BREAKING THE SILENCE:
ZANELE'S JOURNEY TO RECOVERY

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October 2006

A Dissertation submitted in partial fulfilment of the requirements for the degree of Masters of Arts in Clinical Psychology

ACKNOWLEDGMENTS

To my supervisor, Professor Dave Edwards thank you for your supervision, guidance and mentorship during this process. It has been a privilege to work with you.

To Celeste, Tracy and Amy thank you for your friendship and support.

To my partner, Andrew thank your for your understanding, support and encouragement.

To my parents, Dave and Annette Payne, thank you for your emotional support.

To my family in Switzerland, Thomas and Heidi Bachmann, for your generous contributions and support.

And finally, to Zanele, it has been an honour to share your experience with you and watch you transcend the difficulties you have been faced with. May you realise all your dreams.

This research was supported by the NRF Prestigious Scholarship awarded to Charmaine Payne and in part by Rhodes University Joint Research Committee grant given to Professor Dave Edwards.

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ABSTRACT

This study employed a case-based research design to document the psychological assessment and treatment of Zanele, a 15-year-old black Xhosa speaking female who was raped twice in 2006 by the same perpetrator. The aim of the study was to explore whether, the model for assessment and intervention for posttraumatic stress disorder (PTSD) developed by Ehlers and Clark (2000) was effective and transportable to the South African context. Zanele had a sufficient understanding of English for assessment to proceed without use of an interpreter. She reported a number of PTSD symptoms which were causing her significant distress and had impacted on her social and educational functioning. These included flashbacks of the perpetrator's face when she looked at the faces of black men, nightmares about the traumas she had endured and feeling isolated from others. A number of cognitive techniques were utilised in this study, however the central interventions included working with triggers, imagery rehearsal techniques with a focus on nightmares, and reliving with cognitive restructuring within and outside reliving. Psychoeducation and increasing her social support were also important components of the intervention. Her progress was monitored by means of several self-report measures which were displayed in graphic and tabular form. In addition, a thematically selective narrative of the assessment and first 23 sessions of the intervention was written which documents some of the central processes set in motion by the interventions. These results provide evidence that this model was both effective and transportable to the South African population. In addition, the study demonstrated that it is possible for a white English speaking clinician to work with a black Xhosa speaking individual and make substantial therapeutic gains.

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The structure of the report was based on the recommendations of Fishman (2005) who argues that case study methodology does not lend itself to being reported in the same way as experimental studies. It follows the guidelines prescribed by the specialist case study journal, *Pragmatic Case Studies in Psychotherapy.*

1. CASE CONTEXT AND METHOD

1.1 Rationale for Selecting this Particular Client for Study

Cognitive therapy, especially Ehlers' and Clark's treatment model (2000) has been found to be effective in treating posttraumatic stress disorder (Brewin & Holmes, 2003; Clark & Ehlers, 2005). This model of treatment allows for an individualised formulation of a client's difficulties. The case formulation informs the treatment intervention and strategies are used in a flexible manner, with a focus on the area of difficulty at any one point in time. The case study presented here is the second study in a series of case studies written as part of an evaluation of the Ehlers and Clark (2000) treatment model and the transportability of this model to the South African context. Davidow (2005) presented the first case study of a participant who responded well to this particular intervention.

The present paper presents the case of Zanele. There were many reasons for selecting this particular client for the study. The client, Zanele is a 15-year-old Xhosa speaking female who had been raped twice in 2006 by the same perpetrator, and consequently suffered from chronic posttraumatic stress disorder (PTSD) and a major depressive disorder. She comes from an underprivileged background where resources and access to psychotherapy are limited. The treatment and intervention with this particular client proved to be particularly interesting for a number of reasons. First, it highlighted that it is possible for a therapist and client from different cultural backgrounds and languages to work together and make substantial therapeutic gains. Second, it provided evidence that the Ehlers and Clark model was an effective intervention in working with an adolescent from an impoverished South African community. Third, it demonstrated that the Ehlers and Clark treatment

model is transportable to a different context from the one in which it was first found to be effective.

2. METHODOLOGY

2.1 Research Aims and Questions

The aims of this study are: (1) to document the assessment and treatment of a Xhosa speaking adolescent who meets the DSM-IV-TR (American Psychiatric Association, 2000) criteria for PTSD, (2) to use the information obtained during the assessment and treatment of the client to evaluate the transportability and effectiveness of the Ehlers and Clark (2000) cognitive therapy model in the assessment and treatment of PTSD in the South African context, and (3) to identify contextual factors that may impact on the effectiveness of this model.

The research questions addressed in this study are: (1) Is the Ehlers and Clark (2000) cognitive therapy model effective in the assessment and treatment of PTSD in a Xhosa speaking adolescent? (2) Did contextual factors impact on the transportability of this model to the South African context?

2.2 Clinical Methodology

The Ehlers and Clark (2000) cognitive therapy model for the treatment of PTSD was used in the assessment and treatment intervention. This model is formulation-driven, and provides practical guidelines in the assessment and treatment for PTSD. Clinicians utilising case formulation driven psychotherapy subscribe to a hypothesis testing approach to each individual case, based on 'evidence-based nomothetic formulations and therapies as templates for the idiographic formulation and treatment plan' (Persons, 2006, p.167) of individual cases. This formulation-driven approach allows for flexibility by allowing clinicians to use their clinical judgment to make decisions which are guided by theory and continuous assessment (Persons, 2006).

The flexibility inherent in the Ehlers and Clark (2000) model allows an extension of the initial formulation, for example information obtained at a later date is used to update the formulation where necessary, thus enabling a deeper and more comprehensive understanding of the client. This is consistent with propositions advocated for effective cognitive behavioural case formulation techniques (Persons & Tompkins, 1997). During the assessment phase the line of enquiry and specific questions asked enable the identification of a number of predominant cognitive themes, problematic appraisals, and spontaneous intrusions. The client is asked to think about the event and identify the worst things or the most painful moments, thus enabling the identification of possible 'hot spots' (areas which elicit significant emotional distress) and possible meanings associated with these. In addition the clinician assesses the cognitive and behavioural strategies the client employed to cope with the trauma prior to coming for treatment (Ehlers & Clark, 2000).

Each case is formulated individually using information obtained during the assessment phase. The information is carefully organised into various categories of difficulties, thus aiding in the clarity of the conceptualisation and allowing a more focused treatment intervention and identification of appropriate cognitive therapy techniques for tackling particular difficulties the client experiences. The clinician and client enter into a dialogue on the rationale for treatment, with a focus on psychoeducation, namely providing a cognitive understanding of PTSD. This allows for an individualised understanding of the causation and maintenance of the client's PTSD symptomatology, and the specific cognitive and behavioural factors that informed the client's presentation prior to starting the therapeutic process.

The author, who conducted the assessment and intervention, received training in cognitive therapy during her first year of reading for an MA Clinical Psychology. In addition, she was closely supervised and mentored during the treatment of this case by a cognitive therapist accredited with the Academy of Cognitive Therapy who also supervised the research. He has had some training and research contact with the Ehlers and Clark group but is not formally certified with them. The guidelines and principles for assessment and intervention of the Ehlers and Clark (2000) treatment model were used in formulating the case and planning subsequent intervention. This was monitored at weekly supervision and case management meetings.

2.3 Research Methodology

The research methodology drew on Fishman (2005) who provides a comprehensive framework for planning and reporting case studies in research. The pragmatic case study (PCS) method ensures that sufficient attention is paid to quality in a predominantly qualitative case study. The client understood that the data would be gathered systematically for research purposes. She benefited in that she received, free of charge, a state of the art assessment and intervention which probably would not otherwise have been available to her. The researcher and clinician, would benefit from the data collected from the client as it would provide the basis for a Master's research thesis and possible publication. This study is the second of its kind and forms part of a larger project, with the aim of generating a series of 20 cases. This will allow for generalisation based on replication on a case-by-case basis in the future, enabling evaluation of the format and the provision of recommendations for the future (Edwards, Dattilio & Bromley, 2004).

2.3.1 Data Collection

This section describes the types of data that were collected about the client during the course of assessment and treatment.

2.3.1.1 Interviews

Four interviews were conducted which are listed below. A number of self-report scales were administered during these interviews, and are described in the following section.

(i) Screening Interview

One screening interview was conducted where the clinician met with the client for a period of one and a half hours. During this time the client was asked a number of structured questions to assess whether she met the criteria for PTSD, and to rule out any other psychopathology which would exclude her from participation in this study (including current substance use, a severe personality disorder and/or psychosis).

(ii) Assessment Interviews

Three assessment interviews were conducted, with a total duration of three and a half hours. The first two assessment interviews were conducted with the client where information about the presenting problem and the relevant familial and personal history was obtained. In addition, a mental state examination was conducted during this time. The five self-report questionnaires were administered during the first two assessment interviews (see 2.3.1.2 Self-Report Scales described below). The third assessment interview lasted an hour and a half and included meeting the client's mother and obtaining the relevant information from her, which the client had not been able to provide. The information obtained from the screening interview, assessment interviews and the accompanying self-report scales provided a basis on which to form an initial case formulation based on Ehlers and Clark's (2000) treatment model.

(iii) Mid-treatment Research Interview

This semi-structured interview lasted 60 minutes and was conducted by an independent party, also an intern clinical psychologist. It took place after the sixteenth therapy session and the format was adapted from Elliott's (1999) *Client Change Interview Protocol.* During this interview the client was asked a number of questions about her experience of therapy as well as about her perception of the therapist and their ability to work together. She was asked whether she had noticed any changes in herself or her behaviour since therapy had started, if there had been negative effects since the start of therapy, as well as her perception of what was helpful or lacking in the intervention. The client was afforded the opportunity to voice her opinion about the strategies employed during the course of therapy and the usefulness of these in alleviating symptoms or not. The client was then invited to provide an open-ended account of what she had found particularly useful during the course of treatment, or voice criticisms or suggestions for improving the therapeutic experience. The aim of this interview was to assess the extent to which she had benefited from the intervention. The findings of this interview were only made known to the author after session 23. This interview was tape-recorded and listened to by the author. Notes were documented which included all the significant positive and negative information that was reported.

2.3.1.2 Self-Report Scales

Five self-report scales were administered to monitor the client's response to the intervention. Certain of the scales were administered repeatedly and others only twice. The scales used included:

(i) The Beck Depression Inventory II (BDI-II).

This is a 21-item measure, which measures depression based on the symptoms of depression in the DSM-IV (Beck, Steer, & Brown, 1996). The following scores indicate varying degrees in levels of depressive symptoms: minimal (1-13), mild (14-19), moderate (20-28), and severe (29-63).

(ii) The Beck Anxiety Inventory (BAI).

This is a 21-item measure, which measures anxiety symptoms based on symptoms of anxiety in the DSM-IV (Beck & Steer, 1993). The following scores indicate varying degree in levels of anxiety: normal (0-7), mild (8-15), moderate (16-25), and severe (26-63).

These scales were administered on 21 occasions (during assessment and the majority of therapy sessions).

(iii) The Posttraumatic Stress Disorder Scale (PDS).

This scale begins with a checklist of 12 traumatic events in which individuals are asked to indicate how many of these events he/she has either witnessed or experienced. Criterion A includes four yes/no questions inquiring about physical injury to themselves or others. The following section includes 17 items, which correspond to the DSM-IV criteria for PTSD (5 experiencing, 7 avoidance and 5 arousal). The last section of the scale includes 9 items assessing impairment in different life areas (Foa, Cashman, Jaycox, & Perry, 1997). A study was conducted to establish symptom severity scores for a group of individuals suffering with PTSD and a non-PTSD group. The mean score for individuals suffering with PTSD was 33.59, and the non-PTSD group 12.54 (normal).

This scale was administered during assessment and therapy sessions 2, 4, 6, 8, 9, 12 and 17.

(iv) The Posttraumatic Cognitions Inventory (PTCI)-Short Form.

The short form of this scale consists of 26-items, which measure negative cognitions about the self, negative cognitions about the world and self-blame (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999). This scale was administered during the intake assessment and during therapy session 17. This scale was only administered on these occasions due to time constraints and transport difficulties.

(v) The Trauma-Related Guilt Inventory Scale (TRGI).

This is a 32-item questionnaire and includes 3 scales: global guilt scale; distress scale and guilt cognitions scale, and 3 subscales (which correspond to the cognitive factors): hindsight-bias/responsibility subscale; wrongdoing subscale; and a lack of justification subscale (Kubany et al., 1996). This scale was administered during intake assessment and therapy session 17. Again, this was due to time constraints and transport difficulties. This is a lengthy questionnaire, which is relatively time consuming to administer.

2.3.1.3 Monitoring of the Intervention and Client's Response to It

Monitoring of the intervention was achieved using the following:

(i) Tape-recordings

All the sessions were audio-recorded.

(ii) Client's Journal

The client was given a journal in which to document her feelings and experiences of the therapeutic process, which she shared with the author during the process of the intervention. Zanele documented her experience on a weekly basis, with some weeks having more entries than others.

(iii) Supervision

Weekly supervision and case management was undertaken with a cognitive therapist accredited with the Academy of Cognitive Therapy. This allowed for in-depth discussions, and monitoring of the therapeutic process as it unfolded. As was

previously mentioned the therapy supervisor also served as the research supervisor.

2.3.2 Data Reduction

The data was systematically organised into manageable units by means of two data reduction steps. First, the repeated measures on the quantitative self-report scales were graphically displayed. Second, the qualitative data was used to write up a case narrative. These focused on the experience of the client as she progressed through the treatment, including her reports of which strategies were found to be effective as well as obstacles encountered that impacted on or threatened to hinder the effectiveness of the treatment. Whilst the narrative described in this report is selective, nothing important was omitted. The narrative was constructed thematically and was consistent with the client's self-reports, questionnaires, and the information obtained from the external research interview. Thus it was through careful enquiry that ensured that the accounts of the client's experience and process were consistent with the material obtained in the data collection

2.3.3 Data Interpretation

A hermeneutic reading method (Edwards, 1998) was utilised which focused on two broad sets of questions: (1) Questions arising from the research aims, and (2) More specific questions relating to clinical theory, treatment planning and the nature of specific cultural and contextual factors that emerged as salient within the case narrative. This enabled an in-depth qualitative investigation into the effectiveness of the treatment process and thus allowed for the generation and testing of further hypotheses. In addition it allowed an evaluation of the contributions of the various strategies utilised, as well as obstacles to progress in this particular case. The strengths of such intensive analysis was the ability to track psychological change over time, as well as identifying specific psychological processes in therapy (Edwards, 2005b).

2.3.4 Quality Control

The therapy process and outcomes were documented as comprehensively as possible. Firstly, the sessions were tape-recorded and detailed records were documented after each session whilst listening to the tape. Secondly, the recordings were reviewed repeatedly in writing up the case narrative. Third, additional data was collected by means of several self-report scales, which were administered repeatedly to document the clinical status at the start of therapy, and progress as the treatment unravelled. Some of these scales provided qualitative data and others provided quantitative scores. Fourth, an independent party, also an intern clinical psychologist, conducted a research interview with the specific aim of capturing the client's experience of the assessment and therapy process and its impact on her life.

2.3.5 Clinical Setting where the Case was Treated

The study (including therapeutic intervention) was carried out, on an outpatient basis, at Fort England Hospital in Grahamstown. This is a psychiatric hospital which offers both in-patient and outpatient interventions, depending on the nature of the presenting problem. There is a department of psychology at the hospital which allocates patients to respective therapists. However, this therapeutic intervention was not a routine case, as the client was not actively sought for research purposes. In addition the client lived 60km from Grahamstown and it was only due to the research funds that she was able to pay for her transport to come to the therapy sessions. The case was supervised from a nearby university, enabling the therapy supervisor to also supervise the research.

The way in which this case was referred demonstrates some of the intricacies involved in obtaining psychological treatment. The client disclosed to the principal at the school she attended that she had been raped twice by the same perpetrator. This was reported to the Child Welfare Department in the area and the social worker concerned referred the distressed adolescent for psychological assessment and treatment. She was initially referred to the Rhodes Psychology Clinic which referred

her on to the author who had indicated she was interested in treating a case of PTSD for a research project.

2.3.6 Confidentiality

The client gave informed consent to partake in a research project and signed a consent form, which stated that all the interviews and sessions would be audiotaped and that the case narrative would be written up as part of the research process, with a possible publication in the future. The client was assured that her name and identifying data would be altered so that her narrative would not be recognised by individuals known to her.

The author discussed the case material with her supervisor and the research team but the information was not discussed in any other context. The client was given a pseudonym and specific personal information (e.g. where she lived and attended school) was omitted. The client reported feeling satisfied with the arrangements to ensure confidentiality and added that she would feel happy if she was able to assist others who had been faced with traumatic situations similar to her own.

3. BACKGROUND INFORMATION AND PSYCHOLOGICAL ASSESSMENT

3.1 The Client

Zanele, a 15-year-old black female scholar, met the DSM-IV criteria for chronic posttraumatic stress disorder. Her score on the PDS (33.59) fell within the clinically significant range. She reported re-experiencing the traumatic event through recurrent intrusive images and thoughts of the event, at times she felt as if the traumatic events were recurring and she reported intense physiological distress when exposed to cues that resembled an aspect of the event. She attempted to avoid stimuli, such as conversations, activities and places, which reminded her of the trauma. In addition she reported increased arousal, which manifested in difficulties falling asleep, inability to concentrate and hypervigilance. On the BAI, her initial score (50) during the first intake session indicated severe anxiety symptoms.

These symptoms may have been precipitated by her coming to Fort England Hospital to meet with the clinician for the first time.

In addition she met the DSM-IV criteria for a major depressive disorder (single episode). She reported having a depressed mood for most of the day, nearly every day. She stated that she was tearful and became easily upset, especially when she was reminded of the traumas she had endured. She had lost interest in previously enjoyed activities and had low levels of energy. Her initial score on the BDI-II (33) also fell within the severe range, suggestive of a severe depression. However, during the following two assessment sessions her score on the BDI-III (13,13) had decreased and fell within the mild range. This was possibly due to her seeking treatment, being able to talk about how she was feeling and having her symptoms normalised.

