REPRESSED MEMORIES, DEPRESSION AND SUBSTANCE USE DISORDER: A PASTORAL NARRATIVE APPROACH

by

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CLARIFICATION OF TERMS

Acetylcholine: refers to a molecule that functions as a neurotransmitter in the parasympathetic nervous system.

Allostasis: Taking action to accomplish stability in the midst of physiological or behavioural change.

Alter: A self-state that thinks, acts and feels considerably different from other sef-states.

Amygdala: The primary region where the regulation of fear occurs. It receives sensory input from various other parts in the brain and sends out *"*signals*"* to these parts that intervene in fear responses.

Anterior cingulate cortex: A structure located in the middle wall of the frontal lobe.

Autonomic Nervous System: A segment of the peripheral nervous system that provides smooth muscle and glands and therefore influences the internal organs.

Biomedical model: A biological system regarding normal and abnormal activity from gene to phenotype in humans. The system serves as a basis for preventative and therapeutic intervention in human diseases.

Body memory: Memories that are preserved in the body, specifically in the event of trauma where the individual repressed the memory in the brain.

Cardiomyopathy: A disease that affects the heart muscle and causes difficulty with the transferring of blood from the heart to the rest of the body.

Coronavirus: A group of ribonucleic acid (RNA) viruses that cause different respiratory, gastrointestinal and neurological diseases in both humans and animals.

Corpus callosum: A comprehensive thread of nerve fibres that connect the two hemispheres of the brain.

Depersonalization: Feeling of detachment from the self, as if observing oneself from a third party point of view.

Derealization: Feeling of detachment from the environment. People and objects in the environment feel unreal.

Dissociation: A broad range of experiences from mild detachment from the immediate surroundings to a more severe disconnection from both physical and emotional experiences.

Dissociative Amnesia: a process where mental content barred from an individual's conscious memory in order to avoid emotions that can cause distress

Fibromyalgia: A disorder characterized by extensive musculoskeletal pain, followed by fatigue and sleep, as well as memory and mood issues.

Hypothalamus: A division in the forebrain underneath the thalamus (grey matter) which is responsible for regulating the autonomic nervous system. It also regulates the pituitary, which in turn regulates body temperature, thirst, hunger and other homeostatic systems. Another function of the hypothalamus is to regulate sleep and emotional activity.

Inhliziyo iphansi, ingqondo iyagijima (isiZulu): The mind is running, the heart is down.

Irritable bowel syndrome: An extensive condition that involves persistent abdominal pain along with diarrhoea or constipation. It is often linked to stress, anxiety, depression or a prior intestinal infection.

Kufungisa: Thinking too much.

Limbic System: A complex system of nerves and networks in the brain that deals with emotions and memory. It regulates autonomic or endocrine function in response to emotional stimuli. It is involved with an individual's instinct and mood. Basic emotions such as fear, pleasure and anger as well as certain drives such as hunger, sex and dominance are regulated by the limbic system.

Mammalian Brain: The part of the brain that regulates functions such as memory and learning.

Mindsight: The ability to acknowledge one's own thoughts, feelings and memory. It also includes the ability to tune in to the feelings, thoughts and meaning making of others.

Neurotransmitter: A chemical substance discharged at the end of a nerve fibre when a nerve impulse is received. It influences the transferring process of the impulse to another nerve fibre or muscle fibre. One of the neurotransmitters, for example, plays a role in the fight-or-flight response.

Neurotrophin: A group of proteins that are responsible for the survival, development and function of neurons.

Node: A data processing unit that comprises of one or two weighted input connections, a transfer function that connects these inputs and an output connection.

Polyvagal Theory: This theory concerns the role of the vagus nerve in the regulation of emotions, social connection and the fear response. It has provided a more refined interpretation of the biology of both safety and danger. It explains why certain actions of individuals have an influence on how they feel. For example, a kind face or soothing voice can change how they feel.

Repress: To quiet someone or something by force.

Reptilian Brain: Responsible for the regulation of the body's imperative functions such as heart rate, sneezing, swallowing and vomiting.

Scaffolding: Scaffolding conversations enables individuals to distance themselves progressively from their comfort zone and move toward what can be possible for them to know and do. In bridging this gap between the known and the unknown, individuals experience a sense of personal agency.

Second Psychological Birth: This takes place when the "whole" individual develops in a healthy way to form an own unique personality.

Supramodal: Refers to a part of the brain that performs abstract functionality that is customary to one source of sensory data. For instance, the parts of the brain that are concerned with language processing can combine data from the visual, auditory and tactile parts of the brain.

Supress: The action of deliberately preventing a thought or feeling.

Sympathetic Nervous System: Regulates the energy in the body and controls arousal which includes responses such as fight-or-flight.

Ukucabanga kakhulu: Very thoughtful (thinking too much in the Shona language).

Vagus Nerve: Historically known as the pneumogastric nerve. It is the tenth cranial nerve and is connected to the parasympathetic connection of the heart, lungs and digestive system.

Zoonosis: A disease that can be transmitted from animals to humans.

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ABSTRACT

Many individuals who have experienced childhood trauma repress memories of the experience. They block it from their consciousness. As they grow older, their mind does not recall the event and they have no recollection of the experience. However, the traumatic experience does remain part of the individual's life. It is engraved in the body and subconscious mind. This can result in the person reacting to triggers, but not being able to explain the reaction. This study aims to investigate the effects of childhood trauma, repression of the experience or experiences, and mental disorders that can be one of the consequences. The primary mental aspects that this study investigates are dissociation, depression, depersonalization-derealization and dissociative identity disorder. A response to such problems is often self-medication. Therefore, the study also explores the harmful effects of some forms of self-medication on the brain, as well as on primary areas of the individual's life and the body that are significantly affected. A pastoral approach for guiding individuals with mental struggles and, in certain cases, also self-medication, is developed in the study. This is done by means of a combination of Pastoral Narrative Counselling and Daniel Siegel's Wheel of Awareness meditation practice. In this way the pastoral counsellor and counselee can embark on the road to holistic healing together.

DECLARATION OF ORIGINALITY

I, Simonè van Schalkwyk, 16396147, understand what plagiarism is and I am aware of the University's policy in this regard. I declare that this thesis is my own original work. Where other people's work has been used (either from a printed source, Internet or any other source) this has been properly acknowledged in accordance with departmental requirements. I have not used work previously produced by another student or any other person to hand in as my own. I have not allowed, and will not allow, anyone to copy my work with the intention of passing it off as his or her work.

TABLE OF CONTENTS

Table of figures:

CHAPTER 1

INTRODUCTION

1.1 Background

Most people experience some form of trauma at some point in their lives. When a traumatic event occurs, it should receive the necessary attention in order to prevent psychological and spiritual damage. Trauma narratives have existed since the times of Homer, Aristotle and Sigmund Freud (see Oorlog 2016:1). Philosopher Robert Stolorow (2015:13; cf. Oorlog 2016:1) describes the 21st century as the "Age of Trauma". Stolorow's ongoing research project on the nature of emotional trauma was an endeavour to understand how trauma influences a person's mind. Results have shown that emotional trauma has its roots the "absolutisms of everyday life" being shattered (Stolorow 2015:14).

When a significant traumatic event occurs in the world, the emphasis often shifts from the healing of traumatized individuals to attending to the collective. Individual and collective trauma are interrelated. Kaplan (2005:1) explains it as follows: "How one reacts to traumatic events depends on one's psychic history, memories inevitably mixed with fantasies of prior catastrophes … and how it is 'managed' by institutional forces". Trauma studies have developed since the writings of Sigmund Freud. Freud's well-known work titled *Beyond the pleasure principle*, remains significant in discussions on trauma, specifically his explanation of what he called "traumatic neurosis", today known as "post-traumatic stress disorder" (Freud 1920:6). Oorlog (2016:7) explains that these traumatic neuroses differed from other "hysterias" identified by Freud, in the sense that individuals who had been traumatized, showed signs of "subjective ailment". Freud compared this subjective ailment to a feeling of *fright*. The individual is confronted directly and unexpectedly by something frightening. This stands in contrast to *fear* which has a "definitive object" and to which the feeling response is *anxiety*. Where there is fear, the person has had time to prepare. Where there is fright, there is no time to prepare.

For those who suffer from traumatic neurosis, the “fright” often recurs in dreams that persistently take the individual back to the moment of the traumatic event. There is a separation, according to Freud (1920:18), between the conscious and the unconscious. People who have memories of trauma often invest much energy in an attempt to avoid the memories. Those who experience what Freud called “traumatic neurosis”, have either minimal or no control over the memories since they only appear in an unconscious (dreaming) state. In order to protect the person from childhood trauma, *dissociation* takes place. Dissociation then also makes it impossible to address the feeling of “fright”, because that feeling is not accessible. Freud (1977:18) explains why this impedes a person’s progress: “The patient cannot remember the whole of what is repressed in him, and what he cannot remember may be precisely the essential part of it … He is obliged to ‘repeat’ the repressed material as a contemporary experience instead of, as the physician would prefer to see, ‘remembering’ it as something belonging to the past”.

Trauma that occurred during childhood is often repressed. The memories then return in a “disguised” form. In the past, the term “hysteria” indicated a psychological disorder where psychological stress caused a change in self-awareness. This change in self-awareness could include symptoms of dissociative fugue or selective amnesia (see Lewis 2011:298). Repressing memories of trauma can cause the development of dissociative disorders or can lead to other forms of illness and mental illness such as, for example, depression.

This study focuses on the development of dissociative disorders that result from trauma. Such disorders include dissociative identity disorder (DID) and depersonalization disorder. The study explores how memories are formed by the mind and traces the process of how dissociative amnesia develops after a traumatic experience. The aim is to investigate a possible connection between trauma, these disorders and the manifestation of substance use disorder and suicide ideations and behaviour. With a better understanding of these conditions that set in as a result of traumatic experiences, pastoral caregivers can be more effective in their support of the people entrusted to their care. The aim of the study is therefore to identify a

useful pastoral care model for the care and support of sufferers. The narrative approach to pastoral care and counselling and Daniel Siegel's Wheel of Awareness are evaluated for their usefulness in this regard. The aim of pastoral guidance is to provide support to individuals in the painful but necessary process of the integration of traumatic memories. The goal of pastoral engagement is to support psychological and physical healing on the journey to spiritual wholeness.

1.2 Problem statement

Repressed memory, or dissociative amnesia as it is known today, plays a significant role in the lives of individuals who suffer from dissociation disorders as a result of intense or repeated trauma. Mental health problems affect an individual's overall productivity, self-confidence, will to live and social interaction. For effective pastoral care and counselling with people who suffer from these complicated and severe conditions, pastoral caregivers should understand the intricate mental and psychological processes involved. This includes the process of how the mind prevents certain traumatic memories from surfacing and how depression can cause physical symptoms that are often misdiagnosed as, for example, fibromyalgia or irritable bowel syndrome. From a holistic perspective, religion can exacerbate existing mental and emotional problems. On the other hand, spirituality and religion can also play a positive role on the long journey toward healing and wholeness. This study aims to investigate the problems, dangers and potential positive contribution of religion and faith, in order to develop guidelines for effective pastoral care.

1.3 Literature overview and research gap

Dissociative amnesia is defined by Freud (1915:147) as a process where mental content is kept out of an individual's conscious memory in order to avoid emotions that can cause distress (Knafo 2009:172). Otgaar et al. (2019:512) point out that the investigation of psychological trauma and the repression of autobiographical memories has a long history. It began in the 1990's and has continued to this day. It

has been a controversial topic. Frederick Crews (1995:1-30) refers to it as the "memory wars" (Otgaar et al. 2019:519; cf. Pendergrast 2017:xix; Belli 2012:4-14). With regard to repressed memories, the following three main aspects are significant (Otgaar et el. 2019:1073):

- Individuals repress memories that are too traumatic for the psyche.
- Repressed memories can potentially lead to psychopathology.
- The recovery of traumatic memories is essential for the relief of symptoms.

Depression is about the suppression of aggression or "helpless rage". It can result in symptoms such as the loss of interest and pleasure, feelings of guilt and worthlessness, disturbed sleep and even suicide ideations (Lopez Mu Noz and Alamo 2012:1). These are the result of complex neurobiological processes, which involve biochemical, genetic and environmental factors. It is one of the most significant mental disorders in contemporary times. It results in major socioeconomic risks and is detrimental to quality of life. Lopez Mu Noz and Alamo (2012:xxiii) build on the neuropsychological model developed by Heller and Nitscke in 1997. They identify hypo-activation in both the left frontal and right posterior in the brain as a major cause of the cortical pattern of depression.

Neurophysiological studies have shown that depressed individuals have certain deficits that are the driving force of depression. These deficits are connected to serotonergic and stress mechanisms (Lopez Mu Noz and Alamo 2012:xxiii; cf. Cowen 2013:1-14). The depressive state can become recurrent and can interfere with the person's ability to deal with everyday life, including daily tasks such as school attendance, work and self-care. Individuals who suffer from severe depression and who go without treatment are more likely to revert to self-death.

There is a difference between a person "feeling depressed" and depressive disorder. An individual who feels depressed experiences minimal symptoms of depression and only for a short period. Symptoms include a feeling of sadness, loss of interest, the loss of pleasure, reduced energy and decreased activity. Their concentration is impeded. Someone who suffers from "clinical depression" will exhibit more severe

symptoms that last longer (DSM-5 2013:186-188; see Cowen et al. 2013:5; Cesar and Chavoushi 2013:5; Paykel 2008:282). The following criteria are utilized by Cowen (2013:5) for determining the severity of the depressive episode:

Mild Depression	***Moderate Depression***	***Severe Depression***
Depressed mood	Depressed mood	Depressed mood
Decreased energy and reduced activity	Decreased energy and reduced activity	Decreased energy and reduced activity
Reduced concentration	Disturbed sleep	Loss of interest and enjoyment
Pessimistic thoughts	Diminished appetite	Reduced self-esteem and confidence
	Ideas of self-harm	Reduced concentration
		Ideas of self-harm
		Ideas of guilt and unworthiness

The contradictories of good and evil occupy people's daily memory. That is part of being human. In the contemporary world with all its challenges, pastoral caregivers often struggle to attend to the brokenness of the individuals in their care. Marin (2014:24) explains this difficulty as follows: "Clergy are most often the ones scrambling to keep up with the ever-changing constructions of experienced trauma by people in their ecclesial communities". The greatest challenge with regard to trauma is not the trauma in and of itself. It is rather the memories of the traumatic event that are ingrained in the individual's mind. These memories replay themselves, often for the remainder of an individual's life. Pastors should be equipped to identify, understand and effectively guide individuals who go through the process of healing from trauma (Schoeman 2007:15; see Switzer 1989:23).

Substance use disorder, previously referred to as “substance abuse” or “drug abuse”, occurs when substances are used in amounts that are harmful to both the persons themselves and those around them. In the medical field, the term “drugs” also refers to medicines or substances that are used to cure disease, relieve symptoms or to provide certain benefits (O’Shaugnessy 2015:8). Substance use can range from mild (e.g. caffeine) to severe (e.g. cocaine). Substance use disorder is often related to but not limited to the use of:

- alcohol;
- methamphetamine (a stimulant);
- flunitrazepam (a sedative drug);
- ritalin (a stimulant).

Substance use disorder is often caused by other underlying disorders such as post-traumatic stress syndrome (PTSS) which is an anxiety disorder. The effect of the specific substance on the brain is to temporarily “erase” unwanted memories (Tipps et al. 2013:1; see O’Shaugnessy 2018:5, 8-9; cf. Volklow and Boyle 2018:729-730). Stress can also lead to a person craving addictive substances or it can cause a relapse. Tipps et al. (2014:1) put it as follows: “Humans with substance dependence most commonly identify stress and negative mood states as reasons for relapse and ongoing substance abuse.” Some addictive substances have powerful stimulus properties and can temporarily increase excitement, interest and energy levels. However, these levels are depleted rapidly. This can have severe consequences, even intensified thoughts of self-death.

The amygdala is the primary region where the regulation of fear occurs. It receives sensory input from various other parts in the brain and sends out *“*signals*”* to these parts that intervene in fear responses. The hippocampus, the part of the brain that is responsible for learning, also plays a significant role in the regulation or control of fear. If something triggers the remembering or re-experiencing of a traumatic event, it can be psychologically overwhelming to people and they can develop post-traumatic stress syndrome. The DSM-5 (2013:275) categorizes post-traumatic stress

disorder, as it was previously known, as an anxiety disorder. An essential constituent of PTSS is the recollection of fearful memories. PTSS is related to the initiation of a fear memory that is resistant to eradication. Studies that make use of MRI scans, for example, have shown that the hippocampal volume is much lower in patients who suffer from PTSS than those who do not. Tipps et al. (2014:15) explain that, “among individuals diagnosed with PTSD, the incidence of drug abuse and addiction is elevated, with the highest comorbidity observed for alcohol” (Logrip et al. 2011:552).

Substance use disorder is not only detrimental to a person’s body, it also detrimental to the spirit and soul. When pastoral counsellors listen to the stories of individuals with a substance use disorder, be it alcohol or other harmful substances, it becomes evident that the disorder deprives the person of an unencumbered experience and expression of their spirituality. It also detracts from the well-being of families (Woodruff 2003:18). AA founder, Bill Wilson, who himself was a person with a substance use disorder (alcohol), explains his problem as searching for “God in a bottle” (Woodruff 2003:18). Substance use disorder can deprive a person of experiencing God’s sustaining presence. Woodruff (2003:13) identifies the following five tasks of caregivers, namely to:

- **“Show up”**

The first refers to the caregiver being vigilant for any opportunity for contact, assessment, intervention and treatment.

- **“Be dressed”**

The second refers to the caregiver being emotionally and spiritually attentive to pick up essential information. The caregiver should be sufficiently equipped and have the necessary resources to provide effect care for the individual.

- **“Get through the door”**

The third aspect refers to the skill needed to establish trusting relationships with the individuals with a substance use disorder.

- **“Stay in the boat”**

The fourth aspect refers to the pastoral caregiver's ability to journey with an individual even when it seems like an impossible task, rather than just "handing them over" to someone else.

- **"Know when to leave"**

It is essential for a caregiver to know the boundaries of their care and counselling. Pastoral counsellors should be clear as to when assessment and treatment by health and mental health professionals are needed.

An approach that can be useful for pastoral caregivers is the *narrative approach* to counselling as developed by psychologists Michael White and David Epston. It is compatible with pastoral points of departure because it is a respectful, non-blaming approach which places people as the expert of their own life and life-story in the centre. In this approach the individual is separated from the problem – the person *is* not the problem. The focus is on the skills, competencies, beliefs, values, commitments and abilities that will enable them to decrease the power of the problems over their life. This approach provides space for religious beliefs, values and commitments to enter into the conversation and for dialogue with beliefs and values from other areas of life.

Human beings are interpreting beings. They examine daily events in order to make sense of and allocate meaning to them (White 2007:10; cf. Brown and Augusta-Scott 2007:3-4; see Morgan 2000:2). For believers meaning-making is connected to their faith orientation and understanding of being God's people in this world. Individuals relate their lives and relationships by means of various types of narratives. The past, the present and the future are included in these stories. White (2007:4) identifies various the techniques used in narrative therapy as: externalising conversations, re-authoring conversations and "maps" for narrative practice. According to White (2007:5), "maps like these shape a therapeutic inquiry in which people suddenly find themselves interested in novel understandings of the events of their lives, curious about aspects of their lives that have been forsaken, fascinated with their neglected territories of their identities, and, at times, awed by their own response to the predicaments of their existence". Madigan (2019:4) describes how narrative therapy

sees human identity, namely as interpersonal, communal, expansive and contextual. People with a religious orientation understand their human identity and social relationships as well as their interaction with the environment (God's creation) in terms of their faith. The narrative approach to counselling is in these and other respects compatible with a faith paradigm and can be applied effectively to pastoral counselling practice.

Also compatible with a faith paradigm is the *Wheel of Awareness*, which is a meditation technique developed by Daniel Siegel. Though Siegel developed it as a therapeutic technique in the field of psychology, meditation is an age old spiritual technique aimed at enhancing people's spirituality and religious life. As such, this meditative technique is compatible with the aims and methods of pastoral care and counselling and can be applied effectively in this field.

In order to explain the aim of the technique, Siegel (2018:17) compares consciousness to a container of water. When an amount of salt is added to water in a small container, it will be too salty to drink. However, the bigger the container, the less salty the water will taste (Siegel 2018:17). The Wheel of Awareness aims to enable people to increase their awareness in order to "dilute" the effect of the traumatic experience. The aim is to strengthen the person's mind. Faith and spirituality can serve to enhance the person's ability to do so.

This therapeutic model distinguishes between *awareness* and *being aware*. Firstly, *awareness* refers to an individual's knowledge or perception of a situation or a fact. Secondly, *being aware* – consciousness – refers to an individual's state of responsiveness to their surroundings. The skill to distinguish between awareness and being aware or conscious of the surroundings, enables people to engage fully with whatever experience they are having. The Wheel of Awareness is useful to therapy since it facilitates greater well-being in individuals' lives. It has the potential to improve people's inner life and interpersonal relationships. It encourages people to embrace the positive and face the negative without procrastination (Siegel 2018:17-18).

The contribution of this study is to provide guidelines for pastoral care with individuals who experienced trauma and as a consequence have developed mental disorders and harmful ways of coping. For this purpose this study will utilise insights from neuroscience in order to explain what takes place in the brain and why overcoming substance use disorder, which is often a consequence of harmful ways of coping, is so difficult. Integrating Daniel Siegel's Wheel of Awareness meditation practice with narrative counselling can yield a positive outcome with regard to the re-authoring of an individual's dominant narrative of trauma and its consequences.

