

**A QUALITATIVE INVESTIGATION INTO THE APPLICATION OF MARTIN
BUBER'S PHILOSOPHICAL ANTHROPOLOGY TO THE EXPERIENCE OF
TRAUMA AND ITS PSYCHOTHERAPEUTIC INTERVENTION**

STUDENT: Jonathan Sheldon Ress

STUDENT NUMBER: 2240295

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SUPERVISOR: Prof. Charles Malcolm

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Martin Buber, I – Thou, I – It, Dialogue, Relationships, Psychotherapy, Psychotherapist,
Patient, Intersubjectivity theory, Trauma.

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ABSTRACT

A QUALITATIVE INVESTIGATION INTO THE APPLICATION OF MARTIN BUBER'S PHILOSOPHICAL ANTHROPOLOGY TO THE EXPERIENCE OF TRAUMA AND ITS PSYCHOTHERAPEUTIC INTERVENTION

In this minithesis, I firstly review the philosophical anthropology of Martin Buber, particularly as it pertains to psychology and psychotherapy. In addition to what Buber wrote on the topic of psychology and psychotherapy, material from other exponents of Buber on the topic is also presented and explored.

I then highlight the importance and relevance of Buber's theory and constructs in the field of the psychotherapeutic relationship and process. Psychological theories and therapists closely aligned to Buber's views and who draw from his theory are then mentioned. Particular attention is given to Intersubjectivity theory, which has striking correlations and congruence with Buber's theory and philosophy.

Thereafter, the thesis shifts to the topic of trauma as the area of focus. I present different models in understanding and conceptualising the phenomenon of trauma. I then demonstrate that applying a Buberian understanding to the experience of trauma can help shed light on the impact of trauma on a sufferer's life. The aim of the study is then presented: to gain an understanding of the impact of trauma on interpersonal relationships and to determine components of psychotherapy found most helpful in the recovering process.

A qualitative research design is employed in the study. Five participants who had experienced a severe trauma were interviewed using semi – structured interviews that were audio – taped, transcribed verbatim and then analysed using thematic content analysis in order to inductively extract themes from the material. Ethical considerations and measures are discussed.

The results of the study confirmed that trauma has a significant impact on the sufferer's relationships and capacity to relate, but only with regards to trauma of personal or relational nature. The study further demonstrated that understanding the impact of relational trauma from the perspective of Martin Buber's philosophy is particularly useful and appropriate. Furthermore, the therapeutic elements identified as useful by the participants in restoring the debilitating interpersonal impact of trauma, correlated very strongly with the principles that Buber outlined for a therapist and for the therapeutic relationship. Limitations of the study are finally discussed and then conclusions and suggestions for further research are presented.

DECLARATION

I declare that *A Qualitative Investigation into the application of Martin Buber's Philosophical Anthropology to the Experience of Trauma and its Psychotherapeutic Intervention* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Jonathan Sheldon Ress

September 2004

Signed:



CHAPTER 1

INTRODUCTION

‘I become through my relation to the *Thou*; as I become *I*, I say *Thou*.

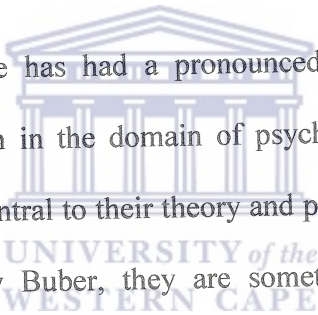
All real living is meeting.’ (Buber, 1958, p. 11).

1.1 Martin Buber, dialogue, and meeting in the I – Thou relationship

All psychotherapy, to a lesser or greater extent, relies on a meeting between the therapist and patient. However, few theories focus on the central role of this meeting as constituting the primary healing factor in psychotherapy. Victor Frankl, famous founder of the school and technique of Logotherapy, believed that human meeting is the most salient factor in psychotherapy while the methodology and technique employed is far less determining (Friedman, 1985a). In the area of human relationships and meeting, one individual stands out as a towering figure – Martin Buber.

Martin Buber (1878 – 1965) is referred to by many titles including philosopher, anthropologist, mystic, and existentialist. His vision and influence encompassed so wide a spectrum that in a sense he defies any classification. In fact, he shunned the tendency to categorise or compartmentalise and could be considered one of the few wise men of our time able to transcend artificial boundaries for the sake of true humanity, his primary area of interest. Throughout his lifespan he was active and influential in many fields including psychology, educational theory, philosophy, theology and sociology. Buber does not belong exclusively to any one of the spheres he influenced; yet through his challenge to them, he calls each back to their real meaning.

At the root of Buber's ideas lies his central ontological construct that 'All real living is meeting' (Buber, 1958, p.11). Fundamental concepts he developed such as the 'I – Thou' relationship, Dialogue, the Between, Imagining the Real, Inclusion, Mutuality and Confirmation all stem from this basic premise (Inger, 1993). Buber referred to meeting in a truly human relationship as an 'I – Thou' relationship, and explained that the meaning of this meeting is not to be found in either of the two partners alone, nor in both together, but rather in the dialogue between them - 'the Between' which they live together (Buber, 1965).



Buber's philosophy of dialogue has had a pronounced influence on the theory and practice of psychotherapy. Even in the domain of psychoanalysis, a group of analysts hold healing through meeting central to their theory and practice. Having been influenced either directly or indirectly by Buber, they are sometimes referred to as relational psychoanalysts (Friedman, 1998).

Buber's philosophical anthropology studies the wholeness and uniqueness of the human. Philosophical anthropology is the tradition Buber traces back to Kant and further beyond, which deals with the question of 'What is man?' Buber's philosophy of genuine dialogue differentiates between mere existence and authentic existence, between being barely human and more fully human, between remaining fragmented and integrating the conflicting polarities of oneself into an active unity, between partial and fuller relationships with others.

This leads to the concept of a 'whole person', an ideal that can be strived for but not fully achieved. What is attainable, however, is a greater sense of wholeness through more awareness and a fuller response in every new situation. Being that Buber's philosophy challenges each person to respond to the unique moment and circumstance we find ourselves in, it is called a situational ethic (Friedman 2002).

True meeting and genuine dialogue require certain conditions in order to occur. The presence or absence of these conditions constitutes the two existential modes or relationships upon which Buber's philosophical anthropology centers. Buber (1958) distinguishes between the 'I – Thou' and 'I – It' mode. The I – Thou is a true subject to subject relationship characterized by qualities such as mutuality, directness, spontaneity, presence and openness. This is where genuine dialogue and meeting can take place. In contrast, the I – It is a subject to object mode, where another is related to not as a full person but almost as an object, an 'It'. This type of relationship is indirect, non-mutual, and utilitarian in nature. Such a relationship is initiated in order to gain something or in order to use the other for one's own needs.

Applying this to psychotherapy, there are many ways and examples of how a patient can be turned into an 'It' by a therapist. A therapist could attempt to use the patient for his/her own purpose or agenda such as when the patient's admiration becomes necessary for the therapist's sense of importance or status. A similar case would be that of a therapist requiring a patient to improve so that the therapist can feel competent and helpful.

However, even though a therapist may naturally desire the patient to improve, the more conscious the therapist is of the patient's freedom to stay ill or get well, the more he/she can respond to the patient as the subject of that patient's own world (Shaffer, 1978).

A therapist can even influence the patient into relating to others in an I - It mode. Maurice Friedman calls this 'one of the violations of reality' of which psychoanalytic psychotherapy has been guilty (Friedman, 1985b). He is referring to the exclusive focus on the inner psychic world with the treating of parents, family and friends as psychic symbols rather than as the concrete social sphere of the person's day - to - day existence. For example, in Jungian therapy, there is the propensity for the other to be regarded as the 'anima' or 'animus' - masculine and feminine aspects of the psyche, or the projected 'shadow' instead of someone of unique value in their otherness.

A tendency to reduce the patient to an 'It' could develop in any therapeutic orientation or context. I once overheard a colleague discussing the patients she sees saying 'most of them are just your typical garden neurotics'. Even the way a diagnosis is used can easily result in patients being related to as less than fully human.

Yet Buber did not see the I - It position as completely useless and did not call for it to be dispensed with. Indeed, that would be unrealistic. To enable us to understand more easily our relationship with others and our initial purpose of meeting, it is necessary at first to relate in somewhat of an 'I - It' mode.

It is only when constantly viewing the other as an object in one's field of experience, that the possibility of a genuine I – Thou relationship is severely impeded. In fact, Buber maintained that most of our existence is actually lived in the I – It position out of necessity. The I – Thou only occurs infrequently during moments of intimacy and connection. Furthermore, the I – Thou cannot be created; it occurs if the conditions are suitable. Buber (1958, p.11) thus remarked: 'The Thou meets one through Grace – it is not found by seeking'.

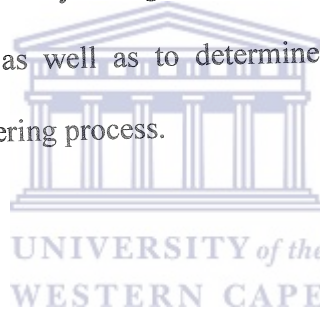
This poses a challenge for psychotherapy since the psychotherapeutic relationship begins as an I – It position where both therapist and patient have expectations of each other. This tendency of the therapist and patient to conform to each of their expected roles can make it difficult for a genuine and spontaneous I – Thou relationship to develop. True 'Meeting' according to how Buber envisioned it cannot be willed or artificially produced. Therapist and patient may therefore only hope and strive to 'meet' but never demand it of each other.

Buber held that two people in a dialogue share a connected human experience that both are struggling to comprehend. Life involves a celebrated diversity to be respected and the process of life consists of plunging into an experience and then reflecting on it. These themes can be regarded as a framework with which to view the therapeutic relationship (Gunzburg, 1997). The conversation between the therapist and patient will reflect the world of 'real living' outside the therapy room. The effective therapeutic conversation therefore contains elements of 'real living' that occur in other arenas and spheres.

When one examines the sphere of psychology and psychotherapy from the perspective of Buber's philosophy, it is possible to catch a glimpse of how fundamentally encompassing and compelling Buber's principles are. This will be done in the literature review.

1.6 The area of focus in the present study

This study focuses on trauma and seeks to demonstrate that the application of a Buberian understanding to the experience of trauma can help shed light on the impact of trauma on a sufferer's life. The aim of the study is to gain an understanding of the impact of trauma on interpersonal relationships as well as to determine components of psychotherapy found most helpful in the recovering process.



CHAPTER 2

LITERATURE REVIEW

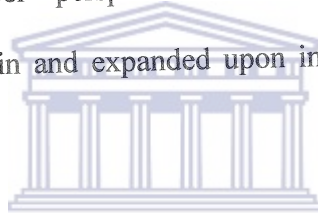
2.1 Dialogical psychotherapy

Apart from Buber's own writings on the topic of psychology and psychotherapy, a large segment of the literature on Buber's philosophy – both in general and as it pertains to psychology and psychotherapy – has been produced by Buber's major exponent, Maurice Friedman. In addition to a plethora of journal articles on the topic of Buber and psychotherapy, he has written many books specifically on the subject of Buber and dialogical psychotherapy – the system of psychotherapy Friedman outlines based on Buber's philosophy. His books on the subject include *The Healing Dialogue in Psychotherapy* (1985) and *Dialogue and the Human Image* (1992). In addition, Friedman was a close friend of Buber and discussed many concepts of psychology and psychotherapy with him in person and via correspondence (Friedman, 1988).

Friedman devoted much to the development and clarification of the model of dialogical psychotherapy which is based on Buber's philosophy of dialogue and the I – Thou relationship. Dialogical Psychotherapy in its broader sense refers to a therapy whose essence is the meeting between the therapist and patient, regardless of what role – playing, analysis or other therapeutic techniques may feature. Once it is recognized that everything that occurs in therapy occurs within the context of the fundamental relationship of patient and therapist, this can be considered dialogical psychotherapy (Friedman, 1998).

What is critical in this approach is not the therapist's skill but rather what occurs between the therapist and patient and between the patient and other people. In fact, much research on psychotherapy outcome has demonstrated that patients attribute successful therapy to their relationship with their therapist rather than to the therapist's technique (Friedman 2002).

