PAST TRAUMA, ANXIOUS FUTURE:
A CASE-BASED EVALUATION OF THE EHLERS AND CLARK MODEL FOR PTSD APPLIED IN AFRICA

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ABSTRACT

This research report documents the therapeutic intervention undertaken with a 23-year-old Swazi rape victim. The format of this research report takes the form of a case study that follows the principles proposed by Fishman (2005). Its aim is to document the treatment process of an individual of African decent in order to establish whether the treatment model can be effective in clinical settings and in contexts and cultural settings different from that in which it was developed. The Ehlers and Clark (2000) cognitive therapy model for post-traumatic stress disorder (PTSD) was utilised to assess, conceptualise, and treat the case. The client entered therapy three years after being raped for a third time. The case formulation identified factors maintaining the disorder as well as how other traumatic and abusive events earlier in her life influenced her response to the rapes. Data consisted off audio-tape recordings and detailed written synopses of each assessment and therapy session, psychometric measurement instruments and self-report scales completed throughout the intervention, material written by the client, and a research interview conducted by an independent party. She was treated for PTSD and comorbid depression over a period of five months in accordance with the principles described by Ehlers and Clark and a narrative of the treatment process was written. The case narrative in conjunction with quantitative data suggested that this model assisted the client in initiating a healing process. As such the model was found to be both effective and transportable to an African context. Various points of discussion are highlighted, including the challenges of working with PTSD and comorbid major depression, the client-therapist relationship, and that a client and therapist from different cultures, backgrounds, and with different home languages can work together effectively using the Ehlers and Clark model.

PAST TRAUMA, ANXIOUS FUTURE:
THE EHLERS AND CLARK MODEL FOR PTSD APPLIED IN AFRICA

The structure of this research report deviates from the standard structure of journal articles. It closely follows a modified format better suited to clinical case studies as recommended by Fishman (2005), founding editor of the online journal *Pragmatic Case Studies in Psychotherapy*.

1. CASE CONTEXT

1.1 RESEARCH QUESTIONS

The research questions and aims provide a preliminary introduction to the case context. This research study ultimately aims to contribute to the investigation of the transportability of Ehlers and Clark's (2000) cognitive therapy model for the assessment and treatment of post-traumatic stress disorder (PTSD). It specifically aims to document the treatment of a person suffering from PTSD and who originates from a background and culture different from that in which the model was developed. This will enable the researcher to comment on the model's transportability from a research to clinical context, as well as from a first world to third world context. Additionally, contextual and cultural factors influencing the implementation of the model can be identified and their effect on treatment explored. The specific research questions are:

1. Is the Ehlers and Clark (2000) cognitive therapy model for the assessment and treatment of PTSD effective in treating a Black African individual meeting the criteria for PTSD (American Psychiatric Association, 2000; World Health Organization, 1992)?
2. Which cultural and contextual factors influenced the effectiveness of the model? How did these factors function to have such an influence? And in what way can the model be adapted to incorporate these factors?

1.2 MOTIVATION FOR SELECTING THIS PARTICULAR CASE

Research indicates that PTSD constitutes a significant public health problem in South Africa and most likely also in the rest of Africa. This is due to the prevalence of high rates of traumatising events typically associated with PTSD in these areas. Such events include road traffic accidents, natural and occupational disasters, and criminal and domestic violence (Edwards, 2005c).

During the past decade there have been substantial advances in the treatment of PTSD through various therapeutic approaches (Foa, Keane, & Friedman, 2000). In particular, research has shown that Cognitive Therapy is an effective treatment for PTSD (Clark & Ehlers, 2005) and Ehlers and Clark describe various successful studies that employed their cognitive treatment model. Despite such pioneering research being done overseas, the question remains whether this model is transportable from a research setting to a general clinical setting, and from the cultural setting in which it was developed to the African context (Edwards, 2005a). This case study, the fourth in what is expected to be a series of at least 20, provides a means for examining these two areas of transportability.

Bongi, a 23-year-old Black Swazi female grew up in Swaziland and moved to Grahamstown during February 2007. She has been raped three times, aged nine, 18, and 20 and suffered from chronic PTSD and major depressive disorder. She grew up in a rural area and was uninformed about depression and had never heard of PTSD. Due to strong avoidance tendencies Bongi found it difficult to engage with some of the therapeutic interventions. Nonetheless, over a period of five months, a healing process was initiated and was gaining momentum.

This particular case study is interesting from various perspectives. First, it documents the challenges involved in using this treatment with a client with strong avoidant traits. Second, it documents the challenges of working with PTSD when there is a longstanding comorbid major depression. Third it documents aspects of the client-therapist relationship and provides a means of examining its significance for the therapy. This is even more relevant due to the fact that a male therapist was treating a female

rape victim. There is research (Resick & Schnicke, 1996) indicating that a treatment approach involving a male therapist treating a female victim of rape can have additional benefits for treatment, such as the victim realising that not all males are untrustworthy. Fourth, the therapist is a white male whose first language is Afrikaans. He is also fluent in English, the language in which the therapy was conducted. So the study shows that a client and therapist from different cultures, backgrounds, and with different home languages can work together effectively using the model. Finally, the study also provided evidence that the Ehlers and Clark model was effective in treating someone from a culture very different from that in which the model was developed.

1.3 CLINICAL SETTING IN WHICH TREATMENT WAS OFFERED

The therapeutic intervention occurred on an outpatient basis at Fort England Hospital, a governmental psychiatric hospital in Grahamstown in the Eastern Cape. The client was seen through the usual referral channels and was not specifically recruited for the research. During May 2007 Bongi consulted the Student Medical Services at Rhodes University (also located in Grahamstown). She was referred to the outpatient Community Psychiatric Services Clinic at Fort England Hospital where she was diagnosed with depression, prescribed an antidepressant (Fluoxetine), and referred to an intern psychologist for psychotherapy at the same hospital.

2. METHODOLOGICAL APPROACH

2.1 RESEARCH METHODOLOGY

In endeavouring to answer the research questions, this qualitative research study employed a case-based research design. Fishman (2005) argues that understanding any specific psychosocial problem requires the development and assessment of solution focussed interventions. This implies that theory and research must deal with problems as they present in actual situations. This entails that the treatment of individuals must be documented, assessed, and studied as independent research entities which will then enable the evaluation of the specific therapeutic intervention and model informing such

treatment (Fishman, 2005). Furthermore, this method allows interventions to be adapted to suit the individual's needs and circumstances, and it enables evaluation of the strengths and weaknesses of the treatment components of the model utilised (Edwards, 2005a). Case-based research requires the collection of comprehensive quantitative and qualitative information over the period of investigation (Fishman, 2005). Quantitative data is gathered by way of repeated administration of various assessment measures throughout the intervention. The qualitative data collected is focussed on the process of therapy, on events during and in-between sessions, at what stages change occurs, and which interventions the participant experienced as valuable (Edwards, Dattilio, & Bromley, 2004). A case narrative was utilised to document the details of the case. A hermeneutic reading method was applied to focus on issues arising from the research aims as well as issues relating to clinical theory, treatment planning, and those influenced by cultural and contextual factors (Edwards, 1998).

This research project forms part of a larger research project, having as one of its goals the generation of 20 similar case-based studies. A series of case-based studies have the advantage of answering detailed questions about the treatment process (Edwards et al., 2004). Furthermore, this approach will contribute to the basis for establishing an evidence-based practice for treating PTSD in South Africa (Edwards, 2005a).

2.2 CLINICAL METHODOLOGY

This research study employed Ehlers and Clark's (2000) cognitive therapy model for assessing, formulating, and treating PTSD. The model is formulation driven and as such could be applied flexibly in accordance with the needs of the client and the progress made in therapy (Ehlers & Clark, 2000).

Applying the model consisted of an assessment phase, case formulation, and the implementation of the treatment plan as proposed by Ehlers and Clark (2000). An assessment was conducted in order to determine relevant issues to be addressed in the treatment program. The assessment was done in a way to individualise the intervention by identifying the client's prominent appraisals, characteristics of her trauma memory, triggers, and behavioural and cognitive coping strategies (Ehlers & Clark, 2000; Ehlers,

Clark, Hackmann, McManus, & Fennel, 2005). Together with this, the client's specific needs as influenced by childhood experiences, comorbid disorders, past traumas, current stressors, the environment, and her culture were taken into account. Next, a case formulation was drawn up based on this information. This led to a treatment plan being designed for the client, with varying emphases being placed on different treatment procedures in accordance with the client's needs (Ehlers & Clark, 2000; Ehlers et al., 2005).

The intervention was a collaborative approach between therapist and client. The therapist also assumed the role of researcher. The case was supervised, on a weekly basis, by Professor D.J.A. Edwards who has extensive experience with the model.

2.3 SELECTION CRITERIA FOR THE CLIENT PARTICIPANT & CONFIDENTIALITY

The participant was selected based on the following inclusion criteria: She had to (1) meet the full DSM-criteria for PTSD, (2) have an African language as first language, while being able to converse in either English or Afrikaans, and (3) consent to the course of treatment being used in this research study. Exclusion criteria were: (1) the presence of a severe personality disorder, (2) current substance abuse, or (3) psychosis. The clinically relevant inclusion and exclusion criteria were assessed as part of the initial assessment process using DSM-IV-TR (American Psychiatric Association, 2000) criteria and clinical judgment. When it was established that Bongi met all the required DSM and research criteria, she was informed about PTSD, the related research being undertaken, and the nature of treatment offered. She agreed to participate in the treatment and research and signed an informed consent form (reproduced in Appendix A) which stated the following: sessions would be audio-tape recorded and the material written up as a case study; that a pseudonym would be used and all identifying details would be changed in order to ensure her anonymity; that she was free to withdraw from the research study at any time; and the case would only be discussed with the supervisor and other researchers participating in the same research study. Record sheets, session records, test protocols and all other data would be stored in the researcher's office at Fort England Hospital.

2.4 QUALITY CONTROL

The researcher/therapist had been trained and supervised in cognitive-behavioural therapy during his first year of Masters training in clinical psychology. During this therapeutic intervention he was closely supervised by an experienced cognitive therapist accredited with the Academy of Cognitive Therapy, an international organisation with worldwide membership. This ensured that the intervention followed the principles of the Ehlers and Clark (2000) treatment model. Furthermore, as discussed in more detail below, the therapy process and interventions were comprehensively documented by audio-tape recording each session, compiling detailed written records, and regularly administering psychometric assessment instruments. Additionally, an independent researcher conducted an interview with the client to ascertain her view on the treatment process and the model employed.

2.5 DATA COLLECTION

In an attempt to ensure the reliability of the information, this research project employed a multi-method approach to assessment and data gathering, using structured interviews, various psychological measures, session records, and psycho-physiological assessment amongst others.

2.5.1 Screening and Assessment Interviews

The screening interview took the form of a semi structured interview and was done as part of a routine interview when Bongi was referred to the clinician during his placement at a community services clinic. After information gathered during the screening interview indicated that all research criteria were met, a series of assessment interviews were conducted. These were informed by the Ehlers and Clark (2000) assessment and treatment model and aimed at eliciting the information needed to formulate the case in terms of the model. During the interviews the diagnosis of PTSD was confirmed, other emotional, somatic, and social problems explored, and details of personal and family history obtained.

2.5.2 Treatment sessions

All treatment sessions were audio-tape recorded and detailed written synopses compiled of each session.

2.5.3 Research interview with independent party

Additional research information was obtained by an independent researcher who conducted an interview with the participant after session 18. The independent researcher was a counselling psychologist with experience in trauma work. The Client Change Interview Protocol (Elliott, 1999) was used as basis for this interview.

2.5.4 Psychometric Measurement Instruments and Self-Report Scales

The following assessment instruments were administered to monitor the client's response to the intervention.

The Beck Depression Inventory II (BDI-II)

This is a 21-item inventory which measures the severity of depression based on the symptoms of depression as described in the DSM-IV (Beck, Steer, & Brown, 1996). The severity of depression as measured by this inventory is indicated by the following descriptions and scores: minimal (1-13), mild (14-19), moderate (20-28), and severe (29-63). This inventory was administered on 22 occasions during assessment and therapy sessions.

The Beck Anxiety Inventory (BAI)

This is a 21-item inventory which measures the severity of anxiety based on symptoms of anxiety as described in the DSM-IV (Beck & Steer, 1993). The severity of anxiety is indicated by the following descriptions and scores: normal (0-7), mild (8-15), moderate (16-25), and severe (26-63). This inventory was administered on 23 occasions during assessment and therapy sessions.

The Posttraumatic Diagnostic Scale (PTDS)

This is a 49-item self-report scale based on DSM-IV criteria for PTSD. As such it assists in the diagnosis of PTSD and in quantifying the severity of PTSD symptoms. The test developers suggest that it is helpful in assessing PTSD in clinical and research settings,

as well as for monitoring response to treatment (Foa, Cashman, Jaycox, & Perry, 1997). Part 1 of the scale lists 12 traumatic events derived from DSM-IV guidelines from which the person chooses those they have witnessed or experienced. Part 2 contains questions relating to timeframes, physical injury, and the person's feelings and thoughts at the time the event occurred. Part 3 contains 17 items corresponding to the DSM-IV criteria for PTSD which are rated according to the severity with which they are experienced. These are used as a basis for the symptom severity score. Part 4 lists nine life areas which might be negatively affected as a result of the event or its consequences (Foa, 1995). Part 3 of this scale was administered during assessment sessions 2 and 6, and therapy sessions 5, 9, 12, 17, and 19.

The Posttraumatic Cognitions Inventory (PTCI)

The 33 Item Short Form was used. This version of the scale consists of 33-items expressed as thoughts or feelings which are rated according to the degree they are agreed or disagreed with. The scale measure negative cognitions about the self and the world, and cognitions related to self-blame (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999). This scale was administered during assessment sessions 4 and 7, and therapy sessions 5, 8, 16, and 19.

2.5.5 Material written by the client

Various pieces of material written by the client provided information about her thoughts, emotions, hopes, dreams, fears, and struggles at various times. These included a seven page letter written to the therapist, various poems, excerpts of magazine articles adapted by the client, and SMS's sent to the therapist in-between sessions.

2.5.6 Supervision

Weekly supervision sessions with the therapy/research supervisor provided the opportunity to explore, discuss, plan, evaluate, and change the focus of the intervention. These were documented and integrated into the treatment planning and case formulation process on an ongoing basis.

2.6 DATA REDUCTION PROCEDURES

The collected data was utilised to generate the following data reduction steps: (1) A case history including a comprehensive account of presenting complaints, (2) a case formulation, (3) an initial treatment plan which was amended as the intervention proceeded, (4) a treatment narrative, and (5) graphical representations of quantitative data.

Data Interpretation and Analysis

Data interpretation was based on the principles set out by Fishman (2005) in the pragmatic case study (PCS) method. This a comprehensive framework which provides guidelines for the interpretation of findings in light of existing clinical theory as well as of theories relevant to the experiences and processes that are prominent in the case material. Data reductions were interpreted using a hermeneutic reading method (Edwards, 1998) based on two broad sets of questions: (1) questions arising from the research aims, and (2) specific questions relating to clinical theory, treatment planning, and the nature of specific cultural and contextual factors that emerged as significant within the case narrative. Research has shown that clients hold certain cultural beliefs at the time they enter therapy (e.g. not ascribing to the notion of "chance") (Eagle, 2004). An important aspect of this research study was to be aware of, and track client's culturally shaped beliefs as the therapy process progressed. How these culturally held views were influenced or changed in the course of therapy will form an important part of interpreting the outcome of the study (Eagle, 2004).

3. THE CLIENT – BONGI

Bongi is a 23-year-old Swazi female. She was born and raised in Swaziland and her first language is SiSwati. Bongi moved to Grahamstown during February 2007 to study for a one-year Post-graduate Certificate in Education at Rhodes University. During the assessment she expressed the wish to "*…have a normal romantic relationship with a guy who loves me for who I am*". Bongi has been raped three times. The first rape

occurred when she was nine years old, the second at the beginning of 2002 (aged 18) and the third in 2004 (aged 20). At the time of the first rape she did not know anything about sex or rape. She was reportedly able to cope relatively well after this incident despite not telling anyone or receiving any physical or emotional support. The second rape was more difficult for her to deal with. It happened in the context of a 2-day-old romantic relationship with a boyfriend who deceived her and forced her into having sex with him and then never spoke to her again. Bongi reported that the third rape was the worst because she experienced it as significantly changing her life, and she felt as though after that everything fell apart.

3.1 ASSESSMENT RESULTS

The Ehlers and Clark model is flexible in that it provides guidelines for assessment and formulation in response to the specific details of each client's experience and the design of an intervention individualised in response to the client's needs. The intervention was based on a collaborative approach between clinician and client. The assessment phase consisted of eight sessions of between 90-120 minutes each. The goal was to elicit information about Bongi's personal and family history, her current problems and symptoms, detailed information about the three rape incidents, and information related to her appraisals, coping behaviour, and belief system. This was used as a basis for a diagnosis, formulation, and treatment plan.

3.1.1 PERSONAL AND FAMILY HISTORY

Bongi was born in Swaziland 23 years ago and grew up on a farm, with her mother and two younger siblings. Her father lived in another country and moved back to the farm permanently when she was twelve. Extended family lived in the area, but contact with them was limited. As a result, home and family represented a significant part of Bongi's world, and what she experienced and learned there had a significant impact on her development and understanding of social and interpersonal interaction. She recalls never having had a birthday party and never receiving gifs. She started grade 1 at the age of five and never failed a grade. Bongi missed her father while growing up. She longed to have him around and to be able to tell him about school, and her friends and dreams.

At age nine Bongi was raped by a well known and respected male person in the community. She never told anyone for fear of being made out a liar and being beaten. She reported feeling depressed since age ten. She described an incident while she was ten where she tried to commit suicide by running into a busy street. This happened during a holiday where the family visited her father where he was living at the time. Her parents were with her at the time and she received a severe beating.

When Bongi's father returned to the farm she was hoping that some of her unmet emotional needs will be fulfilled. Instead, he was so focussed on turning the farm into a productive unit that he rarely spent time with his family. His physical presence did not provide Bongi with what she longed for; to chat with him and to have him hold and love her. Additionally, in order to achieve his goals, he made use of all the resources at his disposal, including Bongi and her siblings. They were often woken up between 3:30am and 4:00am on school days to assist in such tasks as picking and washing vegetables, or feeding animals. When she and her siblings "escaped" to go play or be with friends, they were punished. They were also punished when the task they were given was not done to their father's expectations. Punishment involved being beaten with a belt or stick, and having to complete the task or correct the mistake, no matter what time of day or night. She hated her father and became so fearful of him that until today she gets frightened when she hears a car with a diesel engine – her father only drives such cars.

During grades 11 and 12 (aged 15 and 16) she went to boarding school. She wanted to get away from the farm and her father. After finishing grade 12 in 2000 she went to work for her father until August 2001. She then enrolled at the University of Swaziland and moved to campus. She completed the four-year BA-degree during 2006 (aged 22). During 2002, aged 19, she started modelling and met and befriended many local celebrities. Early in 2002, while away on holiday, she met a male person and believed it was "love at first sight". The next day she was raped by this person and he ignored her after that. The following year, 2003, she entered into a romantic relationship in which she suffered emotional abuse. Her partner ended the relationship after three months. In 2004, aged 20, she was raped by a high profile person involved in the fashion world. Bongi reports that her life changed for the worse after this incident, and that she has not

yet been able to return to her prior level of functioning. Shortly after this she quit her modelling career (end 2004). During 2005 another romantic relationship was ended by her partner after four months. She again suffered emotional abuse in this relationship. Also in 2005, a very close friend and major source of social support died while visiting in another country. This was followed by the death of her brother due to cancer.

During January 2006 she started sleeping much more than usual, cried frequently, and started to drink alcohol and party more regularly. In April 2006 a romantic relationship of nearly a year was ended by her partner. She reports that this was the worst of all her relationships, that she suffered emotional abuse, and that it made her decide not to enter into another romantic relationship soon. After finishing at university in May 2006, she lived with a relative in a nearby town for two months in order to obtain her driver's licence and because she did not want to return to the farm. She then returned to work for her father on the farm for the rest of that year. During this time she was blamed for things going wrong with their farming business. She hoped to change her life by moving away from the farm and Swaziland. She decided to move to Grahamstown in South Africa and enrolled for a Diploma in Education. She arrived in Grahamstown during February 2007. She continued to drink and party regularly on weekends. Due to difficulties with concentration, sleep, and various somatic symptoms, she decided to see a doctor.

Bongi describes her father as a very strict man whose main interest is the success of his farm. He is a very successful farmer and businessman and has entertained the Swazi minister of agriculture on his farm. She describes her mother as a generally caring person who has always tried her best to provide for her children. She is easily influenced by her husband and has never stood up to him. At times she too used to beat Bongi and her siblings. Bongi's sister is two years younger. She has always been a sickly and physically weak person. As a result their parents expected less from her, but she was treated worse and more neglected than Bongi. She still lives at home and Bongi believes that she suffers from depression. Her brother was four years younger than Bongi and died from cancer in 2006. Bongi believes he was favoured by their parents as he received the best treatment. He was also the one who was to take over the farm.

Bongi says that she always had a very good relationship with a paternal aunt (aged 36 currently) who lives close to the farm. While growing up Bongi tried to spend time with her as they could speak comfortably and Bongi felt loved when with her.

3.1.2 THE EXPERIENCE OF RAPE

The following brief accounts of the rape incidents were given by Bongi during the assessment phase. However, she did not give any detail relating to the actual act of rape.

Incident at age 9

Bongi and some friends were playing outside their church building after having finished practicing for a play. All the adults had left when one of Bongi's neighbours, an elderly and well respected man, approached them. He offered them money to buy sweets at the shop which was approximately two kilometres away. As they left he asked Bongi to stay behind and guard the church, which she did. When the other children were out of sight, the man approached her and asked her to accompany him to the back of the church yard. As they sat together, he started touching her private parts and inserted his fingers into her vagina. He then told her to take off her panty and forced her to have sex with him. When the other children arrived back, the man offered them some more money which they took.

Bongi said that at the time she was uneducated regarding sex and rape. She was confused about what was happening to her, but sensed that all was not right. She never told anyone about the incident for fear of being beaten by her parents. After the incident she was very afraid of the man and whenever she saw him she hid or ran away. When her friends asked her about this odd behaviour she lied to them saying that he had recently beaten her.

Incident at age 18

Bongi met the perpetrator at a social gathering while away on holiday. She was immediately attracted to him. He approached her and before separating that day they declared their love for each other. The following day he requested sex from Bongi. She

refused because it was against her religious beliefs and she felt it was too early in the relationship to have sex. He manipulated her by saying that if she truly loved him she would agree to sex. She still refused. He then proceeded to force himself on her and had sex with her. After this incident he ignored her and never spoke to her again.

Bongi reported that being used and rejected in this way was very difficult for her to deal with. However, it did not affect her functioning significantly, which she attributed to the fact that it happened while on holiday away from where she lived.

Incident at age 20

Bongi and a group of models who attended a fashion-show rehearsal were in the home of the organiser to sign contracts. Everyone was promised transport home from the organiser's place. Bongi was the last to be taken home, but when it was her turn, the organiser went to see a friend. Despite not being happy about this, Bongi felt secure as she was in the company of his sister and a friend of the sister. The organiser arrived home very late and suggested that she overnight at his home. When Bongi was alone, the organiser suggested to Bongi that they have sex. She refused and tried to ignore him. As he became more suggestive she left the room and told her friend, his sister, what was happening. Her friend advised her to just give into him and said that she was silly for resisting. She felt betrayed and went to sleep in a spare room. A while later her friend came to her saying that her brother wanted her to go to his room. She refused. Later that night as she was trying to fall asleep in her room, he entered her room and lay down on the bed. He overpowered her and forced himself upon her and penetrated her. After that he left. Bongi left his home early the next morning. After this, she found it hard to cope with everyday demands and it felt as though her life had changed forever. Whenever she saw a picture of the organiser, a famous person in her country of origin, she felt troubled and distressed. After she stopped modelling and acting, there were stories about her in gossip columns and it made her feel exposed and ashamed.

