Chapter 1 – Introduction and motivation

1.1. Introduction

Family violence is not a new phenomenon – it has probably existed in families since the beginning of time. Only recently, however, has violence in the family against children and spouses become recognised as a social problem by professionals and society at large (Barnett, Miller-Perrin, & Perrin, 1997). Years ago the prevailing attitude was that what parents chose to do to their children was their business (Barker, 1998). Today there is a greater professional recognition of its existence and a heightened social unwillingness to tolerate various forms of abuse (Lyon & de Cruz, 1994).

While there are no current national statistics regarding the rate of abuse in South Africa, the issue is certainly prevalent. Ecklely and Vilakazi (Barnett et al., 1997 p. 234) state that the general level of violence in South Africa is so high that violence against certain subgroups is characterised as a "blip on the radar screen". Borrowed statistics from the United States indicate that there has been an emergence of family violence in the past twenty years and that it has become one of the most critical problems facing society. Concerning child maltreatment, for example, data from the annual survey conducted by the National Committee to Prevent Child Abuse indicated that 3,140,000 children experienced some form of abuse (i.e. physical, sexual, neglect, emotional maltreatment) in 1994 (Barnett et al., 1997). In a national survey of parents, Gelles and Strauss (Oates, 1991; Wiehe, 1996) estimate that 11% had been severely violent toward their children in 1985. At least 3.3 million children witness parental abuse each year, including such behaviours as hitting, slapping, and fatal assaults with guns or knives (Osofsky, 1998).

Ammerman and Hersen (1991) believe that the pervasiveness of domestic mistreatment makes it a priority for clinicians and researchers alike. For clinicians, intrafamilial violence represents an overwhelming challenge with respect to assessment and intervention. The consequences of family violence are complex and divergent. No single psychiatric syndrome or symptom constellation has been consistently implicated in any form of family mistreatment. The clinician must choose the appropriate intervention, which is determined by the characteristics of each

particular case. No single theoretical approach or intervention has emerged as the intervention of choice in any area of family violence (Ammerman & Hersen, 1991). With this in mind, this study looks at ego state therapy in the treatment of an abused child.

1.2. Aim and motivation

The aim of this study is to demonstrate a possible clinical application for ego state therapy. This will be achieved by referring to a child abuse case in which ego state therapy was applied. This paper will be an illustration of ego state theory and therapy. It will describe the therapy sessions that took place with a client, Tracey, addressing all the issues commonly arising from child abuse. There is no inference that this form of therapy is the only method available for such intervention, but rather that it is a very suitable method considering the effects of child abuse as seen in the extreme cases of dissociative identity disorder (DID).

This study will look at the nature and effects of child abuse, including physical abuse and the witnessing of marital violence. It will assess the effects of growing up in a chaotic and unstable environment and the impact that alcoholic parents have on a particular adolescent. The author has chosen this topic given the dearth of practical interventions for these types of cases.

1.3. Outline of study

The primary issue that will be addressed is the use of ego state therapy in the treatment of child abuse. A detailed discussion on the response to trauma will show that a degree of dissociation is almost always present, thus emphasising the need for, and the effectiveness of ego state therapy. As already stated, this is not to suggest that ego state therapy is the only appropriate treatment method. However, research in this area does show the scarcity of effective intervention programmes for abused children. Ego state therapy attempts to address all the psychological and behavioural maladjustments of child abuse to effect change in the internal world of survivors, thereby producing change in their external environment.

1.4. Terminology

Child: The literature provides no clear consensus on the definition of a child. There are certain concepts, however, that appear to be strongly related to childhood, such as, immaturity, dependence, vulnerability and trustfulness (Louw, 1993). Children are immature in both the physical and the psychological sense in that certain of their capacities are significantly underdeveloped, such as rational thought (Thompson & Rudolph, 1996), a moral sense (Wicks-Nelson & Israel, 1997), as well as physical strength and other physical abilities. Children are dependent in that care, protection, and guidance are essential for their survival and for their healthy physical and psychological growth. Children are vulnerable in that their underdeveloped capacities contrive to render them susceptible to diverse sources of harm. Lastly, children are trusting in that they are often explicitly trained to obey adults (particularly their parents), and their ability to be appropriately suspicious and critical of others is not fully developed (Louw, 1993).

Childhood trauma: Childhood trauma refers to overwhelming, uncontrollable experiences that psychologically affect a child who lacks emotional, maturational and cognitive development. The child may be rendered temporarily helpless and previous ordinary coping and defensive operations may be compromised (Thompson & Rudolph, 1996).

Dissociation: Dissociation is defined by Briere (1992) as a defensive disruption in the normally occurring connections among feelings, thoughts, behaviour and memories, consciously or unconsciously invoked in order to reduce psychological distress.

A dissociative disorder: The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (Kaplan & Sadock, 1998) defines a dissociative disorder as a sudden, temporary alteration in the normally integrative functions of consciousness, identity, memory or motor behaviour.

Dissociative identity disorder (DID): DID is the name that DSM-IV uses for what has been previously known as multiple personality disorder. DID is a chronic dissociative disorder, and its cause typically involves a traumatic event, usually childhood physical or sexual abuse. The concept of personality conveys the sense of an

integration of the way people think, feel, and behave and the appreciation of themselves as a unitary being. DID can be described as a complex, chronic, dissociative condition characterised by the existence of two or more distinct entities (i.e. personalities) within a single individual, each of which is dominant at a particular time. The individual's behaviour is determined by the entity (personality) with executive control at a given time (Kaplan & Sadock, 1998).

Hypnosis: Brown and Fromm (1986) define hypnosis as a special state of consciousness in which certain normal human capabilities are heightened while others fade into the background. It is best understood as an altered state of consciousness. Hypnosis itself is not therapy, although the relaxation that accompanies it can be beneficial.

Hypnoanalysis: Watkins (1992) describes hypnoanalysis as a sophisticated procedure, practiced within the hypnotic modality, which is aimed at a fundamental reconstruction of an individual's personality – as is the goal of psychoanalysis. Hypnoanalysis is especially concerned with undoing resistances and interpreting transferences and the main objective is achieving reconstructive understanding of repressed material.

Ego state: Watkins and Watkins (1978a) define an ego state as an organised system of behaviours and experiences, the elements of which are bound together by some common principle, but are separated from one another by boundaries which are more or less permeable. Each ego state is conceptualised as constituting of a kind of "sub-self" which has more or less individual autonomy in relation to other states and to the entire personality.

Ego state therapy: Watkins (1992; p. 201) defines ego state therapy as "the use of group and family therapeutic techniques for the resolution of conflicts between the various ego states which constitute a "family of self" within a single individual".

Chapter 2– Abuse

2.1. Introduction

The issue of parental violence toward children became part of the general social and scientific consciousness when a group of physicians published a paper in 1962 coining the term "the battered child syndrome" (Kempe, Silverman, Steele, Droegemueller, Silver, 2000; Oates, 1991; Wiehe, 1996). This work was the result of these physicians repeatedly noting multiple bone fractures in the X-rays of a substantial number of children. Their chief purpose in writing the article was to alert other physicians to the problem in order to facilitate the detection of abuse (Blumenthal, 1994; Corby, 1987).

The article marked the initial use of the medical model, which emphasised the pathology of abusive parents (Gil, 2000). Following this description of child abuse, there was an abundance of publications that addressed the etiology and sequence of abuse. This work focused attention primarily on the most extreme cases of battery, in which children were beaten, burned and tortured by their caretakers, and analyses again emphasised the pathology of abusive parents. The early trends in the literature were geared toward establishing a conglomeration of personality traits that could be used to characterise the typical abusive parents (Burgess, 1991). Abusive parents were described as being psychopathic and emotionally immature, irrational, rigid, compulsive, emotionally disordered and subject to unresolved dependency needs.

The second major step in the history of research into violence toward children occurred when scholars from other disciplines began to work on the problem, in part as a reaction to the defects seen in the first wave of studies (Burgess, 1991). Researchers began to design their studies with better samples and with appropriate control groups. From this work it was learned that most of the earlier psychiatric profiles of abusive parents were inaccurate (Wolfe, 1999), however, the features of parental depression and anxiety were consistently borne out by later research.

As soon as scholars from other disciplines turned to the problem of violence toward children, awareness grew that the correlates of abuse were to be found on levels of analysis quite different from the individual personalities of abusive parents. It was

realised, for example, that societal values and norms could contribute to the acceptance and even the condoning of child abuse. At a less macro level of analysis, it was reported that parents isolated from social support systems in their neighbourhoods and elsewhere were especially likely to be violent toward their children (Kaplan & Sadock, 1998). Other research documented the importance of the social organisation of the family itself, for example, the higher than expected rates of abuse that were found in single-parent households and in families with step relations (Freeman, 2000).

Veltkamp and Miller (1994) maintain that matters became even more complicated when it was found that certain children were especially at risk of being victimised. Children with difficult temperaments were found to be at risk for maltreatment (Kaplan & Sadock, 1998), as well as children who displayed hyperactive and other difficult-to-handle behaviours (Warley & Pettet, 1997). Today, as a result of greater public concern, increased government awareness, and years of interdisciplinary efforts, researchers and practitioners adhere to a multidimensional perspective that accounts for the vast number of stress factors that impinge on the developing parent-child relationship. Child abuse is now considered within its entire social context, both when attempting to identify causes and treatments and also when attempting to understand its seemingly pervasive impact on child development (Salzinger, Feldman, & Hammer, 1993).

2.2. Physical child abuse

With the "discovery" of child abuse during the 1960s (Blumenthal, 1994), and the increased interest in child protection that followed, child abuse definitions have changed rapidly. For example there is currently no uniform law that defines physical child abuse for all jurisdictions within the United States. Most state statutes and experts in the field recognise that physical child abuse includes a range of acts carried out with the intention of harm that puts a child at considerable risk for physical injury. Disagreement continues to exist, however, in regard to behaviours that do not result in any physical signs of injury (e.g. spanking) or that lie in the grey area between "socially acceptable" corporal punishment and that which is excessive (e.g. resulting in broken bones) (Malinosky-Rummel, 1993).

Thompson and Rudolph (1996) point out that the way in which physical child abuse affects its victims is not completely understood, in large part, because of the difficulties associated with studying such a complicated problem. Physical abuse often occurs in association with other problems within the family or in the environment, such as marital violence, parental depression, psychological maltreatment, or low socio-economic status (Gil, 2000). It is therefore difficult to conclude that the psychological problems associated with physical child abuse result solely, or even primarily, from the violent interactions between parent and child. The fact that the abusive pattern takes place in the absence of compensatory factors, such as positive interactions between family members and a social support network, amplifies the detrimental results (Wolfe, 1999).

To add to the uncertainty in understanding the effects of physical child abuse, it is also true that the experience of physical child abuse does not affect each victim in a consistent or predictable way. Specific characteristics of victims' families or their abuse experiences serve to mediate the effects of abuse (Gillham, 1994). Victims whose families are characterised by high stress and whose abuse experiences are more severe for example, tend to exhibit greater levels of psychological distress. On the other hand, victims who benefit from high levels of intelligence and one supportive parent figure appear to be protected in some way and demonstrate fewer psychological symptoms (Barnett et al., 1997).

2.3. Exposure to marital violence

When referring to the effects of exposure to marital violence on children, most specialists in the field concentrate on the consequences of recurrent male-to-female violence (Pittman, Wolfe, & Wekerle 1998). The children are traumatised by the threat of either observing violence or becoming the object of physical assault themselves. Exposure to marital violence is described as a form of trauma that terrorises the children by forcing them to observe a loved one being physically or verbally assaulted. Alternatively the trauma may involve the child overhearing some form of violent behaviour, or seeing the outcome of the assaults. Many other experts conceptualise exposure to marital violence as having to live in a violent and unstable environment or being influenced by negative and limiting role models (Barnett et al.,

1997). Children who are exposed to marital violence are subject to self-blame, feelings of helplessness, neglect, abuse and injury.

Violence and discord in the marriage affects both partners' ability to function in their roles as parents. Rosenberg and Giberson (1991) assert that there are multiple ways in which a parent-child relationship may be affected by a dysfunctional marriage. It is probable that parents will become emotionally unavailable to their children as a result of their preoccupation with their own trauma. Fathers in maritally violent families appear more irritable than other fathers and less likely to be involved in parenting. Parents may rely inappropriately on their children for guidance, support and affection (Kendig & Lowry, 1998). In other situations, parents may have difficulty disciplining their children, and may alternatively ignore or punish their children's behaviours. Mothers in these families are likely to be inconsistent in their parenting style. At times, children may be used as outlets for their parents' frustrations or as scapegoats for problems within the marriage. Marital conflict fosters the emotional and psychological unavailability and lack of responsiveness of parents, increasing the insecurity of parent-child emotional bonds and the quality of parent-child attachments (Cummings, 1998).

A likely repercussion of marital violence is the general poisoning of the family environment, which in turn may indirectly generate the adverse outcomes noted in children exposed to family violence. Over the years, researchers have agreed that the features most needed in a nurturing home are a supportive family and opportunities for the child to interact with peers and others outside the family (Graham-Bermann, 1998). As levels of marital violence increase, levels of family strengths, marital satisfaction and parental satisfaction decrease. It has been found that physically violent families exhibit a dominance hierarchy, lack of organisation and openly expressed anger. In contrast, non-violent families are emotionally spontaneous, share pleasurable activities and goals, and emphasise personal rights and freedom (Gottman & Declaire, 1997).

2.3.1. Effects of marital violence on children

Children in maritally violent homes have been called the "forgotten", "unacknowledged," "hidden", and "silent" victims (Osofsky, 1998). The first

published articles on such children only appeared in 1975 – almost 15 years after Kempe and his colleagues "discovered" physical child abuse. Despite the fact that researchers have begun taking notice of this problem, a shortage of information about how these children are affected persists (Holden, 1998). The literature that is available lacks generalisability and must be considered tentative, but exposure to marital violence is thought inter alias to be related to significant short- and long-term adjustment problems in children (Cummings, 1998).

Three general areas that cause children psychological damage are the immediate trauma, the adverse effects on development and having to live under high levels of stress (particularly fears of injury to themselves and their mother). Some adjustment problems include **emotional distress** (e.g. anxiety and depression), **cognitive impairments** (e.g. lowered academic performance), **behavioural effects** (e.g. aggression, drug use and truancy), **health** (e.g. colds, headaches, bed-wetting and hospitalisation), **mental effects** (e.g. low self-esteem) and **social effects** (e.g. exposure to violent role models) (Holden, 1998). When children witness violence they learn that it is an appropriate way to resolve conflicts. They learn that violence is part of family relationships and that it is a way to control other people (Osofsky, 1998). Children may learn behavioural and cognitive styles for coping with everyday events both from observing their parents in interparental situations and from their own interaction with parents (Cummings, 1998).

Researchers divide these effects into internalised symptoms (e.g. sadness, withdrawal, somatic complaints, fear, anxiety) and externalised symptoms (e.g. aggression, cruelty to animals, disobedience and destructiveness). Many children reared in maritally violent homes show a wide range of externalising and internalising problems (Holden, 1998). Table 2.1. (Graham-Bermann, 1998) lists the associated adjustment problems of exposure to marital violence.

Table 2.1. Problems associated with exposure to marital violence

Externalising Problems - Aggression, alcohol and/or drug use, anger, conduct disorder, cruelty to animals, destructiveness, non-compliance, oppositional
Internalising Problems – Anxiety, depression, excessive clinging, fears, low self-esteem, passivity, withdrawal, sadness, self-blame, shyness, suicidality

Attention deficit disorder

Posttraumatic stress disorder symptoms (anxiety, flashbacks, hyperalertness, guilt, nightmares, numbing of affect, sleep disturbances)

Separation Anxiety

Social Behaviour – Competence Problems - Beliefs in violence in relationships, deficits in social skills, low empathy, poor problem-solving skills

School Problems - Academic performance, poor conduct, truancy

Other - Intergenerational transmission of violence, obsessive-compulsive, somatic symptoms (headaches, enuresis, insomnia, ulcers), temperamentally difficult

A group of broad parameters are expected to mediate the effect of observation: age, sex, stage of development, role in family, and type of violence experienced. Researchers categorise exposure as direct (e.g. modelling) or indirect (parent-child relationship) (Blumenthal, 1994). The impact on children exposed to domestic violence depends on many factors, including the age of the child, frequency and type of violence exposure, amount and quality of support provided by caregivers and other significant adults and experience of previous trauma (Osofsky, 1998). Younger children are more likely to exhibit somatic complaints and experience greater distress than older children who may take on one or more specific externalising or internalising problems (Holden, 1998). Marital violence may have a cumulative impact on negative emotional and behavioural processes in children. Marital discord is associated with children's emotional and behavioural disregulation, attempts to control or regulate the dysfunctional interactions between the mother and father, and representations of the self and family members' relationships that are more negative and pessimistic about the future (Cummings, 1998).

2.4. Parental substance abuse

Several relatively common conditions are associated with family violence, including substance abuse, poverty, unemployment and stress, the direction of causality being unclear (Ammerman & Hersen, 1991). Substance abuse in one or both caretakers places children at risk for abuse. Extensive and prolonged use of drugs and alcohol leads to a compulsive dependence that dominates the parents' existence. Users live for the moment. When the desire for escape controls the psyche, the individual's social and moral standards deteriorate to the point where rationality, objectivity and

responsibility cease to exist. Caretakers in this position become self-centred and stay preoccupied with maintaining their current "high" or with getting their next "fix" (Meadow, 1993). According to the National Committee for the Prevention of Child Abuse (Barker, 1998), sixty percent of the 2.25 million reports of child abuse and neglect in 1987 directly involved drug or alcohol abuse by one or both parents or caretakers.

Parental substance abuse leads to a family environment that can be described as chaotic. There is an atmosphere of inconsistency and unpredictability. The family roles are unclear with limits always changing. There are perpetual arguments, repetitious and illogical thinking. The family is dominated by the presence of alcoholism or drugs and its denial (Veltkamp & Miller, 1994). Adults who were raised by an alcoholic parent frequently describe a childhood filled with fears – often for themselves, other family members and the alcoholic him-or-herself. They may report times when the substance abuser was out of control, rapidly moving from one mood or behaviour to another. There is a sense that the children of these families are deprived of formalised parenting. Oates (1991) points out that the alcoholic parent often forces the child into a caretaking or parental role by virtue of her own regression, neglectfulness or primitive demands.

2.5. Disruptions in developmental processes

Gillham (1994) states that although the effects of some forms of physical abuse are lasting (e.g. blindness) in most cases young bodies heal very quickly. In contrast, the psychological injury of child abuse leaves enduring emotional scars and research shows that abused children experience significant psychological distress and dysfunction. Aber and Cicchetti (Gillham, 1994) comment:

> The thought of a maltreated child conjures up images of bruises, fractures, malnutrition and the like. But it is the emotional damage that … may have the most frequent long-term deleterious effect on the development of maltreated children. (p. 98)

Children are traumatised during the most critical period of their lives. At a time when assumptions about self, others and the world are being formed; when their relations to their own internal states are being established; and when coping and affiliative skills

are first acquired (Veltkamp & Miller, 1994). Mistreatment by a parent, whom the child is pre-programmed to trust and love, is a violation of her core sense of self and one that undoubtedly can have lasting effects on her[1] interpersonal relationships and adjustment (Hobbs, Hanks & Wynne, 1999).

Although there is no specific single pattern that can be described as the profile of abuse, children who experience physical maltreatment are more likely to be physically, behaviourally, and/or emotionally impaired, compared to their non-abused counterparts (Gillham, 1994). Although child abuse may have direct links to some psychological disorders, it is more likely that its impact is conveyed in terms of disruptions in related developmental processes, such as socioemotional and social cognitive abilities (Salzinger et al., 1993). Although not all abused children who face these developmental challenges will develop a form of psychopathology; they are at much higher risk. As they approach adulthood, developmental impairments stemming from child abuse can lead to more pervasive and chronic disorders, notably mood disorders and antisocial behaviour (Wolfe, 1999). Abused children frequently have higher levels of aggression, anxiety, low impulse control, self-destructiveness, and antisocial behaviour (Veltkamp & Miller, 1994).

Table 2.2. (Barnett et al., 1997) displays the most frequently reported effects of physical child abuse for children, adolescents and adults.