Friedman (1998) has provided a comprehensive outline of the model of dialogical psychotherapy. It includes core components of the approach and ten stages of dialogical psychotherapy within a Buber perspective. These ten elements of dialogical psychotherapy are clarified again and expanded upon in a later publication (Friedman, 2002).



Buber regarded the psychological sphere as merely the accompaniment of the dialogue between one person and another. What is crucial is not what lies within the minds of the partners in a relationship, but what happens *between* them. According to Buber (1988), the growth of the self does not occur through our relationship to ourselves, as many believe, but rather by being made present by 'the other' and knowing that we are made present by the other.

2.2 Inclusion (Imagining the real) and Confirmation

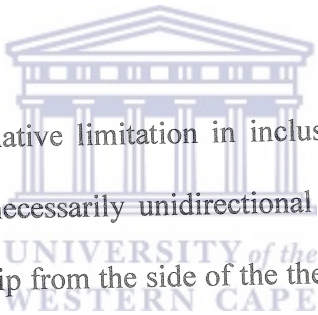
Being made present as a person is what Buber refers to as 'confirmation'. Confirmation is essential for becoming one's true and unique self through a relationship with another

person. Confirmation is a foundational principle in the dialogical psychotherapy that Buber calls 'healing through meeting' and which occurs within the context of an I – Thou relationship. Confirmation means to confirm another's uniqueness by making the other present through a process that Buber describes called 'imagining the real' or 'inclusion' (Friedman, 1998). Buber used these two terms interchangeably and synonymously.

This 'making present' of the other occurs partially whenever two people come together, yet in its essence is only rarely achieved. To make the other present by 'imagining the real', one has to concretely imagine what the other is thinking, feeling and willing. In this process, all one's skills and resources are utilized to understand what the other is experiencing (Buber, 1965). Understandably, this skill would prove invaluable in psychotherapy. However it is not easily achieved, since it requires all assumptions about the patient to be suspended in order to attain it. The therapist must listen carefully to the patient, and be able to convey to the client that they are being understood.

Inclusion may seem very similar to the approach of Carl Roger's Person Centered Therapy where empathy, a non – judgmental attitude and reflection are championed. However, inclusion involves different skills to those required for empathy (Stanton, 1985). Inclusion demands more of the therapist than empathy: to maintain one's own ground and simultaneously experience the other side of the relationship in the manner of a 'bold swinging over into the life of the other person' (Buber in Friedman, 1988, p.214). If one's own 'I' is relinquished in the process this would not qualify as an I – Thou relationship which is necessary for inclusion to occur.

Empathy actually *excludes* one's own concreteness from being brought to the relationship, thus obscuring the actual situation of life. Inclusion then is in fact the opposite of empathy, since rather than obscuring reality; inclusion actually clarifies and facilitates an understanding of the reality of the other's experience after having lived through the event from both one's own side *and* from the other's position. When this skill is sufficiently developed, a therapist can 'imagine the real' of their patient with such clarity that the therapist is able to regard both their own beliefs and their patient's beliefs as valid. This is what Buber termed confirmation. He explained that it emerges out of the practice of inclusion.



Buber did acknowledge a normative limitation in inclusion with regards to the initial stage of therapy. Inclusion is necessarily unidirectional at this stage since the patient cannot experience the relationship from the side of the therapist without either destroying or fundamentally changing the relationship (Friedman, 1985b). This problem is not inherent in a friendship or love relationship where inclusion would be mutually possible.

This does not mean that the initial therapeutic relationship is reduced to an I – It mode. The one – sided inclusion at the commencement of therapy is still an I – Thou relationship predicated on trust, mutuality and partnership in a common situation, which provide the suitable environment for real therapy to occur. Although initially it is the therapist who invests most of the energy on imagining the real, once the therapy progresses to a stage where the patient desires to enter the I-Thou position, a mutual

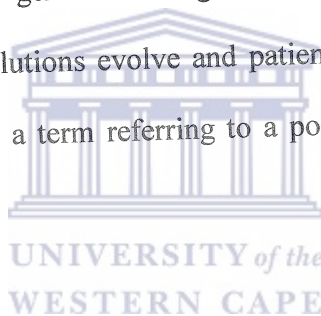
experience of inclusion can then occur enabling both therapist and patient to gain an understanding and appreciation of each other (Gunzburg, 1997).

Through the process Buber described, we do not merely perceive the other person, but also strengthen them in their uniqueness, helping them find personal direction. Confirmation does not require the therapist to choose between either their own or the patient's uniqueness, nor does it require the therapist to impose himself/herself onto the patient. Rather confirmation facilitates the patient's uniqueness in realizing itself in relation to the therapist (Kron & Friedman, 1994).

Confirmation includes a confrontational element in which patients are helped with and against themselves. The therapist joins the patient's struggle to find direction and to incorporate the directionless whirl of his/her life into their dialogue with life. Human beings can be conceptualized as polar rather than simply good or bad. According to Buber, merely accepting or affirming one pole leaves the other pole and the struggle between the poles unacknowledged. It is therefore insufficient merely to reflect back to patients who or what they are and to affirm it. It is necessary to confront them with their unacknowledged polarity so that they will then be ready to take responsibility for it. Until the therapist evokes from the patient that movement towards finding and taking their personal direction, the patient will not become that unique person he/she is called to become by his/her created uniqueness and by what comes to meet him/her (Kron & Friedman, 1994).

Confirmation in therapy includes, in addition to acknowledging polarities within the patient, the holding of the tension of these polarities that so characterize our life: we all exist simultaneously as unique persons yet in relationship to others; as persons in social roles and as professionals but also as partners in a relationship; as guided by rule and structure while also responding spontaneously and authentically to situations.

All of Buber's constructs that have been discussed up to this point: meeting within an I-Thou position, imagining the real / inclusion and confirmation are all encompassed in a conversational space which Buber calls 'the Between'. Here is where the sphere of the inter – human blossoms into genuine dialogue (Buber, 1965). In the context of psychotherapy, this is where solutions evolve and patients are given the opportunity to experience the 'Aha!' moment, a term referring to a point of great insight achieved in psychotherapy.

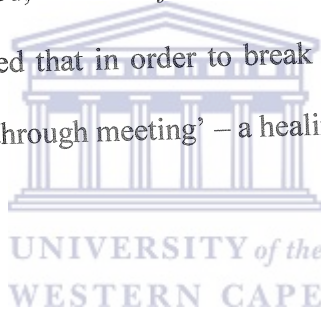


2.3 The 'Between' and the importance of the Inter – human realm

Various orientations in psychotherapy can have radically different conceptualizations of the psyche. This produces different views of what sphere or area the therapy should focus on. The spectrum ranges from the Jungian belief that the psyche *is* existence to the Skinnerian counter-position that the psyche is insignificant since it is not quantifiable. Yet Buber carves out an image of a dialogical alternative to such extreme positions of subjectivism or objectivism. The 'Between' is a crucial sphere which we all are able to access. It is neither objective, nor subjective, nor the sum of the two, but the space where genuine dialogue occurs and where the inter – human field is able to develop and grow.

Buber criticized the tendency of psychoanalysis to '*psychologize*' the world. This term refers to relegating everything exclusively to the realm of one's thoughts, feelings or analyses, thereby escaping meeting the world and life with all its negative and difficult aspects (Buber, 1965). Buber's strong opposition to this 'psychologism' trend was in no way an attack on psychology or psychotherapy per se, but rather on the attempt to subsume all reality under psychological or psychoanalytic categories.

Referring to this phenomenon, Buber (1958) speaks about the delusion of a human spirit bent back into itself. He was referring to the false belief upheld by many that spirit occurs *in* man. In truth, Buber explained, it occurs *from* man, and is to be found between man and his fellow. Buber maintained that in order to break the shackles of 'psychologism' we have to strive for a 'healing through meeting' – a healing *in* and *of* the 'Between'.



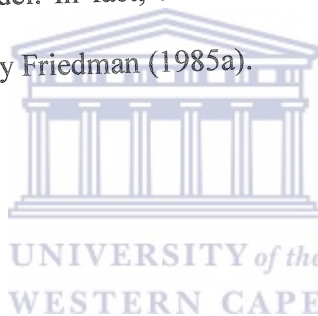
2.4 Integration and wholeness

Buber suggested an alternative term for psychoanalysis, the dominant psychotherapeutic orientation at the time. He proposed the term 'psychosynthesis' which carries the implication that although the life of the soul (psyche) may be dissected in the therapeutic process, the soul is nevertheless a unity (Friedman, 1988). Buber used this term in conscious contrast to 'psychoanalytic' to suggest the procedure from wholeness, as contrasted with approaching something starting from the vantage point of its isolated parts and complexes.

Such a viewpoint carries the underlying assumption that in order for psychology to be successful in its endeavor to understand and heal a person, it must first be grounded in a realistic conception of what a person is. This conception must be able to deal with the individual not only in isolation and in terms of individual complexes of their personality, but also as a whole person in relation to other persons and to society.

Psychosynthesis is also the name of a method of psychotherapy developed by Robert Assagioli. One might think that Assagioli influenced Buber in this regard. However, Buber had already spoken about this concept as early as 1921 – long before the development of Assagioli’s model. In fact, the influence may have been the other way round as suggested and argued by Friedman (1985a).

2.5 Stance of the therapist



Fishbane (1998) emphasizes how Buber’s approach to therapy does not involve an effort to change the patient in a prescriptive manner, such as attempting to impose one’s ‘rightness’ onto the patient. Rather, Buber urges us to approach the patient in such a way that we help them to unfold in their own unique and genuine way. The pull for the therapist to impose change can come from the patient, even when the therapist attempts to work non – prescriptively since patients frequently come to therapy with the expectation of being ‘fixed’.

A hierarchical stance of therapy would be completely antithetical to what Buber expected of a therapist's attitude. Such a stance would include the attitude that the therapist is wiser or smarter than the patient. This stems from the belief that people coming to therapy have deficits that need to be filled. In contrast, many therapists see the core self as wise and full of resources and potential and this would certainly be more congruent with Buber's position.

A therapeutic stance geared toward a more I – Thou relationship could have particular significance when dealing with certain patients. For example, Goldberg (2000) explains that the disturbed, suffering patient often seeks to escape the world of distancing, manipulation and objectification, but is trapped in an assumption: He/she, together with significant others, pretends that conflicts are not related to a lacking in understanding and genuine concern for one another, but because each person is compelled to act in a dysfunctional manner with each other as a condition of their essential personality.

According to Buber (1965), this type of relating can be relinquished if the patient experiences a radical discovery – a 'moment of surprise'. Thus in the healing encounter, the patient must be taken off guard by the freedom to be as he/she intends in the other's presence, in contrast with how others in the past have demanded him/her to be. With such a patient, the depth of healing is then a product of the healer's capacity to sustain the unexpected in relation to the patient (Goldberg, 2000).

2.6 Mutuality in the therapeutic relationship

The stance a therapist should embrace according to Buber is one of mutuality. It is such a salient concept that it justifies a separate discussion. Mutuality comprises elements mentioned above such as the therapist avoiding being prescriptive, imposing onto the patient or attempting to change the patient. However, mutuality encompasses much more than the above – mentioned facets.

The psychotherapist and lecturer Sidney Jourard, author of *The Transparent Self* and *Disclosing Man to Himself*, places Buber's I – Thou relationship or dialogue at the center of therapy. For him, mutuality is an essential therapeutic stance. He believed that the therapist must also share him / herself with the patient and that self – disclosure begets self – disclosure. For Jourard, the heart of the therapeutic relationship is abandoning all urges to shape the patient's behaviour according to any predetermined mould, and he refers to therapy as an honest relationship which slowly becomes an I – Thou dialogue where both parties ultimately experience growth (Friedman, 1985b).

Jourard agrees with Rogers that proper listening encourages self – disclosure, but at the same time, over many years he has come to complement such listening with a variety of other things including giving advice, lecturing, laughing, interpreting, becoming angry, telling his fantasies, asking questions and anything that occurs to him during the therapy session in response to the other person.

Even though this involves trusting what emerges from oneself as a therapist in response to the patient; the therapist nevertheless must still check this response against his/her own judgment and common sense, and limit it to an openness of the therapist in that moment only. This type of mutuality Jourard finds consonant with Buber, explaining that in a genuine dialogue it is impossible to know in advance how one will respond.