3.2 PRESENTING PROBLEM

Bongi visited the university's student medical services during May 2007 complaining of feeling depressed, suffering panic attacks, and generally feeling ill. During our first

assessment session she reported various other somatic and emotional symptoms. Somatic symptoms included constantly experiencing chest pains and a feeling of being unable to breathe, frequently suffering headaches and migraines, often having a painful spinal column, as well as experiencing a pain below her heart. This pain at times was so severe that she felt it in a band across her chest between her stomach and breasts. She has experienced chest pains since 1998 when she sought medical advice and treatment which did not bring clarity or relief. Less frequently there were times when her whole body would shake, her vision was blurred, and she was confused about everything going on around her.

The emotional symptoms she reported included feeling sad, dejected, and being easily irritated. She reported having felt depressed since around age ten. Furthermore, shortly after arriving in Grahamstown her concentration and memory abilities declined, she did not feel like participating in activities she used to enjoy (going to gym, acting, going to Swaziland to visit her family), often chose to sleep rather than spending time with people, struggled to fall asleep, and sleeping much more than she used to. Sometimes she woke up in the early hours of the morning and saw things in the dark. She was unable to describe these, but she felt scared, tense, and often cried.

She said she often thought about dying, but that she would never commit suicide as she could not disappoint the people that loved her. She did admit to hurting herself by pressing the sides of the palm of her hand together hard, by biting her own hands, and by violently shaking her head from side to side. She said that this helped her to transfer the pain she felt on the inside to the outside, as a way to vent the pain, to let it out.

In addition to these symptoms, it was found that when Bongi was confronted by a suspicious looking stranger, when she was alone in a dark place, or when reminded of rape through conversations, news reports on radio or TV, anti-rape campaigns etcetera, she experienced what she referred to as “*automatic thoughts*”. These intrusive thoughts consisted of various images concerned with the rapes. She had difficulty recalling these, and when she did she became visibly distressed. She experienced nightmares with similar content. Bongi reported actively avoiding reminders of the traumas. When she

was confronted with them, she not only re-experienced the trauma through the automatic thoughts, she also experienced physiological discomfort. During the assessment phase, the physiological distress was also brought on by reading the list of the symptoms as set out on the BAI. Bongi also reported feeling very confused regarding her sexual identity. Despite never having been in a relationship with a female, she reported that she might be bisexual.

She appeared to have no understanding of the origin of any of these symptoms. At the time of assessment she was not well informed about depression and had never heard of PTSD.

3.3 VOLUNTARY RECALL OF THE CONTENTS OF IMAGINAL RELIVING

Although Ehlers and Clark recommend the use of imaginal reliving of the trauma during the assessment phase, this was not possible with Bongi. She was not prepared to do this and even just speaking about the rapes caused her distress. She did report experiencing “automatic thoughts” (her words) and she also reported having dreams related to the third rape. Both of these involve scenes in which she is overpowered by someone physically stronger than herself, and re-experience the emotional and physical pain she had felt at the time of the rape. This information and the descriptions she gave provided the basis for a preliminary understanding of her peri-traumatic appraisals and critical hotspots (those parts of the trauma memory that elicit particularly strong distress (Ehlers & Clark, 2000)).

Discussions regarding the rape incidents focussed on the third rape. Reasons for this were that Bongi experienced this incident as the most significant, and she struggled to engage in conversations regarding the rape incidents.

3.4 NATURE OF THE TRAUMA MEMORY

The trauma memory did not appear to have any gaps and the sequence of events was reported chronologically. Parts of the memory where the emotional content was especially intense were quickly passed over.

Triggers

Aspects of the trauma were involuntarily triggered and experienced as intrusive, indicating that the trauma memory was also characterised by affect without recollection (Ehlers & Clark, 2000). Without being able to connect the symptoms to presently experienced stimuli, situations, or people, Bongi would regularly experience intense feelings of anxiety, fear, and hopelessness as well as other anxiety-related symptoms including heart palpitations, an inability to relax, dizziness, and shaking.

3.5 HOTSPOTS AND KEY APPRAISALS AT THE TIME OF THE INCIDENT

As Bongi did not engage in imaginal reliving during the assessment phase, limited information was obtained. The following was inferred from brief discussions about the third rape: hotspots and intrusions usually consist of her being overpowered by a male person physically stronger than herself, of him forcing himself onto her, of the smell of sweat, and of the physical pain she experienced. Associated appraisals were "*I'm helpless and powerless*", "*I gave up and let him rape me*", and "*I can't believe this is happening*".

3.6 DYSFUNCTIONAL BELIEFS AND ASSUMPTIONS

- I have lost my mind, soul, faith, self-esteem, and relationship with God.
- I am going crazy.
- No-one can be trusted, especially men.
- Men cannot love me.
- I have to be strong not to disappoint those I love.
- Everything will be well if I can successfully ignore what happened in the past.
- I cannot change my life.
- I will forever be sad and hopeless.
- After *that experience* I will not feel good for the rest of my life.
- My pride has been taken away.

3.7 THE GENERAL EFFECTS OF THE TRAUMATIC EVENTS ON BONGI'S LIFE

She stated that the most significant changes occurred after the third rape. It felt like she lost many things, the most important being her soul. It represents her self, her agency, her belief in her self and her abilities, and her ability to be happy. She said her life had changed as well as how she viewed the world, perceiving it as a dangerous place where something bad could happen at any time. She also came to mistrust men more. On a practical level, Bongi gave up many activities she enjoyed including modelling, acting, and sporting activities. She did not feel like being with people and increasingly started avoiding them. This often led to her feeling lonely.

3.8 PROVISIONAL DIAGNOSIS

Bongi met criteria for the following Axis I diagnoses: (1) PTSD, chronic type, (2) major depressive disorder, recurrent, moderate, and (3) dysthymia, early onset.

A diagnosis of PTSD was considered given the traumatic rape incidents Bongi reported. Re-experiencing symptoms included intrusive "*automatic thoughts*" and nightmares consisting of images concerning the rapes. During such times she experienced, to varying degrees, psychological distress and physiological reactivation, a sense of literally reliving the rape, and dissociative flashbacks. In order to prevent this she attempted to avoid situations causing it, including being alone in the dark, watching TV programs containing sex scenes, reports about rape, and being involved in conversations about rape. Additionally, she generally felt detached from others. Increased arousal was apparent from her reported sleeping difficulties, frequent periods of irritability and anger outbursts, concentration difficulties, and exaggerated startle response. The following somatic symptoms were also considered to contribute to a diagnosis of PTSD as they could be seen as either anxiety symptoms or parts of flashback experiences: chest pains, feeling unable to breathe, frequent headaches, a painful spinal column, and pain below her heart.

Turning to depression, when Bongi visited the University's Student Medical Services during May 2007, her major complaint was feeling depressed. She reported feeling sad, hopeless, irritable, experiencing significant sleeping disturbances, a lack of appetite, and concentration and memory problems. Furthermore, she reported suicidal ideation,

feeling fatigued, and had stopped participating in activities such as going to gym. From the content of her personal and family history as well as the symptom history, this was not thought to be the first major depressive episode that Bongi has suffered from. As such a diagnosis of major depressive disorder, recurrent, moderate was given.

The additional diagnosis of dysthymia was made based on Bongi's reports that she has felt depressed since age ten, and feeling jealous of herself when she looks at childhood photos of her self where she looked free and happy. She has not felt this way in a long time, and wondered if she ever will be able to feel happiness again. Again, her childhood history, especially since her father returned to the farm, supports such a diagnosis. The fact that she was able to progress through her school grades successfully indicates that she was able to function despite not being happy.

4. GUIDING CONCEPTION – RELEVANT RESEARCH

This section reviews the literature which served as the basis for the conceptualisation of this research and for understanding the important aspects of this case study. After some preliminary definitions the historical development of the concept of PTSD is explored. This is followed by brief discussions on predisposing and risk factors, and theories of PTSD. Then the development of PTSD according to the Ehlers and Clark model is considered in some detail. This is followed by a discussion of rape and cultural factors, emotional responses in PTSD, the assessment and treatment procedures, and the efficacy and transportability of the model under discussion.

4.1 TRAUMA AND POST-TRAUMATIC STRESS DISORDER

The specific meaning of the term "trauma" is determined by the context within which it is used. For the purpose of this research study, trauma refers to severe and often devastating events or experiences posing a threat to a person's life or physical safety (Edwards, 2005a), such as for example violent assault, military combat, hijackings,

exposure to natural or man-made disasters, and being involved in accidents. Although trauma can be described objectively as above, there is diversity in what individuals subjectively experience as trauma. Thus an individual's reaction to the event is taken as the determinant of whether a trauma occurred (Edwards, 2005a).

Post-traumatic stress disorder is a disorder that might develop when an individual's immediate response after being exposed to or witnessing a traumatic event is characterised by intense fear, helplessness, or horror. The severe stressor or trauma involves actual or possible death, serious injury, or a threat to the physical integrity of the person themselves or to another person (American Psychiatric Association, 2000). PTSD can also develop because of continued exposure to longer term trauma (World Health Organization, 1992). PTSD is a maladaptive response that interferes with adaptive coping mechanisms and causes occupational, and/or interpersonal dysfunction. The disorder is further characterised by continual re-experiencing of the event through images, thoughts, perceptions, nightmares and psychological and/or physical reactivity on exposure to triggers. This is usually accompanied by the numbing of responsiveness or persistent avoidance of anything associated with the event, such as thoughts, feelings, conversations, places, activities, people and feeling detached or having restricted range of affect. Furthermore, increased arousal including insomnia, hypervigilance, difficulty concentrating, and irritability or bouts of anger are also common (American Psychiatric Association, 2000).

4.2 HISTORICAL DEVELOPMENT OF THE CONCEPT OF PTSD

Historical and literary references dating back to the third century BC document the psychological effects of trauma (Birmes, Hatton, Brunet, & Schmitt, 2003). Nevertheless there is an ongoing debate regarding the existence and diagnosis of PTSD (Brewin, 2003). In 1861 Dr. Waller Lewis described a syndrome he observed in post office workers involved in railway accidents. *Railway spine* or *postconcussion syndrome* was characterised by sleep disturbances, nightmares involving the accidents, tinnitus, avoidance of railway travel, and chronic pain (Lasiuk & Hegadoren, 2006). In 1889 Oppenheim renamed the syndrome *traumatic neurosis*. Pierre Janet proposed a relationship between hysteria, dissociation, and emotional distress elicited by memories

of past psychological trauma. He based this on his observations of female patients experiencing altered states of consciousness when reminded of upsetting events from their past. He believed that traumatised individuals were unable to integrate memories of painful events into narrative memory, and as a result, these memories and the emotions associated with them remained dissociated from consciousness. When confronted with stressful situations in present life, they would automatically react with agitation, outbursts of anger or violence, psychosomatic complaints, behavioural passivity, and dissociative problems (Lasiuk & Hegadoren, 2006). Working independently from Janet, Freud and Breuer arrived at similar conclusions based on their work with hysteria (Lasiuk & Hegadoren, 2006). Both found that symptoms diminished when the individual was able to verbalise the traumatic memories and associated emotions. This process became known as psychological analysis (Janet) or psychoanalysis (Freud) (Lasiuk & Hegadoren, 2006).

Other research into psychological trauma was associated with war and involved various researchers who each came up with a descriptive term for what they were observing: in 1870 Arthur Meyers described *soldier's heart*, in 1871 Da Costa described *irritable heart*, also known as *effort syndrome*, in 1915 Charles S. Meyers coined *shell shock*, and in 1941 Abram Kardiner used the term *war neurosis*. After World War I, the cost of psychiatric casualties was so high that the identification of psychologically unfit soldiers was undertaken. It was found that every soldier had their breaking point, and so the role of biology and character became less important. Instead, more focus was placed on the role of environmental factors in the development of trauma symptoms. The knowledge gained from trauma-related work done with Holocaust survivors, rape victims, abused children, and war veterans were integrated during the 1970's and influenced the third revision of the DSM. As a result the psychological effects of trauma came to be officially recognised for the first time in 1980 when the American Psychiatric Association included PTSD in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (Lasiuk & Hegadoren, 2006).

4.3 PREDISPOSING, RISK, AND PROTECTIVE FACTORS IN PTSD

4.3.1 Developmental factors

Infants and young children are often protected from the full implications of traumatic events as they have a limited ability to understand and make sense of what is happening (Edwards, Sakasa, & van Wyk, 2005). Their responses to trauma are more often dependent on the reactions of their parents (Staab, Fullerton, & Ursano cited by Edwards et al., 2005). In turn, adolescents and older children are more vulnerable than adults to develop PTSD as they have gained the capacity to understand the threats they are faced with, but do not yet have the same protective resources available to them as adults does. With old-age individuals become more vulnerable to develop PTSD as they become less resourceful and unable to protect themselves (Edwards et al., 2005).

Additional factors that have been found to be associated with instability in the child's developmental environment are also related to PTSD risk. These include previous psychiatric disorders in the family, disruptive behaviour disorders in childhood or adolescence, the use of illegal substances, and a history of conflict with authorities (Marsella, Friedman, Gerrity, & Scurfield, 1996).

Children who suffered sexual abuse are at an increased risk to suffer subsequent sexual and physical abuse in adulthood. This in turn is associated with an increased likelihood to develop symptoms characteristic of PTSD (Edwards et al., 2005). Cloitre, Cohen, and Scarvalone (2002) found that sexual abuse together with a family environment typified by hostile control by parents render individuals vulnerable to be re-victimised in later life. These studies suggest that an unstable or problematic family life in childhood is also associated with vulnerability to the development of PTSD. In contrast, secure attachment within a context of safety during early development provides a foundation for resilience in the face of trauma in later life (Edwards et al., 2005). Other risk factors include parents getting divorced or separated, psychiatric illness in the family, poverty, and belonging to minority groups (Edwards et al., 2005).

Gender is strongly associated with vulnerability to the development of PTSD. Despite the fact that men are more frequently exposed to traumatic events, the incidence of PTSD is higher in women than men (Edwards et al., 2005).

There is evidence suggesting that individuals are more vulnerable to develop PTSD if they have a history of previous trauma, especially child sexual or physical abuse (Edwards et al., 2005). It has been found that experiencing a greater frequency of traumatising events increases the risk of PTSD. However, an adaptive response to earlier trauma can have an inoculation effect (Marsella et al., 1996). The risk of developing PTSD is also associated with the severity of the traumatising events; the more severe the event, the more likely it is that PTSD will develop. Furthermore, the occurrence of significant physical injury or financial loss is associated with greater PTSD symptomatology, and if a person is threatened with deadly weapons or death, they are more likely to be symptomatic than other assault victims (Brewin, Dalgleish, & Joseph, 1996).

The risk of developing PTSD is increased by existing life stressors at the time of the trauma (Edwards et al., 2005). Ruch, Chandler, and Harter (cited in Edwards et al., 2005) found that, in rape victims, a higher level of life stressors in the year before the rape was associated with increased negative psychological effects in terms of emotional distress, negative emotional states, and impairment of normal cognitive functions.

4.3.2 Comorbidity

Mueller, Hackmann, and Croft (2004) report that up to 60 percent of individuals with a primary diagnosis of PTSD also meet criteria for another disorder, most commonly depression, panic disorder, and generalised anxiety disorder. Substance abuse, physical complaints unrelated to the trauma, bereavement, and grieving over losses suffered are found to be prevalent amongst those suffering from PTSD. Whether comorbid disorders exist before the experience of the traumatic event or develop thereafter, their presence complicates the treatment and recovery process.

4.3.3 Social factors

Social support can be valuable if it matches the individual's current needs (Edwards et al., 2005). It might take the form of practical assistance to address immediate problems, or offering emotional support, understanding, and care. It is important in that it might convey a message of self-worth and an ability to cope with the current stress being experienced (Hobfoll, Dunahoo, & Monnier cited by Edwards et al., 2005). Emotional support offered by the family, peer groups, adults outside the nuclear family, and from institutions and organisations such as schools, clubs, or religious institutions can all contribute towards resilience in the individual and offer protection against the development of clinical significant problems in the aftermath of trauma (Edwards et al., 2005).

4.4 RAPE AND PTSD

Rape survivors face not only the various consequences brought about by the rape, but also the reality that a recurrence of their trauma can happen at any time (Foa & Rothbaum, 1998). The majority of rape survivors develop problems associated with emotional and cognitive reactions, interpersonal, sexual, and social difficulties, as well as somatic problems, even in the absence of serious physical injury at the time of the rape (Regehr, Marziali, & Jansen, 1999). Emotional reactions include emotional lability and numbing, self blame, generalised fears, anxiety, depression, feelings of grief, anger, dissociation, poor self-esteem, and suicidal ideation or suicide attempts. The most prominent cognitive reactions include flashbacks and intrusive thoughts, forgetting significant details of the incident, and concentration problems (Regehr, Marziali, & Jansen, 1999).

Fear of rape related situations and general diffuse anxiety are the most common reported reactions to rape. In most cases these are persistent, lasting more than a year. Another common associated problem is moderate to severe depression, often with related suicidal ideation and suicide attempts. Rape victims often respond with anger after the event. Their levels of anger are influenced by factors such as whether the perpetrator used a weapon and the victim's response to being attacked. High levels of anger have been found to be a predictor for the development of PTSD. Dissociative reactions are characterised by a disturbance in consciousness, memory, and/or identity.

Dissociation can serve as a coping mechanism removing the person from a psychologically dangerous event. A relationship between the degree of dissociation and the level of stress or trauma experienced has been proposed (Foa & Rothbaum, 1998; Regehr, Marziali, & Jansen, 1999; Resick & Schnicke, 1996).

Although not enduring, a restricted social life, decreased occupational functioning, and familial and marital problems are regularly reported. Problems related to social functioning are probably related to generalised avoidance created by being fearful of others. Lastly, sexual problems are very common and can be long-lasting. Decreased arousal, sexual satisfaction, and desire are the most commonly reported problems (Foa & Rothbaum, 1998; Resick & Schnicke, 1996).

4.5 THEORETICAL ORIENTATION TO PTSD

Various biological and psychological theories have been developed in an attempt to understand and describe PTSD. Psychological theories include learning theory, psychodynamically orientated theories, and cognitive theories. Of these, cognitive theories are most fully developed and provide the most comprehensive understanding and predictive ability (Brewin, Dalgleish, & Joseph, 1996). Although all approaches to treating PTSD include a range of techniques, significant advances in treatment have been achieved using approaches involving cognitive and behavioural techniques including hypnotherapy, eye-movement desensitisation and reprocessing, psycho-education, and exposure (Foa, Keane, & Friedman, 2000). Cognitive therapy has accordingly been shown to be an effective treatment for PTSD, and recent research in particular suggests that Ehlers and Clark's (2000) cognitive therapy model provides the most comprehensive account of the development, maintenance, and treatment of PTSD (Brewin & Holmes, 2003). The Ehlers and Clark (2000) treatment model is contextualised by briefly describing some of the theoretical models from which it was derived.

4.5.1 Early Theories

Early PTSD theories can be grouped into information-processing theories and social-cognitive theories. Information-processing theories deal with the traumatic event itself, as well as trauma-related threat and fear. The focus is on how trauma information is

represented in the cognitive system and the way in which this information is processed (Brewin, Dalgleish, & Joseph, 1996; Rothbaum, Meadows, Resick, & Foy, 1999). Social-cognitive theories highlight the consequences of the trauma on the person's life and focus on the integration of the traumatic experience into pre-existing world views and beliefs (Brewin et al., 1996).

(i) Information-processing theories

Firstly, Mowrer's (1960) c*onditioning theory* describes how, through the process of classical conditioning, neutral stimuli present at the time of the trauma acquire fear inducing properties when they become associated with elements of the trauma. In addition, due to stimulus generalisation many associated stimuli not present at the trauma also become fear inducing (Brewin & Holmes, 2003).

Lang (1979) proposed that traumatic information consist of stimuli present at the event, such as sights and sounds, as well as the individual's emotional and physiological responses. Cognition and affect was thus incorporated into an automatic response system helping the person to escape danger in that the stable fear memories are automatically activated by stimuli similar to those present at the trauma (Brewin & Holmes, 2003).

The information-processing theory proposed by Foa, Steketee, and Rothbaum (1989) goes beyond conditioning to include the individual's subjective meanings about the event. It is proposed that trauma memories are represented in memory differently than memories of non-traumatic events, implying that they are ordinary memories, but with a different structure. This structure comprises a pathological fear network consisting of cognitive representations of stimuli associated with the fear situation, the individual's responses to the fear situation, and the meaning attached to the fear situation by the individual. The fear network is activated by environmental cues associated with the trauma. As the person attempts to avoid these cues, the fear network and thus also PTSD is maintained. The focus of treatment is the habituation of fear through the activation of the fear network while simultaneously providing information incompatible

with the fear network in order for it to be corrected (Brewin & Holmes, 2003; Rothbaum et al., 1999).

In their *anxious apprehension model*, Jones and Barlow (1990) argue that the variables responsible for the aetiology and maintenance of panic disorder are also involved in PTSD. The main proposition is that cognitive factors present at the time of the trauma are reactivated when faced with associated trauma stimuli, creating a feedback cycle of anxious apprehension. Therefore, as in panic disorder, false alarms occur in the absence of danger (Brewin & Holmes, 2003).

(ii) Social-cognitive theories

The most influential social-cognitive theory, the *stress response theory*, was developed by Horowitz (1986). After an individual's initial shock with the occurrence of the traumatic event, they attempt to integrate the new trauma information with existing knowledge. If this is not successful, psychological defence mechanisms develop which help the person to avoid trauma memories and emotions, as well as to regulate later recall. Recall happens due to an underlying psychological need to integrate old and new information. It occurs in the form of nightmares, flashbacks, and cognitive intrusions. Periods of avoidance and recall follow each other and represent two opposing processes through which the trauma information is incorporated and worked through (Brewin et al., 1996; Brewin & Holmes, 2003).

The *theory of shattered assumptions* is another social-cognitive theory that considers people's internal assumptive worlds. Janoff-Bulman (1992) proposed that three assumptions are important in an individual's response to trauma: that the world is benevolent and meaningful, and that the person themself is worthy. Bolton and Hill (1996) add that for people to act in the world they must believe that: they are competent enough to act, the world is predictable, and the world provides sufficient satisfaction of needs. Traumatic events, being unpredictable and unpleasant, challenge or shatter these assumptions and beliefs, causing intense conflict and feelings of unreality. Janoff-Bulman (2006) expanded on this theory by placing assumptions within the context of schemas. Schemas start forming in infancy and are elaborated throughout life. In

adulthood they have develop into broad, abstract, and rigid schemas. They function to process and interpret new information in a way to maximise possible self-verification through the assimilation of information into existing schemas, or by ignoring the new information. In this way schemas give rise to the basic assumptions mentioned above; which then provide a general sense of security. When a traumatic event occurs, the individual's assumptions are shattered, resulting in the longstanding schema shown to be inadequate. This leads to two sources of anxiety: having to acknowledge that the world is an uncertain and dangerous place, and that the individual's inner world is inadequate (Janoff-Bulman, 2006).

4.5.2 Recent Theories

The *Emotional Processing Theory* developed by Foa and Rothbaum (1998) is an elaboration on the earlier information processing theory of Foa et al., (1989). In one area of development, an individual's knowledge before, during, and after the trauma was related to PTSD. Individuals with more rigid positive or negative pre-trauma views are proposed to be more vulnerable to develop PTSD as the trauma either provides strong contradictory evidence (to positive views), or confirms negative views. Another development focuses on how the individual's negative appraisals of responses and behaviours relate to PTSD. This theory also addresses treatment, by emphasising the use of repeated reliving which is proposed to have various positive effects including decreased anxiety and changed memory structures (Brewin & Holmes, 2003; Rothbaum et al., 1999).

Dual Representation Theory views PTSD as an unsuccessful adaptation to trauma. The theory incorporates aspects of both the social-cognitive and information processing approaches into a framework differentiating between cognitive processes at the time of the trauma and appraisals after the trauma (Brewin & Holmes, 2003). It proposes the simultaneous existence of two memory systems. The first, *verbally accessible knowledge* is intentionally retrievable from autobiographical memories. The second is *situationally accessible knowledge* consisting of nonconscious processing of the traumatic situation and is accessed automatically (not intentionally) when in a situation with similar characteristics or meanings as the traumatic situation (Brewin et al., 1996).

Symptomatology is the result of situationally accessible trauma memories being dissociated from the verbally accessible memory system. Treatment involves converting the dissociated trauma memories into ordinary or narrative memories (Brewin & Holmes, 2003).

