Violence and Mental Health:
Post-Traumatic Stress and Depression

Gillian Eagle

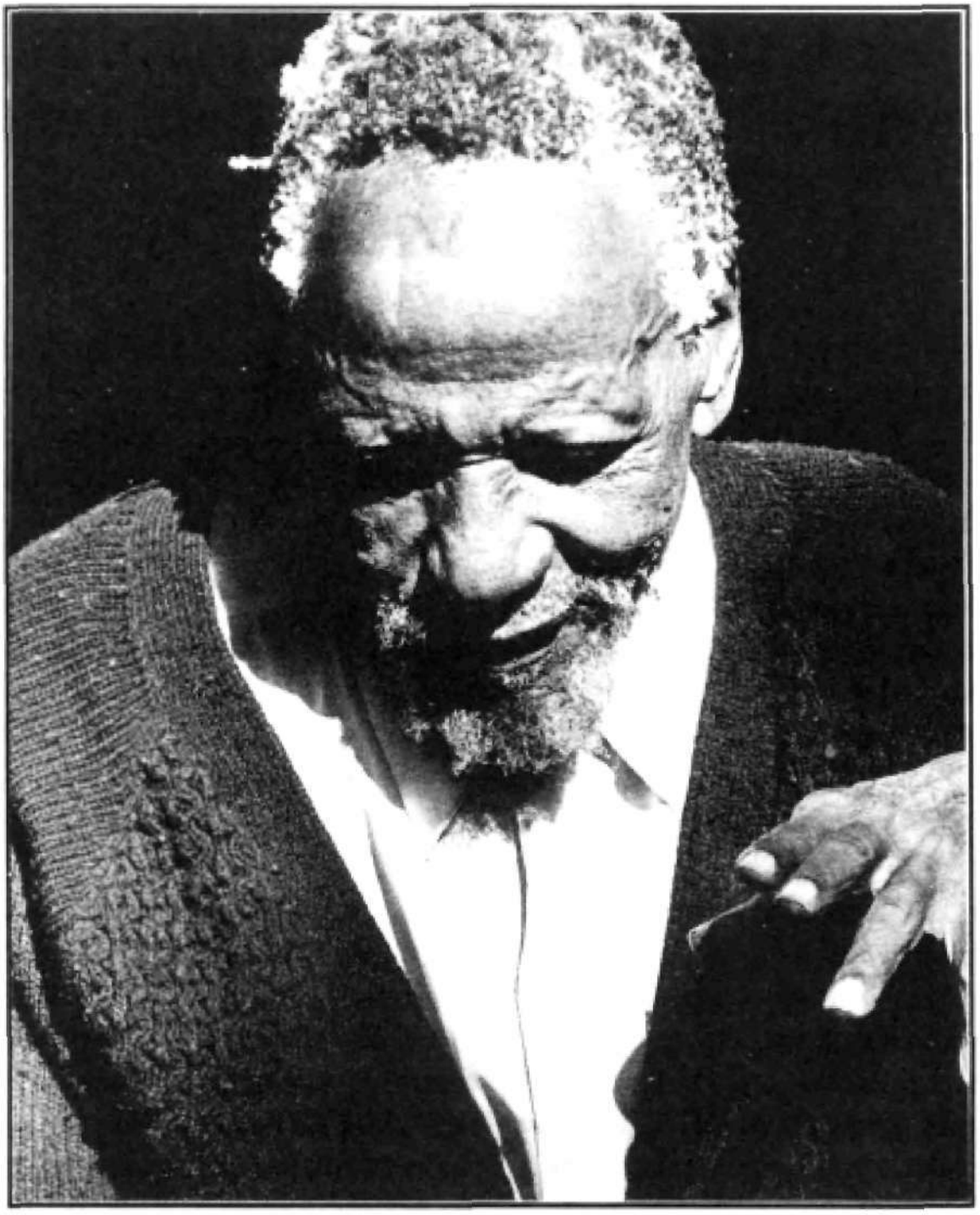
Violence can result in direct physical injury to victims and often has a severe psychological impact as well. The holistic treatment of victims involves an understanding of trauma and psychology. The close inter-relationship between body and mind also suggests that patients may recover better from physical injuries if their psychological trauma is dealt with at the same time.

Many victims of violence may not have physical injuries but will have suffered damage to their mental health. Thus mental health intervention is of central importance. Given the scale of violence in South Africa at present, it is crucial that we continue to develop our understanding of the effects of violence and constantly improve our treatment methods and services.