As an extension of mutuality, Jourard believes in the importance of the therapist's transparency. For example, telling the patient directly and honestly if the therapist does not want to answer a question, or letting it be known if the therapist becomes angry, worried or anxious. Transparency would allow the patient to know the therapist, as the therapist is, specifically during their hours together. Transparency does not require the patient to know about the therapist's life outside the therapy session.

This honesty and spontaneity can correct the patient's transference misperceptions and cause the therapist's responses to be unpredictable, also preventing the patient from manipulating the therapist. Jourard explains that this slowly relieves the distrust of the patient and simultaneously gives the patient a role model of an authentic person that the patient can identify with. This authenticity of the therapist could mean that the relationship changes the therapist as much as it does the patient (Friedman, 1985b).

Jourard acknowledges that self – disclosure when blind to the other or failing to 'imagine the real' as Buber explained, would be therapeutically harmful. He explains that he lost

several male patients since he had merely assumed that they could handle such transparency, thus being sensitive to his own authentic being but not to theirs.

2.7 Theorists and therapists aligned with Buber

There is a significant amount of literature comparing Buber's ideas with a variety of psychological theorists and drawing parallels and correlations. In 1957, there was a public dialogue between Buber and Carl Rogers where many similarities and crucial differences emerged between these two leading proponents in the field of humanism (Cissna & Anderson, 1994; Friedman, 1994). Irving Yalom incorporated Buber's philosophy by emphasizing that an uncertain and spontaneous encounter is necessary for effective therapy and by understanding the essence of psychotherapy as a caring and deeply human meeting between two people. Yalom also experienced diagnosis as inadequate to capture the wholeness and uniqueness of the person that the therapist sees (Friedman, 2002).

Friedman (1992) acknowledges and discusses several therapists and theorists as dialogical therapists. These include: Erwin Straus, the neuropsychiatrist Kurt Goldstein, the German existential – analyst Medard Boss, Erving and Miriam Polster who brought dialogue and the aspect of 'the between' into Gestalt therapy, the German psychiatrist Viktor von Weizsacker, the distinguished American psychologist Rollo May who saw healing through meeting as the channeling of impersonal force into personal dialogue through intentionality, responsibility and decision, and James Bugental who saw presence

as the one essential ingredient in therapy and who authored *Search for Existential Identity*, subtitled ‘Patient – Therapist Dialogues in Humanistic Psychology.’

The famous British Psychiatrist R. D. Laing conceptualized Schizophrenia in terms of separate – ness and relatedness and drew heavily on Buber’s concepts of inclusion and confirmation (Friedman, 2002). Richard Hycner is a Gestalt therapist with a strong leaning towards Buber and his philosophy. He is the author of *Between Person and Person: Toward a Dialogical Psychotherapy* and is the co – director together with Maurice Friedman of the Institute for Dialogical Psychotherapy in San Diego (Friedman, 1992).

2.8 The psychoanalytic and psychodynamic theorists

Within the psychodynamic orientation, several theorists may either be considered actual dialogical therapists or alternatively, their theories bear similarities to Buber’s philosophy to greater or lesser degrees.

Carl Jung went much further than Freud in the direction of acknowledging the uniqueness and other – ness of the patient and therapist. Furthermore, Jung insisted that analysis is a dialogue between two human beings (Friedman, 2002). Yet, Buber and Jung disagree considerably on many issues and Stephens (2001) addresses the renowned Buber – Jung disputations and implications for the boundaries of analytical psychology.

The Swiss psychiatrist Hans Trub attempted to fuse Jung's analytical psychology with Buber's philosophy of dialogue. He was highly regarded by Buber as the man who broke the trail in the recognition and realization of the therapeutic possibilities of dialogue (Friedman, 1992).

Jaaskelainen (2000) compares Alfred Adler's Individual Psychology to Buber's philosophy, applying Buber's concept of I-Thou to Individual Psychology with implications for psychotherapy. Erich Fromm, a neo-Freudian psychologist, maintains that man's nature is a social product and believes that man is genuinely free and responsible (Friedman, 1976). Thus he also has views that are congruent with Buber.

The American psychoanalyst Leslie Farber wrote an essay titled 'Martin Buber and Psychoanalysis' in which he affirms that successful treatment is impossible without 'meeting'. He explains that many disturbances thought to result from the transference are more accurately the striving for or retreating from the desire for a reciprocal relationship (Friedman, 1992).

The Swiss psychiatrist Ludwig Binswanger, initially a Freudian psychoanalyst, founded 'existential analysis' and so shifted from an intra – psychic to an interpersonal theory of human nature, and from an impersonal to an interpersonal therapeutic technique. Similarly, there are significant parallels between Buber's philosophy and Harry Stack Sullivan's Interpersonal Psychoanalysis. Binswanger and Sullivan both concentrate on the way in which the patient structures reality rather than on building structure within the

personality (Frie, 2000). Similar parallels appear with other relational perspectives in psychoanalysis such as L. Aron who authored *A meeting of minds: Mutuality in psychoanalysis* and S. Mitchell who wrote *Relational concepts in psychoanalysis: An integration*.

2.9 The object relations theorists

Several of the object relations theorists exhibit strong similarities and correlations with Buber's philosophy, some of them in a striking manner. In an article entitled 'Winnicott, Buber and the theory of personal relationships', Ticho (1974) presents similarities in the thinking of Buber and Winnicott. Both thinkers highlight the dignity and importance of the individual yet both emphasize that becoming an autonomous person is only the first stage in the path of a relationship, where ultimately one strives towards openness to the 'other' and the world.

Several other striking similarities are mentioned: both Buber and Winnicott have similar goals of life – to be alive, spontaneous, creative, cherishing of one's wholeness and uniqueness and open and receptive to the world. Both theorists place their core concepts along a continuum: Winnicott with regards to the different stages in the development of the true and false self and Buber regarding the I – Thou and the I – It relationships which are also poles of a continuum. As mentioned earlier, the I – Thou is to be viewed more as an ideal to which one can constantly strive to reach higher levels of.

Both Buber and Winnicott also employ the spatial concept for the development of relationships. Winnicott described the transitional object as being located spatially between mother and infant as a symbol for the relationship that later develops into play and culture. Similarly, as mentioned earlier, one of Buber's central foci is the inter-human space called 'the Between'. The paper ends with the suggestion that Winnicott's psychodynamics may complement Buber's phenomenology so that the combination of the two could provide us with a better understanding of personal relationships (Ticho, 1974).

The object relations theorist Harry Guntrip described his theory as close to but not reaching the I – Thou relationship that Buber described (Friedman, 2002). Both Guntrip and Ronald Fairburn proceeded from their object – relations theories toward the direction of a therapy involving healing through meeting. Fairburn was convinced that the patient's relationship to the analyst is what mediates the healing or curing effect of therapy in transforming previous pathogenic relationships through the transference into a new type of relationship both pleasing and suitable to the circumstances of outer reality.

Thus Fairburn and Guntrip oppose the traditional restriction of the analyst to a screen upon which the patient projects fantasies and merely an impersonal mechanical interpreter. Rather they see as the key therapeutic factor a real personal relationship between patient and analyst. Guntrip authored a book called *Personality Structure and Human Interaction* and sees object relations theory emerging from Melanie Klein and

Fairburn's work as a process of exploring and formulating the I – Thou relationship (Friedman, 1985a).

Heinz Kohut developed the school of Self – Psychology, often included under or juxtaposed with the object relations theorists. He recognized that the development of the damaged self is due to either a lack of confirmation from others or the absence of confirmation altogether (Friedman, 2002). In this way, he incorporates Buber's central construct of confirmation in his theory despite using different terms to Buber, such as the concept of mirroring which is central to the theory of Self – Psychology.

2.10 The Intersubjective Theorists

The literature review has highlighted many concepts of Buber's philosophy pertinent to psychotherapy and psychology and has shown parallels with many different theorists in the field. Some have more compatibility with Buber's philosophy and some have less. However, there has emerged out of the Self – Psychology school, a contemporary branch of psychoanalysis called Intersubjectivity Theory. Revolutionary in its approach, this theory has remarkable congruence with Buber's philosophy and principles of psychotherapy, perhaps more than any of the theories and theorists mentioned above.

Although Intersubjectivity Theory emerged out of Self – Psychology, it represents a revolutionary paradigm (Brandell, 1999). It has caused much controversy in the psychoanalytic community and many practitioners have claimed that the theory has completely changed their approach to treatment. The theory challenges basic assumptions of psychoanalysis and in this way actually aligns psychoanalysis closer to humanism. It provides a holistic view of human nature and focuses on experience both in theory building and in the process of psychotherapy. Intersubjectivity Theory has also been termed a ‘psychoanalytic phenomenology’ since it is dedicated to understanding both experience as well as the structures of experience (Jacobs, 1992).

The development of the intersubjective perspective in psychoanalysis occurred over five movements, each marked with a book (Stolorow, Orange & Atwood, 2001). The first phase arrived with the book *Faces in a Cloud* (Stolorow & Atwood, 1979) and showed through psycho – biographical studies that psychoanalytical metapsychologies are formed from the subjective and personal worlds of their developers. The authors concluded that what psychoanalysis needed was a theory of subjectivity itself in the form of an integrating framework that can account for the phenomena addressed by other theories as well as the theories themselves.

The second phase, ushered in with the book *Structures of Subjectivity* (Atwood & Stolorow, 1984) introduced the concept of an intersubjective field – ‘a system formed by differently organised, reciprocally interacting subjective worlds’ (Stolorow & Orange et al, 2001, p.15) – as the fundamental theoretical construct for this framework. Experience

emerges out of interactions within the subjective field, and behaviour and experience can only be understood in the context of that field.

The third book *Psychoanalytic treatment* (Stolorow, Brandchaft & Atwood, 1987) applied the concept of Intersubjectivity to a variety of important clinical issues such as analysis of transference and resistance, therapeutic action and treatment of borderline and psychotic states. The fourth, *Contexts of Being* (Stolorow & Atwood, 1992) revisited four basic tenants of psychoanalytic theory: the unconscious, mind – body relations, trauma, and fantasy, and re – conceptualised them from the standpoint of Intersubjectivity. The fifth book, *Working Intersubjectively* (Orange, Atwood, & Stolorow, 1997) outlined a broad-based philosophy of psychoanalytic practice also referred to as contextualism.

The authors stress the mistaken belief that the intersubjective understanding negates the traditional importance psychoanalysis attributed to the intrapsychic. This is incorrect, as the approach rather than negating the intrapsychic, actually contextualises it (Stolorow, Orange & Atwood, 2001). In other words, the problem with classical psychoanalytic theory according to this approach was not the focus on the intrapsychic, but rather the failure to recognise that the intrapsychic world develops and evolves within a zone of living systems and therefore is context – dependant. Thus the intersubjective approach, instead of dealing only with the isolated individual self, highlights both the individual's world of inner experience, as well as how this is located within and interacts with other such worlds or subjectivities in a reciprocal and mutual manner.

The intersubjective mode is also therefore seen as a more complete field or systems model (Mitchell & Black, 1995). Personal experience is seen as 'fluid, multidimensional and exquisitely context-sensitive, with multiple dimensions of experience oscillating between foreground and background, between figure and ground, within an ongoing intersubjective system of reciprocal mutual influence' (Stolorow, Orange & Atwood, 2001, p.17).

This bridges the previous – existing chasm between the intrapsychic and interpersonal worlds; even the distinction between one – person and two – person psychologies (at present a source of much debate in psychoanalysis) would become obsolete. With this approach, the individual and his or her intrapsychic world are included as a subsystem within a more encompassing relational or intersubjective suprasystem. There is recognition and acknowledgement of the constitutive role of relatedness in the making of all experience and this provides a contextual psychology.

Intersubjectivity Theory unlike other psychoanalytic theories does not offer particular psychological contents that are regarded as universally involved in the development of personality and pathogenesis. Rather, it is a process theory comprising of broad methodological and epistemological principles for the investigation and comprehension of intersubjective contexts in which psychological phenomena, including psychoanalytic theories, arise.