Zanele reported that she was experiencing difficulties in both her social and scholastic functioning due to the symptoms she was experiencing following being raped on two occasions a few months earlier. In addition, she reported that she had not planned to tell anyone about what had occurred as the perpetrator threatened to kill her if she revealed this. It was by chance that her uncle's girlfriend overhead a conversation whilst on the taxi, where someone said they had heard that Zanele had been beaten up by an older male. Following this she confronted Zanele about what had happened. After telling her uncle's girlfriend, Zanele reluctantly reported both traumas to her mother and uncle. Her uncle then accompanied her to the police station where she laid a charge against the perpetrator. She was then taken to a hospital in Port Elizabeth, where a medical examination and HIV test was done. She later reported the crimes to the school principal who referred her to a local social worker. The social worker referred Zanele to the Rhodes Psychology Clinic for assessment and treatment. From here she was referred to the author at Fort England Hospital where the therapeutic intervention took place.

Zanele's decision to not reveal to her mother what had taken place may have been influenced by an event which occurred a few years prior to the traumatic events. She stated that her mother suffered from a heart condition and she was unable to handle distressing information. In 2002 her mother was hospitalised after having a

minor heart attack when she learned that her husband had suffered a serious stroke, from which he would not fully recover. Zanele reported that she was worried that her mother would not recover after hearing about the trauma she had endured.

4. LITERATURE REVIEW

4.1 Contextualising the Research

The South African population has been exposed to high levels of violence both in the past, as well as currently. The incidence of violent crime during the past 10 years has reached pandemic proportions (Edwards, 2005b), and it is reported that South Africans have a higher risk of exposure to violence (such as rape, robbery, murder and attempted murder) than citizens of other countries, with the exception of countries at war (Eagle, 2004). PTSD affects individuals across age, race, gender and cultural divides and constitutes an ongoing public health concern in South Africa (Edwards, 2005b). For example, research was conducted on the rates of exposure to violence in attendees at a primary healthcare clinic in Khayelitsha, Cape Town (Ensink, Robertson, Zissis, & Leger, 1997). Results showed that 94% of the participants had experienced at least one traumatic event during their lifetime, 44% had suffered from PTSD at some point in their lives, and 20% met the criteria to warrant the diagnosis of PTSD at the time of the research (mean duration of PTSD symptomatology roughly five years). The South African Police Service crime statistics indicate that levels of reported rape have increased from 54,293 in 2001 to 55,114 in 2005 (Rape statistics, 2005), which suggests that victims of these crimes make up a significant proportion of traumatised individuals. These statistics highlight the high prevalence of rape in South Africa, which in turn is associated with the production and maintenance of PTSD. This means that rape and PTSD warrant increased attention within the South African context (Edwards, 2005b).

Taking this into account, the trauma of rape is complicated further with the risk of contracting either STD's or HIV. Kalichman and Simbayi (2004) reported that South African women with a history of sexual assault were at risk of being infected with sexually transmitted diseases, including HIV, during the assault. This highlights the

need for increased awareness of the risk of these infections and suggests that this is an important component of interventions when working with rape survivors.

Finally, it is important to note that the high prevalence of crime in the South African society means that clinicians or their supervisor's may have been or become a victim of crime. Thus, Eagle (2005) highlights the importance of recognising the impact of traumatic stress intervention upon therapists, and for therapists to recognise personal shifts in relation to their safety, dependency, trust, power, esteem, independence, frame of reference and intimacy, as changes in these areas of their personal functioning can become destructive and have long-term effects. In addition, she highlights the important role of supervision that should, ideally, include emotional support and an element of debriefing. This is particularly important for clinicians working on the African continent where clinicians are frequently confronted with life threatening and extreme instances of violence and inhumanity on a daily basis. She maintains that it is 'only by acknowledging our anxieties in facing such issues, by "grasping the thorns", can we find the sincerity to intervene...with honesty and sincerity' (Eagle, 2005 p. 207).

The aim of this study is to document the treatment of a rape survivor suffering from PTSD. To begin with it is important to provide a definition of the terms "trauma", and "posttraumatic stress disorder". Following this a brief history of the origin of PTSD will be discussed, as well as current understanding of the causation and maintenance of this disorder. The chapter describes a specific form of treatment of PTSD, cognitive therapy with the main focus on Ehlers and Clark's (2000) treatment model, and highlights the efficacy of these forms of treatment as demonstrated by research findings. Finally the issue of transportability is introduced with examples of therapeutic interventions, which suggest that the Ehlers and Clark treatment model would benefit the South African population.

4.2 Definitions

4.2.1 Trauma

There are various meanings of the term 'trauma' depending on the context in which one is encountered with it (Edwards, 2005a). For the purpose of this study the psychological meaning of trauma will be utilised. In this regard, trauma is conceptualised as 'a disordered psychic or behavioural state resulting from mental or emotional stress or physical injury' (*Merriam-Webster's Collegiate Dictionary*, 2003). During states such as these an individual may experience distressing symptomology, which in an extreme form may be disabling (Edwards, 2005a).

4.2.2 Post-traumatic Stress Disorder

PTSD is defined as a severe response to the exposure to a traumatic event, whereby an individual perceives his/her personhood or the personhood of another under threat of either death or serious injury. The individual's response is one of extreme fear, helplessness or horror. In addition the individual persistently re-experiences the trauma in the form of nightmares or intrusive memories, avoids stimuli associated with the trauma, and experiences persistent symptoms of heightened arousal. This diagnosis is made if the symptoms persist for a period longer than four weeks and cause significant distress or impairment in occupational, social or other areas of functioning (American Psychiatric Association, 2000). Whilst many individuals re-cover in the ensuing weeks or months, others' symptoms persist for years.

4.3 A Brief History of the Origin of PTSD

Since the nineteenth century there has been an increased awareness of the long-lasting implications of traumatic events on individuals' lives. After a railway accident in 1866 the symptoms exhibited by survivors were referred to as 'railway spine'. Since then the names given to traumatic reactions have been closely linked to the circumstances in which the symptoms were seen to have arisen. For example, terms such as 'nervous shock' and 'traumatic neuroses' were succeeded by the

terms 'fright neuroses' and 'shell shock' to describe the symptoms exhibited by survivors of disaster and warfare (Kinchin & Brown, 2001).

By the Second World War a more detailed description of post-traumatic stress was given consideration by psychiatrists. However, variations in naming of the symptoms continued, such as post trauma syndrome, traumatophobia and war neurosis. It was during this time that various researchers noted that civilians who had not been exposed to combat situations were suffering from similar symptoms. Considerable research continued into the 1960s and 1970s in order to gain further understanding and recognition of PTSD. This resulted in the recognition of the condition in the American Psychological Associations third edition of its Diagnostic and Statistical Manual of Mental Disorders in 1980 (Kinchin & Brown, 2001).

4.4 A Brief History of the Progression in Theory and Treatment for PTSD

Various researchers have attempted to explain the psychological processes involved in the development of PTSD, and others have sought to evaluate the effectiveness of treatment models in the assessment and treatment of this condition (Brewin & Holmes, 2003). In order to contextualise Ehlers and Clark's (2000) model it is necessary to provide a brief overview of the theoretical models from which this model originated. First, the early approaches will be discussed followed by a brief discussion of three more recent approaches.

4.4.1 Early Theories

The early approaches include social-cognitive theories, conditioning theory, information-processing theories, and the anxious apprehension model of PTSD (Brewin & Holmes, 2003).

4.4.1.1 Social-Cognitive Theories

Social-cognitive theories include the stress response theory (Horowitz, 1986) and Janoff-Bulman's (1992) theory of shattered assumptions. Both these theories focus on the way trauma impacts on the mental structures already in place and the mechanisms involved in reconciling contradictory information with prior beliefs.

These theories account for the difficulty in integrating inconsistent views of reality and therefore the unstable shifting between states. In addition, they provide important information on a range of emotions and beliefs, as well as the way these are affected by trauma. However these theories do not account for the way in which trauma memories are involuntarily triggered or for the large range of individual differences in response to traumatic events.

4.4.1.2 Conditioning Theory

Conditioning theory focuses on learned associations and the role avoidance plays in the maintenance of PTSD (Keane, Zimering & Caddell, 1985). This theory advocates that fear acquisition occurs when neutral stimuli present at the time of a traumatic event (for example, olfactory and visual stimuli) acquire fear-eliciting properties (conditioned stimuli), through their association with elements of the traumatic event, which directly arouse fear (unconditioned stimulus). The fear associated with the conditioned stimuli are then generalised to a range of stimuli in other situations. It is argued that repeated exposure to spontaneous trauma memories would eliminate these learned associations. However, avoidance of conditioned stimuli, for example distracting oneself, whilst reducing fear at the time, serves to maintain PTSD as it prevents reality testing. Whilst this approach provides a useful explanation of certain PTSD symptoms (e.g. trauma reminders, arousal and avoidance), it lacks sufficient description of the nature of cognitions and emotions involved in PTSD (Brewin & Holmes, 2003).

4.4.1.3 Information-processing Theories

Information-processing theories argue that trauma memories are represented differently to other memories, because they have not been adequately integrated into the wider memory system. In contrast to the above-mentioned theories, this approach is based on the hypothesis that the specific psychopathological features of PTSD are not due to contradictory information that shatters existing mental structures but rather to the nature of the trauma memory itself (Foa, Steketee & Rothbaum, 1989). These theories are based on research on the cognitive structures involved in the processing of memories, and the way in which traumatic events are processed during and after the event. They argue that when the fear network is activated the individual experiences similar physiological reactions that occurred at

the time of the trauma, and ascribes the same meaning given to the previous experience to the current situation.

The fear network is activated using techniques such as imaginal or in-vivo exposure and transformed as new incompatible information is introduced. This results in weaker associations between feared stimuli and their associated meanings, and assists in integrating the information held in the fear network with other memories. However, it is argued that it is the process of habituation of fear that results in meaningful change. Habituation is a process whereby individuals are confronted with anxiety provoking information over lengthy periods of time, with a result in reduced levels of anxiety as the individual realises that the anxiety will not last forever (Foa et al., 1989).

These theories provided a clearer explanation on how information about the traumatic event is processed, and the involvement of various cognitive structures. In addition these theories led to the development of a treatment manual, *Treating the Trauma of Rape: Cognitive Behavioural Therapy for PTSD* (Foa & Rothbaum, 1998). However, these theories are limited in their provision of information regarding dominant emotions, with the exception of fear, and the impact of these on an individual's functioning in the broader context (Brewin & Holmes, 2003).

4.4.1.4 Anxious Apprehension Model

The anxious apprehension model proposed that many of the aspects involved in the etiology and maintenance of panic disorder were not dissimilar to those involved in PTSD (Jones & Barlow, 1990). In addition, they advocate that the experience of panic attacks and flashbacks are similar in nature. Whilst advocates of this model recognise the impact of traumatic events, the associated emotions, and biological vulnerability to developing anxiety disorders, they are of the opinion that it is the post-trauma cognitive factors that result in a ' feedback cycle of anxious apprehension' (Brewin & Holmes, 2003). In other words individuals suffering from PTSD focus on cognitive and physiological cues from the time of the trauma, which results in symptoms of hyperarousal. This leads to symptoms of re-experiencing which creates a feedback loop. Whilst this model highlights important aspects of

PTSD which were lacking in the afore-mentioned theories, it does not discuss post-trauma emotions and cognitions in depth.

4.4.2 Recent Theories

4.4.2.1 Emotional Processing Theory

The earlier information processing theory (Foa et al, 1989) was later elaborated on, and became known as emotional processing theory (Foa & Riggs, 1993; Foa & Rothbaum, 1998). This theory included information held by the individual prior to, during and after traumatic events and the relationship with the development of PTSD. In addition, more emphasis was placed on negative appraisals of others responses and the individual's responses to his/her PTSD symptoms as well as on the resultant behaviours, which affected an individual's perceptions of him/herself. These afore-mentioned components were not adequately addressed in the earlier information processing theories. The key difference between this theory and the early information processing theory is the emphasis on prolonged exposure or repeated reliving as a core component of treatment, which included the above components, with the aim of generating a more organised trauma memory which is more easily integrated within the larger memory network.

4.4.2.2 Dual Representation Theory

The dual representation theory (Brewin, Dalgeish, & Joseph, 1996) attempts to include social-cognitive and information processing perspectives. However, this model advocates that two memory systems operate simultaneously, with trauma memories stored in a different memory system from ordinary memories. This theory differentiates between cognitive processes occurring at the time of the trauma from those occurring post-trauma, with the former processed in an automatic way. Thus, recovery depends on the transformation of fragmented trauma memories into a more coherent narrative. This theory provided useful information on the links between cognitive psychology and cognitive neuroscience (Brewin & Holmes, 2003), and focuses predominantly on memory, cognitive appraisals and emotions. However, it fails to address other important aspects of PTSD, such as conditionability.

The above-mentioned theories of PTSD have progressed over time and have incorporated certain aspects of the earlier theories. From the above it is evident that there is a degree of overlap amongst these theories. Whilst each theory has its strengths, areas lacking in detail have been highlighted in the literature (Brewin & Holmes, 2003). Ehlers and Clark's cognitive (2000) model expanded on earlier theories of PTSD and has attempted to address limitations of the former theories. Presently, their cognitive model for PTSD has been heralded as providing the most comprehensive understanding of trauma, memory and PTSD (Brewin & Holmes, 2003). This model is described in more detail below.

4.5 Causation and Maintenance of PTSD

PTSD is a debilitating disorder that affects various domains within an individual's life and thus significantly influences their ability to function in daily life. Various researchers have attempted to understand and explain PTSD and have proposed different theories about the causation and maintenance of this disorder. Due to the limited scope of this report a comprehensive review will not be offered. This review will focus predominantly on the cognitive theory proposed by Ehlers and Clark (2000), as well as Clark and Ehlers (2005) as it formed the basis of the treatment used with the participant in this research.

According to Ehlers and Clark (2000) PTSD persists when an individual processes the trauma in such a way that there is a sense of a serious current threat, rather than a reaction to a trauma that has already occurred. This perception or sense of a serious current threat arises as a result of: (1) an exaggeration of negative appraisals of the trauma and/ or its consequences, and (2) a disturbance in autobiographical memory. These processes have a reciprocal relationship, which further complicates an individual's ability to recognise the trauma as a specific event that occurred in the past, which may result in faulty interpretations whereby an individual may perceive the trauma as having global negative implications for their future.

Research indicates that the processes highlighted above are frequently accompanied by intrusions, re-experiencing symptoms, symptoms of arousal,

certain emotional responses as well as symptoms of anxiety (Ehlers & Clark, 2000). In addition, it is not uncommon for an individual to adopt a series of behavioural and cognitive responses in an attempt to reduce the distress and perceived threat in the short-term. However, these strategies often stand in the way of cognitive change and thus maintain the disorder (see Fig. 1 below). The key variables in the causation and maintenance of PTSD will be discussed in detail below.

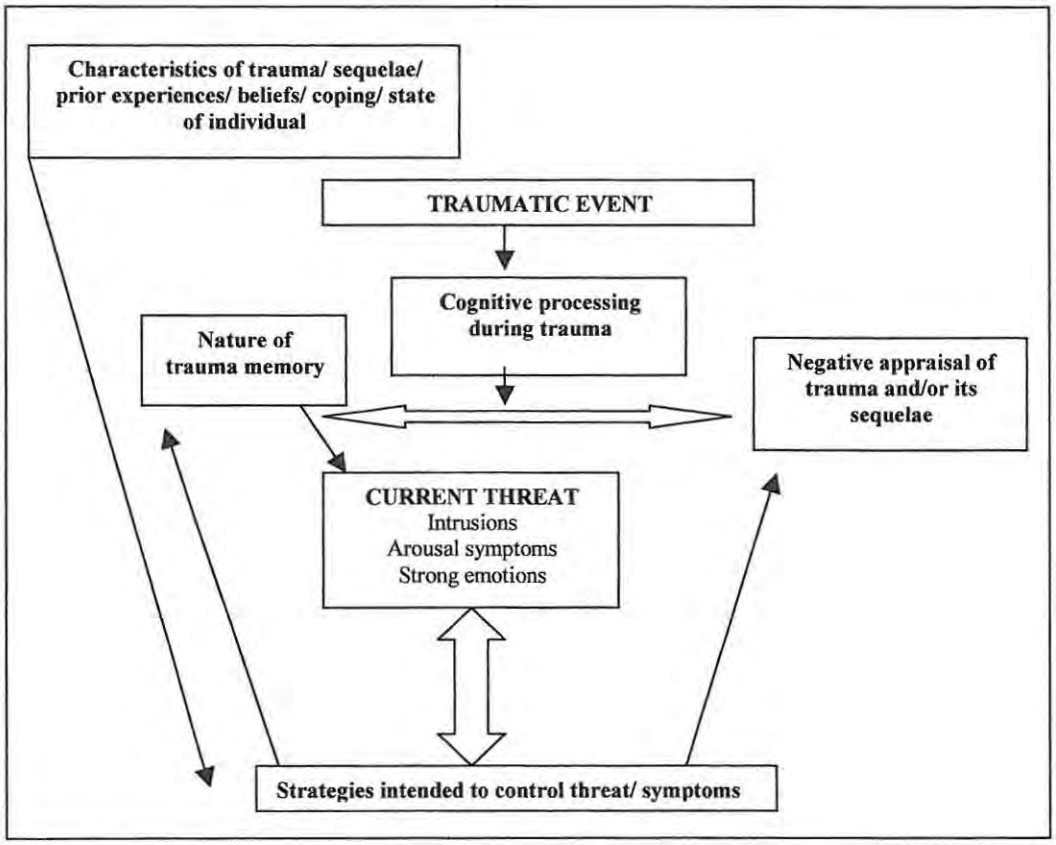

Figure 4.1. A Cognitive Model of PTSD. Adapted from Ehlers & Clark, 2000, p.321.

4.5.1 Cognitive Appraisals of the Traumatic Event

Ehlers and Clark (2000) postulate that several types of distorted appraisal of the traumatic event contribute to a sense of serious current threat. Firstly, an individual may overgeneralise the danger of the traumatic event to normal activities, resulting in these activities being perceived as more dangerous than they are in reality. They may erroneously predict that further catastrophic events will take place in their lives, or the lives of their loved ones, as a result of an appraisal such as "I attract disaster". Therefore these appraisals may serve to generate situational fear, and/or avoidance which serves to maintain their overgeneralised fear. For example, a woman who was previously attacked in a park whilst running might start to believe that parks are dangerous places. By avoiding going to parks in the future, she will not have the opportunity to disprove her distorted appraisal (that parks are not necessarily dangerous places), thus maintaining her fear of going to a park based on a prior experience.