1.3 Methodology

A *qualitative research method* is utilised in this study. The aim is to explore the literature on dissociative disorders, depression and substance abuse in order to trace the connection between dissociative amnesia, dissociative identity disorder and depersonalization disorder, depression and substance abuse, and to ascertain how pastoral care can contribute effectively to the process of healing from the trauma that set all of these conditions in motion. The objectives of this investigation are therefore:

- to come to a better understanding of dissociative disorders that result from immense or repeated trauma;
- to investigate certain individuals' way of coping by means of substance use;
- to make a contribution to the field of pastoral care and counselling with regard to the support of people who suffer from these disorders.

Many individuals experience immense or repeated trauma during childhood and then develop certain disorders during adulthood. The disorders that are the focus of this study are dissociative disorders that involve the repression of memories.

Two mechanisms for avoiding traumatic memories are suppression and repression. The difference is that with *suppression,* the memory is still alive in an individual's mind and it takes much effort to banish it from the mind. Some people try and keep extremely busy to "take their mind off" of the memories that keep encroaching on

their life. *Repression* is a response to the experience of immense or repeated trauma, to the extent that the mind cannot process it. Repressed memories can have an effect on people's relationships, their social life, and how they function in the workplace. These negative effects often motivate them to seek therapy.

This study briefly explores the prevalent theories that explain what these mental orders entail in order to provide insights for pastoral care and counselling. These insights contribute to an understanding of the complexity of doing therapy with individuals with DID, depersonalization disorder and depression. These mental disorders have deep internal and external traumatic roots. A sufficient understanding of the complexity of these matters, decreases the risk of insufficient diagnosis or misdiagnosis.

The following theories explain different aspects of personality, biology, memory processing and detached relationships with caregivers. *Structural dissociation theory* explains that there is a lack of structure and integration in the personality of people who suffer from dissociation (Howell 2011:31). *Disorganized attachment theory* is about the disorganized attachment if parents and their children. Children can react frightened to parents who are perceived as frightening when stressed (Figley 2012:697). Individuals who have experienced disorganized attachment often struggle to adopt healthy ways to self-soothe. *ABC Theory* (see Aggarval 2014:43) explains how unjustifiable thoughts can lead to depression. By employing the ABC technique, individuals can understand the connection between their thoughts, emotions and behaviour. *Betrayal trauma theory* (see Howell 2011:87) addresses incidences where individuals or institutions who should protect, provide resources and contribute to the survival of people, violate the trust of those they should have protected.

The Atkinson-Shiffron Trauma Model developed in 1968 by Richard Atkinson and Richard Shiffron, explains how certain information is lost immediately, other information held in the memory only briefly and yet other information is stored in the long-term memory and is remembered indefinitely (Unsworth 2016:50). Daily experiences are like pieces of information that flow through the perceptual system

and into the short-term memory compartment, which has a restricted capacity. The longer the memory resides in the short-term memory compartment, the greater the possibility for it to be stored in the long-term memory. The Atkinson-Shiffron trauma model is relevant to this study in that it explains the three types of memory: sensory, short-term and long-term memory and provides insight into how memories are stored under normal circumstances on the one hand and in traumatic situations on the other hand.

The study utilises Herman's (1979) *Three Stages of Recovery Model* for the therapeutic journey to recovery with an individual who has been traumatized. The three stages of the model are *safety*, *remembrance and mourning*, and *reconnection*. From a pastoral perspective, this knowledge is invaluable to pastoral caregivers not only to hone their own skills for providing effective pastoral care, but also to have the ability to identify when the severity of the situation goes beyond their capacity to care and the input of a trained therapist is needed. The three stages of Herman's model are explained briefly and then applied to pastoral care (see Howden 2015:109-114):

- **Safety**

Only when the therapist has established a relationship of trust with the traumatized individual can the problem be addressed. In order to be able to foster a sense of safety it is often necessary to develop a social support system with family and close friends. According to Herman (1996:157), individuals who choose to be part of the support system should be willing to have their lives temporarily disrupted. This disruption will not necessarily be long-term since a sense of safety can be restored in a short period of time depending on the support system. PTSS symptoms can be stabilized within a period of approximately three months after the trauma. When a sense of safety has been restored, the traumatized individual can talk about the details of the event or experience. When the details are put into words and the cognitive aspect is engaged. This "dilutes" the emotional aspect and transformation can begin to take place. The process allows for the traumatic event to be integrated into the individual's life narrative in a realistic and non-traumatizing way.

- **Remembrance and mourning**

In order to reconstruct an individual's dominant life narrative it is often necessary to investigate their life history. Their history can provide the context for allocating meaning to the specific traumatic experience. The goals at this stage is to guide the individual to recall both somatic and emotional memory. Non-verbal ways of expression such as drawing or painting are effective for directing intrusive trauma images. The process of remembering traumatic events includes recalling bodily sensations such as sight, smell, sounds or tastes and the memories that are triggered by it. The therapist journeys back and forth in time along with the individual. When the individual can put the event into words and connect them to the different bodily sensations, the trauma narrative can be transformed towards a preferred life narrative.

In the safe presence of a trusted person the individual can be empowered to delve deep into the past and have the courage to re-experience intense feelings. As they do so, they hold on to the sense of safety, that was damaged by the traumatic event, but that they recovered in the caring relationship. The purpose of the back and forth process is to integrate the story of trauma into the individual's life narrative – to establish a testimony. The term "testimony" refers to something subjective, spiritual and private. Howden (2015:113) puts it as follows: "When one bears testimony of the story it becomes a substance for therapeutic work". Victims of trauma have difficulty dealing with the humiliation they feel, which impedes the process of mourning what they had lost. Herman (1997:162) explains that mourning should be perceived as an act of courage and resilience rather than as humiliating. When an individual mourns what they lost during the event, they reconstruct and strengthen their inner life (Howden 2015:113).

- **Reconnection**

Reconnection entails letting go of the old self, which was injured by the trauma. The "death" of the old self is to be mourned. The purpose of *reconnection* is to establish a new identity. The primary experiences related to psychological trauma are hopelessness and isolation. In contrast, the primary experiences of recovery are empowerment and reconnection. At this stage the victimization of the individual is

acknowledged and addressed. The person is empowered to react with resilience when feelings of fear threaten to become overwhelming. Resilience becomes a source of “energy and enlightenment” (Howden 2015:113). According to Howden (2015:114), when people take control and reclaim their identity, they also reclaim their imagination, which had been invaded by disturbing flashbacks. The individual can now re-explore and reclaim past hopes and dreams. Howden (2015:114) points out that this process also has a positive effect on the individuals’s relationships: “The traumatized individual discovers the capacity to enter into the ‘appropriate trust’ with others”. The barriers to intimacy that were erected on account of the trauma memories, can now be broken down. If the traumatic experience and memory have been integrated and processed, the individual has the opportunity to move into a space of emotional and psychological freedom. In the stage of reconnection the person can look at the past with the confidence that they have survived something tragic and are now able to move to the future. With renewed hope they can again celebrate life.

The selection of Herman’s Three Stages of Recovery for pastoral care with traumatised people is appropriate because individuals who suffer from trauma should also receive spiritual guidance without feeling stigmatized. They should find a safe space with the pastoral counsellor. During the painful process of dealing with intrusive memories individuals can rediscover their identity in God and regain a positive sense of self. The narrative pastoral counsellor approaches individuals as the expert of their story and assists in the process of establishing a new and preferred life narrative. The model also includes the idea of “testimony”. Believers who have survived immense trauma often tell their testimony story about the power of God in the faith community. They speak of God’s presence in their lives before and after their trauma. Aspects such as reconnection with others, renewed relationships and letting go of the old self can be found in Scripture. This can strengthen believers’ resolve to embrace the new life and future that is the legacy of the faithful, irrespective of the realities of their existence in this world and what has befallen them.

1.4 Chapter outline

In Chapter 2 *repression* is be explored through the lens of neuroscientific insights. The brain as described “from the bottom to the top”, plays an essential role in how human beings experience trauma and retain traumatic memories. The chapter explaining the mechanism of repression with regard to aspects such as child abuse, dissociation, depersonalization disorder, dissociative identity disorder and body memory. Insight with regard to repressed memories is necessary for understanding consequences of trauma later on in an individual’s life, such as sudden behavioural changes, relationship problems and mental health problems. Repression is often the root cause of certain mental disorders which negatively influence individuals’ overall well-being – their moods and connection to and with others.

Chapter 3 focuses on *depression*. It explores the neurobiology of depression, the connection between depression and mood, and the consequences of depression for people’s experience of human connection. It investigates the roots of depression and explains misconceptions with regard to depression and mental health. The neurobiology of depression is helpful in understanding why individuals suffering from depression often act the way they do. For example, becoming withdrawn or losing interest in things once enjoyed.

Chapter 4 explains how trauma and stress can lead to *substance use disorder*. A case study illustrates how the use of substances can constitute an attempt of the individual to cope with trauma, secondary trauma and PTSS.

Chapter 5 focuses on pastoral care with individuals who struggle with repression, depression and substance use disorder as a result of trauma in their lives. Pastoral narrative therapy and Daniel Siegel’s Wheel of Awareness meditation practice are combined to form an effective holistic pastoral approach to a complex problem which has serious psychological, biological and spiritual consequences not only for the lives and well-being of the individuals themselves, but also for that of their loved-ones.

Chapter 6 presents the findings of the study.

CHAPTER 2

REPRESSION

2.1 The brain from the bottom to the top

When it comes to well-being, the workings of the human brain are relevant. In the case of traumatic events and experiences it is necessary to understand why the brain reacts as it does. This in turn contributes to a better understanding of the actions and reactions of people who have been traumatized. These insights elucidate why certain trauma memories are not stored in long-term memory and how the body can sound the alarm that there are problems that have to be dealt with. Repression can cause damage later on in life.

A significant function of the brain is to ensure survival, also in life-threatening situations. When internal systems do not work adequately it can result in psychological problems. The rational, cognitive part of the human brain is the section that developed most recently in the process of evolution. It occupies only 30% of the skull (Van der Kolk 2014:70). The rational brain's main function is to assist an individual in understanding how certain things work and how people function. It is utilised to achieve set goals, manage time and sequence actions. Various sections of the brain govern functions such as moment-by-moment registration of surroundings, managing the body's physiology, and identifying what creates or sustains comfort. In the womb, just as it did in the process of evolution, the brain develops from the bottom to the top in layers. The most primitive part of the brain, which is already active when a child is born, is the earliest animal brain. It is commonly referred to as the "reptilian brain" and is situated in the brain stem – the place where the spinal cord centres the skull. This part of the brain controls everything that new born babies are able to do such as eat, sleep, breathe and feel temperature.

The hypothalamus, which is situated above the reptilian brain, works with the reptilian brain to govern the body's energy levels. Together they organise the activity

of the heart and lungs as well as the endocrine and the immune systems (Pugh 2018:003, 004 and 006). Their function is to ensure that these life-sustaining systems are maintained. When the organism and its mind is thrown into disequilibrium because of trauma, it can lead to disturbed sleep, fibromyalgia (sensitivity of muscles) or persistent hunger (obesity).

The limbic system, which is situated above the reptilian brain can also be referred to as the mammalian brain. The limbic system controls emotions, detects danger, discerns between pleasure and fear, and distinguishes between what is or is not essential for survival (Pugh 2018:003; see Van der Kolk 2014:57). The limbic system of an infant is structured through a combination of experience, genetic makeup and inborn temperament. Everything that happens to infants therefore contributes to their emotional and perceptual map of the world that is created by the developing brain. When a certain circuit fires often it becomes an "automatic setting" and becomes the most probable response to specific situations and experiences. Daniel Siegel (2010:83) explains it as: "What fires together, wires together". If an infant feels safe and secure, loved and nurtured their brain is trained to explore, play and cooperate. If, in contrast, they feel neglected, unwanted or unloved, it can result in an overwhelming feeling of fear or abandonment.

The emotional brain is at the core of the nervous system and its main function is to ensure well-being. In the face of either danger or excitement, it releases hormones that cause an alert state. Instinctual sensations can then interfere with the activity that was at the time occupying the mind and take the individual in a wholly different direction both physically and mentally. These instinctual sensations have a significant effect on both small and large decisions that individuals make. The emotional brain also sets in motion the "pre-programmed" escape strategy, for example, fight-or-flight responses.

The top layer of the brain – the neocortex – is typically shared with other mammal species. This layer is much thicker in humans than in other mammals. In the second year of a child's life, the frontal lobes, which form the largest part of the neocortex, develop rapidly. The frontal lobes control those characteristics that distinguish

human beings from other animal species. These lobes are responsible for language and communication, as well as abstract thought. Van der Kolk (2014:73) explains that, “despite our excitement about the linguistic feats of chimpanzees and rhesus monkeys, only human beings command the words and symbols necessary to create communal, spiritual, and historical contexts that shape our lives”. The frontal lobes enable human beings to plan, reflect, and predict the outcome of an action. This ability shaped human culture which in turn brought about modernity.

Every sign that human beings automatically register during conversations is connected to one regulatory system. These signs include but are not limited to the other individual’s facial muscle shifts and tensions, and the tone and speed of their voice. The two branches of the autonomic nervous system (ANS), the *sympathetic* (the body’s accelerator) and the *parasympathetic* (the body’s brakes) have the essential function of controlling the body’s energy levels and flow (Stangor and Walinga 2018:242-244; Gordon et al. 2015:205-208) The sympathetic branch is responsible for the consumption of energy and the parasympathetic branch is responsible for the conservation of energy. The sympathetic nervous system (SNS) controls arousal and includes responses such as fight-or-flight. The Greek physician, Galen, coined the term “sympathetic nervous system” approximately two thousand years ago. He observed that this nervous system was linked to emotions (*syn-pathos*) (see Van der Kolk 2014:96). The SNS transfers blood to the muscles for swift action by triggering the adrenal glands to release adrenaline. This speeds up the heart rate and elevates the blood pressure. The parasympathetic nervous system (PNS) fulfils self-preservative functions such as the healing of wounds and digestion. Acetylcholine is produced to control the severity of arousal, slow down the heart rate and relax the muscles. It functions as a neurotransmitter in the parasympathetic nervous system.

In 1994 the Polyvagal Theory was developed by Stephen Porges (1995:104-106; 2011:xiv-xvii, 1, 3-6). The term “polyvagal” refers to the various branches of the vagus nerve. It is responsible for connecting different organs such as the heart, brain, stomach and intestines. The Polyvagal Theory explains the biology of safety

and danger. One explanation builds on the obvious interaction between the instinctive experiences of an individual's own body and the voices and faces of others. It explains why the positive words and actions of significant people can make a person feel safe and secure, whereas being ignored, neglected or dismissed can result in anger or mental problems. According to Van der Kolk (2014:79), this theory "made us look beyond the effects of fight or flight and put social relationships front and center of our understanding of trauma". Mirror neurons register inner experiences and the body makes internal calibrations in response to stimuli from the environment. Though in individualistic cultures uniqueness is the central point of perception, on a deeper level, "our brains are built to function as members of a tribe" (Van der Kolk 2014:82).

For each response in various situations different levels of brain activity are involved. For example, the mammalian brain's fight or flight system protects individuals and prevents them from "shutting down". The reptilian brain, in contrast, sets off the collapse response. In traumatized individuals the collapse response operates as follows: when danger is present, the social engagement system shuts down, responsiveness to other's voices decreases and alertness to threatening sounds increases (Van der Kolk 2014:85). For some, rage makes them feel in control. Van der Kolk (2014:85) puts it as follows: "Activating fight/flight at least makes them feel energized". For this reason, many abused and traumatized individuals feel energized when faced with actual danger. These same individuals feel paralyzed in situations where they are safe.

2.2 Child abuse and repression

Sigmund Freud (1896), who was a medical doctor and the father of the field of psychiatry, wrote on repressed memories in a work titled, *The aetiology of hysteria.* He theorised that repressed memories of sexual abuse during childhood were a precondition of hysteria. He called this the Seduction Theory (see Greenfield 2014:7). Repression is one of the many mechanisms used to protect the psyche from harmful memories. Other mechanisms include displacement, dissociation and splitting (of personalities) (cf. Greenfield 2014:66). Repression can be explained as a

"vertically layered model of mind" (Van der Kolk and Van der Hart 1995:15) because repressed memories are pushed downward into the unconscious mind. According to Greenfield (2014:68), building on Freud's work, "conflict is the key to repression". This can for example be conflict between a person's inherent drive and fears, or conflict between utter hopelessness in the wake of an overwhelmingly traumatic event and the perception of the self. Ancient literature such as the *Epic of Gilgamesh* and the *Odessey* of Homer show that trauma is as old as the human race (see Figley 2012:xxiv). This ancient literature portrays actions and experiences of human beings, such as rape, war, violence, loss, guilt and betrayal. In more recent literature, art, film and television, "trauma" mostly refers specifically to physical injury, which is treated by medical practitioners. However, trauma includes psychological injury.

In the 1990's there was controversy with regard to the recovery of repressed childhood memories in adulthood. These "memory wars" took place among clinicians and memory scientists. The prevalent idea among clinicians was that recovered memories were unreliable and therefore needed thorough investigation (see Patihis et al. 2013:519). However, clinical psychologist Michael Yapko (1994:168) found it plausible that traumatic childhood memories could be recovered accurately in adulthood in therapy or under therapeutic hypnosis, for example. These were then memories of real events in childhood. They were not fabricated (Vredeveldt 2012:1).

Some controversy remains still today. Some clinicians view the recovered memories as reliable, whereas others do not. According to Patihis et al. (2013:529), "the debate regarding the existence of repressed memories and reliability of memory can be taxing given the intense feelings, such as injustice, that are felt on both sides". Nevertheless, this issue bears important ramifications for memory research, as well as for the translation of such research into the therapy room and courtroom". Children often seem to have "forgotten" the traumatic event. Even though a person might not have memories of the event, it is possible that they do have suppressed memories. When they begin to talk about what they do remember, the suppressed memories can return, sometimes as powerful flashbacks. As feelings and reactions are evoked, more memories begin to surface.

Repressed memories cause interpersonal difficulties. When therapists search for the root of these difficulties one possible reason can be repressed memories of a traumatic event (Radel and Simonsen 2008:459). All individuals experience both negative and positive events in the course of their lives. These experiences can include adversity and development, terror and magnificence. No one is exempt from traumatic experiences in their life. Trauma, from the Greek for “wound”, can be described as an unexpected or potentially deadly experience that leaves long-term distressing memories (Figley 2012:xxiv; cf Retief 2004:27).

Adverse childhood abuse (ACE), especially sexual abuse has a variety of negative effects on individuals in adulthood. This can include problems such as substance use disorder, depression, anxiety, and perceptual disturbances (Hughes et al. 2017:356; cf. Felitti et al. 2019:249-251; see Robbins 2019:367). There are significant cultural variations with regard to what age groups constitute “childhood” and “adulthood” (Mintz 2012:17-21; Robbins 2019:367). In the same culture, the understanding of these terms has also changed over time. For example, during the early colonial period in the United States children under the age of 7 were perceived as “innocent” and incapable of making decisions (Robbins 2019:367; cf. Haring, Sorin and Caltabiano 2019:3; Patenaude 2006:5), whereas children from the age of 10 years and above were perceived as “small adults” who were being prepared for adulthood.

During this era, there was wide-spread abuse and exploitation of children. Children were seen as the “property” of their father and he had “property rights” over them (Haring, Sorin and Caltabiano 2019:5). Fathers could use their children for the purposes of hard labour. They even had the legal right to sell the children into slavery. Only since the late 1800’s laws were passed that prohibited parents from selling their children into slavery or forcing them to do hard labour. Child welfare groups were established. They adopted the notion of “in the best interest of the child” and their mission was to intervene in instances of child maltreatment (Chudacoff 2007:39; cf. Patenaude 2006:10).

Though child welfare work was aimed mainly at those who lived in great poverty, interventions were not limited to those who were poor (Perry and DiLilo 2007:147). In 1875, the New York Society for Prevention of Cruelty to Children (SPCC) was established as a refuge for children who had endured abuse and cruelty at the hands of their parents (Robbins 2019:368; see Meyers 1998:39; Miller 2012:9-11; Flegel 2016:18). Shortly thereafter, the SPCC spread to various other states. From the mid-nineteenth century, an extensive child welfare movement swept through the United States (Trattner 2007:108; cf. Perry and DiLillo 2007:147). In contrast to the Freudian school of thought, which tended to regard mothers as complicit in cases of child abuse, other authors such as Margaret Elbow and Judy Mayfield (1991:81), from a feminist perspective, rather viewed the mother as a "co-victim" who was powerless against the perpetrator. More recent scholarly work such as that of Ramona Alaggia and Stacy Kirshenbaum (2005:229-232) investigates patriarchal family structure and the roles designated to people in such families.

In the US history of child protection three periods can be distinguished (Lewandowski 2018:62):

- the colonial period in which protection against abuse was absent;
- the period 1865-1962 in which churches, charities and other non-governmental organizations provided protection for abused children;
- the period 1962 to present where child protective services are sponsored by the government.

Most US states have had child protection laws since 1967 because of an increased concern with regard to physical abuse. Sigmund Freud's (1919:209) theory on sexual abuse evoked much attention and played an important role in the formation of societal beliefs and attitudes toward child sexual abuse (Terdiman 2020:99; see Freud 1896:166). Though the United States was greatly influenced by Freudian thought, there was some hesitancy to legally address what was regarded as "family matters". This meant that the seriousness of the problem was underplayed. Not only was child sexual abuse not taken sufficiently seriously, but children who spoke out

against their abuser later in their life were judged for doing so after so much time had elapsed.

Once reason for people reporting abuse long after the fact was that the person "forgot" the abuse. The repressed memories were then only triggered later in life. The idea of repressed memories was viewed with suspicion and stigmatized by society. Freud's seduction theory played a role in this perception. The theory explains such memories as "false memories" and "proposed that patient reports of sexual abuse were based on unconscious incestuous wishes, rather than actual events" (Robbins 2019:368). Numerous subsequent studies gave rise to the Child Abuse and Treatment Act (CAPTA) of 1974, federal legislation that provided for funding to states for the prevention, assessment, prosecution and treatment of abuse as well as many other services (Gateway 2019:2; Gil 1971:637-648; cf. Kempe et al. 1985:145).