A criticism from the psychoanalytic perspective has been levelled against Intersubjectivity Theory when taken to the extreme position where the mutative factor in treatment is the emotional impact of the therapist and whereby any interpretative content is regarded as having little significance. This position would imply that psychoanalysis lacks a definitive group of procedures even for a class of patients, and seeing interpretation as having no impact, psychoanalysis is reduced to a significant relationship and psychoanalytic therapy is no longer a definable technique (Summers, 1999).

If psychoanalysis is only about providing a relationship in which no principles or parameters can be delineated and elucidated, then a concept of therapeutic process or a theory of technique is impossible to articulate. This prevents psychoanalysis from understanding itself. In such a case where there is no conceptualisation of a process, the idiosyncrasies of each therapist's unique relationship with each patient would determine therapeutic success. This presents the danger of psychoanalysis then becoming a relationship as any other, a type of blind existential encounter that in certain cases may prove successful, however such success would be serendipitous. A balance is called for that can be summarised by a famous philosopher's dictum: Understanding without a relationship is empty but a relationship without insight is blind (Summers, 1999).

2.11 Intersubjectivity theory and Buber

Although Intersubjectivity bears so much resemblance to Buber's philosophy, there is not much literature on this. I will attempt to highlight several fundamental similarities.

As mentioned previously, Intersubjectivity is an outgrowth of the Self – Psychology school developed by Heinz Kohut. Friedman (1992) asserts that dialogue does not include the internalised relations of Object Relations and Self – Psychology despite the many points of convergence. He quotes Harry Guntrip and Charles Brice who point out the limitations in these schools of theory, explaining that there is inadequate description of what occurs between one person and another and the reality of the other is avoided by the theory circumscribing human relationships only in terms of the image of the self placed in the other or vice versa. This critique is similar to Buber’s general critique of Psychoanalysis – that the inter – human, an entire sphere of human reality, is excluded.

However, with regards to Intersubjectivity Theory, the above – mentioned critique is dissolved, since the essence of the theory deals with the interpersonal or intersubjective space. In fact the term Intersubjectivity can almost be considered a synonym for Buber’s fundamental construct of the I – Thou relationship. The I – Thou signifies a subject – to – subject relationship as opposed to a subject – to – object (I – It) relationship. Thus, I – Thou actually is Inter-*subjectivity*, a relationship between *subjects*.

Thus Friedman (2002) agrees that Intersubjectivity Theory relocates the domain of therapeutic problems from the intrapsychic to the interhuman domain. However, what Intersubjectivity Theory provides which Buber does not, is a more psychological theory with the psychological implications and descriptions of what Buber describes philosophically. This does not necessarily involve a reduction by trying to fit the

meaningfulness of Buber's ontology into psychology. It is merely viewing things from a different lens, and thereby actually illuminates the I – Thou relationship, not ontologically as a philosophical construct, but in the way that the I – Thou relationship is experienced (Jacobs, 1992).

As mentioned previously, Intersubjectivity stresses the importance of relatedness in the making of experience and thus introduces the contextual paradigm within psychoanalysis. Relatedness is a core principle of Buber's philosophy and understanding the therapeutic relationship as an intersubjective system of reciprocal and mutual influence comes very close to Buber's concept of genuine I – Thou dialogue (Jacobs, 1992). Thus a therapist who practices from an intersubjective perspective recognises that all phenomena are co – created and the therapist has to be aware of his / her impact in an ongoing way.

Intersubjectivity is not a clinical theory but a set of questions for theories and therefore a metatheory. Clinically, it represents a mindfulness that informs a clinician's thinking and work and can be seen as an attitude. Here the crux of psychoanalytic work is not comprised of particular techniques to be used but is rather the *attitude* with which the clinician approaches the material and the *process* that occurs in the resulting dialogue between clinician and patient (Stolorow, Orange & Atwood, 2001). This description strongly resonates with the conception Buber had of how the psychotherapeutic relationship should be – a healing through genuine dialogue within a therapeutic stance of mutuality that is non – prescriptive.

The developers of Intersubjectivity theory draw on the German philosopher Dilthey who distinguishes between human sciences and natural sciences by their attitude towards the objects they investigate. The natural sciences investigate from the outside and the human sciences from the perspective of the inside. Natural sciences study observable behaviours such as interactions with others whereas human sciences investigate the meanings to the experiencing subject. Dilthey drew a parallel to Buber's thinking and equated the mode of relatedness of the natural sciences to Buber's I – It or subject – to – object mode, and the mode of relatedness of the human sciences to Buber's I – Thou or subject – to – subject mode (Stolorow and Atwood, 1984).

This concept from Intersubjectivity Theory that one attempts to understand another from a perspective within the other's frame of reference is very reminiscent of Buber's concept of inclusion that leads to confirmation. Buber called inclusion 'imagining the real', meaning by this a concrete imagining of the other in oneself, while still retaining one's own self – identity. He defined inclusion in therapy as such: 'The therapist must feel the other side, the patient's side of the relationship, as a bodily touch to know how the patient feels it' (Buber, 1967, p. 173).

Buber explained that in dialogue, there is a special insight or illumination in personally experiencing the confirmation of oneself by another that occurs through inclusion. Confirmation is when one is apprehended and acknowledged in one's whole being by another (Buber, 1965). This requires one to enter into the phenomenological world of the other while suspending judgement, allowing at the same time a genuine personal meeting

to open up between the one in need of help and the helper. Similarly, the intersubjective theorists state that their attitude is 'one of empathic – introspective enquiry, which gives rise to a therapeutic interaction that illuminates (and eventually transforms) the meanings and patterns organising the patient's experience' (Stolorow, Orange & Atwood, 2001, p.25). This resonates strongly with Buber's above – mentioned outline of the illumination that occurs during genuine dialogue.

Buber requested that therapists become fully present and freed from any constraints, to allow them to respond to the patient in a creative and unique way. Buber's anti – systematic emphasis is on the concrete, the unique, and the unexpected. Buber promoted the idea of a 'musical' therapist who is in tune with each unique client and does not merely follow the theorist of his/her school, but instead finds the right method and response for each particular person. Buber thus remarked: 'A real master responds to uniqueness' (Friedman, 1988, p. 222). The intersubjective theorists also encourage 'an emancipation of analysts in both their thinking and their practice, a freeing enabling them to use the full resources of their creativity in the tasks of psychoanalytic exploration and treatment' ((Stolorow, Orange & Atwood, 2001, p.26).

CHAPTER 3

TRAUMA AND BUBER'S PHILOSOPHY

3.1 Models of trauma

There are several different conceptualisations of trauma. The widely employed medical model views trauma as a disorder, diagnostically termed Post – Traumatic Stress Disorder (PTSD). The diagnostic criteria for this disorder are listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM – IV TR).

To qualify for this diagnosis, the person has to either directly or indirectly experience a traumatic event involving actual or threatened death or injury where the response involves intense fear, helplessness or horror. In addition, there are symptoms following the trauma for at least a month of: intrusive re-experiencing of the trauma in various possible ways, persistent avoidance of any stimuli associated with the trauma or numbing of general responsiveness, and persistent symptoms of increased arousal. All of these would have to cause clinically significant distress or impairment in social, occupational or other important areas of functioning (DSM – IV TR, 2000).

The medical model of trauma has been severely criticised by Summerfield and Becker who find it to be an unhelpful concept arising out of a very Western and individualistic context which is stigmatising, pathologising and disempowering (Wirtz, 2003). Even the actual term Post – Traumatic Stress Disorder is criticised, since the word 'post' implies something *after* the trauma, emphasising the event, instead of seeing trauma as a process.

This type of attitude views the response to a traumatic event as pathological, and does not emphasise that trauma is a normal response to very abnormal events (Levenson, Butler & Beitman, 1997). The medical model's dependence on outward signs to establish a diagnosis also negates an approach aligned with Buber where the patient's own subjective experience would be focused on as opposed to focusing exclusively on externally observable signs of trauma. Having taken into consideration the above – mentioned factors, I have chosen to use the term trauma in this study, rather than to refer to its diagnostic label.

Other well – known models of trauma include the psychodynamic and the psychosocial models. The psychodynamic approach conceptualises trauma as an intrapsychic process and views it primarily within this context. The psychosocial model of trauma is a less event – orientated and more process – orientated model that contextualises trauma and thus would incorporate a more systems approach in understanding the process of trauma.

There is a conceptualisation of trauma which views trauma as a potentially transformational and spiritual process that can ultimately lead to an incredibly positive and life – changing experience. This understanding has quite broad applications and can even be accommodated for example within a Jungian psychoanalytic perspective, since the experience of trauma elicits life – death aspects that could be seen as a destruction – creation archetype within a Jungian framework.

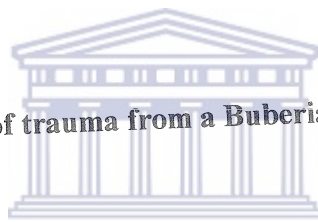
A more holistic model of trauma is the biopsychosocial model. The term biopsychosocial is a composite of three spheres: the biological, the psychological and the social. When applied to the impact and effects of trauma, these three components can be termed the soma element, the psyche element and the intersubjectivity element of the effects of trauma respectively (Wirtz, 2003).

The soma or body element involves primarily the physiological effects of alterations in affect regulation and what is termed the fight – flight freeze, referring to an increased arousal or startle response. The psyche element includes alterations in consciousness and self – perception, and alterations in the person’s system of meaning or belief system such as loss of faith, values and hope. This element is so pronounced in the experience of trauma that trauma has even been termed a disorder of meaning or an existential malaise. The intersubjectivity element refers to the social avoidance, isolation and withdrawal, betrayal of trust, fragmentation and disempowerment that occurs with trauma. This element has particular relevance to Buber’s philosophy, which as mentioned previously, is very closely aligned to Intersubjectivity theory.

A common denominator in many models and conceptualisations of trauma is the breakdown element, where trauma is seen to produce a breakdown in life’s continuity. This disruption often occurs on different levels. On a cognitive level, a person has difficulty assimilating the traumatic experience into previously – existing schemas and assumptions held of the world, self and other (Levenson, Butler & Beitman, 1997). Trauma shatters these assumptions and lead to a breakdown in cognition and attribution.

Trauma can also cause a break in the sufferer's sense of wholeness and self and can lead to a disintegration anxiety where the person fears or believes that they will fall apart. Formulated in terms of the Self – Psychology theory of Kohut, trauma produces dissolution of a coherent self. In fact, researchers found a shared phenomenological and conceptual interface between Borderline Personality Disorder and Post – Traumatic Stress Disorder. This could be explained in terms of the impact on the self described above which obviously would also be present in disorders of the self, one of which is Borderline Personality Disorder. Self – Psychology theory explains Borderline Personality Disorder as developing from traumatic developmental interference in a chronically non-empathic family environment (Simpson, 1994).

3.2 Understanding the effects of trauma from a Buberian perspective



The interpersonal breakdown element is such a pervasive phenomenon in trauma that it appears in the diagnostic criteria listed for Post – Traumatic Stress Disorder in the DSM manual. Under the diagnostic criterion of section C which deals with the persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, the DSM lists ‘feeling of detachment or estrangement from others’ and ‘restricted range of affect (e.g. unable to have loving feelings)’ (DSM IV TR, 2000, p.468).

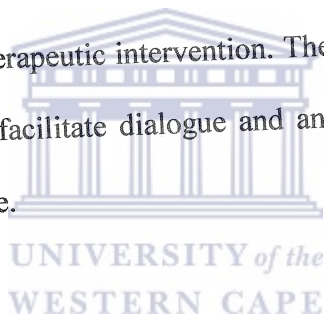
Within a Buberian context, ability to engage in the I – Thou mode or dialogue is disrupted if not completely blocked in the experience of trauma. This can be understood more easily when appreciating that an important element of the response to trauma is not

only mistrust (and even shattering) of one's self but also of the world (Levenson, Butler & Beitman, 1997). Thus both the 'I' (ones self) as well as the 'Thou' (one's sense of the world) are damaged in the experience of trauma and this can preclude the development of an I – Thou relationship in a trauma sufferer. We can now understand the difficulty traumatised people experience when entering or maintaining a relationship once we have appreciated the impact trauma has on the sufferer's sense of self. For a traumatised person to have a sense of self or an 'I' from the outset with which to be able to engage with another 'Thou', becomes unlikely or impossible.