Secondly, an individual may have negative appraisals of the way he/she felt or behaved during the event which could have long-term consequences (Ehlers & Clark, 2000). For example, someone who was raped by her boyfriend, whom she had trusted prior to the event, may question her ability to choose a suitable partner in the future and thus accept that staying single is the only way to keep oneself safe.

4.5.2 Appraisals and Emotional Responses of Trauma Sequelae

According to Ehlers and Clark (2000) most patients suffering from PTSD experience a range of negative appraisals and emotional responses to trauma sequelae, which can produce a sense of current threat and thus contribute to the maintenance of PTSD. These include the way in which an individual interprets their initial posttraumatic symptoms, the way in which they interpret the reactions of others following the traumatic event, and their appraisal of the consequences following the trauma and the perceived effects on other areas of their functioning (Ehlers & Clark, 2000).

These appraisals serve to maintain PTSD as they directly produce negative emotions. The nature of the predominant emotional response will depend on the particular appraisals a patient holds. For example, an appraisal of perceived danger, "nowhere is safe", will result in fear. Other emotional responses that have been reported in the literature are anger, guilt and shame (Lee, Scragg & Turner, 2001). In addition, individuals may increasingly engage in dysfunctional coping strategies, such as thought suppression, which has the paradoxical effect of increasing, rather than reducing, PTSD symptoms.

4.5.3 Memory of the Trauma

The hallmark characteristic of PTSD is the oscillation between re-experiencing and avoiding trauma related memories (Brewin et al., 1996). It is not surprising then that the nature of trauma memory is a complex phenomenon. It is suggested that the characteristics of persistent PTSD such as poor intentional recall, vivid re-experiencing in the form of intrusive memories or flashbacks is due to the way in which the traumatic event is encoded and laid down in memory (Ehlers & Clark, 2000).

4.5.3.1 Poor retrieval

It is postulated that autobiographical memory is retrieved via two different routes (Brewin et al., 1996; Ehlers & Clark, 2000). The first is through 'higher-order meaning based retrieval strategies' (Ehlers & Clark, 2000), also termed verbally accessible knowledge by Brewin (1989). The second route, situationally accessible knowledge (Brewin, 1989), occurs through triggering as a result of the exposure to stimuli or similar contexts which are related to the traumatic event in some way. Autobiographical memory is largely organised in memory thematically or according to personal time periods, which enhances the first route of memory retrieval, but limits retrieval via the second route. Thus, information that is stored in autobiographical memory comprises both event specific information and general information about the period of life in which the memory was stored (Ehlers & Clark, 2000).

Ehlers and Clark (2000) suggested that a number of peri-traumatic influences are in operation during the time of encoding which affect the way in which the trauma memory is laid down in memory. A distinction is made between data-driven processing, which focuses on sensory impressions, and conceptual processing, which focuses on the organisation of the information; the placement of the information in context; as well as the meaning attributed to the situation. Thus, it is argued that the way the event is encoded in these two information processing systems underlies the inconsistent manner in which information about the traumatic event is recalled. In particular, they argue that data-driven processing results in perceptual priming that affects the ability to retrieve information intentionally.

Perceptual priming is a form of implicit memory. Implicit memory is information that has been accumulated by previous experiences that we do not consciously or purposefully try to acquire, for example information received whilst listening to the radio. Implicit memory traces are not easily discriminated from other memory traces, therefore stimuli that are even vaguely similar (poor stimulus discrimination) to those that occurred at the time of the trauma, even if the context in which they are experienced is different to the context in which the trauma took place, can trigger the trauma memory and re-experiencing symptoms, and are more likely to be noticed by the individual. For example, a woman who had been raped during the early hours of the morning noticed that the sound of early morning traffic triggered vivid intrusions of the perpetrator approaching her on a motorcycle.

Patients frequently experience difficulty in intentionally recalling or retrieving a complete memory of the traumatic event, and as a result their recall is often fragmented, poorly organised and lacking in specific detail and the temporal sequence of events is confused and insufficiently integrated into the general database of autobiographical memory (Brewin & Holmes, 2003). However, patients report persistent involuntarily triggered intrusive memories, such as flashbacks, whereby they re-experience events vividly with intense emotional responses.

It is proposed that in chronic PTSD the memory of the trauma has not been adequately incorporated into autobiographical memory and there is insufficient information with respect to its place and time, and its relationship to previous and

subsequent memories (Ehlers & Clark, 2000), resulting in difficulties in intentional recall of the trauma. Thus, an individual may experience difficulties in differentiating the 'here and now' quality of the emotions associated with the trauma memory, and subsequent emotions experienced when perceptual priming occurs as a result of poor stimulus discrimination, which may contribute to problematic appraisals. In addition, the individual may have difficulty linking the event and subsequent information encoded and experience reliving of the trauma through flashbacks and nightmares (Ehlers & Clark, 2000).

4.5.3.2 Intrusive memories

Research findings suggest that individuals experience a reduced perceptual threshold for stimuli temporarily associated with the traumatic event. As a result, cues that were associated to the trauma are likely to result in triggering re-experiencing symptoms in situations that are contextually different (Ehlers & Clark, 2000). Patients frequently report reliving experiences or "flashbacks" of the traumatic event. These episodes of reliving are triggered involuntarily, and are vivid visual images that are triggered by specific reminders, such as sound, olfactory sensations, particular thoughts or images related to the event (Brewin & Holmes, 2003). However, compared to normal autobiographical memory these are often disjointed and fragmentary. The "reliving" of these memories is related to a distortion in temporal sequences so that the event appears to be happening in the present here and now rather than in the past. Research indicates that flashbacks alone or in combination with other thoughts or images were reported by 43% of PTSD patients as the most persistent intrusive cognition (Brewin & Holmes, 2003). In addition, it has been reported that up to 60% of patient's suffering from PTSD reported suffering from chronic nightmares (Krakow et al., 2001).

4.5.4 Maladaptive Behavioural and Cognitive Coping Strategies

Patient's suffering with chronic PTSD frequently attempt to control their perceptions of a serious current threat and the accompanying symptoms through various means. The strategies selected are linked to the individual's appraisals of the traumatic event and/or its sequelae, as well as to their beliefs on how best to cope with it. Individuals' frequently engage in maladaptive behavioural or cognitive coping

strategies such as: (1) Thought suppression, whereby an individual will attempt to avoid any recollection of the traumatic event. This frequently results in an increase in intrusive memories. (2) Certain behaviours may be changed in an attempt to control PTSD symptoms. For example, going to bed later at night in order to prevent nightmares. Whilst these behaviours may be useful in controlling certain symptoms others may increase, such as irritability, fatigue or poor concentration. (3) Selective attention to cues involving threat is a further example of a cognitive process which may serve to increase trauma related intrusions and emotions.

In addition individuals frequently engage in safety behaviours. These are the actions taken to either avoid or lessen the possibility of further trauma from occurring in the future. Examples of safety behaviours are: (1) Avoidance - avoiding thinking about the event by keeping oneself occupied. (2) Avoidance of reminders of the trauma - such as the site where the trauma occurred. (3) Using medication and/or alcohol to control anxiety (Ehlers & Clark, 2000).

Individuals initially utilise these safety behaviours in order to manage or control their PTSD symptoms. However, long-term use of these behaviours can prevent or interfere with change in the problematic appraisals of the traumatic event, limit the probability of the trauma memory being adequately elaborated and stored in autobiographical memory, and frequently serve to strengthen problematic appraisals (Ehlers & Clark, 2000).

Ehlers and Clark (2000) argue that the strategies employed frequently maintain PTSD by: (1) Directly producing PTSD symptoms, for example attempting to stay awake in order to avoid having nightmares, which results in fatigue and low levels of energy. (2) Preventing change in negative appraisals of the trauma and/or its sequelae, for example a patient may believe that the world is a dangerous place and as a result isolate him/herself. This may culminate in feelings of depression. (3) Preventing change in the nature of the trauma memory, for example a patient may resist all reminders of the trauma and therefore fail to update the trauma memory with subsequent information obtained.

4.5.5 Appraisals of the Trauma and its Sequalae

Individuals suffering with PTSD do not perceive the temporal sequence of the trauma as a time limited event that occurred in the past, and frequently see the event as having global negative influences on their future (Ehlers & Clark, 2000). Thus, negative appraisals of the trauma and its sequalae result in a sense of current threat, which can be external (e.g. the world is not safe), or internal (e.g. I am a weak person and will not succeed in life).

Appraisals of the traumatic event may result in a feeling of being under serious current threat. For example, a woman who had been raped may hold the appraisals "I attract danger" or "nowhere is safe". Thus, she overgeneralizes from the event and subsequently interprets normal activities as more dangerous than they are in reality. These negative appraisals create both situational fear and may lead to avoidance, which serves to maintain her fear (Ehlers & Clark, 2000). In this case she might avoid going to bars for fear that her drink may be spiked and she may be raped again. In addition an individual's appraisals of their feelings or behaviour during the event may have implications for the future. For example, a woman who did not fight back whilst being raped might interpret her behaviour as a sign that she enjoyed what had occurred.

Additionally, negative appraisals of the trauma sequelae (e.g. negative appraisals of one's PTSD symptoms, the reactions of others and the implications of the trauma on one's life) can produce a sense of serious current threat and thus serve to maintain persistent PTSD. The negative appraisals serve to maintain PTSD by producing negative emotions (e.g. anger, anxiety and depression), which results in individuals engaging in dysfunctional safety/coping mechanisms. As previously mentioned, in the long run this serves to maintain the PTSD symptoms rather than alleviating them. For example, an individual who interprets flashbacks as a sign that they are crazy might hold a negative appraisal such as "I am losing it". This may result in feelings of anxiety and depression, and thus the individual might withdraw from others with the hope that nobody would notice they are experiencing difficulties (Ehlers & Clark, 2000). This behaviour would serve to maintain certain of the PTSD symptoms (e.g. estrangement from others).

It is argued that the predominant appraisals held in persistent PTSD result in particular emotional responses. For example, an individual whose appraisals are largely concerned with danger will most likely experience emotions such as fear. However, research indicates that most individual's suffering with chronic PTSD experience a wide range of negative emotions (Ehlers & Clark, 2000). Various researchers have highlighted the importance of identifying a range of emotions when working with trauma, including guilt, anger, shame, fear, helplessness and horror (Andrews, Brewin, Rose, & Kirk, 2000; Ehlers & Clark, 2000; Holmes, Grey, & Young, 2001).

Resick and Schnicke (1996) reported that rape survivors suffering from PTSD frequently suffer from depression falling in the moderate to severe range. They argue that it is imperative that treatment interventions include an assessment for depression. In such a case, treatment should be focused on treating both PTSD and depression. Resick (2001) found that rape survivors suffering from PTSD and depression had poorer outcomes than survivors with PTSD alone.

4.5.6 Beliefs and Schemas

Individuals acquire and process a vast amount of information every day. This information is organised and stored in memory, through the development of schemata. A schema is an organising structure based on a collection of previously acquired information, which influences the way in which information is encoded, understood, and retrieved (Resick & Schnicke, 1996). In addition, humans hold core beliefs or assumptions, which serve to guide and assist in daily life, in problem solving and in planning for the future. The three most significant assumptions reported in the literature are: (1) the belief that the world is a predictable safe place, (2) life is meaningful and (3) the self is worthy and others are trustworthy (Janoff-Bulman, 1992).

In most cases traumatic events are unpredictable and frequently produce feelings of helplessness, which challenges one's core beliefs. Thus traumatic experiences frequently shatter existing mental structures such as an individual's beliefs and/or

assumptions (Brewin, 2003). Thus it is not surprising that individuals suffering from PTSD as a result of trauma hold more negative beliefs or cognitions about the world, others and the self (Dunmore, Clark, & Ehlers, 1999) than individual's who have not been exposed to traumatic events.

Foa and Rothbaum (1998) postulated that there are two well-defined ways in which individuals acquire these dysfunctional cognitions. Firstly, individuals who ascribe to a just world view and perceive themselves to be competent, experience some difficulty in assimilating the traumatic experience into previously stored knowledge or schemata, and thus overaccommodate their schemas about the world and others. For example, they may begin to subscribe to a more rigid negative view of the world, themselves and others, and thus believe that that world is a dangerous place and see themselves as incompetent. Secondly, individuals who suffered previous traumas view the world as a dangerous unpredictable place and view the self as incompetent, will have their existing schemas reaffirmed. It is therefore postulated that individuals holding either positive or negative rigid beliefs are more vulnerable to developing PTSD than individuals who are able to differentiate and interpret the trauma as a unique experience that does not have global implications on all areas of their functioning (Foa et al., 1999; Foa & Rothbaum, 1998).

One of the primary goals of treatment is to assist the patient in accommodating schemas to new incoming information, and to decrease the process of assimilation where the traumatic event is changed in some way to fit with prior beliefs or assumptions (Resick & Schnicke, 1996).

4.5.7 Social Support

Social support in the form of emotional support or practical help can be provided by family members, peers, institutions or professionals and is of particular value if it fits with the needs of the individual at the time it is provided (Edwards, Sakaza & van Wyk, 2005). Brewin, Andrews and Valentine (2000) conducted a meta-analysis in an attempt to identify the risk factors for the development of PTSD. Fourteen risk factors were included in this study (namely: gender, age at the time of the trauma, education, intelligence, race, previous psychiatric history, trauma severity, post-

trauma life stress, post-trauma social support, socio-economic status, reported abuse in childhood, adverse childhood factors excluding abuse, familial psychiatric illness, and previous traumatisation). Findings indicated that the effect size for all the factors was modest. However, factors operating during or after the trauma had stronger effects than pre-trauma factors in the development of PTSD, with social support showing the strongest effect size

Research findings suggest that negative appraisals of others' support and response were related to current PTSD, and predicted PTSD symptomatology six and nine months later (Clark & Ehlers, 2005; Dunmore et al., 1999). For example, individuals' may perceive that harm was done to them not only by the perpetrator but by the social world itself, they might feel that others think they are to blame for what occurred, or that they could have prevented the trauma in some way. The perceived negative response may be associated with feelings of anger, sadness and guilt and the individual might isolate themselves from others even further. On the other hand, the trauma survivor might perceive positive or sympathetic responses as harmful if they are interpreted as a sign of weakness.

In addition it has been found that women exposed to violent crimes encounter more negative social support (including indifference and criticism) than men and the relationship between the lack of support and the development of PTSD is higher in women (Brewin & Holmes, 2003). Similarly, Ullman and Filipas (2001) examined correlations between social reactions and PTSD symptom severity in female sexual assault survivors. They reported that negative social reactions such as blaming the survivor, treating the survivor differently, responding in an egocentric way, and employing controlling responses were related to greater PTSD symptom severity.

The above-mentioned research findings indicate that negative social support and social reactions play an important role in the development of PTSD following trauma. In addition, the results highlight the importance of social support, for trauma survivors, which is consistent with their needs at the time it is provided.

4.5.8 Summary

The discussion above highlights the multifaceted nature of the various aspects which serve to both create and maintain PTSD. This demonstrates the importance of a comprehensive treatment plan that targets the different areas of difficulty experienced. The following section focuses on the treatment of PTSD within a cognitive framework, and more specifically using Ehlers and Clark's (2000) treatment model.

4.6 Treatment of PTSD

Various therapeutic interventions have been utilised in the treatment of PTSD. Some examples are hypnotherapy, psychodynamic treatments, pharmacological interventions, eye movement desensitisation and reprocessing, and cognitive behavioural interventions. In the past the majority of the research investigating the efficacy of treatments for PTSD has focused on the efficacy of cognitive behavioural interventions in the treatment of PTSD (Foa & Rothbaum, 1998). However, current literature suggests that Ehlers and Clark's (2000) cognitive therapy model provides the most comprehensive account of the maintenance and treatment of PTSD (Brewin & Holmes, 2003). In addition this model has been strongly and consistently supported by empirical evidence (Brewin & Holmes, 2003).

The following section will provide a more detailed account of Ehlers and Clark's (2000) treatment model, followed by examples of empirical evidence for its effectiveness from the literature.

4.7 Cognitive Therapy for PTSD

4.7.1 Ehlers and Clark's Cognitive Therapy Model

According to Ehlers and Clark's cognitive therapy (CT) model PTSD persists when individuals process the traumatic event in a way that produces a sense of serious current threat (Ehlers & Clark, 2000). The authors advocate that each case is formulated individually and that each patient receives an individualised version of

treatment based on the model's propositions. Thus, the patient's triggers and trauma memory characteristics, appraisals, and cognitive and behavioural coping strategies that serve to maintain his/her PTSD symptomatology are identified and addressed on an individual basis. An advantage of this model is that the treatment procedures are individualised and thus differ from patient to patient according to the specific difficulties experienced (Clark & Ehlers, 2005).

This model incorporates a variety of components in the treatment of PTSD. Examples of these are: psychoeducation, trauma reliving, Socratic questioning, cognitive restructuring, imagery, and behavioural experiments (Ehlers & Clark, 2000). The three primary goals of treatment are: (1) To modify the negative appraisals of the trauma and its sequelae. (2) To reduce re-experiencing by elaboration of trauma memories and discrimination of triggers. (3) To discontinue dysfunctional behaviours and cognitive strategies (Ehlers, Clark, Hackmann, McManus & Fennell, 2005). These goals are achieved using various techniques during treatment in order to maximise change, and are discussed in more detail below.

(i) Assessment Phase

During the assessment interview the clinician endeavours to identify the dominant cognitive themes that the treatment needs to address. In order to facilitate this process patients are asked to identify the most distressing aspects of the traumatic event to assist the clinician in identifying 'hot spots' (areas which elicit significant emotional distress). In addition, the clinician assesses the nature of intrusive images and incidents when an individual dissociates or withdraws. These aspects of the trauma, or its sequalae, are then explored further in order to identify possible meanings ascribed to them. In addition predominant emotions such as anger, guilt or sadness frequently provide useful clues to the dominant cognitive themes (Ehlers & Clark, 2000).