Views on this issue changed significantly over time. Current ideas, norms and policies related to child sexual abuse differ vastly from those of previous eras. Over time, it was acknowledged that child sexual abuse was not limited to incest between fathers and daughters. Incest could also take place between siblings, mothers and sons and fathers and sons. Ellenson (1986:150) broadened the definition of incest and described it as "repeated physical sexual contact between an adult who has violated a position of trust or authority or a caretaking role (regardless of kinship) and a child". Since the term "incest" could be prejudicial, Gilgun and Anderson proposed the more precise and appropriate term of "child sexual abuse" in 2013. According to them, child sexual abuse entails the "misuse of power where someone takes advantage of children for their own sexual and emotional gratification" (Gilgun and Anderson 2013:259). Although most victims know their abuser, only 30% of those are family members and 70% of the abuse takes place in environments other than the home. That would include day care centres, the church (abuse perpetrated by priests and clergy) and Scouts (abuse perpetrated by leaders) (Robbins 2019:371; cf. Smith, Rengifo and Vollman 2008:575; see Boyle 1994:3).

Child sexual abuse became a focus of investigation globally in, for example, methodological studies and feminist studies. New theoretical frameworks developed in fields such as family systems theory, feminist theory and biological psychiatry. Psychoanalyst Alice Miller (2008:47) rejects the Freudian point of view that abuse is based on fantasy. She suggests that repressed trauma is the root of mental illness in adulthood (Robbins 2019:372; see Miller 1981:25; Miller 1984:9). According to Miller (1984:10), children tend to regard their parents as perfect human beings and therefore repress memories of parents' wrongdoing such as abuse. Psychiatrist Lawrence Pazder and his patient Michelle Smith co-authored a book titled *Michelle remembers* in which they explain in detail the recovery of memories of sexual abuse, among others by a satanic cult (Smith and Pazder 1989:46, 71, 82, 94, 114, 195). In her story, Michelle explains that the memories revealed that she had witnessed rituals of human sacrifice. A book titled *The Courage to heal: A guide for women survivors of child sexual abuse* by Ellen Bass and Laura Davis (1988) led to a rapid escalation of research with regard to recovering memories. Bass and Davis (1988:81) point out that though many women do not have memories and others never recover specific memories, this does not mean that they had not been subjected to abuse.

Psychiatrists Richard Kluft (1988:580; 1989:191-193) and Bennet Braun (1986:61; 1990:230), who served on the Advisory Committee for Dissociative Disorders, had a profound influence on the professional acceptance of recovered memories (Searles 2001:621; see Braun 1986:143). Freud's idea of "repression" was replaced by the term "dissociation" (Pendergrast 2017:6; cf. Boag 2006:82; Knafo 2009:172). Features of dissociation include but are not limited to the disruption of memory and identity, for example, amnesia.

Dissociation, which can also cause amnesia (dissociative amnesia) was connected to child sexual abuse and was regarded as a symptom of dissociative identity disorder (DID) (Otgaar et al. 2019:25; cf. Pendergrast 2017:180; see DSM-5 2013:279; Nöthling et al. 2015:2). The International Society of Multiple Personality Disorder (1983) was established for further studies regarding dissociation and was

renamed The International Society of Dissociation in 1994 (Robbins 2019:368). This society arranged annual workshops and conferences. By 1986 accounts of dissociated and recovered memories of satanic ritual abuse (SRA) and multiple personalities had surfaced. A study by advocates against child maltreatment, Catherine Ward and colleagues, found that boys were more willing than girls to disclose sexual abuse if they were given the option to remain anonymous (Ward et al. 2018:460; see Devries and Meinck 2018:367). It is also evident from the study that children are more likely to report sexual abuse in the absence of their parents. Although adults are customarily the perpetrators, children can also be perpetrators of sexual abuse.

Therapists trained in Recovered Memory Therapy (RMT) worked strictly according to a checklist of symptoms in their search for indications that clients had repressed memories of child sexual abuse (Edelstein, Kujoth and Steele 2013:172; cf. Belli 2011:223; see Brainerd and Reyna 2005:372). Techniques that are used to facilitate the person with the “recall” of memories of abuse included hypnotism, the use of a truth serum, guided imagery and psychotic drugs. Memories of child sexual abuse often resurfaced as disturbing flashbacks, mental images and “body memories” that were “true” memories of childhood abuse. Some recovered memories like those of satanic cults are described as more severe and dramatic. Some individuals described the experience as “being drugged, brainwashed, and forced to watch or participate in satanic rituals, and this early abuse is alleged to be the preparation for a later role in young adulthood as a ‘devil’s bride’ or ‘breeder’ who delivers babies solely for the purpose of satanic sacrifice” (Robbins 1997:67). On US talk-show programs such as the Oprah Winfrey Show frightening stories of satanic ritual abuse were told. These shows were mostly dominated by shocking stories of a satanic conspiracy, mind control, ritualistic torture and sexual abuse.

Allegations of abuse that were said to have surfaced during recovered memory therapy had significant consequences that affected both the accused families and the clients themselves. Clients commonly disowned their families and broke off all contact as part of their healing process. Consequences for the client themselves

include that symptoms sometimes worsened during the recovered memory therapy. Another consequence is that, if they claimed to be a survivor of abuse that did not in actual fact take place, it left them with a weakened ability to test reality (Robbins 2019:374). Scott Lilienfeld (2007:53) explains that both RMT and DID-oriented treatment could have a potentially harmful effect on some individuals. Suicidal thoughts and psychiatric hospitalization were some of the consequences for people who received these therapies.

Parents who have been falsely accused of abuse established the False Memory Syndrome Foundation (FSMF) in 1992 (Robbins 2019:374; see Mair 2013:50). They collaborated with mental health professionals and researchers who were empathetic to their situation. Mental health professionals voiced their concern regarding the authenticity of recovered memories and of RMT and DID-treatment (Robbins 2019:374).

Traumatic events touch people's lives both direct and indirectly. Such events include community violence, crime, poverty and most recently also the social ramifications of Corona virus epidemic. Trauma affects individuals physically, mentally, psychologically, socially and spiritually. Simington (2013:1) points out that "many who have been touched by natural disasters view their spiritual distress as the most intense of these responses". Therapeutic models tend not to address this fundamental aspect of humanness. However, an increasing number of psychotherapists are now also investigating methods to assist in the healing process of individuals who are in spiritual distress (Simington 2013:1). Gradually clinicians, doctors and those who have been traumatized have begun to understand that trauma does not only harm the body, it also harms the soul and the psyche.

2.3 Dissociation

Dissociation refers to the experience of detachment from reality and events that would usually have been incorporated as memories (Howell 2011:35). Dissociation causes an individual's self-states to become detached from one another. It is not unusual for an individual to dissociate for short periods of time, such as for example when day dreaming. However, in the more severe form dissociation, in response to

trauma, causes the responses of the physical body to freeze. The senses become dull and numb. The mind dissociates from the body. Both emotional distress and physical responses are reduced by this numbing. When the trauma was so severe that dissociation resulted, there is an increased possibility of the person developing post-traumatic stress syndrome. Simington (2013:2) describes it as follows: “Through dissociation, contact with reality is broken as the mind separates from the body … If the dissociation also becomes severe, the traumatized person may collapse physically.” Dissociation has been connected to psychological and physical problems such as mental illness, pelvic pain, somatization disorders and eating disorders. Most of the research focuses on dissociative identity and less emphasis is placed on other dissociative disorders such as depersonalization-derealization disorder (Hall 2003:283). Another gap in the existing research regards the relationship between childhood trauma and depersonalization. This chapter therefore aims to discuss both depersonalization-derealization disorder and dissociative identity disorder in order to explain the connection between childhood trauma, repressed memories, depersonalization-derealization and dissociative identity disorder.

2.4 Depersonalization disorder

Depersonalization is a symptom of dissociation and is connected to various psychiatric disorders. The DSM-5 (2013:302) describes depersonalization as a disturbance in apprehension. It is characterized by an intense feeling of detachment from the self. *Depersonalization* is the feeling of observing oneself as a third party. Individuals who suffer from depersonalization often feel as if they are living in a dreamlike state (Dockery 2014:1). *Derealization*, a counterpart of depersonalization, is characterized by a feeling of detachment from the environment, the outside world, as though the person were watching a movie. Subsequently, derealization can also serve be a symptom of a panic attack (DSM-5 2013; cf. Dockery 2014:1). When a panic disorder is accompanied by derealization, the individual has a decreased level of functioning. This symptom puts a person at great risk of frequent panic attacks and increased phobic avoidance (Katerndhal 2000:225).

Depersonalization-derealization disorder is not a consequence of substance use. It also cannot be explained by other mental disorders such as schizophrenia, panic disorder, major depressive disorder, acute stress disorder or PTSS. It has to be identified through differential diagnosis. Differential diagnosis distinguishes a specific ailment or condition from others that exhibit similar clinical characteristics. Physicians and other trained medical professionals use differential diagnosis to diagnose the particular disease in patients or to eliminate to some extent other immanently life-threatening conditions. In 1986 psychologist David Clark developed the "Clark Model" (Reinecke and Clark 2003:120) for evaluating catastrophic misinterpretations of bodily sensations. Physical triggers include heart palpitations, dizziness or shortness of breath (Strojny 2014:iv). With each episode of depersonalization the same fear is induced which enhances the arbitrary belief of the individual that they are going insane. This arbitrary belief stems from the stigma attached by society to mental disorders. Depersonalization can also concur with depression and schizophrenia (Strojny 2014:iv). A sufferer, Suzanne Segal (1996:46), calls her depersonalization "a collision with the infinite" and describes it as follows:

> As we made our way along the congested highway, I noticed a perplexing sensation. My body seemed to be dissolving, losing its solidity and disintegrating into the air around me. As I looked through my eyes, I actually perceived my body's form transmuting as it became infused with a spacious, foggy luminosity that erased its previously distinct boundaries. I felt more and more non-localized, as if I was nowhere in particular in that glowing fog, but everywhere at once.

Depersonalization has been recorded since the 1800's. French philosopher Ludovic Dugas coined the term "depersonalization" (see Strojny 2014:17; Simeon and Abugel 2006:77). When individuals enter a state of depersonalization, their anxiety becomes so intense that they often doubt their own sanity. Therapy for individuals with depersonalization-derealisation disorder is especially complex because they struggle to articulate their experience.

Depersonalization-derealisation disorder is chronic and recurring. It creates frustration both for the therapist and the individual. It is a challenge to explain the experience of depersonalization to someone who has no experience of it. Depersonalization is often regarded as a "problem" to be solved. However, it is not possible to change these thoughts and feelings. Often it is exacerbated when individuals obsess and ruminate about it. Fugen and Fair (2010:24) call it "intense self-focus". Obsessive thoughts can be intrusive and forceful. They can also be thoughts with no particular significance that become stuck in an individual's mind. Rumination, on the other hand, refers to a process where an individual's mind persistently brings up issues that have not received adequate attention. It is therefore an ongoing cycle (Fugen and Fair 2010:24). Obsessive thoughts and rumination increase symptoms and elevate the accompanying sensations.

Symptoms of depersonalization include the following:

- detachment from feelings, thoughts and sensations;
- emotional and physical numbness;
- feeling like an outside observer;
- feeling of little or no control over words or thoughts;
- the inability to recall certain moments or experiences.

Symptoms of derealization include the following:

- feeling alienated from the surroundings;
- surroundings appear distorted, blurry, faded or artificial;
- misrepresentation of time, for example, recent events feel like the distant past;
- misrepresentation of distance and the size of objects.

2.5 Dissociative Identity Disorder

2.5.1 Repression and Dissociative Identity Disorder

Dissociative Identity Disorder (DID) is often the consequence of intense and ongoing child abuse, particularly sexual abuse. In adulthood the reality of such people is

fragmented. They live with independent elements of experience that are separated from one another in significant ways. These separated elements include memory, characteristic effects, body image and perception (DSM-5 2013:292; cf. Howell 2011:3).

This condition was previously known as “multiple personality disorder” and renamed “dissociative identity disorder”. The assumption underlying the outdated term is that an individual has different personalities. However, this is not the case. It is one personality and one person, but with dissociated parts (cf. Howell 2011:3; see Barlow and Durand 1995:229).

Dissociative identity disorder is a complex form of complex post-traumatic stress syndrome (c-PTSS). Complex PTSS is described by Figley (2012:435) as “the intrusive avoidance-hyperarousal symptoms of post-traumatic stress syndrome that did not capture the entire clinical image”. The term “complex trauma” is used to describe experiences of recurrent or multiple traumatic events (Brand et al. 2019:513; see Howell 2011:10, 79, 109; Figley 2012:139; Reece et al. 2014:314). These events usually take place during childhood and are of an interpersonal nature. Complex trauma can result in post-traumatic stress syndrome or dissociative disorders (Figley 2012:139; cf. Howell 2011:10, 79, 109; see Sinason 2002:47). Dissociation often manifests in survivors of childhood trauma. This becomes their “coping mechanism”. A significant number of trauma survivors have symptoms such as dysphoria, dissociation, meaninglessness, emotional lability and various other interpersonal struggles (DSM-5 2013:271-275; cf. Walker 2013:23; Shalev and Segman 2008:189). According to Haddock (2001:9), the most distinct features of DID are the presence of two or more separate identities that intermittently take control of an individual’s behaviour and way of thinking (Howell 2011:3; cf. Ringrose 2012:3). When this happens, the person dissociates and an alter or identity that is necessary to protect the individual against triggers and harmful memories, emerges. After this experience, depending on the extent of dissociation, the host – the original identity – will not be able to recall the experience or what happened when the alter was fronting. This cannot be attributed to “typical forgetfulness”. The failure to recall

is not a psychological effect of substance use, for example the excessive drinking of alcohol.

Every identity is unique. All of these identities have their own individual background, character, self-image and name. The host identity is often dependent and depressed. The other identities' names and features are the opposite of those of the host. Certain identities can cause more harm to the individual. They are described as antagonistic or "persecutors" because they intend self-harm. These identities are also rebellious and interrupt or humiliate the other identities while they front (Howell 2011:4; cf. Figley 2012:604). Individuals who suffer from DID can experience incoherence of their memory of past and recent events. In the case of DID, the amnesia occurs according to a particular pattern. It can happen at any given moment and is therefore described as "distorted". A person who suffers from DID displays as many as 100 distinct personalities. The process of transition from one identity to the other is called the "switch" (Ringrose 2012:9; see Howell 2011:80). DID sufferers struggle to understand and explain their situation and manage their daily life (Ringrose 2012:3, 4; cf. Haddock 2001:9).

Post-traumatic stress syndrome has a significant effect on the brain. It also causes individuals with traumatic memories to have flashbacks. PTSS should be distinguished from DID. Post-traumatic stress syndrome (PTSS) can occur at any age or time in an individual's life, whereas DID can originates between the ages of 1-9 (Ringrose 2012:4; cf. Howell 2011:15-25; see Haddock 2001:9). During this period of a child's life the personality is in the process of integration into a coherent whole. This is the age when people develop their distinct characteristics.

2.5.2 Alters

An alter comes to the fore as a desperate effort to suppress and alleviate the overwhelming impact of certain life events (Kluft 2008:267). Individuals commonly experience their dissociated parts as "different people" but they also understand that the different identities form part of one body (Howell 2011:55; cf. Schmutzer 2011:66). The primary structure of the different parts is made up of the identities that can cope with external functioning and communicating with the outside world. There

are parts, however, that do not surface regularly and do not communicate with the outside world. They are the parts that hold the traumatic memories. These parts are often child alters who experienced the trauma first hand and are forced out from the conscious mind and personality splits by suppressing them rather than allowing them surface. Psychologically, individuals who suffer from DID live in a "world" as described by the Karpman Drama Triangle (1968; see Ivaldi 2016:139). The three parts of the triangle are: the *persecutor*, the *victim* and the *rescuer* (see Howell 2011:10). The victim parts are commonly referred to as the "suffering children" because their identities are connected to those who violated their trust and safety. The abuser or persecutor part is the embodiment of the person who maltreated the individual that is suffering from DID. The rescuer part is demonstrated as a real person who is an essential part of the individual's life.

The different alters or identities will now be discussed briefly (Bowlby 2014:32, 36, 42; Ringrose 2012:6-9; cf. Moskowitz et al. 2008:167, 170, 179, 283; see Howell 2011: 58-65):

- **The host**

The host is the individual whose body and name it is. This person is usually in control. Characteristically the host is described as compliant, depressed and weak. The host can also, however, be happy and energetic, depending on the situation. The host remains separate from those parts that hold the intense memories that cause distressing emotions such as violent anger and extreme fear. These intense emotions can cause damage to the way the individual functions on a daily basis and therefore they are separated out.

- **Child alters**

Child alters remain stuck in the specific timeframe in which they were created. For example, if the individual was abused at the age of 7, the alter will remain that age. Child alters can mature with the help of the "adult" alters in the system. When the child part fronts, it must be treated and communicated with in a manner that is appropriate to their age. These alters carry the memories of the abuse and are

therefore kept at the back of the system, they are banished from the front. Child alters ordinarily appear as little, vulnerable souls.

- **Rescuer, soother and protector parts**

When children are traumatized, they can create their own protector, an imaginary parent with excessive self-sufficiency. Consequently, due to the fact that the child has to defend itself by blocking out what is happening to them at that moment a pre-eminent protector, helper or inner caretaker is formed (Howell 2011:139). The protector part's function is to manage rage, anger and escape feelings of guilt and shame. They often perceive themselves as a physically strong male or a powerful animal.

- **Parts with different genders**

When the individual is in danger – especially physical danger, parts of a different gender to the host can come to the front. Their presence can be described as protective and comforting. They can be a physical benefit. These parts are advantageous when the host is in need of extraordinary strength.

- **Abuser parts**

Abuser parts manifest extremely volatile emotions such as anger and condescension for other alters in the system. They are also the parts that are responsible for self-harm and often are referred to in satanic terms.

- **Psychotic or dead parts**

When an individual who suffers from DID presents a psychotic part, only that specific alter is psychotic, not the person. Dead parts share similar characteristics with psychosis and are locked away in the individual's mind. The reason why these alters are formed is the severity of the abuse the individual had to endure. The person was, for instance, either severely abused, or tortured to the point where they almost died or feared that they were going to die. These parts only front when the individual is in a life-threatening situation (Howell 2011:64).

- **Animal parts**

Very few individuals who suffer from DID manifest an animal part. It is not common, but it does occur. When the animal part takes control, the person can display animal-like behaviour such as scratching, biting or running on all fours. Such individuals can have an extreme fear of animals or be overly lovable toward them. This type of alter emerges of a child having been exposed to violence against animals or inordinate cruelty toward a dear pet.

2.6 Detecting clinical and simulated dissociative identity disorder

Individuals who experience dissociation can also experience dissociative amnesia. The challenge is to find ways to distinguish between clinical and malingered amnesia. Brand et al. (2019:513) conducted a study to evaluate the authenticity of the Test of Memory Malingering, which was used to distinguish between clinically diagnosed dissociative identity disorder and malingering.

According to the DSM-5, symptoms of dissociation include discontinuity and fragmentation of identity, memory, consciousness, affect, senses, motor functioning and bodily control (DSM-5 2013:291-306). Depersonalization (feeling unreal), which is a subtype of dissociation and derealization (one's environment feeling unreal), was added to the DSM-5 as an indicator of post-traumatic stress syndrome. Most PTSS patients show signs of dissociation as well as patterns of other symptoms such as vivid flashbacks and risk factors (Brand et al. 2019:514). These aspects differentiate dissociative patients from those who are not dissociative. Brand et al. (2019:514) explains that it is a cause for concern, however, that a great number of mental health care professionals are inadequately trained and equipped in complex trauma. It makes it a more difficult task to distinguish dissociative disorders accurately. Consequently, this can lead to the patients feeling misunderstood and cause a delay in treatment. Another consequence is that dissociative disorders are stigmatized (Brand et al. 2019:517; cf. Ringrose 2012:16; Bowlby and Briggs 2014:61;).

The stigmatization of dissociative disorders is somewhat understandable since, in certain cases, individuals malinger DID to avoid criminal charges. They pretend that they "cannot remember". Recent research has contributed to enabling clinicians to

better recognize and distinguish between clinical DID and malingered DID (Howell 2011:159,160; cf. Guriel and Fremouw 2003: 882; see Barlow and Durand 1995:229). However, making a diagnosis is still a difficult task because certain symptoms of dissociative disorder are also to be found in a variety of personality tests (Brand et al. 2019:514). This can cause the validity of the personality test to be called into question. The Personality Assessment Inventory's (PAI) and its Negative Impression Management is an example. The aim was to detect when patients overstate their symptoms. It includes items that investigate memory loss and the manifestation of multiple personalities. These scales include the PAI, the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) and the Structured Interview of Reported Symptoms (Brand et al. 2019:514). The prevalent research shows that it is important to substantiate forensic and validity scales with complex trauma populations and DID samples (Rogers 2003:165). In order to de-stigmatize dissociative disorders it is important for public and media portrayal of the conditions in films, for example, to be accurate. Brand et al. (2019:514) put it as follows: "Inaccurate public and media portrayals of DID can fuel misunderstandings and skew people's, including clinicians', beliefs about the presentation and even the existence of DID".

2.7 The South African context

One aspect that is highly relevant in South Africa is the emphasis on trauma due to low-middle income, which leads to Posttraumatic Stress Syndrome (PTSS), previously referred to as Posttraumatic Stress Disorder (PTSS) (Koen et al. 2015:2). The South African population has been in a process of transition for many years. Tacoli et al. (2015:10) point out that, "despite a decline in recent years, the rate of urbanization and urban population remains amongst the highest worldwide". Recent studies on different communities have shown that the risk factors of trauma and PTSS in South Africa differ from those in high-income countries. Nöthling et al. (2015:1) point out that PTSS in South Africa is largely associated with sexual violence. During the period of 2011-2012, 66 387 sexual crimes were reported to the South African Police Services. Many more cases were not reported. Victims of rape

and sexual assault are mostly women. They are therefore at greater risk of developing PTSS due to a traumatic event.