Lastly, the Ehlers and Clark (2000) cognitive therapy model is frequently recognised as providing the most comprehensive understanding of the development, maintenance, and treatment of trauma and PTSD (Brewin & Holmes, 2003). Ehlers and Clark's model was developed by combining and expanding on many of the aspects and elements of the above theories, however it is unique in the synthesis it provides. The Ehlers and Clark (2000) cognitive therapy model provides the conceptual framework for this research study and will hence be reviewed in detail elsewhere in this literature review. In what follows, this model is used to explain the development, maintenance, and treatment of PTSD.

4.6 EHLERS AND CLARK'S COGNITIVE MODEL

The model proposes that PTSD results when a trauma and/or its consequences is processed in ways that cause a sense of serious current threat. This sense of current threat is caused by two processes: how the individual appraise the trauma and/or its consequences, and the nature of the individual's memory for the trauma and how it relates to existing biographical memories. When the sense of current threat is activated, the individual has re-experiencing symptoms such as intrusions, symptoms of arousal and anxiety, as well as emotional and physiological reactivation. Experiencing the threat and symptoms leads to various cognitive and behavioural responses which serve to lessen the threat and anxiety. Such responses are efficient in the short term, but also serve to maintain the disorder due to their effectiveness (Ehlers & Clark, 2000).

4.6.1 THE DEVELOPMENT AND MAINTENANCE OF PTSD

(i) Appraisals

The model suggests that those who develop PTSD appraise the trauma and its effects as not being time-limited and having large-scale negative consequences for their future.

The sense of current threat thus created can be either internal (negative views about themselves) or external (no-one is to be trusted) (Ehlers & Clark, 2000).

(a) Appraisal of the traumatic event

A sense of current threat can be created by over-generalising the trauma and as such perceiving various non-threatening activities, places, and people as dangerous. Individuals might assume that disastrous events are more likely to happen to them, or that they attract terrible things. These result in situational fear as well as avoidance, leading to maintenance of negative appraisals and hence fear (Clark & Ehlers, 2005). Furthermore, appraisals of one's own emotions and behaviours at the time of the trauma can have long-term negative implications. According to Ehlers and Clark (2000), appraisals about perceived danger cause fear, for example "Nowhere is safe"; appraisals about the violation of personal rules and unfairness cause anger, for example "Others don't respect me"; appraisals about one's responsibility in causing the trauma result in guilt, for example "It was my fault"; appraisals about one's own violation of internal standards cause shame, for example "I did something awful"; and appraisals about perceived loss cause sadness, for example "My life is forever changed".

(b) Appraisal of the consequences of the trauma

Negative appraisals of trauma consequences that might lead to a sense of current threat include one's own thoughts about the initial PTSD symptoms experienced, as well as about the consequences of the trauma in other life areas such as health and occupation, and assessing other's reactions of the trauma and oneself (Ehlers & Clark, 2000).

Some PTSD symptoms such as reliving the event and flashbacks are clearly associated with the traumatic event. Other symptoms are not always so closely associated with the event, for example irritability, mood swings, poor concentration, and emotional and physiological reactivation. If the person does not recognise these as being related to the trauma, or if they are not viewed as part of the recovery process, they stand the risk of being interpreted as signs of permanent negative change, or as a threat to mental and/or physical health. Appraisals such as these serve to maintain PTSD, firstly by

giving rise to negative emotions such as anger, anxiety, and depression, and secondly by promoting dysfunctional coping mechanisms (Ehlers & Clark, 2000).

Where an individual's life is affected in areas such as health or finances, it can be interpreted as irreversible negative changes and can also fuel coping strategies that will maintain PTSD (Ehlers & Clark, 2000). When others do not speak about the event, the affected person might perceive this as a lack of care or as being blamed. Others might also blame them overtly and be critical or insensitive. This can cause appraisals of having to accept responsibility, or perceiving themselves as unworthy and dysfunctional. Given that feelings of detachment and estrangement from others are common responses in PTSD, social withdrawal which is an important maintaining factor is likely to result (Ehlers & Clark, 2000). When this happens the affected person has fewer opportunities to discuss the consequences of the event with others. This deprives them from the opportunity to receive potential corrective feedback from others that might assist in correcting excessively negative appraisals. Additionally, not speaking about the trauma with others can make it difficult for the victim to later on engage in reliving during therapy (Ehlers & Clark, 2000).

(c) Appraisals and emotion responses

Individuals suffering from PTSD display and describe various intense emotions which are associated with negative appraisals and attitudes. Many avoidance strategies are aimed at coping with these difficult emotional reactions (Edwards, 2005a).

Diagnostic criterion A2 of the DSM-IV states that "the person's response involved intense fear…" (American Psychiatric Association, 2000). *Fear* is often the most dominant emotional response involved in the development and maintenance of PTSD (Lee, Scragg, & Turner, 2001). Feelings of fear easily becomes generalised to other situations, resulting in anticipation of another life threatening event and causing the individual to experience a consistent sense of threat (Edwards, 2005a).

Shame and guilt can have significant negative influences on a person's experience of themselves and their social and help-seeking behaviour. Shame and guilt contribute to

pathology by hampering emotional processing and cognitive integration of the event, as well as interfering with certain therapeutic interventions, such as imaginal reliving (Lee et al., 2001). *Guilt* arises when harm was done to another and the person suffering from PTSD feels responsible for the occurrence of the harm-causing event; when the person is unable to justify their behaviour; and when the person violated their own personal standards of right and wrong (Lee et al., 2001).If the person themselves was harmed, guilt can also arise if they perceive themselves to not having taken the proper precautions to protect themselves from harm. A distinction is made between *external and internal shame*. External shame derives from a belief that others regard one as inferior, defective, weak, or unattractive, either as compared to others or as compared to oneself before the occurrence of a traumatic event. In contrast, internal shame is related to one's own perceived defectiveness and lack of social acceptability. The individual's experience of shame is also influenced by what their family, culture, and society has taught them about what qualifies as shameful (Lee et al., 2001).

Humiliation arises in situations where a person is in a powerless position and is ridiculed or abused, such as torture or in a physically abusive relationship. Humiliation differs from shame and guilt in that the person does not feel that they or any part of themselves brought about the behaviour of the offender. They believe that they were unfairly victimised or harmed. Humiliated individuals tend to ruminate about the event or replay it in their mind, often resulting in feelings of revenge or anger (Lee et al., 2001).

A relationship between *anger* and PTSD has been established (Cahill, Rauch, Hembree, & Foa, 2003). Anger presents a problem in treating PTSD when it inhibits emotional processing of the trauma. This happens when the individual is unable or too afraid to express the anger, or ruminates about revenge or compensation. Anger can assist in the therapeutic process if it can be channelled into helpful behaviours such as assertive behaviour or community work (Edwards, 2005a).

Disgust is caused by witnessing events involving serious injury, mutilation, burn wounds, as well as by sexual abuse (Edwards, 2005a).

Mental defeat refers to the perception that one has given up due to having been completely defeated (Ehlers, et al., 1998). It evokes feelings of loss of autonomy and agency, resulting in giving up one's identity and will. Those having experienced mental defeat often report feeling like an object or as though they were destroyed, resulting in no longer caring whether they live or die (Ehlers & Clark, 2000). Mental defeat at the time of the trauma and/or during previous traumatic experiences is associated with developing strongly held negative appraisals, and also with persistent PTSD (Dunmore, Clark, & Ehlers, 1999; Ehlers & Clark, 2000).

(ii) Memory of the trauma

PTSD is characterised by memory disturbances and unintentional recall of trauma memories. More specifically, intentional recall of a complete trauma memory is often not possible. Instead, the trauma memory contains gaps with information missing, is not recalled chronologically, and is characterised by reduced organisation and fragmentation. In contrast, vivid and emotionally rich memories consisting of thoughts and sensory impressions (visual, physical, etcetera) about aspects of the trauma are involuntarily triggered and experienced as intrusive (Ehlers & Clark, 2000).

(a) Poor elaboration and organisation

The nature of a person's trauma memory is influenced by the way in which data are encoded at the time of the event. The encoding process is described as data-driven processing when the person's focus is on sensory impressions which cause strong perceptual priming and thus memories that are difficult to retrieve intentionally. For this reason data-driven processing is associated with the maintenance of PTSD. Conceptual processing is focused on the meaning of the situation, organising the information, and placing it in context which assists integration of the trauma memory with autobiographical memories (Brewin & Holmes, 2003).

In addition to deficits in the elaboration and organisation of trauma memories, a lack of coherence and organisation characterises the intentional recall of traumatic events (Clark & Ehlers, 2005). Using Brewin's (Brewin et al., 1996) terminology, autobiographical information is retrieved either through intentional recall of verbally

accessible memories, or through the automatic recall of situationally accessible memories when stimuli associated with the trauma situation are encountered. Events and experiences in the autobiographical memory base are organised by themes and timelines, which assists *intentional recall* while *automatic recall* is inhibited. According to Ehlers and Clark (2000), a major problem in PTSD is the poor elaboration and inadequate integration of the trauma memory into a context of "time, place, subsequent and previous information and other autobiographical memories". This serves to explain the memory disturbances, unintentional recall triggered by situational stimuli, and the here-and-now experience of current threat.

(b) Strong perceptual priming

Perceptual priming is in essence a reduced threshold for the awareness of stimuli that were temporally associated with the traumatic event. These stimuli become more likely to be noticed, leading to re-experiencing, even though the context in which they are encountered are different from the event. A research study conducted by Michael, Ehlers, Halligan, and Clark (2005) showed that for assault victims, priming for trauma-related material differentiated between those suffering from PTSD and others who did not.

(c) Associative learning

Ehlers and Clark (2000) propose that associative learning, which assists individuals in predicting what will happen next, is especially strong for trauma-related material. Hence, in PTSD the process of associative learning causes stimuli present before or during the traumatic event to become associated with a sense of perceived current threat. PTSD is maintained because the individual stays unaware of these triggers (associated stimuli) that cause unintentional recall from associative memory. As a result the individual is also unaware that the sense of threat is related to activation of trauma memories, and not from actual current threat.

(d) The reciprocal relationship between the nature of the trauma memory and appraisals

The appraisals of people suffering from PTSD influence their recall of trauma memories in a way that leads them to recall only memories consistent with these appraisals. As a

result, details contradicting such appraisals are not recalled and the appraisals and PTSD are maintained. An inability to remember trauma details or the chronological order of events can give rise to appraisals that maintain a sense of current threat, for example, appraising memory loss as permanent brain damage, or poor temporal order as evidence for responsibility of the event. The here-and-now experience of reliving the event can lead to appraisals maintaining PTSD, for example, becoming fearful while in a safe environment with trusted people might be appraised as having permanently lost the ability to feel safe and relaxed again (Ehlers & Clark, 2000).

(iii) Maladaptive cognitive and behavioural strategies of avoidance

When a perceived sense of current threat arises, the individual attempts to control it by invoking various cognitive and behavioural strategies. The type of strategy used is determined by the individual's appraisals of the trauma and its consequences. These strategies maintain PTSD in three ways. Firstly, they directly produce PTSD symptoms through: *thought suppression* (attempts to force oneself not to think about the trauma leads to intrusive memories being experienced more often); and *behaviours used to control symptoms* which then cause other PTSD related symptoms (avoiding certain places might result in also avoiding one's friends which decrease social support) (Ehlers & Clark, 2000).

Secondly, traumatised individuals often employ *safety behaviours* in an attempt to prevent future traumatic events from happening. Safety behaviours hamper adjustments in negative appraisals related to the trauma and its consequences. As a result, the person continually acts in ways that they perceive will prevent further traumas from happening. There is thus no disconfirmation of the belief that future traumatic events will occur. For example, *selective attention to threat cues* occurs when the individual focus specifically on cues associated with the event, which in turn results in a sense of current threat (Ehlers & Clark, 2000).

Thirdly, when individuals actively try not to think about the event, there is little opportunity for elaboration of the trauma memory and as a result there is no change in the trauma memory. This maintains PTSD. Avoiding reminders of the trauma also

maintain PTSD as it prevents changes in both the nature of the trauma memory and in negative appraisals. For example, if the trauma site is avoided, cues that make retrieval of forgotten details possible are not encountered and prevent an elaboration of the trauma memory (Ehlers & Clark, 2000).

Attempts to minimise symptoms through the use of medication or other substances can inhibit changes in appraisals, for example “Because of my experience I’m not strong enough to cope on my own”. Another maintaining factor is quitting previously meaningful activities such as sport and socialising. Beliefs about how the event changed them permanently are left unchallenged in such a situation.

Ehlers and Clark (2000) suggest that rumination serves to maintain PTSD as it might cause maladaptive appraisals to be strengthened. As rumination is often characterised by “what-if?” questioning and not the actual event details, it also interferes with an elaboration of trauma memory. They further suggest that the cognitive process of dissociation consisting of emotional numbing, depersonalisation, and derealisation also maintain PTSD since they prevent the integration of trauma memories into autobiographical memory.

(iv) <u>Other factors</u>

Factors not covered in the above discussion might impact indirectly on the development and maintenance of PTSD through exerting an influence on an individual’s cognitive processing, appraisals, and cognitive and behavioural strategies (all of which were described above).

If data-driven processing took place during earlier traumas, conceptual processing is less likely in subsequent traumas (refer to section 4.6.1 (ii) a. for definitions). In this way an individual’s *cognitive coping style during previous traumas* can influence the development and maintenance of PTSD when another traumatic event is experienced (Ehlers & Clark, 2000). Characteristics of the trauma, such as the traumatic event being difficult to predict, or being long in duration, can play a role through making conceptual processing of an event more complicated (Ehlers & Clark, 2000). As data-driven

processing (compared to conceptual processing) is more prevalent in individuals with lower levels of *intellectual ability*, this factor that might lead to the maintenance of PTSD. *Substance intake, level of fatigue, extent of arousal, and intensity of the fear experienced* can all influence an individual's level of consciousness and alertness at the time of the event. Lower levels of consciousness and alertness result in the event being processed in a less coherent way, thus making data-driven processing more likely (Ehlers & Clark, 2000).

Prior beliefs and schemas (also see section 4.5.1 (ii)) can impact on the development and maintenance of PTSD in two ways. Firstly, if a traumatic event or its consequences shatter a person's positively held beliefs, decreased self-esteem and a loss of trust in the person themselves, others, and the world might result. Secondly, if a negatively held belief or pre-existing schema is congruent with the effects of the traumatic event, these beliefs and schemas are confirmed and elaborated, reinforcing maintaining factors (Foa & Riggs, 1993; Janoff-Bulman, 1992).

Prior traumatic experiences can act as risk and maintaining factors in that they are often linked to the most recent trauma, causing appraisals to be more negative and severe. Additionally, a later trauma with similar characteristics can provide cues for the recall of memories and emotional responses from previous traumas (Ehlers & Clark, 2000).

4.6.2 NATURE OF INTRUSIVE RE-EXPERIENCING AND MEMORIES

Ehlers, Hackmann, and Michael (2004) suggest that the term "intrusive thoughts", used in earlier literature, is a misnomer. They propose using the term "intrusive memories" which consist of spontaneously activated, unwanted, memories containing brief sensory fragments of the trauma experience.

According to the *warning signal hypothesis*, intrusive memories consist of stimuli that, through temporal association with the trauma, acquired the status of warning signals that serve to warn the individual against impending danger. This explains the reason for intrusive memories being accompanied by a sense of serious current threat. The warning signal hypothesis can assist in identifying the moments with the most significant

emotional impact which needs processing. It is also valuable in educating patients about the nature of re-experiencing symptoms through explaining the working of triggers (stimuli bearing a resemblance to stimuli that immediately preceded the warning signal) (Ehlers et al., 2000).

The most common intrusive memories consist of visual sensations, but can also contain bodily sensations, sounds, smells, and tastes. During intrusive re-experiencing there is a lack of awareness that the content of memory is from the past. In the extreme case of a dissociative flashback the individual has no awareness of their surroundings and "relives" the event in the present. Not only are the sensory impressions re-experienced, the emotions, physical reactions, and behavioural responses experienced during the trauma are also re-experienced or re-enacted in the present. *Affect without recollection* is a less severe form of re-experiencing. Physiological sensations and emotions experienced at the time of the trauma are re-experienced, but without recalling the event (Ehlers et al., 2004). Lastly, intrusive memories must be distinguished from non-memory intrusions such as rumination and evaluative thoughts which might occur more frequently than intrusive memories (Ehlers et al., 2004).

4.7 TREATING PTSD WITH EHLERS AND CLARK'S MODEL

The delivery of a therapeutic intervention employing Ehlers and Clark's model (2000) is preceded by an assessment phase, a case formulation, and a treatment plan. The model is formulation driven and individualised for each client by identifying their idiosyncratic appraisals, memory characteristics and triggers, and the behavioural and cognitive strategies employed. As such it allows for flexibility and adjustments to be made to the treatment plan according to the client's needs and as the treatment phase reveals new information (Ehlers, Clark, Hackmann, McManus, & Fennel, 2005).

4.7.1 Assessment Phase

The aims of assessment are to establish the nature of the trauma memory and to identify the cognitive themes, problematic appraisals, and cognitive and behavioural strategies to be addressed in therapy (Ehlers & Clark, 2000).

To ascertain the *nature of the trauma memory*, it is necessary to determine the extent of gaps in memory, whether the events are remembered chronologically or if the sequence is scrambled up in memory, and to what degree the memory and automatic intrusions have a here-and-now quality and is accompanied by sensory and motor experiences (Ehlers & Clark, 2000).

To identify the *cognitive themes*, it is necessary to enquire about what the person experienced as the worst aspects and most severe moments of the trauma. To assist this process, the aspects of the trauma memory eliciting intense distress and also the content of intrusive images are explored to identify their meanings. Another source of cognitive themes is the nature of the most prevalent emotions such as fear, shame, and guilt (Ehlers & Clark, 2000).

In order to identify maladaptive appraisals, it is necessary to determine what the person has experienced as the most difficult and distressing since the event occurred, as well as their beliefs about the future and beliefs regarding symptoms and how others behave towards them. Furthermore, identification of appraisals can also be achieved through careful questioning, examining responses to self-report inventories such as the Post Traumatic Cognitions Inventory (Foa et al., 1999), as well as exploring hotspots which are identified by examining the content of intrusions and through engaging in imaginal reliving.

Cognitive and behavioural strategies are identified by eliciting: the person's thoughts about good ways in which to deal with the trauma and its consequences, what they avoid, how they respond to intrusions, whether they ruminate and the contents of rumination, and what they think might happen if they allow themselves to think about the trauma freely (Ehlers & Clark, 2000).

4.7.2 Formulation and Treatment Plan

The assessment phase provides information for a case formulation. The treatment plan is then based on the case formulation together with the following three treatment goals: (1) modifying excessive negative appraisals of the trauma and its consequences, (2)

reducing re-experiencing by elaboration of the trauma narrative and the discrimination of re-experiencing triggers, and (3) decreasing/eliminating dysfunctional cognitive and behavioural strategies (Ehlers & Clark, 2000). The treatment plan incorporates specific interventions which are chosen based on their ability to achieve the treatment goals. These interventions are more fully discussed under the treatment phase below.

4.7.3 Treatment Phase and Specific Interventions

The treatment phase commences by providing the client with a rationale for the treatment. This involves normalising of, and education about, the individual's PTSD symptoms; how their coping strategies might be maintaining the disorder; and introducing the treatment plan as well as the aim of complete processing of the trauma (Ehlers & Clark, 2000).

Goal one: Modifying negative appraisals

As described in section 4.6.1 (i), negative appraisals of the trauma and its consequences are important developmental and maintaining factors for PTSD. After appraisals have been identified during the assessment, the next step is altering these appraisals through Socratic questioning and employing standard cognitive-behavioural techniques (Clark & Ehlers, 2005). When a negative appraisal has been modified into a more adaptive positive or neutral appraisal, it is incorporated into the trauma memory. Ways of doing this include incorporating the new appraisal into the trauma narrative during subsequent reliving, by amending the written or verbal trauma narrative that was previously given by the individual, and utilising imagery transformation techniques (Ehlers et al., 2005). Moreover, engaging in behavioural tasks can assist in disproving or changing negative appraisals. Imaginal reliving for example can serve this purpose when a person believes they will go crazy or are not capable to tolerate thoughts involving the event. "Surviving" the imaginal reliving can provide evidence to the contrary. When imaginal reliving focuses on the parts of the trauma memory on which the individual base their negative appraisals, it can provide information incompatible with these negative appraisals (Grey, Young, & Holmes, 2002).

Goal Two: Reducing re-experiencing

When the trauma memory is elaborated in a way that creates a coherent trauma narrative, a reduction in re-experiencing usually results. A coherent trauma narrative is characterised by placing the series of events in chronological sequence and in context (Clark & Ehlers, 2005). This can be accomplished using three techniques. Firstly, the person can write a comprehensive narrative of how the event unfolded, including their experience of it and the thoughts they had at the time. This is very beneficial when details of what and how the event happened are vague or muddled. Additionally, using drawings and models can add value. Secondly, imaginal reliving involves the person recalling the event in their imagination, exactly as it happened. They then verbally describe everything recalled, including what they see, hear, smell, think, and feel, both physically and emotionally. This technique is effective in activating all sensory modalities of the trauma memory which can then be placed in context. Thirdly, the place where the event happened can be revisited. Being at the scene can provide the person with information that has been forgotten or which can help in explaining how/why the event happened. The person also gets the opportunity to "see" that the event is over, which might reduce the future sense of current threat (Clark & Ehlers, 2005).

Re-experiencing can also be decreased by the discrimination of triggers which involves two steps. Triggers are identified through a thorough analysis that determines when and in which situations intrusions are experienced. Furthermore, it is determined how the characteristics of the environment or people that were involved in the trauma are similar to the content of intrusions. In this way the individual is also trained in spotting triggers themselves. Next, the associations and differences between the triggers and aspects of the trauma memory are made explicit in an attempt to help the person to discriminate between *then* and *now* when future intrusions occur (Clark & Ehlers, 2005).

Goal Three: Decreasing dysfunctional cognitive and behavioural strategies

These strategies help the individual to reduce the sense of current threat in the short-term, but the long-term effect is that PTSD is maintained. Dysfunctional strategies are identified by discussing the consequences of the trauma, and how the person is trying to cope with it (Clark & Ehlers, 2005). These strategies often include safety behaviours and avoidance. Behavioural experiments are often employed in an attempt to help the

individual drop the strategy, the motivation being to reclaim their lives. They can be encouraged to start engaging in activities (or similar ones) they gave up after the trauma, and to perform an activity without using the safety behaviour. It is important to identify and explore beliefs that can prevent the individual from implementing the more adaptive behaviour (Ehlers & Clark, 2000). People experiencing regular intrusions and who believe that forcing themselves not to think about the event will minimise intrusions, can be given a thought suppression experiment. When it has been demonstrated that explicitly trying to avoid a specific though increase the frequency of recollection, they can be asked to experiment with allowing the intrusions to freely enter and leave their mind (Ehlers & Clark, 2000).

4.8 TREATMENT EFFICACY

During the past decade, the treatment of PTSD using various approaches including cognitive, behavioural, psychodynamic, and pharmacological models have proved to be effective (Foa et al., 2000). Research has shown that cognitive therapy in particular is an *effective* and *acceptable* treatment for PTSD in that significant improvements are achieved during treatment and are maintained at follow-up (Clark & Ehlers, 2005). There is an increasing expectation for clinicians to be able to justify, using scientific proof, the treatment approaches they engage in, as well as demonstrating efficacy in the contexts in which they operate. This can be achieved through producing evidence-based practice (Edwards, 2005a).

4.8.1 Efficacy of the Ehlers and Clark Cognitive Therapy Model

Ehlers and Clark (2000) describe various studies that employed their cognitive treatment model. In all the studies the dropout rate was very low and the significant improvements in PTSD symptoms, disability, and depression were maintained at follow up, done at between 6-9 months. Additionally, the pretreatment-to-posttreatment effect size was high in all studies, the minimum being 2.25. These studies included various groups of people with PTSD symptoms, ranging from those suffering from chronic PTSD to people who have experienced a trauma only 3 months prior.