In order to identify problematic appraisals of the traumatic event and/or its sequalae, the clinician explores the patient's views on his/her difficulties following the event, his/her beliefs about the symptoms experienced, beliefs about the future, and perceptions of the reactions received from others. During this phase, the clinician

assesses the cognitive and behavioural strategies employed to cope with the memories of the trauma, and identifies the nature of the trauma memory and associated intrusions. Questions the clinician seeks to answer are: Is the trauma memory coherent? Does it have a 'here and now quality'? Or is it confused and/or fragmentary, and are there significant gaps? (Ehlers & Clark, 2000).

On completion of the assessment phase, and before the commencement of treatment, the clinician and patient enter into a dialogue on the rationale for treatment. Firstly, the clinician normalises the symptoms (specifically intrusions, hyperarousal and numbing) by describing these as a normal reaction to an abnormal event. This provides an opportunity for the clinician to provide psychoeducation on the development and maintenance of PTSD. Secondly, the clinician explains that the coping strategies used may have been useful in the past, but in this situation may be maintaining their symptoms. Thirdly, the clinician introduces the treatment plan which involves processing the event fully and reversing the factors which serve to maintain their current condition (Ehlers & Clark, 2000; Harvey, Bryant & Tarrier, 2003). Metaphors are frequently used to increase the patient's motivation to engage in the therapeutic process. For example, that of a jigsaw puzzle where all the pieces are scattered all over the floor. If the pieces are left on the floor one is likely to stumble over them. However, if they are pieced together, the puzzle can be filed away (Ehlers & Clark, 2000). In addition patients are offered the opportunity to raise any questions or share concerns they may have about the process ahead. This both empowers and encourages patient's to take ownership of their recovery.

(ii) Treatment Phase

(i) Goal 1 – Modifying Negative Appraisals.

Negative appraisals of the trauma and/or its sequelae are identified using various cognitive techniques. The negative appraisals may be identified through examining the nature of the intrusions and identifying 'hot spots' (Ehlers & Clark, 2000). Following the identification of the negative appraisals Socratic questioning and imagery techniques such as 'rewinding' and 'fast-forwarding' can be used to modify these appraisals.

Once the patient identifies an alternative appraisal, the new appraisal is incorporated into the trauma memory (Ehlers et al., 2005). This can be achieved by means of a written account, revisiting the site, during cognitive restructuring during reliving (Grey, Young & Holmes, 2002), or by incorporating the new appraisal during a subsequent reliving (Speckens, Ehlers, Hackmann & Clark, 2005). An example provided by Ehlers et al. (2005) describes how a patient felt intense guilt about a motor vehicle accident he had been involved in, with the appraisal that he could have prevented the accident from occurring. After revisiting the site where the accident took place he recalled the speed at which he was travelling and calculated that he would not have been able to increase the braking time in retrospect, and thus it would not have been possible for him to avoid the accident. The treatment procedures used to modify negative appraisals of the traumatic event and trauma memory are illustrated in Figure 4.2 below.

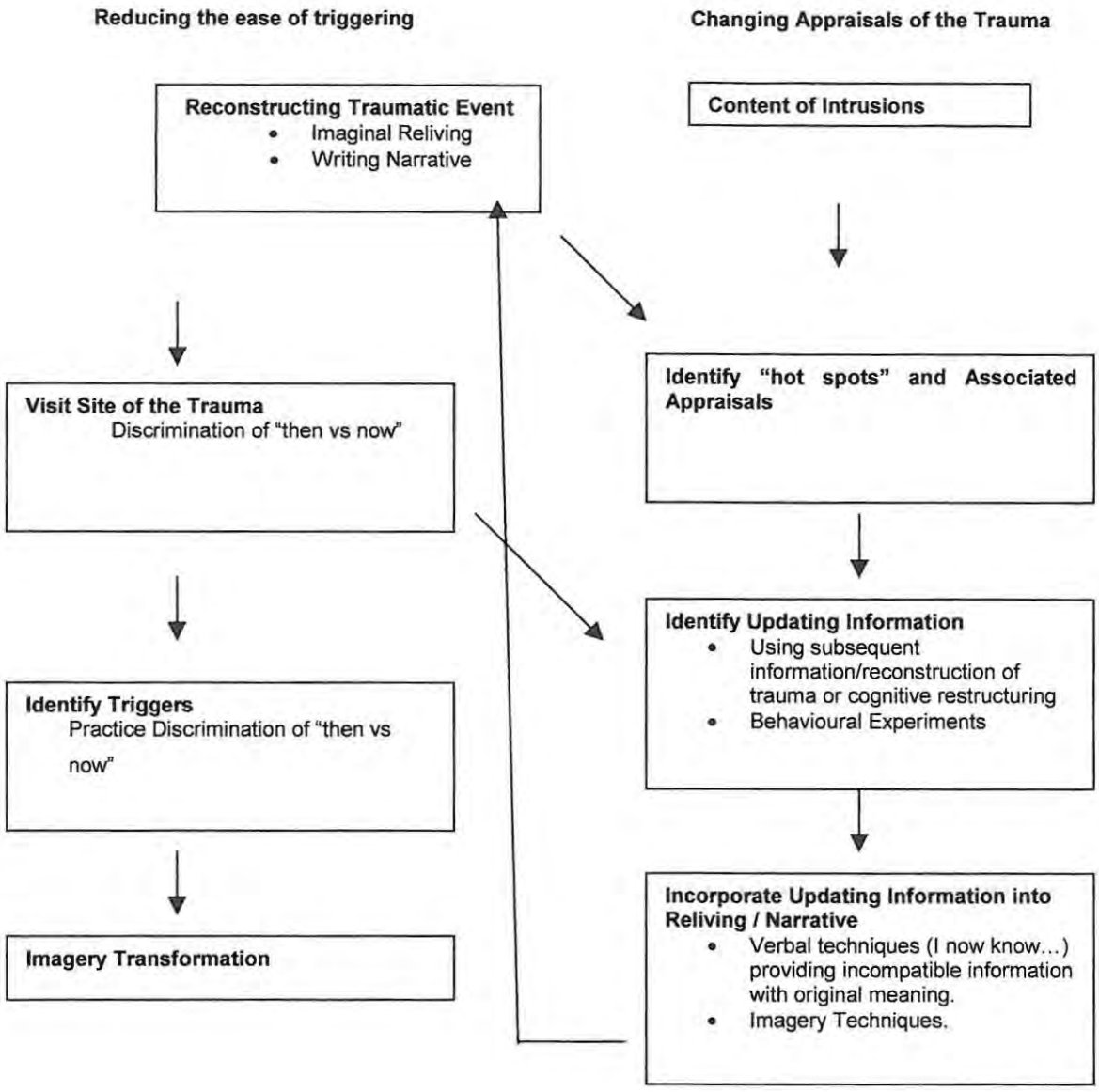

Figure 4.2. Cognitive Therapy for PTSD: Treatment Procedures for Reducing Re-experiencing Symptoms and Changing Appraisals of the Trauma. Adapted from Ehlers & Clark, 2000, p. 417.

(ii) Goal 2 – Reducing Re-experiencing.

During this stage of the treatment process the clinician assists the patient in developing a coherent narrative of the trauma, which begins before the event took place and terminates when the patient is in a safe place. This enables the events of the trauma to be placed in temporal and spatial context (Ehlers et al., 2005). The creation of a coherent narrative updates the autobiographical memory which serves to both reduce negative appraisals (as in goal 1), and inhibit intrusive memories or flashbacks of the event from reoccurring (Ehlers & Clark, 2000). Three main strategies are used to facilitate this process and were mentioned above, namely writing a detailed version of the event, revisiting the site and imaginal reliving of the event. In addition, depending on the nature of the re-experiencing techniques such as exposure, where the individual is exposed to situations or individuals similar to situations or events at the time of the trauma in a contained environment (Foa & Rothbaum, 1998), and dream restructuring (Krakow et al., 2001) may also be utilised.

The second aspect of this stage of the treatment process focuses on discriminating triggers. The discrimination of triggers is twofold. Firstly, to establish when and in what context intrusions occur, which is used to identify triggers. Second, to break the link between the trauma memory and the associated triggers. For example, a woman who had been sexually assaulted by a balding man frequently experienced flashbacks whilst at the bank and perceived them to be coming out of the blue. On further examination she realised that the bank teller was a balding man of the same age and race as her attacker. In the event that the re-experiencing symptoms continue, imagery techniques can be used (Ehlers et al., 2005).

(iii) Goal 3 – Changing Dysfunctional Behaviours and Coping Strategies.

Patients frequently utilise avoidance strategies in an attempt to cope with their sense of current threat. However, these strategies may provide some immediate relief but in the long-term serve to maintain PTSD because they interfere with the elaboration of the trauma memory. To achieve this treatment goal clinicians discuss the consequences of the strategies used and encourage patient's to either drop or reverse the strategies, first during a behavioural experiment during therapy and later

in other contexts. The completion of these exercises results in a decline of intrusion frequency (Ehlers et al., 2005).

4.8 Efficacy of Treatment

Clinicians are under an increasing obligation to engage in evidence-based practice. This has resulted in an expectation that they provide justification that the approaches used to treat clinical problems is based on scientific thinking. In addition it is important that the treatment demonstrates efficacy in the contexts in which it is utilised (Edwards, 2005a). Controlled trials have indicated that cognitive therapy is both an acceptable and effective treatment for PTSD. It is has been shown to be highly accepted by patients with substantial improvements occurring both during treatment and follow-ups. In addition it can be effectively distributed into routine clinical settings (Clark & Ehlers, 2005).

Due to the scope of this paper the main focus will be on investigating the efficacy of the Ehlers and Clark (2000) treatment model for PTSD. This will be followed by research findings on the efficacy of this model and will also include research findings on the effectiveness of cognitive therapy in treating PTSD in rape survivors.

4.8.1 Efficacy of Cognitive Therapy Treatment for PTSD

Resick (2001) reviewed seven controlled studies, each of which included at least a component of cognitive therapy in the treatment of PTSD. Two of the studies focused on the early intervention of PTSD and included both cognitive therapy and exposure therapy. Three studies examined cognitive processing therapy (CPT), which is primarily cognitive therapy. Results of the study indicated that their specific treatment (CPT) was more effective in the treatment of PTSD compared to no treatment, relaxation, supportive counselling and fared similarly to exposure treatments. The two remaining studies compared 'pure' (Resick, 2001, p. 326) cognitive therapy with a combination of cognitive restructuring and exposure therapy. Results from both these studies indicated that both groups improved substantially. However, neither form of therapy was found to be superior.

Kubany et al. (2004) examined a second treatment-outcome study of cognitive therapy for battered women with PTSD (CTT-BW). The study included 125 formerly battered women from diverse ethnic backgrounds. The women were randomly assigned to either an immediate CTT-BW condition or to a delayed CTT-BW condition. The immediate CTT-BW group received treatment which included two individual sessions per week, up to 11 sessions in total, and consisted of psychoeducation, stress management, exposure, exploration of the trauma memory, self-monitoring, cognitive therapy for guilt and assertiveness training. Two weeks post-therapy the CTT-BW received their post-therapy assessment. At this time, roughly six weeks after their initial assessment, the CTT-BW received a second pre-treatment assessment. Results of the study indicated that PTSD symptoms had remitted in 87% of the women who received treatment. In addition there were also corresponding reductions in guilt, shame and depression and an increase in self-esteem. These improvements were maintained at 3 and 6-month follow-ups. In comparison PTSD and depression amongst the women in the delayed CTT-BW condition did not diminish between post therapy assessments. The techniques used in this study are techniques that are included in the Ehlers and Clark (2000) treatment model, which suggests that these interventions are useful in treating individuals from diverse backgrounds such as the South African population.

The above-mentioned studies highlight the effectiveness of cognitive therapy in treating PTSD. In addition these studies highlight the importance of a multi-component package of treatment strategies in the treatment of PTSD. The following section explores the efficacy of Ehlers and Clark's (2000) treatment model for PTSD.

4.8.2 Efficacy of Treatment with Rape Survivors

The contributions of the researchers mentioned below have been assimilated into a more comprehensive treatment model, that of Ehlers and Clark (2000) cognitive therapy. Each of the studies mentioned below incorporates at least an aspect of cognitive therapy.

Foa, Rothbaum, Riggs and Murdock (1991) investigated the efficacy of prolonged exposure therapy (PET), stress inoculation training (SIT), and supportive counselling (SC), with results from a waitlisted (WL) control group on women suffering from PTSD following rape or physical assault. Results on post-treatment assessment found that the three groups that received active treatment had improved significantly. The findings suggested that immediately following treatment the SIT and PET groups improved on all three clusters of PTSD symptoms (re-experiencing, arousal and avoidance). However, the SC and WL group only improved on the arousal symptoms. At follow up 55% of those treated with PET no longer met the criteria for PTSD, compared to 50% who received SIT and 45% who received SC. A second study (Foa et al., 1999) compared PET to SIT, a combination of PET and SIT, and a waiting-list control group. The results of this study showed improvements in symptoms of patients receiving all three active treatments, whilst the WL control group did not improve. At the six-month follow-up 75% of the PET patients, 68% of SIT patients and 50% of PET/SIT patients, no longer met the diagnosis for PTSD, whilst the waiting list patients retained the diagnosis of PTSD.

Foa and colleagues (Foa, Hearst-Ikeda, & Perry, 1995) conducted a study investigating whether a brief intervention could reduce PTSD symptomatology over the rate of natural recovery in the early months following rape and/or sexual assault. The treatment consisted of four two-hour therapy sessions, beginning one month following the incident, and included psychoeducation, imaginal and in vivo exposure, and cognitive therapy whereby distorted beliefs about the event were challenged. In this study comparisons were made with a matched control group who were not treated but were repeatedly assessed. Results of the study indicated that treatment accelerated recovery. The patients who received the brief treatment intervention showed a 72% mean reduction in symptom severity compared to 33% in the control group.

Resick and Schnicke (1996) proposed CPT as the treatment of choice for PTSD. They conceptualise PTSD as the result of faulty interpretations between prior schemata and incoming information (namely, rape). CPT includes both cognitive and exposure based interventions with the aim of facilitating the expression of affect

and to accommodate the traumatic event within general schemas regarding self and world. The CPT (Resick & Schnicke, 1996) treatment manual for treating rape survivors outlines twelve therapy sessions which include psychoeducation about PTSD, providing an explanation of/and rationale for treatment and education about the reciprocal relationship between cognitions, emotions and events. In addition this manualised treatment includes an exposure component whereby a detailed narrative of the traumatic event is written down and processed throughout the therapeutic process. The treatment includes challenging maladaptive beliefs and assumptions and replacing faulty thinking patterns through cognitive restructuring. Weekly homework assignments are given to enable the patient to practice techniques learned during the therapy sessions.

Nishith, Resick and Griffin (2002) investigated the efficacy of PET and CPT for female rape survivors with PTSD. Both the treatment groups consisted of 54 patients each. The women assigned to CPT received 12 biweekly sessions of therapy over a six week period with a total of 13 hours of therapy on termination. The women assigned to PET received nine biweekly sessions over a 4.5 week period, with a total of 13 hours of therapeutic intervention on termination. Results showed that there was an apparent shift in PTSD symptoms after the first exposure session, suggesting that this may be an active ingredient of change in both treatment conditions. The avoidance symptoms in the CPT showed a linear decline compared to the PET group which avoidance symptoms increased initially. The explanation given is that cognitive therapy is the primary therapeutic component in CPT. In comparison PET consists of intensive exposures which are effective in bringing about habituation in PTSD symtomatology, but result in an immediate increase in avoidance symptoms. On termination of therapy PTSD symptoms in both PET and CPT treatment groups had decreased from moderate-severe to mild symptoms. However, due to the increased focus on prolonged exposure in PET, in an attempt to bring about habituation in PTSD symptoms, there is an immediate increase in avoidance symptoms and higher rates of drop out than in CPT. Whilst both these treatment interventions were effective in reducing symptoms of PTSD, it appears that the addition of cognitive therapy is advantageous in reducing symptom severity in a shorter period of time.

4.8.3 Efficacy of Ehlers and Clark's Cognitive Therapy Model for PTSD

Gillespie, Duffy, Hackmann and Clark (2002) investigated symptomatic change, following treatment, in a consecutive case series of 91 patients suffering from PTSD following a car bombing in Omagh, Northern Ireland. The treatment consisted of cognitive therapy in line with recommendations of Ehlers and Clark (2000). After an average of eight sessions considerable reductions in symptoms of PTSD, as well as depression were noted.

Ehlers et al. (2003) conducted a study to ascertain whether cognitive therapy or a self-help booklet provided in the initial months after a traumatic event was more effective in preventing PTSD than repeated assessments. The participants were motor vehicle accident survivors who met the criteria for persistent PTSD. Initially the participants completed a three week self-monitoring phase. Those who did not recover during this phase were randomly assigned to receive either cognitive therapy (CT), a self-help booklet (SH) based on cognitive behavioural therapy, or repeated assessments (RA). The main assessment for all participants was conducted at three and nine months. Results indicated that CT was more effective at reducing the symptoms of PTSD, depression, anxiety, and disability than SH and RA. At follow-up only 3 (11%) CT patients had PTSD compared to with those who received SH (17 [61%]), or RA (16 [55%]). The effect size for the CT group (2.0) was significantly above that of the SH (close to 1.0) and RA (<1.0). However there was not a significant difference between the latter groups.

Later research (Ehlers et al., 2005) investigated the efficacy of cognitive therapy in treating 20 patients suffering from PTSD in a consecutive case series. Patients were selected based on the following inclusion criteria: 18-65 years old; meeting the diagnostic criteria for PTSD linked to a discrete traumatic event during adulthood; and the time since the trauma was at least six months. The treatment followed the recommendations put forward by the Ehlers and Clark (2000) model. The treatment demonstrated high acceptability and the results indicated significant improvements in symptoms of PTSD, anxiety and depression. At termination 90% of the patients no longer met the diagnosis of PTSD, which was maintained at a six-month follow

up investigation. The reported effect size of 2.82, is double that reported in other studies.

Results obtained in the consecutive case series were later replicated in a randomised control study (Ehlers et al., 2005). Ehlers and Clark's CT was compared to a 3-month waitlist condition. Results indicated that CT led to large reductions in symptoms of PTSD, as well as depression, anxiety, and disability. In the CT group 71% of the individuals no longer met the criteria for PTSD, which was maintained at a six-month follow up study. In comparison, there were no changes in symtomatology in the waitlisted group. The effect size of 2.25 was double the effect sizes obtained in other studies.