An understanding or recognition of some of the linguistic effects of trauma may shed some insight into how trauma frequently causes a marked inability to engage in true dialogue with another, particularly on a verbal level. Linguistically, the experience of trauma can be so intense and its impact so overwhelming that frequently it cannot be expressed and put into words. According to Winnicott, trauma characteristically encompasses an unthinkable situation that cannot be expressed with the verbal means that we have most readily available to us and sufferers lose their ability to use their imagination and to symbolise. Therefore, interventions for trauma may incorporate symbolic aspects or techniques that engage the different senses. Even on a biological and physiological level, it has been recognised that trauma affects the Broca centre of the brain that deals with speech ability and can result in the inability to put an experience into words. This is evident in the typical speechlessness often observed in traumatised patients (Wirtz, 2003).

Seeing that our primary medium of relating to others is through verbal means, our relational capacity would obviously be jeopardised if trauma has such a profound verbal impact. Another common experience in trauma is that the patient experiences extreme isolation both because of a difficulty or inability to engage with others and because of experiences that others find they are unable to understand or relate to. It is therefore frequently emphasised that particularly with trauma, the therapist must always exhibit a non – judgemental and empathic stance (Levenson, Butler & Beitman, 1997).

With the above – mentioned aspects taken into account, Buber’s theoretical constructs, particularly the principles of inclusion and confirmation, are particularly relevant to the experience of trauma and it’s therapeutic intervention. They become a means of enabling a platform that will allow and facilitate dialogue and an I – Thou mode of relating to resume in a trauma sufferer’s life.



CHAPTER 4

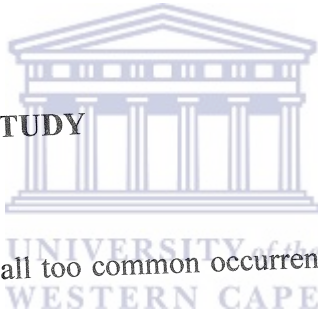
AIM AND RATIONALE OF THE STUDY

4.1 AIM OF THE STUDY

The aim of this study is twofold:

1. To gain an understanding of the impact of trauma on interpersonal relationships.
2. To determine components of psychotherapy found most helpful in the process of recovering from trauma.

4.2 RATIONALE FOR THE STUDY



The experience of trauma is an all too common occurrence in South African society and an area of particular concern within the field of psychology. While there is a large body of literature on the effects of trauma, there is comparatively less understanding of the processes that facilitate recovery. It is hoped that investigating methods of dealing with trauma could contribute to the field of mental health in general.

CHAPTER 5

RESEARCH DESIGN AND METHODOLOGY

A qualitative methodology and design was chosen in the present study. Five participants were interviewed using semi – structured interviews.

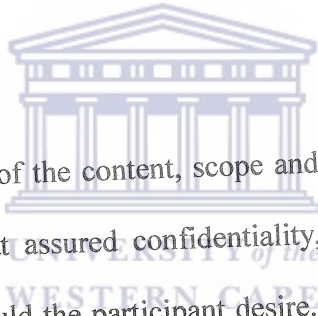
5.1 The qualitative approach

According to Mason (1996), there are three essential qualities of qualitative research. Firstly it is grounded in an interpretive philosophy that employs flexible methods of data generation. Secondly it is sensitive to the social context and lastly, it uses methods of analysis that involve an understanding of complexity, detail and context. Within the qualitative research approach, the research strategy is a contextual one where the focus of an individual case or a small amount of cases is on the specific context of the meanings that emerge. In this approach referred to as the ‘insider perspective’, the general meaning of the data is more salient than the specific meaning of its parts (Mouton, 1996).

Qualitative methods are specifically geared toward discovery, exploration and inductive logic (Patton, 1990). An inductive approach involves the researcher making sense of the data without imposing pre – existing expectations on the data. Inductive analysis starts with specific observations and then builds toward general patterns. However, the initial focus is on the full understanding of individual cases before those unique cases are combined or aggregated.

Employing semi – structured interviews with more open – ended questions allows for an inductive approach since if questions are closed – ended, items are then predetermined based on some theory and this results in a more deductive process. Using semi – structured interviews as the mode of data collection also allows for a flexibility of enquiry where the questions followed do not have to be in a rigid order and more questions can be included as the need arises according to what emerges in the interview. This method suits a study of the experience of trauma from the approach of Buber’s philosophy, which demands a flexible and unique approach.

5.2 Ethical considerations



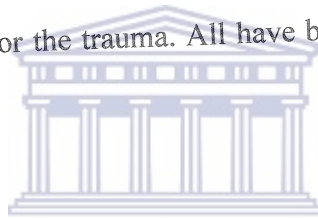
All participants were informed of the content, scope and nature of the study and signed forms of informed consent that assured confidentiality, anonymity and permission to leave the study at any time should the participant desire. Participants were also given an approximate idea of how long they could expect the interview to last. All participants agreed for the interviews to be recorded and were interviewed at their homes except one who preferred to be interviewed at work.

Each participant was offered the provision of some feedback of the results of the study upon its completion and each participant accepted this offer. At no stage were any of the participant’s files read. No additional information about the participants was given by the participant’s therapist to the researcher, apart from that which was directly divulged in the interviews.

5.3 Data Collection

5.3.1 Selection of participants

The participants in this study were selected from the private practice of a psychiatrist. The psychiatrist had agreed over the period of one month to informally ask all of his patients who had experienced a trauma whether they would be prepared to participate in the study. From this process, five people agreed to participate in the present study. They had all been exposed to a severe trauma and were in the process of receiving a psychotherapeutic intervention for the trauma. All have been in therapy for less than six months.



The sample included two participants who had experienced traumas of an impersonal nature and three participants who had suffered personal or relational traumas such as rape and incest. One of the participants had experienced both rape and incest. The sample attempted to be as representative as possible, with representations of different races, languages and cultures. However, all the participants in the study were female. The participants ranged from age 33 to 46.

A possible reason for the sample's homogenous gender could be due to gender differences in attitudes towards seeking help and psychotherapy. A substantial body of research has confirmed the presence of gender differences in attitudes toward

psychotherapy (Leong & Zachar, 1999). In fact, Johnson (1988) found that women reported a higher tolerance of the social stigma associated with obtaining psychotherapy than men did. Women were also more receptive than men in acknowledging a need for help and to sharing their concerns with others.

Butcher et al. (1998) extended Johnson's results with their finding that women were more likely than men to have sought counseling, to have contemplated talking with a psychologist or a psychiatrist, and to have recommended therapy to family and friends. Not only do women express more favorable opinions toward psychotherapy than men do, but they seek it in greater numbers (Wills & DePaulo, 1991). A possible factor in these gender differences is that men are typically socialized to solve their own problems without seeking guidance or revealing vulnerable emotions (Mahalik, 1999). Furthermore, adherence to the traditional male role characterized by strength and emotional neutrality appears to be antithetical to the role expectations held by patients in a therapeutic setting (Levant, 1990).

5.3.2 The interviewing process

The participants were all interviewed using semi – structured interviews that were recorded. Although the research interest was primarily geared towards the relational impact and aspects of the trauma and its psychotherapeutic intervention, questions were more open – ended in the beginning stage of the interview. The interview started with rapport building between researcher and participant, since this is the suggested practice

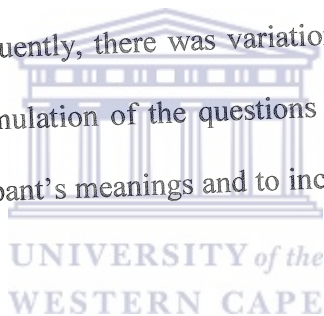
when commencing a qualitative interview (Mouton, 1996). To this end, some brief open – ended questions were asked around the trauma in order to give the participant the freedom to say as much or as little about the trauma as they wished and to help establish rapport.

Thereafter, the questions focused more on a phenomenological examination of the relational impact of the trauma for the participant and the experience of the psychotherapeutic process. The bulk of the remaining questions involved a further unpacking of these experiences to elicit a richer description and understanding of which elements of the therapeutic process and relationship the participant found helpful in dealing with the trauma. Thus the interviewer was guiding the process to a certain extent with a somewhat structured approach, whereby after the beginning of the interview, more specific questions formulated with the intention of eliciting certain material specific to the aim of the study were introduced.

However, questions such as these with a more particular thrust and research agenda were introduced gradually. An attempt was made to carefully weave them into the other more open – ended and less guided questions almost as a carpet weaver would carefully weave a strand between other strands of material. This technique is germane to the methodology of semi – structured interviews. Pope and Mays (2000) refer to a non – rigid format that initially employs open – ended questions for the purposes of exploration. Thereafter, the interviewer diverges from more open – ended questioning by introducing more specific questions so that an idea or response may be pursued or further amplified.

In addition to the steps of the above – mentioned template, further and even more guided questions can then be introduced and this was done in the present study. Furthermore, in keeping with one of the chief aims of a qualitative interview, the interviewer attempted to be both sensitive to and interactive with the language and concepts that emerged in the interview (Pope and Mays, 2000).

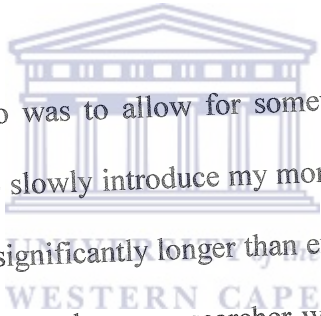
The interview took place within the context of a flexible agenda that had several aims. These included exploring material beneath the surface of the topic being addressed, clarifying what is said in as much detail as possible, and constantly establishing whether the interviewer has understood the meaning of the participant's statements rather than relying on assumptions. Consequently, there was variation in the order of the interview questions as well as in the formulation of the questions themselves since there was an attempt to examine each participant's meanings and to incorporate specific language used by each participant.



5.3.3. Self – reflexivity in the interviewing process

Due to the nature of the qualitative interview being semi – structured and rather flexible in nature as has been explained above, it is common in qualitative interviews to find the interview proceeding in a manner which was unexpected (Pope and Mays, 2000). This necessitates the interviewer to have some degree of self – reflexivity in the interview to assist in deciding how to respond to and deal with unexpected reactions or irrelevant material that may emerge.

During the interviews conducted for this study, it was found that interviews frequently took much longer than was expected. Due to the nature of the study investigating people's experience of trauma, it seemed that many participants felt a need to retell their trauma and experiences in quite a lot of detail. Although I had certain intentions as a researcher; namely to proceed from a more open – ended exploration of the trauma to more specific areas of relational disruption and therapeutic restoration, I often had to first contend with a long and involved account of the trauma from the participant. This often involved mentioning details and information that bore no significance to what was being investigated.



My intention in such a scenario was to allow for somewhat of a cathartic experience while at the same time, trying to slowly introduce my more focused questions. This often resulted in the interview taking significantly longer than expected. During the interview, I thus often needed to balance my needs as a researcher with the needs of the participant, sometimes even providing a little bit of containment in the midst of a tremendously traumatic recollection.

Self – reflexivity includes sensitivity not only to ways in which the research process may have shaped the data collected but also to ways in which the researcher may have impacted on the research process and outcome. Such factors include personal characteristics such as gender, class or professional status. I think that my gender could have had quite an important effect; to what extent this impacted on the outcome of the

data is difficult to say. In all of the interviews, I was a male who was interviewing a woman, often who had been assaulted and traumatised by a male. This made me wonder what impact this could have had in the interview and at times during an interview, although there was never any animosity directed to me personally or as an interviewer, I did feel uneasy and uncomfortable. This may be due to the sometimes very personal or intimate details and information participants chose to divulge to me that I had not specifically desired or intended to hear, but due to the nature of the traumas tended to surface in some cases.

5.4 Data analysis

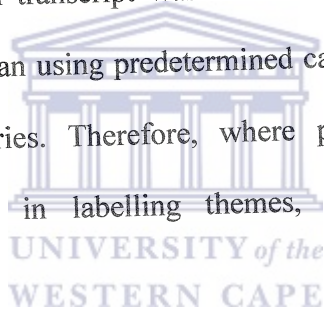
Kelly and Terre Blanche (1999) explain the process of data analysis as a reading through of the data a number of times and then extracting themes and categorising to break the data down. Thereafter the data is built up again in new ways comprising elaboration and interpretation.