Gillespie, Duffy, Hackmann and Clark (2002) undertook an intervention based on the Ehlers and Clark (2000) model following a car bomb explosion in Northern Ireland in 1998. DSM-IV-TR (American Psychiatric Association, 2000) criteria for PTSD were met by 91 individuals. After on average eight sessions, treatment results showed that those treated experienced a significant decline in PTSD and comorbid depression. (This study is more fully described in section 4.12 below).

Ehlers et al., (2003), conducted a study involving motor vehicle accident survivors meeting criteria for persistent PTSD. The aim of the study was to investigate whether cognitive therapy or a self-help booklet used during the initial months after a trauma was more effective in preventing PTSD as compared to repeated assessments. After completing a three week self-monitoring phase, participants who had not recovered were randomly assigned to receive either cognitive therapy (CT), a cognitive behavioural oriented self-help booklet (SH), or repeated assessments (RA). As far as reducing symptoms of PTSD, depression, and anxiety, CT was found to be more effective than SH and RA. The effect size for the CT group was 2, which was significantly higher than that of the SH (approximately 1) and RA (less than 1). At follow-up 11% of CT patients still suffered from PTSD compared to 61% of the SH group and 55% of the RA group.

Another research study was done by Ehlers et al. (2005) investigating the efficacy of cognitive therapy in treating 20 individuals suffering from PTSD. Inclusion criteria included being 18-65 years old, meeting diagnostic criteria for PTSD resulting from a discrete traumatic event during adulthood, and the trauma having occurred more than six months prior. Treatment followed the guidelines proposed by the Ehlers and Clark (2000) model. An effect size of 2.82 was achieved (double of that reported in other studies), as well as significant reductions in PTSD symptoms. This study incorporated a randomised control trial that was compared to a 3-month waitlist condition. Results indicated that cognitive therapy resulted in substantial reductions in symptoms of PTSD, depression, and anxiety, with an effect size of 2.25. Symtomatology in the waitlist group remained unchanged. Of those in the CT group, 71% no longer met the criteria for PTSD after the intervention. Treatment gains for both studies were maintained at a six-month follow-up.

In light of the above, cognitive therapy and specifically the Ehlers and Clark (2000) model have been shown to be effective treatments for PTSD (Brewin & Holmes, 2003; Clark & Ehlers, 2005).

4.9 SCHEMA THERAPY AND CHILDHOOD ABUSE

The Ehlers and Clark (2000) model places a strong focus on maintaining factors. However, in cases where there is a prominent history of early abuse and trauma, it is important to also place sufficient focus on a developmental analysis. In this case it was achieved by incorporating aspects of Young, Klosko, and Weishaar's (2003) schema-theory into the therapeutic intervention.

The definition of "schema" varies according to the specific subject area or psychological theory one consults. For the purposes of this research project, the definition used by Young et al. (2003) is applied and is used interchangeably with "early maladaptive schema":

> *A schema is a broad, pervasive theme or pattern comprised of memories, emotions, cognitions, and bodily sensations regarding oneself and one's relationships. A person's behaviour does not form part of the schema; it is considered a response to the schema itself. Schemas develop during childhood or adolescence and are maintained and elaborated during one's life to the extent that they move from being adaptive to becoming significantly dysfunctional*.

Specific schemas described by Young et al. (2003) which are relevant to this case

1. Abandonment/Instability schema: the person perceives significant others who are responsible for providing them with support and emotional connection as unreliable.
2. Emotional Deprivation schema: the person expects that their desire for adequate emotional support will not be met by others. This might include amongst others the absence of nurturance, attention, understanding, empathy, and protection.
3. Mistrust/Abuse schema: the person has an expectation that others will intentionally hurt, abuse, humiliate, or take advantage of them.

4. Subjugation schema: the person surrenders control of their needs or emotions to others due to feeling coerced, or perceiving their own desires, feelings, and opinions as unimportant or invalid.
5. Emotional Inhibition: the person excessively inhibits spontaneous feelings, actions, or communication so as to avoid disapproval, shame, or losing control over their impulses. Most frequently anger and aggression, as well as positive emotions are avoided.

Young et al. (2003) also describes the "detached protector" mode which is a maladaptive style of coping, employing avoidance as its main way of coping. The detached protector functions in such a way as to shut off the person's emotions and they disconnect from others in order to protect themself from pain. It further cuts them off from their own needs and they attempt to appease others. This is done in order to protect themself from possible harm from others by avoiding punishment. People switch to a detached protector coping style when intense emotions are stirred up in them during therapy sessions or outside of it. Person's who frequently invoke this way of avoiding usually present with symptoms that include psychosomatic complaints, depersonalisation, blankness, substance abuse and binging, self-harm, and compliance. They might appear to be good clients, doing what they are asked to, being on time, and displaying appropriate behaviour. They often report feeling numb or that they are unaware of what they are feeling.

Childhood experiences

Research done by Nishith, Mechanic, and Resick (2000); Regehr, Marziali and Jansen (1999); and Masten and Coatsworth (1998) provide evidence that resourcefulness in coping with crises is the result of self-schemas developed through positive early life experiences and positive attachments with early caregivers. Resilience in the face of adversity is associated with having a close relationship to a caring and reliable parent figure, with parenting that is authoritative and combines warmth with structure and firmness, and with connections to supportive extended family networks. In contrast, it has been argued that significant losses, traumas, or failures of early parenting render individuals more vulnerable to emotional distress in adulthood. It has also been found

that individuals more vulnerable to emotional distress in adulthood tend to generalise the schemas formed in childhood to their adult relationships. In particular, schemas of women who had been sexually abused as children reflected mistrust and expectations that others would be hostile, distant, unfriendly, and not be genuinely interested in them. Furthermore, it is suggested that sexual abuse combined with a family environment characterised by hostile parental control render individuals vulnerable to re-victimisation. Herman (2001) states that traumatic events "shatter the construction of the self that is formed and sustained in relation to others." She also suggests that trauma survivors oscillate between experiencing a need for intimacy and withdrawal from close attachments. This manifests as moving between social isolation and anxious clinging to others.

Young et al. (2003) describes two approaches that can be used therapeutically in the context of the therapeutic relationship: empathic confrontation and limited reparenting. Empathic confrontation is an approach that involves a genuine emotional bond wherein the therapist truly cares for the client. Through expressing understanding of how the schema came into existence and the difficulties it creates, the therapist empathises with the client. Simultaneously however, the therapist emphasises the importance of change and motivates working towards it (Young et al., 2003). The therapist uses limited reparenting to provide the client with emotional experiences that they never received in childhood (and that contributed to the formation of schemas). These are used to assist in fostering change by working against the schema (Young et al., 2003).

4.10 CULTURE AND PTSD

Marsella et al., (1996) suggest that there are three dimensions to consider when working with any psychiatric disorder and specifically with PTSD namely: personal uniqueness, universality, and culture. In PTSD personal uniqueness refers to the person's idiosyncratic perception of the traumatic event (as this will determine whether PTSD develops or not), as well as other personal factors affecting the development and maintenance of, and recovery from PTSD. Universality refers to the biological heritage shared by all humans and includes the similar ways in which all people react to certain stimuli. Marsella et al. (1996) defines culture as:

> "*…shared learned behaviour which is transmitted from one generation to another to promote individual and group adjustment and adaptation. Culture is represented externally as artefacts, roles, and institutions, and is represented internally as values, beliefs, attitudes, cognitive styles, epistemologies, and consciousness patterns.*" (p. 10).

They further suggest that in the evaluation and treatment of traumatised individuals, clinicians need to be sensitive to possible influences of cultural factors. Adopting an approach that includes a developmental perspective can allow for the consideration of a person's multi-culturality (Marsella et al., 1996).

According to Eagle (2004), ethnocultural aspects and beliefs relevant for South Africa and the African context include: humans being viewed as part of a holistic system, and not as separate from it and exerting an influence on it in a unidirectional way; the needs of the group are placed before those of the individual; a non-dualistic conceptualisation of mind-body functioning; ancestors play an important role in African society and they are believed to communicate through dreams (dreams are a common occurrence in people suffering from PTSD); and dreams are taken to give direction and are therefore often seen as advice or instruction. Furthermore, a person's cultural experience can have an influence on what sense they make of the traumatic event, how their affect is expressed and modulated, what resources they have available to assist in coping, the social support available and to what extent it is utilised. Additionally, an individual's specific or subtle expectations of therapeutic help are also dependent on their culture (Swartz, 1998).

It is important to pay attention to ethnocentricity. In the context of this research project, ethnocentricity can be defined as the tendency to view the Westernised conception of thinking and behaving as the correct, moral way, while simultaneously rejecting or minimising the importance of any other conceptualisation. Ethnocentric bias results when ethnocentricity leads practitioners and researchers to ignore or minimise ethnocultural aspects (Marsella et al., 1996). Ethnocentric bias can have the following

general negative influences in psychiatric practice: developing inappropriate standards of abnormality and normality; deficient knowledge about the expression, course, diagnosis, assessment, and outcome of psychiatric disorders; and the use of inappropriate therapy procedures (Marsella, Chemtob, & Hamada, 1990).

Other cultural factors that can play a role in PTSD are a person's identity and roles. According to acculturation models, when a person moves away from their traditional culture, belief systems, practices, and influences, towards those of the dominant culture, a *multicultural identity* develops, which can lead to various self-conceptualisations. This links back to personal uniqueness described above, and can have an influence on the development of PTSD (Marsella et al., 1996). Lastly, according to role theory, the roles a person assume can result in them simultaneously having more than one ethnic identity, each consisting of different beliefs and attitudes (Pearlin cited by Marsella et al., 1996). It is a complex task to separate out which role and its corresponding beliefs are at work in influencing PTSD in such an individual.

Despite the vast quantity of literature on the possible influence of an individual's culture on mental health, there is some debate regarding whether culture in actual fact plays a significant role. Furthermore, two recent case studies (Davidow, 2006; Payne, 2006) treating Black Xhosa speaking women and employing the Ehlers and Clark model, found that differences between (1) the therapist's and client's cultural backgrounds, and (2) the culture of the client and the dominant culture in which the Ehlers and Clark model was developed, had negligible bearing on the therapy process.

4.11 TRANSPORTABILITY

Despite innovative research being done on understanding and treating PTSD in Europe and America, the question remains whether the treatment models and interventions developed there will be effective for treating PTSD in the African context. This raises the issue of *transportability*, and to address it, research needs to consider the following two specific areas regarding the Ehlers and Clark model: whether the model is transportable from a research setting to a general clinical setting, and, from one cultural setting to another (from a first world to a third world context) (Edwards, 2005a).

Concerns regarding transportability are related to whether the treatment provided is relevant to the population receiving the intervention, given that it was not specifically designed for them; failure to consider local cultural and environmental factors; and the standard of training of those delivering the treatment (Schoenwald & Hoagwood as cited in Edwards, 2005a).

There are studies providing preliminary evidence that the basic components of PTSD treatment models can be successfully transported to clinical settings and different cultural contexts (Edwards, 2005b). Following a car bomb explosion in Northern Ireland in 1998, Gillespie et al., (2002) undertook an intervention in a community setting which was based on the cognitive therapy treatment model developed by Ehlers and Clark (2000). Treatment was given by National Health Service staff, who received brief specialist training in cognitive therapy for PTSD before administering the treatment to 91 individuals meeting the DSM-IV-TR (American Psychiatric Association, 2000) criteria for PTSD. Results showed that those treated experienced a significant decline in PTSD. In addition, 53 percent of participants had a comorbid Axis I Disorder. Comorbidity was not associated with poorer treatment outcome and a significant decline in symptoms of depression was also observed. This study thus provided evidence that the Ehlers and Clark (2000) model can be generalised to a clinical setting.

Furthermore, a South African based case study using the Ehlers and Clark (2000) model conducted by Smith (2006) provided evidence of transportability from a research to a clinical setting. The case dealt with an English-speaking white South African hijacking survivor who had been severely disabled by PTSD for a period of two years. Several suicide attempts eventually led to the need for inpatient treatment in a psychiatric hospital. Substantial improvement in the patient's mood and a significant reduction in post-traumatic symptoms were achieved within eight weeks of intensive therapy. Up to three sessions per week, with a total of 18 therapy session were conducted.

Eagle (2005) suggests that factors including race, class, and ethnic classification might impact on the therapeutic intervention. As a result these factors will also influence the

transportability of a treatment model such as that used in this case study. It is therefore important to take cognisance of different cultural contexts in establishing transportability. Eagle suggests that PTSD has been successfully treated using the Wits Trauma Model (Eagle, 2005), which has many similarities to Ehlers and Clark's (2000) cognitive therapy model in that both make use of cognitive therapy techniques.

In two case studies carried out locally, both Davidow (2006) and Payne (2006) treated rape survivors of African descent using the Ehlers and Clark (2000) model, showing transportability between cultures. The therapeutic intervention implemented by Davidow consisted of ten therapy sessions, spanning twelve weeks. Despite the intervention not having been finished, at termination a significant reduction in depression and anxiety levels were reported and the patient no longer met diagnostic criteria for PTSD. Hence this study suggests that the model might be effective in treating PTSD in multicultural societies such as South Africa. Payne treated a 15-year-old rape survivor in the course of 21 therapy sessions. The patient met the criteria for chronic PTSD and she was also suffering from major depression. Again, despite therapy not being completed, therapeutic gains were made to the extent that the model was found to be transportable to the South African population. Neither of these studies found specific cultural factors unique to the African context that caused significant difficulties with applying the model. This suggests that the assessment, formulation, and treatment phases comprising the Ehlers and Clark (2000) model are not culturally biased and thus transportable to different frameworks and worldviews.

Karpelowsky and Edwards (2005) describe a phenomenological case study involving a student suffering from Acute Stress Disorder following a series of repeated traumas and witnessing the mutilated corpse of his brother. The intervention incorporated in-depth descriptions of the traumatic events, four guided imagery sessions, the identification of dysfunctional beliefs and assumptions, and cognitive restructuring. The client reported significant reductions in symptomatology at termination. The results of this study suggest that integrative psychotherapy employing imagery work is effective within the South African context. No cultural factors were found to influence the therapeutic process.

5. FORMULATION & TREATMENT PLAN

5.1 CASE FORMULATION

Although the Presenting Problem in section 3.2 describes the main complaints with which Bongi struggled, what follows can be viewed as a detailed elaboration of this, with a focus on the PTSD related symptoms and taking cognisance of the information required for applying the Ehlers and Clark model.

Predisposing Factors

To gain an understanding of Bongi and her presentation, the influence of her early home environment and relationships must be considered, especially her relationship with her parents. Due to her parent's "absence" in her life, her core emotional needs for secure attachment, including nurturance, acceptance, and safety were frustrated. At a very early age this instilled Bongi with a belief that her need for love, nurturance, safety, and to be heard and understood would not be met. She thus came not to expect these in her relationships with her caregivers and significant others. According to the schema theory of Young et al., (2003), it is hypothesised that Bongi developed the Abandonment/Instability and Emotional Deprivation schemas early on in life. As a result, it was and still is difficult for her to form deep, intimate relationships, especially with men. When she now perceives, at an unconscious level, that she is treated in the same way as when she was young, these schemas are activated resulting in her experiencing strong negative emotions such as anger, shame, or fear. Additionally, when she enters into a relationship, she has an expectation that her needs will be unfulfilled. The presence of these early maladaptive schemas and their influence on her idiosyncratic way of relating interpersonally is hypothesised to have made Bongi vulnerable to the onset of depression.

At age nine Bongi was raped and never told anyone for fear of being punished. As a result she was alone in trying to make sense of this traumatic event and in coping with the emotional and psychological consequences that included fear, anxiety, shame, and confusion (she did not know anything about sex at the time). Bongi experienced a loss of self-esteem, self-worth, and, as a result of her existing vulnerability to become

depressed, she possibly developed her first major depressive episode. This is supported by her reporting feeling depressed since age ten and attempting to commit suicide by running into a busy street. As Bongi was able to progress through her school grades successfully, it is hypothesised that the major depressive episode subsided and was followed by a period of dysthymia.

Bongi's core emotional needs to be spontaneous and playful, and to freely express herself were undermined as a result of the way she was treated after her father's return to the farm when she was twelve − she was forced to work slavishly, receiving regular beatings, and her mother did not stand up for her. She learned that she must disregard her own needs in favour of those of others. It was also necessary to gain her parent's approval, avoid punishment, and to maintain some kind of relatedness to them. According to the schema theory of Young et al., (2003), it is hypothesised that Bongi developed the Mistrust/Abuse, Subjugation, and Emotional Inhibition schemas during the time that she and both her parents lived on the farm. Thus she developed internalised rules about placing the needs of others before her own, even if it led to unhappiness, a lack of self expression, few close relationships, and less focus on her own academic performance at the time. In this way she learned to place her focus on the needs and wants of other's in interpersonal interactions. Bongi became emotionally inhibited, especially regarding the expression of her anger. All of these factors perpetuated the dysthymic disorder she suffered in between later major depressive episodes.

Precipitating Factors

During the past five years the main themes of her schemas have been reinforced by extreme events and situations briefly described below. These can also be conceptualised as risk factors for the PTSD that developed after being raped for a third time.

In 2002, aged 18, Bongi was date-raped while away on holiday. The pain of rejection was so intense that it outweighed the consequences of having sex against her will. Bongi learned from this experience that expressing emotion (love in this case) leads to

being hurt and rejected, that her expectation of love (verbalised by him) will again not be met, that men cannot be trusted, and that she will get hurt in intimate relationships. During 2003, aged 19, Bongi was involved in a romantic relationship in which she agreed to sex in order to please her partner. Despite this sacrifice she ended up feeling emotionally abused by him. During 2004, aged 20, Bongi was raped by a modelling organiser she worked with. She experienced this as very traumatic and her life started to fall apart as a result. She developed PTSD as well as another major depressive episode.

Not only have her early maladaptive schemas together with the previous sexual abuse rendered her vulnerable to further trauma and re-victimisation, but various other factors have also acted as predisposing factors to her developing PTSD. The fact that these incidents of abuse were not effectively processed but rather avoided made any future trauma more likely to negatively influence Bongi. Suffering from depressive disorders for many years made the development of PTSD more likely as it interfered with the natural recovery process. Another factor that contributed to the development of PTSD is the *severity* of the impact it had on her life, which can be seen in for example her giving up modelling and acting. This impact was also on an emotional level as she felt as though she was destroyed (*mental defeat*). Lastly, a lack of social support contributed not only to her developing PTSD, but it also served to maintain it.

Maintaining Factors

In 2005, a very close friend of Bongi died unexpectedly. She lost one of the few people who made an effort to understand her, and someone who was an important source of support. In the same year another romantic relationship was ended by her partner after four months. She had again agreed to sex without really wanting to. During the following year, 2006, she mourned the loss of her brother who died of cancer. The idea that the world is dangerous and that nowhere is safe was reinforced. Later in 2006 Bongi's most recent romantic relationship ended after less than a year. Again she suffered emotional abuse, gave in to sex unwillingly, and was the one who ended up being rejected. The series of failed relationships reinforced the belief that she must suppress her own needs and emotions in order to keep the relationship going, but that even this sacrifice

ultimately fails. She also learned that she cannot expect nurturance and care from those most likely to be in a position to offer it.

Research has shown that life stressors at the time of the trauma and thereafter serve to influence the development and maintenance of PTSD. The above series of traumas and failed relationships served to maintain her PTSD by preventing Bongi from entering a process of healing. There were also other maintaining factors. The fact that Bongi never spoke about the rape incidents served to maintain the feeling of shame and did not allow the opportunity for elaboration of the trauma memory. Further, no-one knew what she was struggling with and so they could not offer her the support, comfort, and nurturance she needed. Her vulnerability to depressive disorders complicated the manifestation of PTSD and any recovery process was hampered. Bongi also used avoidance strategies, such as sleeping too much, avoiding people, abusing alcohol over weekends and partying until late. She also had a superficial positive outlook on the future which made her minimise the influence of past events and current symptoms. Lastly, she learned to suppress her emotions, especially anger which prevented her from acting assertively and taking care of herself.

Her move to Grahamstown (2007) represented another failed attempt to change her life. Additionally, she was far away from familiar contexts in which she could experience some superficial level of comfort with her friends, well established routines, support of her aunt, and a physically safe home environment. The adjustment process contributed to increasing levels of anxiety, and together with not experiencing the anticipated positive change, another major depressive episode was precipitated. This led Bongi to seek help and enter therapy.

5.2 TREATMENT PLAN

The treatment plan and decisions regarding the implementation thereof was based on Ehlers and Clark's (2000) model, taking into account information obtained during the assessment phase and case formulation, new information arising during therapy sessions, and discussions with the case supervisor. Given that there had been eight assessment sessions and, because of her vulnerability, it was not appropriate to include

a reliving session, it was judged important that the treatment proceed at a pace that she could handle. Given that the first sexual abuse incident had occurred when she was nine, and that there were long established early maladaptive schemas, it seemed likely a relatively long term therapy was indicated. The treatment plan was thus flexible, focussing on difficulties and particular needs as they arose.

Bongi was clearly committed to therapy as she attended assessment sessions twice weekly for a month. However, she found it difficult to engage in dialogue relating to the actual incidents of rape. As a result Bongi found many of these sessions very challenging on an emotional level. She attempted to avoid conversations about the rape incidents by easily and extensively answering questions related to her day to day functioning and current difficulties as well as other issues that were less evidently related to rape. When she did speak about the rape incidents and the content of re-experiencing, she was brief and vague, making it impossible to distinguish between incidents in terms of re-experiencing symptoms, triggers, and appraisals. Hotspots could also not be identified. She was not ready to engage in imaginal reliving during this phase. It was postponed until later in the intervention.

As Bongi was unable to speak about the rape incidents in detail during assessment, important information needed in order to apply the model was still missing when the therapy phase started. For this reason the first three sessions (before I went on leave) were set out to focus on eliciting the content and nature of her trauma memory, the content of re-experiencing, and appraisals related to these. The aim was then to use this information in subsequent sessions to elaborate the trauma memory and to modify negative appraisals.

The table below provides a summary of the treatment plan.

Treatment Goals	**Interventions**
1) Motivation, future planning,	▪ Psycho-education regarding diagnosis and treatment

reducing suicide ideation	process ▪ Negotiate treatment goals
2) Increase social support	▪ Psycho-education about benefits ▪ Motivate her to share her story with a friend ▪ Motivate her to find other sources of support
3) Reduce intrusive re-experiencing	▪ Identify hotspots with the use of imaginal reliving & subsequent reliving of hotspots ▪ Imaginal reliving in order to elaborate on the trauma memory ▪ Cognitive restructuring & cognitive restructuring within reliving ▪ Explain and identify triggers and hotspots by using warning-signal hypothesis ▪ Reduce nightmares with imagery rehearsal and restructuring
4) Create a coherent narrative	▪ Cognitive restructuring within reliving – insert updated and corrective information ▪ Socratic questioning
5) Modify negative appraisals	▪ Explore the origins of these beliefs ▪ Verbal challenging of beliefs through Socratic questioning and reality checking ▪ Evidence-based arguments ▪ Psycho-education regarding hind-sight bias

6) Drop avoidance mechanisms	▪ Identify avoidance mechanisms engaged in ▪ Psycho-education about the maintenance of PTSD ▪ Explore & develop more adaptive coping strategies
7) Monitor progress	▪ Administer self-reporting instruments throughout the treatment intervention ▪ Interview with independent assessor

Table 5.2: Treatment plan

Most therapy sessions took place on Saturdays and lasted between 90 and 120 minutes. Sessions usually started with Bongi completing inventories and her reporting on events and her own mental state during the past week. If appropriate we recapped the previous session and discussed what was achieved. The aim of the current session was then shared with her, followed by the implementation of the intervention. A break was often taken during the second half of sessions.

6. THE COURSE OF THERAPY

Initial session

Bongi showed up at our first scheduled therapy session looking very distressed. She was unable to utter a word for about ten minutes. She sat crying softly, at times looking up at me. When she was able to speak, the first thing she mentioned was her current accommodation problem. She had to vacate her place of residence for the duration of the university vacation and the alternative accommodation she had organised became unavailable today. It was therefore not appropriate to address her PTSD and the focus was on allowing her space to express her emotions, and to examine possible solutions to her accommodation problem. During the session Bongi was able to organise accommodation. She phoned a friend who agreed to help her. Although she has had a

stormy relationship with her recently, that evening Bongi phoned me and, sounding very jovial, told me that she had moved in with her friend and that all was going well.