The brief review above indicates that Ehlers and Clark's (2000) CT model is effective in treating individuals suffering from PTSD. The studies which investigated the effectiveness of this model reported smaller or no drop out rates, and reported larger effect sizes than other researchers (Edwards, 2005b).

4.8.4 Summary

In light of the above discussion cognitive therapy and more specifically the Ehlers and Clark (2000) model are effective treatments for persistent PTSD (Brewin & Holmes, 2003; Clark & Ehlers, 2005). The next section focuses on the issue of transportability of treatment models from one context to another.

4.9 Transportability

Whilst there is considerable evidence to support the efficacy of cognitive therapy for PTSD in the United States of America and the United Kingdom, the question of transportability to third world or developing countries has been less adequately researched (Edwards, 2005b). Schoenwald and Hoagwood (2001) argue that the dissemination of effective treatments is an important step towards increasing the prevalence of evidence-based practice. However before this is possible the issue of the transportability of treatment models requires further investigation. These authors caution practitioners that premature dissemination of any treatment, prior to

establishing its effectiveness within a particular context, may have a negative influence on the way in which the treatment is received at a later date. In addition, these authors highlight various aspects such as limited resources, insufficient training and diverse client populations which are important variables that need to be considered, particularly in third world settings, which threaten to impact on the transportability of treatment interventions from first world countries.

Thus, the question of transportability of treatment models in general, and the Ehlers and Clark (2000) model in particular, to the social and cultural contexts found within South Africa is essential, highlighting the need for further research (Edwards, 2005b). Two questions pertaining to the transportability of this model are: (1) Is this model transportable from a research setting to a routine clinical setting? And, (2) Is this model transportable from one cultural setting to another cultural setting or from a first world to a third world context.

There is evidence to suggest that the basic components of PTSD treatment models are transportable to other contexts (Edwards, 2005b). This will be discussed further, with the focus on treatment interventions that have been conducted in the South African context, and found to be effective in the alleviation of PTSD symptomatology.

Eagle (2005) reported that individuals suffering with PTSD have been successfully treated in accordance with the guidelines outlined in the Wits Trauma Model. She argues that integrative psychotherapy should be the treatment of choice for individuals exposed to trauma. This model proposes the use of an integrative psychotherapy approach, namely drawing on the strengths of both cognitive behavioural and psychodynamic schools of thought. This model includes five components, which will be briefly described. First, patients are asked to describe the traumatic event in the present tense including information about their thoughts, cognitions and feelings at the time of the trauma. During this phase various techniques are employed, for example using metaphors, Socratic questioning, imaginal exposure and cognitive reframing. Second, the clinician and client enter into a dialogue about the nature of the symptoms experienced. The clinician normalises the symptoms, and provides psychoeducation on the link between the

traumatic event and the symptoms experienced. Third, the clinician explores issues such as self-blame and survivor guilt, with the aim of restoring the individual's self respect. Techniques such as guided imagery, asking the client to assume a third person position in assessing their actions or counteracting responses from others, and cognitive reframing are utilised in this phase. The fourth component focuses on encouraging mastery and an increasing the client's sense of agency. Numerous strategies are used to achieve these aims. Examples are: providing affirmation of behaviours that were adaptive or necessary at the time of the trauma, for example compliance with a gunman's demands which assisted in the individual's survival; anxiety management techniques; assisting the client in increasing their support networks; thought stopping and behavioural rehearsal techniques. Finally, the clinician facilitates in the creation of deriving meaning from the traumatic experience. This component is an optional one, as creating meaning from adversity is frequently done over time. However, clients may spontaneously speak about their search for meaning. In situations such as these, the clinician assists the client in establishing meaning by engaging with the individual's unique belief system which may include cultural, spiritual, existential, and political values. In addition, cognitive restructuring is used to assist clients in setting future goals and finding direction in life (Eagle, 2000).

The utility of the model described above was demonstrated in Eagle' s (2004) work with a young black South African attempted rape survivor. This intervention included a telling of the trauma narrative, identification of cognitive appraisals, normalisation of symptoms, imaginal exposure, cognitive restructuring, guided imagery, behavioural exercises and psychoeducation. Throughout the therapeutic intervention attention was paid to the client's cultural beliefs. For example, the client reported that she understood the attempted rape and the resultant symptoms as a result of a curse that had been placed on her for abandoning her friend whom was later murdered. However, during the course of therapy she came to the conclusion that the curse may have been directed at the perpetrators of the crime and not herself. She was then able to understand that she felt guilty about what had happened to her friend, and was able to let go of feeling responsible for what had occurred. Eagle (2004) argues that respect for an individual's cultural beliefs, an appropriate understanding of the differences inherent to Western and African

cosmologies, and the resultant implications for psychotherapy is of crucial importance in intercultural counselling if an individual is to re-conceptualise and rewrite their narratives.

Following the guidelines advocated by the Wits Trauma Model, Straker (1994) treated three adolescent sisters suffering from PTSD following the murder of their father during the civil war in the late 1970's. The girls reported suffering from insomnia, nightmares and a common dream whereby their father's spirit appeared to them informing them to restore his genitalia to his body. Straker utilised various cognitive techniques and included intensive retelling of the story, exploration of feelings of guilt and facilitated the creation of meaning from their experience. In addition she incorporated both Western and African insights in the treatment of PTSD. The sisters reported that their symptoms had dissipated after two days of intensive treatment.

The studies by Straker (1994) and Eagle (2004) followed the guidelines proposed by the Wits Trauma Model. This model advocates integrative psychotherapy in the treatment of traumatised individuals, it is formulation-driven, and offers flexibility in the treatment intervention based on the needs of the client at the time. Research obtained thus far suggests that this model has been beneficial in treating PTSD in the South African context. The propositions advocated by this model are similar to those advocated by Ehlers and Clark (2000).The success of the Wits Trauma Model in an African context supports the expectation that the Ehlers and Clark cognitive model for the treatment of PTSD may be transportable to the South African context.

A phenomenological case study conducted by Karpelowsky and Edwards (2005) describes the psychotherapy process with a student who presented with acute stress disorder following numerous motor vehicle accidents (MVA's), and identifying his brother's body following one of the MVA's. The therapeutic intervention drew on integrative psychotherapy over a period of three months, and consisted of 22 sessions ranging from one to two hours each. The intervention included an in-depth description of the traumatic events, four guided imagery sessions, identification of dysfunctional beliefs and cognitions, cognitive restructuring and the creation of meaning from adversity. At termination the client reported significant shifts in his

relationships with other family members, and a decrease in intrusive images and nightmares. In addition, he came to the conclusion that he was not able to alter the course of events, but had obtained mastery over them and thus these images no longer controlled him. Finally he was able to focus on more positive memories of his brother. This study suggests that integrative psychotherapy, and more specifically working with imagery, is effective within the South African context.

Finally, Davidow (2005) treated a rape survivor of African descent using guidelines advocated by Ehlers and Clark (2000). The therapeutic intervention spanned twelve weeks, and consisted of ten therapy sessions overall. The treatment included an assessment intake, psychoeducation, identification of cognitive appraisals and dysfunctional beliefs, cognitive restructuring, and imaginal reliving. At termination there was a significant reduction in levels of depression and anxiety experienced, and the patient no longer met the diagnostic criteria for PTSD. This study was the first in a series of case studies underway, of which this study is included, and suggests that this model may demonstrate effectiveness in treating the South African population. Although this study outlines the treatment of one individual, the results suggest that the Ehlers and Clark (2000) treatment model may be effective in treating PTSD in multicultural societies such as South Africa.

Whilst the studies above suggest the possibility of transportability for treatment models of PTSD, further research is necessary (Edwards, 2005b). Thus the aim of this study is to investigate the transportability of Ehlers and Clark's (2000) cognitive therapy treatment model for PTSD to the South African context.

5. ASSESSMENT AND FORMULATION

The therapeutic intervention and treatment followed the guidelines proposed by Ehlers and Clark's (2000) treatment model for PTSD. The intervention, for the purposes of this report, consisted of one screening interview, three assessment interviews of 50mins-90mins (3 with the client and one with her mother), and 21 individual therapy sessions with the client. Although Ehlers and Clark (2000) advocate that reliving is an important component of the assessment, this aspect of the treatment was only conducted during sessions 11 and 15 as the client found it

extremely difficult to speak about the two incidents when she was raped. Although she provided a brief account of what happened during the assessment phase it was decided that the reliving exercise would be conducted when the therapeutic alliance was stronger and the client was better able to cope with the anxiety-provoking information.

5.1 Assessment

Zanele met the criteria for PTSD (chronic) on the basis of clinical interviews, which was consistent with the scores obtained on the BAI (50: severe), the PDS (42), and PTCI (107). At the time she was also suffering from a major depressive episode, which fell in the severe range (see 2.The Client for a more detailed description). This diagnosis was made from a combination of both her presentation at the time of the intake sessions, as well as her score on the BDI-II (33: severe). Her mood appeared depressed and she reported mixed feelings of sadness, anxiety and fear.

5.1.1 Intake and Assessment Interviews

The main focus of the assessment sessions was to screen for PTSD, and to gather personal and familial history in order to gain an in-depth understanding of the client's presentation and thus assist in guiding the case formulation. In addition the client and therapist entered into a dialogue on the rationale for treatment and drew up a list of difficulties that would be worked on during the treatment process. The information obtained during the intake sessions is outlined below.

5.1.2 Family History

Zanele's father, Lwanda, worked as a construction worker and was the sole breadwinner in the family. It was reported that he abused alcohol and cannabis, and during times of intoxication he would physically assault his wife. The family struggled to survive as the wage Lwanda received was frequently spent on substances. In 1999 Nomsa (Zanele's mother) began working as a chef to supplement the family income. In 2002 Lwanda suffered from a severe stroke. Following this he found it difficult to walk and was unable to communicate effectively with others. As a result, he lost his job and has received a disability grant since. It

was reported that after his stroke he began drinking heavily and became more violent and abusive towards his wife.

In 2004 Nomsa divorced her husband and moved into her own home. Zanele continued to live with her father, her father's brother and his girlfriend and their children, and her paternal grandmother. Zanele described the living conditions as overcrowded and extremely basic. Despite her father's untoward behaviour towards his wife, Zanele described her relationship with her father as being extremely close. She reported that she enjoyed her father's company and could speak to him about anything. In addition she said that she had a good relationship with her mother, whom she described as a very soft emotional individual. However, Zanele's home environment changed when her family heard she had been raped. Her paternal grandmother beat her and told her that she was useless. Zanele packed her belongings and moved in with her mother the same day. She reported that she missed seeing her father every day, but did not want to have contact with his mother.

Nomsa had a daughter out of wedlock before she met Zanele's father. When they married it was decided that Noku (now aged 21 years) would live with an uncle in another area. She attended an English medium school until she was six years old when she returned to live with her mother. However she did not cope academically as the new school she attended was conducted in Xhosa. As a result she went to live with the same uncle with whom she had previously lived with. Nomsa continues to live with her maternal uncle to date. Zanele described having a close relationship with her sister, and said she loved having her sister at home during school holidays.

5.1.3 Personal History

Zanele reported that her mother suffered from high blood pressure and thus experienced some difficulties whilst she was pregnant. However, Zanele was delivered normally without complications. It was reported that she was a sickly child until the age of one year, when she became more robust. She reached her developmental milestones timeously and no neurotic symptoms were reported in childhood. Zanele started school at seven years of age and always performed well

at school, falling within the upper section of the class. She made friends easily, but preferred to have a smaller group of close friends. She is currently completing Grade 8 and has hopes of becoming an accountant.

Zanele and her family attend the Old Apostolic Church on Sundays and she reported that they lived by their religious beliefs. Thus Zanele believed that sexual intercourse was reserved for marriage. She had never been in a romantic relationship, stating that she wanted 'to focus on her studies and make something of her life'.

5.2 Formulation

An examination of Zanele's early home environment provides a deeper understanding of her current presentation. Zanele lived in an authoritarian, patriarchal system where her father was seen as the head of the household, and thus she and her mother had to obey the rules he laid down. Although she reported having a close relationship with her father, she witnessed many incidents when he beat her mother. In addition, the family frequently went to bed hungry as he had spent the income on substances. This may have resulted in the development of unconditional schemas that 'men cannot not be trusted', 'men are abusive to women' and the underlying assumption that 'women must obey men's orders'.

There were many factors that precipitated Zanele's presentation with PTSD. Namely, she was raped twice by the same perpetrator in January and February 2006. She did not tell anyone what had happened as the perpetrator threatened to kill her if she did so. It was only after her father's brother's girlfriend confronted her about what she had heard that she spoke about what had happened. After reporting both incidents to the police, in March 2006, she worried that the perpetrator would carry out his threats. Her paternal grandmother had beaten her and told her that she was 'useless' after hearing that she had been raped. It was at this time that Zanele realised that she did not have the support she needed from all of her family members. She felt isolated and alone, and feared for her life. In addition, she reported that she was experiencing difficulty sleeping and thus was not able to concentrate at school. She reported feeling concerned that her school work would deteriorate as a result of this.

The following factors served to maintain Zanele's presentation. She attempted to avoid sleeping so as to avoid having nightmares and she avoided people, places and conversations that reminded her about the trauma. She had limited social support and suffered with feelings of hopelessness. Her unconditional belief that men could not be trusted was reactivated, as were the maladaptive schemas and faulty appraisals she had at the time of the traumatic events. She feared for her life, which resulted in her withdrawing from others which served to alienate her further. In addition she was suffering from depression as a result of the PTSD symptoms she was experiencing. As previously mentioned, her scores on all the self-report scales fell within the clinically significant range.

5.2.1 Nature of Traumatic Events

During the assessment phase Zanele provided a brief account about the traumas she had endured. She was extremely emotional when she spoke about the traumatic events for the first time during the therapeutic intervention. The information provided below incorporates information obtained during the assessment phase, as well as information obtained during subsequent sessions, including both the reliving exercises.

5.2.1.1 January 2006

Zanele reported that she and her best friend were on their way home after visiting her friend's grandmother. An older male called them but they ignored him and continued on their journey. She reported that she did not know the individual by name but had seen him in the community. He then approached them and grabbed Zanele's arm. Her friend started to run which left Zanele feeling afraid as she felt that something bad was going to happen to her. She called out to her friend, and asked her to call her uncle to help her. The perpetrator shouted after her friend stating that he would beat her if she did this. Zanele reported that she was afraid that he was going to rape and then kill her. He forced her into some bushes nearby where he proceeded to beat her face and arms. He told her to take off her pants. She said that she felt extremely afraid and was unable to do so. He then pulled her pants off himself. He then began to rape her. Whilst this was occurring she saw a

woman walking nearby. She wanted to call for help but did not as she feared for her life. She then saw a man walking close by. She screamed for help, asking him to call the police. He came to see what was happening but left soon after this when the perpetrator convinced him that Zanele was his girlfriend. Zanele reported feeling angry when the perpetrator said this. After raping her he told her to go home and threatened to kill her if she told anyone about what had taken place.

5.2.1.2 February 2006

Zanele reported that the second traumatic event occurred on a Saturday afternoon in February. She went to one of the shops in the area in which she lived. Whilst in the shop she saw the individual who had raped her in January. She felt extremely afraid, avoided making eye contact with him and left the shop. He followed her out of the shop and grabbed her arm. He told Zanele to accompany him. She asked where they were going, but he responded by telling her not to ask questions. She tried to run away but he told her that it was pointless, as he would catch her anyway. He took Zanele to his home where they were met by his pregnant girlfriend. Once in the house he assaulted his girlfriend with a piece of wood, focusing on her face and her abdomen. His girlfriend's face was bleeding and she was crying. He then pushed her out the door, and told her to go home. This caused Zanele significant distress, as she feared for the unborn child. She reported thinking that if he could do this to his own child, what would to happen to her. At his point she thought that he was crazy. He locked the door and told her to pull her pants down. When she did not comply with his demand he pulled them down. He then hit her face with his hands. She reported that she was not able to see properly for some time. He then proceeded to rape her. After he raped her she stood up and dressed herself. She walked to the door hoping that he would let her go, but he told her that she was not going anywhere. He told her that he was going to sleep but if she wanted to stand by the door that was her decision. Zanele reported that she stood by the door crying whilst he slept. During this time she was afraid that he would rape her again when he awoke. At quarter to four in the morning he woke up and told her to go home. Again he threatened to kill her if she told anyone what had happened.

5.2.2 General Effects of Traumas on Client's Life

Zanele described that her life had changed since she was raped. She said that she found it difficult to communicate with others, adding that many people in the area in which she lived had heard about what had happened to her. She was worried that she would be treated differently as a result of this. She struggled to concentrate at school, and on more than one occasion had fled from the classroom due to flashbacks she was experiencing. Her appetite had decreased and she found it difficult to sleep at night. In addition, she reported being hypervigilant and easily startled by others, even in situations where she was safe.

5.2.3 Contents of Re-experiencing and Voluntary Recall

During the assessment phase Zanele reported two intrusions, which appeared to come out of the blue. The first was a waking intrusion, namely seeing the perpetrator's face superimposed on the faces of black males. The second intrusion being hit on the head with a screwdriver. During the therapy process she reported a third intrusion. She reported that she experienced nightmares about the first time she was raped as it had occurred. Zanele reported that in order to cope with these distressing episodes she would distract herself or leave the situation to avoid the intrusions. In addition, she would try to avoid sleeping so as not to have nightmares.

5.2.4 Key Appraisals at the time of the Trauma

One key appraisal was identified during the intake sessions. This was identified by exploring aspects of the traumatic events which she found distressing. Zanele reported that the perpetrator grabbed her arm and her friend ran away. On further exploration she revealed that she had interpreted the uncomfortable feeling she experienced in her stomach as a sign that she was going to be raped. Although a second appraisal emerged later, during session 18. Zanele reported that after she was raped she thought she may have been infected with either HIV or an STD and saw her future being taken away from her.

