these problems, it is important to situate the treatment within the political context existing at present.

The country is now in its fifth State of Emergency. Among the many psychologically destructive aspects of emergency legislation, is the set of laws relating to detention without trial and more recently restriction orders.

Since June 1986 over 30,000 people, including 10,000 children, have been held under these conditions. Some detainees have been interrogated, some have been tortured (Foster et al, 1987), and most have been released without having been charged. Although detention without trial is continuing to be used as a repressive measure, restriction orders have taken over as the preferred form of psychological torment.

The hunger strikes of late 1988 and early 1989 were an unqualified victory for

the detainees. They forced a reduction in the indiscriminate use of detention without trial. Many detainees simultaneously had gone on hunger strike as the last available avenue to protest against their detention. The hunger strike spread to many detention centres over the next months. This was an attempt to force the state's hand to release political detainees who were in danger of becoming permanent political prisoners.

The hunger strikes created a serious dilemma for the State. The securocrats pressurized the government to ignor the hunger strikers but, perhaps for the first time in its history, the government overruled the recommendations of State Security. Presumably the authorities had been influenced by their fears of international outrage and contempt should a political detainee, jailed without trial, die of hunger while in custody. Many of the hunger strikers were released.

Now a new phase of repression was introduced. Many of the released detainees were placed under restriction orders. The state hypothesized that the use of these restrictions would bring about a more muted national and international response while still achieving greater atomisation of individuals and their communities. Unfortunately these suppositions have been supported by the mistaken belief, even among the politically aware, that the present form of suppression is preferable to detention without trial. However, Amnesty International itself suggests: "many restrictees may be regarded as prisoners of conscience because their freedom of movement and other basic freedoms are limited." (Amnesty International, May 1989.)

We believe that, in some significant ways, this form of "imprisonment" is worse than detention without trial. Many ex- detainees who are now restricted, reach a point when they begin to wonder if they were not "safer" and less vulnerable while in detention. (What a reflection on our society that being incarcerated without recourse to the courts, should be regarded as preferable to being "released and free".) This paradox emerges as it becomes clear that restrictions are creating considerably more severe and potentially longer-term psychological damage to restrictees than that which resulted from the experience of indefinite detention.

Details of restrictions placed on individuals differ from person to person, but the object is to impose severe limitations on freedom of movement, of association, of occupation and of political activity. The restrictee is often obliged to remain within a specific magisterial district and to be at a specified address between certain hours. In addition all restrictees have to report to a police station at least once and often twice a day between specific hours. Restrictees are also usually prohibited from taking part in political activities, associating with restricted organisations, teaching or publishing. Thus, although restrictees are being "returned to their families

and communities", they are being prevented from returning to anything remotely reflecting "normal life".

It has become widely acknowledged in South Africa that the psychological effects of detention without trial can be categorised under the diagnosis of Post-Traumatic Stress Disorder. However, psychotherapists working with ex-detainees over extended periods of time discovered a more complex set of problems. Many ex-detainees did not respond to treatment in the way one would have anticipated from the literature on Post- Traumatic Stress Disorder (Kelly, 1985; Somnier and Genefke, 1986). These ex-detainees often appeared unable to work through the traumatic experience : psychic numbing and concentration difficulties persisted. Nightmares and events of traumatic re- experiencing continued beyond the expected period. It became clear that the environment in which the ex-detainees were living and to which they were returning after each therapy session was exacerbating the problems. Ex-detainees often felt threatened with re-arrest and re-detention. In fact they appeared to be living in circumstances which could not correctly be defined as those of post-traumatic stress but more accurately as a situation of on-going or continuous stress. This necessitated subtle changes in treatment. Therapists had been anticipating similar results to those obtained by professionals working with traumatized populations in other places in the world. However, what was not immediately realised was that victims of torture and imprisonment in Argentina, Chile and Cambodia, who were being treated as refugees had found some safety in an adopted country. They may have had the added problems of being immigrants in strange surroundings, but they had been removed from the real dangers, threats and reminders of their abuse. This was not the case with the individuals we were seeing in the South African context.

This provides the background for our present treatment of detainees and restrictees.

PSYCHOTHERAPY WITH RESTRICTEES

Psychotherapy usually helps clients to explore painful feelings connected to traumatic experiences and through this process to minimize the emotionally detrimental effects of such experiences. Therapy does this, in part, through enabling clients to let down their protective defences and it is in this vulnerable state that the therapeutic process takes place. Theoretically, narcissistic defence mechanisms evolve in the normal course of infantile development to protect the infant from the vulnerability of annihilatory inner impulses. These defences continue to protect individuals from the potentially overwhelming anxiety of facing their own mortality. Two significant narcissistic fantasies, which protect individuals from this exposure, are the belief in their own grandiosity and the omnipotence of someone else.