Three days after the session Bongi sent me a SMS asking me to contact her. She did not have much to say and sounded very dejected. We confirmed our next session for the following day.

Session 2

> "*I'm angry…about everything. Do you have pills to kill someone with? A butchers knife or pot?…I want to kill her, chop her body up, cook it…feed it to the dogs…*"

Bongi started the session with these words and her mental state was congruent with the content. On greeting me she did not smile as she had often done and she looked very serious. She reported experiencing a headache, and physical pain below her heart and in her abdomen. Out of character for her, she also told me that I should appreciate her coming today as she struggled to wake up and because it was cold outside. Her BDI-II score was 37 and her BAI 52. Given the intensity of her distress, it was again not appropriate to embark on the intervention planned for the session, and the focus was on the immediate cause of her distress.

Bongi's anger was the result of various altercations with the friend who had provided her with accommodation. She felt judged and criticised. She was so angry with her friend that she was afraid that she might lose control and physically attack her. Other incidents during the week had added to her frustration levels. She had responded by smoking, trying to forget about it, irregularly talking about it, and often being rude to other people.

In due course she settled down, and I decided to continue with the planned session. I asked her about the content of the "automatic thoughts" she referred to during the assessment, and the nature of the associated feelings. I spoke about how the past was brought to the present and how she often feels angry, physical pain, worthless, and tearful. However, the content of her response was very superficial and lacked emotional

depth. I continued and asked her about the actual content of the thoughts. During the silence that followed she gave me a stern look, put her upper body down on her legs, looked up at me with tears in her eyes and said:

> "*I don't like you much right now. You don't understand…I'm going through a very difficult time…I'm a victim of circumstances and now you ask me to think about these things that make me feel bad…I am angry with you…*"

At this point she reached for her bag, asking if she may leave. I told her that she was free to leave, but that right now I am concerned about her. In this way I managed to get her to stay a few minutes. Although she was still upset when she left, the anger was not overwhelming anymore.

Session 3

This was our last session before I went on leave for two weeks. I decided to use the session to re-establish rapport, review what we had done together thus far, and to provide motivation for future therapy. This decision was based on the way in which the previous session ended, not wanting to expose Bongi to an emotionally intense session that might cause distress in the days to follow, and her mental state at the start of the session. Bongi was again visibly upset and distressed. She reported being very angry with her friend who was providing her with accommodation because of the way she had been treating her. Bongi's mood was so low that she reported having thoughts about killing herself. She assured me that despite thinking about suicide, she would not act on such thoughts. Nonetheless, we discussed the possibility of having her admitted to the voluntary ward at Fort England Hospital. She agreed that it would be beneficial, but by the end of the session she was still undecided. She said that she would let me know what her decision was. Two days later she sent me a SMS:

> "*…I'm fine and happy. I'm sorry I won't take the option you suggested, thank you so much though. If I change my mind I'll let you know…*"

Session 4

After a two-week break the main aim was to gauge Bongi's motivation to continue with therapy, and if she was interested, to provide her with a preliminary case formulation

and motivation. Bongi arrived at the session looking confident and she was cheerful. She spoke loudly, made jokes, and laughed. She reported feeling happy and provided some reasons. She had moved in with a different friend, her finances were sorted out, and she had started smoking marijuana during the last two weeks which helped to keep her stress levels down. She completed two BAI's, one for the first week of the break (score of 42), and another for the second week (score of 17). The BDI-II was administered once for the two week period and the score was 6.

After some hesitance, she told me that during this time she voluntarily had sex with two different men. The one was older than her father and the other of similar age to herself. She did not enjoy the sex, but wished it would end while they were busy. She also felt disgusted, guilty, and was reminded of the rape incidents.

I provided Bongi with a reading which was intended to serve as motivation, a chapter from Etherington (2003) entitled "Trauma, the Body and Transformation: A Narrative Inquiry". This chapter was chosen as it was written by a female survivor who suffered sexual abuse occurring over an extended period of time. She did not seek professional help for many years after the abuse. Eventually she suffered with so many symptoms that her illness was not initially linked to the prior abuse. After entering psychotherapy her condition began to improve. Bongi read the chapter during the session and reported that it made sense to her and that she gained insight into some of her struggles. Recognising some of the similarities between herself and the author was helpful to her. Both were sexually abused and struggled with similar symptoms such as reliving the abusive situations and somatic complaints seemingly unrelated to the abuse. The fact that the author made therapeutic gains encouraged Bongi and she stated that she needed to see therapy through.

I went on to provide Bongi with a brief formulation, focusing on the core of those parts currently described under precipitating and maintaining factors in section 5.1. Bongi seemed to easily follow the explanation and confirmed this by stating that she understood.

Session 5

Bongi entered the session appearing withdrawn and unwilling to engage verbally. Her eyes were downcast, and she made little eye contact. It was as though she found it difficult to speak. When she did, her responses were unusually short. After some time had elapsed that was filled with silence, staring, and stern looks from her, she reported feeling angry, hopeless, and as though she was being punished for no reason. She said it felt as if she was going crazy, meaning that she was confused about why she experienced these emotions. She asked if I have a stress-ball she could use. Her BAI score was 38 and her BDI-II 37.

She had been doing well until four days ago when she bumped into the person that raped her most recently. He was in Grahamstown to attend a conference. She felt like running away, but instead chatted with him and even gave him her telephone number when he asked for it. Although she had been ignoring the messages he had sent, she felt very upset by his presence in town. The thought evoked by the messages had been that he was unaware of the tremendous negative influence he had had on her life and she felt very angry.

Later in the session we discussed the shame and anger she was experiencing. It was placed into context of what we were trying to achieve in therapy; for her to overcome the shame and become more empowered, and to be able to use the anger to behave more assertively. It was further suggested that as an attempt to deal with the shame, she tell someone whom she trusted about having been raped. Before ending the session I motivated Bongi to speak about the content of her flashbacks in a future session as she had not yet been able to do so. She appeared to be much less distressed by the end of the session, speaking more and on occasion laughing.

Session 6

Bongi arrived at the session looking euthymic and relaxed, and with her hair cut very short. She reported having had a taxing week at school, but that this helped keep her mind and body busy which helped her not to think about the rape incidents. This offers insight into her moderate BDI-II score of 14 and low BAI score of 17. She went on to

describe that her hair had felt *heavy* before she had it cut, something that usually happens when she feels very stressed.

In order to clarify for her how I was conceptualising the therapy, I spent some time explaining how I understood the impact of the relational patterns that had been established while she was growing up, on her current relationships. I summarised for her that her relationships were characterised by (1) a lack of nurturance and care, (2) abuse on different levels, and (3) her frequently being misunderstood. Together these had the effect of leaving her needs unmet. In an attempt to get these needs met, she tried to please others. It was hypothesised that she attempted to please others as her mother modelled this pleasing behaviour in attempting to appease her father; her father overtly required her to please him with farm work by sacrificing her own time, friends, and childhood; and she had came to expect bad things in relationships and thus she tried to please the other person before they disappointed her. She asked if it was possible to change one's life of 23 years:

> "*I've tried many times before… by changing my look and cutting my hair …and by leaving home and attending Rhodes in a small town …I don't believe I can change it anymore*"

I told her I believed it was possible to get beyond the hopelessness and continual emotional pain. As it was clear from this statement that Bongi had no concept of psychological change and what it would entail, I explained that in order to deal with these, two areas needed to receive attention. She needed to thoroughly process the past traumas she had suffered. She also needed to experiment with new ways of relating to people which did not lay her open to further abuse and which would enable her to find meaningful relationships in which she was valued, respected, nurtured, and cared for.

Since this would involve her becoming more assertive, I suggested that we do some role-plays. In the first, I wanted her to experience an alternative and more assertive way to have handled the conversation she had had last week with the man who had previously raped her. In the second I suggested she enact a scene in a nightclub where

a man she had no interest in approached her and offered her a drink. Despite giving verbal indications that she was not interested, she accepted a drink from him and engaged in an extended conversation. When this was pointed out to her she explained that she did not want to hurt his feelings. This was addressed through Socratic questioning and cognitive restructuring in order to lay the groundwork for future role-plays and provide a framework for experimenting with new behaviour in similar situations.

At the end of the session she felt less hopeless and reported that she was motivated to make a success of therapy and to get her life back on track. The following day she sent an SMS:

> "*I forgot to thank you for yesterday's therapy. It was empowering and fun, thank you…you are the most understanding and caring person I never had but wish I did…*"

Session 7

Bongi arrived at the session stating that she was feeling "fabulous", adding that she decided to feel this way. However, she appeared dysthymic, her motivation was low, and her response time was somewhat slower than usual. On enquiry she reported being very tired from a busy week as well as from the previous night's party. Her BDI was 23 and her BAI 36, another indication that she might not have felt as well as she reported. She requested that we cancel the next session, "*…just to take a break*", however, by the end of the session she had changed her mind.

During the session Bongi reported having had a conversation with a friend two weeks ago during which she told her that she had been raped. She reported doing this because they were both sharing emotionally difficult things and because it was suggested in an earlier session. She said she felt comfortable talking to this friend, yet was anxious before telling her. The friend responded with sympathy. She said she was proud of herself for being able to do it, and that she did not feel ashamed at the time of the conversation.

In reviewing our previous session, she reported feeling empowered by the knowledge she gained because she obtained some insight into her own ways of relating and behaving in certain situations. To follow this up, I planned to suggest that we use this session to work on assertiveness training as this would give her some tools to enable her to change her old ways of relating and interacting. This session included a great deal of psychoeducational material, so I recommended that she take notes during the session which she did. We then went on to discuss various components of assertiveness as set out by Alberti and Emmons (1982). Bongi pointed out where some of these were influenced by cultural factors such as eye contact, physical contact, and volume of one's voice. The thought component of assertiveness was elaborated on using Albert Ellis' Rational-Emotive A-B-C theory of human behaviour (Lange & Jakubowski, 1978).

Assertive behaviour was explained by contrasting it with aggression and non-assertiveness, and explaining that it is a kind of middle ground. Her own typical expressions of anger were used as examples of aggressiveness, and her regular pleasing and compliant responses as examples of non-assertiveness. It was suggested that a more healthy and adaptive way for her to interact with people was the midway, by being assertive. Emphasis was placed on the fact that the essence of assertiveness is to appropriately express to others what you want or need, or do not want and need, as well as your associated feelings.

This was followed by exploring the influence of some of her early relationships and common socialisation messages on assertive behaviour, for example, the message: "Don't be selfish, think of others first", had been interpreted by Bongi to mean that she did not have the right to put her needs before those of anyone else, preventing her from assertively standing up for herself, her rights, and her needs.

We discussed the role-play we did in the previous session. She confirmed that the non-assertive way in which she had acted was the way she would often respond to a man approaching her. I again drew her attention to the fact that, although she was not interested in him, she accepted when he offered to buy her a drink and continued to

speak with him for a long time. She acknowledged that her behaviour might create the wrong impression. I suggested that we redo the role-play and that this time she should not accept the drink. She was able to refuse the drink, but could not get herself to end the conversation. My challenge elicited the following responses:

"*But I don't want to hurt him*", and

"*My friends always ask me why I don't have a guy and don't want to speak to one for any length of time*".

As the second response implied that she felt pressurised by her friends to have a boyfriend, I suggested we role-play her having a chat with a friend and assertively telling her friend that for various reasons, she is currently not interested in dating. First we swapped roles and I modelled it for her. When it was her turn to speak to the friend she did so hesitantly, and afterward expressed scepticism about whether she would be able to be as direct as I had been.

Session 8

Bongi arrived at the session looking euthymic and reported feeling tired due to working late the previous night. Her BDI was 3 and her BAI 18.

Although I had regularly encouraged Bongi to engage in imaginal reliving throughout the treatment phase, as yet she had never indicated a readiness to go ahead with it. As imaginal reliving forms an important part of the intervention strategy, the aim of this session was to educate her more fully about what it entails, to practice it with a neutral event, and if she felt able, to engage in reliving one of the rape incidents.

Bongi was given excerpts from a case (Payne, 2006) that formed part of the same larger research study as this one. It contained details of the imaginal reliving that was done with a rape victim. After reading these Bongi described some of the similarities between her situation and that of the case she had read. She also said that reading about the other case and the results achieved inspired her and that she felt more willing to engage in imaginal reliving now. The process of imaginal reliving and how it is conducted was explained to her. After listening attentively she reported not feeling well physically and

emotionally, and that she did not feel up to doing it during the current session. We agreed to postpone it until our next session and I assured her that the reliving would take place in a safe environment and that enough time would be left over to ensure that she would be able to regain her composure before she left.

Session 9

Bongi reported having had a tough week but that she was feeling fine. Her BDI was 17 and her BAI 31. She started the session by saying that she had come in today to tell me she decided not to continue with therapy, and that she did not wish to discuss the reasons. I felt surprised and disappointed. However, this turned out to be a very convincing joke, one that was probably indicative of a very real and intense fear of engaging with the imaginal reliving that was planned for today's session.

I briefly demonstrated imaginal reliving with a neutral event. She reported not *wanting* to do the reliving, but that she was ready to do it now. She chose to describe the *third* rape. We briefly discussed the reliving and I reminded her that she must describe as much detail as possible, including what she saw, heard, smelled, was thinking, and what she was feeling. I also asked her to describe the event as though it was happening now, in the first person and in the present tense. It was explained that she might experience intense emotions and bodily sensations, but that she would be safe. I asked her to close her eyes, to relax, and to start whenever she was ready.

She looked scared and was quiet for a long time before starting to speak. At first her eyes were open. As she got closer to the actual rape she closed her eyes. Her breathing became deeper, and she cried at times. Throughout, she appeared to be calm, except at one point where, for a few moments she threw her head back and when she came forward, opened her eyes and asked "*Where am I?*" She later reported that it felt as though she was back in his house in Swaziland. She realised where she was and relaxed somewhat as she became aware of me telling her that she was in my office in Grahamstown and safe.

To get an objective indication of the effect of the reliving I asked Bongi to complete the BDI-II and BAI again after regaining her composure. Instead of reporting on her mood and symptoms over the past week, I asked that she answered according to how she felt currently. Her BDI changed from 17 to 43 and her BAI from 31 to 41.

Extended formulation

At this point in the intervention, it was possible to elaborate on the assessment results and formulation, provided in sections 3 and 5 above, given the new information that became available during the reliving session, combining with it information gathered during the first nine therapy sessions. This elaboration of the formulation pertains mainly to the maintaining factors as described in section 5.1.

(i) Appraisals and hotspots

The following hotspots and key appraisals at the time of the incident were identified:

1. As he entered the room Bongi felt extremely anxious and afraid: "*I'm helpless and powerless*".
2. After a long struggle he used his superior strength to finally push her down on the bed and forced himself into her: "*I gave up and let him rape me*", "*I can't believe this is happening*".
3. At one point her upper body fell off the bed and she hit her head on the ground: "*The pain is overwhelming, my spine feels like it is breaking*".
4. After he left Bongi felt intense shame and disgust: "*I'm contaminated, scrubbing with soap and hot water cannot wash me clean*", "*What will my friends say?*"

(ii) Prominent Emotions Experienced

Anger – Bongi described feeling as though she has a devil inside her, and that at times she was afraid of what she might do to someone who confronts her at a time she experienced intense anger. When questioned about how she expresses her anger she answered: "*I often scream or try to hit and kick the person who angered me. Sometimes I want to kill them*".

Anxiety – Bongi clearly described extremely high levels of anxiety for a few hours before, during, and after the third rape incident. Subjective reports about her own mental state, as well as her scores on the Beck Anxiety Inventory suggested that Bongi presented with high levels of anxiety throughout the treatment period as well.

Disgust – "I feel like not even soap, hot water, and a great deal of scrubbing will cleanse me." She experienced this feeling right after being raped as well as during reliving and at other times during the intervention.

Guilt – During imaginal reliving when this feeling was activated she felt partly responsible for being raped because she believed she placed herself in a situation where she could easily be raped. She also experienced guilt as she believed she gave up fighting and allowed him to rape her. Cognitive restructuring assisted her in reducing feelings of guilt. At the stage where this emotion was no longer activated through reliving or discussion, self report measures also indicated that she did not believe herself to be responsible.

Hopelessness – Bongi asked, "*…will I ever get my life back, will things always hurt and feel so bad inside me…I think it will…*". Her feelings of hopelessness are clear from such questions and also from her thinking that it would be better to be dead. However, at times when Bongi felt better, she appeared to be very positive about the future.

Mental defeat – During the third rape Bongi felt as though she is being destroyed and murdered.

Misunderstood – Bongi's relationship with her parents formed the basis for this feeling as their needs always received priority above hers. Seeking care and nurturance in romantic relationships and being abused instead reinforced this feeling. Also, saying no to sex and then being raped exacerbated this feeling.

Powerlessness – Bongi felt powerless not only against the rapist who was much stronger than her, but also felt powerless to change her life.

Shame – Bongi described feeling ashamed during the rape incident and shortly thereafter, worrying about what her friends will say about her. She said that, just like a doll whose arm has been broken off must feel ashamed of being incomplete and ugly, she feels ashamed because of how she has been changed by the rape. Bongi also described how she would have been proud to be a virgin, and that being raped has replaced her pride with shame. Her experience of shame was highlighted by her request for me not to look at her while she told me about the rape incidents; not ever having told anyone about being raped; and feeling as though she wants to be alone after sessions where no-one can see her. Shame has the effect of shutting Bongi down, making her remove herself from social interaction, and instead spending time alone or sleeping.

Session 10

Three days after the previous session I unexpectedly met Bongi on campus and enquired how she was doing after the difficult session a few days ago. She said “fine” and we went our separate ways. The day before our next session I decided to contact Bongi to confirm the session. She told me she did not want to attend the session owing to being angry with me. She reported becoming angry when I asked her how she was doing earlier in the week. She reluctantly agreed to attend.

As she entered the office I felt rather uncomfortable because of the telephone conversation we had the day before. Bongi appeared euthymic (BDI-II of 14 and BAI of 20). In the first part of the session, I set out to address her anger. I planned to give her space to experience and express it, while retaining my own composure and surviving it myself. When I referred to our telephone conversation she reported not currently feeling angry, and that she had only been acting the previous day when we spoke on the telephone. Despite feeling relieved I doubted her honesty. Bongi further reported not feeling angry at the end of the previous session, but that she became more aware of her anger as the week progressed. She said that after the session ended, she went to her room and felt very lonely, empty and wanted to do something to “bring herself back”,

something to make her feel herself again. She went to stay with a friend but she did not feel any better. This sequence of behaviours and feelings was very similar to those she had after getting back to her residence after the third rape.

I decided to continue to focus on her anger and on the interpersonal process between us as I was concerned that it could undermine our working relationship. This seemed important as she had reported being angry throughout the week. I drew some parallels between the reliving session and the rape itself. When she was raped, she did not want to have sex and clearly said so. Similarly, in the therapy she had made it clear that she did not want to do the reliving session, but would do so since I had been insisting on it. So in both situations, despite her protests, two males went ahead and forced her to comply with their needs. As I was speaking I could see how the look on her face changed – her chin slowly lowered and she was glaring at me, saying nothing.

After a brief pause, giving her opportunity to voice her anger if she could, I continued and contrasted therapy with the rape incident. I explained to her how the rapist ignored her "No's" solely to satisfy his needs, while I pushed for reliving in an attempt to help her find healing, and although both events caused the same emotions, I was motivated to do it because I cared about her. At this point she started crying, more than she had ever cried in any session. After she dried away the tears I continued and ended off the discussion by telling her how brave I thought she was to do the reliving and that it showed that she was serious about the healing process. She again cried spontaneously.

Right at the end of this session I asked if she wanted to ask or say anything. She hesitantly said "no", but it was obvious that there was something, and so I encouraged her to share. After some silence she went on to say that she had felt empty, lonely, and lost for a very long time. Also that when I told her I cared about her, she could see in my face that I meant it and that it was the first time in 18 months that someone told her that and meant it. She cried again. She then described her own metaphor for our therapeutic process:

> "*…it is like uprooting trees, taking them out with roots and all; as they are pulled out some damage is done to the earth and a whole is left, but it is for the best…*"

After a short break we continued the session by speaking about various topics. I asked her what the best part of herself was that she felt she lost after being raped. She said it was that part of herself without which she has felt empty, namely, her soul. We also spoke about guilt, an issue that frequently came up during reliving. She made a pie chart assigning herself 20% of the guilt for being raped, the rapist getting the other 80%.

Late in the afternoon she sent me a SMS thanking me for the session and for helping her cry. She also mentioned feeling drained and that she had been sleeping since the session ended.

Session 11

Bongi had a BDI-II score of 21 and a BAI score of 57. Her affect before starting with the inventories was euthymic, compared to after having completed them when she appeared to be emotionally distressed. She also reported currently experiencing some of the same symptoms she had experienced during the few days after the previous session: a painful spine, pain in her chest and below her heart, a painful lower body, blurred vision, and feelings of anger.

As the appraisal that she had lost her soul had caused Bongi much concern, we decided to address it. We agreed that her soul represents what might also be described as her self, her agency, her belief in her self and her abilities, and her ability to be happy. I explained how her soul had been under attack for very long: having an absent father in early childhood, being raped at age nine, having abusive parents as an adolescent, abusive romantic relationships, losing both her close friend and brother, and being raped twice more. However I expressed my belief that, although her soul had been damaged and its growth marginalised, it was still very much alive. The discussion led to the discovery that her self or soul needs to heal. This would involve stopping the abuse, nurturing her soul, and when the time was right, to promote its growth. Eventually this process would involve allowing others “close” to her again.

This brought us to the important emotion of shame. Psycho-education regarding shame and its relation to trauma was given, including distinguishing between internal and external shame. She said:

> "*Shame to me means feeling bad about myself…I don't like myself…and I cannot face the world…because I'm worthless. Something terrible has been done to me…*"

Bongi went on to speak about the shame she experienced during the rape, as well as after the incident and currently. Cognitive restructuring was used in an attempt to influence her experience of shame.

The session ended with me reinforcing her assertive behaviour on the phone during the week. She had very assertively told a man that had been interested in dating her that she would not go out with him. He had not bothered her since.

Three days after our session Bongi sends me a SMS saying:

> "*The students were swearing at me today. I'm so afraid. I can't think of anything I've done to them. I've got more than enough torture from the teachers and now the learners too. Some of them look older than me and they abuse drugs, they are disruptive in class. I don't want to go there anymore…I don't have energy to prepare lessons for tomorrow…I'm feeling very drained*".

Session 12

Bongi had a BDI-II score of 28 and a BAI score of 51. As she sat down, she took out a soft-toy and tightly held it during the rest of the session. She said it felt like she had been cursed. She reported feeling tired and that she was busy moving out of her residence (for the duration of the university vacation). She also reported having had many problems with her learners, including that some of them threatened to harm her. This left her feeling numb, afraid, and unable to relax at school or after hours. There was an incident with a fellow student teacher in which Bongi allowed herself to be mistreated. We engaged in a brief discussion about how this situation could have been handled more assertively.

During supervision the question was raised whether her distress at school was caused in part by re-experiencing. As such the aim of the session was to investigate the possible operation of triggers and to explain to Bongi the warning signal hypothesis, the role of triggers, and how these are related to re-experiencing. Shortly after having started this discussion Bongi's demeanour had changed to being despondent and she was quiet. Despite her having shared with me in previous sessions that explicit sex scenes on TV, songs about sex, and the word rape seemed to act as triggers for her, she appeared to become more and more distant as I referred to these. When I asked her about the content of her automatic thoughts and intrusions, she was silent. While staring out the window and speaking very slowly she said:

> "*I don't need help anymore…I must just accept that this is how my life will be…*"

I got a real sense of finality from Bongi, as though she was about to terminate therapy. As a result I decided not to challenge this obvious dysfunctional belief and to also abandon the rest of the session. After sitting in silence for some time, I empathised with Bongi and encouraged her to express her emotions, which she did hesitantly. Before leaving she agreed to attend the next session.

Session 13

Bongi had a BDI-II score of zero and a BAI score of 4. This was in direct contrast with her reporting that she had been feeling tired, drained, and like a body without a soul during the past week. She had received a letter from Rhodes University containing academic results significantly better than she expected. She said:

> "*I know I must be happy about the results, but I have no space for happiness because there is too much sadness*".