5.2.5 Dysfunctional Beliefs and Assumptions uncovered during the Assessment

Socratic questioning was used to uncover the following dysfunctional beliefs and assumptions Zanele held at the time of the trauma and in its aftermath: 'I will not be able to relate to people in the way that I used to'; 'People will not relate with me in the way they used to'; 'Nowhere is safe'; 'Men are dangerous'; 'My family are ashamed of me'; 'People who I thought would stand by me have let me down' and 'I cannot rely on others'.

5.3 Treatment Plan

The original treatment plan was to have 12 to 19 therapy sessions of 90 minutes each twice per week. However, the treatment plan was prolonged due to various difficulties which surfaced during the therapeutic process. The treatment outline was based on the Ehlers and Clark (2000) model, based on information obtained during the assessment phase and case formulation (see Table 1). The treatment plan and intervention decisions were guided by theory, continuous assessment, discussions with the client and the clinician's supervisor. Thus, the treatment plan was flexible and focused on difficulties as they arose. These decisions were based on the clinician's clinical judgment, discussion with the client and consultations during supervision.

Table 1

Treatment Outline based on the Ehlers and Clark's (2000) model

Maintaining Factor	Intervention
Behavioural, cognitive and emotional avoidance ▪ Avoiding sleep so as not to have nightmares. ▪ Avoiding talking about the traumas. ▪ Fleeing when flashbacks occur.	▪ Psychoeducation. ▪ Therapy journal. ▪ Thought suppression demonstration. ▪ In-vivo exposure. ▪ Use of imagery to change nightmares.
Unelaborated trauma memories, hotspots and appraisals never updated. ▪ She should have called for help. ▪ Her future has been destroyed. ▪ If anyone finds out what happened, I will be rejected. ▪ He is going to kill me. ▪ The policemen will not believe me if I report what happened.	▪ Reliving ▪ Cognitive restructuring within reliving. ▪ Therapy journal. ▪ Socratic questioning.
Dysfunctional assumptions. ▪ I am helpless. ▪ I am HIV positive, so I do not have a future. ▪ I will be rejected if anyone finds out my status.	Locate and target assumptions. ▪ Cognitive restructuring and behavioural interventions.
Limited social support.	▪ Disclosure of HIV status to mother during therapy session. ▪ Increasing involvement with social worker.

6. COURSE OF THERAPY

6.1 Session 1: Working with Triggers

During the last intake session Zanele reported that she had been experiencing difficulties at school. She stated that if a male teacher walked into the classroom she had flashbacks of the perpetrator. She reported feelings of intense fear and anxiety, heart palpitations, sweating and feared for her life. On one occasion she fled from the classroom. She added that she experienced the same flashbacks whilst at home with her father and uncle. During the last intake session Zanele was informed that another professional working at the hospital would be attending the following session to assist with the exposure exercise. She reported feeling afraid but said she wanted to feel better and would like to attempt this method of intervention. However, she did not arrive for the first therapy session stating that she had forgotten about therapy. However, it appeared that she might have been anxious about what the therapy session entailed.

When she arrived for her session later during the week she was cheerful and engaged well. Both the scores on the BDI (12) and BAI (12) had decreased since the last assessment intake session. I provided Zanele with a detailed account of what the exposure task would entail. Namely, that Raffi would enter the clinician's office and sit on a chair on the other side of the room. I would ask her to focus on Raffi's face and report back what she saw. I reflected that she would probably find the exercise difficult and anxiety provoking, but that I would be sitting beside her and no harm would come to her. I added that when she was ready Raffi would move half a metre closer to her, adding that this would occur twice. I told her that during the exercise I would be talking to her and asking her about how she was feeling (using the Subjective Units of Distress Scale: where a score of 1 indicated very low levels of distress and a score of 10 indicating very high levels of distress), adding that her anxiety would probably increase but that we would work together to ensure that she would leave the clinician's office feeling contained.

When she felt ready to begin with the exposure, Raffi entered the clinician's office and introduced himself to Zanele. He sat at the other end of the room facing her. At

first she found it extremely hard to look directly at him, but with some encouragement and assurance that she was safe she continued with the task. Zanele became tearful, she experienced some difficulty breathing, and she reported that her heart was beating fast and that she was sweating profusely. At the start of the exercise she rated her SUD's at 10. She reported that she saw the perpetrator's face and had to look away. After a few minutes had passed she focused on Raffi's face again. I asked her to describe how Raffi looked similar or different to the individual who had raped her. She was able to differentiate between the two individual's, stating that Raffi had a darker complexion, was taller, and that his eyes, nose and mouth were different. She reported feeling more calm and said that Raffi could move closer.

This occurred for the second time and she was able to differentiate between the two men again. The exposure lasted for approximately twenty minutes, when Zanele reported that she would like to discontinue with the exercise. She rated her SUD's level a 5, and said that she was feeling calmer. The session continued with a discussion on her experience of the exercise. She reported that although she found the task extremely anxiety provoking, she realised that she was able to survive these brief moments of distress by utilising various techniques she had used during the session. I provided an explanation of the bodily sensations she had reported, describing that they were elicited due to the trauma memory and the danger she had felt at that time, rather than a response to a current danger. Before Zanele left the session she reported feeling okay and much calmer than she felt when she arrived.

The rationale for beginning the therapeutic process with an exposure task, namely working with triggers, was due to the significant distress the client experienced as a result of flashbacks of the perpetrator's face. She found these particularly distressing as they threatened to impact on her scholastic functioning.

6.2 Sessions 2-5: Containment, Psychoeducation and Case Management

Session 2

I waited in anticipation, wondering if Zanele would arrive after the last session, as it was evident during the previous session that she had found it difficult to confront the triggers which reminded her of the traumas she had endured. To my surprise she arrived fifteen minutes early, smiling. She reported that she was feeling 'great', adding that she was sleeping better (six hours a night), she had not had any flashbacks of the perpetrator's face and she had gone to the mall (something she had not done for some time). Her score on the BDI was 9 (minimal), on the BAI her score was 8 (mild), and on the PDS (11: within normal rage). She reported that she had two intrusive images, of being beaten on her face and body, which seemed to come out of the blue during the past week. In addition she added that she had not seen her father for some time as he lived in close proximity to where the perpetrator lived, and she was afraid to visit him.

Session 3

When Zanele arrived for her third therapy session she was tearful and reported feeling anxious and afraid. Her score on the BAI showed an increase (12) since the previous session. In contrast, her score on the BDI (7) had decreased. When asked if anything had happened since the last session she said that the individual who had raped her had been granted bail and had been spotted in the area where her father lived. She became increasingly emotional as she remembered his threats that he would kill her if she told anyone about what he had done to her. Zanele reported that she was frequently alone at home as her mother often worked the late night shift. We explored various safety precautions in the interim until we were able to have additional professionals on board. Some of the issues discussed were: to accompany her mother to work; spending the night with her grandmother when her mother was at work; not walking to school or to the shops alone; and to walk in well lit areas where there were other people in the vicinity should she require assistance. The main focus on the session was on containment and validation for what she was experiencing. I informed her that I would contact the social worker after the session to establish what strategies were in place to ensure that Zanele's safety was not

undermined. Ten minutes before the end of the session I left to purchase a mace spray for Zanele, using the research grant funds available. It appeared that her personal safety was at risk and thus I felt it necessary to respond to this sense of threat. When I returned I gave the mace spray to Zanele who then practiced taking the lid off as quickly as possible.

I contacted the social worker in the area in which Zanele lived and informed her of my concerns. The social worker stated that she would meet with Zanele and accompany her to the magistrate court where she would assist her in applying for a protection order. In addition I also contacted the investigating officer to inform him of the concerns I had for my client's safety, and to establish whether there had been any further developments in the case and the possibility of apprehending and prosecuting the perpetrator.

Session 4

When Zanele arrived for her fourth therapy session she was tearful and reported feeling anxious and frightened. Whilst her score on the BDI had decreased (5: minimal), her score on the BAI had increased significantly (18: moderate). She stated that she had not met with the social worker, as there had been a misunderstanding with regards to where they were to meet. Zanele reported that she was unable to spend time at home alone and had accompanied her mother to work over the weekend, as she was afraid the perpetrator would harm her further. She experienced difficulties sleeping (an average of 4 hours per night) as she had nightmares about the trauma's she had endured. She thus attempted to stay awake to avoid dreaming about this. In addition she reported having intrusive images of being assaulted and beaten, and the flashbacks of the perpetrator's face had returned when she looked at the faces of black men.

Zanele's score on the PDS (23) had increased and fell within the upper range of symptom severity. She reported symptoms of hyperarousal, palpitations, difficulty breathing and excessive sweating whilst dreaming and when she experienced the flashbacks and intrusive images. In addition, she reported finding it difficult to concentrate. The focus of the session was on containment and psychoeducation on her bodily symptoms as a response to the trauma memories. It was explained that

the bodily symptoms she was experiencing was her body's response to reminders of the trauma and how she had felt during that time, rather than in response to an immediate danger. However, her current predicament was validated as well as her fear of being harmed by the perpetrator. Safety measures and precautions were explored and Zanele reported that she would be meeting with the social worker the following day to apply for a protection order.

The social worker contacted me the following day, after meeting with the local magistrate. She reported that they had been told that it was not possible to apply for a protection order, as the offence was not 'a domestic dispute'. However, during this meeting it was decided that policemen would accompany Zanele's uncle (who could identify the perpetrator) to the perpetrator's home to deliver a verbal warning. He was told that if he came into close proximity of her he would be arrested. In addition, the magistrate confirmed that the case had been dropped due to a lack of evidence as the events had occurred in January and February 2006 and Zanele reported the crimes in March. Following this conversation I contacted the officer who had been investigating the case to verify what information would be needed to re-open the case. He reported that this would depend on the witnesses' statements (Zanele's friend and the perpetrator's girlfriend). He said that he was still trying to locate their whereabouts.

Session 5

As in the past two sessions, Zanele's mood appeared depressed and anxious, and she reported feeling 'very sad'. Her mood and affect were congruent. She was tearful and displayed signs of anxiety, e.g. frequently shifting her posture and wringing her hands. Her scores on the BDI (28: moderate) and BAI (37: severe) had increased significantly since the last session. Zanele provided an account of what had occurred at the magistrate's office and added that she did not understand why the case had been dropped. She said that she had been told that this was due to a lack of evidence. Zanele reported that she felt that the policemen did not believe her. However, she said that she felt slightly more at ease knowing that the perpetrator had received a verbal warning. She added that she believed that justice would be done and that he would be held accountable for the crimes he had committed. She demonstrated courage by encouraging her mother to accompany

her to the police station in order to ascertain what the status of her case was. Again she was told that the case had been dropped. Despite feeling extremely emotional, with a combination of different feelings (in particular sadness and anger) she said that she felt empowered when the investigating officer told her that I had contacted him on three occasions. She reported feeling confused about the outcome, but continued to believe that justice would be done.

The remainder of the session focused on psychoeducation on PTSD. I attempted to explain this complex phenomenon in as simple terms as possible in order that she understood her symptoms in a way that was meaningful to her. I explained that the symptoms she reported (flashbacks, intrusive images, nightmares, hyperarousal, avoidance, and symptoms of anxiety) were collectively known as PTSD. This concept was explained in the following way: Post (after), traumatic (namely, the event: rape), stress (symptoms of anxiety), disorder (a normal response to an abnormal event). Zanele expressed relief that her experiences had a name, that therapy would assist in alleviating these symptoms, and that other individual's who had been exposed to various traumas had also experienced these symptoms and thus she was not the first person to suffer in this way.

I explained the process of recovery to Zanele using the snakes and ladders model (Kinchin & Brown, 2001). Square one was described as representative of the traumas she had experienced. Recovery starts on square 2. Some trauma survivors reach 100 in a few rolls of a dice, or over a period of weeks or months depending on the nature of their symptoms and receiving the assistance required. It was explained that recovery could take a couple of weeks or a longer period of time and that some trauma survivors may need longer to recover and travel around the board going up the ladders (e.g. therapy; support etc.), and at times might have to travel down the snakes (e.g. depression; avoidance; anniversary of trauma etc.). This model was useful in explaining that the process of recovery is not always smooth, at times unpredictable and includes different stages of recovery along the way. Despite this, seeking psychotherapy and additional support the trauma survivor would progress along the board, accompanied by the therapist, at a pace that he/she was comfortable with. Zanele expressed interest in this explanation of recovery, stating

that she had never heard of snakes and ladders and was excited to share what she had learnt with her mother.

Before leaving the session she added that she missed her father desperately but was afraid to visit him. However, she was excited to attend a sports day at one of the local schools with one of the social work student volunteers. In addition, she decided to spend the weekend with her maternal grandmother as her mother had to work the late shift over the weekend. We then discussed the possibility of doing the exposure exercise (working with triggers as in session 1) in the next session, as Zanele reported that the flashbacks of the perpetrator's face had returned, which was causing her significant distress and affecting her social and occupational functioning. It was decided that this required further intervention. She agreed, stating that if it would help to reduce her flashbacks she would be willing to do it again.

After the session I contacted the investigating officer again. He reported that witnesses had not been located. However, he said that in the event that they were located the case would have to be discussed with the magistrate. If there was sufficient evidence the magistrate would decide whether the case would be re-opened or not.

6.3 Session 6: Working with Triggers

At the start of the session Zanele completed the self-report questionnaires. Her scores on both the BDI (32) and BAI (39) fell within the severe range. Her score on the PDS (28) had increased and fell within the high range of symptom severity. She reported experiencing intrusive images of being assaulted on the head with a screwdriver. In addition she was only sleeping an average of two hours per night, as she did not want to have nightmares. She reported that she had gone to the mall over the weekend with a social work student volunteer. Whilst the volunteer was paying for their lunch the perpetrator's brother approached her and told her that his brother was going to beat her up when he next saw her. At this point she became extremely emotional and broke down and cried. She said that she was so afraid that she did not tell anyone about what had happened. Together we explored various

alternatives as to how she wanted to tackle this issue. In the end she identified her uncle as someone whom she could trust and would be able to speak to about this incident. She appeared to be more contained and said that she felt calmer than when she had arrived to the session.

At this point I became extremely aware of one of the ethical guidelines: first do, no harm (Allan, 2001). Although Zanele had decided that she would like to do the exposure exercise during this session, I was cautioned by the fact that she had been re-traumatized over the weekend. I raised my concern about doing the exercise with her but she felt that the exercise would assist her in daily functioning and therefore decided that she would like to proceed with the exposure exercise (working with triggers).

The session focused on working with triggers and played out as in session 1. Raffi assisted in the exposure exercise and again Zanele was asked to differentiate between what the perpetrator looked like to what Raffi looked like. During this session Raffi moved closer to Zanele on two occasions, after she reported that she was ready for him to do so. Zanele experienced a range of emotions and reported the same bodily sensations that she had experienced at the time she was raped. She became tearful and at times found it difficult to breathe and could not look at Raffi's face. Initially she reported a SUD's level of 10 but this decreased gradually as the session progressed. The duration of the exposure was roughly 40 minutes and came to an ended when Zanele appeared to have habituated to the feared situation, and she reported a SUD's level of 4. She left the session feeling contained. She was given a snakes and ladders board to take home to assist her in explaining the process of recovery to her mother.

6.4 Sessions 7-10: Nightmares

Session 7

Zanele arrived to this session smiling. At the start of the session I explored Zanele's experience of the last session which focused on working with triggers. She reported that she had found the exercise anxiety provoking at the time, but she stated that she felt calmer after having completed the exercise. She said that she experienced

a flashback of the perpetrator's face the following day and been able to withstand it. She did not try to avoid the situation by looking away or fleeing but chose to practice the techniques she had learnt during the session (looking for the differences between the perpetrator's face and the individual she was looking at). She said that she understood why her body was reacting in the way that it was and she knew that the feeling would pass.

Her face lit up when she told the clinician that she had played snakes and ladders with her mother. She felt empowered and expressed feeling that she had a role to play in her recovery. She felt supported and understood when her mother told her that she was satisfied with her therapeutic gains and encouraged her to continue with the process.

I felt excited by the shift in Zanele, that she appeared to be taking ownership of her recovery process but at the same time realising that there was still a long journey ahead of us. She surprised me again by stating that she had told her uncle about the incident at the mall, despite the perpetrator's threats that he would harm her further. Her uncle and two police escorts visited the perpetrator's home for the second time to serve him with another verbal warning. She appeared to be satisfied with this outcome. I provided positive reinforcement and reflected that it appeared that she was taking back some of the control she felt that she had lost when she had been raped. She smiled in agreement.

Zanele said she had brought her school report with her to share with me. She stated that most of her results fell within the high 70% range, except mathematics in which she received a 59%. She reported feeling proud of what she had achieved and added that her mother was rewarding her for her good results by purchasing her a cell phone. Again I provided positive reinforcement for what she had achieved despite the difficulties she was experiencing in her personal life.

She then reported that she continued to experience difficulties sleeping (2 hours per night). She stated that she had nightmares about being raped. She said that at times she saw the perpetrator's face, his mouth was moving but she could not hear what he was saying. This was discussed further and mutually decided that working

on her nightmares and sleep difficulties would be an important component of the therapeutic intervention.

She said her sister came home for the school vacation and she told her sister that she was seeing a white therapist. This surprised her sister, as she had not spoken to a white person for longer than ten minutes. This opened a discussion on Zanele's experience of working with a therapist from a different culture, who spoke English. She said that initially she found therapy quite anxiety provoking, as she did not know many white people. She added that she had to get used to the way I spoke. Then she smiled as she said that her English had improved. She left the session in high spirits adding that she was excited to show the volunteer her school report.

Although the therapeutic process was relatively well underway the reliving component was further put on hold as it appeared that Zanele's difficulty sleeping due to nightmares was impacting significantly on her daily functioning. She reported feeling tired all the time and she was not able to concentrate on her schoolwork. These difficulties appeared to require more urgent attention at this point of the therapeutic process.

Session 8

Zanele's mood appeared depressed and she was anxious and tearful for a large portion of the session. She said that she was not feeling well and thought she might be coming down with the flu. Her score on the BAI (43) fell within the severe range, and her score on the BDI (26) in the moderate range. Her score on the PDS (18) showed a decrease, indicating a reduction in posttraumatic symptoms. She reported that she had not had any flashbacks (images of the perpetrator's face) since session 6, which focused on working with triggers. However, she continued to have intrusive images of being assaulted, and slept on average two hours per night due to the nightmares she was experiencing. I introduced the therapy journal to Zanele and encouraged her to write down her thoughts and feelings, as well as about her experience of therapy as the process unfolded.