Factors that are generally associated with mental illness in South Africa include poverty, gender inequality and child-headed households. Due to a lack of emotional support many individuals live under enormous pressure. According to Nöthling et al. (2015:1), it seems as though the prevalent situation in South Africa is also characterised by resilient responses rather than the adoption of maladaptive ways to cope, such as dissociation. This resilience can be reinforced when traumatic experiences are narrated. Telling the stories of trauma decreases the effect the trauma has on the people. The sharing of traumatic experiences changes the perspective of the narrator. Survivors of childhood trauma tend to adopt more beneficial ways of coping when they have the opportunity to resolve and integrate their trauma. Such individuals have less risk of developing disorders such as PTSS (Nöthling et al. 2015:1).

The Cape Town area, the Cape Flats, is known for its high rates of poverty, unemployment, domestic violence and gang-related violence. According to Wilkinson (2002:2), the ever present gangs in and around schools give rise to significant problems for both the community and the Western Cape Education Department. Gangsters interrupt education in schools and the principals and learners live in fear of the danger of gangsters who can open fire at any time, with no regard for human life.

In 1997, the Safe Schools Programme (SSP) was developed by the Western Cape Education Department (WCED). The reason for this programme was that lives were in danger and many young learners had already died in public shootings. Wilkinson (2002:2) explains that “the project aimed to develop schools into centres of excellence with an emphasis on quality teaching and learning, strong community links and effective governance and management”. The intention was to investigate and deracinate the primary cause of the crime and violence that affect schools. The SSP staff consists of a manager and seven co-ordinators with their individual functions in the Education Management and Development Centres (EMDC’s). The

SSP also has a call centre with a toll free number for the purposes of crisis intervention at schools in the Western Cape. The call centre is available for the purposes of (Wilkinson 2002:3):

- providing assistance to individuals who experience emergencies such as gang related violence, assault, hijackings, bomb scares and abuse;
- reporting vandalism, theft, arson, fights and bullying;
- providing advice and information on various concerns such as AIDS, substance use disorder and rape.

2.8 Body memory

When the traumatic experience has passed, the human body still “remembers” it, as though it has been engraved in the body. Trauma is not stored in the left-brain memory area. It is “remembered” by the body and is encoded as a bodily and emotional state and not as a narrative. The reason for this is that it feels safer. Thought processes as slow, but memories that are stored in the body will automatically sound the alarm when there is a threat of something similar to the trauma experience. When fear, hopelessness or loneliness is remembered as a feeling without an event, it is not experienced as a *memory*. Individuals then act, feel and imagine without recognizing the influence of past experiences on their present reality. This is also the cause of triggering. It is the body’s instinctive physical reaction to all stimuli that are in some way connected to the previous threat.

The human body is mediated by information received from the brain. It is shaped by internal information and readjusted through implicit and body personification (body memory). Bodily experience is created from early on in the process of human development. This takes place by means of the integration of sensory and cultural information. The sensory and cultural information is collected by six different representations of the body, namely (Riva 2018:243):

- the *sentient body* (minimal selfhood), an unchanging geographic structure that starts prenatally and combines the signals of the interoceptive system with prioceptive and vestibular sensitivities;

- the *spatial body* (self location), the merging process in an egocentric frame of sensory information;
- the *active body* (agency), the merging process in an egocentric frame of sensory information which involves the movement of the body in space;
- the *personal body* (whole-body ownership), the combination of various elements of the body into a coherent whole-body portrayal;
- the *objectified body* (objectified self), a third-person portrayal of the body;
- the *social body* (body satisfaction), the merging in an allocentric structure of the objectified body with social regulations as well as narratives relating to the body.

These six representations can be integrated into a methodical supramodal illustration that is known as the “body matrix”. The primary objective of the body matrix is to enable the self to protect its psychological equilibrium. The human body can be perceived as having two layers, namely, the habit body (body memory) and the body at this moment (body representations). Body memory assigns to the self an understanding of how to treat one’s body. According to Gallese and Sinigaglia (2009), “we can envisage the body memory as a manifold of action possibilities allowing the practical attunement of the body to its environment” (see Riva 2017:243). Body memory enables the creation of short-term body images that provide concurrent information regarding the posture and location of the body (Riva 2017:243; O’Shaugnessy 2000). Two significant functions of the body are communication and socializing. These two functions have a direct impact on the formation of body memory in various cognitive functions. The development of body representation systems in childhood stretch as far back as the development of the sense of self and identity and the management of action and representation. This is an intricate process that can evolve in a disjointed manner.

The field of phenomenology has increasingly emphasised the aspect of the “dimension of the subject” which could become the foundation of psychoanalysis (Fuchs 2018:1). The notion of “psychic apparatus” that stems from Sigmund Freud’s

early brain theory, refers to an entity that functions as a metaphorical “inner container” (Fuchs 2018:3). When images and memories are integrated as “object representations” or *imagos* they occupy the different sections of the psyche. With the help of drive energies they develop a life of their own. As a result, the ego remains divided from essential components that are situated in the different compartments.

The understanding of the different functions of the various parts of the brain sheds light on why and how certain individuals “unconsciously forget”, but subconsciously “remember”. The blocking of memories as coping mechanism only provides temporary relief to the individual who has to deal with overwhelming memories. When trauma and trauma memories are not worked through in a positive and healthy manner, it can cause these memories to manifest as physical symptoms.

CHAPTER 3

DEPRESSION AND MENTAL HEALTH

3.1 The neurobiology of depression

Depression often sets in after a specific traumatic event and experience. People who become depressed often struggle with confusion as to the cause of the depression. Many make the judgment that they have “no reason” to be depressed. This chapter explores the neurobiology of depression in order to contribute to a better understanding of the balances and imbalances of brain chemicals that put individuals at risk of developing depression. If people better understand the neurobiology of depression, it can reduce self-blame and stigmatization.

Depression is commonly referred to as a “mood disorder” because of a persistent disruption of the affect. Disruptions of affect can be either positive or negative (Cowen et al. 2013:4). In the case of depression the effect is negative. Depression is a long-term condition. The individual who suffers from depression is at risk of a relapse of a depressive episode because depression is a chronic disorder and can be triggered easily (Caraci et al. 2018:496). Depression causes an inability to function and the person runs the risk of self-death. Depression is often an indication of conflict in the inner psychological reality (see Ngcobo and Edwards 2012:1). Individuals with long-term clinical depression have difficulty socializing and they are at risk of succumbing to the harmful use of benzodiazepine, a group of anti-anxiety drugs that have a muscle relaxing and sedative effect (Palazidou 2012:3; cf. Lòpez-Munoz and Àlamo 2012:7, 9).

Depression is considered “long-term" when it has been present for a minimum of two years. In the case of long-term depression the risks are higher. Long-term depression causes increased inability to function and people often present with cardiac and respiratory symptoms. Long-term depression has a neurobiological foundation that is connected to functional and structural brain abnormalities.

Two fundamental aspects that can cause depressive disorders include genetic vulnerability and stress (Lòpez-Munoz and Àlamo 2012:xxiii, xxiv, 2-3,13-15; cf. Baldwin and Birtwistle 2002:26-27). When the regulation of the hypothalamo-pituitary-adrenal (HPA) axis becomes impaired, hippocampal volumes and prefrontal cortex (PFC) activity decreases and the homeostasis of the neuro-circuit is disrupted (Palazidou 2012:1). Antidepressant medication can elevate the neurotrophin in the brain and restore neuronal growth and activity (Ciccone 2015:85; cf. Andrade and Rao 2010:379). These medications can also balance the interaction between neuro-circuit anatomical structures. Recent brain research has focused especially on the brain's capacity for plasticity with regard to interaction with the environment – both physically and psychologically. Individuals who suffer from depression are at greater risk of severe physical health issues such as artery disease and diabetes and worsening of symptoms of other conditions. Symptoms of depression can be relieved with adequate medication and during the period of remission, maintenance treatment can also be administered (Palazidou 2012:2; cf. Andrade and Rao 2010:38; see Baldwin and Birtwistle 2002:31). Individuals who are in remission must receive maintenance treatment to prevent relapse and recurrence (Cowen et al. 2013:216-217; cf. Lòpez-Munoz and Àlamo 2012:19).

The duration of the depression is influenced by how long it remains untreated. There is a difference between a depressive *episode* and depressive *disorder* (Cowen et al. 2013:5; cf. Palazidou 2012:14-16). Most individuals experience sadness at certain times in their lives due to stressful or traumatic life events. Few also develop depressive disorder. The criteria used to determine whether it is clinical depression include the severity, duration of negative emotions such as sadness and functional impairment (Cowen et al. 2013:4, cf. Fiske et al. 2009:4, 5, 6; see World Health Federation 2012:9, 10, 11). "Secondary depression" is a type of depression that can be brought on by drug treatment steroids. Symptoms of a depressive episode include the following (Cowen et al. 2013:4; see World Federation for Mental Health 2012:7; DSM-5 2013:163):

CATEGORY A	CATEGORY B
• Depressed mood	• Reduced concentration
• Loss of interest and enjoyment	• Reduced self-esteem and confidence
• Reduced energy and decreased activity	• Feelings of guilt and unworthines
	• Ideas of self-harm
	• Disturbed sleep
	• Diminished appetite

The three categories of severity that have been identified, are the following (Cowen et al. 2013:5; see World Federation for Mental Health 2012:7; DSM-5 2013:163):

- *Mild Depressive Episode* – an individual experiences two symptoms of category A and two symptoms from category B.
- *Moderate Depressive Episode* – an individual experiences two symptoms of category A and three symptoms of category B.
- *Severe Depressive Episode* – an individual experiences all of the symptoms from category A and at least four symptoms of category B.

For determining whether an individual has a major depressive episode, the following symptoms should be evident, according to the DSM-5 (2013:125):

- experiencing a depressed mood for the longer part of the day most days by either subjective report (feelings of sadness or emptiness) or observation made by others (the individual appears to be emotional);
- evident decrease in interest or pleasure in all or almost all activities previously enjoyed;
- notable weight loss without being on a diet or weight gain;
- insomnia or hypersomnia most days;

- psychomotor agitation or retardation nearly every day (restlessness or being slowed down);
- fatigue or loss of energy almost every day;
- feelings of worthlessness or extravagant guilt most days;
- decreased focus or concentration, indecisiveness most days;
- persistent thoughts of death, continuous thoughts of suicidal without a specific plan, or an attempt at self-death or a specific plan for self-death.

Major Depressive Disorder is one of the most common mental disorders. Women are more likely to suffer from it than men. According to Cowen et al. (2013:v), "lifetime risks vary from 10 to 25% for women and 5 to 12% for men … with some indication that these estimates have risen over the past two decades". Major Depressive Disorder is damaging for both individuals and families. Some individuals experience severe trauma but do not subsequently suffer from depression. Cowen et al. (2013:v) emphasize that genes, neurochemical balances or imbalances, brain circuitry function, information processing and cognitions differ from person to person.

The following three categories of acute clinical depression can be distinguished (DSM-5 2013:296; cf. Krishnan 2008:7; Cowen et al. 2013:6-8):

- **Melancholic depression**

Some individuals experience what is referred to as "biological" symptoms. These include a loss of appetite, psychomotor changes, constipation, reduced libido and amenorrhea (abnormal absence of menstruation). Another symptom can be mood changes. People mostly feel at their worst in the morning. By means of these symptoms that are called "melancholic", a specific group of depressive disorders are identified, namely major depression with melancholia in DSM-5, or a depressive episode with somatic symptoms in ICD-10. Melancholic symptoms are often difficult to identify. Melancholic depression is related to various clinical correspondents including the following:

- more severe symptoms;
- a family history of depression;

- poor response to placebo medication;
- more evidence of neurobiological abnormalities (decreased latency to rapid eye movement sleep, cortisol hypersecretion).

- **Psychotic depression**

Severe depressive disorder leads to a loss of function in social and occupational spheres. Delusions and hallucinations are symptoms of psychotic depression. They are referred to as “mood congruent”. For example, an individual who has a delusion of guilt can be convinced that a minor dishonesty will be made public (extreme humiliation) and that that they will receive severe punishment.

- **Atypical depression**

This term “atypical depression” is commonly assigned to disorders of moderate clinical severity. These disorders have the following characteristics:

- different depressed moods along with mood reactivity to positive events;
- overeating and oversleeping;
- extreme fatigue and heaviness in the limbs;
- noticeable anxiety.

Individuals who exhibit these clinical symptoms tend to overreact to perceived or actual rejection. They are sensitive to negative reactions from others, especially rejection. These individuals are often seen as “difficult to live with” or people with “difficult personalities”, rather than as individuals who suffer from a depressive disorder. A lack of discipline, the untimely discontinuation of treatment or ineffective treatment, can impede the achievement of full remission.

Depressive and anxiety disorders are often concurrent. People who suffer from anxiety often also develop depression, which exacerbates the anxiety (World Federation for Mental Health 2012:7; cf. Fiske et al. 2009:10, 11). In the 1930’s the discovery was made that the limbic system plays a significant role in the experience of emotions (Cowen et al. 2013: 66; cf. Palazidou 2012:4; see Krishnan 2009:2, 3, 5,

10). Neuroanatomist James Papez explained the “system of emotion” in 1937 and identified a collection of brain structures around the brainstem (see Rouse 2019: 326; cf. Payne and Cooper 2003:89). These brain structures include the cingulate gyrus, hippocampus, hypothalamus and the anterior thalamic nuclei (Rouse 2019:326-327; cf. Palazidou 2013:3; see Ponzetti and Jorgensen 1999:479). Papez saw this circuit as the operative route for communication between the four brain structures. This process facilitates the cortical control of emotion and also has the task of storing memories. With the rise of various neuro-imaging techniques, such as magnetic imaging (MRI), positron emission tomography (PET) and functional MRI (fMRI), the prominence of the “neuro-circuit of emotion” was confirmed. This neuro-circuit was expanded to include other essential brain areas, especially in the prefrontal cortex (PFC). These different brain areas and their connections control the maintenance of stable emotional states. When they malfunction, depression can be the result (Palazidou 2012:3). The prefrontal cortex, situated in front of the premotor area, is responsible for the planning of difficult motor actions, conscious movement (Meyer 2013:101; Lòpez-Munoz and Àlamo 2012:45) and the integration of intricate sensorimotor information regarding motivation and affect (Palazidou 2012:4).

Depressed individuals should be facilitated to recognize and acknowledge their depression and resolve their inner conflicts (Ngcobo and Edwards 2012:1; Uys and Middleton 2004:347; Robertson et al. 2001:84). This can prevent anger outbursts or offensive language toward others. If individuals who suffer from depression are given a non-judgmental safe space in which they can deal with their anger, they can be liberated from the pressure they feel to “act normal”. When people feel that they should hide the symptoms of depression, they ten to try and “fight” the symptoms of depression. Ngcobo and Edwards (2012:1) articulate the danger of this as follows: “If depression is ‘fought’ in the hope that it can be defeated, then further defenses are employed to stop the creative impulses and not allow their release”. When trapped energy is released it can facilitate overcoming the root cause of the depression.

Historically, depression has been either underreported or inadequately reported in South Africa due to many factors, including colonialist attitudes, apartheid,

inadequate health resources and cross-cultural misunderstandings (Noyo 2018:24 ; cf. Steady 2005:144; see Ngcobo and Edwards 2012:2). In the Southern African context cultural understandings of depression include *kufungisa* (thinking too much) in the Shona language of Zimbabwe (Akyeompong et al.q 2015:52; Den Hertog et al. 2016:385-400), and *ukucabanga kakhulu*, (very thoughtful) and *ingqondo iyagijima, inhliziyo iphansi* (the mind is running, the heart is down) in isiZulu (Ngcobo and Edwards 2012:2).

Human behaviour and language function together. Therefore, in order to understand behaviour, it is essential to understand language. Memories from childhood can be positive or negative. It is often difficult to put them into words, especially if individuals were either too young to allocate meaning to the events, or they are afraid that they will be judged to be delusional. Depression can be the beginning of an individual journey through the depths to a person's soul. A young person articulates his experience as follows (Ngcobo and Edwards 2012:4):

> Some people say life is a joy, but no one can have joy without hardships, as hardships can teach you a better way to enjoy joy. Until now I have discovered that you can understand life better through hardships than through joy.

However, not every individual who suffers from depression has such creative possibilities. Many experience the intense horror of unrelenting and intense pain. According to Health24 (2019), depression was diagnosed in 25% of South African employees. The revenue lost as a result of diminished productivity amounts to 5.7% of South Africa's Gross Domestic Product (GDP). The South African Depression and Anxiety group and Discovery Health also released the following statistics on depression in South Africa (Health24 2019):

- The occurrence of depression in South Africa is approximately 9.7%.
- Approximately 20% of South Africans will experience a depressive episode at least once during their lifetime.

- In South Africa, there are some 23 self-deaths daily. For every one self-death there are 10 attempts.
- Depression costs the country approximately 20% more than the income generated by the tourism industry.
- The South African Stress and Health Study has shown that individuals with depression are unable to work some 57 days of the year.

The World Health Organization (WHO) predicts that worldwide by the year 2030 the number of self-death and disability due to depression will exceed that of war, accidents, cancer, stroke and heart disease (Schmidt 2018:144; cf. Rottenberg 2014:1; Nettle 2006:5). WHO reports also show that in youth between the ages of 10 and 19 depression is the primary cause of illness and diminished capacity.

According to the biomedical model developed in 1910 by Abraham Flexner, depression is a genetic illness. Though antidepressants are available, only approximately a third of individuals go into full remission after treatment (Rottenberg 2014:2). Psychologists differ as to where in the body the cause of depression is located. For some psychologists it is located in the brain. Others attribute depression to a person's thought patterns (Sochting 2014:75; cf. Marchand 2012:108; see Craighead et al. 2008:294). Yet others locate the roots of depression in an individual's childhood or relationships (Carr 2015:639; see Carr 2012:188). Rottenberg (2014:2) cautions that the idea that depression and its symptoms are an indication that something fundamental is wrong with a person, is a false premise.

3.2 Depression and pain

Depression is often overlooked as a possible contributing factor to physical pain in for example the back, joints, muscles or organs, or headaches and intense fatigue (Rijavec and Grubic 2011:346). The reason is that physical pain is mostly seen as having a physical rather than a mental cause. Pain is described by the International Association for the Study of Pain as "an unpleasant sensation and emotional experience associated with a real or potential damage to the tissue, or the equivalent of such damage" (Rijavec and Grubic 2011:346; cf. Misery and Ständer 2010:62; Dahl and Lundgren 2006:8). Two categories of pain are distinguished, namely *acute*

and *chronic* pain. Acute pain appears abruptly and is caused by something specific. This can include burns, cuts or broken bones. Chronic pain is long-term. It can linger even after the injury or illness has healed or subsided. Conditions that are associated with chronic pain, include: cancer, nerve pain and back pain. Individuals with chronic pain can suffer physical effects that cause strain on the body such as tense muscles, lack of energy or restricted mobility (Rijavec and Grubic 2011:346).

Somatic symptoms and complaints of pain for which there is no apparent physical reason, can be related to depression. Such a “pain disorder” is described in the DSM-5 (2013:309-327) as “somatoform disorders”. When depression is diagnosed, the pains and aches that the individual describes, should be taken into account. In order to explain why depression and pain co-exist it is necessary to examine the neurobiological pathway if pain as well as the individual’s psychological background (Rijavec and Grubic 2011:348). Neurotransmitters in the human body such as glutamate, substance P, and gamma-aminobutyric acid are set in motion with chronic pain and depression.

3.3 Depression and mood

In the 20th century, there was a focus on mood in psychological investigation (Rottenberg 2014:3). However, the reliability of the results of these investigations were often questioned. From a psychological perspective, “mood” is seen as either a positive or a negative emotional state with different levels of intensity that changes in response to circumstances and events in life (Polak et al. 2015:3). Moods are commonly uniform and slow to change. People often cannot determine the source of the mood. Emotion, on the other hand, is a sudden, specific feeling that is experienced in response to a certain event.

In the 13th century and earlier, what is today referred to as “emotions” were known then as affect, passions and perturbations of the soul (Friedson 2017:xxiii; see Jackson 1986:15). Already in the 14th century the term “depression” was coined. It is derived from the Latin *deprimere,* which means to “press down”. An individual is “pressed down” physically and emotionally (Friedson 2017:xxiii). The term “depression” was also used to refer to individuals’ social status, which was closely

related to their mental state. In that era, persons who suffered from depression were deemed “mad” or “a sinner”. They were treated harshly.

In the 20th century CAT scans and functional magnetic imaging made the investigation of the innermost parts of the human body possible. In the last 30 years highly developed assessment methods and technologies have enabled mental health professionals to measure mood and emotion (Bryant et al. 2014:79; cf. World Health Organization 2004:19). A new field called “affective science”, has emerged (see Coan and Allen 2007:3-6). Tools and techniques are used to measure the moods reported by individuals. There are also systems that measure behaviour in the laboratory and in the field (Rottenberg 2014:3). They provide different ways to observe the physiology of mood and emotion. Functional brain scans and miniature sensors monitor the body as people go about their daily routines. This has led to new insights about “normal moods” and a better understanding of the reasons for the high incidence of depression. The mood system influences how people feel, think and operate. It also serves as a guide for their bodily reactions to the world (Rottenberg 2014:3). Four types of moods, two high and two low, that influence an individual’s life, are the following (Polak et al. 2015:3; Rottenberg 2014:3):

- **High moods**

High moods stimulate and activate individuals to engage in ways to achieve rewards more zealously:

- positive high activation: enthusiasm, excitement and cheerfulness;
- positive low activation: calmness, relaxation and peacefulness.

- **Low moods**

Low moods are a “stop-and-think” mechanism, which limits certain actions and behaviour and focuses on threats and obstacles:

- negative high activation: anxiety, hostility and stress;
- negative low activation: sadness, depression and feeling miserable.