One of the major difficulties experienced by local therapists arises from the fact that our clients live under a repressive regime. They have to return to a hostile and threatening environment after each therapy session. It could be destructive for clients to be too vulnerable when they return to the dangers of life under restrictions.

Restriction orders, by their very nature, leave restrictees exposed to the real threat of assassination. They are confined to set areas at specfic times and any would-be assassin can easily discover their routine. The visits to the police station bring constant reminders of past detention and of the lack of true freedom. These visits also curtail the number of hours available for to travel to work, for hours at work and for the return home with sufficient time to report once again at the police station. Those restrictees who used to work for progressive organisations are usually prohibited from continuing such employment and are often unable to obtain other work because of the limits on their time. Economic impotence is profoundly debilitating and increases distressing feelings of emotional and financial dependence on family and friends. Without economic independence, it is extremely difficult to maintain a sense of worth and self-esteem. Restrictees are left with few ways in which to maintain their confidence as productive individuals. The meaning with which they have previously endowed their lives (usually some form of community activity or political involvement) is crushed.

Restriction orders create a paradoxical environment with which the individual has to struggle. Inversions are made of accepted concepts such as freedom, independence and safety. Such inversions lead to confusion and destabilisation. The restrictee is supposedly free and in the "sanctuary" that is home. This concept of home incorporates images of privacy and security; a place in which to relax and let down one's defences in the knowledge that the surroundings are protective and sacrosanct. But for restrictees,home becomes a prison in which they have to monitor their own activities and become their own probation officer. They are unable to protect their privacy or that of the family because the home is open to routine police checks at any hour of day or night. The decisions they are able to take and the amount of independence that they have is severly limited. Even their leisure activities are limited and their freedom to avoid anxiety-provoking situations in their enviroment has been removed. There is additional stress because restrictees see themselves as being co-opted into the very system they are fighting to change, having "to police themselves" in abiding by their restrictions.

Feelings of impotence, isolation and depression begin a process of inner disintegration. This is promoted by a real threat to physical safety. In our daily lives, few of us have to contemplate the possibility of our own mortality . As described above, we have developed defence mechanisms to protect us from such traumatic exposure. These defence mechanisms are difficult to

maintain under conditions of severe stress. Restrictees are constantly aware of their inability to protect themselves and of the helplessness they experience in the face of overt and hidden dangers. Homes have been petrol bombed and activists have been assassinated in daylight. Furthermore, the powerful authority figures of government and police are anything but benign and family and friends are unable to protect the restrictees from harm. To live with the daily knowledge of possible death with no way of escape, is to experience annihilatory anxiety. There are few satisfactory ways of coping with such extremes of trauma.

Suicide may seem for some individuals to be an option. Psychotic distortion of reality may be another. Enormous quantities of psychic energy may be used to deny the presence of all danger. These alternatives affect the psychological functioning of the person to the extent that intra-psychic structural change may occur. The risk of permanent damage is increased by the cumulative nature of the stress and the absence of ways to gain emotiomal relief. Restrictees may not leave their neighbourhoods nor may they go into hiding. On even the simplest level they may not go out in the evening with friends nor be in the company of more than a set number of people at one time.

Therapists are no longer treating people who have survived traumatic experiences. Indeed, we are working with individuals in the process of being destroyed. We are witnessing the psychic effects of cumulative stress and are referring to this as Cumulative Stress Disorder.

A CASE STUDY

A brief case study is offered to illuminate some of these "symptoms" and effects of restriction orders, and the difficulties encountered by therapists. The insidious and intentional damage being perpetrated on individuals simply because of their political beliefs will be clearly visible.

Certain details in the following case have been altered in order to protect the identity of the restrictee and maintain client confidentiality.

The restrictee is a 21 year-old male student who was detained for a period of six months allegedly because he was a member of his Student Representatuve Council. Prior to his detention he worked on week-ends to earn money to put towards the support of his family. His father died a few years previously. He has an older brother who earns a low salary. He has a wife and young baby to support. His sisters are both still at school and his mother is in domestic employment. Her earnings are insufficient to cover all the family expenses.

J. was deeply concerned about his family during his detention, but gained support from fellow detainees and reassurance from his mother on the few visits she was allowed. His comrades encouraged him to continue his studies

while detained. He persevered throughout his incarceration, although he had difficulty concentrating at times.

J. was referred to our service for medical and psychological treatment. He arrived at the offices a few days after his release from detention. He had been served with a restriction order on his release. He presented with difficulties in concentrating and complaints of poor memory. These upset him greatly because he had been allowed to return to school and was eager to make up the work he had missed while in detention. He said he found himself "thinking of other things" while in class. He had heard that it was helpful to talk about the detention as one way to recover from it. During detention, he had even fantasized describing his experience to the press. He felt frustrated by the prohibition against talking to the press as well as his personal restriction from addressing groups of people.