Table 2.2. Effects associated with physical child abuse

Children
Medical complications: bruises; head, chest, and abdominal injuries; burns; fractures
Cognitive difficulties: decreased intellectual and cognitive functioning; deficits in verbal facility, memory, perceptual-motor skills, and verbal abilities; decreased reading and math skills; poor school achievement; increase in special education services
Behavioural problems: aggression, fighting, defiance, property offences, and arrests
Socioemotional deficits: delayed play skills, infant attachment problems, poor social interaction skills, deficits in social competence with peers, avoidance of adults, difficulty making friends, deficits in prosocial behaviours, hopelessness, depression, low self-esteem

[1] Throughout this study the female pronoun is used for clarity

Adolescents

Antisocial behaviour: violent interpersonal behaviour, delinquency, violent offences, substance abuse

Other: attentional problems, depressed school performance, increased daily stress, low self-esteem, and homosexuality

Adults

Criminal/violent behaviour: arrests for delinquency, adult criminal behaviour, marital violence (for adult males), received and inflicted dating violence, physical abuse of own children

Substance abuse: abuse of alcohol and other substances

Socioemotional problems: self-destructive behaviour, suicidal ideation and behaviour, anxiety, hostility, dissociation, depression, unusual thoughts, and interpersonal difficulties

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The above table shows that recent research indicates that physical child abuse is associated with detrimental effects on the child's emotional, social, and intellectual functioning. It is essential to recognise and acknowledge that abuse of a child can lead to major developmental damage, which has ongoing implications. The effects do not simply disappear as the child reaches adulthood (Walker, 1992). It is further believed that many of the social and behavioural impairments that begin in childhood and persist in adulthood may contribute to the intergenerational transmission of abuse (Barnett et al., 1997). The developmental disruptions and impairments that accompany child abuse set in motion a series of events that increase the likelihood of adaptational failure and future behavioural and emotional problems.

These complexities suggest that the study of the psychological effects of child abuse must not only consider the immediate impacts of maltreatment. It should also include their subsequent interference with, and impacts on, normal human development over the long term because the effects of child abuse are usually dynamic and interactive (Lyon & de Cruz, 1994). Although some of the initial reactions of victims to their abuse may decrease with time, such disturbances, along with abuse-specific coping behaviours, typically generalise and elaborate over the long term if untreated (Wolfe, 1999). How an individual child reacts to being abused will depend on the complex interaction between the child's own personality and predisposition, her unique family circumstances and the nature, severity and duration of the abuse (Kenward & Hevey, 1992). Following are a number of relationship difficulties that typically result from

child abuse followed by some psychological implications for children exposed to abuse.

2.5.1. Poor relational representations

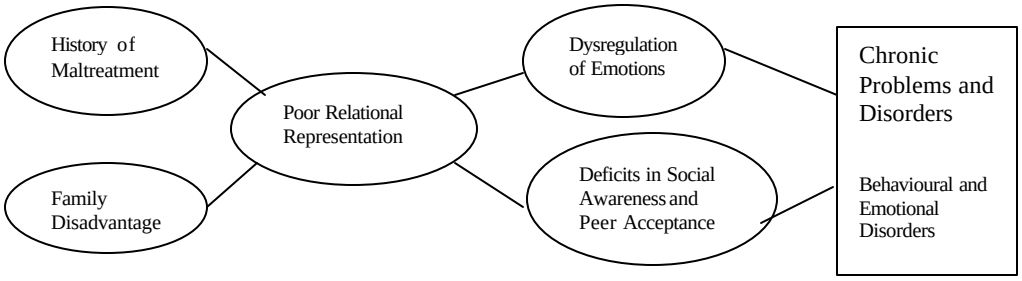

Figure 2.1. Mediational pathways depicting the relationship between child abuse and developmental disorders (Wolfe, 1999) p.37

Abused children may form future relationships shaped in part by their inappropriate knowledge of power assertion, emotional rejection, or other possible components that interfere with the establishment of positive, supportive relationships. The above model proposes that child abuse and similar forms of maltreatment set the stage for poor relational representations (Salzinger et al., 1993). Children's early relationships with caregivers and others provide them with experience, knowledge, and expectations that help them to form representational models of relationships that are carried forward to new situations. These relationships also provide the basis for the formation of their interpersonal style and therefore infants who adapt to hostile or unavailable caregivers by withdrawing or being constantly alert will use similar methods with peers and other adults (Osofsky, 1998). The lack of a secure, consistent basis for relationships places maltreated children at greater risk of falling behind in their cognitive and social development and can result in problems regulating their emotions and behaviour with others (Barnett et al., 1997).

2.5.2. Infant attachment problems

Child maltreatment is known to disrupt the important process of attachment, a critical, ongoing process beginning between 6 and 12 months of age. The intimacy problems of abuse survivors appear to centre primarily on ambivalence and fear regarding

interpersonal attachment and vulnerability (Salzinger et al., 1993). The interference of abuse with the child's developing sense of security and belief in a safe world begins early on in childhood. Work by Bowlby and Ainsworth, in what is generally referred to as the "attachment" literature, suggests that early childhood experiences have significant impacts on later emotional and interpersonal development. It is thought that early parental support: nurturance, consistency and responsiveness, produce a secure attachment between parent and infant (Graham-Bermann, 1998). This attachment enables the child to approach the world with confidence and, when faced with potentially alarming situations, is likely to tackle them effectively or to seek help in doing so. In contrast, early parental neglect, ambivalence, inconsistency or maltreatment is likely to disrupt or prevent an optimal parent-child connection, leading the child to distrust or fear parental contact, and yet often feel abandoned without it. Such infants exhibit insecure or anxious attachments (Pittman et al., 1998).

Episodes of child abuse, whether chronic or sporadic, can disrupt the natural process of attachment and interfere with children's ability to seek comfort and to regulate their own physiological and emotional processes. Consequently, maltreated children are more likely than other children to show an absence of an organised attachment strategy (Wolfe, 1999).

Both comparative and prospective studies support the conclusion that child abuse during infancy and early childhood is related to insecure attachment relationships with the caregiver (Graham-Bermann, 1998). Longitudinally, abused children who showed early attachment problems are more likely to reveal declining developmental abilities over the first two years of life, especially in critical areas of speech, language, and social interaction.

Without consistent stimulation, comfort, and routine to aid in the formation of secure attachment, maltreated infants and toddlers have considerable difficulty establishing a reciprocal, consistent pattern of interaction with their caregivers (Tower, 1996). Instead, they show a pattern described as insecure-disorganised attachment, characterised by a mixture of approach and avoidance, helplessness, apprehension and a general disorientation. This insecure-disorganised pattern occurs much more often among maltreated samples of mothers and infants – as high as 80% (Wolfe, 1999).

Children's beliefs about themselves and others follow from their initial attachment experiences, so an insecure-disorganised pattern can have significant repercussions in later stages of development. Children form complex mental representations of people, relationships, and the world during this period that influence their future thinking and behaviour (Rossman, 1998). Normally, their emerging view of themselves and their surroundings is fostered by healthy parental guidance and control that invokes concern for the welfare of others. Because such opportunities are seldom available to maltreated children, however, emotional and behavioural problems are more likely to appear because of their maladaptive view of themselves and others. Development of language and symbolic play also allows them to represent their growing awareness of self and other, influenced by both maturational and environmental factors.

These early patterns of parent-child interaction may also lay the foundation for subsequent difficulties in social interactions for older children. Physically abused children exhibit poor social interactions with peers as well as adults. Difficulties include trouble making friends, deficits in pro-social behaviour (e.g. smiling) with peers, and delays in a number of interactive play skills (Egeland & Vaughan, 2000). Difficulties extend into adulthood when intimate relationships are formed with partners.

2.5.3. Dysregulation of emotions

Parent-child attachment and the home climate also play a critical role in emotion regulation, another early developmental milestone. Emotion regulation refers to the ability to modulate or control the intensity and expression of feelings and impulses, especially intense ones, in an adaptive manner (Salzinger et al., 1993). Emotions serve as important internal monitoring and guidance systems designed to appraise events as beneficial or dangerous and to provide motivation for action. Emotions serve interpersonal regulatory functions as well, and emotional reactions and perceptions help young children understand their world (Rossman, 1998).

Most children learn emotional regulation naturally, through emotional expression and explanations given by their caregivers. Abused children, in contrast, live in a world of emotional turmoil and extremes, making it very difficult for them to understand, label,

and regulate their internal states. Expressions of affect, such as crying or signals of distress, may trigger disapproval, avoidance or abuse, so maltreated youngsters have a greater tendency to inhibit their emotional expression and regulation (Wolfe, 1999).

2.5.4. Deficits in social awareness and peer acceptance

Child abuse contributes to difficulty inferring emotional responses and behavioural intentions from others, which in turn can lead to maladaptive interactions with peers and dating partners, low self-efficacy and peer rejection (Malinosky-Rummel & Hansen, 1993). These relationship deficits carry over into adolescence, where those with a history of maltreatment have a limited ability to demonstrate basic relationship skills, such as empathy and positive, non-threatening communication (Wolfe, 1999).

The development of empathy and social sensitivity to others during the pre-school years are prerequisites to the development of positive, reciprocal peer relationships. Physically abused children show little skill at recognising distress in others, most likely because this has not been their experience. Abused children show deficits in social sensitivity and awareness. Children with maltreated experiences have greater difficulty, relative to non-abused children, in identifying facial expressions depicting various emotions (Egeland & Vaughan, 2000).

Studies of peer interactions involving abused and non-abused children in naturalistic settings further established the importance of these underlying social deficits. Parker and Herrera (Wolfe, 1999) compared interactions of 16 school-age children and their friends with the interactions of non-abused children and their friends. The interactions of abused children and their friends were marked by less intimacy and more conflict than dyads without abused children. Findings suggest how abused children bear a behavioural resemblance to their own abusive parents regarding their tendency to isolate themselves, to respond aggressively under a range of circumstances (Pittman et al., 1998)

2.5.5. Difficulties with intimacy, trust and authority

Many adults with histories of childhood maltreatment report difficulties in forming or sustaining intimate relationships (Kendig & Lowry, 1998). Most child abuse occurs in the context of relationships and it is therefore common for abused children to fear,

distrust or experience ambivalence about interpersonal closeness. Interpersonal difficulties of child abuse may be understood as arising from two sources. Firstly, immediate cognitive and conditioned responses to victimisation that extend into the long term (e.g. distrust of others, anger and/or fear of those with greater power, perceptions of injustice, low self-esteem). Secondly, accomodation responses to ongoing maltreatment (e.g. avoidance, passivity, adversariality and ingratiation) and abuse-related stress. These various reactions and responses, although understandable given the survivor's early life history, nevertheless interfere with daily interpersonal functioning and access to critical resources such as relationships, acceptance and support (Oates, 1991).

Children who were abused often have difficulties with intimacy, trust and authority. Trust requires the suspension of defensive activities and an assumption of safety at the hands of another and is therefore especially difficult for most people who were maltreated as children (Kendig & Lowry, 1998). Based upon childhood experiences of victimisation by one or more caretakers, significant numbers of adult abuse survivors appear to associate relationships with maltreatment. Consequently, they may either (a) avoid interpersonal closeness altogether or (b) accept some level of aggression in intimate relationships as normal or appropriate (Bass & Davis, 1986).

Early relationships shape what the child knows, her ability to do things and her understanding of events and relationships. Therefore, if the child has known hostile, punitive relationships with adults, this is what she comes to expect or rely on. These relationship histories are most likely carried forward over generations through the process of coherence, in which the individual continues or re-establishes relationships congruent with her past relationship experience. Accordingly, relationship patterns seem to be learned merely by being in relationships and once established seem particularly difficult to change (Salzinger et al., 1993). The untreated survivor's expectation of continued victimisation, difficulties with trust, adversarial perspective and tendency to "overreact" to perceived rejection or devaluation may lead to considerable isolation from – and rejection by – the social milieu. As a result, true friendship may be rare for such survivors, as may be enduring romantic relationships.

2.5.6. Hostility and manipulation

Some maltreated infants and toddlers become hypervigilant, looking for any clue related to a possible verbal or physical outburst, a further example of the impact of their unpredictable and at times fearful circumstances involving caregivers. Hypervigilance not only includes constant scanning of the environment but also developing the ability to detect subtle variations in adult behaviour, such as facial, intonational, and body language, that alert them to possible danger. Sometimes they learn to placate angry parents to avoid becoming the target. As disorganised toddlers become pre-schoolers, however, hypervigilance and similar ways of adapting to their environment give way to various forms of controlling behaviour toward the parent(s) and others (Wolfe, 1999). Controlling behaviour may take the form of pseudomaturity, such as looking after the parent and the household or emotional immaturity, such as excessive tantrums and non-compliance. This developmental transition among maltreated children – which differs significantly from nonmaltreated children – is believed to compensate for the absence of an expectable environment by controlling and organising the parent (Rossman, 1998).

Child abuse survivors tend to see the world as a battleground – where one endeavours to win (or lose) in order to survive. Manipulation refers to those superficially non-aggressive behaviours engaged in by an individual in order to extract goods and/or services from those who would not otherwise bestow them (Rosenberg & Giberson, 1991). From the survivor's perspective, manipulation is historically appropriate survival behaviour. It is based on (a) powerful needs for certain interpersonal supplies; (b) the assumption that nothing in this world is freely given and that the survivor does not inherently deserve gifts; and (c) her previously developed skills at extracting needed resources from a hostile environment (Lutzker, 1998).

Despite the theoretical appropriateness of manipulative behaviour in light of the survivor's childhood experience, the net result of tricking or coercing others is usually estrangement from them. The survivor may become caught in a vicious cycle (Osofsky, 1998). Initially neediness and perceived unworthiness motivate the manipulation of others who although perhaps briefly awarding the desired behaviour or object, eventually respond with anger and rejection or abandonment. This produces

greater dysphoria and emptiness in the survivor and further manipulation (Bass & Davis, 1986).

A high level of aggressiveness would also appear to be a dominant characteristic of many abused children (Salzinger et al., 1993). Empirical studies and clinical experience both suggest that children's aggressiveness toward others – commonly expressed as fighting, bullying, or attacking other children – is a frequent short-term sequel of various types of maltreatment. In general, it appears that such behaviour represents a generic externalisation of the child's abuse-related trauma and dysphoria, as well as, perhaps, the effects of modelling the abusive parent's behaviour. The net effect of this angry aggression is often social isolation and unpopularity (Malinosky-Rummel & Hansen, 1993). Studies show that many abused children lack empathy with the distress of others and had a tendency to respond maliciously (Kenward & Hevey, 1992).

2.5.7. Posttraumatic effects

The early descriptions of children's responses to trauma suggested that these reactions were mild and transient. Since then, however, reports have emerged of more severe and long-lasting reactions to trauma in childhood (Wicks-Nelson & Israel, 1997). The diagnosis of posttraumatic stress disorder (PTSD), according to the DSM-IV (APA, 1994), requires that the person be exposed to a traumatic event that includes a threat of death, serious injury or physical integrity to the self or others, and where the person's response involves fear, helplessness or horror. Three categories of symptoms must be experienced for more than one month in order for the diagnosis of PTSD to be made: reexperiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and persistent symptoms of increased arousal (difficulty sleeping, irritability, and difficulty concentrating) (Wicks-Nelson, 1997).

Child abuse represents an ongoing trauma. The violence and abuse are therefore best understood as continuous rather than as discreet or unitary traumatising events (Osofsky, 1998). PTSD may not develop until months or even years after the event. Once begun however, posttraumatic stress symptoms of these children may be recurrent and ongoing.

The first clinical feature in physical abuse survivors is the painful reexperiencing of the event. Flashbacks occur when an event triggers angry or rageful feelings, when there is overt conflict with others, when violent events occur or if they are in the presence of someone who is in some way physically frightening (Rosenberg & Giberson, 1991). The reexperiencing of the traumatic event is in the form of repetitive play, dreams, and intense distress on exposure to cues related to the event (Wicks-Nelson & Israel, 1997). Another clinical feature of childhood trauma is hypervigilance to danger – not only for potential physical injury, but also for psychological trauma such as betrayal, abandonment or injustice. This expectation of injury may lead to hyperreactivity in the presence of real, potential or imagined threats (Lyon & de Cruz, 1994).

Other posttraumatic symptoms of physical abuse survivors appear to involve autonomic arousal (e.g. tension, "jumpiness", flinching), avoidance of abuse-related thoughts or stimuli, violent nightmares and intrusive thoughts of being violent or of suddenly being injured (Graham-Bermann, 1998). These intrusive violent thoughts may be especially frightening, since, as a result of their suddenness and perceived uncontrollability, they seem to suggest uncontrollable aggressive impulses and, possibly, violent behaviour (Malinosky-Rummel & Hansen, 1993).

The mental status examination often reveals feelings of guilt, rejection and humiliation. A pattern of emotional numbing may be present. Clients may also describe dissociative states, panic attacks, illusions and hallucinations. Cognitive testing may reveal that clients have impairments of memory and attention. Associated symptoms can include aggression, violence, poor impulse control, depression and substance related disorders (Kaplan & Sadock, 1998).

2.5.8. Anxiety

Child abuse is, by its nature, threatening and disruptive and therefore victims of such maltreatment are prone to feelings of fearfulness or anxiety, even well after the abuse has transpired. Some of the frightening qualities of child abuse may reside in the implications it has for the child regarding general vulnerability and susceptibility to violation, regardless of how dangerous the event may be perceived to be by another person (Rossman, 1998).

Clinical experience suggests that adults and adolescents with childhood histories of abuse frequently present with cognitive, classically conditioned and somatic components of anxiety. In congruence with Beck and Emery's cognitive model of anxiety disorder, anxiety related to abuse seems typically to involve the following:

- Hypervigilance to danger in the environment, whether objectively warranted or not
- Preoccupation with control, with the belief that even a slight loss of self-determination or self-protection could lead to danger or catastrophe
- Misinterpretation of objectively neutral or positive interpersonal stimuli as evidence of threat or danger (Briere, 1992).

Paradoxically, child abuse usually takes place in the copresence of human relationships and closeness, yet at the same time involves intrusion, abandonment, devaluation and/or pain (Barnett et al., 1997). As a result, the child or adolescent abuse victim may form a classically conditioned association between various social or environmental stimuli and danger, so that a variety of otherwise relatively neutral interpersonal events stimulate fear. For example, a formerly abused adult or adolescent may become anxious in the presence of intimate or close relationships, especially fearful of evaluation, or frightened when interacting with authority figures (Briere, 1989).

2.5.9. Passivity, self-blame and low self-esteem

Studies have demonstrated a higher incidence of emotional difficulties in physically abused children compared to controls. School-aged children, for example, have been found to display lower levels of self-esteem relative to controls (Malinosky-Rummel & Hansen, 1993). People make significant assumptions about themselves, others, the environment and the future based on childhood learning. Because the experience of child abuse victims is, by definition, usually negative, these assumptions and self-perceptions are often distorted (Oates, 1991). The assault can be understood as affecting the individual's perception of the self as valuable, the self as competent and the world as altruistic or neutral (Veltkamp & Miller, 1994). The meaning of the abusive event to the child and the immediate response of caretakers influence the degree of trauma that the child may experience. Frequently the child is left to

construct her own meaning or interpretation of violent events (Graham-Bermann, 1998).

Compounding the child victim's sense of danger is the lack of defence against such threats. There are few real options of defense available when a child is assaulted or exploited by an adult due to the child's lesser social status, her training for obedience, her smaller physical size and her lesser physical strength. This often makes resistance impossible, or unsuccessful, and typically temporary and after the fact (Briere, 1989). These represent some of the psychologically abusive aspects of victimisation.

Other cognitive impacts of physical abuse result because of the parent justifying the abuse to the child while it is occurring. Therefore, in addition to the intrinsic psychological aspects of physical abuse, physically abusive parents often justify their violent behaviour toward the child by making concomitant blaming or critical statements about her, implying that the physical abuse is deserved punishment. These justifications are likely to increase the victim's sense of guilt, shame, and responsibility for the abuse and thereby intensify the child's sense of personal badness (Kenward & Hevey, 1992). The blame may also be apportioned indirectly, after the fact, by a victim-blaming social system that implies that the victim must have done something to deserve the abuse. This internalisation of others' negative statement and judgements during or following child abuse frequently produces further guilt, shame and self-blame in adult survivors.