The underreporting on the above two inventories was hypothesised to be due to Bongi's tendency to view things as superficially positive at times.

The main aim of this session was to review and elaborate on the work we started in the previous session. The working of triggers and the warning-signal hypothesis was comprehensively explained to Bongi. Examples unrelated to her experiences were used

to clarify these explanations. It was surprising to see how drastically her affect changed from dysphoric to looking pleased as she came to understand how triggers operate in a way to warn her about possible current threat. This led to a discussion of possible triggers activating re-experiencing in her life currently. These included feeling threatened or afraid, seeing sex scenes on TV or in movies, encountering the word rape on radio, TV, or posters, when she is alone with a male person in a room, and sometimes 'randomly' when she is alone in her room, day or night. The earlier discussion in this session was made relevant to each of these triggers and she was asked to try and identify others in her own time.

As it had been three weeks since last dealing with her guilt, and to establish if there had been any shift in her sense of feeling responsible, we ended off by returning to the pie chart representing the rapist's and her own guilt. She said that her guilt must be reduced from 20 percent to 15 percent.

Session 14

Bongi entered the session looking cheerful. Her BDI-II score was 14 and her BAI score 30. She smiled as she announced that she had finished her practical work at the township school, and that she had received a letter from Rhodes University with further academic results, all better than she expected. She also received some poems written to her from some of the learners, containing phrases such as: "you were friendly, kind, never in a bad mood…"; "you were never despondent…"; "your existence impacted upon us"; "we will miss you"; and "you touched our hearts". Her good results and the positive responses from the learners were used to challenge some of her negative appraisals such as "I've lost my soul" and "I've lost my mind".

She mentioned that she had become aware of another trigger. She would get shaken up every time either a male or female unexpectedly touched her. She usually responds with an outburst of anger. This was discussed and linked to our work in the two previous sessions.

This was followed by introducing the concept of hotspots and educating her about how they relate to the intense emotions re-experienced when triggers cause flashbacks. She was unwilling to relive any of the hotspots, but spoke about parts of the last rape incident she considered to be hotspots. The first was at the moment where he pushed her down on the bed and forced himself into her. She said she felt destroyed, terrified, murdered, and experienced physical pain all over her body. It is hypothesised that Bongi experienced *mental defeat* at this point during the rape. As we spoke I noticed that she was experiencing increasing emotional distress. When I reflected this, she reported currently feeling overwhelmed by fear, shaky, helpless, and angry. I assured her that she was in my office and safe which seemed to relieve some of the intensity of these emotions.

We went on to discuss the prominent feelings of fear, helplessness and powerlessness, pain, and being defeated, including that they were normal and adaptive at that time, why they are still experienced presently, and how they relate to other aspects of her life. This discussion included cognitive restructuring. Returning to her guilt and feeling responsible for being raped, she said that the percentage of guilt on the pie chart should be reduced from 15 percent to zero.

While regaining her composure she told me of feeling something inside her, and that she had experienced it before. She was unable to describe it as it was not a physical object, but it had the effect of making her feel nauseous, dizzy, and caused pain in her chest and below her heart. She felt that she had to throw up to get rid of it. She also described three nightmares she experienced recently: this indescribable thing inside her killed her by melting her body from the inside; there were a lot of worms inside her chest eating her from the inside; and lastly, she puts her arm down her own throat and pulls something out, something she cannot describe. In an attempt to reframe these, I interpreted them as dreams representing the therapeutic process and that a healing process had been initiated.

Before she left the session, she took the marble-based pen-stand given to her as a present from the learners at the school she taught, and put it on my desk. She did not

give it to me but said that I must keep it for her. I left it on my desk in a place where it was easy for her to see next time.

In the week after this session Bongi again consulted a psychiatrist due to her severe levels of anxiety. She was prescribed Imipramine, an anti-depressant.

Session 15

Bongi had a BDI-II score of 9 and a BAI score of 15. As Bongi had been experiencing much distress recently, and had been without a supportive network, an attempt was made to provide her with an initial source of nurturance. A guided imagery technique described by Lee (2005) was employed. I asked Bongi to imagine and describe in detail a perfect mother or nurturer. Lee (2005) describes how such an image could assist some individuals in incorporating a nurturing dimension into their lives. While comfortably sitting with her eyes closed, Bongi described her perfect nurturer:

> "*She is someone that looks like a confident and proud Black woman, wearing a comfortable long red dress with flowers on it…She is smiling, has loving eyes, and the way she smells has a calming effect on me…as if I want to breathe in deeply. She is concerned about my life…She communicates with me telling me that she loves me and cares for me…that she is proud of me…now She is hugging me…I feel secure, calm…happy*".

By the end of this description Bongi appeared calm and relaxed. She confirmed this. The guided imagery process seemed to have been a deep and moving experience for her.

I then asked Bongi to recall and relive the nightmares she described in the previous session, integrating them into one. Again with eyes closed, she went on to describe the content of the nightmares as evil worms were tossing and turning in a small space inside her. The worms said: 'We want to get out' and 'We'll start eating you'. She recalled experiencing painful burning and tingling feelings inside herself during the dream. She beat her chest repeatedly, drank boiling water, and tried to vomit, but without experiencing relief. Sometime later she put her hand and arm down her throat and removed something hard and shapeless with worms clustered together on it. She threw

it away and then passed out. I asked Bongi to imagine her perfect nurturer being with her as she wakes up, taking care of her and healing her. This ended with Bongi seeing herself healed physically and emotionally, feeling relaxed and assured, and the worms and thing she took out of herself being burnt in the fireplace. She reported feeling comfortable, calm, relaxed, and happy after finishing these reliving and guided imagery exercises. At this point we were about halfway through the session and decided to take a break.

Enquiry into new triggers revealed that she had not observed any new ones. We proceeded to work on the hotspot related to the moment where Bongi said “I gave up and let him rape me”. New information arising in this discussion was that the rapist became irritated and angry with her continual attempts to push him off and to get away. As we entered into this discussion, Bongi did not become visibly distressed. She was clearly not experiencing the intense emotions she usually does when we speak about the rape incident. When I pointed this out she responded with:

“*Yes, it feels like I’ve done this before so the emotions are not so intense now*”.

This was the first indication of reduced emotional reactivation and I was very excited. Bongi did not seem to think it such a big deal, and I did not force my excitement upon her. When I went on to reframe her ‘giving up’ not as being helpless or as permission giving, but rather as intelligent survival behaviour. She agreed and said that she had also come to think of it in this way.

The surprises were not yet over. Before the session ended, Bongi told me that she had a boyfriend for a few days last week. On the day she ended the short-lived relationship, they were alone in her room kissing. At one point she realised that he was getting ready to have sex. She stopped him, and assertively (her word) told him that she was not ready to go any further. She also said that she would like to end the relationship. He respected her decisions and had not pestered her since.

Finally, she said the reason she got into the relationship was because she felt lonely. I made use of this opportunity to address the task of reclaiming her life. I explained that

people whose lives have been affected by trauma often give up activities they used to enjoy before the event (modelling, acting, and going to gym in her case) and one focus of the therapy was to help her find ways to begin taking part in these or similar activities again. She smiled and said that she had accepted an invitation from some friends to go to gym tomorrow!

Session 16

Bongi's BDI-II score was 10 and the BAI score 31. She entered the session appearing more quiet than usual and somewhat dysphoric. She reported having felt dizzy, numb, fatigued, and empty for the last two days. We were unable to find anything that might have given rise to these feelings. She also reported having missed home very much today. She phoned her mother to confide in her, but her mother did not give Bongi the opportunity to share her feelings, but, instead, spoke about the weather and herself. Although being friendly with her mother while speaking to her, Bongi remembers calling her "swine" afterward. Yet, she denied being angry at the time. It was pointed out to her that this is an example of her subjugating her own needs in favour of those of others. Bongi also reported that she was able to draw on the image of her perfect mother to assist her in calming down shortly after the conversation.

After I had suggested the next intervention, which was to do another guided imagery exercise building on that done in the previous session, Bongi responded by saying she did not want to do it and would rather go home. After some fruitless exploration into her response, I asked her what she would like to do now if she was free to do anything. She said she wants to squeeze a stress-ball. I repeated the question, emphasising that she does not have to limit herself to being in my office or even this town. Without thinking about a response, she instinctively answered: "*I'd like to scream*". After a brief discussion she reported that she was in fact feeling very angry. Suggestions to express the anger, either by screaming (presently or later when alone) or expressing her anger during imaginal reliving were met with certain refusal. Further discussion revealed that as a child, and even to this day, she was never encouraged to express any form of anger, and that it is viewed as negative and unacceptable. By this time I was starting to sense her frustration with my attempts at motivating her to express her anger. I made a

final attempt by asking her about her views of the usefulness of expressing anger generally. Bongi responded by saying that it is a good thing to express one's anger because it helps one from getting rid of intense emotions that would otherwise build up inside oneself. This session ended after an hour, our shortest session to date.

Session 17

Bongi reported having had a very good week with lectures going well and her finalising plans to travel to America and thereafter to England where she had secured a teaching position for 2008. She appeared relaxed and cheerful, smiled often, and spoke louder than she usually did. Her BDI-II score was zero and her BAI 3.

Our discussion started off with me enquiring if she had become aware of more triggers. She had not, but in her rather lengthy response about specific triggers and their functioning, it was clear that she had understood and internalised much of our previous discussions on the topic. However, as the discussion continued I could see her facial expression change. It seemed as though she drifted off, she lost her smile, and became somewhat distressed.

The main aim of the session was to address her anger which had again surfaced in the previous session. We discussed how she gets angry when either she feels misunderstood, or when her needs are not met interpersonally. Also, that she usually reacts by either "losing it" and becoming verbally and/or physically aggressive, or by invoking a "detached protector" which helps her to cut off from others in order not to feel the overwhelming anger.

As we spoke something happened. I became aware of an intense headache, and moments later Bongi reported also suffering from one. A little while later I started to feel as though I was suffocating and felt like opening the door. It was not long before Bongi asked if she may lie down on the floor as she felt being pulled down by gravity, both physically and emotionally. She lay down and made small talk. This was followed by silence before we decided to take a break.

After the break we returned to the problem of anger. I again suggested that she had to work through areas related to anger. It was explained how many past incidents had created a reservoir of built up anger which she has never expressed due to her belief that it was wrong to express anger. Consequently she had never dealt with these incidents on an emotional level. She agreed and said that the explanation made sense. However, she protested saying that these issues are in the past and that she did not want to revisit them, as doing so placed her back in the negative emotions experienced then. I suggested an alternative approach, that she should make a list of people she was angry with. This list consisted of one of her ex-friends, an ex-boyfriend, the last rapist, and her mother. I suggested that she write each one's name on a piece of paper which she did without hesitation. I then suggested that she write down what she would have liked to have said to them in the past and now, what they did to her, and how this affected her and made her feel. She started eagerly and quickly wrote down one sentence under each name. She then said she was stuck and did not know what else to write. Her response to my suggestions was that she did not want to continue with this exercise, as this too would put her back in those emotions that were once caused by these people.

It was hypothesised that she was less motivated in this session as she was feeling good and did not want to spoil this feeling, and because the therapeutic process was coming to an end. This was our third last session. In the next session she told me that she cried during the week when she was thinking that therapy would soon be over.

Session 18

Bongi reported having had an average week. Her BDI-II was 2 and her BAI 8. She experienced two nightmares that were unrelated to past traumas. She described using some of her old perfume, and when it had a "bad effect" on her, she realised that the perfume acted as a trigger. The bad effect she referred to was suddenly experiencing intense negative emotions associated with bad experiences during the last two years. The necessity and importance of recognising triggers were reinforced in a brief discussion.

Given that Bongi's anger had a significant influence on therapy and her life, as was evident throughout therapy and again in the previous session, the aim of this session was to emphasise the importance of dealing with it. Bongi was given a chapter to read on anger from Kennerly's (2000) "Surviving Childhood Trauma." She reported finding it very insightful. We returned to the previous session and I described to Bongi what I felt in the session, the headache and feeling of suffocation. This was done to explain and show her that although the traumatic events are in the past, the emotions they caused were not, they were still active in the present and so strong that I was able to feel them myself. I went on to link our discussion to *past anger* as defined in the book. The discussion included describing anger as an untreated reservoir of toxic waste that is activated every time she becomes angry in the present or when triggers activate this pent up anger directly. She enquired as to how to deal with it and we explored some possibilities. This discussion took our focus to the future, including possible future therapy options for her. As we started on this topic, Bongi started crying. I reflected her feelings of sadness and loss as she started preparing to leave Grahamstown and terminating therapy. In dealing with these Bongi described that she has had a good year in Grahamstown and that she felt as though therapy had benefited her in her personal life and growth, and academically.

Session 19

This was our final session. Bongi arrived more than an hour late because the transport she had organised had failed to picking her up. As a result she entered the session extremely angry and unable to participate initially. She said that we should end the session if I had nothing to say. The first time her very intense look of anger lifted somewhat was when I handed her a sheet of paper containing a mini emergency plan, the details of the book we used in the previous session, and my email address. Shortly after, about ten minutes into the session, she asked to take a break.

The aim was to provide Bongi with an overview of the process, and to discuss what we achieved, and what we were unable to accomplish. She spontaneously reported that she had to just accept her life as it is and move on, because it was too complicated to get back on track. In the course of a long discussion I explained to her why it was so

difficult for her to deal with a 23-year life characterised by neglect, emotional and physical abuse, and three rapes. Further, that over the last five months we had worked hard on initiating a process of healing, and that she has the opportunity to complete this process in the medium-term. This was made clearer by drawing her life, represented by a timeline, together with possible future paths she might choose to take. This seemed to instil hope and she said that she would find a therapist to continue this process with in future.

7. THERAPY MONITORING

7.1 INDEPENDENT RESEARCH INTERVIEW

The interview was conducted by an independent researcher in the week before the last therapy session. Bongi became tearful on various occasions as many of the questions reminded her about the approaching end to therapy.

Early on in the interview Bongi acknowledged her need for future therapy. However, speaking about her current treatment, she seemed to equate therapy with the therapist, and she expressed doubt as to whether she would again find a therapist she would perceive to be as interested, understanding, and caring. This made her hesitant to pursue future therapy. She mentioned at first feeling uncomfortable in the presence of a male therapist, but decided to continue seeing him because of the understanding she experienced right from the start. In time she felt comfortable enough to speak more openly.

Bongi could not think of anything that could be done to improve the model, but emphasised the importance of feeling understood and cared for, as well as the focus that was placed on emotions. She reported experiencing the reliving as particularly upsetting, and that she would not engage in it again. In speaking about reliving she elaborated and described how it operates and why it could be helpful, displaying a good understanding of, and memory for, what she learned in therapy sessions.

Bongi addressed the issue of social support. She reported feeling very lonely as she did not have close friends in Grahamstown. Not even the fact that she lived in a residence with many other female students countered this. This was partly due to the fact that they irritated her by getting excited about boyfriends, while she wanted to avoid men, even in conversation.

Bongi reported feeling crushed before entering therapy. She spoke of not yet knowing who she was and feeling as if she does not have a life. She believes that she still needs to work on accepting herself, on speaking about her experiences to others, and on being more assertive. Speaking about the changes she experienced since entering therapy, she reported beginning to feel alive with the help of therapy. She said that therapy also helped her in becoming more confident, and being better able to take care of herself. As such she found therapy to be a valuable experience.

7.2 GRAPHICAL REPRESENTATION OF REPEATED MEASURES

Graphical displays and brief interpretations of the repeated measures on the Beck Anxiety Inventory (BAI), Beck Depression Inventory (BDI-II), the Posttraumatic Diagnostic Scale (PTDS), and the Posttraumatic Cognitions Inventory (PTCI) are provided below. This data represents the quantitative part of the research project and complement the case narrative. Particular assessment and therapy sessions are represented by an abbreviation indicating the number of the session, for example, the second therapy session is T2.

7.2.1 Beck Anxiety and Depression Inventories (BAI & BDI-II)

The BAI and BDI-II were administered during most of the assessment and therapy sessions.

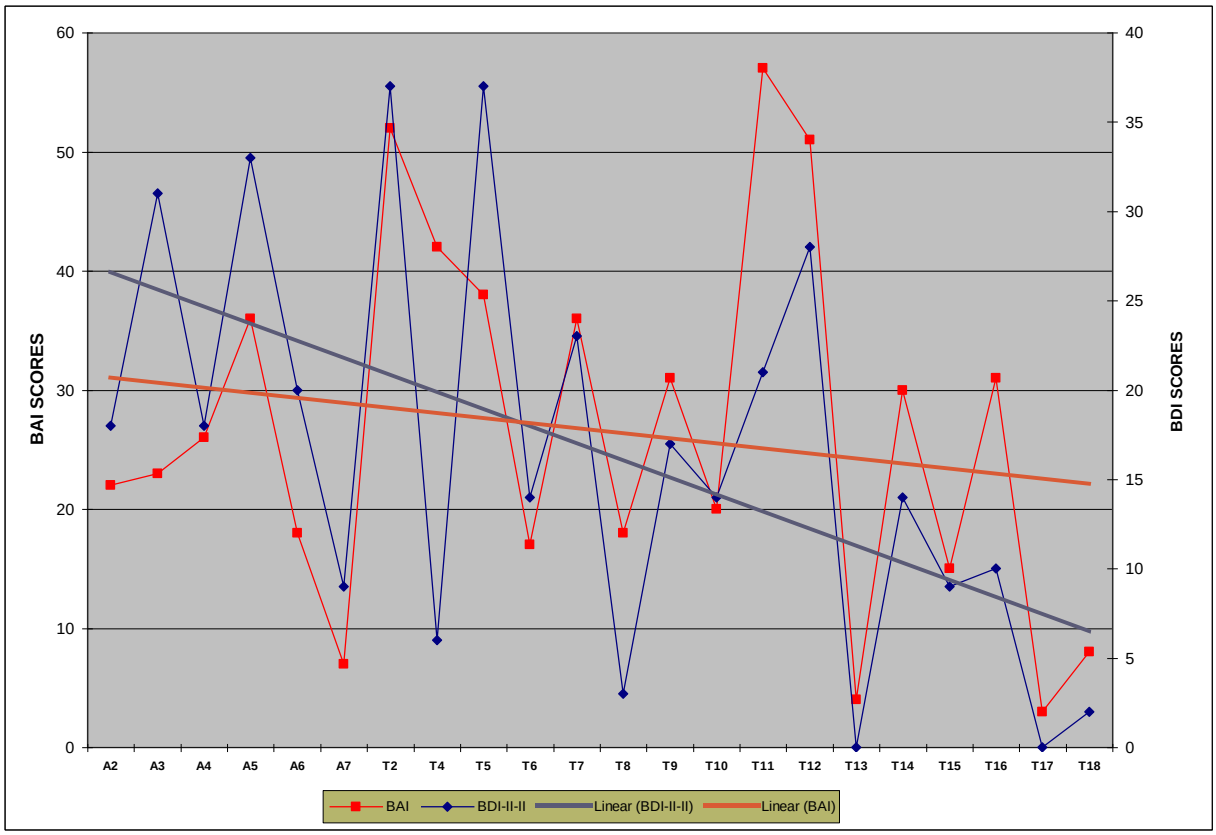

Figure 7.2.1: BAI and BDI-II

Red lines represent Bongi's BAI scores, with the zigzag line representing actual scores. The thick straight line is the trend-line, representing an average (or trend) of anxiety scores over time. It is calculated by transforming the actual scores obtained over time into a smoothed graph (the trend-line) which can be used to predict future data values. The fact that the trend-line has only a slight slope to the right, indicates that despite a slight decline, Bongi's levels of anxiety did not diminish significantly during the period of intervention. On the contrary, as therapy required Bongi to speak about traumatic past events that she has avoided, it had the effect of increasing the levels of anxiety she experienced before entering therapy. This is clear from the rise in anxiety levels at the beginning of both the assessment and therapy phases, with a slight decline as each phase progressed. As the healing process had not reached its conclusion at termination, her anxiety levels had not shown a clinically significant decrease. Another factor responsible for her consistently high levels of anxiety is that Bongi had to work at a township school for ten weeks, where the stressful nature of the work and the environment itself made Bongi feel anxious and vulnerable.

Blue lines represent Bongi's BDI-II scores. During the first two months of the intervention Bongi's levels of depression, as measured by the BDI-II, were moderate, but also reached severe levels. The significant fluctuations in some of her scores between sessions might be an indication of how well her avoidance strategies were functioning. However, as indicated by the prominent slant in the trend-line, a steady decline in depressive symptoms is observed. During the last month and a half, her levels of depression fell within the normal range. There might be various reasons for the decline in Bongi's levels of depression. Entering therapy provided her the opportunity to share her story and so she was heard and understood for the first time. She also found a place where she was respected and received care and nurturance. As a result she did not feel as alienated and alone as before therapy commenced. Bongi also gained insight into her functioning and condition, and she was supported and encouraged. Additionally, during the last month of the intervention, Bongi was on anti-depressant medication. Also, given the content of session 7, the possibility of underreporting cannot be excluded.

During the first half of the intervention, Bongi's depressive symptoms were more prominent when compared to her anxiety symptoms. During the second half this trend is reversed. This can be related to her feeling more hopeful that healing can occur as well as the fact that the traumas were not processed, leading to anxiety and other emotions still being triggered easily.

Lastly, although there is a general tendency for her BDI-II and BAI scores to follow each other (similar levels of depression and anxiety are reported together), it is important to note that her levels of depression decreased despite a maintenance in the levels of anxiety.

7.2.2 Posttraumatic Diagnostic Scale (PTDS)

The PTDS was administered during assessment sessions 2 and 6, and in therapy sessions 5, 9, 12, 17, and 19.

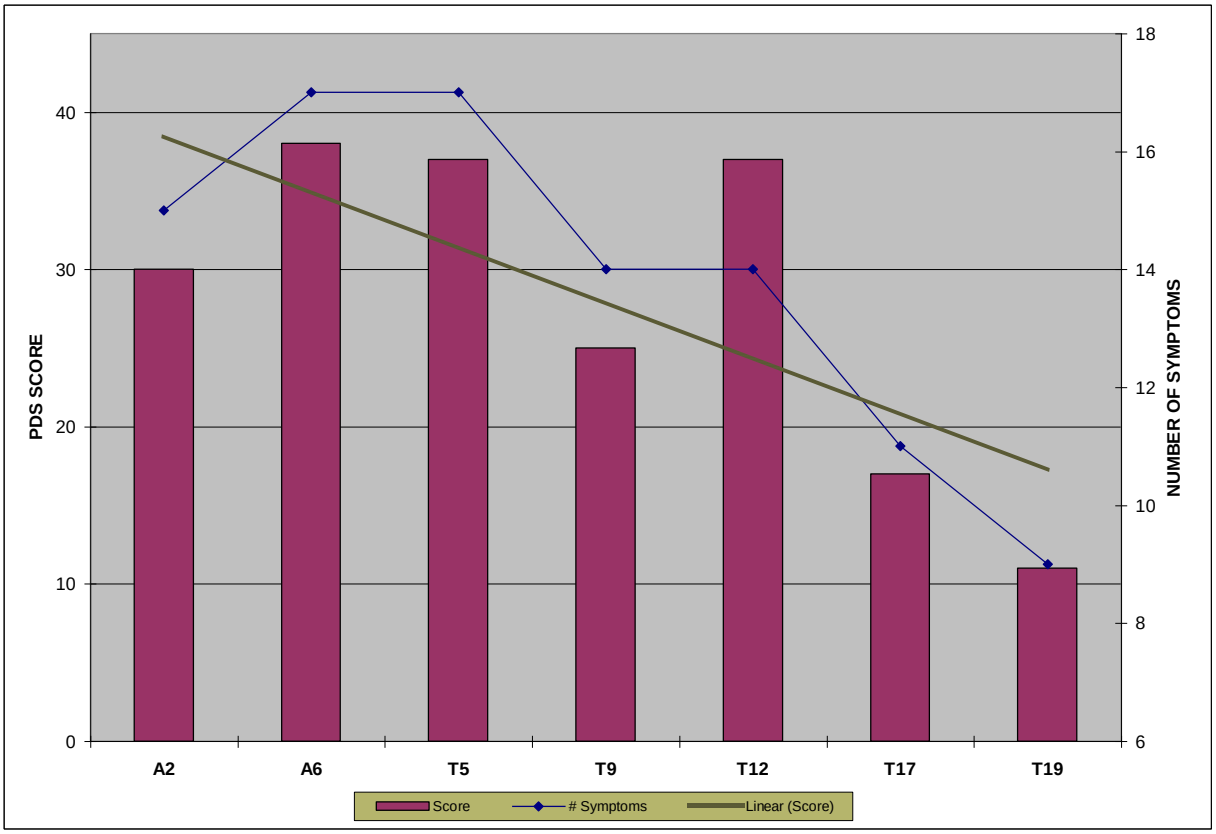

Figure 7.2.2: PTDS

Purple bars represent Bongi's PTDS symptom severity scores. Scores of 10 and below are considered Mild, between 11-20 are Moderate, between 21-35 are Moderate-Severe, and above 36 are Severe. The presence of a purple bar indicates that as measured by the PTDS, criteria for PTSD were met, suggesting that Bongi met criteria for PTSD throughout the intervention. (The absence of a purple bar would have indicated that PTDS criteria were not met). The thick black line is the trend-line (calculated as described above) for the symptom-severity scores. It indicates a downward trend, meaning that on the whole, Bongi experienced a decline in PTSD symptoms and/or their severity. This trend, together with the fact that symptom severity scores fell in the moderate range during the last few weeks provides evidence of the progress that had been made in therapy.