He spoke with surprising ease of his feeling and seemed to feel reasonably good about himself. He was confident that he would cope with his restrictions, although they were burdensome. He was simply relieved and happy to be home. He was sure that he would find another weekend job with which to supplement the family income. He was highly motivated to achieve at school and was willing to give himself time to recover from his ordeal.

J's response was typical of clients coming so soon after their detention. There is a sense of euphoria in being back with family and friends. The therapist recognized this as a transitional phase and allowed J to go at his own pace without interpreting the possibility that J may be blocking out painful memories and anxieties about the future.

On his next visit,one week later, his concentration and memory were improving and he was thinking of writing the school tests within the next three weeks. He mentioned that he felt as if he had become his own jailer and often was extremely anxious, particularly when he looked at the time. He explained this by saying that he then became aware of his enforced trips to the police station, and the curfew that prevented him from participating in after-school activities, or making use of the school's library. The latter made his study problematic because he could not afford to buy the books.

He also alleged that he was being harassed when going to the police station to sign and felt angry about this. He was trying hard to abide by all the restrictions and was irritated when unnecessary hurdles were placed in his way. He had not had time to search for employment that week.

In spite of these stresses, he said he was feeling stronger and that his family and teachers were understanding and supportive. He wished he could go out at night with his friends and missed this form of relaxation. Nevertheless, he

appeared to be handling his situation extremely well and was making productive use of his time.

The therapist reflected that he felt he was making progress but also encouraged him to explore his angry feelings. One of the problems for the therapist was to discern whether the complaints about harassment were "realistic" or whether they were an indication that the defences were loosening and his anxiety was increasing.

In his third session he reported that during the previous week, he began to wonder if someone was setting a trap to push him into breaking his restrictions. He claimed that the police at the station were suggesting that he didn't have to report to them; they said they had no record of his name on file. He felt that someone was following him home from school.

It was now becoming clear that he was, indeed having difficulty in sustaining his defences. It appeared that the daily visits to the police station re-evoked his detention experiences and acted as environmental cues triggering intrusive thinking. He was being confronted with the real nature of his distorted "freedom" and fake "independence". He began to realise his helplessness in many areas of daily life. He felt angry. He spoke anxiously of the police intrusions into his home at night to ensure he was obeying his restrictions. He was not only upset for himself but angry that these calls woke his sleeping family, often at midnight. His guilt towards his family was growing because he had been unable to find a weekend job and realised that few would employ him because of his time restraints. Now that he was no longer in jail, he felt responsible for his failure to find employment. He was free. He believed he had no excuse.

Despite these worries he reported that he had written and passed the class tests. He was proud of his achievement. However he was restless and tense throughout the session and often seemed to interrupt his own flow of thought.

The next session saw a marked deterioration in his behaviour. He fidgeted and often stopped mid-sentence. He complained that he was not sleeping at night and had lost his appetite. He was depressed and frightened. The events he then described could well have been the sole cause of his deterioration.

He had been followed by a stranger on his way home from the police station. The stranger had called to him by name, "So, J?"
and then driven away. Someone kept phoning him at night to enquire if he was there. He began to fear that his house might be petrol-bombed and his family burnt to death. Theoretically, the defence mechanisms with which he had protected himself, were being severely tested and had begun to crumble. He obviously was not omnipotent: he could not keep himself or his family

safe. There was also no-one in his life who he could idealise and with whom he could merge to gain a sense of security. He could not rely on remaining alive from moment to moment.

The final shattering of these defences occured when he was told of the death of another young comrade who had been shot on his way home after signing at the police station. J. stuttered through the entire session. He expressed fantasies of "going into hiding" and "escaping". Each time he would come close to the terror of his possible death, he would yawn and change the subject. He expressed anger at the teachers who now complained of his lack of concentration and involvement during class. He was angry that his lawyer could not protect him. He was angry that his therapist was not helping; wasn't making him feel better. He had thought he could trust her and rely on her and yet she could not alter his situation. It seemed as if she too had become one of his enemies. J expressed the wish to withdraw physically and psychologically from his environment and stated that he thought he might be re-detained. He had in fact packed a suitcase to be prepared. He finally admitted to fantasies of disobeying his restriction orders in order to get himself re- detained. It was strange that he was thinking of jail as a place of saftely and security. He was extremely depressed.