The Psychological Consequences of Violence

Victims, witnesses and, occasionally, perpetrators of violence can suffer from post-traumatic stress as a result of exposure to a traumatic incident or precipitating event. Survivors of violence can present with intrusive recollection of the event, emotional numbing or withdrawal and hyper-arousal. In some cases, personal or situational factors may intensify the effects of the trauma, resulting in Post-traumatic Stress Disorder (PTSD). (See the DSM 3-R Diagnostic Criteria for PTSD in the article before this one). If the psychological effects of trauma go untreated, more complicated disorders may develop. This includes clinical depression, psychosomatic symptoms, phobias, chronic anxiety and 'acting-out behaviours', for example, alcohol abuse and wife battery.

Post-traumatic stress is associated with powerlessness, an acute disruption of one's existence and extreme discomfort. Thus, victims usually present with acute features of anxiety and regression. They can lose their trust in their own ability to cope as well as their faith in humankind. Many survivors of violence become frightened of the symptoms they experience and, failing to recognise them as "normal", fear that they may be going mad. It is important for both mental health personnel and their clients to remain aware that post-traumatic stress is the natural response of a 'normal' person to an 'abnormal' situation, rather than the result of some intrinsic pathological process.



PTSD is a 'normal' response to an 'abnormal' situation. *Photo: Tessa Colvin*

In working with trauma survivors, several local mental health personnel became aware of the limitation of the DSM 3-R categorisation of PTSD. In terms of DSM 3-R, symptoms were expected to gradually diminish once life returned to normal, usually within a six month period. It became apparent to South African personnel that many victims were returning to situations in which danger persisted and multiple traumas could be commonplace. Gill Straker, a clinical psychologist, conceived of the category, Continuous PTSD. Clients suffering from this condition had symptoms similar to PTSD, but their symptoms were prolonged and, rather than diminishing, they intensified over time.

Short-term Psychotherapy

In keeping with DSM 3-R, the preferred treatment for most victims of violence is short-term psychotherapy. It is felt that medication represses, rather than alleviates, symptoms. This often creates a further dependence and lack of sense of control on the part of the client, who is already experiencing decompensation. However, psychotropic medication can be useful to ensure that clients have adequate rest in the form of unbroken sleep.

At the Wits Trauma Clinic, victims of violence are initially offered four treatment sessions and the therapy is usually short-term, averaging 2 to 3 meetings. In each session an attempt is made to incorporate the following components: assisting the client to re-experience feelings and thoughts by means of a detailed recounting of the event; 'normalising' the client's symptoms by focussing on expected responses to trauma and the 'adaptive' function of these responses; and helping the client to recognise and to establish coping mechanisms to deal with the violence and its aftermath. This may include establishing support networks and referral to appropriate sources. A common phenomenon is 'survivor guilt' and a fourth aspect of treatment is the restructuring of maladaptive thinking in this regard.

The therapist's role is to solicit information, offer support and affirmation and serve an educative function. Due to the tendency for people to regress after situations of extreme and unanticipated stress, clients are often vulnerable and the therapist needs to pace the intervention to match the client's resources. However, counsellors need to be careful not to set up dependence in the relationship. The goal is to assist the client to regain a sense of self-sufficiency as soon as possible. In some cases, it is possible to reframe the client's sense of the experience to a point where he/she recognises some mastery and may even experience a sense of increased commitment to living, having survived the trauma.

Continuous Stress and Previous Trauma

In cases of continuous traumatic stress, psychotherapy has to be modified to allow the person to maintain optimal defences. The therapeutic approach would be more cognitive in emphasis, avoiding deep emotional catharsis and focusing strongly on the development of coping and survival mechanisms. In these cases, longer term supportive therapy may be necessary.

Other conditions may also necessitate long-term intervention. These include the exposure of pre-existing trauma, for example, sexual abuse; a lengthy period of silence around an event, such as a rape that happened years previously; or pre-

existing psychiatric or personality problems. At the Wits Trauma Clinic, therapists are generally advised to keep their intervention somewhat narrowly focussed on the traumatic experience which brought the client for treatment, rather than follow up on other problems, unless these appear to be integrally related to the trauma. Where such complicated presentations arise, clients are usually given the option of referral to other agencies or therapists for longer term counselling, following the trauma work.

Group Therapy

One to one counselling is the first treatment of choice as victims tend to experience events very personally and often wish to protect close friends and relatives from the worst of their experience. However, there are occasions when group counselling can be very effective, particularly as an adjunct to individual counselling. Group therapy can be very powerful in 'normalising' symptoms, as participants recognise common features in others. It can also provide a support system which allows for the sharing and reinforcement of coping skills. At the Trauma Clinic, we have engaged in some very effective couple counselling.