These feelings of self-blame, shame and guilt also serve as an attempt to make sense of the maltreatment, a process that can lead to self-deprecating conclusions, including that the child deserved the abuse and that she is inherently bad (Oates, 1991). This negative self-evaluation is what Briere (1992) calls an abuse dichotomy. The abuse dichotomy is hypothesised to proceed in a series of quasi-logical inferences. These are based on the maltreated child's understanding of the meaning of aversive parental behaviour and her relatively primitive cognitive processes at the time (characterised by dichotomous thinking and egocentricity). Briere (1992 p. 76-77) points out that the series of conclusions appears to proceed as follows:

1. A parent or other trusted adult is hurting me, emotionally or physically.
2. Based on how I think about the world so far, this injury can only be due to one of two things: Either I am bad or my parent is (the abuse dichotomy).
3. I have been taught by other adults, either at home or in school, that parents are always right, and always do things for your own good (any other alternative is very frightening). When they occasionally hurt you, it is for your own good, because you have been bad. This is called punishment.
4. Therefore, it must be my fault that I am being hurt, just as my parent says. This must be punishment and I must deserve this.
5. Therefore, I am as bad as whatever is done to me (the punishment must fit the crime: anything else suggests parental badness, which I have rejected). I am bad because I have been hurt. I have been hurt because I am bad.
6. I am hurt quite often, and/or deeply, therefore I must be very bad.

Together, such cognitive reactions to child abuse and attempts to draw logical conclusions from it appear to produce what initially seems illogical: passivity, self-blame and low self-esteem because of being unfairly treated by another. The extent of self-hatred that these dynamics can engender is often startling (Veltkamp & Miller, 1994).

2.5.10. Helplessness

There are two types of responses to the feelings of helplessness that accompanies abuse. The first type of response is a pervasive learned helplessness that extends to all areas of the victim's life; the second is an over investment in control. Perceptions of helplessness and chronic danger are thought to result from the fact that the abuse occurs when the victim is a child, and therefore physically and psychologically unable to resist or defend against the abuser (Wiehe, 1996). Because such experiences are often chronic and ongoing, feelings of hopelessness regarding the future are also likely. As discussed in the abuse dichotomy, the child may have made assumptions about her inherent badness, based on misinterpretation of maltreatment as punishment for unknown transgressions (Bass & Davis, 1986).

The most predictable impact of this dynamic is the victim's growing assumption that she is without recourse or options under a widening variety of circumstances. Not only may child victims come to accept the extent to which avoidance of abuse is beyond their control; they may subsequently generalise this assumption to other, less

uncontrollable, events, and respond accordingly. Chronic exposure to situations wherein one is unable to terminate powerful aversive stimuli is thought to lead to subsequent "learned helplessness" and impaired self-efficacy (Rosenberg & Giberson, 1991).

Powerlessness related to abuse may also present as passivity in the face of danger and self-perceptions of inadequacy and inability to cope with aversive circumstance. This sense of helplessness to stop painful or intrusive events can render the survivor especially vulnerable to revictimisation later in life, and lead her to accept or endure dysfunctional or abusive interpersonal relationships. Similarly, there may be a tendency for some survivors to predict negative outcomes prematurely, leading to avoidance of challenging tasks and subsequent procrastination or underachievement in school, work or other important endeavours (Lyon & de Cruz, 1994).

In contrast to the passivity and impaired self-efficacy, other survivors of child abuse appear to deal with experiences of powerlessness through extreme investment in control. Having learned that abuse is primarily a question of who has power and who does not; some victims grow to view assertion as a primary goal of life. Survivors for whom control is a major issue may impress others as being extremely (and perhaps unnecessarily) individualistic and self-sufficient – to the point that help or support from others is viewed as intrusive or demeaning. This preoccupation with individuation and self-determination may result in isolation and alienation in contexts where intimacy and/or vulnerability are called for (Rosenberg & Giberson, 1991).

2.5.10. Depression

While there has always been consensus that children can experience sad affect, Wicks-Nelson and Israel (1997) state that there has been considerable variation of opinion as to whether or not youngsters experience the full range of affective, somatic, cognitive, and behavioural attributes characteristic of major depression in adults. In order to resolve the issue it has been suggested that it is important to make a distinction between the symptom of depression and the disorder called depression. Several studies have shown the link between physical child abuse and subsequent depressive symptoms (Kenward & Hevey, 1992). The symptom of depression refers to a negative mood state, which consists of the experience of sadness, the loss of

interest or pleasure and the lack of responsiveness (Wicks-Nelson & Israel, 1997). Martin and Beezely (Kenward & Hevey, 1992) found that abused children have an impaired capacity to enjoy life – they often appear sad, preoccupied and listless. As a disorder, depression consists of the symptom of negative mood state accompanied by certain somatic, cognitive, and be havioural problems (Wicks-Nelson & Israel, 1997).

The child's depressive difficulties can relate to feelings of helplessness (Thompson & Rudolph, 1996). A learned helplessness explanation of depression suggests that some individuals, due to their learning histories, come to perceive themselves as having little control of their environment. Helplessness conceptualisations emphasise how the person thinks about activity and outcome – a person's explanatory style. An explanatory style in which one blames oneself for negative events, views the causes of the event as being stable over time and generalisable across situations, is thought to be characteristic of depressed individuals (Wicks-Nelson, 1997). Depressed children suffer from distortions in attributions, self-evaluation, and perceptions of past and present events. They exhibit a more external locus of control (an indication that they feel less capable) resulting from a perceived inability to succeed socially and academically (Thompson & Rudolph, 1996).

2.5.12. Dissociation

Dissociation is defined by Briere (1992) as a defensive disruption in the normally occurring connections among feelings, thoughts, behaviour and memories, consciously or unconsciously invoked in order to reduce psychological distress. Dissociation is an effective method for minimising the effects of trauma and coping with the pain and humiliation. Children cannot physically remove themselves but they can remove themselves psychologically (Walker, 1992).

These dissociative activities ultimately involve a trade-off: the victim sacrifices fully integrated functioning in order to lessen the sometimes overwhelming anxiety and pain associated with complete awareness of traumatic events (Briere, 1992). Although dissociation is functional while the individual is a child, it can become dysfunctional as she grows into adulthood (Walker, 1992).

Briere (1992) identified three types of dissociative behaviours, (that relate specifically to alterations in thoughts, feelings or awareness,) each of which is quite common among abuse survivors: disengagement, detachment/numbing and observation, all of which will be expounded on below.

I. **Disengagement**. Probably the simplest and most common form of dissociation, disengagement involves a cognitive separation of the individual from her environment at times of stress or trauma. This dissociation behaviour consists of withdrawal into a state of affective and cognitive neutrality, where thoughts and awareness of external events are, in a sense, placed on hold. Most periods of disengagement are relatively brief, ranging from seconds to several minutes and the depth of dissociation is usually quite shallow. These time-out periods, although sometimes volitional, frequently occur without conscious intent. In the latter case, the individual may be surprised to hear from others that he or she is inattentive during discussions or other interpersonal interactions (Briere, 1992).

II. **Detachment/Numbing**. This term refers to instances when the dissociating person weakens the intensity of negative feelings associated with certain thoughts, memories or ongoing events so that she can engage in necessary activities without being distracted or immobilised by psychological pain. In its chronic form this numbing process may result in an individual who is psychologically removed from her feelings and who may, in fact, be relatively unaware of feelings per se. When it occurs more acutely, detachment may present as a sudden loss of reactivity to internal or external events that otherwise would produce distress or dysphoria (Briere, 1992).

III. **Observation**. Finally, dissociation referred to as observation occurs when traumatised individuals experience themselves as watching (as opposed to participating in) events in which they are directly involved. In its acute form, observation has much in common with the depersonalisation and out-of-body experiences found in many PTSD sufferers. Chronic observation, however, usually presents as an ingrained tendency to avoid the direct experience of stressful or traumatic events. Abuse survivors utilising this dissociative pattern will frequently describe a feeling of calm that can be traced to a sense of being

"outside looking in" and therefore not directly threatened by potentially frightening or aversive stimuli (Briere, 1992).

2.6. Conclusion

Children from abusive families have typically grown up in a family context that is inconsistent and disorganised, and one that fails to provide appropriate developmental opportunities and stimulation (Salzinger et al., 1993). Children who are subject to a chronic pattern of serious physical abuse live in a highly unpredictable world. They live in fear and have to be continuously vigilant about the moods and reactions of the adults around them (Kenward & Hevey, 1992).

It is being increasingly recognised that children who are exposed to marital violence are also at increased risk of being physically abused by one or both of their parents (Graham-Bermann, 1998). Hughes, Parkinson, and Vargo (Holden, 1998) have graphically labelled this the "double whammy effect". Straus and Gelles (Wolfe, 1999) found that men who reported beating their wives were also more likely to report abusing their children. Cummings (1998) states that interparental violence and violence by parents towards their children are highly correlated. Furthermore, children who witness spousal abuse exhibit adjustment problems similar to those of children who are victims of parental violence themselves (Dale, Davies, Morrison & Waters, 1986).

In short the literature demonstrates both the depth and breadth of the consequences of child abuse. Resulting problems manifest in a variety of forms and can become deeply ingrained in the personality structure of the individual. Without adequate assistance these problems can be both pervasive and pernicious, possibly crossing into future generations. Clearly the therapeutic response to such a condition therefore needs to be sensitive but precise. Interventions in child abuse are of the most delicate in the therapeutic lexicon and are always a challenge to both client and therapist.

Chapter 3 – Child abuse interventions

3.1. Introduction

There are not many intervention programmes available for children and adolescents who have experienced abuse (Lundquist & Hansen, 1998). The need to develop intervention programmes for maltreated children has become increasingly evident in the continuously growing number of child abuse cases (Fontana & Robinson, 1976). Despite the prevalence of developmental, behavioural and emotional problems, the majority of intervention programmes available have either not included or not evaluated child-focused intervention components. Wolfe (1999) suggests that child-centred programmes are less common than parent-oriented interventions largely because parental behaviour is often the primary concern. However, this viewpoint does not consider children that have been removed from their family of origin and placed into out-of-home care.

Kaufman and Rudy (1991) state that abuse survivors' needs are broad based and necessitate comprehensive services and well-designed programmes that are developmentally appropriate, with flexibility to meet each child's particular needs. The therapy of traumatised children and adolescents is often extremely complex and confusing. Sophisticated understanding of both the nature of the psychological effects of trauma and of the therapeutic process of psychotherapy is necessary to design and implement a useful intervention programme (Chu, 1996). Intervention is about helping clients recover from the emotional pain they are experiencing because of their maltreatment (Wiehe, 1996).

Although the intervention of severely traumatised clients requires sophisticated understanding and interventions, the basic tenets of therapy are nevertheless still applicable to these clients. In particular the provision of a safe and containing environment is of central importance. Without a sense of safety in both the therapeutic relationship and the client's outside life, little can be accomplished. As clients are able to experience themselves in a safe environment they are able to move forward and progress in their intervention (Chu, 1996). Walker (1992) notes the significance of the initial contact made by the client with the therapist. Experience of trustworthy relationships is often limited or non-existent and relating well to another person in any

depth or for any length of time may be an unknown experience. The process of therapy implies that they have to trust someone sufficiently to talk about what has previously been a forbidden subject without being betrayed.

Abuse invades the boundaries of the body and the self. Making the boundaries clear can help make therapy a safer place. Knowing that they will be seen on a regular basis for the same amount of time, gives the client some security and predictability. Neither caring nor predictable behaviour has been part of the abused person's experience, and it is important that the therapist establishes both within the therapeutic framework (Walker, 1992). Therapists need to be clear about their own boundaries and to communicate these to clients. Many of those who have been abused experience a morass of feelings that are chaotic and overwhelming (Walker, 1992). External boundaries that are safe, clearly understood from both sides and that do not collapse when faced with challenge, begin to act as a counterbalance to the chaos, as well as reflecting an alternative model of behaviour.

The client needs assurance that they can proceed at a pace that is comfortable and that there will be no pressure to disclose anything that cannot yet be tolerated. A constant dilemma in working with abuse survivors is how to avoid becoming yet another person who invades while also not ignoring or denying the realities of the abuse, as many others have done (Shelton, 1982). The development of trust is central to the process. Those who have been abused have grown up in a world that has proved itself extremely untrustworthy and therefore the development of trust is not simple. Abuse has meant the complete disregard of privacy in a most exploitative and invasive manner. It is essential to ensure confidentiality. If trust is to develop, clients need to feel that they are taken seriously, and that what they say is accepted and believed.

Careful, empathic listening and a calm supportive presence are critical. Clients may in part feel very committed, but in part very doubtful. Therapy is a painful process and needs to be openly recognised as such. Mixed feelings are almost inevitable; they need to be identified and accepted (Walker, 1992). As trust in the therapist develops, more details of the abuse are likely to be remembered and reported. If memories have been repressed, their return can induce powerful, conflicting and unpredictable feelings. Some memories occur as flashbacks, which are terrifying in their immediacy

(Kaplan & Sadock, 1998).

The psychotherapeutic process is a powerful interpersonal tool, capable of enabling both positive therapeutic growth and psychological harm. Therapists must take seriously the potential of the psychotherapeutic process to harm clients. For example, therapists must avoid collusion with client's ingrained debased sense of self and should help clients limit unending repetitions of reenactments of abusive relatedness. Well conceived psychotherapeutic efforts can have dramatic and positive effects. Such intervention offers abuse survivors new hope, and many clients are able to move forward and substantially improve their lives (Chu, 1996).

3.2. Survivors of abuse

A central aspect of therapy focused on abuse is the recognition that adults or adolescents abused as children are survivors – individuals who have persevered despite often extreme childhood trauma and later abuse-related difficulties. This appreciation of the strength (rather than pathology) implicit in survivorhood underlies much of the philosophy of intervention in this area, primarily in terms of the respectful stance required by the therapist (Kaufman & Rudy, 1991).

This type of therapy suggests that the client is not mentally ill or suffering from a defect, but rather is an individual whose life has been shaped, in part, by ongoing adaptation to a toxic environment (Shelton, 1982). Therefore the goal of therapy is less the survivor's recovery than her continued growth and development – an approach that utilises the survivor's already existing skills to move beyond her current level of adaptive functioning.

This approach aims for survival at a new level, for an even better survival. The job of the client is to go back to frightening thoughts and images of her childhood and to update her experience of herself and the world. The therapist's job is to engineer an environment where the client can do this important work and to provide the safety and respect that the client deserves in the sessions.

3.3. Symptoms and defences

Implicit in this abuse perspective is the notion that what some see as dysfunctional survivor behaviour is usually the logical and psychological extension of survivors' childhood experiences: reflective of their accommodations to early victimisation and/or their responses to later abuse-related distress. There are several clinical implications of this perspective (Berliner, 1991).

1. Because such behaviour is or was adaptive, it is inherently pragmatic rather than symptomatic. In other words, the behaviours in question are not passive symptoms of some greater disturbance, but instead usually reflect the client's ongoing attempts to cope and respond to the environment as effectively as possible. The dysfunctional component of such behaviour thus rests not in its form, but rather in the abuse-related assumptions or perceptions that motivate its appearance and the internal states that support it. Therefore the goal of therapy ceases to be solely the removal of any given set of symptoms, but also the updating of abuse-distorted assumptions and the resolution of abuse-related trauma (Briere & Runtz, 1987).
2. Because such behaviour serves a psychological purpose, the survivor does not easily give it up. Awareness of the functionality of many survivor behaviours therefore may protect the therapist from unnecessary preoccupation with client resistance or from wasting time trying somehow to convince the survivor of the illogic of her behaviour. Instead, the therapist avoids what the former abuse victim views as anti-survival suggestions or admonition in the absence of either (a) a change in whatever is addressed by the behaviour or (b) new, more effective coping strategies (Briere, 1989).
3. The therapist can be informed by "symptomatic" client activities. They offer data regarding both (a) what the survivor's early life must have been like, such that the behaviours in question were logical adaptive responses, and (b) what the client's current experience must be, such that she engages in these early behaviours now (Berliner, 1991). It is often only through a true appreciation of the client's immediate motivation for seemingly dysfunctional behaviour that the therapist can truly understand the survivor's day-to-day experience without pathologising it.

Ultimately, the therapist's understanding of the defensive and adaptive aspects of symptomatic behaviour allows her to identify more clearly the underlying cognitive

and affective events of the client's childhood history, and therefore to envision more accurately the actual targets of intervention. Without such a view, therapy may easily become misdirected toward superficial outcomes and/or inappropriate goals (Bass & Davis, 1986).

3.4. Conclusion

The aim of intervention for abuse survivors should be an integrated awareness of the present and the past, of previously split-off or compartmentalised internal experiences. This focus requires the client to approach a state that she has spent much of her life avoiding. Through dissociation, avoidance, denial and other defensive strategies, the survivor reduces any pain related to the abuse – primarily by disintegrating and narrowing conscious awareness (Shelton, 1982).

The therapy for abuse survivors endorses an entirely different set of principles. It assumes that greater awareness of the past and present allows the survivor to discover and address the basis of her discontent. It further assumes that this process in some sense reworks the client's early reactions to trauma by providing adult-level insight into the "whys" and "whats" of the victimisation, as opposed to the retained cognitive reactions and impressions of an injured child (Berliner, 1991). This understanding promotes the survivor's developing self-acceptance, and assists in her rejection of the myth of personal badness. Additionally, the therapeutic re-experiencing of previously dissociated traumatic events without significant dissociation provides the survivor with an important opportunity to process abuse-relevant affects and to develop a new relationship to her internal experience (Briere, 1989).

From the client's perspective, therapy is not necessarily a straightforward process of learning and understanding. Instead, it often represents an ongoing, distressing contradiction that implies giving up her defences and survival strategies to confront painful memories and their implications, in order to survive better and hurt less. Given this perspective, the therapist may better understand client resistance or acting out as, instead, the client's sometimes desperate reliance on previously effective coping strategies in the face of a very frightening process – attempts, in fact, to survive therapy psychologically (Lutzker, 1998).

In light of the seemingly dangerous expectations and goals of psychotherapy, the client's willingness to continue intervention and somehow trust the therapy process is an act of extraordinary bravery. The therapist should directly acknowledge this courage. Such recognition not only reassures the client that the clinician is aware of the arduousness of the therapy process for the survivor, but also helps the clinician to develop and maintain the respect and supportiveness required of those who work with former child abuse victims (Bass & Davis, 1986).

Chapter 4 - Ego states: theory and therapy

4.1. Introduction

According to Watkins and Watkins (1996), human personality develops through two basic processes, namely differentiation and integration. These processes operate both concurrently and intermittently. Through integration a child learns to put together concepts such as dog, cat, rabbit and horse and therefore build units that are more complex called "animals". By differentiation, she separates general concepts into more specific meanings, such as learning to distinguish between a cat and a rabbit (Watkins, 1993). Therefore, the child, by refining these concepts, develops more adaptive control of the environment. As integration may be considered a "putting-together" process, differentiation may be called a "separating" process. Through putting together and separating human behaviour, an experience evolves. Both processes are normal and adaptive (Hartman, 1995). Normal differentiation permits individuals to experience one set of behaviours at a party and another at the office. Differentiation is adaptive, and some separation of personality segments should make for better personality functioning. This separating or differentiating process is called dissociation (Watkins & Watkins, 1990).

4.2. Dissociation

Watkins (1993) states that most psychological processes lie on a continuum of lesser or greater degrees of intensity, for example, anxiety is generally adaptive in its lesser intensities. As it increases, it tends to become more maladaptive and finally can become completely incapacitating to the individual. This is also applicable to dissociation. Braun, Bernstein and Putnam (Chu, 1996) and others have proposed the concept of a dissociative continuum with dissociative experiences ranging from normal to pathological. Dissociative identity disorder (DID) only represents the extreme and maladaptive end of the continuum that starts with normal differentiation (Watkins & Watkins, 1996).

In the dissociation continuum, normal and neurotic ego states lie between simple adaptive differentiation at the one extreme and the severe dissociation of true dissociative identity at the other (see Figure 4.1.). The variable here is the rigidity or permeability of the separating boundaries. Normal separations in everyday life are

exemplified by patterns of behaviour and experience resulting in the average person's function being different while at work or during periods of recreation (Watkins & Watkins, 1996). At the left-hand of the continuum is normal dissociation, as represented when daydreaming, absorption in a book or a movie and normal childhood imaginative play. Next, come more pathological forms of dissociative and trance-state phenomena, such as highway hypnosis, which are not freestanding psychiatric disorders. Further to the right lie dissociative disorders of increasing complexity, chronicity and severity related to more extreme trauma (Ross, 1996).

Watkins (1979) describes dissociation as a defensive process in normal individuals, which reduces anxiety by keeping apart cognitively dissonant elements. Only in its extreme form is it manifested as a true dissociative identity disorder in which case normal adaptive differentiation has changed into maladaptive dissociation (Hartman, 1995). With maladaptive dissociation the boundaries between two or more ego states becomes rigid and impermeable, thus preventing communication. Therefore Watkins and Watkins (1993) believe that people must be considered as "multiplicities" even though these entities remain unconscious and do not overtly appear as in cases of DID (Hartman, 1995).