Recently there has been an increase in self-help psychology books about happiness. They introduce different techniques for achieving happiness. Rottenberg (2014:3), points out that people tend to search for guidance in culture as to which emotions are regarded as acceptable, which are unacceptable and how to manage negative feelings. However, when too much effort is made and value is placed on happiness, it will probably result in a lack of happiness. Happiness should not be set as a goal that has to be achieved at all cost, because then other experiences will be set aside. There would for instance, be no opportunity for working through negative emotions. They will simply be suppressed. Consequently, an individual will have to strive of contrive to be happy around others even if it is not how they truly feel. Rottenberg (2014:4) puts it as follows: “Rising happiness standards widen the gap between what we want to feel and what we actually feel”.

3.4 Depression and human connection

Depression is commonly associated with loss. This includes the loss of relationships, the loss of an ideal, the unreconciled loss of a loved-one in death (Hugh Cole 2015:45; Friedson 2017:xix). Conscious or unconscious trauma can be the root cause of depression. Symptoms can be either noticeable or obscure. Another related aspect is the fear and anxiety caused by the realization of mortality. Shabad (2006:414) articulates it as follows: “Our quest for answers to our human condition seems to be met only with impenetrable silence from the universe that won’t respond to our pleas to spare the innocent from suffering”. If the universe is silent, human beings depend even more on one another for comfort and finding their purpose. They try to make the most of their mortal life by creating relationships that give meaning to and increase the quality of their lives (Friedson 2017:xx; cf. Trisel 2015:62-64; Krause 2007:518-519). One factor that contributes to depression is the experience of loneliness, which cannot be escaped because it is intrinsic to human existence (Friedson 2017:xxi; cf. McGraw 1992:321; Mushtaq et al. 2014:1-4). Loneliness can cause pain, which in turn increases vulnerability to depressive thought patterns.

The Greek physician, Hippocrates (460-370 BC), was one of the first to write about depression (Phillips 2014:6; see Swanepoel 2009:143). In his day, what is called depression today was referred to as *melancholia*. Hippocrates described the features of *melancholia* as loss of appetite, sadness, sleeplessness, irritability and restlessness (Friedson 2017:xxiii). Throughout the centuries, these symptoms were criteria for diagnosing *melancholia.* The medical field used Hippocrates' work as their guiding principle. In his work, *The nature of man,* Hippocrates theorized that the human body comprises four main liquids: blood, phlegm, yellow bile and black bile. He drew a connection between fluids in the human body and a person's physical, mental and emotional state. This theory was referred to as *humouralism* (Friedson 2017:xxiii).

3.5 Roots of depression

People have the need to feel recognized. This begins in infancy and affects their entire lives. Psychiatrist Margaret Mahler (1897-1985) received much recognition for her work on the development of early attachment and the process of separation and individuation. Mahler and colleagues Fred Pine and Anni Bergmann are known for the idea of a "second psychological birth". According to Mahler, Pine and Bergmann (1975:691; see Mahler et al. 2002:3) this second psychological birth takes place when the "whole" individual develops in a healthy way to form an own unique personality (Friedson 2017:4).

A child's first relationship is with the primary caregiver. According to Mahler et al. (2002:4), the infant experiences a state of psychological union with the primary caregiver as though there is no separation between them. Infants cannot distinguish between the external and the internal worlds (Gehart 2012:58; cf. Bloom 2009:54; see Irwin 2002:25). Their mental state is the central focus of their own universe. They feel safe and secure. As time progresses, the feeling of security is tested. They learn to crawl and walk and gradually move away from the primary caregiver to explore out of curiosity. Along with this development – crawling, walking and curious exploration – a sense of individuality is formed.

The strength of the bond between infant and the primary caregiver is put to the test in the moment of separation (exploring) and the moment of returning to one another. If an infant developed a safe and secure attachment with the caregiver the child will feel more confident in separateness and be better able to maintain an inner sense of security (Friedson 2017:4). On the other hand, if infants are exposed to an unwelcoming environment and their needs and desires are neglected, they can feel lost and abandoned. A lack of resources that are needed for a healthy and secure life, can cause an individual to revert to the "dependent infant" stage (Friedson 2017:4). This, in turn, can lead to feelings of inadequacy and the inability to make positive changes for themselves, both on a personal level and in their social milieu. These processes are referred to as mirroring and mentalization. Mentalization is the ability of individuals to recognize their feelings, thoughts and actions. It also enables the individual to recognize the feelings, thoughts and actions of others and allows them to be able to relate and differentiate. It is utilised when people attempt to make sense of social situations (Friedson 2017:5). According to Fonagy and Target (2007:921), "when infants cannot create such dyadic states the coherence and complexity of their self-representation is dissipated; they move closer to states of disorganization in both the emotional and cognitive domains. Phenomenologically, not casually … this state is an aspect of severe depression".

Young men are often also affected by depressive symptoms, which have a negative effect on their health. Childhood trauma and poverty play a fundamental role in adult depression (Hatcher et al. 2018:79). According to Hatcher et al. (2018:79), the effects of trauma and poverty in childhood that result in depression in adulthood, is not sufficiently investigated in sub-Saharan African settings. Their study with young men of low income, who experience a lack of food security and education, showed that the majority of them were exposed to some form of child abuse. Their conclusion was that household poverty is a primary cause of child abuse, which can then result in mental disorders in young adulthood. There are, however, ways to assist those individuals who live in an environment of poverty. Hatcher et al. (2018:80) propose that structural interventions with regard to food security,

employment and parenting, can break the intergenerational nexus of poverty, trauma, and health in peri-urban settings.

Young persons, who transition from childhood to adulthood, can be greatly disrupted by physical and sexual abuse. The disruption is brought on by physiological and neurobiological changes, which are the result of chronic stress. Hatcher et al. (2018:80) find that sub-Saharan African children are particularly vulnerable to sexual, physical and emotional abuse. Young men tend to experience more physical abuse and young females more sexual abuse.

The condition of persons for whom it is extremely difficult or impossible to put their feelings into words is referred to as alexithymia (see Van der Kolk 2014:121). Often traumatized individuals – both adults and children – struggle to find a way to describe how and what they are feeling. The reason for this is that they cannot recognize and interpret their physical sensations. According to Van der Kolk (2014:122), “they may look furious but deny that they are angry, they may appear terrified but say that they are fine”. People who struggle with alexithymia often use language of action rather than language of emotion. They experience emotions as a physical issue rather than as a warning that there are issues with which they still have to deal. Therefore, instead of feeling anger or sadness, they experience muscle pain, bowel problems or other physical symptoms that cannot be explained medically. As a result, traumatized individuals often lack the ability to express emotions such as frustration. They are not in tune with their bodies, which “contributes to their well-documented lack of self-protection and high rates of victimization” (Van der Kolk 2014:122). They also have difficulty feeling pleasure, sensuality and that their life has meaning.

3.6 Misconceptions and treatment

A common misconception with regard to mental illness is: *An individual is either mentally ill or mentally healthy.* Such a binary view contributes to the stigmatization of mental illness. A common belief is that people who have no family history of mental illness will remain mentally healthy. Although biological factors do play a role

in mental illness, external factors such as the environment and a person's upbringing also contribute. People often "hide behind a smile". They can be successful in their career, have a loving spouse and appear to have a "normal" life, but still have mental health challenges.

A second common misconception is: *Individuals with mental illness are more likely to be violent.* School shootings and other violent crimes are commonly linked to mental illness. Criminals are frequently portrayed as mentally ill. However, many individuals with mental illness are not violent at all. According to the American Psychological Association, only 7.5% of crimes were committed by individuals with mental illness. Factors such unemployment, poverty and substance abuse are more common reasons why people commit violent acts and crime. However, these facts are not acknowledged adequately. More emphasis is placed on the "flaws" of people who suffer from mental illness than on what they accomplish despite their mental illness.

A third misconception with regard to mental illness is: *Individuals with mental illness cannot retain employment or maintain relationships.* Individuals with mental illness face many challenges and limitations. This can influence their ability to work or make social connections with others. However, many can still work toward their goals in spite of the challenges and limitations they face. Mood disorders such as depression can cause an individual to succumb to stress quicker and then feel demotivated to carry out their tasks at work. Therapy and practicing breathing techniques can improve their lives and enable them to accomplish what has to be done.

Another misconception about mental health is the idea: *Everything can be fixed with medication.* Medication for depression and anxiety help to regulate the chemicals in the brain. Medication is not a replacement for therapy. The clinician monitors the medication in order for it to be of maximum benefit to the person.

A singularly detrimental misconception regarding people with mental health challenges is: *Individuals with a mental illness and suicide ideations are just "looking for attention".* The consequence of such an attitude is often that people who need help and families who need emotional support are judged rather than cared for.

When mental illness is misdiagnosed, the real condition goes untreated. This can have consequences for the individual and society that include unemployment, a strain on the economy, and the person turning to substances or self-death (NAMI 2006; TAC 2016). Consequences of untreated mental illness include the following:

- **Mental deterioration**

Mental illness among adults has intensified and increased from 2% to 2.7%. Individuals who have not consulted a professional therapist after one year of diagnosis are at higher risk for mental “deterioration” than those who had consultations.

- **Unemployment**

Cross-sectional research has confirmed the pervasiveness of mental illness and the rise of unemployment rates (WHO 2003:16-28).

- **The economic cost of mental illness**

In 2016 and 2017 researchers conducted a study to investigate what costs can be attributed to mental illness in South Africa. They found that approximately R 894 billion was spent on mental illness in order to provide assistance to the individuals who struggle to get by on a daily basis (Docrat et al. 2019:706). Mental illness adds to economic costs. Consequences include increased visits to emergency rooms, an increase in chronic illness, inappropriate health choices and a higher mortality rate.

- **Self-death**

An estimated 804,000 self-deaths due to mental illness have occurred globally in 2012. Since then the number of individuals who took their own life has increased rapidly. In South Africa the rate of self-death has increased to 23 per day in 2020. This can be attributed to the extra pressure due to the Covid-19 pandemic and financial crises (Bantjes and Kagee 2020:238).

Other impediments to people received appropriate help and treatment include medical costs, ignorance, and the social stigmatisation of mental problems. A lack of knowledge and harmful attitudes with regard to mental health impede the seeking of help. People's understanding, management and prevention of mental health problems are built on their knowledge or lack thereof. The stigma attached to mental health problems and the accompanying beliefs and attitudes affect how people respond to the idea of seeking psychological help. The following three types of stigmatisation are prevalent (Loganathan 2012:93-94):

- **Social stigma**

Social stigma refers to the discriminatory attitudes and beliefs towards mental illness and those who suffer from it. Such beliefs include that people with mental illness are less intelligent and less capable that others.

- **Self-stigmatisation**

Self-stigmatisation is the process in which a person with a mental illness diagnosis becomes aware of public stigma, internalises the stereotypes and applies these to themselves.

- **Structural stigma**

Particular policies of institutions such as, for example, governments, companies and schools that place restrictions on the rights and opportunities of individuals living with mental illness can be seen as systemic or structural stigmatisation. Structural and public social stigma together exacerbate personal stigmatisation.

3.7 Mental health and the global environment

Global events such as wars and pandemics can also have an influence on mental healthy. In the current context the Covid-19 pandemic is a case in point. The term "pandemic" is derived from the Greek word, *pan* (all) and *demos* (the people). It is generally used to refer to a pervasive disease, which "affects all the people". Qui et al. (2017) describe pandemics as "disease outbreaks that become widespread due to infection being spread from human to human". Various significant pandemics have been recorded in human history. These

include flu strains such as the Spanish Flu, Hong Kong Flu, Swine Flu, as well as Ebola, and most recently also Covid-19. Characteristics of a pandemic include the rapid spread of the disease, its geographic extension, its novelty and severity, minimal population immunity, and the infectiousness and contagiousness of the disease. A disease is therefore called a “pandemic” when it is pervasive, highly contagious and affects a whole countries and continents simultaneously. Crises related to these pandemics have an impact also on mental health, the economy and national security and regional stability around the globe. The Covid-19 pandemic is seen as the most catastrophic disaster of the 21st century. The Coronaviruses differ from other types of disease in that individuals who carry the virus can be asymptomatic and unaware of the fact that they have contracted it. Consequently, they are not tested and do not report their status, which can increase the rate of infection.

With regard to *health effects* of pandemics, millions of people were infected throughout history and a great number of deaths occurred. One example is the “Black Death”, a plague of the 14th century that killed more than half of the population in Europe. In the 18th century three pandemics occurred, namely Swine Flu in 1919-1920 that caused 20-40 million fatalities, Asian Flu in 1957-1958 that caused 2 million fatalities and Hong Kong Flu that caused 1 million deaths. Qui et al. (2017:6) put it as follows: “Infectious disease disasters, including pandemics and emerging infectious disease outbreaks have the potential to cause high morbidity and mortality in the world, and in fact, they may account for a quarter to a third of global mortality”. One of the most serious and deadly pandemic diseases is termed “influenza”. Key features of influenza pandemics include high incidences and fatality rates: approximately 250 000 to 500 000 deaths per year and rapid, wide-spread transmission. In the past decade, the risk of a human influenza pandemic has increased. This led to the rise of a new worldwide pandemic, Covid-19.

The *economic effects* of a pandemic include the greatest recession since the Great Depression in 1929, increasing poverty, which left many without income or food, and the loss of income from those who die of the disease. The United Nations Development Programme predicts that the Coronavirus will cause a decrease in the Gross Domestic Product (GDP) of South Africa which will then only begin to recover by 2024. This will cause setbacks with regard to the issues of poverty, unemployment and inequality (Regional Bureau for South Africa 2020:4). South Africa and other countries are experiencing a second wave which is stronger and much deadlier that the first. The only viable measure to take against the spreading virus is a state of lockdown to minimize contagion. These measures restrict human contact and has an effect economically on businesses and socially on people's movement and gatherings. The loss of economic activity will have a long-term effect

The *social effect* of the pandemic can be seen in the areas of travel, leisure, education and sports. The first non-pharmaceutical intervention was the closing of schools. The temporary closing of schools and cancelling of public gatherings did contribute to a decreased mortality rate related to the Covid-19 pandemic in 2020.

Pandemics have an *effect on safety and security* on a world-wide and personal scale. The outbreak of an infectious disease heightens the risk of bioterrorism, including biological weapons and bio-terrorist attacks. As the Covid-19 pandemic persists outbreaks of violence can be seen globally. Individuals from China and East-Asian descent experience racism and hatred due to ignorance and the stigmatisation of China as the "origin" of the virus. In South Africa cases of police brutality have been reported where police officers used excessive force on individuals who breached the curfews regulations (Qiu 2017:8).

On a personal and social level, there has been a significant increase in domestic violence in South Africa since the beginning of Covid-19. The social restrictions

that are put into place for the health and safety of individuals also cause isolation. Abused women and children are even more vulnerable as they are shut in with their abuser. Children are isolated from other trusted figures to whom they could turn for support. The abuser, who is often in constant fight-flight mode, cannot flee due to the lockdown. Frustration escalates, fight mode kicks in and this leads to domestic violence. Dependence on substances and the subsequent withdrawal during lockdown can also lead to escalating violence. In 2020 more than 2 300 cases of domestic violence were reported in South Africa (Gonese et al. 2020:9, Heins 2020)

A recent study of the Kaiser Family Foundation on 2 April 2020 highlights the *psychological effects* of Covid 19 (Son et al. 2020:2). Half of the adults in the study had themselves contracted the virus or had a loved one who contracted the virus. They report that this experience had a significant effect on their mental health. This, in turn, affects a person's physical health, immunity and resilience. The human body's biological immune system is impaired by stress. This makes it more vulnerable to the coronavirus and other diseases. The heart condition known as "stress cardiomiopathy" or "broken heart syndrome" increased and intensified since the beginning of the Covid-19 pandemic. Broken heart syndrome is mostly caused by intense stress and extreme emotions. It can be brought on, for example, by the sudden loss of a loved one, divorce or financial stress. The sudden release of adrenaline in large amounts weakens the heart muscle and causes heart palpitations.

Many losses are directly linked to the Covid-19 pandemic. People lost loved-ones or were close to death themselves. In South Africa, by 10 January 2021, approximately 1 231 597 new cases of infections were identified with 33 163 deaths. Other losses include the loss of freedom, opportunities, connection, physical touch and affection, routine, and certainty about the future. The disruption caused by the pandemic also often triggers unprocessed past traumatic experiences.

CHAPTER 4

SUBSTANCE USE DISORDER

4.1 Stress and substances

Every human experience of trauma is unique to the individual. Some exhibit stress-related behaviour in response to traumatic experiences, whereas others do not. Post-traumatic stress symptoms generally fade after some time. However, in some instances the symptoms linger. These symptoms disrupt people's lives and relationships. Stress-related reactions can develop into severe psychological problems. In an attempt to cope, some people can turn to substances. Others experience what is referred to as "post-traumatic growth". These individuals come to an acceptance of what has occurred and how it has changed their identity in a positive way.

Substance use disorder is a chronic, relapsing brain disease. The individual experiences and overwhelming desire to use a substance that has a harmful effect on them (Volklow and Boyle 2018:729; cf. Hruska and Delahanty 2014:36,38; see Volklow 2007:5). It can also refer to a physical dependence, a physiological need for a specific substance. If the substance is withheld or reduced, the person experiences withdrawal symptoms. It is described as a *brain disease* because substances have the ability to alter the brain structure and also because of the way in which it functions. Volkow (2007:5) explains it as follows:

> Addiction is a lot like any other disease, such as heart disease. Both disrupt the normal, healthy functioning of the underlying organ, have serious harmful consequences, and are preventable and treatable, but if left untreated, can last a lifetime.

Psychologists describe substance use disorder as compulsive, obsessive and difficult to control. Another sign that it is becoming a disorder is when initially pleasurable behaviour begins to interfere with daily life, work, health and relationships (Hanson and Fleckenstein 2017:177; DSM-5 2013:483; see Koob

2011:55; Koob and Simon 2009:2; Ghodse 2002:4). Four primary motivations for using substances include (Volklow 2007:5): feeling good, feeling better, doing better, curiosity. Most addictive substances provide a pleasurable and relaxing feeling. They reduce feelings of anxiety, stress and depression (Marel et al. 2016:8; see Ouimette and Read 2014:54; O'Shaugnessy 2015:8,23-14; Koob and Simon 2009:2).

4.2 Neuroscience and substances

The human brain is the most complex organ in the human body. It is the organ that produces memories, thoughts, actions, feelings and experiences. The human brain is responsible for learned experience and shaping personalities. It is where all human activity is regulated (Carter 2013:121; cf. Gonçalves 2008:93; see Volkow 2007:15). With the harmful use of substances or alcohol, three main parts of the brain that are most affected are the following (Varcarolis 2014:63; Koob and Simon 2009:4; Volkow 2007:15, 17):

- **Brain stem**

The brain stem regulates the main functions that are important to life – heart rate, breathing and sleeping.

- **Cerebral cortex**

The cerebral cortex comprises of sub-parts that each have their own unique function. Certain areas control the senses whereas others control thinking processes – problem solving, decision making and planning (frontal cortex). The frontal cortex is also referred to as the "forebrain".

- **Limbic System**

The limbic system houses the brain's reward circuit. Its function is to connect different brain structures that control the ability to experience pleasure. When human beings experience a feeling of pleasure, it motivates them to repeat the behaviour that provides pleasure and which is fundamental to their existence. The limbic system can be activated by healthy activities such as eating and socializing. However, it can also be activated by the use of harmful substances. The limbic

system regulates mood. Mood can be altered by substances that interrupt the brain's communication system. The way in which neurons in the brain would normally send, receive and process information, is hindered. Marijuana and heroin are examples of substances that activate neurons. This happens because their chemical structure closely imitates that of natural neurotransmitters. Consequently, the resemblance between the two structures – the chemical structure of the substances and that of the neurotransmitter – misleads receptors and allows the substances to attach themselves onto neurons and activate them. However, even though the substances imitate the natural chemicals in an individual's brain, they do not activate the neurons in the same way that neurotransmitters do. This then leads to altered communication between neurons in the network of the brain.

Many substances produce a pleasurable feeling because they stimulate the release of high levels of the dopamine hormone. This hormone is an example of a neurotransmitter that is present in the parts of the brain that control movement, emotion, motivation and the feeling of pleasure. Overstimulation due to the use of a substance has a euphoric effect which, in turn, causes a craving for the substance. Trauma and substance dependence are closely connected. It is difficult to recover from one without also attending to the other (Ouimette and Read 2014:36). Three hypotheses that explain how PTSS and substance use disorder (SUD) co-exist, are the following (Gogos et al. 2019:2943; see Yilmaz and Dilbaz 2016:93; Barsky and Silbersweig 2017:313):

- **The self-medication hypothesis**

According to the self-medication hypothesis, PTSS occurs prior to SUD. The individual tries to relieve the negative effect of their trauma through self-medication. This can lead to the problem of the harmful use of substances.

- **Substance-induced anxiety enhancement hypothesis**

According to the substance-induced anxiety enhancement hypothesis, the harmful use of substances after a traumatic event can lead to the development of PTSS

symptoms. The reason is that the substances have a negative effect on how the human body responds to stress.

- **The shared vulnerability hypothesis**

According to the shared vulnerability hypothesis, PTSS and SUD occur almost simultaneously because both contribute to the vulnerability of the person. Almost half of women who receive treatment for the harmful use of substances experienced a traumatic event such as rape or sexual assault. For quite some time psychologists interpreted PTSS through the lens of fear and conditioning. The person cannot get rid of the memory of being in mortal danger. The person develops a learned response to that memory (Baldwin 2013:1551; Ouimette and Read 2014:39; Koob and Le Moal 2008:3117). However, clinicians now also recognize that PTSS can be the consequence of moral injury (Held et at. 2017; Pearlmann et al. 2014:4). This widens the scope to include both violence done to the individual and actions they took or did not take.