The therapist experienced the projective identification of J's helplessness. But she also experienced her own impotence and this was accompanied by a strong need to "do something". She too was being confronted with the disturbance to her narcissistic fantasies. Her skills and abilities to explore J's inner world and his transference reactions seemed irrelevant in the face of his truly aggressive and life-threatening reality. She offered to write to his principal and teachers explaining the impossibility of concentrating under the present conditions. J. agreed with some relief. She asked the school to be supportive and allow him to sit in the classroom, where he felt momentarily safe in company, even if he was mentally "not present". She also referred him to one of the doctors in the Detainee Service for sleeping pills and to assess the presence of clinical depression. (The doctor prescribed a mild anti-depressant.)

J returned the following week feeling slightly better. He was now sleeping and less depressesd although he was still unable to eat much and was behaving self-destructively. He was challenging the authorities at the police station and being aggressive when they made house "visits". The therapist interpreted this as as a wish to be re-detained and explored the dangers in his behaviour.

J avoided talking about the possibility of assassination and the therapist refrained from pushing him. He had strongly resisted her gentle acknowledgement of his avoidance. He had begun to re- repress his internalized bad objects and was attempting to deny the presence of the real

persecutors.

He asked if there was a way of learning how to relax and the therapist took him through a relaxation excercise. She was surprised at the ease with which he closed his eyes and allowed her to lead him through the excercise and a following guided fantasy. Perhaps her attempts to give some concrete help the previous week had re-instated her as a trustworthy person.

When he returned the following week the change in J was surprising and disconcerting. He appeared relaxed and unconcerned. He had decided to write the exams over the following two weeks and had been studying well and consistently. His appetite had returned and he had practised the relaxation excercise daily. He avoided all anxiety-provoking topics.

The therapist was in a dilemma. To confront or interpret the defences would open J to his terror and pain; would make him vulnerable to his real environment and his inner world. To follow his lead would be to collude with what could be termed "pathological defences" and perhaps prevent any working through of the trauma. She chose to follow his lead. In exceptional circumstances, so-called pathological defences may be the only ones that enable an individual to survive and cope. To increase someone's vulnerability when there really are people "out to get him", is uncaring and possibly unethical.

The therapist made another appointment with him for the week after his exams. Two days before his next appointment, J visited the offices to report that the exams seemed to have gone well and he was copying with his life. He had a meeting with his lawyer at the same time as his next therapy appointment so he had come in to cancel it. He said that he would make another appointment when he needed to. The therapist was not in the office at that time and the arrangement was left that J would make the next contact. For several months he made no further contact with the office.

Did J cancel because the therapist had colluded with him? Did he cancel because he was afraid to re-open his wounds? Perhaps he wanted to continue the relationship, but did not know how to do this without having to explore the traumas he wished to repress? Or did he cancel because he was feeling that he was copying, that travelling to the city from his home in the township was burdensome and exposing and that he was no longer that desperate for help?

The therapist could console herself only with the knowledge that he was alive. Had he been assassinated, the office would have been informed through the grapevine.

CONCLUSION

The real situation in which continuing cumulative traumatic stress is being treated, presents therapists with clients who are in the process of disintegration and not at the end of a traumatic experience. The therapists are confronted with existential helplessness and the cruelty and sadism of powerful others. These objective problems have necessitated the use of wider environmental networks to provide support for the clients as well as for the therapists. Therapists are being sharply confronted with their own limitations which seem more overwhelming in this area of work that in any other theraputic endeavour.

There is a danger in a paper like this one, that because the damage to the sufferers is stressed, a picture may be created of a future generation of irreparably damaged citizens. This is not the case. There are obviously differing responses to being restricted. These are influenced by a number of interacting factors, including: the nature and severity of the restriction orders; the pre-detention (restriction) personality structure with its ego-resources and internalized ofject relationships; the support systems in the environment; the amount of damage caused during the detention; and the availability of therapeutic assistance.

Nevertheless all restrictees suffer abnormal amounts of stress that accumulates as the conditions persist or deteriorate. This stress can be expected to result is the occurance of at least some symptoms eventually. The limitless nature of the trauma and the variety of dangers inherent in being restricted to a confined area have a cumulative psychological effect.

With prolonged and cumulative traumatic stresses serious intra- psychic changes may occur in some individuals. This change could lead to the development of chronic psychological disorders which could prove resistant to therapy, even in a post-apartheid society.

REFERENCES

Amnesty International (1989) **South Africa: Restrictions under the State of Emergency Regulations**. London: Amnesty International.

Foster, D, Davis, D & Sandler, D (1987) **Detention and torture in South Africa**. Cape Town: David Philip.

Kelly, W E (ed) (1985) **Post-Traumatic Stress Disorder and the war veteran patient**. New York: Brunner/Mazel.

Somnier, F E & Genefke, I K (1986) Psychotherapy for victims of torture. **British Journal of Psychiatry, 49**, 323-329.