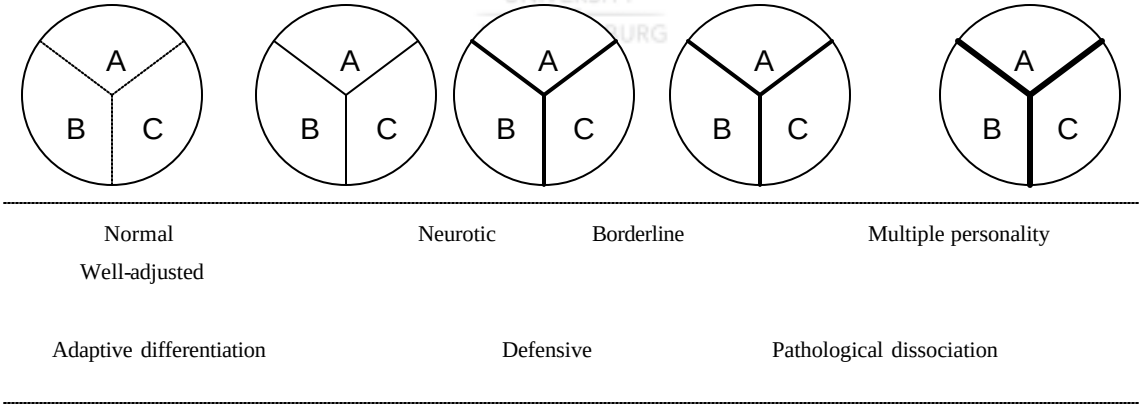

Figure 4.1. Differentiation-dissociation continuum

4.2.1. Dissociative identity disorder

As adaptation to everyday problems of life become more complex and stressful, the separating boundaries between incompatible states become less permeable in order to minimise conflicts between incompatible states, which would cause increased anxiety. In the lower intermediate area, characterised in Fig. 4.1. as "defensive", one finds

processes like rationalisation, compensation, reaction formation and other neurotic defense mechanisms. These involve partial shielding of the individual from the conflictual consequences of direct contact with unacceptable elements in mental life, such as the unwillingness to assume responsibility or guilt for misbehaviour. These mechanisms are adaptive in the sense that they keep the individual freer from stress. These mechanisms are considered to be more immature and can be a step in the direction of less-adaptive behaviours. The extreme of this continuum is reached when the boundaries are so rigid and impermeable that there is little or no interaction between states. If the dissociation is complete, the individual, when ego state A is executive, is not conscious of the behaviours and experiences that occurred when B is executive. There is then broad amnesia for these events, and a dissociative identity disorder is manifested.

Ego states, therefore, can be normal, adaptive, defensive, or dissociative, depending on the permeability of their separating boundaries. This permeability or rigidity having been influenced by the severity of internal conflicts and the individual's perception of her need to escape mental "pain". There can be many degrees of dissociation. In some cases, the different personalities do not know that each other exist. Each is aware only that there are blank periods in its existence, time that cannot be accounted for. Here, the boundaries between the two personalities are so rigid and impermeable that there is no penetration. One ego state has no access to behaviours and experiences in the other and is unconscious of the existence of the other (Watkins & Watkins, 1979).

The core phenomenology of DID is the existence of distinct personality states that take turns being in executive control of the body and are separated by varying degrees of amnesia (Ross, 1996). The secondary features include such items as periods of missing time; coming out of blank spells in unfamiliar surroundings, unsure of how one got there; being told of disremembered events; finding objects in the environment that cannot be accounted for; distinct changes of handwriting; referring to oneself as "we" or "us"; and auditory hallucinations. The secondary features each exist on a spectrum from normal to severe forms increasingly specific for DID. For instance, internal dialogues and monologues are part of common experience, but a fully ego-

alien voice shouting out commands inside one's head intermittently is outside the range of normal experience (Ross, 1996).

In other cases of dissociation, there is a one-way awareness. Personality (A) is aware of the existence of Personality (B), but (B) is not aware of (A). There are other cases in which the two (or more) states know of each other's existence but treat the other as object, not subject (Watkins, 1978a). It is important to note that these cases only represent the extreme on a continuum of personality organisation. In other words, many people, who are considered within the normal range of functioning, may have comparable divisions within their egos or segments of self but these are not separated by boundaries that are as rigid and impermeable (Douglass & Watkins, 1994).

4.2.2. Dissociation in relation to childhood abuse

During the past two decades, there has been an increasing interest in the psychological process of dissociation, its role in psychosomatic symptoms, maladaptive behaviour, and methods of treating it. However, the focus was largely on its severe ramifications evidenced in amnesia and DID, which is a severe maladjustment in which the personality clearly fragments in gross ways that are overt and quite observable (Hartman, 1995). Such a focus has resulted in an emphasis on its pathological effects as found in severe mental illness and to the neglect of its more normal manifestations as an adaptive defense. This more normal aspect of dissociation is demonstrated in many behavioural, adjustment problems and in various neurotic and psychosomatic reactions (Watkins & Watkins, 1996).

Clinicians in the dissociative disorder field regard DID as the paradigmatic example of the psychological response to severe, chronic childhood trauma. They view DID as exhibiting the relationship between trauma and all types of symptomatology through its primary and secondary features and comorbidity. This suggests that DID clients are the extreme cases illustrating general principles of the trauma response (Ross, 1996). There are many similarities between DID clients and other child abuse survivors. In early studies of DID, the finding of childhood abuse was nearly universal, leading investigators to propose a link between dissociative symptoms and early trauma. Some investigators, who investigated the effects of psychic trauma on children, proposed a model in which dissociation is "learned" by children as a way of

escaping overwhelming experiences (Chu, 1996). This mechanism may begin as a conscious attempt at self-hypnosis, but eventually becomes an automatic and uncontrollable response to trauma or stimulus associated with trauma. Similarities in family characteristics, victim symptoms, and community response indicate that dissociative disorder clients may represent some of the more severely abused and severely symptomatic on a continuum of survivors of child abuse (Goodwin & Sachs, 1996).

Dissociation enables such events to be "forgotten", or at least emotionally distanced (Chu, 1996), as several studies have demonstrated, extensive childhood abuse before adolescence frequently results in either partial or complete amnesia for the abusive events. Not remembering abuse does not free persons from reexperiencing aspects of the abuse. Instead, many survivors of childhood abuse are frequently tormented by intensely dysphoric feelings such as helplessness, depression, anger and isolation that are connected to the forgotten abuse. Children who have been physically abused often dissociate from their feelings and from the memory of their abusive experience to cope with the traumatic event. The abused child learns quickly that the expression of anger towards the abusers only results in more abuse. Accordingly, the child dissociates the anger and trauma, which means the ego splits in such a way that the feelings of pain, guilt, fear, confusion and powerlessness are separated from the thinking self in order to survive the traumatic experience. If early dissociations are effective in adjusting to an abusive and punishing home environment, more dissociations or segmentations may occur (Grove, 1995). Although dissociation is initially helpful because it enables the individual to live without constantly feeling the emotional pain and fear which is usually a natural reaction to abuse, it eventually impedes growth and becomes a destructive force within the individual. In other words, what started out as a survival strategy, can become a desperate and often self-destructive lifestyle.

4.3. The concept of ego states

An ego state may be defined as an organised system of behaviour and experience whose elements are bound together by some common principle, and differentiated from another by more or less permeable boundaries (Watkins, 1993). Ego states constitute a kind of "subself" which has more or less individual autonomy in relation

to other states and to the entire personality. For the purposes of adaptation, these ego states that represent different cognitions, perceptions, affects, and behaviours are partially dissociated from each other. The separation between the various ego states occurs due to the mechanism of dissociation that can be very mild, whereby there is a very flexible boundary between the various ego states (Torem, 1987).

Ego state theory is an extension of the principles and findings that have been noted in the severe maladjustments of DID. The ego state theory of Watkins and Watkins (1996) stems from writings by Paul Federn and his associate Edoardo Weiss, whose concepts they have elaborated and developed further. Federn was the first to formulate the concept of ego states as an organised entity of the ego (Torem, 1987). According to Watkins (1992), ego state theory provides a model in which the self is conceptualised as a family of ego states designed to provide the most adaptive behaviour in a variety of different and changing contexts in day-to-day living. Ego states are thought of as existing as a family of subselves that can function well, or like many families, have varying degrees of dysfunction. When there is dissension or a gross lack of cooperation, pathology occurs (Frederick & Phillips, 1995).

As the personality develops from birth (and even before) psychological aspects such as behaviours, experiences, feelings, ideas, memories, attitudes and response potentials are not stored in a random fashion within the brain. Rather they are organised into patterns, large and small, according to the relatedness of their function. These states act in many ways like separate individuals, composed as they are of "part person" responses. In their pure form they become spontaneously manifest in dissociated personalities (Gainer & Torem, 1993). However, they can be similarly activated within the hypnotic modality.

As the separating boundaries become more rigid and impermeable, the states become more overt and pathological, the extreme degree of which constitutes true multiple personalities. The existence of these states at covert as well as overt levels has been verified through many research and clinical studies (Hartman, 1995). People do not think, feel, observe or act the same way all the time. Different response patterns, however, do not only result from different precipitating conditions, but also from different internal feelings, motivations and cognitions within the individual.

Sometimes external conditions provoke different responses within the individual because a different personality "segment" or "part" has been activated and has become "executive" or "dominant" within the person. When one has been activated it is known as the "executive" which is sensed in the here and now. All items within it are potentially available to the present experience (Phillips, 1993).

According to the ego state theory human personality is not a unity (although it is usually experienced as such), but it is separated into various, unique entities that serve different purposes. An ego state is an organised system that presents a coherent pattern, which may represent an age or relationship in the individual's life (Watkins & Watkins, 1997).

There are many ways of conceptualising ego states. There may be a core ego, which contains a number of behavioural and experiential items that are more or less constant in the normal individual. This core ego presents to the individual and to the world a consistent determination of the way she and others perceive her "self". The boundaries of this core ego are not rigid and can be expanded or contracted to include more or less psychological material (Watkins, 1971). The other ego states may have more specifically defined boundaries. They may be considered as segments of self that were differentiated for adaptive purposes in the course of normal development. Some may also represent introjects from significant others, or may have been split off from the core ego because of a trauma. When the boundaries of such an ego state are relatively permeable, and not rigid, it is seen as a normally adaptive entity, serving as a defense for the individual going through the trauma. When the boundaries become rigid and impermeable it is termed dissociated, which, as discussed, may in its extreme form may become the alter of a multiple personality (Torem, 1987).

Watkins and Watkins (1997) suggest that ego states develop by one or more of the following three processes: normal differentiation, introjection of significant others and reactions to trauma. Through normal differentiation, the child learns, for example, to discriminate between people who are friendly and those who are not. She not only makes such simple discriminations, but also develops entire patterns of behaviour that are appropriate for dealing with friendly people (for example). This allows the individual to focus on each particular daily situation adaptively with minimal

interference from nonrelevant elements of the personality (Torem, 1987). These changes are considered quite normal, yet they do represent syndromes of behaviour and experiences that are clustered and organised under some common principle. As such, they can be considered ego states (Phillips, 1993).

The boundaries between these entities and other personality patterns are very flexible and permeable. The child in school is quite aware of herself in a playground situation. Playground behaviours, however, are not as easily activated when at the school desk. She is now in a different ego state, and there is resistance at the boundaries. These less-clearly differentiated ego states are usually adaptive and are economic in providing appropriate behaviour patterns when needed (Watkins & Watkins, 1996).

Through the introjection of significant others the child erects patterns of behaviour, which if ego-cathected become roles that she herself experiences and if object-cathected represent inner objects with whom she must relate and interact. For example, if a girl introjects a punishing parent, she may be constantly depressed as she tries to cope inwardly and covertly with a continuation of the accusations and abuse originally heaped on her by the real parent. However, if she ego-cathects this state (e.g. infuses it with self-energy), she will not suffer, but she will abuse her own child. She has identified with her bad parent. She not only introjects the abusing parent, but also introjects the drama of the original parent-child conflict (Watkins, 1993).

Finally, as discussed above, some ego states may arise as adaptive responses to trauma (Frederick & Phillips, 1995). When confronted with overwhelming trauma, rejection, or abuse the child may dissociate. Ego states become more sharply differentiated from one another as the separating boundaries become increasingly less permeable (Watkins, 1993).

4.3.1. Characteristics of ego states

To understand and deal with ego states one must consider their origin. Often they were first created when the individual was quite young. Accordingly, they think concretely like a child. Adult logic may not reachthem, although they often talk in an adult voice. It is as if they were frozen in time. Most adults have lost the ability to

think concretely like a child, and therefore we are at a disadvantage in dealing with child ego states (Watkins & Watkins, 1997).

A common characteristic of ego states is, although they are capable of growth and change, they may often be fixated at the time of their creation. Therefore, a 5-year-old ego state, which was developed by a child at that age perhaps to deal with a traumatic event, may talk and act with the concrete "paralogic" typical of a 5-year-old. Understanding this point can be of great significance when a therapist is dealing with it. To resonate well with this state, the clinician needs to be able to use a child's terminology and logic.

The therapist should be aware that the child ego state was formed to adapt to the conditions of previous experiences and that it's attempts to function today often result in maladaption. Watkins and Watkins (1997) state that it was developed to enhance the individual's ability to adapt and cope with a specific problem or situation. One ego state may have taken over the overt, executive position when dealing with parents and another on the playground.

Another common trait is that once created, ego states are highly motivated to protect and continue their existence. It is much easier to modify the motivations of ego states and change their behaviour constructively than it is to attempt their total elimination. A related corollary to this persistence is to realise that the original ego state came into being to protect and facilitate the adaptation of the primary person. It remained because it had a certain amount of success. Behaviour modification means that it was positively reinforced, first for coming into existence, then for continuing its being. The fact that it is efforts may now be counterproductive is irrelevant, as its earlier conditionings will hold precedence (Watkins & Watkins, 1997).

4.4. Definition of ego state therapy

According to Watkins (1992), ego state therapy is an intervention modality based on an eclectic-psychoanalytic approach and can be regarded as a sophisticated form of hypnoanalysis. It is aimed at conflict resolution and may employ any of the directive, behavioural, psychoanalytic, supportive, existential, and even relaxation or biofeedback techniques of therapy. It is based on ego state theory and derived from

both Watkins and Watkins's (1990) therapy with true DID cases and from research with normal volunteers.

Ego state therapy is the utilisation of individual, family and group therapy techniques for the resolution of conflicts between the different ego states that constitute a "family of self" within a single individual (Watkins, 1993). Any technique that can be used with an individual client during therapy can also be used with an ego state (e.g. regression, abreaction, ego strengthening and desensitisation) (Watkins, 1992).

Ego state therapy is indicated for clients who are sufficiently motivated, are moderately to highly hypnotisable, and present with clearly circumscribed symptoms which are usually also related to a specific trauma. The therapist should be guided by available clinical case studies and clinical outcome research in deciding whether to include ego state therapy in the intervention plan for a particular client (Hartman, 1995).

4.4.1. Goals of ego state therapy

This mode of therapy is concerned with the notion of how much the individual's behaviour is the result of dissociated ego states that have rigid, nonflexible boundaries. The therapeutic goal of ego state therapy is to attain peace among ego states so that they become an integrated internal family, wherein the needs of each ego state are met, and contribute to the adjustment of the person as a whole. The application of these techniques is directed towards the ego states and not towards the whole individual (Watkins, 1993).

Ego state therapy may be regarded as a form of internal diplomacy. It has been found useful in treating a wide variety of problems ranging from habit disorders, obesity, smoking cessation, anxieties, phobias, conversion disorders, psychosomatic disorders and also in treating dissociative pathology, as DID. There is now a substantial body of clinical and research studies that have demonstrated the effectiveness and increased efficiency of ego state therapy in the treatment of many normal and neurotic disorders (Watkins & Watkins, 1990). In ego state therapy, the relevant ego states and the interpersonal relationships between them are each activated and studied. Their influence on the entire individual is then evaluated, after which appropriate

therapeutic interventions are taken. The goal is therefore to decrease the individual's tendency to dissociate.

The client who dissociates and experiences these changes as "mood swings", "states of confusion", or "lost time" develops an awareness of her condition. With the use of ego state therapy, the confusion is replaced with a greater clarity and understanding, and a sense of self-mastery (Torem, 1987). The goal of ego state therapy is not total fusion of all the ego states into one fully "fused" ego, but rather integration. Integration refers to increased permeability of ego state boundaries and improved internal harmony resulting in better cooperation and congruence among the various ego states (Watkins, 1992).

The goal is to move the client back along the continuum by reducing rigidity of the state boundaries, lessening conflicts between ego states, internally meeting the needs of each state, and promoting mutual understanding through inter-state communication (Watkins & Watkins, 1990). The therapist does not need to struggle with that resistance that the various ego states exhibit to maintain their identity and existence, a separateness that may originally have been incurred by attempts at normal, adaptive differentiation. Original needs are recognised but turned into constructive directions. By not challenging their unique identity but by increasing the communication of ego states with each other, we encourage an adaptive togetherness (Watkins, 1993).

It should be noted that it could be fatal to therapy to suggest that some ego state should be eliminated (Watkins & Watkins, 1996). Some ego states may be maladaptive; however, the strategy is not to eliminate any ego state even if it is responsible for maladaptive behaviour. Instead the strategy is to promote more adaptive behaviour by providing the dissociated ego state with a broader perspective and greater insight through improved access to the additional ego resources (Gainer & Torem, 1993).

4.4.2. Personality as a multiplicity

Paul Federn made two significant contributions that are relevant to the understanding of personality. First, he believed that whether a physical or mental process was experienced as a part of the self (I or me) or as an object (he, she or it) was

determined by the nature of the energy (ego or object) activated. Second, Federn believed that personality was not simply a collection of perceptions, cognitions and affects, but that these were organised into clusters or patterns, which he called “ego states” (Watkins, 1993).

A state is activated or made “executive” by its investment with ego energy, “I energy”, selfness. It is then experienced, and all its respective items become available to the person. It is “the self” in “the now” (Watkins, 1978b). There is therefore, within each state a common jurisdiction. Once that jurisdiction is activated all items within it become part of the present self (Watkins, 1976). Therefore, when an ego state is activated, it views itself as the subject “I” and experiences other ego states and the rest of the individual as an object “she”, “he”, or “it” because they are currently invested with object energy (Torem, 1987).

Recent research on personality has proposed several theories of “multiplicity” as opposed to the view that personality is a unity. The basic tenet of these theories is that multiplicity is a normal organisational principle of the human psyche. In this approach, the client is treated as a multiplicity whose personality segments can become activated (made overt) by hypnosis. This is done because ego states, unlike true multiple personality alters, do not usually become overt spontaneously but they require hypnotic activation most of the time (Phillips & Frederick, 1995).

There are many conscious part selves (multiplicities) in the human mind, outside the awareness of the overt self. These part selves function with relative autonomy, are capable of rational cognition and can even make decisions about reality. Hartman (1995) in congruence with Watkins and Watkins postulates that part selves are at some level overt or covert and that dealing with them as unities is inefficient. Internal personality segments or ego states represent bodies of functions that have been developed for the better adjustment and in some cases even for the purpose of survival of the individual.

Since an ego state consists of those behaviours, perceptions and experiences that are bound together by some common principle and separated by a boundary from other such states, an ego state may be large or small. It may extend over a substantial part of

an individual's living, such as his relationships with parent figures, or it may represent a single moment in time, such as a traumatic experience (Watkins & Watkins, 1980). They may represent current modes of behaviour and experience, or, as in the case of hypnotic regression, include many memories, postures and feelings that were apparently learned at an earlier age. Ego states exist in different dimensions. A single item may be common to several. For example, a fight with a sister may be part of a "relationship-with-sister" ego state; it can also be part of a nine-year-old ego state (Watkins & Watkins, 1979).

Ego states are activated hypnotically and usually communicate through the speech of the hypnotised subject or as internally visualised figures. Some ego states may need to undergo a certain amount of maturation to achieve therapeutic goals. Like individual clients, individual ego states can also communicate in other ways such as with symbolic, sensory, and motor signals as well as through other complex affective and physical manifestations, which may not be recognised (Frederick & Phillips, 1995).