The thin blue line represents the number of PTSD symptoms Bongi reported. As is evident from the graph, the number declined as therapy progressed. A closer

investigation revealed that Bongi reported less re-experiencing symptoms (as compared to symptoms of avoidance and increased arousal).

7.2.3 Post-traumatic Cognitions Inventory (PTCI)

The PTCI was administered during assessment sessions 4 and 7, and in therapy sessions 5, 8, 16, and 18.

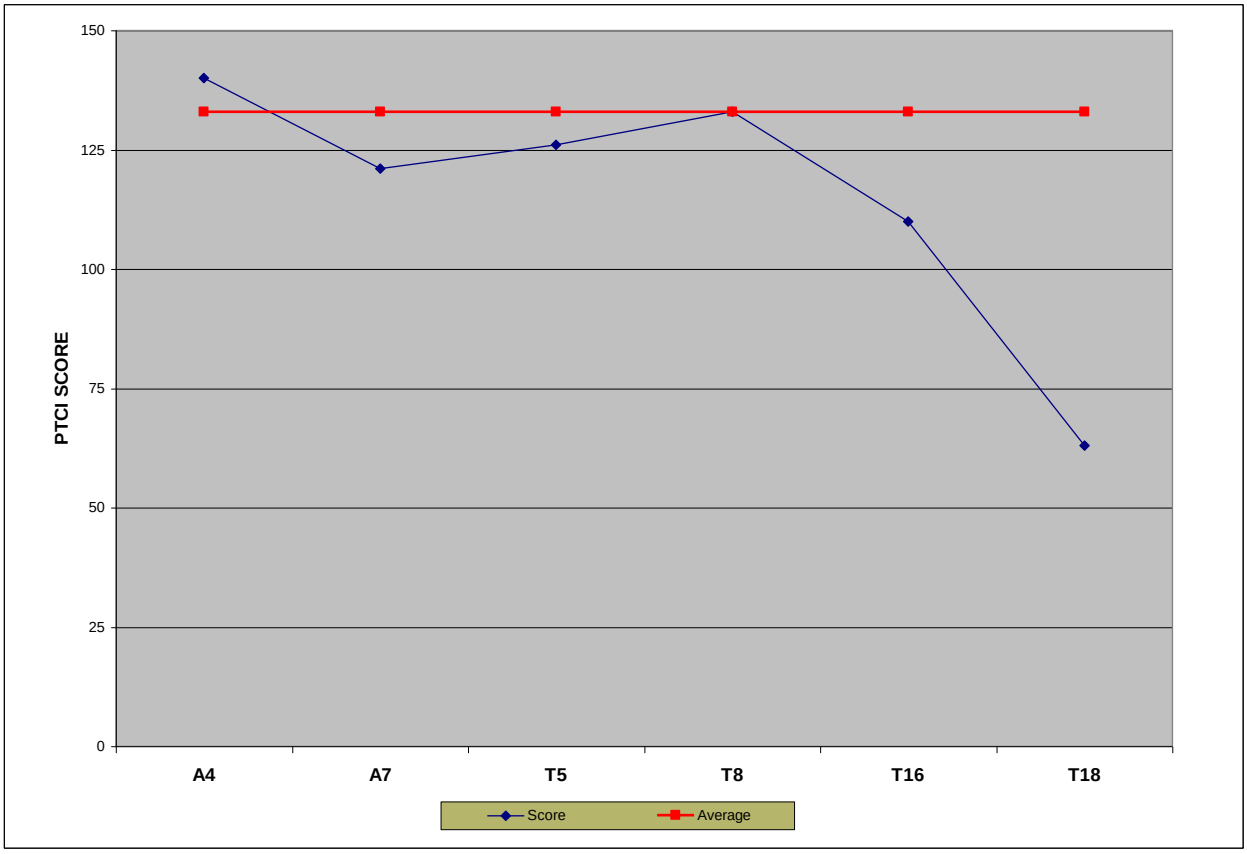

Figure 7.2.3: PTCI

The horizontal red line represents the average PTCI score for those in the normative sample who presented with PTSD after exposure to trauma (Foa et al., 1999). The blue line represents Bongi's scores. From the second assessment session, her scores were never higher than the average score. Additionally, there is a downward trend over time, indicating a decline in the strength with which her trauma related beliefs and cognitions were held. Despite this decline, all her scores excluding the score in session T18 were within one standard deviation of the mean. According to the authors of the PTCI, it has a

"*…superior ability to discriminate between traumatised individuals with and without PTSD*" (Foa et al., 1999). This means that according to the PTCI, Bongi still fell in the group suffering from PTSD. The fact that the last score, in T18, is more than one standard deviation below the average indicates that according to the PTCI, Bongi did not fall in the group meeting criteria for PTSD at termination. However, because there is a tendency in her scores to vary, consistent scores below one standard deviation over time must be obtained before it would be possible to consider that she no longer meets PTSD criteria according to the PTCI.

PTCI Measures

Scores highlighted in red indicate the maximum for a particular cognition, while those in blue indicate the minimum.

	Bongi's scores							***Normative sample*****	
	A4	**A7**	**T5**	**T8**	**T16**	**T18**	**Average***	**Mean**	**Standard deviation**
Self-blame	2.40	2.80	2.60	4.00	2.20	1.20	2.53	3.20	1.74
Negative cognitions: World	5.71	4.86	6.29	4.86	5.86	4.71	5.38	5.00	1.25
Negative cognitions: Self	4.19	3.48	3.29	3.76	2.76	1.14	3.10	3.60	1.48

* This represents her average score obtained as calculated from the six administrations of the test

** The normative sample consisted of individuals suffering from PTSD

Table 7.2.3: PTCI measures

Except for a fluctuation in therapy session 8 (in which she reported feeling tired) when she recorded her highest score, Bongi's self-blame scores showed a slight decline over time, reaching its lowest level in session 18. At this point her score was more than one standard deviation below the mean, indicating that at the time of last administration her self-blame was at a level lower than that of those suffering from PTSD. These results

are consistent with her attributing herself 20 percent blame for the third rape during the therapy phase, and this percentage then dropping to zero as the intervention continued.

Bongi's negative cognitions about the world showed a lot of fluctuation. Her average score on this measure over the period of the intervention falls within one standard deviation of the mean, indicating that the strength of her thoughts fitted with those of others suffering from PTSD. This is expected as Bongi was still experiencing the world as a dangerous and unpredictable place towards the end of the intervention. However, during the last administration in session 18, her score is just below one standard deviation lower than the mean, indicating that for the first time her cognitions were not as negative as those of the normative sample.

Bongi's negative thoughts about herself showed a steady decline over time, reaching its lowest level in session 18. During the last two administrations of the PTCI, her negative thoughts about herself were at a level lower than that of the normative sample. This can be understood in terms of Bongi gaining confidence in her ability to take care of herself, as well as feeling understood and cared for in the therapeutic relationship.

As the PTCI has been shown to distinguishing between individuals with and without PTSD, Bongi's results on the PTCI measures indicate that she did suffer from PTSD throughout the intervention. This seemed to have changed by the second last session (T18) when her total PTCI score and the various scores on the PTCI measures were at a level lower than that of the normative sample.

In summary, quantitative measures show that over the period of the intervention, Bongi's levels of depression decreased while her anxiety levels remained fairly constant. Regarding PTSD symptoms, despite a moderate decrease in such symptoms, she experienced clinically significant symptoms throughout the intervention. Hence PTSD was diagnosable throughout the intervention.

8. DISCUSSION – EVALUATING THE RESULTS

As discussed in section 1.1, the first research question asks whether the Ehlers and Clark (2000) cognitive therapy model for the assessment and treatment of PTSD is effective in treating a Black African individual meeting the criteria for PTSD? Secondly, which cultural and contextual factors influenced the effectiveness of the model? How these factors functioned to have such an influence? And in what way the model can be adapted to incorporate these factors? These and other questions that arose during the intervention will be considered in an attempt to establish the effectiveness and the transportability of the Ehlers and Clark model. In so doing, this study will contribute to documented knowledge concerning the transportability of treatment models to the African context. Although premature termination had clinical implications for this case, it is not a limiting factor in terms of the research as there was enough material from the therapy that did take place to effectively evaluate the model.

The treatment model will be evaluated by considering the results of the quantitative measures analysed in the previous section, as well as using the case narrative to discuss and assess the outcome of the three treatment goals. Lastly, the content of the interview conducted with the client by an independent party is considered.

8.1 QUANTITATIVE MEASURES

According to the results evaluation, these measures indicate that at the end of the prematurely terminated treatment process, Bongi was still suffering from PTSD. However, there were indications that the number and/or severity of her PTSD symptoms were decreasing. It was found that her general levels of anxiety remained clinically significant throughout the intervention, but that her depressive symptoms declined. Therefore, as assessed by self-report measures, the model would have required several more treatment sessions in order to bring about complete relief from PTSD symptoms. However, despite the presence of longstanding depression and significantly elevated anxiety scores, Bongi started to experience a decrease in PTSD symptoms.

In conclusion, the Ehlers and Clark model has been shown to be effective in bringing about change in longstanding and severe PTSD and comorbid depression. However, the possible influence of other factors, such as the anti-depressant medication she was taking towards the end of the intervention, must also be taken into account.

8.2 TREATMENT GOALS EVALUATED USING THE CASE NARRATIVE

As the Ehlers and Clark (2000) model aims to treat PTSD by achieving three broad goals, a process evaluation of the model constitutes an investigating of the extent to which these were attained.

Goal 1: Reducing re-experiencing

At the start of the assessment process re-experiencing was very prominent and easily triggered. The first time Bongi read through the BAI she re-experienced various emotional and physical symptoms so intensely that she requested to lie down on the floor.

As the intervention continued, emotional and physical reactivation was easily observed during therapy sessions, especially when Bongi was busy completing inventories, or when we were discussing her symptoms, triggers, hotspots, or the actual past traumas. Re-experiencing was still present at the end of the intervention, but there was some indication of improvement. She was able to fill in the BAI without any reactivation; on some occasions she could speak of the symptoms she experienced during the week without re-experiencing them; and on one occasion while we were discussing a hotspot (therapy session 15) she casually said that she was not experiencing any symptoms currently. Therefore, although re-experiencing was still present, there were indications that the intensity and/or frequency were declining. As was seen above, this is supported by the quantitative results. Factors contributing to the lower intensity and/or fewer symptoms include Bongi coming to understand the working of triggers and hotspots and their relation to experiencing a sense of current threat through the warning-signal hypothesis.

Goal 2: Appraisals of the trauma and its consequences

Through the course of the intervention Bongi revealed many negative appraisals such as having lost her mind, soul, and faith; going crazy; that no-one can be trusted; and that everything will be well if she can successfully ignore what happened in the past. She also assigned herself blame without thinking it through; she felt ashamed because she saw herself being changed by the abuse; and she believed that she was contaminated and that no amount of scrubbing would cleanse her. Due to the number and strength of some of the appraisals it was not possible to address them all.

Appraisals causing feelings of guilt were addressed and dealt with successfully. Appraisals related to her feeling as though she had lost her soul and mind were influenced in a way helping her gain a new perspective and provided her with objective evidence that it was still alive. The appraisal of going crazy was indirectly addressed and corrected. Through sharing the case formulation (and reformulations) with Bongi she came to understand that what she was experiencing was a normal reaction to trauma. Despite understanding, and at times agreeing that to ignore the influence of past experiences would maintain her symptoms, she still fell back on this way of thinking when feeling hopeless. The appraisal that no-one can be trusted was partially addressed through discussions about people she trusted and who did not hurt her during 2007. Unfortunately only two of these people were males, hampering the work on this appraisal.

There were times where the work we had done on a particular appraisal seemed to have altered her perspective, only for the same appraisal to reappear in a later session. The model predicts that this would happen if the appraisal was related to material that had not yet been emotionally processed.

Goal 3: Dysfunctional coping strategies

Before entering therapy Bongi never spoke about being raped. This dysfunctional coping strategy was altered to some extent. During the intervention, she had spoken about each of the rape incidents on more than one occasion, and she had told a friend that she was raped. However, despite not missing any therapy sessions, she frequently refused, or was unable to engage in discussions about the details of rape incidents.

After the third rape Bongi started giving up many activities she enjoyed, including modelling, acting, and participating in sporting activities. Additionally, she did not feel like being with people and increasingly started avoiding them. As a result she often felt lonely. At the end of the intervention Bongi was less likely to avoid people, although this still happened. She went to the gym with some friends on a few occasions, but not as frequently as before. She had not started taking part in other activities. The influence of academic responsibilities possibly played a role here.

8.3 EVALUATION OF THE STATUS OF THERAPY AT TERMINATION

Early termination resulted when Bongi completed her academic course and left Grahamstown to return home. As such the therapy process had not reach completion. Given that the model is formulation driven, another therapist can take over the case without disrupting the therapeutic process excessively and could carry on with the implementation of the proposed treatment plan. Issues requiring further consideration were:

- ~ Re-experiencing: As flashbacks and autonomous reactivation of emotions and somatic symptoms still occurred, the process of identifying and working with triggers need to be continued. Additionally, further cognitive restructuring in relation to hotspots is required.
- ~ New appraisals and their integration into trauma memory: Work on negative appraisals was not complete. Also, new appraisals that have already been derived were not yet integrated into trauma memory due to Bongi's reluctance to engage in imaginal reliving.
- ~ Depressive symptoms and maladaptive schemas: These were considered to be interrelated and both were addressed during the therapy process. Due to their longstanding nature a continued focus is required.
- ~ Dysfunctional relationship patterns: Although this was highlighted, further exploration and linking to maladaptive schemas is needed to explore the origin of her relationship choices and to work on changing existing patterns.

~ Social support: Bongi needs assistance to secure the appropriate support from family members, friends, and possibly community based resources such as support groups for trauma survivors.

Summary

Taken together, the information discussed above appears to indicate that the therapeutic intervention played an important role in Bongi's life through the initiation of a healing process. However, the effectiveness of the model cannot solely be judged on the above results. There were various factors exerting an influence on the application and effectiveness of the model, some of which included Bongi suffering from depression and the presence of childhood maladaptive schemas. Such factors cannot be neglected in an evaluation of the model. Hence, the effectiveness and transportability of the model will be commented on after a discussion regarding these and other factors that influenced the application of the model.

8.4 FACTORS AFFECTING THERAPY AND THE APPLICATION OF THE MODEL

During the five month period of the intervention, a healing process was initiated. This in itself was a big accomplishment for Bongi who believed that she was unable to change her life. However, an important question remains. Why, after five months of assessment and therapy, did this process not reach completion? This question becomes even more relevant when one considers that similar case studies recently carried out at Rhodes University have shown that PTSD symptoms can be relieved significantly applying this model. Davidow (2006) and Payne (2006) both treated rape victims of African descent who suffered from PTSD. After 10 and 23 sessions respectively, these clients did not meet criteria for PTSD any longer. Additionally, Smith (2006) successfully treated a white male who had been suffering from PTSD for two years within a period of eight weeks (18 therapy sessions).

8.4.1 Restrictive Factors

(a) Maladaptive schemas formed in childhood

Herman (2001) reports that it is not uncommon for survivors of childhood abuse to struggle with two core problems, those related to their traumatic experiences, and also relational problems. However, individuals are often unaware of the influence of their childhood experiences on these problems when they seek professional help. Herman recommends that therapists with this awareness should initially respond to the client's damaged relational capacities, while postponing interventions aimed at dealing with the trauma (Herman, 2001).

As discussed in sections 4.5.1/2 and 4.6.1 (iv), beliefs and schemas can influence the development and maintenance of PTSD. Consequently, beliefs and schemas are expected to also influence treatment and the efficacy of the model employed. This was indeed found to be the case with Bongi. As she had developed various maladaptive schemas during childhood, she required intensive work on these schemas before being able to receive maximum benefit from therapy focussing on the treatment of PTSD. If Bongi decided to stay in Grahamstown and continue with therapy for another year, the treatment plan would have been adapted to incorporate this requirement. Initially the focus would be on schema focussed work aimed at altering maladaptive schemas, but also incorporating anger management, assertiveness training and other features deemed necessary. As progress is made in these areas the focus would gradually shift towards trauma related work.

A study that followed this approach is described by Grey, Young, and Holmes (2002). They treated a 26-year-old female assault survivor. She experienced various intrusions, the most severe one being related to a peri-traumatic hotspot causing feelings of shame and humiliation, with the related personal meaning that "I'm bad". Cognitive restructuring outside and within reliving, verbally and using imagery techniques were used unsuccessfully in attempting to reduce the distress experienced in relation to this hotspot. This led to reformulating the case: "I'm bad" was a core belief originating in childhood and caused this peri-traumatic hotspot, associated meanings, and negative appraisals. Over the next few months therapy did not focus on trauma work. Instead, schema focussed cognitive therapy techniques were employed to change this core belief. Approximately half of the total number (51) of sessions was spent on schema

focussed work. This case illustrates that when long-standing dysfunctional beliefs match some personal meaning of something related to the trauma or its consequences, it can have serious effects on the treatment process.

Comparing the case study described above with Bongi's case reveals some similarities and differences. In both cases a young female assault survivor was treated. Both experienced shame, but different core beliefs and assumptions were at work. In the case described above, the core belief was uncovered during failed attempts to change a hotspot. In Bongi's case core beliefs and assumptions were identified during the course of reformulation. Hence, in this case study, reformulation assisted in recognising the need for an intervention not focussed solely on trauma work. In the above case the uncovering of the core belief led to reformulation. Both cases illustrate that longstanding dysfunctional beliefs that are later linked to trauma or its consequences can have serious effects on the treatment process by extending the treatment period. At this point the two cases followed different approaches. Due to the flexibility offered by Ehlers and Clark's model, as well as time constraints, this case study addressed both issues simultaneously. In the other case trauma work was abandoned altogether to focus on schema related interventions.

(b) Previous rapes and comorbid depression

It was found that Bongi having experienced previous traumatic rape incidents complicated the assessment and treatment phases in that it was difficult to differentiate between how symptoms, triggers, hotspots, re-experiencing, and appraisals were related to each of the incidents. This was further hampered by Bongi's reluctance to engage with imaginal reliving, understandably caused by her underlying vulnerability and lack of resources, both within herself and her environment. The Ehlers and Clark model places much emphasis on factors such as triggers, hotspots, and re-experiencing content, and for this reason, when the model is used in a case where multiple traumatic incidents occurred, the therapist must pay close attention to how these factors manifest.

Some of Bongi's core beliefs and assumptions regarding herself and the world, formed within the context of maladaptive schemas and in later abusive romantic relationships,

were reinforced by repeated incidents of sexual abuse. This, together with the fact that Bongi never worked through these incidents as they occurred, suggests an accumulation effect as is evident in the intensity of her beliefs, assumptions, and symptoms experienced. In using the model the therapist must take into account that factors other than the traumatic incident caused or reinforced the beliefs or assumptions. The extent to which the patient has worked through the event, whether in therapy, through talking with friends and family, or during cultural rituals or practices must also be considered in this regard. As the model proposes that a lack of emotional processing is responsible for avoidance, the person's level of avoidance is another factor to consider.

Comorbid depression influenced therapy in two ways. Bongi frequently reported feeling tired and not having energy to do anything. Consequently she often lacked the motivation to engage with the intervention or did so half-heartedly. This happened, to varying degrees, in three assessment sessions and in therapy sessions 2, 5, 7, 11, and 12. In session 5 for example, Bongi reported feeling hopeless and as though she was being punished. She was withdrawn and unusually quiet, giving brief responses. Given that this model requires the active participation of the client, this affected the effectiveness of interventions negatively because it had the effect of slowing down therapeutic progress. On the other hand, on a few occasions when Bongi experienced relief from the depression, she felt so good that she did not want to engage fully with therapy for fear of her mood changing for the worse.

If the model is implemented in a case where the client has comorbid diagnoses, the therapist must determine how these other disorders might impact on the various interventions employed by the model. Comorbid depression for example is characterised by fatigue, poor concentration, feelings of hopelessness and guilt, and suicidal ideation. A person struggling with fatigue and concentration problems will take a long time to complete inventories and they will find it difficult to participate in the session. An individual feeling overwhelmed by hopelessness would not be motivated to engage with therapy as they cannot see the potential benefits or do not believe that there can be any benefit. Guilt is not only characteristic of depression, it is also frequently found in PTSD which might complicate the treatment.

(c) Lack of social support

Due to Bongi being neglected and abused during childhood, she never came to experience her parents as a source of emotional support and understanding. Seeing that she never learned to rely on them for support, she currently struggles to perceive her family, or anyone else, as a possible source of support. As an effective support network is one of the essential factors in the recovery from trauma (Brewin & Holmes, 2003), Bongi was at a disadvantage throughout the intervention. Furthermore, having recently moved to Grahamstown, she had various acquaintances but not any close friends to confide in. Towards the end of the intervention, as Bongi started to develop some intimate relationships, she began to develop a network of people that could possibly support her. She was able to tell one of her friends about being raped, and she befriended people off campus. However, Bongi experienced feeling separated from herself and others (a typical symptom of PTSD) and thus found it difficult to feel comfortable enough within this developing support network to trust them with her experiences.

Her inability to rely on and trust others became evident during therapy when she reported not having spoken to anyone about being raped (except mentioning it to the nurse where she went to get tested for HIV after the third rape). This slowed down both the assessment and therapy phases as she was not used to speaking about such sensitive information. Also, speaking about it caused Bongi to experience shame, both during and after sessions, which reinforced her avoidance of others who could possibly offer her support.

Through engaging with therapy Bongi experienced not only shame, but also other short-term negative effects such anger, fear, hopelessness and other intense emotions. Due to a lack of social support Bongi tried to deal with these by herself through withdrawing from others, sleeping, or by trying to forget. In this way the lack of a support network had a secondary effect in that maladaptive coping behaviours were reinforced.

In conclusion, based on the evidence of this case, if a client has a history of abuse they will in all likelihood find it difficult to build a support network. It can be useful to assist the

client in this area early on in therapy by encouraging them to actively seek support from possible sources including extended family members, peer groups, and organisations such as clubs or religious institutions. Addressing reasons for why they might be hesitant to do so is important. In addition, the absence of a support system outside of therapy might make the client vulnerable to continued re-experiencing of the intense negative emotions activated during therapy. If the client does not have an effective support network which can assist them in coping with the after-effects of therapy, it is recommended that the therapist be cautious in using techniques that might be experienced as emotionally challenging by the client, such as imaginal reliving.

(d) Anger

Herman (2001) writes that survivors of abuse and assault frequently oscillate between moments of uncontrolled expression of rage and intolerance of aggression in any form. This was certainly the case with Bongi. She moved from being extremely angry and feeling as though she could kill someone, to times where she did not want to speak about anger and denying being angry when she clearly was. Her anger had a definite influence on therapy and the application of the model. It is clear from Bongi's history that a lot of her anger might be related to abuse from her parents, boyfriends, and sexual abusers. However, her unwillingness to express and speak about her anger is related to at least two other factors. First, she grew up with the message from her parents that one is not allowed to express anger. Expressing anger was therefore associated with guilt. Second, Bongi said that expressing her anger also "puts her back in those feelings", referring to the feelings she would rather avoid due to their intensity, which included anger, loneliness, confusion, as well as various somatic symptoms. Thus, expressing her anger opened Bongi up to experiencing other difficult emotions.