The type of data analysis used in this study was an inductive one, where hypotheses are not generated initially with which to approach the data. Rather the researcher becomes familiar with the material by reading through it many times, making notes and diagrams and any such technique in order to induce themes from the material itself. The method of data analysis that was used is an interpretive analytic method which incorporates both quasi – statistical and crystallisation / immersion styles. This particular method is outlined in Kelly and Terre Blanche (1999) and comprised the following five stages:

1. Familiarisation and immersion. The audio recordings of the five interviews were transcribed verbatim and in doing so, the researcher started to become more familiar with the material. The transcripts were then read through many times over while making notes and other techniques to enable even more familiarity with the material.

2. Inducing themes. The material is examined with the purpose of eliciting the organising principles that underpin the material. This is an inductive, bottom – up approach in which each transcript was read individually in order to elicit and isolate themes, rather than using predetermined categories and looking where the data fits these categories. Therefore, where possible, the language of the participants was used in labelling themes, rather than using theoretical terminology.

3. Coding. The data was then broken down into coded, meaningful sections that were then clustered together under code headings that were further analysed as a cluster and in comparison with other clusters. The data was coded using highlighter pens. The theme induction and coding stages often blend into each other, because the themes often change during coding as a better understanding is developed of them and how they relate to other themes.



4. Elaboration. The previous stages of inducing themes and coding break up the characteristic linear sequence of material so that remarks or events that may be distant or separate are brought closer together, generating a fresh perspective on the data. Themes from each participant were also compared and contrasted with each other in order to identify over – arching themes and to derive a summary description of the impact of trauma on relatedness and helpful therapeutic factors.
5. Interpretation and checking. A written account is made of the material studies using thematic categories as sub – headings. This interpretation is then reread in order to look for discrepancies, contradiction, possible weak points, over – interpretation and prejudices.



CHAPTER 6

RESULTS

The five participants will be referred to as A, B, C, D, and E for the purposes of confidentiality and simplicity. Since the aim of the research was twofold (refer to aim of the study), the themes that emerged were grouped into two: trauma themes and therapy themes. This categorisation will extend into the discussion chapter where the results will be discussed under the same two headings. In addition, within these categories, distinction will be made between impersonal/non – relational and personal/ relational traumas. Verbatim extracts from the transcripts are presented after each theme in brackets to illustrate the theme using the participant's own words and to substantiate the particular choice of theme. After the presentation of themes in each section, overarching themes that were isolated are listed.



6.1 Trauma themes

Participant A (Impersonal trauma)

The participant experienced the trauma as **life threatening** [‘...the blood started coming out of my ears and my nose, so I had a fractured skull in seven places, I had bleeding on the brain. I was in a coma for like five days in ICU, it was like hectic, and then the doctor said to my mom that I’m not going to make it.’].

The participant also expressed concerns about **medical complications** resulting from the trauma [‘He (the doctor) said that there is a slight chance of her being a vegetable...I think my worst fears are epilepsy, the doctors said I might get epileptic fits ... and I used to get these blackouts ... and then it started happening twice a week ... three times a week’].

Finally, there emerged a theme of **embarrassment** and an inability to tell the truth behind the traumatic incident [‘I’ll never tell anyone ... even in the hospital... I don’t tell people’].

Participant B (Impersonal trauma)

Participant B also experienced trauma as **life threatening** [‘... I would have died ...my heart stopped twice and my lungs fell flat, very critical...and then in the hospital on a few occasions ... I nearly died’].

There was also concern around **medical complications** of the trauma [‘...third degree burns, it goes into my muscles and locks and my arms are tight... this arm isn’t doing very well... he said this arm is not going to be normal’].

The impact of the trauma on the participant’s **physical image and people’s reaction** to this was identified as a theme [‘...someone phoned me and asked me if I knew what I looked like, my face was black and my hair, I had long hair and it got burnt and my skin

was just in pieces... my face was three times the size of its size, my lip was out there... my daughter... could only recognize me by my feet and legs.'].]

The participant found that her **relationships improved after the trauma** with both family and friends ['No, not at all, it brought people closer to me...people's attitude they really reached out to me... it has not made any negative impact on my relationships, its made it better...'].]

Participant C (Personal trauma)

A religious theme emerged of the participant experiencing a **loss of purity** as a result of the rape trauma ['I always believed in purity. I wanted to be pure all the time, I wanted to keep my virginity... I started going to church but nothing was helping...I got saved'].]

The participant experienced **other people's and family member's disbelief of the rape** ['...other people don't have to believe you when you tell them you are raped. ...my parents didn't want to believe that I had been raped. They believed that I was ready to have sex but I wasn't ready...'].]

A theme of **isolation and lack of support** emerged ['...I wasn't getting any family support, I wasn't getting support from anyone. I resorted to tablets, they were the only thing I could rely on...you cannot get love from the outside you have to love yourself...and I don't have friends, I'm a loner.'].]

The participant experienced a **betrayal and loss of trust of others and the world** [‘...even if I can give my heart out to a person...they out to backstab me...I’m just there to be a sucker, that I can help them with whatever, you know, many of them after that they move on with their lives, they forget...I’ve never found a good person...people out there are gold diggers or back stabbers, there is nobody who is honest in this world.’].

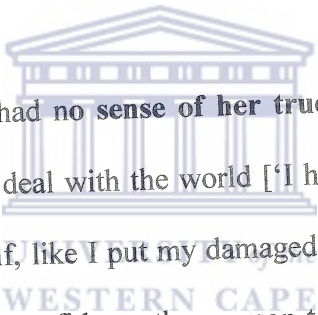
A theme of **revenge** and **anger** emerged [‘...in some cases I would want to revenge...I would go out there just to make them...you know just to revenge...there was anger...’].

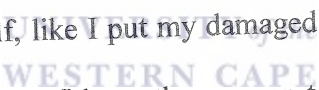
Participant D (Personal Trauma)


The participant experienced a **removal of power** as a result of the trauma [‘... a real power thing... in this whole process I had had my power taken away from me...’].

The participant experienced **anger** and took **revenge to regain power** by disrupting as many relationships as she could [‘...I became a very angry individual ...it would be a power trip...I would just string them along and then cut them off. It was a whole power trip. Now it was my turn, it was almost like a revenge trip that I went on. Anyone, any male was fair game... I would make it a mission to split that couple up. I did a good boyfriend, girlfriend, engaged couples, married men, I mean I went on a complete rampage.’].

The participant also experienced a **family member's disbelief of the rape** ['The biggest problem I think was with my grandmother... the worst thing was that my grandmother didn't believe what my mother had told her'.].

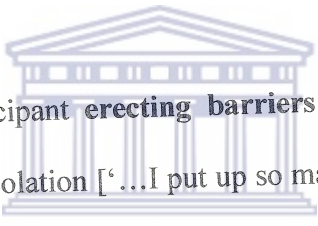
The participant **isolated herself** as protective mechanism and **avoided relationships** by throwing herself into her work completely ['...I pushed people away that's what I did... if you stay away from people they can't hurt you anymore...I was isolating myself, I used enormous walls. I think it got to the point where I didn't even know who I was anymore. I had no reference of myself...spending most of my life at work and throwing myself into my work...awful as far as relationships go.'].


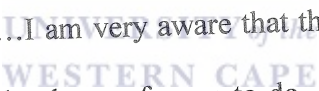
The participant found that she had **no sense of her true self** and that furthermore she **created a false self** in order to deal with the world ['I had no reference of myself...It's almost like I created another self, like I put my damaged self on the shelf to sit and heal and I created this other super – confident other person to deal with the world and to be cruel and nasty to the rest of the world.'].



The participant found as a result of the trauma that she experienced an **absence of any real feeling**, and that she would almost mechanically engineer the relationships that she had ['I was so disconnected from myself and from reality almost...no feeling. I was engineering it. I had engineered and that's what I did with all my relationships.'].


Participant E (Personal trauma)

The impact of the trauma on participant E's life was almost completely in terms of **interpersonal isolation and stigma** associated with the trauma:

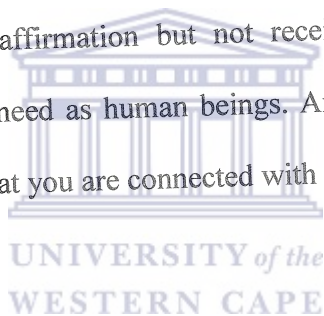
The participant found that people would **avoid talking** about the trauma and that others also experienced it **difficult to deal with** the fact that she had been traumatised in a social context ['...very much isolation and stigma...don't want to deal with it...too heavy and they gone...that interpersonal isolation...maybe they felt they needed to respond in a specific way which they then didn't know how.'].


A theme emerged of the participant **erecting barriers** in social settings that further compounded the interpersonal isolation ['...I put up so many barriers and defences...they back off...very distinct barriers...I am very aware that the barriers are there and attempt to break them down but that is hard even for me to do, so for somebody else to try and access me on an intimate level or in a relationship must have been very hard.'].

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The participant felt that she held **strong opinions** and was quite **vociferous** around the topic of trauma and that in a social context this isolated her even further ['...I'm desperate to get people to understand that these are important issues. I think that what concerns me is that there is no outrage. I don't know what has to happen...I think this also puts up a barrier between me and people on a social level because they can't understand the outrage I have whether or not I want to make them aware of my experience.'].


A theme of a **preoccupation with safety issues** was a further relationship and interpersonal barrier [‘...I was strongly aware of how here you are always on guard and looking out at anything that can happen at any moment...and sometimes with people in relationships this has also impacted...people don’t understand why I’m almost obsessed with my own and other people’s safety. They say yes, you have been through a trauma, but you can’t impose your levels of safety on other people.’].

Participant E also experienced a **lack of acceptance and affirmation** from others in social settings and a lack of a sense of interconnectedness with other human beings [‘...I would perhaps seek out that affirmation but not receive it at all...a sense of that interconnectedness that we all need as human beings. And very often in social settings you don’t receive that feeling that you are connected with other human beings...’].



Overarching themes

IMPERSONAL TRAUMAS (participants A and B)

- Participant’s life in danger
- Participant’s concern around medical complications

PERSONAL TRAUMAS (participants C, D and E)

Very strong overall themes (appearing in three or more participants)

- Interpersonal isolation

Other less prominent overarching themes

- Family member disbelief of rape
- Revenge and anger

6.2 Therapy themes



Participant A (Impersonal trauma)

The participant experienced the **therapist as a friend** and felt this to be helpful [‘...I don’t see him as a therapist; I see him as a friend that I can talk to...’]. Similarly, the participant felt that the therapist did **not push** her in any way and was **non – prescriptive** in this aspect [‘...he is not pushy, when I went there he didn’t say this is what happens or this is where we start...’]. The participant also experienced the **therapeutic atmosphere and environment as relaxed** [‘He is so relaxed...what else was nice, the atmosphere...environment was nice...made you feel so at ease...’].

Participant B (Impersonal trauma)

The participant experienced the **therapist as caring and interested** and **approached her as a person**, not as a trauma case[‘...is interested on whatever comes my way...Dr. M is very concerned about me, he cares about me, who I am, a lot more than maybe the trauma...’]. The participant experienced **being listened to** as very helpful [‘All the time I feel he is helping me because he is listening to me...’].

Participant C (Personal trauma)

The participant found **medication and religion more helpful** for her than therapy [‘I think the tablets are helping me...I pray a lot. That’s where I get my strength from. I hate to go to therapy...’]. The participant also felt that it is preferable to **help yourself** and felt **discontented with therapy** [‘I hate to go to therapy, you can’t help someone unless they want to help themselves. I have to help myself...’]. The participant exhibited a strong striving and ideal **to be in control and have strength** [‘...to be more in control, over everything around me...I have changed, I can handle situations...help me to be bold...should be there to tell you to be strong’].

The participant did however feel that the therapist being **non – judgemental** was helpful [‘...helping me...finding someone who can listen to you without judging you.’].

However the participant **did not appreciate empathy** and desired rather to be understood [‘...we don’t want people to sympathise with us, we don’t want sympathy, we want you to understand what we are going through.’].