4.4.3. Communication between ego states

Ego states can be activated by the use of hypnotic and non-hypnotic techniques. Communicating with the ego state responsible for the client's maladaptive behaviour is done to identify that specific ego state and to allow that ego state a new form of communication using words in a written or spoken form. In doing so, it is important to follow the principle of separating the intention from the actual behaviour. This opens a deeper level of choice for the desired change to take place. The original intention of the behaviour is reviewed and understood as an adaptive form in a special context in one's past associated with stress or trauma. The persistence of such behaviour in the present becomes maladaptive due to a changed set of circumstances in a new context of reality in the present. The communication with the hidden ego states moves towards taking on new alternative behaviours of higher adaptive quality to replace older behaviours while maintaining the original intention for adaptability and survival (Torem, 1993).

It takes special skills and creativity in communicating, negotiating, mediating, and persuading resistant ego states to change their behaviour. Accent is put on remembering one's original intention of acting for the sake of survival. No ego state

exists in a vacuum, it is part of a whole system, and behaviour by any ego state must take into account the consequences on other ego states and on the whole person (Torem, 1993).

4.4.4. Conflict resolution

Ego states can function together in relative harmony. Component ego states within any given person may be cooperative, integrated, and interacting. Alternatively, they may be warring, dissonant with each other, and pushing for contradictory goals (Watkins, 1976). Ego states that are cognitively dissonant from one another or have contradictory goals do frequently develop conflicts with each other. This may create severe internal conflict, which mostly appears between covert ego states. These may be manifested by anxiety, depression, or any number of neurotic symptoms and maladaptive behaviours. For example, obesity often results from pressures on the executive personality by a disgruntled, covert ego state (Watkins & Watkins, 1979). When the boundaries between ego states are relatively nonpermeable then disharmony may occur whereby one ego state gets involved in actions and behaviours which may be in conflict with other ego states or the entire individual. In this case ego states function with relatively high autonomy and with little consideration for the needs of the entire individual (Torem, 1987). If they are highly energised and have rigid, impermeable boundaries, multiple personalities develop.

Conflict between ego states has been commonly postulated as being at the basis of neurotic symptoms. The traditional formulation is to consider it as a struggle between two sets of needs, or between socialised and antisocial motivations. It could equally be considered as a conflict between two different incompatible ego states, each trying to become dominant. Such conflicts require an internal diplomacy not unlike what is done when treating true multiple personalities. However, since the contending ego states do not spontaneously appear overtly, they must generally be activated through hypnosis (Watkins & Watkins, 1996). Disagreements are resolved through internal dialogue, mutual recognition of various conflicting needs, interests, and desires and finally a decision is made through compromise with recognition of the demands and limitations of reality and the possible consequences of future behaviour (Torem, 1987).

4.4.5. Communication with ego states using hypnosis

There are many ways to contact ego states. A simple method is to hypnotise the client, either with a formal induction, progressive relaxation or imagery (Watkins, 1993). The most direct way is to hypnotise the client and ask if there is a part that feels different from the main personality, or that feels an emotion the therapist knows is counter to what the client feels in the waking state. In other words, the purpose is to find out if there is a part of the personality that is in conflict with other parts, and which is available under hypnosis. The first time this is done, it is important to add a disclaimer, to the effect that if there is no such separate part it is okay. This is to avoid producing an artifact. It is possible for a very good hypnotic subject to produce whatever she thinks the therapist may want (Watkins, 1993). However, an artifact will not usually last or produce meaningful results.

Another method of contacting an ego state, after the initial hypnotic induction, is to suggest descending plush-covered stairs together with the therapist. At the bottom of the stairs, it is worthwhile to suggest a room with a couch and a chair and "other furniture". The therapist suggests that the client will sit on the couch while the therapist will sit on the chair. The therapist anticipates that several ego states might enter the scene. That anticipation will depend on knowledge gained from previous sessions. Once the setting in the hallucinated room has been established the therapist can evoke an ego state if one or more are available at this point in therapy (Watkins, 1993).

If the client reports seeing nothing, a separate ego state may still exist. It may mean one is not sufficiently formed to be a separate vocal or visual entity, because the segments of the personality are very permeable. Alternatively, it could be that no one is willing to make an appearance at this time. The therapist needs to separate out only those ego states pertinent to a given problem the client wants to resolve. Sometimes there is initial resistance to communicate verbally. If this happens options are given to communicate either in writing or through the host ego state, and assurance is given that each ego state will be treated with respect and dignity (Torem, 1993).

Hypnosis – itself a form of controlled dissociation – is the modality within which the intervention strategy of ego state therapy has been most speedily carried out.

However, practitioners not skilled in hypnotherapy (Watkins & Watkins, 1996) can use a non-hypnotic technique of ego state therapy, for example inducing a semi-hypnotic trance through the use of relaxation methods. Hypnosis is both a focusing and dissociative process. Through hypnosis the therapist and client can focus on one segment of personality and temporarily dissociate away other parts (Watkins, 1993).

Janet (Watkins & Watkins, 1990) initially recognised the close relationship of hypnosis to dissociation, and recent clinical and experimental studies with DID have reported that such cases are characterised by high hypnotisability. In fact, the disorder has been defined by some as one of "spontaneous hypnosis" (Watkins & Watkins, 1990). In other words, when confronted by more pain, guilt and rage than they can tolerate, abused children may dissociate this mental "hazardous waste" into multiple personalities to protect themselves from the pain of the abusive experience. The original and primary personality now no longer feels misery. The mechanism when initially employed is adaptive and helped the child cope with an overwhelmingly hostile social environment.

Working hypnotically with clients suffering from DID, Watkins and Watkins (1979) discovered that ego states behaved like "covert" multiple personalities. The ego states demonstrated behavioural and experiential content and when interviewed under hypnosis, reported individual self-identity.

Although most experts believe that hypnosis is characterised by an altered state of consciousness, it has eluded a single, simple definition. The trance state affords greater accessibility to the client's inner world, vivid fantasies, personally meaningful memories and intense emotions, which spontaneously emerge and increasingly colour the interaction. With a sensitive and respectful therapist, the client learns to trust and respect, on which a strong therapeutic alliance is built (Hartman, 1995).

If the therapist is skillful in inducing hypnosis and offers the client a series of successful experiences without challenge or feeling vulnerable, then trusts develops in the relationship. Trust also grows if the therapist fosters an atmosphere in which much of the experience emerges from the client's own inner resources, rather than from a preconception imposed by the therapist.

4.5. Techniques of ego state therapy

4.5.1. Building trust

The first and most important task for the therapist, and a "must" before undertaking serious therapeutic work, is the establishing of trust. All behaviour, whether verbal or nonverbal, is scanned by the client, especially by those who experienced abuse as children (Grove, 1995).

It is understandable that ego states might resist engaging with the therapist in an attempt to maintain a system that has been in operation for many years. They have much at stake to maintain the status quo, even if the system is damaging to psyche or soma (Phillips & Frederick, 1995).

When activating an ego state, it needs to be treated with courtesy, even if the thinking seems naïve or preposterous to the therapist. An ego state is not a thing or a process. It is a part-person, and as such, it wants to be accorded the dignity of being heard with respect (McNeal & Frederick, 1993).

Good relationships therefore need to be established with each state including the malevolent ones. Malevolent ones are often protective in their origin. Initially, they were adaptive, at least temporarily. In working with such a state, it becomes essential to underscore its protective function. Perhaps then a change to more benevolent behaviour is possible (Phillips & Frederick, 1995).

States introjected in childhood and those resulting from childhood trauma think concretely and literally like children. A concrete thinking pattern is essential when working with ego states. The child who has been traumatised through abuse dissociates part of herself, remains as a child ego state within the adult, and continues to think as she did during the trauma (Watkins, 1993). Time stands still for this ego state and therefore it needs to learn more constructive behaviours in order to protect the entire personality.

4.5.2. Diagnostic exploration

After the client and therapist have identified the presence of an ego state(s), it is time

to become acquainted. The therapist needs to ask for:

1. Its age and origin: “How old was (name of client) when you came to be?” If a specific age is given then the therapist asks, “What was happening at that time?” The specific age gives a clue to a possible trauma that might be abreacted at a future session.
2. It’s name: “What name would you like me to call you?” If it resists a name, then “is it all right if I call you by the age you gave me?” Since the ego state has appeared it makes sense that it wants to be heard. If the therapist expresses interest in the opinions of the ego state, then that state is most likely to agree to a word that will bring it forth under hypnosis. Persons want to be heard, even part-persons.
3. Its needs: “What needs do you have?” or more indirectly, “What do you want (name of client) to do?” The satisfaction of needs is vital in ego state therapy. By satisfying needs, co-operation can be established. Needs are normal, but the internal behaviour to achieve those needs can be destructive. Ego states, like whole persons, have achievement needs, dependency needs, protective needs, destructive needs and safety needs. Needs are often disguised by behaviour quite contrary to the satisfaction of such needs. For example, a punitive state most often has a protective need (Watkins, 1993).
4. Its function or internal behaviour: The problem arises internally when an ego state has, for example, a strong achievement need and then nags and criticises other states to achieve a goal that is never good enough. The surface symptom may then be in the form of depression or anxiety. An ego state is usually willing to change its internal behaviour if its underlying need is being met.
5. Its degree of permeability: Is the ego state aware of “anyone else” within that inner world? That is to say, who knows whom, and what are the attitudes toward each other.
6. Its gender: Ego states are not always the same gender as the client. If a female client was abused by a male as a child, then at least one ego state is likely to be male. A male ego state in a female client usually designates strength rather than sexuality. A female ego state in a male client usually denotes a mother figure (Hartman, 1995).
7. Nonemotional part: Sometimes a nonemotional part of the personality is available. It has wisdom; it is nonjugemental; it has information as to the internal landscape;

and it can be a great resource for the therapist. Its inner function is to observe.

The above information should be obtained gradually and not by a shopping list of questions at the first meeting. The categories provide understanding for the therapist on how to proceed toward the therapeutic goal (Watkins & Watkins, 1996).

Upon first meeting with an ego state, the therapist's attitude sets the tone for future interaction. Since most ego states were created when the client was a child, the best way to communicate is to for the therapist to think like a child (Watkins & Watkins, 1996).

The therapist should assume that "everyone" is listening. The therapist is less likely to make an error that will infuriate an ego state other than the one being addressed. It is a gross error to express to the one being addressed that it is more co-operative, nicer, or better in some way than the other ego states.

Ego states and the total personality must understand that the resolution of emotional conflict lies within not outside of the individual. For example, if an internal child state feels lonely and rejected because of abandonment experiences in childhood, the solution lies in someone nurturing within the system, not by a nurturing adult in the outside world (Watkins & Watkins, 1996).

A certain degree of dependency is desirable in a good therapeutic relationship. The therapist must be willing to make a commitment to the client and be willing to accept and tolerate a degree of dependency. Both no dependency and overdependency in the therapeutic relationship may sabotage the process. This conflict is considered as a balance between "objectivity" and "resonance". When the therapist is objective, the client's problems are viewed like an outsider, unaffected by them emotionally. The therapist does not contaminate her perception and understanding of the client by her own feelings, experiences, or perhaps transferences. When the therapist resonates, she uses her whole self through temporarily introjecting the client and her situation, so that she can coexperience what she is going through. Resonating too deeply without appropriate, objective safeguards will result in overdependency being encouraged. The therapist needs to balance the two (Watkins & Watkins, 1996).

Internal dialoguing is the best way to understand the relationship between states. For example, if an ego state appears to a client in the hallucinated room, then the therapist can suggest they talk to each other, silently or aloud. If the conversation is silent, the therapist can always inquire what happened. Ego states can contain information or feelings about past experiences that are amnestic to the main personality. The goal of therapy is to make the primary person co-conscious of painful experiences currently dissociated within underlying ego states. Co-consciousness between states promotes the erosion of amnestic barriers. Such erosion opens the door to differing states understanding each other (Watkins & Watkins, 1996).

4.5.3. Integration and fusion

Integration and fusion are not seen as synonymous. The goal of ego state therapy is not total fusion of all ego state into one fully "fused" individual. But, rather, it is an increased permeability of ego state boundaries and improved internal harmony resulting in better cooperation and congruence among the various ego states (Gainer & Torem, 1993). Fusion suggests an amalgamation of all states into a single unit. Watkins and Watkins (1996) believe that the typical human being is not fused. Integration implies co-operation in a mutually needs-meeting resolution of differences. Sometimes two or more ego states find that their needs and the expression of those needs are so similar that it is no longer necessary or advantageous to divide their energies and be separate. They may simply decide to stay together – which is their choice not the therapist's.

Ego state therapy seeks to provide the client with improved access to existing strengths and resources that are held within other ego states. These resources are unavailable in the dissociated ego state.

Experience with ego state therapy shows that activating, studying, and communicating with various ego states decreases the client's tendency to dissociate (Gainer & Torem, 1993). If an ego state is split off during trauma in childhood, that entity retains the feelings of the experience and the thinking of that moment in time. It does not grow up with the rest of the personality. It is as if that ego state were encased in a cocoon in which time had frozen and stood still. Communication and interaction increases

boundary permeability and growth, resulting in reduced dissociation (Watkins & Watkins, 1996).

Finding a constructive state to care for them, play with them, or satisfy whatever apparent need can help fearful states. Such a needs-meeting process, in order to be effective, must be with the consent of both parties. They need to work out the details of their "contract" with each other through internal dialoguing (Phillips, 1993).

4.5.4. The safe room technique

Ego states want to feel "safe". This means that they have the need to be protected from harm and possible annihilation. In order to accomplish this, a "safe place" should be created (Hartman, 1995). The safe room can be used for a specific ego state or for the total personality, whatever seems appropriate to do. This technique can also be practised at home.

4.5.5. Dealing with critical states

In coping with critical states, the approach of choice is more likely to be confrontational, logical or practical. Often a demanding state can be motivated to change if it really understands that a change of internal behaviour is to its advantage. For example, an ego state whose need is achievement might be willing to change its nagging behaviour if it can be convinced that speaking more positively, more supportively to the one who is procrastinating will bring about more achievement. Sometimes it is useful to suggest trying out this kind of tactic for only a few days, allowing the critical one to determine how successful the change was. Then it has a choice of continuing the new behaviour or returning to old familiar patterns. Under these circumstances, the therapist should also contact the one who is procrastinating to gain its co-operation. Giving the critical state choice to try something new has great appeal. The critical, ambitious ego state versus the internal procrastinator represents an original conflict from the client's past (Phillips & Frederick, 1995).

For example, a parent may have nagged the youngster to study. Unless the student was happy to do the homework, resistance will develop within the child, regardless of the actual behaviour of the youngster at that time. With repeated naggings, the individual will introject this drama and grow up feeling both the "should" side of

itself and the "I don't want to" facet of the personality when challenged to achieve (McNeal & Frederick, 1993).

4.5.6. Resolving internal conflicts

In order to undo original conflicts, it is sometimes necessary to return to those experiences via hypnotic regression, perhaps to undertake an abreaction. A therapist cannot force incompatible ego states into a single, unified personality without removing the divergent motivations first so that the two "part-persons" become more dynamically similar. If ego state A is a nice, pleasant well-behaved personality while ego state B is angry, rebellious against all authority and vindictive, they cannot be forced by a simple suggestion into a permanently stable individual. The internalised rage and hatred must first be released from ego state B, the origins of it revealed and the anger pressures resolved before the conflict can be resolved (Watkins, 1978b).

One ego state can converse with another, silently or aloud, either by the therapist's suggestion or spontaneously. The therapist must allow the ego state to say what it wishes in order to give credence to what is communicated. Suggesting what one ego state should say to another is akin to directing a play and it does not spring from internal sincerity and is unlikely to be effective (McNeal & Frederick, 1993).

4.5.7. Pain transfer

Under hypnosis, pain within an ego state can also be drained into an adult state who agrees to accept it. It is essential that both agree to the arrangement. Some ego states are reluctant to let go of the pain for fear that they might die, have no power, or have no reason to exist. On the other hand, if the adult state has repressed the pain for many years, it also is reluctant to take it back. It needs to be gently persuaded along the lines of its individual logic, its individual ways of thinking, so that it will believe in the advantages of such a change (Phillips & Frederick, 1995).

4.5.8. The use of volunteer states

A volunteer state can also be used to help a child state, such as in the following verbalisations: "Susie would you look at the door of our room. I am going to ask a volunteer to come in to help you out. It will be someone who wants to do this. I do not know who that might be. Let me know who comes in."

This technique is never used unless the therapist is certain that there is a nurturing aspect to the client. After the frightened one sees someone, the therapist can ask for a description. Then internal dialoguing and communication with the therapist proceeds. The purpose is to meet the child's needs with the agreement of the volunteer (Phillips, 1993).

Another method of helping the child state might be for an adult state to snatch the "child" away from an abuser. The therapist can describe a room with a one-way vision screen where they can view what is happening on the other side. Then the therapist may suggest a consciously recalled setting from childhood, such as when the client was a little girl in her bedroom (Phillips & Frederick, 1995).

4.5.9. Use of an observer state

Helpful ego states should be involved during therapy because ego states sometimes resist remembering specific experiences, which is an indication that they fear something. The activation of an observer can be useful in this regard. An observer is not an emotional participant (Watkins & Watkins, 1980).

The availability of an observer state can be of tremendous value. It can be asked to take the client to a certain experience, or to an experience of the observer's choice. It can be consulted for advice or for an appraisal of the internal scene. After an abreaction, the observer might be able to tell the therapist how effective the abreaction was and if it needs to be repeated. It can give information as to the internal status quo, give clues as to procedure (Watkins, 1993).

4.5.10. The affect bridge

Watkins (1971) suggests that when psychoanalytic therapy has failed, the failure has often been caused by the intellectualisation of the therapy. It has dealt only with ideas and has not elicited feelings, emotions and affects. Therefore, the forgotten or pathogenic experiences that may lie at the basis of some conflict are not revealed in their true, living experiential colours. To be understood, integrated, and controlled, a forgotten experience must be lifted from repression in all of its original vividness, its original "feelingness". "Insight", to be genuinely therapeutic, must be total and must

involve full visceral and muscular, as well as cerebral, responses. An understanding must be “felt” as well as “known”.

Watkins (1971) coined the term “affect bridge” to describe a procedure which has considerable value in breaking through the interminable stalemate of an intellectualised therapy. It employs the flexibility of hypnosis to cross the time lines from present to past more rapidly, and it emphasises the utilisation of common elements, “bridges”, between present and past experiences which are affective or emotional in nature. The client is encouraged to allow her associations to move along chains of “affect” instead of chains of “ideas”. Therefore, when repressed experiences do emerge into consciousness much vivid feeling and re-living usually accompany them.

The “affect bridge” is a method that can often facilitate the process of association, helping the client to move from present transferred experiences to their earlier origins. It can often shorten the intervention process, and it assists in vitalising insights by stimulating the affective components of re-lived experiences.

Finally, it must be recognised that all the transference-countertransference problems that involve interactions with a whole person can also exist between therapists and ego states and the therapist should always be aware of this.

4.6. Conclusion

Ego states are personality segments, which manifest relative degrees of autonomy from each other, and from the whole person depending on the permeability of the boundaries which separate them from each other. These entities when hypnotically activated regard themselves as having individual identities. Each experiences itself as subject (I) and the whole individual or any other state as object (she, he or it). Each has a definite behavioural and experiential content and a role in the psychic economy of the individual that is adaptive or defensive. In some individuals, the boundaries, which differentiate states, are more permeable, thus promoting a generalised unity in the person. In other cases, the boundaries are rigid and impermeable thus increasing differences between the personalities as they alternate in becoming “executive”. Well differentiated states can describe their roles and clearly depict how they differ from

other states. They also report on areas of cooperation and conflict with each other. Individual ego states often give themselves a name, which generally differs from that of the entire person or of other states (Watkins & Watkins, 1980).

Chapter 5– Methodology

5.1. Introduction

The goal of the research was to demonstrate the process of ego state therapy and its outcome when treating an adolescent who has been exposed to ongoing physical abuse as well as ongoing violence in a chaotic home environment. The process entailed capturing the essence of her individual experience and the research underlying the study was qualitative in nature. This individual approach allowed for greater flexibility and a more in-depth investigation with the participant.

5.2. Qualitative case study research

Early in the 20th century the case study as a research method was common and well respected. However, as quantitative methods gained ascendancy in the social sciences the case study became disreputable, and was shunned by social scientists in the 1960s and 1970s. Recently there has been a revival of interest in case study research in several fields, including psychology (Moon & Trepper, 1996).