Trauma affects different people differently. Some can experience trauma and move on, whereas others turn to substances in an attempt to cope. Findings suggest that the genetic predisposition of a person plays a role in the level of vulnerability to substances (Koob 2011:63; see Koob and Simon 2010:6). Context and the environment also play a role. People who have experienced abuse in childhood can feel that they are ready to deal with difficult and traumatic life experiences, since they are survivors. Others suppress and avoid negative emotions. People who develop PTSS are usually from the latter group (Patel and Patel 2019:16; see Ouimette and Read 2014:69). PTSS can have a long-term effect on a person's mental health. In the human brain, PTSS shares similarities with anxiety disorders. For example, the limbic system can overwhelm the body with a large amount of stress hormones such as cortisol whenever images of the traumatic event resurface in the consciousness (Naff 2013:65; cf. Wilson and Keane 2004:27, 65). Neuro-imaging indicates that the chemical process in the brain that is set in motion by trauma can damage or shrink the hippocampus. The hippocampus is associated with how human beings integrate memories. This can explain why the brain does not "file" traumatic memories as

long-term memories, but remain current and vivid through flashbacks and nightmares. Many individuals who suffer from trauma attempt to cope by “self-medicating”, which puts them at risk of substance use disorder. Self-medicating can include the use of alcohol or other substances or compulsive gambling, eating, shopping, exercising or participating in risky sexual behaviour (Garland et al. 2013:176; see Dass-Brailsford and Myrick 2010:204).

Individuals with substance use disorder often do not realize that they have lost control of their behaviour. The result is psychological dependence, namely the need to use a substance or revert to specific detrimental behaviour in order to relieve negative emotions. Individuals with substance use disorder are often stigmatized as pleasure-seeking hedonists who lack self-control (Sattler et al. 2017:415-423; see Yang et al. 2017:378; Matthews et al. 2016:2-13). However, their compulsive behaviour is a response to stress or psychological problems (Yang et al. 2017:378; Matthews et al. 2016:2-13). They failed to developing healthy and constructive coping strategies and then reverted to negative and destructive measures. Substance use disorder is then secondary to the more complicated underlying primary cause. Substance use disorder has consequences for the economy in terms of health care costs. It also plays a role in an increased crime rate and overall low productivity (Ellis et al. 2013:1-12, 303, 231, 281; Van Heerden et al. 2009:2).

Substance use disorder can cause anxiety and depression. It exacerbates existing problems such as anxiety disorders, including PTSS. Tipps et al. (2014:1) have investigated the relationship between the use of harmful substances, memory and PTSS. Their investigation focuses primarily on three types of substances that specifically have an effect on the brain, namely nicotine, cocaine and alcohol. These substances influence neurobiological mechanisms and change the way in which an individual learns and remembers. Tipps et al. (2014:1) examine how these three substances affect cognition and emotion and how they control, reinforce or terminate the emotion of fear. They explain how these substance can be an obstacle in the treatment of PTSS.

Substance use disorder has a complex effect on memory. Stress is the main factor, since it regulates the rewarding effect of harmful substances, strengthens cravings and can contribute to a relapse (Grossman 2013:561; Koob et al. 2010:201; Sinha 2009:105-130). Substances can change an individual's biological response to stress (Ouimette and Read 2014:36; see Tipps et al. 2014:1). Consequently, substances that improve people's mood, can affect their memory positively (improve memory) or negatively (impair memory).

The DSM-5 (2013:271) describes PTSS as having persistent, involuntarily and disruptive memories of traumatic events. Individuals also experience persistent nightmares connected to the traumatic event or events. That causes distress. They have flashbacks, which causes them to feel as though the event is taking place at that moment (Levine and Van der Kolk 2015:7, 124; see Nöthling et al. 2015:1; Luther 2019:163). According to Tipps et al. (2014:15) and Logrip et al. (2012:1-13) the primary risk factors that increase vulnerability to the development of PTSS include:

- the intensity of the trauma;
- socio-economic factors;
- substance use disorder.

Various studies have indicated that some 75% of combat veterans who suffer from PTSS meet the full criteria for alcohol dependence (Teeters et al. 2017:69-74; see Tipps et al. 2014:16; McCauley et al. 2013:1-3). Those who suffer from PTSS and also have substance use disorder tend to exhibit more severe symptoms of PTSS, specifically of avoidance and hyperarousal.

In order to explain the comorbidity of PTSS and substance use disorder, two primary pathways have been scrutinised (Tipps et al. 2014:16; see McCauley 2013:6; Jacobsen et al. 2001:1185). According to the first pathway, substance use disorder develops prior to PTSS. Substance use disorder can cause impaired judgment which can lead to people putting themselves in harm's way in order to procure the substance. Consequently, elevated levels of physical and physiological trauma

occur. Chronic substance use disorder can also cause increased levels of hyperarousal, anxiety and neurobiological stress.

The second pathway proposes that PTSS develops prior to substance use disorder. Substance use is a way of self-medicating, which serves as a coping mechanism. Substances that increase the risk of depression include alcohol, cannabis and opioids. These substances also intensify PTSS symptoms. This pathway is compatible with the behavioural theory of substance use disorder (see Saladin 1995:645). According to this theory, the negative emotions experienced by people who suffer from PTSS, serve as a motivation for the use of substances that have a relaxing effect and make them feel better. More than half of the victims of crime who were exposed to torture, sexual violence, enslavement or other highly traumatic events, turned to substances as a way of coping. The root cause of behavioural problems such as the use of harmful substances, is often also the cause of the PTSS.

Even though the substances differ and have a different effect on an individual, addictive substances are used by a “single disease population” (Tipps et al. 2014:17). For example, though cocaine and alcohol have very different properties, both are used in the PTSS population (see Souza and Spates 2008:11, 13-15; McCrady and Epstein 2013:542; Miller et al. 2013:88). The type of substance that is chosen, depends on the specific set of symptoms of PTSS that the individual experiences. Cigarette smoking is the most common form of dependence among individuals who suffer from PTSS because of its relaxing properties (O’Shaugnessy 2015:333; cf. Gordon 2008:10, 14; Volkow 2007:23). Cigarettes are readily available and affordable. Emotional numbing – similar to depression – is connected to the number of cigarettes an individual smokes and how difficult the person finds it to stop smoking (Heshmat 2015:13; see Tipps et al. 2014:17; Leventhal and Zvolensky 2015:177). The effect of cigarette smoking is that it decreases hyper-vigilance and the intensity of other PTSS symptoms. An individual with a long-term history of the use of substances is at risk of developing a malfunctioning of stress hormones. This

can increase the person's vulnerability to stress. This can ultimately contribute to a relapse of people in recovery from substance use disorder.

Koob and Le Moal (2008:3117) developed the *allostatic model* to indicate the shifted stress response curve with regard to psychostimulant dependence. They define allostasis as "'stability through change and a continuous readjustment of all parameters towards a new set point … An allostatic state can be defined as a state of chronic deviation of the regulatory system from its normal (homeostatic) operating level" (Koob and Le Moal 2008:3117). The model indicates that addictive substances can act as stressors that initiate a "compensatory opponent process" to sustain an individual's stress and hormone levels (Koob and Le Moal 2008:3118; cf. Tiipps et al. 2014:18). Therefore, when an individual is continuously exposed to substances, the compensatory process shift begins to position itself downwards. This means that every process has an affective balance, for example, pleasant or unpleasant, which is followed by a secondary opponent process. The opponent process is set in motion after the primary process is silenced. Recurrent exposure to substances weakens the primary process and enhances the opponent process. Substance use disorder is the outcome of the emotional combining of pleasure and withdrawal. At the beginning of substance use, there are high levels of pleasure, whereas withdrawal symptoms are weak. As the levels of pleasure derived from substance use progressively decrease, the levels of withdrawal symptoms increase. This also explains why individuals with PTSS and substance use disorder react differently to conversations about trauma than those who do not have PTSS.

Cocaine has a negative influence on PTSS in two ways. Firstly, it increases the risk of exposure to traumatic events when the individual begins to crave the substance. Traumatic events and substances are associated with each other. Substance dependence can cause reckless behaviour in order to get hold of the substance. Secondly, it increases the individual's vulnerability to PTSS because it causes a clash in the stress response systems (Brady et al. 2019:206; see Khoury et al. 2010:1078). Individuals with PTSS who use the substance cocaine as coping mechanism have a slimmer chance to heal. Alcohol is the most common substance

used by men who suffer from PTSS (Zipvel et al. 2019:29; see Tipps et al. 2014:18; World Health Organization 2005:432). The risk of developing alcohol dependence increases as the PTSS symptoms worsen. Intoxication can either elevate or reduce fear-based learning. Fear-based learning is when the hypothalamus releases large amounts of chemicals to the sympathetic nervous system and adrenal-cortical system (Simon et al. 2020:322; see Hughes and Baylin 2012:63; Stone 2001:78). The individual finds it difficult to accomplish even the smallest task, because the brain is overwhelmed by fear. According to Tipps et al. (2014:18), “sub-intoxication levels prior to a traumatic event could increase the possibility of forming a fear memory”. Individuals who are only under the influence of alcohol, are mostly still aware of their surroundings. Therefore, when a traumatic event takes place, they will be able to remember the event and in certain instances be traumatized by it. In contrast, “high levels of alcohol might be expected to impair this fear memory formation, possibly having a protective effect” (Tipps et al. 2014:18).

When alcohol is used to relieve symptoms of PTSS such as anxiety, it can cause negative emotions to linger. This explains why elevated levels of alcohol consumption are connected to intensified and long-lasting PTSS symptoms. Behavioural changes that are most evident in binge drinkers can be attributed to the changes in the way in which the amygdala and the prefrontal areas function (see O’Daly and Trick 2012; Stephens and Duka 2008:317; Stephens et al. 2005:394; Leventhal and Zvolensky 2015:177). According to Tipps et al. (2014:20), “a possible consequence of impaired prefrontal functions, which normally modulate the output of the amygdala, might be that alcoholic patients are predisposed to recall averse experiences that are normally suppressed, thus enhancing the re-experiencing of PTSS symptoms”.

Significant experiences and events are more likely to be engraved in an individual’s memory than events with little significance. The reason for this is that significant experiences and events cause elevated stress hormone responses (Squire and Dede 2015:1-3; see McGaugh and Roozendal 2008:10). When the secretion of these hormones is restricted, it can cause the loss or significant weakening of the

memory of the traumatic or stressful event. When an overflow of stress hormones is dispersed after a traumatic event, it can lead to abnormal memory organization. This can become apparent as PTSS symptoms. Abnormal activity in the HPA axis can extend the availability of sympathetic hormones. This can increase the abnormal organization of memories (Herman et al. 2016:603-607; see Stephans and Wand 2012:469, 471-474; Hruska and Delahanty 2014:36). The stress-related chemical, cortisol, has been found to be less in individuals who do not consume alcohol and cope with stress situations in a healthy way. This is also the case when individuals who have a family history of alcoholism do not become dependent on alcohol themselves. When there is a family history of alcoholism, it can result in elevated cortisol levels in reaction to opioid receptor hindrance (Ouimette and Read 2014:37; see Rachdaoui and Sarkar 2013:594, 598-603). They are at greater risk of a weakened immune system. This can lead to fatigue, depression or anxiety. Opioids can reduce the craving for alcohol, but then risk opioid dependency (Volkow 2018:11, 12; see Lee et al. 2015:2-6; Ouimette and Read 2014:40). Research with regard to the neuro-circuitry of dependence focuses mainly on the parts of the brain that are connected to motivation and reward (Volkow et al. 2019:2116-2126; MacNicol 2017:142-146). These are the brain regions that limit compulsive behaviour.

Functional imaging studies show that increased dopamine in and around the nucleus accumbens (NAc) increases the effect of addictive substances (Watson and Sibadi 2017:194; see Volkow et al. 2007:1061; Koob and Volkow 2010:407). Neuropsychological tests have shown that individuals with a substance use disorder present deficiencies (Ouimette and Read 2014:40; see Nussbaum 2013:117; Horton and Wedding 2008:708). The neuropsychological tests assess the cognitive functioning of an individual. It measures aspects such as attention, problem solving, I.Q., visual-spatial skills, academic skills and social-emotional functioning. Neuro-imaging research has indicated reduced activity in the orbitofrontal cortex – where emotion and memory are regulated – when an individual enters a state of sobriety after alcohol intoxication (Ouimette and Read 2014:40).

The functioning of the anterior cingulate cortex (ACC) in a person who suffers from PTSS is impaired. This is exacerbated by the use of harmful substances (Ouimette and Read 2014:40). The ACC carries out complex cognitive functions such as empathy, impulse control, emotion and decision-making. A decrease in ACC activation can increase the risk of PTSS symptoms. The “affective subdivision” of the ACC is responsible for the assessment of emotional stimuli. It allocates motivational value to stimuli and regulates emotional responses. When ACC activation is impaired, it can cause symptoms of heightened psychological and physiological stress and emotional distress that are linked to PTSS (Ouimette and Read 2014:41).

Every year approximately 90,000 deaths can be linked to the use of illicit or prescription substances and alcohol. Some 48,000 deaths are linked to the use of tobacco (Volkow 2007:3). People of all ages can be affected by harmful substances, from babies in the womb, to adolescents, to adults. Children who use harmful substances do not perform well academically and often fail to complete their education. Adults suffer from impaired memory and struggle to focus on their responsibilities. The use of harmful substances can impair people’s social skills and lead to poor social behaviour. Work performance declines. People with substance use disorder often create a hostile environment for their family. The environment is chaotic and often violent. It causes much stress for children. Such children often suffer abuse and neglect. These conditions, in turn, impair their development. Children who grow up in such an environment often also turn to substances. This means that the problem is transmitted from one generation to the next (Volkow 2007:3).

4.3 Harmful substances

In this section, some of the most common harmful substances used by individuals who suffer from trauma-related disorders are explained briefly. These substances include stimulants, sedatives and hallucinogens. Harmful substances include the following (National Institute of Drug Abuse 2020:2-30; see O’Shaugnessy 2015:442-450):

- **LSD**

LSD, also known as lysergide, lysergic acid, acid and microdots, falls into the category of hallucinogens. It can cause psychological dependence but is not addictive, due to the speed with which a person develops a tolerance for the substance. Examples of chemical hallucinogens are psilocybin in “magic mushrooms” and mescaline – a white, water-soluble, crystalline powder. LSD comes in the form of small, coloured tablets that are taken orally, or it is absorbed in paper or sugar cubes. The effects last for approximately 4-12 hours.

Short-term effects include:

- restlessness;
- dizziness;
- feeling cold and shivering;
- an uncontrollable desire to laugh;
- visual distortion, distortions of sound;
- mystical, pseudo-religious experiences (not common);
- loss of emotional control;
- unpleasant or terrifying hallucinations;
- overwhelming anxiety, despair or panic;
- self-harm can be attempted.

Long-term effects of LSD include:

- If LSD is used over a long period, it can increase the risk of mental disturbances such as depression.
- If there is an existing mental disorder, LSD can cause permanent damage.

- **KHAT**

KHAT, also known as Cat, chaat, mriaa and quat, falls into the category of central nervous system stimulants. Dependence on this substance is solely psychological. The primary ingredient is cathinone. Cathinone is an amphetamine-like substance, which is the main cause of the psychological dependence. KHAT is made of the

leaves and small twigs of the Catha Edulis plant, that is found in tropical environments. The substance is commonly used as a social stimulant in various countries around the world. In is also used in some traditions as a treatment for depression, fatigue, obesity and gastric ulcers.

The *short-term* effects of KHAT include:

- appetite suppression;
- dry mouth;
- euphoria;
- increased alertness;
- talkativeness;
- hyperactivity;
- rise in blood pressure, pulse, respiratory rate and temperature;
- insomnia;
- poor concentration;
- aggressive verbal outbursts;
- hallucinations.

Long-term effects include:

- constipation;
- stomach ulcers (with regular use);
- erectile dysfunction and low sex drive in men;
- increased blood pressure in young adults;
- risk of heart attack.

- **Ketamine**

Ketamine is also referred to as “Kit-kat”, special K, Super K and Vitamin K. This substance falls into the category of general anaesthetics with analgesic properties. It is taken orally. The liquid anaesthetic is heated and dissolved in water. It then forms ketamine crystals. It can be sniffed or smoked. When ketamine is smoked, it has a bitter taste and produces an immediate high. For heavy ketamine users the preferred

method is to inject it directly into a muscle. This substance can have a disturbing effect when taken in a noisy environment such as a club. Therefore, ketamine is commonly used in a quiet and peaceful environment. Due to its analgesic properties, ketamine is used in human and veterinary medicine.

Short-term effects include:

- hallucinations;
- feeling paralyzed;
- repetition of words or actions;
- out-of-body experience;
- the inability to feel pain;
- in cases of overdose there are severe reactions such as seizures, difficulty breathing and heart failure.

Long-term effects:

When ketamine is used over a long period, it has a detrimental effect on a person's memory, attention and ability to learn. Other long-term risks include psychosis and inflammation of the bladder and ureters, which can cause spasms, bladder pain and blood in the urine.

There have been cases where a person's bladder had to be removed surgically because of the extreme infection and inflammation. The most obvious sign of the use of ketamine is deliberate self-inflicted painful injuries such as cigarette burns.

- **GHB**

GHB is also known as Liquid X, GBH, Liquid E, gamma hydroxybutyrate and sodium oxybyte. It can become addictive when used in high doses over a long period of time. It is sold in three forms, namely liquid, capsules or powder. GHB was previously used as an anaesthetic for the treatment of narcolepsy, insomnia and nicotine withdrawal. Currently in the United Kingdom, it has no licensed medical purpose or usage. GHB is a main ingredient of date rape drugs due to its paralyzing effect. It is now illegal. Its effect is similar to that of alcohol.

Short-term effects include:

- talkativeness;
- euphoria;
- drowsiness (wears off 4-8 hours after consumption);
- headaches;
- gastrointestinal symptoms such as stomach pain and vomiting;
- loss of consciousness (high doses);
- seizures (high doses);
- decreased heart rate;
- low blood pressure;
- respiratory arrest.

Full recovery from the effects of GHB takes place after approximately 96 hours. Hospital treatment is often necessary. Fatalities have also been reported after high doses of GHB because it causes cardiorespiratory depression. Other fatalities are due to accidents while under the influence of the substance. There have been reports of individuals who were convinced that they were able to fly and fell to their death.

Long-term effects include:

- feeling hung-over for 2-3 days;
- insomnia – can last for two weeks;
- dizziness – can last for two weeks.

An indication that a person is using GHB is regular spells of fainting.

How severe trauma can cause PTSS and lead to substance use disorder is illustrated by the following case study. It also demonstrates how an individual with PTSS becomes hyper-aroused and is easily startled by the smallest things. Furthermore, the case study illustrates the phenomenon of secondary trauma and its consequences. The story shows the connection between trauma and harmful substance use, both in the case of primary and secondary trauma.

4.4 Case study

Simon was a police officer in South Africa during the 1980's. Many perceived him as a role model, especially his fellow officers. Simon's daughter, Angelica, always listened attentively when he talked about his days in the police force. Some stories had an emotional effect on her. Others made her laugh. As she grew older this bond grew stronger as he shared more detail about his experiences. Most of the stories were traumatic and shocking. Angelica developed a deeper sense of the negative effect of the traumatic experiences on his life. Some nights she could hear him scream in his sleep. When she asked him about his dream, he could not remember that he had dreamt. Simon told his daughter the following six stories that had the greatest impact on his life.

One day he was called out to attend to a case where a woman with a mental disorder was walking around the neighbourhood naked. If a house was unlocked, she would enter. After Simon managed to remove her from the last house she had entered, calm her down and covered her body with a blanked, he arrested her. On his way to the police station, Simon looked in the rear-view mirror and noticed that she was kicking the roof of the police vehicle with her high-heeled shoes. Upon arrival at the police station, she was transferred to a psychiatric centre for evaluation. She was diagnosed with severe schizophrenia and had substances in her system.

On another assignment, Simon was called out to the scene of a high speed chase. The perpetrator, who was in possession of a stolen vehicle, already had a police record. Simon was concerned for the safety of other people, because the man was driving recklessly. Simon was forced to use his firearm. He fired several shots in the general direction of the perpetrator, the last shot was fatal.

On another occasion, the police were called out to a house that was on fire. The family consisted of the parents and two children – a boy, 7 years old and a baby daughter who was a few months old. According to the evidence, the parents were asleep when the boy got hungry and wanted to make himself something to eat. He used the stove to prepare the food, but burned it. He was scared of how the parents would react and hid the hot pan under the girl's cot on the carpet, which caught on

fire. The boy ran to the parents' room and woke them up, but by that time the house was already covered with smoke and flames. The police arrived at the scene and brought the individuals to safety. After the fire was extinguished, Simon rushed into the house to search for the baby. He stumbled upon a horrible scene. The baby could not be saved.

At one point, Simon realized that his teeth were beginning to chip and break. He had a condition that caused teeth erosion. He was in constant pain. He began taking pain medication which put him on a constant "high". One day he was again called out to a high speed chase. Though he felt drowsy, he drove at high speed pursuing the perpetrator. He did not notice the sharp turn in the road and lost control over the police vehicle, which almost overturned. Fortunately, he gained control again and an accident was averted. After this ordeal, he had his teeth removed and received dentures.

On another assignment a caregiver, who was also the domestic worker of the house, was angry with her employer who did not pay her salary. The neighbours heard the child crying frantically and telephoned the mother. When the mother arrived, the child was severely beaten and barely alive. When Simon arrived at the scene, it was clear to him that the caregiver took her anger out on the child. He was furious, but could not show his emotions or act on them. He had to remain professional.

As she listened to his stories, the daughter, Angelica, realised that the scenes that affected him most, were those where children, elderly people and animals were involved. He explained in detail the accident scenes he had witnessed as well as the responsibilities involved in cleaning up the scene. What he found worst was to have to inform people that their child, husband, wife, mother, father, grandmother or grandfather had died.