In session 10 the positive influence of experiencing anger was clear: when her anger towards me (and probably her abusers) subsided, it made way for very intense feelings of hurt, which she has tried to avoid for a long time. This had a positive effect on both the therapeutic relationship and Bongi's healing process. However, her anger mostly had a negative effect on therapy. Although it never prevented her from attending sessions, it did prevent her from engaging with me or the specific intervention planned

for the session. This happened in varying degrees in the following sessions: 2 (angry with a friend and with me later in the session), 3 (angry with same friend), 5 (met the person who raped her most recently on campus), 16 (angry with her mother, and later in the session frustrated with me), 17 (unwillingness to engage in discussion), and 19 (angry with people promising but not providing transport to therapy). In these sessions her anger was so overwhelming that she was unable to step back and gain distance from it. Therefore she could not bring herself to focus on what was happening in the session, and as a result, the model could not be fully implemented and slowed down the therapeutic and healing processes.

As anger is a common emotional response in PTSD, the therapist must be aware of its source. When the anger is related to the trauma, the Ehlers and Clark model makes provision to specifically target it. However, as in Bongi's case, intense anger might also be related to and influenced by other factors, such as lack of agency and helplessness. If the therapist becomes aware that this is a recurring problem, it can be beneficial to negotiate with the client and decide on a particular way of dealing with the anger as soon as it emerges, such as exploring its origin and doing relaxation exercises.

(e) Rational Interventions versus Emotional Presence

Herman (2001) describes the role of the therapist working with traumatised individuals as both intellectual and relational, so that both insight and empathic connection are offered. Herman refers to Kardiner's observation that the therapist is responsible to enlighten the client as to the nature and meaning of their symptoms, while adopting an attitude of a protecting parent. This in turn is in accordance with the use of limited reparenting (see section 4.9) by Young et al., (2003).

From the formulation and case narrative it is clear that Bongi needed treatment for PTSD just as much as she needed care, nurturance, and understanding. By entering therapy she found a place where she received both. It did not take her long to show a preference for receiving care and understanding, and to shun away from the very difficult and emotionally intense PTSD interventions. On one hand this had the effect of slowing down the implementation of the Ehlers and Clark model, but at the same time, it

enabled the application of it by keeping Bongi in therapy. Although the empathic, nurturing part of the relationship is not made explicit in the Ehlers and Clark model, without it, the model is unlikely to be applied successfully. These aspects become more important with more severe pathology, such as with individuals exposed to continued longer term trauma; or when the trauma occurred within the context of interpersonal relationship (see section 8.4.2 (a) for further discussion of this).

At times I found it difficult being in a position where I had to offer both, and finding a balance was not always easy. This was most clear in session two when Bongi became openly angry with me, telling me that I do not understand her situation and struggles. At the time my focus was on the content of intrusive memories as this is an important part of the model. This is an example of how easily the client's current needs can be missed when there is pressure, from whatever source, to apply the model. In this particular situation, I felt pressurised to speed up the therapeutic process as the assessment phase was long and the first session was spent on her accommodation problems. Supervision assisted me in realising that the therapeutic process will be slow, and that paying attention to contextual and situational factors forms an important part of the model, even if they are not explicitly discussed by Ehlers and Clark (2000). For this reason, although the model provided guidelines, supervision and personal reflection by the therapist is required in order for the therapy to be effective.

8.4.2 FAVOURABLE FACTORS

(a) Therapeutic Relationship

The therapeutic relationship is essential in trauma work, especially when the trauma occurred within an interpersonal context where psychological abilities originally formed within relationship were damaged. Recovery from such trauma is best facilitated in the context of relationship where damaged psychological abilities can be restored (Herman, 2001). Kardiner (cited in Herman, 2001) defines the role of the therapist involved in trauma work as an assistant to "help the patient complete the job that he is trying to do spontaneously". This definition emphasises the importance of a collaborative

relationship as well as the limited reparenting proposed by Young et al. (2003) in schema focussed work.

Herman (2001) goes on to propose that disempowerment and disconnection from others are the core experiences of psychological trauma. At the end of our very first meeting which lasted less than 40 minutes, there was already an indication that Bongi felt these core experiences counteracted through me providing her with something her parents did not: when it came to light that Bongi was raped, I immediately offered to refer her to a female therapist. This gesture, of inviting her to make an important decision concerning her own life, contributed to her deciding to continue therapy with me. Why? It is hypothesised that this seemingly trivial offer made Bongi feel *empowered*, even if it was for only a short while. This becomes more significant if one considers that this occurred in the context of an assessment session, where Bongi was given the opportunity to speak and be listened to, and as a result felt less *disconnected*. As therapy progressed, Bongi continued experiencing empowerment and connection in the context of the therapeutic relationship. In this way the relationship had a very important impact on therapy as it helped Bongi to stay in therapy.

The literature regarding the Ehlers and Clark (2000) model does not make explicit reference to the therapeutic relationship and it is thus easy to miss the important role it can play in the implementation of the model. The importance of the relationship is however supported by the collaborative aspect of the model.

Young et al. (2003) describes two approaches that can be used therapeutically in the context of the therapeutic relationship; empathic confrontation and limited reparenting. A continuous attempt was made to use these therapeutically through employing the relationship at a process dimension. Empathic confrontation was used whenever I became aware of a schema being triggered. This most frequently happened when Bongi felt helpless and unable to exert an influence on her situation and when she became angry. This was usually followed by me relating how the specific issue causing her reaction related to her childhood and why it is important to address it. Some examples of limited reparenting used with Bongi included: being a transitional source of stability

(being available consistently on a weekly basis and responding to messages and requests); by being honest, open, genuine and creating a nurturing atmosphere through providing care, warmth, and empathy by preparing her for, and postponing difficult techniques such as imaginal reliving, and by responding to external stimuli (setbacks in relationships, problems with accommodation); providing encouragement and acknowledging progress made academically and in therapy; inviting her to make choices regarding therapy goals, techniques used, and homework; and assisting her in asserting her own rights and needs and in setting appropriate boundaries for herself.

Due to its flexibility and fact that it is formulation driven, the Ehlers and Clark (2000) model allows for interventions based on the therapeutic relationship to be incorporated into the treatment plan. It also provides the client with the opportunity to speak about many different experiences, memories, thoughts, believes, and struggles, which will lead to the activation of schemas.

(b) Ongoing Formulation

At the end of the assessment phase a case formulation was drawn up. Due to the interrupted start to the therapy phase, this formulation was shared with Bongi in only the fourth session. She said that it helped her to gain insight into many of her problems, and that she realises her need to be in therapy. The timing of sharing the formulation with her turned out to be good because it served as motivation at the time we entered a new phase of therapy.

As was stated in section 4.7, the Ehlers and Clark model is formulation driven, allowing for flexible application. Through a process of continuous discussion in supervision it was possible to reflect on the content and the process of therapy sessions. In this way the formulation was continuously consulted, elaborated, and refined. Formulating the case turned out to be an ongoing process which proved useful for two reasons. Firstly, as my understanding of both Bongi and the case deepened, I was able to make better sense of previously obtained information and of what was going on in sessions. This assisted me in being better able to attend to Bongi's needs and to plan sessions in a way that maximised the potential benefits. Secondly, in session 6 I shared an updated

formulation with Bongi; and new ways of conceptualising issues were shared continuously throughout the intervention. For example in session 6 we discussed the important relationships in her life, especially those with her parents. The aim was to provide her with insight into how these relationships has influenced her current unhealthy ways of relating, and also how these can be responsible for her feeling depressed and hopeless.

From her responses it seemed that each time she gained from this in that she came to a better understanding of her struggles, herself, and of the reasons why some of the techniques employed can be beneficial. She reported feeling empowered by the knowledge and it made her more willing to continue therapy despite the difficulty thereof. This flexibility the model offers in terms of formulation was thus used to great benefit.

8.4.3 CULTURAL FACTORS INFLUENCING THE APPLICATION OF THE MODEL

As observed in section 1.2, PTSD is a significant health problem in Africa and a complicating factor in its treatment is the co-existence of many diverse cultures. Several researchers have emphasised the need to focus on ethnocultural aspects in an attempt to identify and exclude sources of potential ethnocentric bias in psychotherapy (see section 4.11). Case studies such as the present provide a valuable opportunity to identify and understand such ethnocultural factors.

On the basis of this literature, various potential sources of cultural influence on the application of the model and therapy were considered. However, what was more striking was the absence of any difficulties related to any obvious cultural differences. Firstly, there were no cultural prescriptions or norms that prevented Bongi from engaging with therapy itself or any part of the model. Secondly, culturally related factors including language, the expression of emotion and anger, social support, and somatisation were found to have had a negligible influence the therapeutic process. Therefore, this case study involving a client and therapist from different cultures, backgrounds, and with different home languages, has shown that there are no cultural factors interfering with establishing a close therapeutic relationship or with working together in applying the Ehlers and Clark model.

8.4.4 TRANSPORTABILITY

Returning to the research questions and taking into account the results of the quantitative measures, outcomes of the goals of therapy, together with consideration of the factors influencing the application of the model, the following conclusions can be drawn: the model is judged effective in treating an African individual meeting the criteria for PTSD. Despite the PTSD diagnosis not being resolved at termination, the presence of various complicating factors, for example previous traumas and high levels of anger makes the gains that were achieved significant enough to allow for such a statement to be made. Furthermore, the outcome of this case study support the evidence showing that the Ehlers and Clark (2000) model is transportable, both from a research to clinical context, and from a first world to third world context.

As far as this case study is concerned, no cultural factors unique to the African context were found to have an influence on therapy or the application of the model. However, as discussed above, several contextual factors might have impacted on the transportability of the model in this case. These factors are: 1) the influence that early maladaptive schemas had on therapy, 2) the impact of comorbid depression, 3) prior sexual abuse experienced by the client, and 4) lack of an effective support network while engaged in emotionally difficult trauma work.

8.4.5 RESEARCH LIMITATIONS

As the format of this research project is that of a single case study aiming to evaluate the treatment process of an individual, findings and implications derived from it are not generalisable to all situations. However, as this study forms part of a larger project which will generate a series of similar cases, the outcomes of this study can be added to this database from which generalisations would be possible (Edwards et al., 2004).

Another limitation is that the self report questionnaires administered were developed abroad and not designed for the African population. They were in no way adapted to the client's situation, ignoring possible language, cultural, and contextual factors. During the assessment phase, with the first few administrations of the questionnaires, Bongi struggled to understand some items. She struggled most with the PTCI, but also with a

few items on the PTDS and BDI-II. This was dealt with by me explaining the meaning behind the question or statement.

Conclusion

An important conclusion drawn from this case study is that where there is a longstanding history of abuse, the integration of a schema-therapy approach is indicated. In particular, such an approach needs to place a great deal of attention on the therapeutic relationship.

Although termination occurred prematurely, the client benefited through participating in the therapeutic intervention. Consequently, the Ehlers and Clark model was shown to be both effective and transportable to the African context. Contributing to these results are a thorough assessment phase, a formulation driven therapeutic phase, and the general flexibility of the Ehlers and Clark model.

REFERENCES

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders, (4th ed., text revision)*. Washington, DC: Author.

Alberti, R.E. & Emmons, M.L. (1982). *A Guide to assertive living: Your perfect right*. Impact Publishers. San Luis Obispo, California.

Beck, A. T., & Steer, R. A. (1993). *Beck Anxiety Inventory Manual*. San Antonio TX: Psychological Corporation.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory Manual*. The Psychological Corporation. San Antonio, TX: Harcourt Brace and Company.

Birmes, P., Hatton, L., Brunet, A., & Schmitt, L. (2003). Early historical literature for post-traumatic symptomatology. *Stress and Health*, 19(1), 17-26.

Bolton, D. & Hill, J. (1996). *Mind, meaning, and mental disorder*. Oxford: Oxford University Press.

Brewin, C. R. (2003). *Post-traumatic stress disorder: Malady or myth?* New Haven: Yale University Press.

Brewin, C. R., Dalgleish, T., & Joseph, S. (1996). A dual representation theory of posttraumatic stress disorder. *Psychological Review*, 103(4), 670-686.

Brewin, C. R., & Holmes, E. A. (2003). Psychological theories of posttraumatic stress disorder. *Clinical Psychology Review*, 23, 339-376.

Cahill, S. P., Rauch, S. A., Hembree, E. A., & Foa, E. B. (2003). Effect of cognitive-behavioural treatment for PTSD on anger. *Journal of Cognitive Psychotherapy*, 17, 113-131.

Clark, D. M. & Ehlers, A. (2005). Post-traumatic stress disorder: From cognitive theory to therapy. In R. L. Leahy (Ed.), *Contemporary cognitive therapy* (pp. 141-160). New York: Guilford.

Cloitre, M., Cohen, L. R., & Scarvalone, P. (2002). Understanding revictimization among childhood sexual abuse survivors. *Journal of Cognitive Psychotherapy*, 16, 91–111.

Davidow, A. (2006). *From the 'here and now' to the there and then: The evaluation of the effectiveness of Ehlers and Clark's model for treating PTSD in a rape survivor*. Unpublished Master's in Clinical Psychology research report, Rhodes University at Grahamstown.

Dunmore, E., Clark, D. M., & Ehlers, A. (1999). Cognitive factors involved in the onset and maintenance of posttraumatic stress disorder (PTSD) after physical or sexual assault. *Behaviour Research and Therapy*, 37, 809 – 829.

Eagle, G. T. (2004). Therapy at the cultural interface: Implications of African cosmology for traumatic stress intervention. *Psychology in Society*, 30, 1-22.

Eagle, G. T. (2005). Grasping the thorn: The impact and supervision of post-traumatic stress therapy in the South African context. *Journal of Psychology in Africa*, 15 (2), 197-207.

Edwards, D. J. A. (1998). Types of case study work: A conceptual framework for case-based research. *Journal of Humanistic Psychology*, 38, 36-70.

Edwards, D. J. A. (2005a). Treating PTSD in South African contexts: A theoretical framework and a model for developing evidence-based practice. *Journal of Psychology in Africa*, 15, 209-220.

Edwards, D. J. A. (2005b). Critical perspectives on research on post-traumatic stress disorder and implications for the South African context. *Journal of Psychology in Africa*, 15, 117-124.

Edwards, D. J. A. (2005c). Post-traumatic stress disorder as a public health concern in South Africa. *Journal of Psychology in Africa*, 15, 125-134.

Edwards, D. J. A., Dattilio, F. M., & Bromley, D.B. (2004). Developing evidence-based practice: The role of case-based research. *Professional Psychology: Research and Practice*, 35, 589-597.

Edwards, D. J. A., Sakasa, P., & van Wyk, G. (2005). Trauma, resilience and vulnerability to PTSD: A review and clinical case analysis. *Journal of Psychology in Africa*, 15(2), 143–153.

Ehlers, A. & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, 38, 319-345.

Ehlers, A., Clark, D. M., Dunmore, E., Jaycox, L., Meadows, E., & Foa, E. B. (1998). Predicting response to exposure treatment in PTSD: The role of mental defeat and alienation. *Journal of Traumatic Stress*, 11(3), 457 – 471.

Ehlers, A., Clark, D. M., Hackmann, A., McManus, F., & Fennell, M. (2005). Cognitive therapy for post-traumatic stress disorder: Development and evaluation. *Behaviour Research and Therapy*, 43, 413-431.

Ehlers, A., Hackmann, A. & Michael, T. (2004). Intrusive re-experiencing in post-traumatic stress disorder: Phenomenology, theory and therapy. *Memory*, 12, 403-415.

Ehlers, A., Hackmann, A., Steil, R., Clohessy, S., Wenninger, K., & Winter, H. (2000). The nature of intrusive memories after trauma: the warning-signal hypothesis. *Behaviour Research and Therapy*, 40, 995–1002.

Elliott, R. (1999). Client change interview protocol. Retrieved October, 15, 2007, from http://www.experiencial_researchers.org/instruments/Elliott/changei.html

Etherington, K. (Ed.) (2003). *Trauma, the body and transformation: A Narrative Inquiry*. London: Jessica Kingsley.

Fishman, D. B. (2005). Editor's Introduction to PCSP – From single Case to database: A new method for enhancing psychotherapy practice. *Pragmatic Case Studies in Psychotherapy* [Online], 1, Module 1, Article 2, 1-50. Available: http://pcsp.libraries.rutgers.edu

Foa, E. B. (1995). *Posttraumatic Stress Diagnostic Scale Manual*. Minneapolis, MN: NCS Pearson.

Foa, E.B., Cashman, L., Jaycox, L., & Perry, K. (1997). The Validation of a self-Report measure of post-traumatic stress disorder: The posttraumatic diagnostic scale. *Psychological Assessments*, 9(4), 445-451.

Foa, E. B., Ehlers, A., Clark, D. M., Tolin, D. F., & Orsillo, S. M. (1999). The Posttraumatic Cognitions Inventory (PTCI): Development and validation. *Psychological Assessment*, 11(3), 303-314.

Foa, E. B., Keane, T. M., & Friedman, M. J. (2000). *Effective treatments for PTSD: Practice guidelines from the International Society for Trauma Stress Studies*. New York: Guilford.

Foa, E. B., & Riggs, D. S. (1993). Post-traumatic stress disorder in rape victims. In J. Oldham, M. B. Riba, & A. Tasman (Eds.), *American Psychiatric Press review of psychiatry* (Vol. 12, pp. 273-303). Washington, DC: American Psychiatric Press.

Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape: Cognitive-behavioural therapy for PTSD*. New York, NY: Guilford.

Foa, E. B., Steketee, G., & Rothbaum, B. O. (1989). Behavioral/cognitive conceptualisation of post-traumatic stress disorder. *Behavior Therapy*, 20, 155-176.

Gillespie, K., Duffy, M., Hackmann, A., & Clark, D. M. (2002). Community based cognitive therapy in the treatment of post-traumatic stress disorder following the Omagh bomb. *Behaviour Research and Therapy*, 40, 345 – 357.

Grey, N., Young, K., & Holmes, E. (2002). Cognitive restructuring within reliving: A treatment for peritraumatic emotional "hotspots" in posttraumatic stress disorder. *Behaviour and Cognitive Psychotherapy*, 30, 37 – 56.

Herman, J. L. (2001). *Trauma and Recovery: From domestic abuse to political terror*. London: Pandora.

Horowitz, M. J. (1986). *Stress response syndromes* (2nd ed.). Northvale, NJ: Jason Aronson.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York, NY: Free Press.

Janoff-Bulman, R. (2006). Schema-change perspectives on posttraumatic growth. In Calhoun, L. G. & Tedeschi, R. G. (Eds.), *Handbook of Posttraumatic Growth* (pp.81-97). London: LEA Publishers.

Jones, J. C., & Barlow, D. H. (1990). The etiology of posttraumatic stress disorder. *Clinical Psychology Review*, 10, 299 – 328.

Karpelowsky, B., & Edwards, D. (2005). Trauma, imagery, and the therapeutic relationship: Langu's story. *Journal of Psychology in Africa*, 15(2), 185 – 195.

Kennerly, H. (2000). Overcoming childhood trauma: A self-help guide using cognitive behavioral techniques. London: Robinson.

Lang, P. J. (1979). A bio-informational theory of emotional imagery. *Journal of Psychophysiology*, 16, 495 – 512.

Lange, A.J. & Jakubowski, P. (1978). *Responsible assertive behavior: Cognitive/behavioral procedures for trainers*. Champagne, IL: Research Press.

Lasiuk, G. C. & Hegadoren, K.M. (2006). Posttraumatic stress disorder part I: Historical development of the concept. *Perspectives in Psychiatric Care*, 42(1), 13-20.

Lee, D. (2005). The perfect nurturer: A model to develop a compassionate mind within the context of cognitive therapy. In P. Gilbert (Ed.), *Compassion: Conceptualisations, Research and Use in Psychotherapy* (pp. 326-351). London: Routledge.

Lee, D. A., Scragg, P., & Turner, S. (2001). The role of shame and guilt in traumatic events: A clinical model of shame-based and guilt-based PTSD. *British Journal of Medical Psychology*, 74, 451-466.

Marsella, A. J., Chemtob, C., & Hamanda, R. (1990). Ethnocultural aspects of PTSD in Vietnam War veterans. *National Centre for PTSD Clinical Newsletter*, 1(1), 3-4.

Marsella, A. J., Friedman, M. J., Gerrity, E. T., & Scurfield, R. M. (1996). *Ethnocultural aspects of post-traumatic stress disorder: Issues, research, and clinical applications*. American Psychological Association, Washington, DC.

Masten, A. S. & Coatsworth, J. D. (1998). The development of competence in favorable and unfavorable environments: Lessons from research on successful children. *American Psychologist*, 53, 205–220.

Michael, T., Ehlers, A., Halligan, S. L., & Clark, D. M. (2005). Unwanted memories of assault: what intrusion characteristics are associated with PTSD? *Behaviour Research and Therapy*, 43, 613-628.

Mowrer, O. H. (1960). *Learning theory and behaviour*. New York, NY: Wiley.

Mueller, M., Hackmann, A., & Croft, A. (2004). Post-traumatic stress disorder. In J. Bennett-Levy, G. Butler, A. Hackman, M. Mueller, & D. Westbrook (Eds.), *Oxford guide to behavioural experiments in cognitive therapy* (pp. 183-201). Oxford: Oxford University Press.

Nishith, P., Mechanic, M. B., & Resick, P.A. (2000). Prior interpersonal trauma: The contribution to current PTSD symptoms in female rape victims. *Journal of Abnormal Psychology*, 109, 20–25.

Payne, C. (2006). *Breaking the silence: Zanele's journey to recovery*. Unpublished Master's in Clinical Psychology research report, Rhodes University at Grahamstown.

Regehr, C., Marziali, E., & Jansen, K. (1999). A qualitative analysis of strengths and vulnerabilities in sexually assaulted women. *Clinical Social Work Journal*, 27, 171–184.

Resick, P. A., & Schnicke, M. K. (1996). *Cognitive Processing Therapy for Rape Victims: A Treatment Manual.* Newbury Park, CA: Sage.

Rothbaum, B. O., Meadows, E. A., Resick, P., & Foy, D. W. (1999). Cognitive-Behavioral Therapy. In W. Yule (Ed.), *Post-traumatic stress disorders: Concepts and therapy* (pp. 60-83). New York: John Wiley.

Smith, T. (2006). *Frozen In Time To Reclaiming One's Life: The Evaluation of the Ehlers and Clark Cognitive Therapy Model in the Assessment and Treatment of a Hijacking Survivor*. Unpublished Master's in Clinical Psychology research report, Rhodes University at Grahamstown.

Swartz, L. (1998). *Culture and mental health: A southern African view*. Cape Town, Oxford University Press.

World Health Organization. (1992). *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines*. Geneva: Author.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York: Guilford.

Appendix A: Consent Form

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CONSENT FORM

I, _____, consent to engage in the therapeutic process and research study with Francois van der Linde in the treatment of Post-traumatic Stress Disorder.

I understand that:

1. The researcher is an Intern Clinical Psychologist conducting research as part of the requirements for a Masters Degree in Clinical Psychology at Rhodes University.
2. The treatment I will receive will form part of a larger project and will contribute to a larger case series aimed at identifying effective treatments for people who have experienced trauma.
3. The sessions will be audio-tape recorded and may be listened to by other psychology professionals bound by the standard regulations of confidentiality.
4. I understand that my participation in the research will not compromise the therapeutic process and professional standards of my therapy.
5. When the research is published, I understand that a pseudonym will be used and all identifying details will be changed in order to protect my anonymity.
6. As I am helping to add to the body of clinical knowledge by participating in the treatment, all the services offered by Francois van der Linde will be free of charge.
7. I am free to withdraw my consent to participate in the treatment at any time but understand that any data collected will form part of the research study.
8. In the event that consent to participate in the treatment is withdrawn, I will have an interview with the researcher/therapist explaining my reasons for this withdrawal.

Signed, _____ _____

Client/Research Participant Date