This reawakening of interest in case study research has come about for several reasons. First, historically, case studies have had tremendous impact on the social studies (Kazdin, 1998a). Second, methodologists have advanced powerful arguments for the value of case study designs. Third, the growing interest in qualitative methods in the social sciences has led to increased interest in qualitative case study methods. Fourth, case studies have been promoted for their potential to bridge the gap that has developed between research and practice in applied social science fields.

Moon and Trepper (1996) argue that almost all clinical innovations which occur daily in therapeutic practice, through either design or serendipity, go unnoticed. As therapists do not consider the work they do as part of the process of clinical research, their innovations go untested, uncirculated and ultimately unused by anyone other than themselves.

Case study research offers an approach for clinicians that wish to systematically examine their own dinical innovations and present these to other clinicians. Case study research is flexible and is more concerned with hypothesis generation than

hypothesis testing (Mahrer, 1998). Like other qualitative methods, case study research allows for a greater interaction between the case being studied and the investigator, increasing the possibilities for new and important information being discovered. Case study research is usually descriptive and discovery-oriented (Hayes, 1998).

5.2.1. The case study

The case study has been defined in many different ways. Traditionally, the case study has referred to the intensive investigation of the individual client (McLeod, 1996). Case reports often include detailed descriptions of individual clients. The descriptions rely heavily on anecdotal accounts of the therapist to draw inferences about factors that contributed to the client's situation and changes over the course of treatment (Stake, 1995). Aside from the focus on the individual, however, the case study has come to refer to a methodological approach in which a person or group is studied in such a fashion that inferences can be drawn about the factors that contribute to changes. Thus even if several persons are studied, the approach may still be that of a case study. Often cases are treated on an individual basis, but the information that is reported is aggregated across cases, as in reports about the efficacy of various treatments.

In general, the case study has been defined heterogeneously to denote several different things, including the focus on the individual, reliance on anecdotal information, and the absence of experimental controls. A central feature of the diverse definitions is that case studies differ from experimental demonstrations. Texts on methodology usually discount the case study as a preexperimental design and use it as a point of departure to show that experimentation is the alternative means for obtaining scientifically validated knowledge. However, case studies and experiments fall on a continuum that reflects the degree to which scientifically adequate inferences can be drawn (Hayes, 1998).

Many disciplines have used the study of cases to advance knowledge. Illustrations can be provided from virtually every branch of psychology in which the individual subject has provided important information (Kazdin, 1998b). The intensive study of the individual has contributed to clinical research and practice by providing a rich sources of hypothesis about the bases of personality and behaviour and by serving as a place

to develop and apply intervention techniques (McLeod, 1996). While the case study is not experimental research it can, under certain circumstances, lead to knowledge about treatment effects for a given client that approximates the information achieved in experimentation.

The purpose of experimentation is to rule out threats to internal validity, which serves as alternative rival hypotheses of the results (Marshall & Rossman, 1990). Case studies do not provide the arrangements that permit conclusions that are as clear or generalisable as those available from experimentation. However, many of the threats to internal validity can be ruled out in case studies so that conclusions can be reached about the impact of treatment.

The case study as a potential source of scientifically valid information warrants careful scrutiny for several reasons. First, the case study has had a tremendous impact on psychotherapy. Individual cases and series of cases have exerted remarkable influence on subsequent research and practice. Second, the case study draws attention to the frequently lamented hiatus between clinical practice and research. Clinicians have access to the individual as their most convenient and feasible investigative tool. Kazdin (1998a) believes that the case study occupies an extremely important place in clinical work. Case studies are widely recognised to serve as an important place to develop hypotheses about clinical problems and to explore innovative treatments.

Case studies have been loosely and heterogeneously defined to include a variety of uncontrolled demonstrations aimed at showing that treatment produces therapeutic change. However, case studies may vary in how they are conducted and reported. The distinctions that can be made among case studies have important implications for drawing unambiguous conclusions. In qualitative research, cases are selected on the basis of their theoretical significance rather than in accordance with rules of randomised or stratified sampling (McLeod, 1996).

5.3. Information gathering

Information can be collected prospectively or retrospectively. In the former, a research question is developed, a decision on which future case or cases to examine is made, and then information is collected as the case progresses (Marshall & Rossman,

1990). In the latter, the research question is developed, a decision on which previous case or cases to examine is made, then information already collected on that previous case or cases are examined.

When doing research retrospectively clinicians reflect back over the cases they have seen over the past year to identify either (1) a case in which something interesting or unique happened that might be worth further scrutiny or (2) a theme that has been noted in several cases (Mahrer, 1998). The next step after the initial reflection is to understand the essence of the observation (Stake, 1995). This entails understanding the meaning of and reason for the observation. It also involves looking at whether the discovery might occur again under similar circumstances and whether this has been done before. Finally, a decision must be made whether to pursue this as a case study (Marshall & Rossman, 1990).

Once the clinician is clear about what she wishes to examine a research question needs to be established (Stake, 1995). When doing case study research, questions should (1) get at the core of the research idea, (2) be broad enough to allow for flexibility during information collection, and (3) allow for new questions to be generated. Case studies, like other qualitative methods, are best when they allow for the greatest flexibility.

Written case notes are most commonly used as the basis for information collection in the single-case study. In a retrospective study, the clinician would have to use the notes that are available. How complete and accurate the notes are may determine whether the study can be realistically done with a particular case. For a prospective study, the clinician can plan to take more detailed progress notes than usual and then write periodic summaries of the case (Mahrer, 1998).

Qualitative researchers have frequently suggested that research design, information collection and analysis are simultaneous and continuous processes. Analysis is not perceived as a separate phase as in quantitative research but rather a constant interplay of information gathering (Marshall & Rossman, 1990).

5.4. Information analysis

The purpose of information analysis is to answer the guiding research questions and to generate new hypotheses for further research. Complete case reviews are often used as a form of information analysis. With this method, the clinician intensely reviews the progress notes, looking for patterns consistent throughout, changes as a result of interventions, and important clinical themes. A written case summary is then made to help consolidate the findings for the clinician.

It is important for the clinician to present the case to colleagues, along with the research question and initial hypotheses and impressions. This allows for less isolation and more accurate results. The colleagues can validate and help refine the findings as the case moves along and also help clarify the results of the project (Hayes, 1998). Although not appropriate for all case studies sometimes the best interpreter of results are the clients themselves. Certainly if the research question involves therapy outcome, asking clients if certain interpretations are accurate is reasonable.

5.5. Methodologic orientation of this study

Information was gathered from the weekly therapy sessions held with Tracey. Detailed notes were taken during each session and later analysed during supervision. The same process was followed during each session. This entailed a brief discussion of the previous week and any subsequent significant events. The therapist then used a method of relaxation in order to induce a semi-hypnotic state. This state provided access to the various ego states, allowing the therapist and client to work through various issues. After the client emerged from the semi-hypnotic state the therapist would ask her for her interpretation of the images. This was then discussed. Therefore it is clear that analysis of the information was continuous in that it interwove with other aspects of the research process as is characteristic of qualitative research (Bryman & Burgess, 1994).

Therapy provided an open mode of observation. It took place in a free and non-directive situation, which was at the same time guided by theory. It was both descriptive and interpretative (Marshall & Rossman, 1990). The visualisations required the client to assume a passive attitude towards her own train of thought and

dispense with all conscious control over her mental processes. The mode of observation was open and explorative.

Kvale (1986) states that the attitude of the therapist should ideally be that of a presuppositionless listener. This meant that the therapist listen without engaging in selective hypothesis testing. This entailed openness to the vague, the ambiguous, the contradictory and the unexpected. The therapist should have focused less on whether the client reported factual occurrences or fantasies but rather on the psychological meaning of what was said.

The mode of observation was also descriptive. Following the principle of a presuppositionless listener, it entailed a non-categorising approach to what was taking place at the moment. The observations were reported in the form of qualitative descriptions. The descriptive focus was on the meaning of the observed behaviour, whereby description and interpretation were intertwined (Bannister, Burman, Parker, Taylor & Tindall, 1994).

The observations are, in principle, not intersubjectively reproducible by any observer. They took place in an intensive two-person relationship. The therapeutic interpretation of meaning is open to multiple meanings and layers of meaning of an act. It involved hypothesis generation and hypothesis testing (Foster & Parker, 1995). Therapy does not maintain a strict line of demarcation between information and meaning, between description and interpretation. The concept of multiple determination implies that the one and the same act may have multiple meanings and motives. The meaning of an act may be ambiguous and contradictory; therapy entails a methodological tolerance of ambiguity in the interpretation of meaning (Kvale, 1986).

5.5.1. Positioning the participant

The object of ego state therapy is a developing subject. The client's life history and her childhood are a central theme of the analysis. The interpretations are a means of instigating the client to relive the traumatic episodes in her past and thereby surpass their determination on her present behaviour.

Ego state therapy is a human relationship; it entails a communicative interaction, a reciprocal personal involvement, with levels of disclosure from the client. Therapy involves a complex interaction between the therapist and the client. It is a joint venture, an attempt to change a process together with the person involved, the "object of inquiry" participates in the process of investigation (Kvale, 1986). The therapeutic situation is not a neutral, "objective" relationship, but entails a personal involvement of client and therapist. The personal involvement of the therapeutic relationship is contrary to the traditional requirements of scientific neutrality. It may involve the danger of subjective bias in the therapist's interpretations, and a suggestibility of the client towards accepting interpretations.

The intensive case studies of single subjects break with the traditional criteria of large samples of representative subjects (Taylor & Bogdan, 1998). The open mode of observation violates the requirement of formalised observation procedures and systematic recording of the observations; and the tolerance of vague, ambiguous and contradictory phenomena contrasts with the requirement of science being based upon certain and exact quantifiable facts. The emphasis on interpretation of meaning contrasts with the demands of separating descriptions and interpretations, of distinguishing facts and meaning, as well as with the more drastic relegation of meaning from a natural science psychology (Bannister et al., 1994). The unfolding temporal context, with changes in interpretation, contrasts with the requirement of science based upon immutable facts. The human relationship of the therapy situation with the personal involvement of client and therapist violates the requirement of detached neutral observers (Taylor & Bogdan, 1998).

5.6. Conclusion

The goal of any research project is to add value to the field under scrutiny. The methodology chosen here, a qualitative deconstruction embracing a case, answers different questions to any of the other research options available. In some respects psychologists have tended to elevate modernistic approaches, controlled environments, random samples and high powered statistics above qualitative exploration, with the view that the reliabilities of qualitative approaches are open to question. The position taken here follows Rychalk's (1988) argument that rigorous science does not necessarily have to take place within a modernist frame. Qualitative

research, in all its forms, should be a rigorously practised as experimental research. There are more and less useful ways of undertaking all kinds of research. The question is not which type of research is preferable, but rather the application of high standards in all designs.

Chapter 6– Therapeutic intervention

6.1. Introduction

The client, Tracey, was in weekly therapy for a period of eight months. The current chapter will look at the process of therapy that unravelled in these sessions. The main therapeutic tool was the use of visualisations, with ego state therapy forming the theoretical background. The visualisations made it possible for her to be regressed back to earlier age levels in her life. The therapeutic process thus saw the emergence of many different ego states. By the activation of particular states, elements comprising those states became available to consciousness. Tracey's regressed ego states displayed feelings and opinions that they had previously experienced (Watkins, 1978a). Also activated were old introjects, for example her parents behaviour at that time. The activation of these states meant that the therapist, through questioning or association, was able to explore Tracey's entire living space. This entailed eliciting narratives on feelings, events, significant relationships and emotional conflicts that existed then, but which did not necessarily exist directly in the present ego states. Each ego state included a finite number of experience elements, and each had some kind of boundary that distinguished it from other, different states.

6.2. Biographical information

Tracey's demographic and personal factors can be summarised as follows: she was a 13-year-old girl; her ethnic group was not clear, as her mother was coloured and her father was white, which might have resulted in ethnic identity confusion. She belonged to a low socio-economic group and was a devout Christian. At the start of therapy, she had been in the home for the past year, having previously lived in another children's home for a year and a half. She was taken away from her family of origin after the neighbours notified the Department of Welfare.

Before Tracey was removed from her parents' home she witnessed continual abuse towards her mother and was exposed to physical abuse from both parents. Both parents were alcoholics, which suggested that they might have failed to provide the love and acceptance Tracey would have needed to accomplish important tasks in each life stage. She lost her grandfather whom she loved dearly. There were also suggestions of sexual abuse although these were not confirmed. Other factors that

needed to be considered included extreme poverty and the lack of family structure, resulting in complete disorganisation. Tracey's crises encompassed a psychological, physical, environmental, social and cultural event. There were also critical aspects such as the fact that the abuse was pervasive, unpredictable and uncontrollable.

Tracey's human environment of family, relations, friends and community was never one to be relied on. The people in her life were unstable and unpredictable, with the exception, it seems, of her grandfather. When Tracey was removed from her parents' home at the age of ten to be placed in the children's home, she was separated from three of her siblings. Tracey had no contact with her parents or other siblings. At the beginning of the intervention there was a definite resentment towards the children's home and a yearning to be at her parental home again to start her relationships over. The parental home was idealised while the children's home was devalued. As the intervention continued this split became less and less apparent and her view of her parents and their actions began to change.

Her siblings comprised of a twin brother and four other siblings. Her twin and her younger sister lived with her in the children's home. She had an older brother and sister who had reportedly left school and lived with an uncle. Her youngest brother of three reportedly still lived with their mother because the Department of Welfare had been unable to locate her in order to remove him. Tracey appeared to look up to her older siblings and got along well with her twin brother, however, there was a lot of conflict between her and her younger sister, and their relationship was characterised by regular fighting.

Tracey was in grade 7. She enjoyed school and described her academic performance as "okay". The idea of being either a social worker or a missionary appealed to her. She was very committed to Christianity and found a lot of solace in her faith. In the first session, she stated that she sometimes asked the L-rd why He had made her, but she knew that He had a plan for her. Although she was a good athlete and had won a gold cup for the 100 and 800 metres, she was not involved in any sports at the time, as she was too old for any of the teams.

6.3. Clinical impressions

Tracey was referred for therapy by the children home's social worker who described Tracey as having difficulty with her peer relationships and displaying a lot of aggression. In her brief, she stated that everybody rejected Tracey. When Tracey began therapy, she displayed insight and maturity, despite her difficulties and young age. It seemed to be difficult for her to express herself; yet, it was clear from the outset that she was willing to co-operate. Beneath the surface of the ego state that appeared in the first session, there was a hint of pent-up anger, emotional sadness and frustration. In the first session she drew a picture of a girl with tears running down her face because, as she explained she felt sad. She went on to say that she tried to laugh to make herself feel better and less angry.

6.4. Therapeutic process

Knowledge and understanding of Tracey increased during each session. A semi-hypnotic state was induced and visualisations were used to both gather information and make interventions. Tracey had an active imagination that made the exploration real and creative. She was very susceptible to the mind-altering state and a willing participant. The visual imagery that was evoked was therefore vivid and rich.

Each session began with a discussion on the previous week and any issues that had arisen. In the beginning this also included mentioning any display of aggression, although over time these incidents diminished in frequency. Thereafter the semi-hypnotic state was entered into using a relaxation method. Tracey was directed to either descend down stairs or down a road with houses numbered one to thirteen. At times she was free to describe whatever came to mind as she crossed through the last phase of relaxation. She was asked to vividly describe the scene so that the therapist could envision her surroundings. A dialogue ensued with the various ego states that emerged. Tracey freely produced the images and ego states but the therapist directed the dialogue between the various ego states through questioning or suggestion. Towards the end of the visualisations, Tracey was directed to her safe place. Much of the work was intense and overwhelming, and therefore a safe place needed to be created. A safe place provided somewhere for Tracey to go after the intensity of the emotions evoked during the visualisations, to feel contained and protected. Its purpose was to provide closure for the visualisations. When Tracey felt ready she exited the

semi-hypnotic state and a discussion ensued on what had transpired in the visualisation. The fact that Tracey was of a young age did not influence the interpretation of events and they were spoken about.

6.4.1. Session one

The first session entailed a history taking and a family genogram was drawn. The ego state that Tracey presented in the first session came to be known as the executive ego state. Executive ego state means that state most highly energised that it is considered to be the one activated at that moment (Watkins, 1978a). It is the "self" of the "now". This ego state spoke in an abrupt way and walked with a masculine slant. This tough representation seemed to be alienated from its feminine side. It soon became clear that this tough exterior became the executive state in an attempt to protect her vulnerable and fragile ego state, the part of her that had been exposed to the abuse that had lead feelings of hurt and pain. Therefore, her angry, rebellious ego state was initially the one that presented at therapy. As the intervention progressed, this executive ego state gave way to other expressions of self, possibly through the reliving of the various experiences that had caused her to adopt such persona.

Despite this tough exterior, Tracey seemed open to the experience of therapy – she displayed enthusiasm and excitement at being the focus of attention for forty-five minutes. An attempt was made to create a feeling of safety and security by keeping this session flexible and allowing her to direct the process. This session set the tone for the nature of the intervention. The therapist's role was one of collaborator rather than expert. This was facilitated by the respect the therapist had for the way in which Tracey had dealt with her difficult experiences and the fact that the therapist herself did not have any practical experience in this area. The client was therefore the expert in her own life experiences. This starting point empowered Tracey to cover ground that may otherwise never have been reached.

6.4.2. Session two

Tracey returned with even more enthusiasm – the client-centred approach had given her a sense of importance. She began the session by mentioning a dream she had had in the last week. In it, she described seeing an image of a doll standing at her bedroom window with a knife. She was terrified and ran to call the other children but none of

them could see the doll and made her feel like she was making the image up. Despite everyone else's disbelief, she saw the doll and it was pointing the knife at her.

In this session, it was confirmed that Tracey was an excellent client for ego state therapy. As the intervention continued many ego states emerged, each one providing the therapeutic process with rich material with which to work. It was possible to meet and converse with a variety of ego states through visualisations, which were induced by placing the client into a semi-hypnotic state. In this particular session, Tracey's progressed or executive ego state made way for her regressed ego state. This regressed ego state carried feelings of fear, loneliness, frustration and betrayal. These were the emotions evoked in Tracey by the doll. The children who refused to believe her in the dream represented the authority figures in her life as well as her progressed ego state. Neither of these allowed Tracey to remember or process the difficulties she had experienced but instead forced her to repress them. The progressed ego state threatened her by saying that no one would believe her. The feelings of openness in the first session were been kept in check by her progressed ego state.

The polarity ego state for the progressed self was the regressed self. These two ego states may have represented her intrapsychic response to the various traumas she had continuously experienced. Watkins and Watkins (1992) describe how the ego of a trauma survivor splits into two functional parts, namely the regressed self and the progressed self. The traumatic feelings are of such intensity and power that the developing ego is unable to contain and symbolise them. They are therefore split off and contained deep within the mind in the form of the regressed self.

The progressed self develops as a highly evolved answer to the dilemma of having to hide hurt feelings. The word progressed denotes being 'beyond her years'. The function of the progressed self was to protect the real/authentic self, which had been wounded. The progressed self served as persona and a rigid container for Tracey. Its rationale was that it would not let the hurt or regressed self emerge for fear that it would be hurt again. It therefore had to avoid feelings of hurt, shame, guilt and pain at all costs.

When Tracey bought into this process and lead a life in accordance with the progressed self pretending that all was well and never sharing her pain, the progressed self was satisfied. The moment she decided to break this cardinal rule of silence, the progressed self became nervous and did its best to put Tracey back in her place of silence. It appeared that therapy was the arena for this cardinal rule to be broken and the progressed self seemed to increase its censorship the more Tracey spoke. As the sessions grew more intense, the progressed self tried harder to implement his will, each time in stronger more violent visualisations. The progressed self believed that it was only doing its job of protecting the regressed self. It was doing whatever it needed to keep the regressed self, silent and safe.

Her safe place was created in the second session. As a safe place, Tracey described a room filled with pictures of singers and dancers. She described a black floor and peach walls with windows looking out onto trees. An older version of Tracey was there who for purposes of clarity will be called Kim. Although it may not be mentioned in the following details of each session – Kim accompanied Tracey through many of her visualisations. She was the one constant ego state and served as a container for Tracey. This provided her with security and stability. Tracey always expressed a sense of relief after sharing the information. However as the events became more sensitive it became harder and harder for her to endure. Kim was often in the safe place with her, a companion with whom she was able to compose herself again.

6.4.3. Session three

Tracey felt safe enough in the third session to introduce into therapy the physical abuse by her father towards herself and her mother. While in the semi-hypnotic trance, she experienced three regressions and described the following events. The first was being hit by her father at the age of six for not wanting to go to church because she felt ill, and having to lie about her bruises to her peers and teachers the next day at school. The second was an incident in which was thrown off her parent's bed by her father at the age of nine months resulting in her hitting her head. The last incident described during this session, at the age of eleven, was that of her mother being hit by her father and the vivid image of blood. At the time Tracey had threatened to phone the police.