Simon retired from the police force in the late 1980's and became an alcoholic. This was how he tried to escape the horrors that were haunting him every day. Alcohol allowed him to escape to "another world" where he could create a preferred story. He imagined that he could save the victims. In the 1980's counsellors were not readily available to members of the police service. They also did not have the knowledge of

neuroscience that is available today. Men who showed their emotions were stigmatized in society. All of this caused inner turmoil in Simon. This became increasingly chaotic. The reason he left the police force was because it became difficult to separate his work life from his personal life. This caused serious tension in his marriage. At the time his wife was pregnant with their first child. He stopped drinking and sought other ways to cope. He focused on his wife, their unborn child and on animals. After have left the police force, he became a draftsman and started a business with his brother. On his way home from work one day four men hijacked him at gun point. He got out of the vehicle and handed over everything that he had, including the vehicle. At first it appeared as though the four men were about to leave, but then one of them pointed the gun directly at Simon's face. He does not recall how he managed to escape and ran to a nearby informal settlement. The residents had heard the gunshots and closed their doors. He kept running and tried to jump over a wall. However, by then he was tired and did not succeed. The four men caught up to him, forced him onto his knees on the gravel and attempted to stab him. He managed to escape, though he cannot recall how.

On yet another occasion, on his way to work, a motorist ran a red light and crashed into Simon's vehicle. The perpetrator fled the scene of the accident. The canopy of his vehicle fell on two school girls who were waiting at the bus station. The injuries that Simon had sustained were severe. His ribs were broken, internal organs were torn, his feet were crushed and he had serious head injuries. The girls sustained minor injuries but were also taken to the hospital. During his stay in the hospital, his nose drip kept sliding out, so one of the nurses glued it to his nose. When it had to be removed when he was discharged, it was extremely painful.

The accident changed his life. He could no longer go biking or mountain climbing with his children – activities that they had enjoyed very much. The events also had an impact on Simon's family, especially Angelica, since she and Simon shared a close bond. Now an adult, Angelica still has flashbacks of that day when she thought her father might not be coming home. She was 10 years old at the time.

The case study illustrates how trauma affects not only the individual, but also the loved-ones. Whereas the victim suffers from primary trauma, the loved-ones can experience severe secondary trauma. Secondary trauma refers to the effect of one person's direct trauma on others who were not traumatized directly, but indirectly. In the study of Knight and Ellis (2018:1) on primary and secondary trauma, one participant stated: "I think that's the ongoing damage that we always have when you enter into someone else's horror … it changes who you are fundamentally, and I think there's got to be a way to be able to answer that within yourself, saying, I'm okay with that, but I'm acknowledging I'm a different person. That's an aspect of secondary trauma … that who I am is fundamentally different".

Angelica was subjected to another experience that caused secondary trauma for her. One night when she was still very young, early primary school, she was alone in the living room when she caught a glimpse of a war movie on television. Just then her father called her to another room to listen to a song from a CD her mother had purchased that day. Since that night, every time she hears the song she gets flashbacks of the horrible scene she witnessed on television.

The purpose of the case study was to illustrate how trauma and secondary trauma can lead to substance use disorder, especially alcohol. Simon used alcohol to the extent that it began to negatively affect his personal life, especially his marriage. He also began to lose his sense of identity. He recovered from alcohol dependency and began smoking cigarettes because it helps him to relax and stay calm when he experiences a trigger. Angelica also suffered from substance use disorder for a period in her life, but has been fully recovered for quite a while now.

CHAPTER 5

PASTORAL NARRATIVE COUNSELLING

5.1 A pastoral narrative approach

This study opts for narrative counselling as a useful point of departure for pastoral counselling with people with depression and substance use disorder. This chapter identifies useful aspects of the narrative therapy model that can be applied effectively in the pastoral guidance of those who had traumatic experiences and consequently developed substance use disorder. Narrative pastoral counselling developed out of the narrative therapy theory and techniques of Michael White and David Epston to assist individuals to break free from the influence of "the problem" on their life. This approach respects counselees as the expert of their own story. The problem is the problem, the individual is not the problem. Useful techniques include:

- rites of passage;
- scaffolding skills in discernment;
- taking it back practice;
- reclaiming joy and celebration;
- deconstruction;
- applying the absent but implicit
- externalization.

With these techniques the aim is to develop a *preferred narrative* for the individual's life to replace the negative dominant problem story. Dominant problem stories have a negative impact on people's personal life, relationships and work life. Often problem stories are the consequence of labelling by others, for example: "problem child", "difficult person", "a failure", an "addict". The aim of narrative therapy is to create a story that focuses on people's abilities, strengthen their skills and boost their self-confidence. Narrative therapy also focuses on their commitments, aspirations, values, goals and dreams.

Pastoral ministry is about holistic care – for the spirit, soul and body – as people live their lives in relationship with God. Marais (2006:7) describes spirituality as "the experience of making meaning informed by a relationship with the transcendent or divine in life". People's beliefs have a fundamental influence on the way in which they make meaning – how problems are defined, the causes of and solutions to these problems, and what meaning can arise from adversity and obstacles. Their spirituality can either contribute to or hinder their healing. Meaning-making takes place through stories. Spirituality plays a fundamental role in how the story unfolds.

From a narrative therapy perspective, knowledge is constructed not discovered. Therefore, an individual's experience or experiences can be interpreted in different ways. There is not only one right way to interpret experiences. Hankle (2016:5) puts it as follows: "According to this approach the stories people tell themselves are the organizing elements for their experiences, shaping and forming their behaviour."

A point of departure of the narrative approach is that language is the foundation of reality (Hankle 2016:6). Narratives enable individuals to maintain a sense of connection with the past while proposing a new direction for the future. Individualized folklore and narratives systemize and shape perceptions, understandings and behaviour. Language is therefore a significant factor in therapeutic interventions. From a psychological point of view it is the emotional and evaluative features of a story that connects past experiences in order to develop a constructive perception of the self. Such a perception of the self in turn contributes to the framework of appreciation for the present, and to the possibility of anticipating a positive future. Certain truths such as moral, spiritual, psychological and metaphysical truths must come to an integrated whole in the narrative. For this reason, Christian counsellors can make use of the narrative approach within the limits of the specific "supra narrative" of the Christian story (Hankle 2016:10).

5.2 Narrative Therapy

In narrative therapy individuals interpret their identity and express how their problem or problems affect their life (White 2007; see Morgan 2002:2; Abels and Abels

2001:1-3, 23-32, 57-62; White 1998:v, 3, 4). Kazdin (2000:387-389) explains narrative therapy as “a novel approach to psychotherapy devised along constructivist lines”. Narrative therapy developed as a prominent approach to counselling in a variety of therapeutic settings. The significant element is that the person is seen as the expert of their own story and life, rather than the dynamic that the therapist is the expert in the counselling relationship. The point of departure is that individuals have many skills, beliefs, hopes, commitments and values that can assist them in coping with the difficulties they face in life. Points of departure in the theory of narrative therapy include (Kazdin 2000:387-389; Sieberhagen 2000:1):

- Reality is socially constructed.
- Reality is established through language.
- Narratives systematize and uphold reality.
- There are no fixed truths.
- Individuals’ lives are multi-storied.
- Problems are externalized.
- Problems are deconstructed.

Various techniques and maps are applied in narrative therapy. Maps of narrative practice provide an understanding of the therapeutic landscape – what has been addressed and what still has to be addressed (see White 2007:9, 263; Anthony 2004:2-8; Morgan 2002:17, 33, 39, 45, 51; Eliot 2001:63, 73-75, 84, 86; Freedman and Combs 1998:47, 63-66, 120-124). The maps of practice are the following:

- **Scaffolding skills in discernment**

Scaffolding conversations enable individuals to progressively distance themselves from their comfort zone and move toward change that is possible for them. As they bridge this gap between the known and the unknown, people can experience a sense of personal agency. This sense of agency enables them to balance their life and move its course toward their goals. This they can do in ways shaped by their own understanding and life skills. The gap between the known and the unknown can be referred to as a “zone of proximal development” (White 2007:263).

When the influence of substances overpowers an individual's life and identity, it becomes difficult for them to make a distinction between life-threating and life-preserving actions. When the use of harmful substances has a strong hold on an individual, life-threating action is often the result. The assumption is often that people who use harmful substances tend to be in denial about their substance use and should be shown the true nature of their "disorder". When their denial is challenged, it often results in feelings of shame and the loss of agency and the authorship of their life story.

When distance is created between the individual and the substance use with the narrative therapy technique of externalisation, "effects questions" can be posed. Effects questions include both material and physical questions that relate to the "consequences of action" (Anthony 2004:6). Examples of effects questions are:

- *How has the substance use influenced your career, important relationships and your health?*
- *Has the substance use caused any significant problems in your life?*
- *What effect has the substance use had on your hopes, dreams, aspirations and direction?*

Subsequently, "unique outcomes" can be discovered. Examples of questions designed to discover unique outcomes include:

- *Do you think that speaking to your friend was a significant event?*
- *Why do you say so?*
- *How did speaking with your friend relate to self-care?*
- *The joy that you have mentioned earlier did not involve substance use, is this a new type of joy?*

- **"Taking it back" practice**

Michael White (1997), in an article titled, "Challenging the culture of consumption", distinguishes between the perspectives on the harmful use of substances of the Alcoholics Anonymous Foundation and narrative therapy (White 1997:43). According to White (1997:44), "the notion of conscious purpose, rites of passage, a buddy

system and practices of witness" are characteristics of the Alcoholics Anonymous Foundation. White (1997:45) stresses the importance of an organized community response. Narrative therapy emphasises the use of metaphors. He explains it as follows (White 1997:46): "All metaphors that are taken up in the development of externalizing conversations are borrowed from particular discourses that invoke specific understandings of life and identity. Choosing what metaphors to use is based on what is most viable in the particular situation, given all ethical considerations".

- **Reclaiming joy and celebration**

An aspect of the culture of consumption of alcohol and other substances is the connotation of celebration, joy, pleasure, transgression, laughter and creativity. When people gather to have fun without alcohol or other substances, they are in essence challenging the culture of consumption and deconstructing "addiction". Individuals develop the ability to take conscious action toward creating a preferred narrative of life.

- **Deconstruction**

Deconstruction is a technique through which to locate roots of the problem of excessive alcohol consumption and addiction that can be found in a social, historical, political, cultural and personal discourses. This means to deconstruct or examine dominant stories in order to disclose the story's roots often with the intention of uncovering certain ideas, inconsistencies or flaws. Deconstruction in narrative therapy refers to the process of externalizing a discourse or discourses that have been internalized. Anthony (2004:3) explains that "such externalization allows us to challenge, when strategically appropriate, the internalizing of deficit centred language and pathology and the tendency towards thin-description which is also readily available in the culture of 'recovery'".

- **Applying the absent but implicit**

"Experts" often attempt to find the reason behind substance abuse disorder in such a way that the individuals with the disorder feel ashamed. Anthony (2004:4) describes

this as psychologising a person's motive for action. The "absent but implicit method" in narrative therapy enables individuals to express what it is about the use of substances that was or perhaps still is important to them. It is also a way of observing the person's past in a non-judgmental manner and discover what the individual appreciates and values in and about life. Where the use of substances has become the focal point of a person's life it can often be linked to the person's hopes and values. Anthony (2004:5) explains the value of the "not-knowing position" in the narrative approach as follows: "To honestly not know what is best for the client is important because it is likely that the person will realize if you have a set opinion, and this will often be experienced as an imposition".

- **Rites of passage**

"Rite of passage" is a powerful metaphor for preparing for an unknown journey. The beginning of this journey can be confusing, disoriented and painful at first. The rite of passage serves as a map that creates a space for individuals to plot their journey in three phases:

- separation;
- the liminal space;
- re-incorporation.

When people's experiences are seen in terns of rites of passage this can prepare them for the difficult and stormy journey that lies ahead. The image also serves to motivate them to persevere even when the journey becomes difficult. Exercises can include interviewing or listening to the testimonies of those who have had a similar experience. This prepares people for their journey and practices the skill to ask for help when they feel overwhelmed. The "migration of identity map" is beneficial in that it describes the liminality phase clearly. It also serves as encouragement when the individual experiences withdrawal symptoms. The uncertainty and psychological discomfort they experience in the liminal space can lead to relapse because the substance problem feels more familiar and less uncomfortable.

- **Externalization (naming the problem)**

The idea of externalization is to separate the person and the problem. The problem is the problem, the individual is not the problem. Narrative therapists listen to the description of an individual's experience and identify a specific word or phrase that negatively affects the individual's life. The problem is given a name and identity, it is personified. For example, depression can be called "the dark hole" or "the thief". Externalizing conversations have the following functions:

- to open space for taking action against the problem;
- to reduce feelings of guilt and blame and make space for responsibility;
- to diminish the effects of pathologising, labelling and diagnosing;
- to open possibilities for people to describe themselves, others and relationships from a perspective that is not problem saturated;
- to decrease unproductive conflict.

Together the counsellor and the client are co-constructors of a shared reality (Dreyer 2000:175; see Müller 1996:16). The main focus of pastoral narrative counselling is not on *what* happened, exploring the detail of the event, but rather to ascertain how the counselee interprets and experiences the event or events (Dreyer 2000:175; see Müller 1996). Practicing mindfulness in tandem with narrative counselling is a useful addition that can facilitate the engagement with and acceptance of what is, what feelings and thoughts are experienced in the moment.

5.3 Mindfulness for pastoral counselling: The Wheel of Awareness

5.3.1 Mindfulness

In his 2018 work, *Aware: The science and practice of presence*, psychiatrist Daniel Siegel explains the benefits of meditation, which is rooted in both science and practice. Meditation is not only a spiritual or religious practice. It has benefits on a holistic level. Since the aim of this study is holistic healing and well-being on a spiritual, psychological and biological level, the usefulness of meditation practice to complement narrative therapy for dealing with trauma and substance use disorder is explored. Meditation practice serves to strengthen "the muscles of the mind" (Van

Dam 2017:36; see Pepping et al. 2016:544). What people do with their mind, also changes their body, especially the brain. The body reacts to the feelings, thoughts and intentions that the mind creates. Siegel (2018:105) describes the process of kind intention as follows: “How intention glows determines where attention goes, neural firing flows and neural and interpersonal connection grow”. On the journey of self-recovery it is imperative to consider where the person’s focused attention lies (Siegel 2018:105-106). Exploring the significant landscape of their own mind can provide people with a sense of security.

Mindfulness is about enabling optimal interaction of the three mental pillars of *attention*, *open awareness* and *kind intention* (Siegel 2018:45-46):

- *Attention* focuses on one task or object. The mind concentrates on one particular object to the exclusion of all else. All else is “blocked out”.
- *Open awareness* is the ability to observe the context and be responsive to the surroundings.
- *Intention* is the ability to maintain a positive and compassionate attitude towards the self and the world.

When these three elements interact well, the mindfulness that emerges allows the individual to perceive the events of life as they transpire without judgement or excessive rumination (Siegel 2018:46). A lack of mindfulness is detrimental to a person’s physical and mental well-being. Mindfulness prevents wasting mental energy and power. A lack of mindfulness can be detrimental to relationships and work challenges.

Cultivating mindfulness can be useful for overcoming the problem of the use of harmful substances. Studies have shown how mindfulness influences various aspects of an individual’s well-being (Kong et al. 2020:5; Bester and Naidoo 2016:245-247; Brown and Ryan 2003:822-824&832). Benefits of mindfulness include (Siegel 2018:3; Siegel and Siegel 2014: 21-48; Davis and Hayes 2011:198-205):

- improved immunity;
- slowed aging process;

- sharpened problem-solving skills;
- strengthened epigenetic regulation that prevents life-threatening inflammation;
- adjustment of cardiovascular factors which improve cholesterol levels, blood pressure and heart function;
- enhanced neural integration in the brain which enables coordination and balance in functional structural connectivity within nervous system.

Mindfulness can be conducive to overcoming the substance use disorder in that it focuses on awareness. People can be enabled through this technique to become aware of and recognize the nature of the cycle of behaviour that is characteristic of the disorder. Once they see it for what it is, that insight can be the motivation for doing what it takes to break free and take the road to recovery (Siegel 2018:290-295; see Germer et al. 2016:225; Peltz 2013:xv). According to Siegel (2018:147), "addiction is fuelled by dopamine releases in the body … Any addiction is simply an over-attachment to a specific external trigger (like substance ingestion) that causes its releases". When the technique of mindfulness is mastered it empowers a person to navigate their lives away from these behaviours (Siegel 2018:147; see Pykett et al. 2016:9).

Studies have shown how mindfulness contributes to empowerment. It increases the ability to discern between what people *need* and what they *want*. When this distinction is made, the disorder becomes less overpowering. It then increases the possibility to recover completely from the disorder over time (Siegel 2018:139; see Brewer 2017:29&30; Berridge and Kringelbach 2015:661). The first study of a mindful awareness practiced was done in the Mindful Awareness Research Center at UCLA (Siegel 2018:39). The goal was to investigate how mindfulness practice based on breathing as the focal point of meditation can assist both adolescents and adults in overcoming the challenges of maintaining focus and attention. The results were strengthened attention skills with the mindfulness practice in individuals with attention deficits who participated in contrast to the individuals who take medication.

Mindfulness of the breath can assist the individual in becoming the "master" of their own mind (Siegel 2018:44). As a result, meditation can also be referred to as "mind

training in action" (Siegel 2018:45). The goal with using the Wheel of Awareness meditation is to strengthen individuals' mindfulness and their well-being. It also aims to balance their brain's ability to observe energy and information flow within the mind.

Figure 5.1 below is a visual representation of the Wheel of Awareness with its different segments as well as the different areas of focus within each segment. The HUB represents an individual's awareness and the RIM represents everything of which individuals should be aware (Siegel 2018:5):

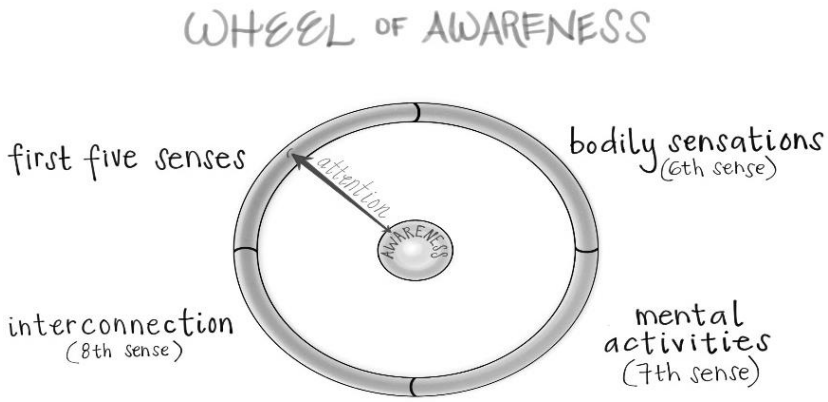

Figure 1: Daniel Siegel (2018:5)

5.3.2 The mind

The way in which the mind regulates information and energy influences the person's life (Varela et al. 2017:99, 206; Siegel 2015:1). According to Siegel (2018:51), the activities of in the mind include feelings, thoughts, memories and attention. For Siegel (2018:51) the term "mind" refers to the "core of our experience of being alive, from feelings and intuition to thinking, memory, attention, awareness and intention". "Relationship" refers to the sharing of energy and information flow (Siegel 2018:52). From an anthropological, sociological and linguistic point of view, mental life happens between people, therefore in relationship. The brain "can be seen as an embodied mechanism of energy and information flow" (Brown et al. 2013:240; Rejeski and Gauvin 2013:657-659). The embodied brain comprises of a "within-mind" inside of a "skin encased" body including the "skull encased" brain. Relationships take place "between minds". However, they can also be seen as "inner and inter-minds" – both within and between the origins of the self (Siegel 2018:52).

From this point of departure, the following four aspects if the mind are central (Siegel 2018:40-42):

- **Consciousness**

The term “consciousness” refers to both the subjective experience of being aware and the entire self. People who read a book are aware of the existence of the words and their meaning. Therefore, consciousness is comprised of knowns (e.g. the words) and knowing (understanding meaning). The rim metaphorically symbolizes the knowns whereas the hub represents the knowing.

- **Subjective experience**

Subjective experience is the texture of life that is experienced as it is lived. Awareness of the subjective experience, expressing it to oneself (e.g. writing in a journal), and sharing it with others (e.g. in conversations about what is going on in the inner mind), is conducive to well-being. According to Siegel (2018:54), subjective experience can be referred to as “the prime of reality” which “cannot be reduced to anything other than itself”.

- **Information processing**

Information processing refers to the way in which human beings absorb the flow of energy in the brain, body and relationships with others, and attach meaning to it. Siegel (2018:55) sees “information processing” as a “pattern of energy with symbolic value” which represents something other than the energy itself.

- **Self-organization**

Self-organization controls the regulation of the flow of energy and information. It is a feature of the development of intricate systems. It differs from intuition. Its roots lie in the flow of the components of intricate systems. It then goes back to its roots to shape that from which it has emerged. Siegel (2018:55) explains how it “recursively regulates its own origins, shaping its own becoming and then further shaping its own emergence”. The unfolding of the system is enhanced by self-organization which takes place through differentiating and making connections. It is possible to block

this self-organization process by shutting down differentiation and connection. Then the system no longer moves in harmony as a unit. This causes confusion or even mayhem.

The Wheel of Awareness facilitates well-being. Siegel (2018:56) uses the acronym FACES for the self-regulating feature:

- flexibility;
- adaptability;
- coherence;
- energy;
- stability.

Studies on well-being have shown that an integrated brain is the fundamental predictor of health and happiness. This is also referred to as an “interconnected connectome” (Siegel 2018:56; see Sporns 2016:107 & 108; Contreras 2015:234 & 235). When the areas of the brain are connected, the coordination and balancing of the brain are mechanisms of enhanced regulation. This process is about how individuals regulate attention, emotion, thought, behaviour and relationships (Siegel 2018:56).