I introduced the imagery rehearsal technique (IRT) proposed by Krakow and colleagues (2001). First, it was explained that her nightmares were a likely

consequence of the traumas she had been exposed to and may serve a role in emotional processing of the traumas. Second, nightmares can be controlled by targeting them as habits or learned behaviour. Third, working with imagery whilst awake influences nightmares because what we think about during the day are related to dreams during the night. Fourth, nightmares can be changed into a more positive, new imagery. Fifth, rehearsing new dreams can either reduce or eliminate nightmares. Zanele listened attentively and reported that she understood the above explanation.

I then asked her to describe one of the nightmares she was experiencing. Zanele reported that she dreamt about being chased and caught by the perpetrator who proceeded to rape her. She was asked to write down the dream in as much detail as she could remember in her therapy journal during the session. She was then asked to change the ending in any way that she wished, and to write down the new ending. Without prompting she closed her eyes and used imagery to rehearse her new dream for ten minutes. When she opened her eyes she described her old nightmare and how she changed it. Zanele enjoyed this aspect of the exercise and came up with many different endings. For example, she overpowered the perpetrator and ran away or another ending where she called for help and someone came to her aid. She was encouraged to mentally rehearse a new dream for at least five to twenty minutes per day.

During this session, Zanele's resourcefulness and commitment to her recovery was evident. She understood the explanation of the imagery rehearsal technique and required little prompting during the exercise. For example, once she had written down the changed dream ending she closed her eyes and used imagery to rehearse her new dream.

Session 9

Zanele arrived smiling and reported that she was feeling much better than she had over the past few weeks. She was smartly dressed and had her hair stylishly fashioned in long braids. Her scores on the BAI (37) and BDI (17) had decreased since the last session, as had her score on the PDS (15). She had received a cell phone from her mother as a reward for her exam results and her sister had come

home for the school holidays. She stated that she had been rehearsing the imagery techniques each day and reported that, although she continued to have nightmares (roughly three times a week), the endings of the nightmares were different. She said that although the perpetrator attacked her, she was able to either defend herself or run away and thus she was not raped by him.

She reported that she had been writing in her therapy journal and had added various phrases and quotes that she liked. She had included a quote by Jesse Jackson, 'I am not responsible for what happened to me, but I am responsible for picking myself up', which the clinician had given her. In addition she added others which she had collected and had written some of her own phrases, such as, 'you strike a woman, you strike a rock'. She left the session in high spirits stating that the volunteer would be taking her and a friend to the National Arts Festival in Grahamstown over the weekend, which she was looking forward to.

Session 10

This session continued along the same themes as the last session. She continued to practice the imagery techniques and changing the dream endings. For the remainder of the session we discussed the reliving exercise to be conducted during the following week, and what this entailed. The rational for this exercise was provided. The nature of trauma memories was discussed. She was informed about the nature of trauma memories, that they were stored in a different place from other memories. Therefore, they were unlike other memories because they are not constantly updated and reinterpreted. Thus the rationale for reliving was to update the normal memory store by activating the trauma memory and updating it with new information by means of identifying 'hotspots' and cognitive restructuring.

The rationale for conducting the reliving during the following sessions was due to Zanele's demonstrating sufficient ability to cope with anxiety provoking material. This was apparent during the sessions which focused on working with triggers and during the imagery rehearsal which focused on nightmares. In addition she had begun to incorporate the trauma memory into her biographical memory and was better able to speak about the traumas she had endured. In addition her sleep

pattern had normalised and she appeared to have more resources available to cope with the reliving exercise.

6.5 Sessions 11-15: Reliving and Therapy Journal

Session 11

Zanele arrived for this session looking extremely anxious. Her score on the BAI (38) had increased slightly, probably in anticipation of what was to occur during the session. However her score on the BDI (9) remained constant. Before starting the reliving exercise I acknowledged that she was feeling afraid and anxious. We entered into a discussion about the bodily sensations she was likely to experience during this exercise, and how they would be similar to those experienced at the time of the traumatic events. However, the context in which she was in was different, she was not immediate danger, and she would be in a safe environment in the clinician's office. The guidelines proposed by Ehlers and Clark (2000) and Grey et al. (2002) were drawn upon in the following sessions.

Although the rationale for reliving had been discussed in a previous session, I felt that it was important to discuss this again. I felt this was necessary in putting the client at ease about what was to occur, and provide an opportunity for the client to raise any concerns she might have about the exercise before we started. The following excerpt is taken from the session

C: Do you know what the word memory means?

Z: Ja.

C: Ok. Everytime we see something or hear something it is stored in our memory. But sometimes what is different is that trauma memories or the trauma of being raped is put into our minds but it is done in a different way to other memories. For example, maybe you can remember when you were a little girl...maybe you can remember your first day at school. I don't know if you can remember that? Maybe when you think back now, you remember your first day at school being a little bit different to what it was like when you were little. Maybe on your first day of school you might have walked into this big building and you might have been scared...going to a new school and maybe you didn't know anyone. And now when

you look back, because you are older, you understand that maybe I was was scared then but it is okay now...now I have been at school for a long time and school is not so scary anymore. But maybe when you were six or seven years old school seemed scary because it was new, but maybe because of what you know about school now it seems different. Does that make sense?

Z: Ja.

C: And in the same way what happened to you when you were raped twice is that the memory is in your mind somewhere. It is stored there, but because it is difficult to think about and talk about, the new information is not going there to change that memory. So everytime you think about it, it feels like it is happening again or you feel the same feelings like you felt then.

Z: Ok.

C: So part of what we are going to do today is to try and help change that memory or try and help you work through it to help you feel better. Do you have any questions for me before we start?

Z: No.

I told Zanele that it was up to her which trauma she chose to speak about during this session. She was asked to describe the trauma in the first person, in the present tense as if the event was occurring now. She was asked to include as much detail as possible, including visual, auditory and physical information. She became extremely emotional and cried, at times uncontrollably, and she experienced difficulty breathing. She reported various physical symptoms such as sweating, heart palpitations, and tightness in her stomach. During the course of the session she provided a detailed account of the first time that she was raped, which was the first time that I heard a full account of this incident. I asked various questions such as 'how are you feeling now?', 'what is going through your mind?', 'what do you see, and smell now?'.

At times she found it hard to speak in the present tense, partly due to the intensity of the emotions being tapped into but possibly due to English not being her mother tongue. At these times I re-phrased what she was saying into the present tense. For example:

Z: He grabbed my arm.

C: OK, so he is grabbing your arm.

Z: He pulled me into the corner.

C: Ok, he's pulling you into the corner.

As the session progressed Zanele found it easier to speak in the present tense, although occasionally I continued to re-phrase what she was saying. I used Socratic questioning to identify associated cognitions and meanings for each hotspot, and repeatedly asked her to report her SUD's level. During the reliving session hotspots were identified and the associated appraisals were challenged. For example, at one point she said 'I am scared that he is going to kill me'. Using the fast forward technique to the here and now, I asked her what she knew now that she did not know then. She said that she was still alive and realised that the fear that she had of dying was a fear that was associated to the trauma memory at that point in time and that her life was not in immediate danger.

At times Zanele would 'whizz through' (Ehlers & Clark, 2000; Grey et al., 2002) aspects of the trauma, which indicated that these were particular areas of difficulty or hotspots. At these times the rewind and hold technique was used to establish the cognitive appraisals at the time of the trauma. For example, she stated that after beating her on the head with a screwdriver he raped her. I asked her what she had seen whilst this was occurring. She then added that she could see buildings and she later saw a woman walking nearby. She wanted to scream but the perpetrator told her that he would kill her if she did. She then saw a man walking nearby and called for help. She reported feeling afraid that the perpetrator would kill her for disobeying his instructions.

The following aspects of the trauma elicited the highest SUD's levels: 'he is going to kill me if I scream'; 'I am helpless'; 'feeling dirty and smelling funny'; 'everyone will laugh at me if he throws my panties away'; and being hit on the head with a screwdriver. These areas were worked on during the reliving and the cognitive appraisals were challenged and discussed further. Zanele came to the following conclusions at the end of the session: I was not helpless, I did scream for help and he did not kill me. I reported the incident to the police, so I am not powerless. I

reported the incident to the police and he did not kill me for telling others. He did not throw my panties away, and I was not laughed at. When I did report the crime, I received empathy and support. I am not powerless. He does not control me.

On completion of the reliving exercise Zanele appeared much calmer and reported a SUD's level of 6. Although she had found the exercise extremely difficult she said that she realised that she could survive these moments of distress. When she left I took time to reflect on the session. Whilst I felt privileged that Zanele was able to share this emotional experience with me, I felt partly responsible for arousing this intense pain within her. What had occurred during the session had moved me deeply, and the intensity of emotions that I felt after the session heightened my awareness of how much this young adolescent had been carrying on her own. I waited in anticipation, wondering whether she would return to therapy.

Session 12

To my surprise, Zanele arrived early for this session. Her scores on the BAI (35), the BDI (8), and PDS (4: normal) had decreased since the reliving exercise. She was cheerful, talkative and engaged well during the session. She reported that although she was still feeling anxious, she felt 'more calm' than in the past. She said that she had not experienced any flashbacks since the sixth therapy session and added that since the reliving exercise she had not experienced any nightmares and was sleeping an average of seven or eight hours per night. During this session it was noted that Zanele no longer met the criteria for PTSD. She reported that coming to therapy had assisted her in her ability to speak to her mother about what had happened to her, by means of discussing what we had covered in therapy. During this session we discussed her experience of the reliving exercise. She said that although it was scary she was happy that she had gone through with it, as she was feeling much better. We discussed the various hotspots that had been identified during the reliving and continued challenging them and updating them with new information. One of the negative appraisals that had been challenged was that 'all men are bad'. During this session it appeared that some of the emotional charge had dissipated or lessened from some of the hotspots, as she was able to speak about these with less emotional intensity.

Session 13

Zanele arrived to this session smiling. She was cheerful and engaged well. She stated that she was feeling 'much happier' as she was no longer experiencing flashbacks, intrusions or nightmares. Her scores on the BAI (26) and BDI (7) had decreased since the last session. She told me that she had brought her journal to the session, as there was something that she wanted to share with me. She had written an account of how she had experienced the reliving exercise. Thus, in her own way she continued to re-update the trauma memories and integrate them into her autobiographical memory store. She had written that she was not ashamed of what had happened to her and urged others who had been traumatised to seek help and speak out.

I reflected that she looked calmer than she had in the past consistent with her self-reports. However, I wondered about her score on the BAI and explored the symptoms she had reported further. It was during this session that I realised the importance of exploring the answers on the questionnaires qualitatively. Zanele stated that she was afraid of seeing dead people. On further exploration she said that in January of this year, a short time before she was raped for the first time, she witnessed a hit and run where a pedestrian was knocked over by a car and killed. She reported that it had been a terrible sight, but she said that the actual incident did not cause her as much distress as what happened after the incident. She stated that her friend and herself were the only witnesses to the incident, and were thus interrogated by policemen. She said she was afraid during the interrogation as they had asked many questions, were abrupt and she felt they implied that she was lying. Thus, her schemata at the time were that 'policemen are scary', 'they ask many questions' and 'they do not believe what I tell them'.

Zanele then revealed that this was one of the main reasons why she had not reported what happened to her. I reflected that in a previous session she revealed that she received support and empathy when she reported that she had been raped. She nodded in agreement and added that she now knew that some policemen were 'good, caring and helpful people'. Thus her schemata for policemen had changed and she felt empowered to speak to them in the future. At the end of the session

Zanele told the clinician that she felt motivated to assist others who had experienced similar traumas to her own.

Session 14

Zanele's scores on the BAI (22) and BDI (7) decreased since the last session. Her PTSD symptoms that were the focus of treatment had dissipated and she continued to sleep well. She spoke about how grateful she was to have a family who had been so supportive through her ordeal, despite her finding it extremely difficult to disclose what had happened initially. She reported that her dream was to buy her mother a house. Whilst she reported feeling gratitude towards her mother, it appeared that she was assuming a parentified role within the family. We then discussed the second reliving session for the following week. The rationale for a second reliving was to ascertain whether there were any hotspots remaining which required further intervention.

Session 15

Zanele reported that she was feeling anxious about the reliving exercise today but added that she wanted to go ahead with it as the last reliving had proven to be beneficial to her. Her scores on both the BAI (23) and BDI (8) had increased by one point, as they had before the last reliving in anticipation of what was to follow. Again, she became extremely tearful and reported similar bodily sensations that she had felt during both traumas. The following hotspots were identified and rated with SUD's levels of 10: Being hit in the face; watching him beat his pregnant girlfriend on her stomach; when he told her to drop her pants; locking her in his house while he slept and feeling afraid that he would kill her when he woke up; wanting to call for help and not being able to do so; arriving back home the next day and worrying that she would be asked where she had been. These hotspots were identified through careful observation of her affect and by using techniques such as Socratic questioning and the fast forward and rewind techniques (Ehlers & Clark, 2000; Grey et al., 2002).

Cognitive restructuring and challenging the negative appraisals was done during the reliving. Zanele reported that she 'should have screamed' as this might have saved her. When she was asked why she had not screamed she reported that he had

threatened to kill her. When she saw him beating his pregnant girlfriend's belly she thought 'if he can do that to his unborn child, he may do worse to me'. She was afraid he would beat her, which he did. However, she now knew that she survived his beating. She updated her trauma memory by stating that he had let her go the following day and not killed her. She was afraid that she would be asked where she had been, but she did not see anyone when she got home. Instead she bathed herself and went to sleep. Zanele appeared calmer towards the end of the reliving and reported a SUD's level of 2 before she left the session.

I contacted the police station who was dealing with Zanele's case and was told that the investigating officer had moved to another town. He contacted me the following day to say the case had been withdrawn by the prosecutor due to a lack of evidence. He informed me that the statements provided by the witnesses did not provide enough evidence to have the case re-opened.

6.6 Sessions 16-17: Reflection on Therapeutic Process

Session 16

Zanele reported feeling 'fine'. Her scores on the BAI (18) and BDI (6) had decreased further. The focus of the session was on exploring her experience of therapy thus far and establishing whether there were areas that required further intervention. She reported that she felt that therapy had been beneficial and had assisted in reducing her symptoms of PTSD. I enquired about her understanding of the decrease in her levels of anxiety and depression. She said her mother told her that the perpetrator who raped her had raped another young girl and had been taken into custody. She reported feeling safer knowing that he was not in a position to harm her.

Following this session I wondered whether it was time to consider beginning the termination phase. Zanele no longer experienced nightmares, intrusions or flashbacks of the perpetrator's face. In addition her sleeping pattern had normalised, she was performing well at school and had resumed many of her previous social activities.

Session 17

With the above-mentioned factors in mind, the main focus of this session was to obtain data by means of self-report questionnaires and asking Zanele's opinion about other areas of concern that would require further intervention. This session gathered information in order to ascertain future therapeutic interventions, as well as documentation for research purposes regarding the effectiveness of the intervention. Her scores on the BDI (3), BAI (14), and PDS (2) had decreased even further.

6.7 Sessions 18-23: A Change of Status and Disclosure

Session 18

Zanele appeared cheerful and happy initially but as the session progressed she became tearful and upset. Although she reported feeling much better than previously, her mood and affect were incongruent. Her scores on the BAI (10) and BDI (6) had decreased further, possibly due to reports that the perpetrator was still being held in custody.

I reflected that I had gone through the self-report questionnaires and asked Zanele how she would feel about discussing some of her responses to certain questions. On the PTCI, Zanele reported that being raped had ruined her body/parts of her body. When this was explored further she became extremely emotional and cried uncontrollably. I reflected that it seemed to be extremely difficult for her to speak about these issues. She nodded. I wondered what made it hard for her to speak about this. She said she was worried that others would laugh at her. I acknowledged how hard it was for her to speak openly about what concerned her, and reflected that she had felt similar feelings in the past (about speaking about the traumas). I reflected that in the past she had felt better when she spoke about her conflicted emotions, but at the same time encouraged her to take her time in speaking about these issues. After a few minutes passed, she made eye contact and said that she had developed "blisters" around her genital area and that she had noticed a discharge. In addition she reported that she was afraid that she might have been infected with HIV or another infection. Again, she became extremely emotional. I

reflected that at the start of the therapeutic process she said she had an HIV test at a hospital in Port Elizabeth. She said that she had but had never received the result. I asked Zanele what she knew about HIV. Her knowledge was very limited, which appeared to increase her anxiety at thought of having contracted something she did not understand. The focus of the session shifted to psychoeducation around HIV and sexually transmitted diseases (STD's). I drew on knowledge I had obtained during an *HIV/AIDS Care and Counselling* Course during my undergraduate studies. With this information at my disposal we entered into the pre-test counselling phase. I gave Zanele reading material on HIV to assist in increasing her knowledge about this diagnosis (van Dyk, 2001).

Unfortunately the volunteer who had been transporting Zanele was no longer available to continue doing so. It had therefore been arranged that she would take public transportation and a member of the community support group would accompany her. Zanele did not arrive for the next session. When she was contacted she said she waited for the taxi but it had not arrived. Whilst it is possible that this occurred, I could not help but think that maybe she was afraid about where the therapy session was going, namely exploring her HIV status.

Session 19

Zanele score on the BAI (14) increased, but her score on the BDI (4) had decreased. I reflected that her levels of anxiety seemed to have risen, and I wondered whether anything had happened during the week. She became tearful and said that she was afraid she may have contracted either HIV or an STD as a result of being raped. She reported that during their life skills class their teacher had spoken about 'safe sex' and the risk of contracting HIV or an STD if protection was not used. Zanele said that she felt anxious and wanted to run out of the room, but was worried about what her classmates would think.

She managed to speak to her mother about her concerns and requested that her mother accompany her to the clinic to have the relevant tests done. However, her mother had not been able to take a day off work. In addition, she said she would prefer to disclose her status to her mother herself rather than a doctor telling her. She reported that she was concerned her mother would have a heart attack if she

tested positive, as her mother had been admitted to hospital after she had a heart attack shortly after her husband had a stroke.