This session highlighted the fact that Tracey had predominantly experienced males as violent and aggressive. In each of the above episodes the male figure was the aggressor and the female was the vulnerable "victim". Consequently one purpose of therapy needed to be to nurture alternative male and female ego states. The male ego state needed to be one that could be non-aggressive, kind and loving, so that Tracey would understand that not all men abuse women and therefore she should come to expect not to be abused. This had to happen in order for her to break the cycle of abuse and demand respect from any future partner. Through the course of intervention it emerged that Tracey's grandfather seemed to represent the only adult male who had treated her with respect and kindness.

In contrast to her devalued male ego state – whose only response to women was to hurt them, this third session also introduced a positive male ego state in the form of the policemen who Tracey hinted at in the last described episode. It is important to note the contrast between these masculine ego states. The policeman ego state can be equated with qualities of protection and positive strength. It would become clear in the sessions to follow that these two male ego states were struggling for supremacy over the conscious mind.

6.4.4. Session four

A primary reason for Tracey's referral was her consistent aggression towards her peers. In the fourth session she stated that she had had an argument with a boy and had hit him. After a brief discussion about the details of the fight, Tracey went into a visualisation in which she found the introjected teacher ego state. The teacher ego state was giving a life orientation course to learn about life and becoming a teenager, she was going to teach her how not to become angry so easily. She was teaching the angry, tough Tracey positive relating methods. The therapist aligned herself with the introjected teacher to facilitate the process of therapy. The introjected teacher assisted the therapeutic process enormously. Tracey looked forward to 'visiting' her each session. In order to carry on the therapy at home, she wrote letters to this ego state during the week. This ego state highlighted the fact that the solutions to Tracey's difficulties lay within herself and the process of intervention simply needed to facilitate Tracey's access to these solutions.

It was also in this fourth session that Justin was introduced. It soon became clear that Justin was a young educable male ego state that was capable of learning positive traits and ways of interacting with girls and women. Justin joined them in the lesson in which the teacher ego state teased them and made them angry in order to educate them on alternative ways of handling anger rather than physical fighting, for example ignoring the comment. All visualisations were followed by a discussion of what Tracey understood from them and some direction from the therapist. In this particular session it was important to clarify that it is okay to feel angry but that there are more appropriate ways of expressing it. It was also important to clarify with Tracey that the only way of expressing anger that she had been exposed to was through violence and therefore she needed to learn alternative methods of dealing with anger.

6.4.5. Session five

The fifth session involved consolidating the previous four sessions through discussion; there was no visualisation. The common themes up until now had been violence, aggression and anger. These themes were discussed. The way in which her family dealt with anger were looked at as they were effectively the only ways she had been exposed to. Violence and aggression had been acceptable methods of venting frustration and anger in her family of origin and she now needed to find her own alternatives, for example expression of anger using words.

6.4.6. Session six

While in the semi-hypnotic state during the sixth session, Tracey descended a set of stairs leading toward an open gate. She walked through, and described a long hall with windows and doors on both sides and pictures of elephants along the walls. At the end of the hall there was a door. She went through the door and found a bathroom, which she described. She also described the courtyard she could see through the window. She said there were trees and a washing line with baby's clothes hanging on it. She could hear a baby crying and went to find it. When she found him, she picked up the baby and stopped the crying with a pacifier, putting him to sleep.

This baby represented another male ego state – even younger than Justin. In order for Tracey to believe that men can be kind and not abuse women she needed to develop a

positive male ego state within herself. Therefore in the last part of the visualisation, instruction was given to help Tracey nurture the little boy. He was named Riaan. Without the young educable masculine ego states, Tracey's male ego state would have grown up to be violent and abusive. His young age implies that he was at an educable age and that he could be taught that not all men are abusive to women. The young masculine ego states were the germination and beginning of a new positive masculine ego state. Tracey established a very real connection between herself and the baby boy. She learnt how to nurture him without any suggestions. She fed him, bathed him, and as he grew older, played with and talked to him.

6.4.7. Session seven

A long break followed session six, as it was exams and school holidays. The next session was therefore about reconnecting. There was a lot of confusion about whether Tracey's father or a stepfather had abused them. She would often refer to him as her father and then immediately correct herself, calling him her stepfather. According to the social worker it was her father. When clarification was sought from Tracey, she said that just before she was removed from her home she was told that it was not her father because a "real" father would never treat them like he did.

Once this confusion had been discussed Tracey described, while in a semi-hypnotic state, a violent interaction between her brother and his friends. She vividly described them fighting with knives and her brother throwing a brick into another boy's face. Tracey's teacher ego state accompanied her on this journey and a debate ensued about Tracey stopping the fight. The teacher ego state pleaded with her not to because she would get hurt but in the end Tracey won and ran into the argument, getting stabbed in the back. She described bleeding and her brother apologising for not stopping the fight when she asked him to. She was helped to the nurse's station where she was stitched and put to bed.

The violent interaction appeared to be the voice of the progressed self, trying to make himself heard again, this time more even more forcefully. This ego state emerged in the second session and can be described as that part of her that felt threatened by the emergence of Tracey's hidden memories. His purpose was to prevent these memories

from emerging at all cost. The violent image came to warn Tracey that these memories were better left unspoken.

The visualisation ended with the teacher ego state buying some chocolates and flowers for Tracey while she slept in her safe place. This was a nurturing and containing gesture. As Tracey's repressed memories attempted to make themselves heard, Tracey needed to be assured that regardless of what she brought to the intervention she would be heard and believed.

6.4.8. Session eight

The progressed self was not going to let hurt emerge so easily and In the eighth session it made itself heard again. While in the semi-hypnotic state, Tracey described herself watching a movie in which a little girl got permission from her father to choose a teddy bear for herself that he had made, but the teddy bear was evil. The teddy bear made the little girl become evil too. That night the little girl locked herself in her room where a lamp started talking to her, telling her to fetch a knife and stab her older brother. She refused, ran out of the room, threw the teddy bear into the fire, and broke the lamp. The commonality between the teddy bear and the lamp was hatred and evilness. The little girl was described as happy, strong, cute and beautiful. The diametrical opposite, positive traits that were used to describe the little girl served as a glimmer of hope. While the progressed self threatened to silence her a strong, determined feminine ego state emerged. This feminine ego state was confident about her femininity and believed in herself.

6.4.9. Session nine

The ninth session provided the opportunity to address the previous two violent visualisations. As if she sensed the intensity of the ensuing experience, Tracey was at first reluctant to enter the semi-hypnotic state. After acknowledging the pain that accompanied the visualisations the therapist felt it was an important enough critical moment to take a directive stance and explain to Tracey the concept of repressed memories. She agreed to enter the visualisation where she encountered a man in his early thirties, named Uncle Arthur. She described him wearing a "superga" hat and T-shirt and brownish-yellowish pants with "All-star" tackies. When Tracey was asked what his purpose was (why was he there) she said that he wanted her to forget her

memories and the events that happened in the past. In an attempt to incorporate him into the therapeutic process rather than alienate him, Tracey was asked if it would be possible for the therapist to talk to him directly. This was an unusual occurrence as usually the therapist did not speak directly to the ego states but rather through another ego state. The therapist thanked Uncle Arthur for doing such a wonderful job of trying to protect Tracey and keeping her safe but that at times memories needed to be remembered and expressed. After a lengthy debate he agreed that it was important for Tracey to be aware of her traumatic memories in order for the experience to become integrated. The repressed memories were leading to her aggressive behaviour and other dysfunctional traits in her day-to-day living.

This working alliance lead to a memory of her mother and father engaged in a physical argument. Arthur lead her to a black house, making it clear the whole way that he was only going to show her this and no more. As Tracey entered the house she painted a vivid scene of what was happening. It was a Friday night and her mother and father were drunk. She described her father as more drunk. There were five mirrors in a row on the wall. Her mother went to cook supper but her father started "going crazy". She went on to describe him coming into the kitchen and grabbing and hitting her mother. Tracey at this point cried out that she could not take it, but she continued with the description, which involved her mother having a glass thrown at her and beginning to bleed, and her father smashing the five mirrors. Her mother walked into the hallway and there was blood on the walls. Tracey repeated that she could not take it, and ran out of the house to phone the police. This experience was naturally very difficult for Tracey and she displayed a lot of grimacing. She seemed both frightened and saddened by the event. It was however important for the therapist to encourage her to endure it as only once she allowed the event into consciousness could it be dealt with. The incident needed to be retold and reexperienced in order for it to become part of her life. Only once this had occurred would it stop influencing her actions and thoughts, it allowed her to take control of the event rather than have the event control her. After reliving comes re-empowering.

However it was important to be able to contain the event and in an act of containment Uncle Arthur took Tracey to her grandfather's grave. She was very close to him and this environment offered her a lot of solace. When she exited from the visualisation,

she was still visibly distressed and the therapist assured her that the "nought" had been closed, and that those memories would only be revisited in an environment in which it would be safe to do so. The therapist also assured her that in the meantime Uncle Arthur would continue to protect her.

After the reliving of this experience, it was important that the intervention process helped to empower Tracey. Uncle Arthur was overdeveloped (as his age indicated) and he protected Tracey by never allowing her to be exposed to the memories of the traumatic events. The moment Tracey began opening up in therapy, he became persecutory in the form of the violent visualisations, as if to say, "people won't believe you", and "you should be ashamed and humiliated". It is important to note that this one ego state could have jeopardised therapy. It was only after catharsis that change and growth could begin.

6.4.10. Session ten

In the following session the therapist returned Tracey to the exact scene where the previous session had ended – her grandfather's grave accompanied by Uncle Arthur. Uncle Arthur seemed happy to see Tracey, and said that he wanted to show her something. But first, Tracey had a long silent conversation with her grandfather. When she was ready, Uncle Arthur said that he would like to take her to door number twelve. When Tracey arrived at the house she described the exterior in detail. It was a brown house surrounded by a long wall with a maroon gate. There was a dog in the garden and she also noted the grapes and peaches.

It was again a Friday night, both her mother and father were inside drinking. She again distinguished between the amount each parent had drunk, with her father having drunk more. Her mother left the house to buy sweets for the children. When she arrived home Tracey described how her father dragged and slapped her mother. At this point the other children were outside playing and did not hear their mother screaming. Tracey's body movements became very descriptive of the scene she was witnessing - she moved and squirmed. She described her mother being kicked and her eyebrow bleeding. The children came inside to find the floor covered in blood. Tracey turned her body away from the therapist. Her father took her mother to the bathroom to get the blood off her face. The children tried to open the door to see what was

happening. Their father did not want to let them in but the mother insisted that they should see what their father had done to her.

The therapist at this point encouraged Tracey to speak to both her parents to express her emotions surrounding what she had witnessed. She first clarified the above story with her mother by asking her what happened. Then she turned to her father and told him that he was a "pig" because he "liked" hitting women. In an attempt to justify his actions he told Tracey that he did not mean to hurt her mother. Tracey was not prepared to buy his argument and strongly resisted being convinced. She told him that she would like to see him sent to jail, and he promised not to do it again.

Uncle Arthur suggested that Tracey's father should be sent somewhere where he could learn to stop drinking and hitting her mother, and that her mother should be sent to a shelter for abused women. Tracey agreed to this suggestion and symbolically sent her father to be rehabilitated and her mother to be protected. This implied that there were alternative ways of behaving as adults and parents and that one can expect to be treated differently. Tracey returned to her grandfather's grave, which served as a safe place.

An individual can introject people, ideas or processes. It became clear that Tracey had introjected a violent, abusive father and a powerless mother. In the beginning, Tracey placed a lot of emphasis on the fact that she wanted to go back to her mother. She was focused on her mother and idealised her in many ways. She never spoke about being abused by her mother and always portrayed her mother as the victim. It became clear that Tracey had a split image of her mother – whom she saw as having only positive traits. This may have implied that Tracey had a split within herself. She had split off all the anger at the negative aspects of her mother, who was never there for her.

The children's home replaced her nuclear family as a structure but while it offered more stability, patterns of rejection from authority continued. It appeared that Tracey had a tendency to exacerbate and anger the adults in her life. Despite the abuse she was exposed to, and the instability of not knowing how her parents were going to be on any given day, the children's home was not a positive alternative when the intervention began. In the beginning she expressed the wish to see her family and the

strong desire to start over with all her relationships. This highlighted the split within Tracey again. The children's home carried her negative projections while her parents' home carried the positive projections. The children's home made her feel restrained, unheard and powerless, however, as time passed her home has become less and less of a focus and this could perhaps be attributed to the intervention process. Towards the end of the intervention Tracey began to see the negative characteristics of her mother and felt able to express them. This implied that the split within herself had begun to integrate and she herself was now able to possess both positive and negative traits.

6.4.11. Session eleven

In the eleventh session, Tracey said that she had been disturbed by an incident at school. Her teacher told her that she "won't get anywhere with an attitude like that" and had kicked her out of class. Therefore this therapy session was spent discussing what sort of image she portrayed to the world and how she would like that image to change. It was a containing session after the previous difficult sessions. A long gap followed this session as Tracey went away with her school, she was then sick and school holidays started soon thereafter.

6.4.12. Session twelve

This session was a reconnecting session, and also served as an evaluation session. The therapist and Tracey discussed what events in therapy stood out for her and what changes had taken place in her behaviour. She seemed surprised to realise that she was no longer fighting as much and was positively interacting with her peers on more occasions. She had enjoyed the visualisations, although noting how difficult they had been; she had also enjoyed being able to discuss her family. The therapist had taped some sessions, which she thoroughly enjoyed, as there was an element of self-importance in this.

Tracey chose this session to bring up the topic of boys. She spoke about boyfriends she had had and about a boy she had recently met. She was shy in the beginning but soon felt comfortable. The relationships she described were not emotionally or physically intimate. It seemed that they could rather be described as flirtatious encounters, with writing of letters and sending messages through friends. She was not currently involved with anybody and she ended the session by saying that she will

find the "right one". Her description of the right one was superficial in terms of looks and the therapist touched on qualities like respect and absence of violence in relationships.

6.4.13. Session thirteen

This session was deliberately left unstructured. Once the semi-hypnotic state was entered into, the therapist asked Tracey to describe the scene she had entered. She painted a picture of a long street with different coloured houses – yellow, brown, pink and peach. She saw trees, cars and birds in the sky. She described herself walking down the street for a long time before coming to a brown house, with a puppy outside. She then described herself walking through the gate up to the front door and knocking three times. The maid answered the door and Tracey asked to see the baby living there. It became clear that Tracey had decided to visit Riaan. She described herself being taken to the "madam" of the house and asking her if she could see the baby. The "madam" recognised her and commented on the fact that Tracey had grown – her hair had grown and she was taller. This was positive reinforcement of the changes made through the year.

When she walked into the baby's room she was surprised to see a bed rather than a cot, and it occurred to her that he had also grown. He was not in his room so Tracey went to look for him in the TV room. While she walked to the TV room she described a long hall with pictures of the baby on the wall as well as pictures of trees and animals. She expressed surprise at how much he had grown when she found him sitting in front of the television. He was now two years of age.

She told Riaan that she had come to see him because she had been worried about him and was curious to see how he looked. She was worried that his adopted parents may have thrown him away, or that they had moved. She felt relieved that they were still there. Tracey then began interacting with Riaan, offering him a drink and asking him how old he was. She told him how much she had missed him. He asked her how she knew him. She replied that it was a long story, and then turned off the TV and began. She explained to him how she had heard a baby crying and had felt sorry for it. She picked him up and carried him along the hallway and then down the road to Justin. She told Justin that she could not look after the baby but Justin knew of a couple that

could not have kids and he gave the baby to these people. The little boy asked her if his parents are therefore not really his parents, and she told him that she did not know who his real parents were. Riaan responded by saying that he wished that Tracey was his sister and asked her to come and live with him. Tracey explained that she was living in a very special place – the children's home (she did not explain what this was). They finished their cold drinks and went to play outside on the bicycles. This was clearly an age-inappropriate conversation for a two-year-old but it was clear that Tracey had connected with this young educable male ego state and was nurturing his development.

When Tracey said that their time together was up, Riaan expressed regret that she had to leave. He said that she felt like a sister to him and she explained that she needed to go home but assured him that she would come back to visit. The mother thanked Tracey for coming to visit because Riaan did not have many friends as he only went to crèche on a Monday, Tuesday and Wednesday. Tracey said that she would come back to visit as she did not have a lot of time that day. But then, almost in an attempt to extend their time together, she asked if she could bath Riaan. She bathed him and put on his "Bart Simpson" pyjamas. After having supper with them, Tracey said she had to leave as it was getting late. She thanked them saying that she had enjoyed her day and hoped that they could do it again, and perhaps next time go swimming. She clarified when his birthday was - it was two days before hers – and she said she would visit him on his birthday. They walked Tracey halfway to the gate and Tracey thanked them for their time and for the sweets. Riaan started to cry and held onto Tracey's shirt and told his mom that he did not want her to leave because they played so nicely. Tracey explained that she had to leave.

At this point Tracey said to the therapist that she felt like crying with him because she had not seen her little brother (3) for such a long time. The visit ended with Riaan telling Tracey that he loved her, that he did not want her to leave and that he would always remember her because she had saved him. Tracey was reluctant to leave Riaan and returned back to the gate after she had walked halfway down the street. He was still standing at the gate and she said that maybe she would come back next week. They were both very excited and jumped around. They then said a final good-bye.

6.4.14. Session fourteen

The first thing that Tracey commented on in this session was the fact that she was growing up physically and emotionally and that it was too much for her. She noted that her hair had grown and her attitude had changed. She said her feet had grown and her body was changing (she was growing breasts and had started wearing a bra). While the intervention had dealt predominantly with Tracey's traumatic life experiences, these needed to be seen against the backdrop of entering adolescence. Therefore in addition to the emotional work, physical changes were taking place and Tracey was also asking herself fundamental questions of who she was.

Tracey was reluctant to enter into the visualisation as she was finding them emotionally draining and traumatic. Acknowledgement was given as to how difficult and painful the sessions to date must have been for her but that when she was ready it was important to continue the process that the intervention had begun. Therefore when she felt that she was ready a semi-hypnotic trance was entered into. She saw a young woman who was twenty years old – this was Kim who was mentioned in the first session. Kim had dark brown curly short hair and green-brown eyes. She was wearing a tank top with three-quarter pants and earrings. She was pretty and had a smile on her face. She was riding a bicycle. It is important to note that she was described so positively. There was a twenty-three-year-old girl with her who Tracey described as having black hair and a dark skin colour. Her name was Jo-Anne and she was roller-blading.

Kim told Tracey that she enjoyed riding her bicycle, roller-blading, sleeping, playing with the neighbour's kids and that she was very happy. She said she worked as a cashier at a shopping centre. Then she asked Tracey if she could give her advice – she wanted to tell her that she should finish school and go to university to get an education. Kim explained that she was never able to study further because she did not have any money and therefore she would like Tracey to have the opportunity, to which Tracey agreed. Kim told Tracey that she was a beautiful girl and that she must stay away from drugs and alcohol because they are dangerous. Tracey refused to accept that she was beautiful but thanked her for the compliment. It was clear that the teacher ego state was giving Tracey the advice. There was a part of Tracey that was willing to accept her positive traits and paint a different future for herself.

Kim then offered to take Tracey on a journey to one place. She gave her a pair of roller-blades and socks. They roller-bladed together down a long road until they came to an old house. Tracey asked her why she brought her to this house and she answered that it was a memory. Tracey immediately responded that she did not have any memories; Kim said that she was going to start having memories again; she almost gave her permission to start recalling past events that had to date been denied.

Kim told Tracey to go into the house, but Tracey was reluctant and told her that it would be "too bad" for her to remember it. Kim assured her that it would be beneficial. Kim asked her if she remembered the day that her father used drugs because she wanted her to recall that day. Kim went on to describe the course of events. Tracey's mother was sober and she asked Tracey to ask her dad, who was sitting outside, for money for food. Tracey first asked, and then pleaded with her father, but he refused to give her any money. The mother then went to ask the father for some money and again he refused. Tracey's mother tried again, this time sitting down next to the father and asking him for money for the kids for food. The mother then secretly took his bag with "dagga" in without him noticing, and went back inside the house. Tracey asked her father again for money but this time he held up his hand as a trigger and threatened to shoot. The kids ran away from him into the house. They closed all the windows and doors. The father came towards the house and started knocking. He started shouting for them to give him his dagga or they would die. He then said that if they did not give it back they would not get money for food. He began kicking the windows out. Tracey ran out the house and phoned the 10111 (the police) and asked them to come to the house, giving them the address. The police came but they rode past the house three times. Eventually, out of frustration, Tracey ran into the middle of the road to stop the police car. She begged the policemen to help, and explained to them that their father sat at home drinking while their mother had to work. The policemen asked the mother if she could prove that the father had dagga, and Tracey interrupted saying "yes sir". She ran to fetch the dagga. The policemen asked them if they wanted to lay charges to which they responded yes. The policemen were "big" and "strong".