We have run debriefing groups with personnel who have been involved in offering treatment in situations of violence. There may also be a need for debriefing groups for members of violence monitoring teams, media workers, politicians and others who are constantly witnessing violence. Other forms of intervention include the sharing of information through the medium of pamphlets, newspapers, radio and television and educative programmes in schools and other settings. For example, the Project for the Study of Violence has initiated a school programme on mediation and negotiation skills as alternatives to resorting to violence in dealing with conflict situations.

Trauma counselling can be viewed as both curative and preventative. If victims receive good therapeutic intervention as soon as possible, this can prevent the development of other serious disorders. With early intervention, clients often acquire knowledge which they can use to assist others in their community.

Counsellors almost inevitably experience an increased sensitivity to their own vulnerability as a consequence of providing trauma counselling. Counsellors need to have access to peer support so as to have the opportunity to talk through the feelings which this type of work evokes.

Violence and Depression

The DSM 3-R criteria for PTSD include a number of symptoms which are related to anxiety and depression. Emotional numbing, loss of interest in outside activities

and withdrawal from social contact are all features of depression. Concentration difficulties and sleep disturbance can occur in post-traumatic stress and clinical depression. Thus, there are common as well as different features in the two categories of disorder.

In our experience at the clinic, depression usually only tends to arise following complications in the experience and treatment of PTSD. In one rape case, a black woman experienced secondary victimisation by her community and the police and this led to depressive features. These features came to a head when her rapists were acquitted in court, at which point she developed suicidal impulses. In situations where mastery of the situation seems impossible for personal or structural reasons, for example, through loss of employment following traumatic injury, a sense of helplessness and hopelessness is perpetuated and depression is a logical consequence of these feelings.

Anger Against the Self

Depression resulting from loss often represents the turning of anger inward against the self rather than against the cause of the loss, for fear of possible retribution. The aggressor may dehumanise or objectify the victim who, in turn, can experience this dehumanisation as a temporary loss of 'identity' or a loss of a sense of personal power in one's ability to appeal to the perpetrator. Victims often describe the shock and disbelief they felt when they were targeted by apparently arbitrary or feelingless violence. The victim fears reprisal and this tends to invoke powerful feelings of impotence and regressive behaviour such as pleading or even loss of control over body functions.

If survivors do not have an opportunity to recognise these responses as 'normal' and adaptive, they may be unable to transcend this sense of powerlessness. If such feelings endure and become dominant in the person's functioning, depression may ensue. For this reason, an important feature of psychotherapy is the facilitation of anger in a contained setting, where the client has the opportunity to express feelings of rage and fantasies of revenge. This can be viewed as part of 'normalising' the symptoms, allowing the person to channel their aggressive energy in a socially acceptable manner, for example, in taking the perpetrator to court, giving evidence to a commission of enquiry or training in self defence. In cases where victims have been exposed to previous trauma or abuse, there is a tendency to 'learned helplessness' in which they internalise a 'victim identity'. Longer term therapy is usually required.

Loss of Hope

However, for many communities in South Africa, 'learned helplessness' may well be a social, rather than a personal, phenomenon. Many people in oppressed communities appear to have lost hope. During the apartheid years, black township residents could clearly identify the enemy, in the form of the security forces, which threatened their community from outside. However, the present violence is often internal to communities, unpredictable, highly visible in its impact and the perpetrators are not easily identifiable. The continued exposure to violence, together with an inability to clearly perceive its origins and motivations, leaves community members drained and often resigned to their situation. Gibson, Mogale and Friedlander (1991) cite evidence of this despair in the drawings of children from Alexandra Township. The drawings reflect a preoccupation with death and injury and a pervasive feeling of 'deadness'. The mothers of these children also suffer from depressive symptoms.

Evidence of widespread clinical and sub-clinical depression in community groupings was also noted in a study of internal refugees around Pietermaritzburg. Michelson assessed a large group of people displaced by violence. In many cases, these survivors of violence were dealing with multiple losses, including loss of loved ones, loss of home and possessions, loss of livelihood and loss of their community. She found significant levels of both PTSD and depression in her subjects.

Informal clinical observations have suggested a general increase in depression in the South African population as the economic recession makes itself felt, violence increases and political developments progress slowly and unevenly. The country seems to be exhausted by decades of unrest and struggling to maintain hope.

However, we cannot afford to ignore the political gains that have been made and the resilience of both communities and individuals in facing and dealing with the threats they have been exposed to. We need to make effective gains for peace before even this resilience is lost.

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