The participant felt that the **traumatic impact cannot be removed** from a person and is always part of a traumatised person [‘It’s something that you take to the grave. It’s something that you going to live with, it follows you, you can’t get rid of it.’].

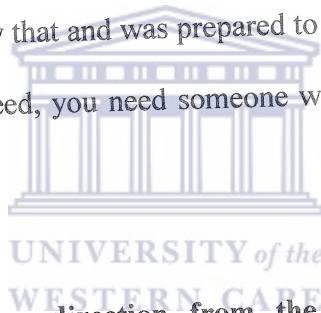
Participant D (Personal trauma)

The participant found it helpful that the therapist had a **holistic attitude and approached her as a whole person** [‘...the nice thing about him is that he looks at you holistically...it’s like you a whole person.’]. The participant also experienced the **therapist’s openness and honesty** as helpful [‘...when I ask a question I need a straight answer and I don’t want something hidden from me...and he doesn’t, if I ask a question, I get a straight answer and I appreciate that.’].

The participant experienced a shift in therapy which resulting in a **regain of self and capacity to relate and feel emotions** [‘...it wouldn’t affect me at all emotionally...wouldn’t resonate with me...but it’s almost like something has shifted, you know when you have a row of mirrors ...they all just suddenly shift into place...I’m in my body again...it’s almost like I’m present in my own body again.’].

The participant found the therapist to be **centred and calm** ['...he is very centred as well...his is very calm and it's almost like he is very calm and focused and nothing can rattle him.']. The therapist was also experienced as **flexible**, providing what was needed at the right time ['...completely flexible...encouragement when I needed encouragement...he knew when I needed a bit of validation...knowing when to respond and when to interrupt and when to ask questions...also he brings in all sorts of interesting things...'].

The participant felt that the therapist put in as much work as the participant and that it was a **mutual and reciprocal relationship** ['So for me it was an enormous effort to do all that stuff and I think he knew that and was prepared to put in as much work as I was to get it done...that's what you need, you need someone who will put in as much work as you are.'].



The participant preferred some **direction from the therapist** rather than merely receiving empathy ['...sometimes you need direction in a thing like this...I didn't want a 'shame' - I wanted a yes and then what, I needed a bit of help and guidance...'].

The participant also felt that one **never recovers fully from trauma** but integrates it into one's life and build around it ['I don't know if one ever fully recovers from these types of trauma, I think one integrates these traumas into your life and one builds around these traumas.'].

Participant E (Personal trauma)

The participant experienced having **less barriers or enforced boundaries in therapy** as helpful in dealing with the very painful experience of trauma [...the very strict boundaries that a lot of therapists enforce, I understand it at an intellectual level but on an emotional level, that makes it very hard because you talking about extremely painful experiences...'].]

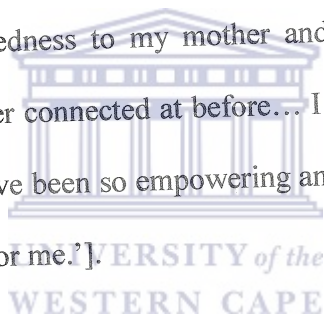
The **genuineness and care of the therapist** provided a safe space [...someone is prepared to try and help you...you sense that. It is genuine...very compassionate...made a profound impact on me...I felt safer, somehow I felt able to just be in that safe space and feel safe and feel that this person really cared.'].]

The **flexibility** of the therapist was found to be very helpful as opposed to previous experience where therapists were rigid [...she went out of her way to accommodate me...the therapist this year...flexible and accessible...more available...I found that people go at the problem in a very traditional way...a very traditional almost prototypical approach, like have to do number one, than number two, then number three, but as we know this doesn't work well with human beings.'].]

The participant found that **being dealt with as a human being** and not as a problem was very liberating, as was finding out that her responses were in fact normal human responses to a traumatic experience ['Sometimes I think you feel not entirely human in

that therapeutic relationship...it's the problems that are being dealt with but it's not the person that's being healed always...was so liberating to be able to hear that this is within the parameters of being normal and having human responses.']. Related to this, the participant also experienced the **transparency of the therapist** as very helpful where the therapist shared something as a fellow human being ['...she would say things like "my daughter and I were in an attempted hijacking". And you would go wow...because sometimes those boundaries are so reinforced and you think maybe we should make a hole in the wall and you go and talk to a hole in the wall.'].]

The **quality of the therapeutic relationship** enabled a deeper capacity to relate to others ['...a sense of connectedness to my mother and to my friends...we definitely connected at a level we've never connected at before... I think that's very much because my therapeutic relationships have been so empowering and loving...feeling that you have worth...a very important shift for me.'].]



The participant felt that because she was able to **reconnect with her self**, she could develop a **true sense of self**. She felt that this would **facilitate relating to others** ['...I was able to access me as well, I could connect to me...I think if I make it more of a focus then it will have more of an impact on how I relate to other people.'].]

The participant also expressed **doubt whether any woman can truly move beyond the trauma** ['It has become such a multi-factorial issue in your life that I don't know if there is any woman that feels she can truly move beyond it.'].]

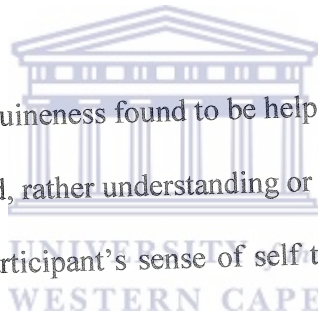
Overarching therapy themes

Very strong overall themes (appearing in three or more participants)

- Flexibility and non – prescriptive attitude of therapist experienced as beneficial
- Inability for participant to ever move completely beyond the trauma
- Being approached as a whole person / holistic approach

Other less prominent overarching themes

- Therapist's care and genuineness found to be helpful
- Empathy not appreciated, rather understanding or direction from therapist
- A reconnection with participant's sense of self that facilitated more optimal and genuine relating to others once again



CHAPTER 7

DISCUSSION

7.1 Trauma themes

Impersonal traumas (participants A and B)

Regarding the two participants who had not experienced personal or relational traumas but rather traumas of an impersonal nature such as paraffin burns, no themes of any relational disruption as a result of the trauma emerged. In fact with participant B, a theme emerged that on the contrary, both her family and friendly relationships had actually improved with people extending themselves and going out of their way to help.

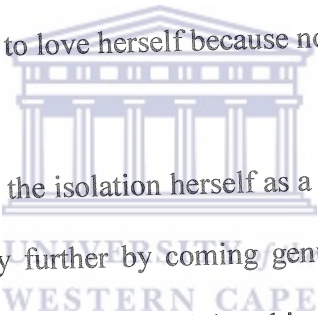
The two overarching themes that emerged from the impact of trauma were those of the participant's life being threatened and concern about medical complications related to the trauma. This could be expected with severe traumas that left both participants in serious medical conditions requiring hospitalisation. The fact that specifically in the impersonal traumas, relational disruption did not occur, whereas with all three relational traumas this very much did occur is in and of itself a very strong general theme.

Participant A experienced embarrassment relating to the circumstances around the traumatic event and felt unable to share this with people. This was the only interpersonal impact of the trauma that emerged in the participants who experienced impersonal traumas. Yet this aspect still did not cause any relational disruption. Despite participant B experiencing some difficulty with regards to people's reaction to her physical appearance, she did not find this to hampering her interpersonal relating in any way.

Personal / relational traumas (participants C, D and E)

In all three of the participants who had experienced a trauma that was personal or relational in nature, strong themes of relational disruption emerged; some of which can be understood within the context of Buber's theory.

A strong general and overarching theme regarding the impact of trauma that emerged in all three participants was interpersonal isolation. This manifested in different ways however. Participant C experienced isolation and a lack of support together with a distinct feeling of betrayal by almost everyone except one friend of hers. She was the only one to feel betrayed to such extent that the whole world seemed evil and uncaring to her and she asserted that she has to love herself because no one else will.



Participant D almost brought on the isolation herself as a type of protective mechanism in order to prevent being hurt any further by coming/genuinely close to people. She did come close to many people on an external level, but this was a revenge initiative whereby she would seduce men and then attempt to destroy as many relationships as she could, regardless of what type they were. A further pattern she developed very strongly which increased her interpersonal isolation, was that she threw herself into her impersonal work sphere. She found this had the advantage of preventing any close interpersonal contact.

It is noteworthy to examine how participant D expressed the interpersonal isolation that she brought upon herself: 'I was isolating myself; I used enormous walls. I think it got to the point where I didn't even know who I was anymore. I had no reference of myself.'

This suggests that because she was isolated from other people, she was not able to have a strong sense or reference of herself at all. In Buber terms, this could be understood in terms of a lack of confirmation from others (see literature review). Buber explained how confirmation from another allows us to be able to know our own uniqueness in relation to others. In other words, it is through the confirmation we receive from others that we do in fact have a reference point for ourselves.

Participant E experienced such pervasive interpersonal isolation that all the trauma themes that emerged were sub – themes of this general theme. This participant found people’s reactions to her in a social setting particularly difficult and negative. She admitted that she has strong opinions about certain aspects pertaining to the trauma that she is often very vocal about. This phenomenon, in addition to a preoccupation with safety, was often exhibited in social circles and together with the purposeful erecting of social barriers, contributed to a lack of acceptance and affirmation from others. She described this as failing to experience a sense of interconnectedness with others. This theme can be understood employing a Buber understanding: interpersonal barriers and difficulties in a social context would prevent dialogue in an I – Thou mode from occurring, and more particularly, would result in a lack of inclusion and confirmation by others which was the experience of this participant.

Other prominent overarching themes, although not as strong, included a family member’s disbelief of the rape when the participant reported it to them, and the revenge and anger of the participant. A family member not believing the rape would obviously impact on

the relationship between participant and family member. Already within a context of interpersonal isolation, this disruption in the relationship with a close family member makes the sufferer's isolation that much worse.

Participant C and D both experienced anger and a desire for revenge. Participant D actually acted out on her wish for revenge in a pronounced manner. She experienced her gang – rape as a strong experience of having her power taken away from her (another theme of participant D) and went through a promiscuous revenge seeking stage where she would lure men into becoming involved with her and then cut them off. In this manner she would also go out of her way to disrupt as many relationships as she could, breaking them up through seducing the male of the relationship. The victims ranged from dating couples to engaged and married couples. Although on the outside, she would lure men into what seemed a relationship from their point of view, she felt she was actually not able to have a meaningful relationship with anyone, be it male, female or even her parents.

The remaining trauma themes – themes that emerged in no more than one of the participants, included both themes that correlated with Buber's theory as well as other non – related themes. Participant C experienced a strong disruption of relational trust that she described as a pervasive feeling of betrayal, where she found that if she gives her heart or trusts people, they almost inevitably backstab her. She asserted that in her experience this applies to both males and females and that she has never found a good person. She also found that many people would only enter a relationship with her in order

to use her. This very much resonates with Buber's construct of an I – It relationship which lacks genuineness and openness, and in its extreme, is only utilitarian in nature.

Participant C also demonstrated quite a strong religious theme that manifested in terms of a negative effect that trauma had on her state of purity. The participant came from a Roman Catholic background and held the importance of purity and innocence in very high esteem. The rape was experienced as a removal of her purity, and it seemed that the participant turned to her faith in the face of this trauma much more than psychotherapy, and found more and strength and solace in her belief rather than in anything else (see following section on discussion of therapy themes).

Participant D experienced two further related themes. Firstly she felt that she had no sense of her true self and had created a false self in order to function and deal with the world. It reached the level where the participant stated: 'I didn't even know who I was anymore. I had no reference of myself.' This impact of trauma on a person that causes a shattering or dissolving of the self was discussed earlier in the section dealing with understanding trauma.

A second theme that emerged which relates to the above – mentioned loss of her authentic self, was experiencing a lack of feeling when it came to her relationships – even those of her children. The relationships that she did have, she coldly engineered in an almost mechanical fashion. Thus, it appears that since the participant had no sense of herself or no 'I' with which to enter a relationship with another 'Thou', the possibility of a genuine relationship would be almost impossible. This situation had changed once she

began her therapeutic process and slowly regained a sense of her self with which to engage in a relationship.