Men were consistently depicted as violent and aggressive. It was only internal the memory – whether factual or fantasy – of her stopping the policemen in the road that alternative way of being a man was represented. The split masculine was presented by the police ego state which represented protection. This was the second indication that Tracey could understand and conceptualise that men could be good. The symbolism of this story was that Tracey had finally triumphed over the violent masculine. However after victory must come redemption. The young educable masculine go states now became critically important so that Tracey could introject a non-abusive and non-violent masculine ego state allowing her to experience a loving relationship with a partner. A positive feminine ego state had also begun to be germinated, one which had the potential to be kind, gentle and loving, in order to prevent her current principle feminine ego from growing up to be angry, tough and abused.

6.4.15. Session fifteen

In this session, Tracey described feelings of despair. She felt that although she was trying very hard to change, the world did not seem to be listening. The sibling rivalry between her and her sister, which had been the backdrop of many sessions, came to the fore in this session. She felt that everyone always believed her younger sister Ruth. This was more than an expression of jealousy - she had an acute awareness of not being able to portray herself to the world in a different way. She felt that Ruth was able to portray herself as an angel. She felt very angry, hurt and sad. Therapy involved discussing practical ways of allowing a different ego state to dominate so that Tracey could own some of those characteristics in Ruth that presently irritated her and to stop carrying all the negative traits for her and Ruth.

She then stated that she did not even feel like she had parents. She said that she never saw them and that they never came when they said they would. She felt they were deceitful and that their promises always came to naught. According to the social worker there was no contact between her and her parents. She concluded that the next time they phoned, she was going to tell them that it does not work like this and that they could not just phone when it suited them. To tie the session together she stated that even when they lived at home, her parents only saw Ruth's good side.

6.4.16. Session sixteen

This was an important time for Tracey as she had been assigned to a couple who she visited on some weekends and during the holidays. It was a significant step because she was separated from Ruth for the first time and it gave her space in which to experiment with an alternative ego state. She began behaving in a completely different manner. It was a big boost to her self-esteem. It also helped the therapeutic process, as now in addition to finding new ego states representing alternative male and female personalities, she could also experience and interact with different types of people.

6.4.17. Session seventeen – final session

Therapy began with a brief discussion on what school she would be going to the following year. Tracey then decided that this session should be spent visiting Kim to say "good-bye". The visualisation was left unstructured and Tracey found herself in what she described as the first room that she had ever seen Kim in, with the posters on the walls. The room was clean but Tracey noticed some clothes on the bed and when she asked Kim why they were there, Kim told her that she was going to visit some kind people. They discussed these people and Tracey told her that she had also met some kind people to whom she was going that Friday.

Kim and Tracey proceeded to have some coffee while listening to the radio. She told Kim that she liked going to "her people" because then she was not so lonely. She also told her that in order for her to continue going there, she would have to stop fighting and being cheeky. Then she assured Kim that she was trying and was getting it right. Kim told her she had tried her best and she hoped she could "keep on". This was positive reinforcement for Tracey's efforts over the last year in attempting to change her behaviour. It was not only about a change in behaviour but also a change in the way she viewed herself.

While they were watching television and chatting, there was a knock at the door. Tracey immediately felt very scared while Kim opened the door slowly. There was a person with his back turned. Kim felt so scared that when the person turned around she slammed the door and ran away. There was another knock and someone said, "It's

me, don't you recognise my voice?" Kim said that the voice sounded familiar and she went back to the door. She opened the door and Justin was standing there.

Kim asked him if could see any changes in Tracey and he answered that he could see that she was inquisitive, polite and "stuff". Therefore both her teacher ego state and young masculine ego state reinforced changes in Tracey. Possibly the young masculine ego state saw Tracey's feminine qualities that had begun to emerge. After spending some time together Tracey walked Justin to the gate and said good-bye.

Kim and Tracey sat until there was another knock at the door. Tracey commented that perhaps it was Justin again but when they opened the door Riaan and his mother were there. Tracey asked them in surprise how they knew that she was there to which they answered that they had bumped into Justin who had told them. Riaan jumped into Tracey's arms and said that he had missed her. They went to play outside together but the mother said that they could only stay for a while, as Riaan had to go the dentist. They ate and drank. It was time for Riaan to go – he said good-bye and Tracey told him that she would miss him.

Tracey told Kim that she thought they had had a wonderful day. They said good-bye to each other and Kim walked her to the gate and gave Tracey a present. The visualisation was nearing an end but Tracey said, "Wait, I want to visit my grandfather". She walked to the grave with some red and white roses. She put the flowers down and was flooded with the emotion of why he could not be with her to celebrate Christmas (this final session was in November). She became teary and said that she wanted her grandfather to always be with her and that he would always be in her heart and that she loved him. She said that she was finished and the visualisation ended.

This session almost served as a summary for all the previous sessions. An alternative executive ego state had begun to emerge, one which was engaging and soft in manner. New masculine and feminine ego states had also emerged. The masculine ego state was able to treat women with respect and not be violent or aggressive. The feminine ego state was confident about what she wanted and demanded to be treated with respect. It also was able to incorporate feminine qualities of beauty and charm. Tracey

seemed to have transformed from an angry, aggressive teenager into one who saw herself as kind, thoughtful and caring.

6.5. Conclusion

Only on retrospective analysis can one truly appreciate the depth of work done throughout the year. Upon initially receiving the case there was a feeling of hopelessness as to how much benefit the intervention would really have. Her circumstances were unlikely to change; the changes that needed to take place would have to be internal. Tracey herself needed to be empowered and the therapy needed to allow for a change in the internal dynamics.

As the above sessions show, each traumatic event produced an ego state in order to help Tracey cope with her day-to-day living. However, although these ego states served their purpose at the time that they came into being, their behaviour became inappropriate over time, and impacted negatively on Tracey's actions and social relationships. This is why she was referred for therapy. Therapy needed to be about allowing repressed emotions and experiences to emerge in order for them to be processed and dealt with. Only by doing this could her life experiences be fully integrated, which would require the cooperation of the various ego states.

The therapeutic setting was used to create a container for Tracey's anger, hurt and vulnerability. The intense nature of these feelings required a container to allow them to emerge. Ultimately it was hoped that Tracey would introject the therapeutic setting and take it with her into her day-to-day life. An aim of therapy was enabling Tracey to contain her emotions, so that she would be able to fight less and express her frustration and anger in ways that were more appropriate and at the appropriate people. Tracey would then be able to form meaningful relationships with her peers and adults.

A central aspect of all of the above entailed integrating the split in her psyche and beginning to form a whole individual with both positive and negative traits. Tracey needed to acknowledge her various ego states and learn from them. There were certain key ego states that played an integral role throughout the therapeutic process and allowed critical breakthroughs to occur.

During the course of intervention, the male and female ego states went through significant changes. It was only when Tracey was able to send the abusive, violent and aggressive male for rehabilitation that an alternative male ego state could begin to emerge, with qualities of strength, protection, love, respect for women and kindness. Similarly, once Tracey had acknowledged the negative traits of her mother – that of both vulnerable victim and abusive parent, the female ego state could begin developing into a strong, charming, beautiful lady who demanded to be treated with respect.

All the crucial changes and breakthroughs were made possible by acknowledging when the ego states were formed, going back to these traumatic incidents and processing them. Therapy would have been jeopardised if an alliance had not been formed between the therapist and the progressed self. The progressed self came into being to suppress the traumatic memories in order to hide the hurt and pain. It felt threatened at the emergence of these memories. It was only by allowing the regressed self to express these emotions, that Tracey could begin the process of healing.

The intensity of the emotions experienced made it very important to create a safe place, which could become a familiar holding ground for Tracey after the trauma of the visualisations. Similarly, the introjected teacher who accompanied Tracey during the visualisations allowed her to feel safer than she would have on her own.

Ego state therapy was not the only therapy that could have been used. However, it did provide a useful framework with which to view Tracey and her past experiences. The nature of the semi-hypnotic trance used may have speeded up the process of discovery and growth. Also, the nature of therapy was not pre-determined; it was pursued largely due to Tracey being such an outstanding candidate for this type of therapy. It is probable that due to the complexity of Tracey's case, had a specific route been determined, with no room for direction from the client, little would have been achieved.

Having said that, the therapist's role could possibly have been a more directive one. Tracey was given a lot of leeway, which allowed for the emergence of states and

memories that would otherwise have been difficult to access. However, more therapist direction could have facilitated dialogue between the ego states, which would have made the therapeutic process even more beneficial. The ego states that emerged were dealt with primarily during the visualisations; more detailed discussion and interpretation of these events should have concluded each session.

The executive ego state denied her hurt and pain, using toughness as protection from the world. This ego state probably developed because of the abuse she experienced. It's thoughts would probably be that Tracey must not show her hurt or she will be rejected again. She must therefore act aggressively and rudely to conceal the pain. The opposite of this ego state would be the ego state that presents as hurt and scared. The world refuses to listen to this part of her, as it does not correlate with her 'rebellious' exterior.

As therapy progressed, Tracey discovered other ways of being. She described herself as sometimes happy, sometimes wonderful, cute if she wanted to be and capable of not fighting. She also played with the idea that she was beautiful. These were alternative ego states that did not correlate with the executive ego state. Her executive ego state demanded that she be disobedient, cheeky, rude, talkative and aggressive. As therapy progressed there were more and more times when she gave expression to alternative ego states by being obedient, well mannered, polite and not aggressive.

The character she had constructed had a 'bad' attitude, was cheeky and aggressive and below the surface (the regressed self) was the opposite polarity of wanting to be loving, kind and helpful. Tracey had started to recognise that she was also the opposite of how she predominantly behaved. In the last session, she said that she knows that she can have a good attitude, be loving and kind. This realisation will allow her to start experiencing the whole of life. Her ego states reflected an internal dynamic. The role of therapy was to reconcile the internal dynamics.

Over the year she began to experiment with different ways of being and a gentler, more feminine, side began to emerge. She began taking pride in her appearance and began experimenting with different hairstyles. She often giggled with delight during

the sessions and spoke about her infatuation with a boy. The therapy room became a safe environment for her hurt and pain to emerge.

Chapter 7 - Conclusion

7.1. Introduction

The aim of this study was to explore the possibility of using ego state therapy in the context of an adolescent's experience of physical child abuse within a chaotic family environment influenced by substance abuse by both parents. A study of the available literature on the subject matter seemed to reveal a general dearth of guidelines for therapists in dealing with such complexity. This was part of the rationale for attempting to use ego state therapy on this client. This was particularly informed by the growing body of literature (Ross, 1996) which links dissociative symptoms and disorders to childhood experiences of abuse, and it is exactly these symptoms that ego state therapy addresses.

The alarming statistics of the incidence of child abuse clearly highlight the need to develop intervention programmes for maltreated children. Despite the short and long term problems associated with child abuse the majority of intervention programmes focus on the abuser rather than the abused. While it is true that the general tenets of therapy are applicable when dealing with abuse, the issues specific to such clients need to be addressed when designing an abuse focused intervention programme.

The development of dissociative defenses appears to occur more readily in childhood. There is also increasing evidence to suggest that severe dissociative disorders are frequently linked to early childhood trauma (Goodwin & Sachs, 1996). This is because children have a greater innate dissociative capacity, as well as a less mature and developed capacity to tolerate stress. This partly explains why severely abused children develop more dissociative symptoms (Chu, 1996). Therefore, dissociation appears to be an available psychological defense in children whose limited coping capacities are overwhelmed by extremely traumatic events. While ego state therapy is presented as an intervention option for the treatment of child abuse, it is not intended to be a protocol.

7.2. Overview of this study

Ego state therapy appears to provide an effective framework in which to address this dissociation. Tracey presented with aggression and poor peer relationships. This,

together with her history of childhood abuse, indicated that her personality was somewhat disintegrated as a result of the various ego states formed at the time of the trauma. Also, ego state therapy is indicated for clients who are motivated and hypnotisable. Tracey met both these criteria. Ego state therapy involves the resolution of conflicts between the various ego states that are causing intrusive and distressing symptoms as well as maladaptive behaviours. This approach has proven effective with adult victims suffering from the after-effects of childhood abuse (Hartman, 1995). Grove (1995) points out, however, that the application of these techniques with children, and specifically abused and traumatised children has been severely neglected.

Tracey provided the opportunity of assessing these techniques on an abused adolescent. Various ego states emerged during the intervention process and ego state therapy was used to address the life events that emerged through the course of the intervention in a meaningful way. Each ego state had its own origin, history, thoughts and feelings. According to Watkins & Watkins (1997), the dissociative formation of Tracey's ego states was a creative human response to the trauma she had experienced. The ego states were adaptational and had come to help, and it was crucial to realise this in order for the therapy to advance. Ego state pathology occurred when the parts were not in harmony with the others, acted on their own and produced symptoms. Such ego states could be thought of as not being in cooperative communication with the other ego states. This was viewed as protective and is frequently associated with trauma. In order for maturation and healing to take place the ego states needed to have experiences with the other ego states. As ego state therapy proceeded, the parts developed more co-consciousness, that is, the sharing of mental content and feelings with one another. This advancement was one of the many precursors of integration. Integration occurred when the parts were in communication with one another and were working together harmoniously and co-operatively.

The last session with Tracey indicated the usefulness of this therapy with adolescents. In this session all the various ego states presented in an integrated fashion. The therapy showed a progression from repressed memories influencing Tracey's day to day behaviour to allowing these memories to be processed, experienced and dealt

with. The dialogue between the various ego states made a profound impact on Tracey's interaction with the world and perception of self.

7.2.1. Strengths of this study

This study presents a theoretical overview of the existing literature on both the effects of physical child abuse, exposure to marital violence and parental substance abuse as well as ego state theory and therapy. It adds to the knowledge base clinicians and/or future researchers with a knowledge base from which to understand an adolescent's reaction to and experience of these areas of abuse. The study generated a number of suggestions for further research and a number of implications and hypotheses for clinicians working with survivors of childhood abuse were raised. It is hoped that this documented exploration and interpretation of the use of ego state therapy for the intervention of childhood abuse contribute to the neglected area of treatment models for these individuals.

Qualitatively regarded, the intensive study of an individual gave the therapist a broad context for interpreting the meaning of her behaviour. The therapist obtained a unique and penetrating knowledge of the relation of the client's behaviour to her present life situation and to her past history, which may have provided a basis for understanding the more general conditions of human behaviour (Kvale, 1986). The sheer number of observed events in one therapy exceeds those of many psychological research projects and the therapeutic method in general is conducive to the development of knowledge (Mahrer, 1998). It also allowed for the generating of advances throughout the field of psychotherapeutic practice, opening new avenues of psychotherapeutic research and integratively blended theory, practice and research in the field of psychotherapy.

The strength of the therapy research method involved the intensive study of an individual case that may have given a comprehensive understanding of individual development. The open mode of observation made possible the discovery of unexpected phenomena. The interpretation of meaning gave access to depth knowledge of human existence and the historical dimension gave a context for the formulation and the testing of interpretations. The human relationship of the therapeutic situation involved the trust necessary to get disclosure of the deeper levels of Tracey's personality.

7.2.2. Limitations of this study

The qualitative approach to describing and analysing the experience of one adolescent permitted a wealth of information to emerge. It is clear, however, that the study cannot be generalised to other cases or similar situations. The individual case study therefore involved several pitfalls as a research method. There is the danger of overgeneralisation from small number of cases to the population at large; and the focus on individuals as units of study may lead to an individualisation of social problems, neglecting their historical basis (Kvale, 1986). Although the study suggests that ego state therapy might be a productive intervention for child abuse, this cannot be stated categorically. The particular racial and socio-economic demographics of the client might further complicate any generalisability. The study also does not offer an exact protocol for applying ego state therapy, even in cases that might be highly similar.

The lack of systematic observational procedures made the documentation dependent on the therapist's selective memory and notes. With the large number of observed events, the structuring of the extensive material was in danger of becoming highly dependent on the therapist's guiding interest. The private, closed therapy situation and the lack of systematic recording made an intersubjective control of the reported observations difficult. A further limitation of the study is that it fails to report on whether Tracey maintained any of the gains made during therapy.

7.2.3. Recommendations for further research

This study constitutes a qualitative analysis of the perceptions of a single individual. On its own it cannot provide the whole picture of the experience of childhood abuse. However, as Tesch (1990) points out, as the qualitative descriptions of various studies within the same field accumulate, they will make it possible for investigators to gradually recognise the phenomenon in the sense of a second, fuller knowledge. For this reason, similar studies on the individual's experience of childhood abuse and the use of ego state therapy as an intervention could add to the findings of this study. Specifically, it would be valuable to determine whether similar findings would be elicited from participants from different racial and socio-economic groups.

Furthermore, it is recommended that experiential research be carried out comparing ego state therapy with other protocols.

7.3. Conclusion

This work arose directly in response to an actual therapy case. The motivation behind such a presentation was to share a unique case with other clinicians and/or future researchers. The case study showed the use of ego state therapy with an abused adolescent. While no generalisations can be made from one case study, it is hoped that further research can be done and that clinicians can consider an alternative treatment method when dealing with traumatised adolescents. This study does not purport to necessarily hold any universal applicability but aims to give a perspective on the particular treatment process of a particular client. Essentially the study followed a qualitative research approach, which infers the intensive study of a single case. The goal of the study was not to support a hypothesis but rather to generate rich descriptions of phenomena.

The study presented an overview of the relevant literature pertaining to physical child abuse, exposure to marital abuse and substance abuse by parents as well as ego state therapy. The case study described certain ego states that emerged during the therapeutic intervention with the client. These ego states can be seen as the result of her exposure to abuse within her home environment. The detailed case study was presented to illustrate the application of ego state therapy to a survivor of childhood abuse. As stated above the general lack of information available on the treatment of children and adolescents who have been removed from their homes of origin motivated the use of ego state therapy. At no time was the purpose to propose that ego state therapy was the only beneficial intervention for survivors of child abuse, however, this particular case study certainly seems to indicate its appropriateness.

The success of the intervention can be seen in the final session, which demonstrated the integration of Tracey's personality that had taken place over the course of the year. The changes in her behaviour and interaction with her peers and those in authority also indicated the usefulness of this approach. Tracey's emotional development was evident and she seemed to reap the benefits from the time spent in therapy.

Ego state therapy is an extension of understandings and procedures developed through the study of severe dissociation. It is based on the assumption that dissociation can be an extreme and maladaptive splitting but that it exists along a continuum, ranging from normal and adaptive differentiation, through an intermediate zone of defensive personality separation. It combines theoretical concepts originally proposed by Paul Federn with techniques of hypnoanalysis to develop a therapeutic approach that promises greater efficiency in the intervention of many normal, neurotic, and psychosomatic conditions, as well as in true dissociative identity disorders (Watkins & Watkins, 1996).

There has been a great need for a psychodynamic therapy that could achieve significant personality reorganisation in less time than required by traditional psychoanalysis. In light of the increasing constraints of managed health care practitioners need to be ever way of the amount of time needed for long term psychotherapy. As medical aids pay much of the remuneration to psychotherapists and other third party reimburses (Watkins & Watkins, 1996), psychoanalysts have had difficulty securing compensation since that approach requires several sessions a week, often for many years. The greatest need in psychotherapy today is to find ways of constructively changing maladaptive behaviour more efficiently and in a shorter period (Watkins, 1993). Ego state therapy shows great promise in moving to that goal, where therapists can provide significant psychological help to more people with modest expenditures of time and cost.

Briefer forms of intervention, such as behaviour therapy and cognitive therapy, while operating within a much shorter time frame, do not generally achieve the more profound character reorganisation that is often required for long-lasting results, especially in the intervention of DID. Ego state therapy holds substantial promise when a therapist seeks psychodynamic resolution of unconscious conflicts within comparatively lesser number sessions (Watkins & Watkins, 1996). Consequently it seems to be an appropriate therapy for the South African context given the financial constraints of the majority of people in the country.

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