5.3.3 Mind training and integration

A map is useful for plotting the human journey. It helps to display the landscape of what is yet to be discovered, in a visual way (Siegel 2018:71). The Wheel of Awareness functions as a map. The destination of the journey that is represented through it, is wholeness, freedom and integration. The Wheel depicts the various aspects of the mind and the processes that take place in the mind (Siegel 2018:71). This map presents “the region” of mental life. The primary goal of the journey with the Wheel of Awareness is to integrate consciousness and increase the strength of the mind. The aim is to balance the flow of energy and information in an integrated manner.

Training and exercising focused attention with the first and second segments of the Wheel of Awareness serve to release energy from various parts of the body and

brain. The first segment is about the first five senses namely sight, hearing, smell, taste and touch (Siegel 2018:76). The second segment is about internal signals of the body such as sensations from the muscles or from the lungs. This energy is released from the brain, the gut and the heart which control the energy stream and information flow into awareness (Siegel 2018:161). The Wheel of Awareness enables a concentrated focus on the integration of consciousness. Exercising meditation with the help of the Wheel of Awareness assists in maintaining attention. Distractions are noted and redirected. Training the mind can change the neural firing in their brain (Siegel 2018:161).

A result is that certain parts of the prefrontal cortex begin to grow. This supports the theory that enhanced attention and emotion regulation strengthen energy and information regulation. The cortex, limbic area, brain stem, human body and social world are extensively connected to form a whole. The process of neural integration serves to shape emotion and mood, attention and thought, relationships and morality. Integration is needed for these executive functions to be performed effectively. Another result is that the hippocampus, situated in the limbic area, expands when it is exercised. It functions as a neural node, which connects broadly divided areas (Siegel 2018:162). The hippocampus also contributes to processing memories and regulating emotion. The amygdala regulates severe emotional reactivity. An enlarged amygdala can benefit by the practice of meditation. A further result is that the corpus callosum facilitates connection between right and left sides of the brain. Studies of compassion practices have shown that there is increased integration during meditation practice.

The Wheel of Awareness contains each of the three pillars of mind training – attention, open awareness and kind intention. On these three pillars, the process of growth and integration in the mind is built. A focus on awareness enables human beings to become less distracted. Should distractions appear they are able to divert attention back to the focal point. Mind training enhances the process of integration (Siegel 2018:149; see Simons et al 2016:105-112; Tang 2011:382). This happens when the excessively differentiated and constricted binding of the posterior cingulate

cortex with other nodes such as the medial prefrontal cortex becomes less dominant. As a result, different nodes become part of a more complete integrated brain. According to Siegel (2018:149), the more the sense of self is integrated, the more the brain activity too, becomes integrated. The study of Brewer et al. (2012:366-369) shows that mind training can contribute substantially to overcoming substance use disorder and anxiety through the process of the integration of the dominant posterior cingulate cortex. Consequences of insufficient integration include depression, anxiety and addictive behaviour.

5.3.4 Application of the Wheel

Regular exercises with the Wheel of Awareness enhance the integration of consciousness which increases emotional stability even in the midst of trying circumstances. The Wheel of Awareness is an example of how emotional stability can emerge from intercession that focuses on consciousness and integration. Use of the Wheel of Awareness enhances the ability to reflect on inner mental experiences, expand self-awareness, and self-perception. Children and adolescents can also be taught how to exercise their mind with the help of the Wheel of Awareness. This technique can help them understand their own mind better and make them less vulnerable to the effects of emotional disruption. This, in turn, can make them less likely to reach for coping mechanisms such as substance use, in an attempt to deal with emotional disruption.

With regard to *children,* the Wheel of Awareness can enrich their minds and enhance their growth. The visual representation of how the mind works can enable them to understand that they have the power to choose how they prefer to live their lives. Siegel (2018:279) explains that, “with the ideas of focused attention, open awareness and kind intention built into the visual metaphor of the Wheel, children are offered the major ways research suggests we can create more health and happiness in our lives”. Many of the regulatory circuits in the human brain develop during the first 9 years of a child’s life. They are shaped by genes and experiences. Experiences include relationships, patterns of communication between individuals that entail a sense of being acknowledged and understood, cared for and feeling

connected. Communication is the exchange of ideas. This exchange can have the power to alter the way in which the mind develops.

With regard to *adolescence*, this is the life stage when identity develops. Physical, physiological, neurological and social changes take place. In his book, *Brainstorm: The power and purpose of the teenage brain*, Daniel Siegel (Siegel 2018:280) explains the essence of this period with the acronym ESSENCE:

- ES: emotional spark
- SE: social engagement
- N: novelty seeking
- CE: creative exploration

Emotional spark, which occurs during adolescence, has to do with the brain, its transformation and remodelling. The limbic area changes and produces powerful emotions and mood states. According Siegel (2018:287), filters in the brain "can shape our nonconscious information processing, and they can influence what enters awareness as they serve also as filters of consciousness constructing our sense of self in the world". Siegel (2018:285) explains that the "downside of this emotional spark is moodiness and irritability; the upside is passion and vitality".

Social engagement (SE) is about adolescents connecting and collaborating with others. In the modern era, adolescents' world was about competition for limited goods. The pressure led to unnecessary stress and discouragement. In a postmodern era pressure has escalated. There are many more pressures than competition for limited goods.

Novelty seeking (N) is about changes in the brain's evaluative limbic circuitry. The evaluative limbic circuity and its reward system can cause adolescents to engage in unusual and dangerous activities and behaviours. When the evaluative assessment of the limbic system is altered, it can cause the development of "hyper irrational thinking". In this kind of thinking only the positive outcome of a choice is taken into account, which can lead to dangerous decisions. Pleasure is the focus and the consequences are not thought through. This focus on novelty can result in injury or

even death. Balanced novelty seeking, on the other hand, can result in the appreciation of life to its fullest.

Creative exploration (CE) is about when adolescents begin to question adult knowledge and imagine for themselves how the world could and should be. Creative exploration can result in disappointment, disillusionment and despair when the adults who were once seen as role models, are now perceived as "just people". Balanced creative exploration, on the other hand, can strengthen the imagination. It is therefore crucial to guide adolescents toward healthy growth – physically and mentally. This would entail a balance of passion, connection, courage and imagination.

The way in which adolescents are approached and treated by parents, teachers, coaches and society, has a direct impact on both their developmental identity and the future of the world. The Wheel of Awareness serves as a "mindsight tool" to help them develop insight and empathy, and achieve integration. This forms part of a larger toolkit for constructing an internal compass so that adolescents can decide on the direction of their lives during this difficult period of their lives. It also helps them to prepare for adulthood with a more integrated brain and resilient mind.

5.3.5 Practicing the Wheel of Awareness

The practice of the Wheel of Awareness will now be explained briefly. Firstly, the person finds a peaceful and quiet place to sit, stand or lie down. The structure of the Wheel is kept in mind throughout the exercise. There are guidelines for the different segments of the Wheel. The practice follows the following steps (Siegel 2018:65-68):

Step 1 – Segment 1 (the first 5 senses)

- Focus attention on breath – let the sensation of breath fill the awareness.
- Imagine oneself in the centre of the Wheel.
- Imagine moving the spoke of attention out from the hub of knowing to the first segment of the rim.
- Focus attention on the sensation of *hearing* (let the awareness be filled with the sensation of sound, hold for 15 seconds and let go).

- Turn the focus to the sense of *sight.*
- Let go of the sense of sight and focus on the sense of *smell*, letting different aromas fill the awareness.
- Let the sense of smell go and focus on the sensation of *touch* (clothing touching the skin, feet touching the floor).

Step 2 – Segment 2 (6th sense)

- Breathe in and hold for 5 seconds, breathe out.
- Now imagine moving the spoke of attention to the segment that focuses on the body, the sensations of the muscles, bones and internal organs.
- Start with the face. Let the sensations of the muscles and bones in the face fill the awareness.
- Slowly move attention up to one's forehead and then to the top of the scalp; down to the muscles of the throat and neck.
- Now focus attention on shoulders and slowly move attention to both arms to the fingertips.
- Bring attention to the upper back and chest, move to one's lower back and the muscles of the abdomen and then focus on the sensation of the hips.
- Stream down to the legs to the tips of the toes.
- Now move attention to the pelvic region. Open the awareness to the sensations of the sexual organs and then move attention to the intestines. Start with the lower intestines deep in the abdomen; move upward toward the stomach region at the top of the abdomen.
- Focus attention on gut sensations up from the stomach through the centre of the chest, opening to the sensations of the esophagus that connects the stomach to the throat and the interior of the mouth.
- Move the attention to the respiratory system, beginning behind the cheekbones with the sensations of the sinuses, then to the nose … and to the mouth … and then down the front of the throat to the trachea (the tube responsible for supplying life-giving air down to the centre of the lungs).

- Focus the attention on the heart region, opening attention to the sensations of the heart.
- Now let the sensations of the whole body fill the awareness – from head to toe.

Step 3 – Segment 3 (7th sense)

- Breathe in – hold for 5 seconds – breathe out.
- Move the spoke to the third segment, which represents mental activities such as emotions, thoughts, memories, beliefs, intentions, hopes and dreams.
- Invite any mental activities – thoughts, feelings and memories – to enter the awareness (the hub of knowing).
- Be open to whatever rises to the surface from the rim of mental activities.
- Remaining focused on mental activities, pay special attention to the way in which a mental activity first arises in awareness. Answer the following questions in the mind:
    - Does it arise suddenly or gradually?
    - Once it has become present in the awareness, how does it remain present?
    - How does the mental activity – the thought, memory or emotion – leave awareness?
    - Does it leave suddenly or gradually?
    - Is it replaced by another mental activity?
    - If it is not replaced immediately by another mental activity, what does the gap between one mental activity and the next feel like?

Step 4 – Segment 4 (8th sense)

- Breathe in – hold for 5 seconds and breathe out.
- Imagine moving to the fourth and final segment of the rim which represents relationality – connections to people and the things outside the body.
- Open awareness to people who are physically close at this given moment … then let go …

- Now open a sense of connection to family and friends who are not in the immediate space … hold for 5 seconds and let go …
- Focus attention on connections with people from work, school, church or the community … hold for 5 seconds and let go …
- Now bring the focus to connection with the individuals in the neighbourhood, on the continent … hold for 10 seconds and let go …
- Next, expand the sense of connection to all living beings on earth … hold for 10 seconds and let go …
- Breathe in and breathe out. Get ready to open the eyes.

5.4 Mindsight

Daniel Siegel's (2010) book titled *Mindsight: The new science of personal transformation,* explores the human ability to know one's own mind and to have a sense of the inner world of others. This ability can nurture a healthy mind and heart (Siegel 2010:vii). His studies on emotional and social intelligence find that self-awareness and empathy contribute to an abundant life. According to Siegel (2010:vii), "excellence in these capacities helps people flourish in relationships, family life and marriage, as well as in work and leadership".

"Mindsight" refers to a process that enables human beings to observe and change the course of energy and information within the Triangle of Well-Being (Siegel 2010:xi; cf. Baldini et al. 2014:220). Mindsight is the capacity to recognise this flow in the self and in others. The flow entails the distribution of energy and information flow through various ways of communication. The flow can be altered through awareness of and the intention to influence the fundamental aspects that shape the route that the energy and information flow take. Siegel's (2010:xviii) "Triangle of Well-Being" identifies three elements that, if they function well together, can contribute to a better quality of life. These three elements are observation, objectivity and openness.

Interaction with others can trigger emotions such as anger or frustration. This causes confusion if the individuals themselves do not understand the reason for their emotions or behaviour (Siegel 2010:xii-xiii). Mindsight enables individuals to reflect

on the relationship between body and mind. This ability is necessary for managing powerful emotions. Meditation is one of the main techniques used to exercise mindfulness. Mindsight is not only practiced during religious quiet time. It can be utilized any time when people experience hardship in life (Siegel 2010:xii-xiii). For example, when individuals begin to feel anxious in a busy and noisy environment, mindsight enables them to realise that it is not the environment causing the anxiety, but rather the increased heartrate. They can learn to control the influence of the heartrate on emotions and deal with the situation more effectively. Mindsight enables people to see the world differently. People who exercise mindfulness develop the capacity to perceive the world from others' point of view. Without the capacity for empathy, conflict based posturing that paralyzes the majority of humanity, continues.

The goal of mindsight is a balanced, harmonic self. The term "harmonic self" refers to the ability to keep the personality balanced, which enables a person to adapt to external change more effectively and comfortably (Siegel 2010:102). It also enables people to remain "stable" and faithful to their core values. Mindsight enables people to acknowledge, appreciate and overcome challenges.

When it comes to mindsight, resilience and emotional health, one should keep in mind that the brain, like the rest of the body, needs exercise. This includes reflection on thoughts and creating new connections between the thoughts. Associating ideas and reflecting on ideas strengthens the neural relationship between the ideas (Siegel 2010:83). Mindsight also enhances memory. When individuals stay motivated during the process of representation of past and future thoughts in full detail, the same areas of the brain will be activated (Siegel 2010:83). The areas that light up when what is happening in the imagination is also experienced in real life. Neuroscience has demonstrated that thoughts alter blood flow and neural signals. Neural behaviour has a direct effect on how individuals manage challenges in their environment. This in turn causes certain parts of the brain to react automatically to certain situations. The prefrontal cortex, situated behind the forehead, is responsible for moral judgment, attention, a sense of time and a sense of identity. The insula regulates emotions and the response to the emotional expressions of others. Mirror

neurons are differentiated cells that aid with the understanding of others' intentions. Siegel (2010:83) explains that "by dedicating time to train our minds, we're better able to deal with unexpected challenges". By practicing mindsight, a person can acquire greater control of what happens in these regions of the brain.

Mindsight helps to manage discomfort. Mindsight focuses more on the right side of the brain, since one of its main functions is to regulate emotional awareness (Siegel 2010:107). People often feel more comfortable with rational thinking, which is regulated by the left side of the brain. Nonverbal communication games can stimulate the right side of the brain. With nonverbal communication, facial expression is observed closely and imitated. For example, when the sound of the television is turned off the emotions of the characters can be "read" in their facial expression.

Another way in which the right side of the brain can be stimulated is by journaling. The person can record emotional sensations and imagery of experiences rather than rationalize them. When an individual confronts intense emotions, various techniques that focus on bodily sensations, can be utilized. The "body scan" is one such technique. This entails lying on one's back and focusing on the different parts of the body. Specific sensations in the body can cause distraction. However, with regular practice the mind can learn to focus on the mental images of a "safe space" in order to remain in control of responses.

Mindsight can play a role with regard to feelings and character traits. Emotions can be overwhelming and distressing. Mindsight helps a person to realise that emotions and feelings are only fleeting human experiences (Siegel 2010:25). They are not an indication that an individual is either flawed or dysfunctional. Meditation teaches individuals to focus on one thing at a time. If distraction occurs, it becomes increasingly easier to redirect the attention back to the focus. Siegel (2010:27) uses the image of the mind as an ocean. Feelings and emotions flow over the surface in the form of ripples or a storm. Ripples or storm are only visible on the surface. The bottom of the ocean is calm. Mindsight exercises rest on the three pillars of observation, objectivity and openness. The mind is "observed" and the causes of distraction acknowledged. Distractions can occur during meditation or during daily

tasks. Distractions appear as negative thoughts and decrease productivity. The aim is to train the mind to follow the direction of that on which the attention is focused. It is possible to observe thoughts and the feelings and emotions they engender. In this way, a person can become aware of prejudice or automatic reactions. One becomes aware of how thoughts shape experience. The aim is to remain “open” and acknowledge that judgemental, depressing or confusing thoughts are only temporary. Feelings and emotions are natural, even those that are negative. Individuals can learn from them and change them.

The way in which children are brought up shapes how they interact with the world. Some caregivers or parents show little to no affection as the child develops and transitions through adolescence to adulthood. Some children are given too much responsibility too soon. They often experience a sense of failure and the idea that to rest when they are tired means that they are lazy (Siegel 2010:155-157). Often adults who grew up in such an environment are not able to talk about feelings and emotions. Siegel (Siegel 2010:156) emphasises that these misconceptions learned during childhood, follow people into adulthood. However, they can be overcome through practising mindsight. People can, for instance, write down their memories from childhood and their more recent adult memories. The narrative that make sense of the past can be scrutinised. Discouraging and harmful interpretations can be identified. This can bring about a sense of relief. Alternative, preferred stories can be devised, both about childhood and adult life. It then becomes less difficult to break down emotional barriers.

Mindsight is also useful when it comes to relationship problems. Being receptive to open and attentive listening, especially during an argument, is a crucial skill for successful relationships (Siegel 2010:20). If a person is receptive, the others feel acknowledged and that their emotions are valued and validated. This encourages them to open up. Problems can then be solved more swiftly and effectively. Being reactive, in contrast, is the action that takes place when other’s complaints are interpreted as a threat (Siegel 2010:20). Then people react with fight, freeze or flight. They either attack, are defensive or withdraw from the communication. Mindsight

facilitates receptiveness toward others. A useful technique in this regard is the “timeout method”. For example, when people have a conversation about a sensitive topic they monitor their emotional state. When one person reaches the reactive stage, the conversation is “timed out”. The only conversation continues when both have calmed down and are again receptive.

Mindsight can be useful when dealing with past trauma. Painful repressed memories can lead to anger outbursts or excessive drinking, for example. Repressed memories affect the individual on a subconscious level. The brain represses memories but the body does not “forget”. Mindsight techniques can facilitate memories of physical difficulties to be recalled (Siegel 2010:120). Mindsight enables the brain to focus on a specific part of the body. This activates related memories and can enable the person to heal from the trauma.

CHAPTER 6

FINDINGS

The purpose of this study was to investigate repressed trauma memories and how they can influence an individual's life unconsciously. It explored the connection between trauma, body memories, depression, physical pain and mental challenges as well as the connection with it to substance abuse. Often people seek medical attention for physical symptoms while the root cause of the pain lies elsewhere. However, there is a connection between an individual's beliefs and their sense of well-being. Religion, meditation and prayer play a significant role in positive beliefs, comfort and resilience. Although spirituality does not necessarily "cure" a condition, it can serve as a place of strength and refuge. Stigma with regard to mental health problems often causes reluctance to seek psychological help. Many then rather self-medicate and some develop substance use disorder. The study has shown that misconceptions regarding mental disorders abound. On a spiritual level individuals can find a renewed sense of hope. Faith and religion can provide structure for their lives and faith communities can be a safe space where groups or individuals can have conversations about their belief and struggles. This can have a positive influence on their mental health and foster a sense of connection and the experience of acceptance. This, in turn, can contribute to reducing the number of self-deaths or the harmful use of substances.

Religion and spirituality are often perceived as being the same. However, religion is a systematic and community-based network of beliefs. Spirituality, on the other hand, is an internal feeling of closeness to a higher deity or God in Christianity. Both religion and spirituality play a significant role in mental health. Religion can provide social connection and a sense of belonging. This enables people to cope better with challenging situations. It provides time and space for spiritual and mental rest. It teaches compassion, forgiveness and gratitude. It identifies life

lessons. Spirituality strengthens people's sense of identity and courage. It focuses on their relationship to the transcendent. Techniques such as meditation and self-reflection can be expressed in forms such as art, poetry, myth or religious practice. This can foster a renewed sense of belonging in the world.

Mental struggles that are often the result of traumatic experience include depression, depersonalization, derealisation and dissociative identity disorder. These problems can cause detachment from thoughts, memories, the surroundings, and a person's identity and actions. In the midst of the world-wide pandemic Covid-19 much trauma, loss of life and grief is experienced on a larger scale than before. Reduced rituals due to prohibitions often cause people to struggle to find closure. An increased rate of self-deaths due to financial struggles or isolation has been seen. Pastoral caregivers who journey with people through the trials and tribulations of life and death, are called upon to provide support through crisis, loss and grief. Prayer and spiritual messages might not be enough. In order to provide effective support, pastoral caregivers need a deeper understanding of mental conditions from which people suffer and of the underlying causes.

This study aimed to provide insight into mental health struggles that are associated with traumatic experiences and a subsequent battle with substance use disorder. The insights of narrative therapy and the spirituality technique of Daniel Siegel's Wheel of Awareness meditation offer a method that can be conducive to a person moving forward toward healing, sustained physical and mental health, and the ability to author the preferred narrative of one's life. Through useful techniques from narrative therapy such as scaffolding skills in discernment, "taking it back" practice, reclaiming joy and celebration, deconstruction, applying the absent but implicit, rites of passage**,** and externalization, people can be guided to construct a preferred story for their life. They are given a voice and are enabled to tell their own story according to their own experience without judgement. In this way pastoral caregivers can contribute not only to the improvement of the lives of individuals and families, but also to the

bigger picture, which Kotzé (2002:30) describes as follows: “The more we participate in such a way that the voices of all, especially those who have been previously silenced, can be heard, the more we can research and co-construct, in an ethical manner, an ethical, just and ecologically sound world to live in”.

The journey from a dominant problem story to a rich and preferred story can follow the route guided by questions such as: In your life prior to substance dependence, how did you try to cope with intrusive trauma memories? In what way did you hope that the substance would make you feel better? How did you manage to cope when the substance was not available? Was there sense of spiritual enrichment during the times that you managed to cope without the substance? What aspect of this achievement would you want to stand out? What aspect this achievement would you want God to notice?

Through such questions the focus is on the ethical values that highlight and strengthen the person's life-giving power, abilities and potential rather than on those powers that deny them wholeness and well-being. The person's achievement is emphasised. Rich descriptions are developed and the people are given the opportunity to see themselves through the eyes of God. Persons who develop substance use disorder as a consequence of trauma and mental struggles, are often treated as victims rather than as survivors who have agency over their own lives. Through a combination of narrative techniques which focus on the agency of the person and the Wheel of Awareness meditation practice that strengthen the inner self, their resilience can be enhances and the traumatic experience can be re-interpreted. Pastoral caregivers journey with hurt people on the road to awareness, change, and healing. They journey together in God’s presence however this is perceived by people in their individual spiritual experience. In conversations about God and individuals' personal experiences with and about God, richer descriptions are created. In this way their individual human story is linked with the story of God.

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