7.2 Therapy themes

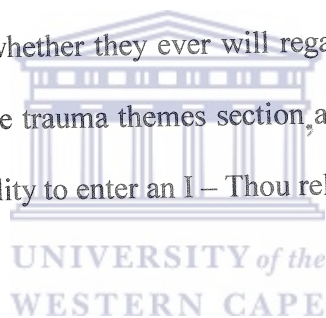
Unlike the trauma themes section, in the therapy themes section, themes relevant to Buber's theory did emerge even in the participants who had experienced an impersonal trauma. Since there was not as much of a distinction between the impersonal and personal traumas in this section, all the participants will be discussed under the same heading.

Three very strong overarching themes emerged with regards to the therapeutic aspects in the intervention of trauma. Firstly, flexibility and a non – prescriptive attitude of the therapist were found to be beneficial. Secondly, a strong pervasive theme was the feeling that the one is never able to move completely beyond the trauma. Thirdly, the experience of the therapist as approaching the participant as a whole person and holistically was found to be very beneficial.

Flexibility within the stance and practice of the therapist has been previously spoken about (see literature review) as an extremely important facet of a psychotherapy that follows a Buberian approach. The therapist, in order to allow for genuine dialogue and a more I – Thou mode of relating, cannot approach a patient in a rigorous or prescriptive manner. The I – Thou relationship is one which is genuine and occurs spontaneously; it cannot be forced (Buber, 1958).

Furthermore, a non – prescriptive attitude very much correlates with a component of Buber’s ‘I – Thou’ construct, namely the freedom to be as one intends in another’s presence which occurs as a result of not trying to impose or be prescriptive. As mentioned in the literature review, Buber asked for therapists not to impose anything onto patients, but rather to allow them to ‘unfold’ and realise their true uniqueness.

The fact that the theme of an inability to ever truly move beyond the trauma was such a pervasive and overarching theme cannot be necessarily explained in terms of Buber. It may suggest, however, that the effect that trauma has on the self can be so profound and intense that sufferers wonder whether they ever will regain their initial sense of self and wholeness. As mentioned in the trauma themes section, a dislocation from one’s self and sense of ‘I’ would preclude ability to enter an I – Thou relationship with another ‘Thou’.



The strong theme of the benefit of the therapist approaching the participant as a whole person in a holistic manner including treating the participant as a person and not as a problem is fundamental to Buber’s theory. As dealt with at length in the literature, this is one of the most fundamental and pervasive elements of Buber’s theory and how he envisioned a therapist to be. Buber championed a non – judgemental, caring and genuine approach that proceeds from a holistic understanding and perspective striving for higher levels of wholeness (Friedman, 2002). The aspect of dealing with the participant as a normal human being rather than a problem is a direct and pointed reference to the benefit of an I – Thou relationship over an I – It one.

Other somewhat less prominent, but nevertheless overarching themes that emerged were: the therapist's care and genuineness, a reconnection with the participant's sense of self that facilitated more optimal and genuine relating once again, and that empathy was not appreciated from the therapist in participants C and D; rather understanding and direction respectively.

These themes all strongly correlate with Buber's principles. The I – Thou relationship is most definitely predicated on the basis of genuineness and care. If these qualities were lacking, it would be outright impossible to achieve what Buber describes as the components and aspects of an I – Thou relationship and dialogue.

The theme in which participants found that their reconnection to their sense of self facilitated more optimal and genuine relating, once again ties in with the theme mentioned in the trauma themes section, where the impact of trauma posed an inability to relate to another 'Thou' since one's own sense of self or 'I' is so harshly affected. The fact that after some therapy, two of the participants experienced a reconnection to their sense of self indicates that the therapeutic interaction and relationship can restore such disruption.

Finally, regarding the unfavourable attitude towards empathy and sympathy, the participant disliked being shown empathy and rather desired something else that would depend on each unique patient (understanding in participant C and direction in participant D). It was mentioned in the literature review that Buber does not request that therapists

merely have empathy; he demands more: that therapists practise the very difficult inclusion, which involves more than empathy and necessitates an understanding of the patient (Friedman, 1988).

Buber explained that inclusion must lead to confirmation involving a confrontational element in which the therapist joins the patient's struggle to find direction and to incorporate the directionless whirl of their life into their dialogue with life (Kron & Friedman, 1994). Thus practising from a Buberian perspective would automatically have incorporated more of an understanding and guidance or assistance of the patient towards more direction that the patient arrives at with the help of the therapist. Since a Buberian therapist would be especially sensitive to the unique needs of the patient, any such need or request of the patient would be more easily fulfilled from a Buberian perspective.

The remaining therapy themes – themes that appeared in no more than one participant, are also important. Some of them have particular correlation to Buber's concepts.

A theme in participant A was the value of the therapist being very relaxed that the participant could relate to him almost as a friend. Although Buber did not necessarily want therapists to be relaxed, he did envision therapists as being in tune with how the patient is feeling. Thus, if a patient would have wanted or needed their therapist to be relaxed, Buber may very well have endorsed this.

Participant B found that the therapist was very caring and took an interest in her. She also found that having someone listen to her well was very beneficial. Naturally, the qualities described above can all be located within the type of therapeutic stance Buber outlined, although each particular theme is not mentioned directly by Buber. Rather these qualities are all implicitly included in Buber's construct of an I – Thou relationship. Obviously if someone is not interested or does not listen properly to another, they will be unable to enter the I – Thou mode of relating that Buber described.

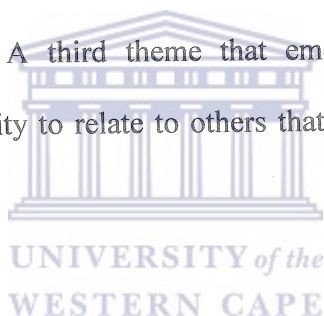
A number of themes emerged in Participant C that indicate dissatisfaction with the therapy process and with the general notion of going to therapy. One theme was that she disliked going to therapy feeling that she needs to help herself instead. A related theme emerged of a striving to be in control and to develop her inner strength. She found medication and religion more helpful than psychotherapy. What she did find useful in the therapeutic relationship, however, was the non – judgemental quality of the therapist.

A possible reason for this deviation in attitude to the therapy could be that this participant was from a different cultural group to all the other participants. Research has demonstrated that different cultures exhibit different attitudes to psychotherapy and counselling (Balabil & Dolan, 1992).

In participant D, other themes that emerged were an openness and honesty of the therapist, the therapist as being centred and calm and the therapist contributing as much as the patient to the relationship in a mutual and reciprocal manner. The first two themes

could be congruent within a Buber paradigm, to a greater or lesser degree, depending on the patient. The last theme of mutuality and reciprocity is critically salient in Buber's concept of therapy as outlined at great length in the literature review section of this study. The I – Thou mode in which dialogue occurs is almost by definition a mutual and reciprocal relationship.

With participant E, in addition to the presence of virtually all the overarching themes, there appeared three further themes. The participant found the existence of fewer barriers in the therapeutic relationship helpful. In a related theme that could almost be extended from the above, the transparency of the therapist sharing something as another human was found to be beneficial. A third theme that emerged was that the participant experienced a deepened capacity to relate to others that was enabled by the therapeutic relationship.

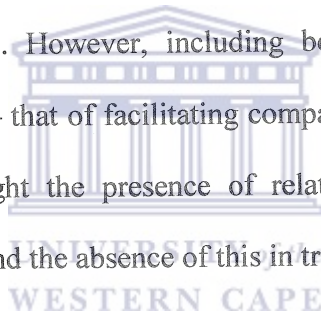


The first two themes clearly emphasize and confirm the importance of the therapeutic relationship being transparent and human, all qualities depicting an I – Thou relationship as Buber explained. The third theme which possibly did not emerge in the other participants due to differences in the duration of the therapy, indicates that the relational disruption that occurs in the experience of interpersonal trauma can be alleviated in the context of a more I – Thou type of therapeutic relationship.

CHAPTER 8

LIMITATIONS OF THE STUDY

All of the participants were female in the present study. Thus, the sample generalizability is restricted and one is unable to generalize outcomes of the study to both genders. Future research should test the generalizability of these findings to gender diverse populations. The sample also contained five subjects and thus was quite limited in size. Furthermore it was not a homogenous sample since some of the traumas were of an impersonal nature whereas the rest were of a personal nature and this would further limit the possibility of generalizing from the sample. However, including both types of trauma did prove advantageous in another way – that of facilitating comparisons between the two types of trauma and helped to highlight the presence of relational disruption specifically in personal or relational trauma and the absence of this in traumas of an impersonal nature.



CHAPTER 9

CONCLUSION AND RECOMMENDATIONS

This study attempted to investigate the impact of trauma on interpersonal relationships and to establish which components of psychotherapy were found useful in the restoration of the interpersonal impact of trauma, all through the lens of Martin Buber's philosophy and theory.

The results of the study confirmed the hypothesis that trauma has a significant impact on the sufferer's relationships and capacity to relate, but only with regards to trauma of personal or relational nature. A suggestion for further research would be to further investigate whether impersonal trauma has an impact on interpersonal relationships using a larger sample that contains more than merely two participants who suffered impersonal trauma as in the present study.

The study has demonstrated that Buber's theory could be incorporated into a more comprehensive model of trauma that explains the interpersonal and relational impact of trauma on the sufferer's life. Such a model would also go a long way to highlight the importance of the interpersonal impact of trauma in the treatment process and help procure the necessary qualities in the therapist for effective psychological intervention.

The study further demonstrated that understanding the impact of relational trauma from the perspective of Martin Buber's philosophy is particularly useful and appropriate. Furthermore, the therapeutic elements identified as useful by the participants in restoring the debilitating interpersonal impact of trauma, correlated very strongly with the principles that Buber outlined for a therapist and for the therapeutic relationship. It is hoped that this will bear some significance and utility for a further and broader understanding of the experience and phenomenon of trauma that can contribute in some small way to the general area of mental health.



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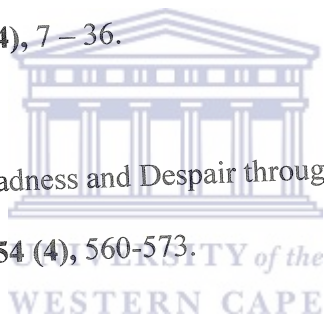
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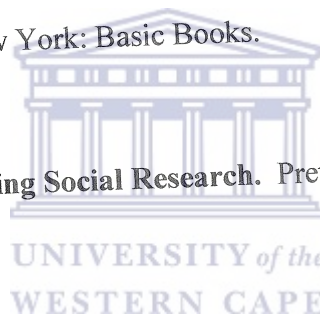
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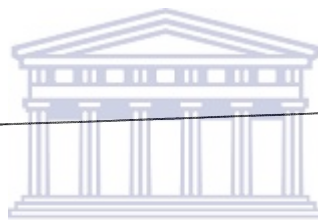
APPENDIX A

Consent Form

I, _____

Hereby declare that I was not coerced into participating in this study. Ethical issues were discussed with me regarding confidentiality and anonymity. I was informed of the nature of the study and its purpose. I am also aware that I am free to decline from participation as well as to withdraw from the research study if I choose.

Participant's signature _____



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Researcher's signature _____

APPENDIX B

INTERVIEW QUESTIONS

- 1) Could you tell me a little about the trauma and how you were affected?
- 2) How did you cope with the effects or deal with them?
- 3) Did you experience a negative effect on your relationships and if so in what way?
- 4) Could you elaborate a little more about what exactly was difficult in your relationships? Did you find that you were the one with a problem communicating, or was it a problem with others not being receptive or able to communicate with you, or was it a combination?
- 5) How did your relationships change after the trauma, how were they different before?
- 6) How did you experience the counselling or therapy you received? Was it helpful?
- 7) How much counselling / therapy did you receive?
- 8) What component of therapy was helpful for you?
- 9) Can you identify a critical moment in the therapy in which you really felt helped?
- 10) What about the therapist was helpful or useful for you?
- 11) Did you feel that your therapist was able to enter your world of experience in any significant way? If so, how?
- 12) Did the therapy affect your experience of relatedness and relationships? If so, how?
- 13) At what stage did you feel you had recovered from the trauma and its impact on your relationships? What happened to make you feel this way?