In addition she reported that she had gone to the police station with her uncle to establish the whereabouts of the perpetrator but had been unable to obtain the relevant information. She said that she would arrange to go back as soon as her uncle was able to accompany her.

The remainder of the session focused on psychoeducation on HIV and STD's, and exploring the pros and cons of being tested. Zanele was able to elaborate on the pros of being tested relatively easily. She stated that one of the cons would be that she did not know how she would handle a positive diagnosis. She added that in May 2006 she saw a man who had hung himself from a tree after hearing that he was HIV positive. This was explored further and it appeared that Zanele identified with his sense of hopelessness about hearing that he was HIV positive. However, she added that the pros outweighed the cons and she knew that antiretroviral therapy was available to assist in the management of the disease. Zanele decided that she wanted to be tested for various infections as soon as possible. It was agreed that I would make an appointment at the clinic for the following week, and would meet her there.

Session 20

I met Zanele at the clinic fifteen minutes before her consultation with the doctor. She reported feeling extremely anxious and afraid. I asked her whether she would like me to wait for her outside or accompany her into the doctor's consulting room. She asked if I would go in with her. Once in the doctor's room she became extremely emotional and cried. The doctor was extremely empathetic and explained what he would need to do. He said he would need to do a physical examination in a separate section and then he would need to take blood samples. Zanele cried bitterly at hearing that she needed to have blood taken, and stated that she was afraid of needles. I sat with her as she held my hand and tried to console herself. Following this, the doctor explained that she needed treatment for gonorrhoea and that the other test results would be available the following week.

I met Zanele in my office shortly after this. She was tearful and anxious and needed containment. She said that she was was worried about receiving her results the following week. She then said that even if she did test positive, she knew that her life would not be over and she could choose to live a happy life. However, she stated that her mother had told her that everything was going to be fine and she should not worry about her results. This irritated Zanele as she could see through her mother's denial, stating that her mother did not know what the results would reveal.

She reported that she was going on a school camp over the weekend, which she was looking forward to, and she added that it would assist in taking her mind off thinking about her results. She said that her family knew that she was seeing the doctor today and were supportive in her decision to do so.

Session 21

Six days later the doctor contacted the clinician to inform her about Zanele's test results. He informed me that she had tested HIV positive. In addition she had been infected with chlamydia and syphilis. Although I suspected this would occur, I felt my heart sink. I began thinking about how I was to reveal this information to Zanele. After some time I realised that there was no easy way of telling someone about a positive result, and thus decided to do what seemed appropriated during the session, guided by Zanele's preference for how she would like to hear the test results.

Zanele arrived to the session looking upset and exhausted. She reported feeling scared about hearing her results. She was extremely emotional and cried as soon as she entered my office. Her score on the BAI (9) had decreased which came as a surprise to me. However her score on the BDI (6) had increased by two points. I reflected that the waiting must have been difficult for her to endure. She nodded in agreement, adding that she had lost her appetite. I asked her about her plans for the remainder of the day and asked who would be at home when she returned. She said that she planned to go to her grandmother's house after the session.

I told her that I had received the results and asked her if she would like to read them herself or whether she would prefer it if I read them to her. She asked me to read them. I told her she had been infected with HIV, as well as chlamydia and syphilis. She appeared completely stunned, her eyes widened and she broke down and sobbed uncontrollably. I sat with her and reflected how she appeared to be feeling, namely shocked with mixed feelings of intense sadness and anger. I reflected that it was okay to cry and to express how she was feeling. I said it was okay if she did not feel like speaking, and added that I would sit with her for as long as she needed. It was silent for some time before she said that she did not know how she would tell her mother. She added that she felt hopeless, that she would not be able to pursue the career she wanted or buy her mother the house she dreamed about. I reflected that there appeared to be many things going on in her mind, and perhaps she felt like her life was over. I validated her feelings, but gently stated that it was okay to feel these things immediately after hearing an HIV positive result but that with time, and together in therapy we would work towards feeling more comfortable with this result.

I reminded her about the articles I had given her about individual's who with treatment had continued living relatively normal lives for many years. She nodded. We then discussed the importance of going to a clinic to receive treatment for the STD's she had been infected with. The session ended with a discussion about how Zanele would disclose her results to her mother. She asked if it would be possible for me to meet with both her mother and herself later on during the week to disclose her status to her mother. In addition, she asked me to inform the social worker of her status.

After the session, I sat in my office and reflected on the extremely emotionally laden session. I felt angry that so much could befall this young vibrant adolescent, and I was frustrated that justice had not been done. It suddenly occurred to me that no amount of pre-test counselling or psychoeducation would lessen the emotions involved in hearing one is HIV positive. However, I continued to have faith that Zanele's courage and suffering would not break her spirit and she would continue to aspire to more and lead a fruitful life, although it may not be the life she had initially planned for.

I contacted the social worker and arranged a meeting with her the following day. We discussed the availability of resources, such as clinics and social support groups, in the area in which Zanele lived. She said she would arrange for someone to accompany Zanele to the clinic in order to obtain the treatment she needed for the STD's she had been infected with.

Session 22

I met with Zanele for ten minutes to ascertain how she felt. She stated that although she was extremely anxious, she wanted her mother to know what the results were. She asked the clinician to share them with her mother. At this point her mother was invited into the clincian's office, with Zanele still present. She came into the room commenting on the heat, possibly to lighten the mood. I reflected that Zanele and I had been working together over a period of months, as she was aware. I acknowledged that Zanele had been faced with many challenges during the course of the year, namely that she had been raped twice and that she had been working extremely hard in therapy to work through these difficulties.

I wondered whether Zanele had told her about her consultation with the doctor. She said that Zanele had informed her about this. I told her that I had received the results and Zanele had asked that we meet today to share them with her. At this point Zanele began to cry. I shared the results with her mother as Zanele looked on to see how her mother would respond. Her mother smiled and said 'it's okay'. Zanele sobbed as her mother repeatedly said, 'sukulile. Yomelela' (Be strong, don't cry). Through her tears Zanele managed to say 'mama, I have HIV'. This was an extremely intense moment as her mother fought her own tears. I reflected that it was a difficult time for both of them, and validated that Nomsa was trying to be strong for her daughter. I then added that sometimes strong people cry, and that was okay. Zanele asked for her mother's support during this difficult time. Nomsa then asked Zanele to ask me what food she should buy to keep her healthy. I acknowleged her wanting to care for her daughter and wanting to assist in any way that she could. I reflected that Zanele appeared to be healthy at the moment but these were some of the things that we would continue to discuss in the future sessions. I informed

Nomsa that Zanele needed to go to a clinic in order to secure treatment for the STD's, stating that they were treatable.

The session ended with a brief discussion on disclosure. Zanele asked her mother not to tell anyone about her status, with the exception of her sister, at this point in time. I reminded Zanele that I would be on leave the following week, and I reflected that it seemed like a very difficult time for us to have a break in therapy. I told her that I would contact her during our session time the following week. In addition I gave her my cell phone number in the event that she felt the need to contact me in the interim.

Session 23

Zanele's scores on the BDI (6) and BAI (9) remained unchanged from the previous session. She reported that she had enjoyed the school holidays as her sister had come home. She reported that they had gone to the mall together and cooked dinner for her mother. I asked her whether the social worker had taken her to the clinic in the area in which she lived. She said no, and then with a smile she added 'I took myself to the clinic'. She reported that she had been given the treatment that she needed to treat chlamydia and syphilis. She took the tablets out to show me, and informed me when she had to take them. She said that the sister at the clinic had been very kind to her and invited her to have tea with her during her break times at school. Zanele went to have tea with the sister the day before our session and during this time she had a blood test to check her CD4 count. I reflected that she had made some very important decisions in her life during the past week and asked her how she felt about this. She smiled and said 'so happy'. She added that she had read the articles and pamphlets I had given her on HIV and she had come to the realisation that she still had a future, just a different one to the one she had previously planned. She said that she was considering going back to the police station and informing them of her status, in the hope that the case would be re-opened.

I found this session extremely moving for a number of reasons. Zanele managed to speak about her status in a more contained manner than in the past. She has begun to take personal responsibility for her well being, without any prompting and has

started creating her own social support network with individuals at the clinic. She has started thinking about her future and living with HIV. In addition she reported that she wanted to take a stronger stand against the perpetrator.

For the purposes of this report I thought this an appropriate place to end. Zanele has begun to take ownership of her life in many areas and she is engaging in activities that she previously enjoyed as well as increasingly engaging in and forming new relationships with others. However, the therapeutic process with Zanele will continue. The following areas will be explored further in therapy: building social support and establishing secure contacts for future treatment; psychoeducation; living with HIV; and exploring her plans for the future.

7. THERAPY MONITORING: GRAPHICAL PRESENTATION AND TABLES OF REPEATED MEASURE SCORES

Figures 3 through 5 provide graphical displays of the repeated measures on the Beck Depression Inventory (BDI-II), the Beck Anxiety Inventory (BAI), the Posttraumatic Diagnostic Scale (PDS). Tables 2 and 3 display the measures obtained on the Trauma Related Guilt Inventory (TRGI), and the Posttraumatic Cognitions Inventory (PTCI). The data obtained from these self-report scales complement the case narrative. The scores were collected during the assessment intakes and during various therapy sessions. Of particular interest is the sharp decrease in scores at the start of treatment, the subsequent rise in scores at the time the reliving was conducted, followed by a steady decline in scores. It should be noted that the therapeutic process had not come to an end at the time of writing this report, thus only the information that was gathered up to the 23rd therapy session was included. The results obtained from the self-report scales are discussed in relation to each other over the course of therapy, as they are closely linked and thus impacted upon each other.

7.1 Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), and Posttraumatic Diagnostic Scale (PDS)

Zanele's scores on the BDI (33), BAI (50) and PDS (42) fell within the clinically significant range during the first screening session. This may have been the result of meeting the clinician for the first time, as well as confronting the difficult material after a few months, which may have heightened her awareness of the symptoms she was experiencing.

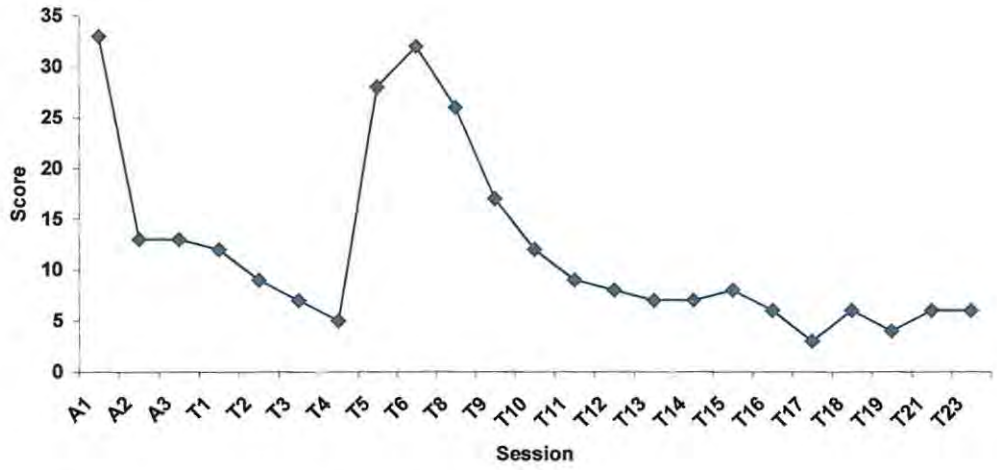

Figure 7.3. Beck Depression Inventory

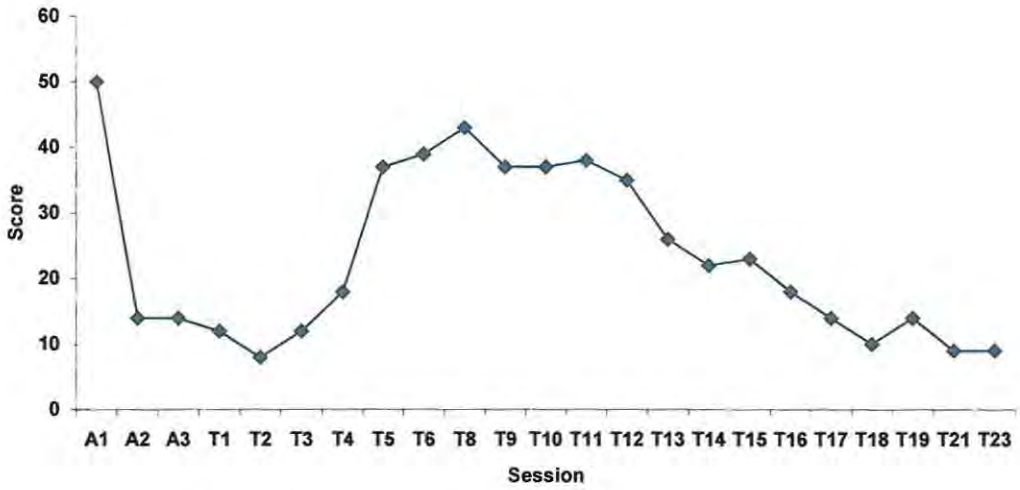

Figure 7.4. Beck Anxiety Inventory

Her score's on the BDI (13) and BAI (14) decreased substantially after the first screening session. This may have been a result of her keeping what had happened to her a secret for some time. Attending therapy appeared to enable her to share her story in detail for the first time, thus she did not feel as alienated and alone as she had felt prior to the first intake session. During session 28, although not discussed in this report, the clinician shared the graphical displays of the BAI and BDI with Zanele, in an attempt to obtain her understanding of what had led to a reduction in distress following the first intake session. She reported that psychoeducation regarding the nature of PTSD and normalisation of her symptoms was a key factor in this reduction. She reported that it was at this time that she realised that she was not 'going crazy'.

Her scores on the BDI declined steadily between the third assessment session and therapy session 4. This was consistent with a decrease in the BAI scores obtained during the third assessment session and the second therapy session. Thus, it appeared that the reduction in her anxiety and depressive symptoms were largely the result of the strategies that focused on working with the triggers of the perpetrator's face. During session 2 Zanele's score on the PDS (11) fell within the normal range. She reported that she was able to sleep better (6 hours a night), she

had not experienced any flashbacks of the perpetrator's face, and she had begun to engage in previously enjoyed activities such as going to the mall.

However during session 3, Zanele's BAI (18) score had increased from mild to moderate range of anxiety. Her score on the PDS scale (23), although not in the clinically significant range fell within the upper level of symptom severity. She reported an increase in symptoms of hyperarousal, palpitations, decreased sleep, excessive sweating, nightmares, intrusions and flashbacks. It is noteworthy to mention that she heard that the perpetrator had been granted bail at this time. During this session she reported that the flashbacks of the perpetrator's face had returned. She continued to experience difficulty sleeping due to nightmares she was experiencing, and had intrusive images of being assaulted. The increase in these scores may have been precipitated by her fearing for her life, and her visit to the magistrate's court, with the hope of obtaining a protection order against the perpetrator not materialising.

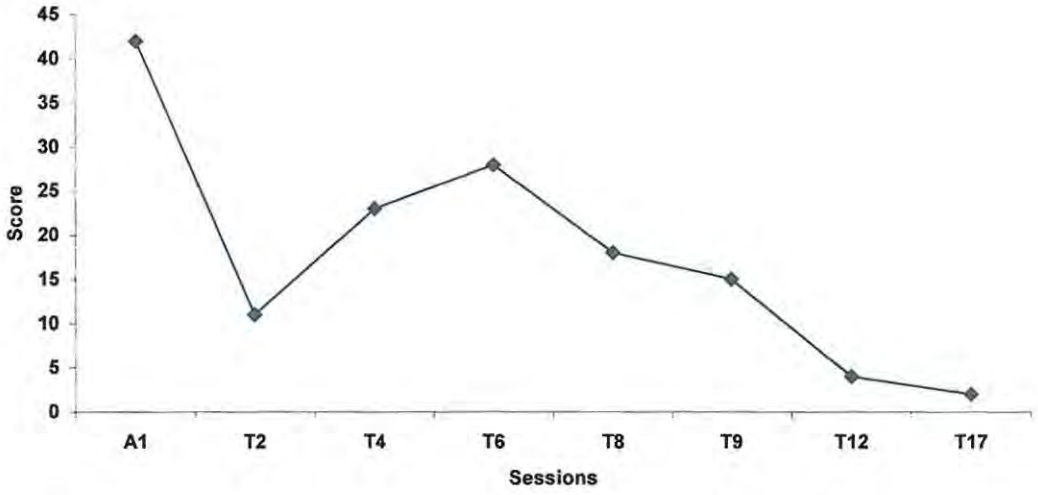

Figure 7.5. Posttraumatic Diagnostic Scale

Her score's on the BDI (28) and BAI (37) showed an increase in session 5. This was possibly due to the magistrate informing her that the case against the perpetrator had been withdrawn. She felt they did not believe her account of what had occurred. Her scores on the BDI (32) and BAI (39) remained in the severe range during session 6. In addition her score on the PDS (28) fell within the high range of

symptom severity. This appeared to be precipitated by the perpetrator's brother intimidating her, as well as her knowledge that she would be re-doing the exposure exercise, working with triggers of the perpetrator's face during this session.

By session 8 Zanele's score on the BDI (26) fell within the moderate range. Her score on the BAI (43) had increased. She reported that she was afraid to sleep at night due to nightmares she was experiencing. In addition she continued to experience intrusions of being assaulted. She continued to sleep for two hours a night and worried about the impact of her lack of sleep on her scholastic functioning. However, her score on the PDS (18) had decreased. This appeared to be the result of the dissipation of flashbacks of the perpetrator's face following the exercise in session 6.

During session 9 there was a reduction in the scores on the BDI (17), the BAI (37) and the PDS (15). The reduction in these scores follows the imagery work on dreams during session 8. Although Zanele reported that she continued to have nightmares, the endings were different in that she was not raped. Her score on the BDI (12) had reduced even further by session 10. However her score on the BAI remained the same.

At session 11 Zanele's score on the BDI (9) had decreased further. However, her score on the BAI (38) had increased slightly. This was understood as an increase in her levels of anxiety due to her knowledge that she would be doing the reliving exercise during the session.

After the reliving in session 11 the scores on the BDI (8), BAI (35), and PDS (4: normal) had decreased. Zanele reported feeling ' more calm' since the reliving. In addition she was sleeping 7 or 8 hours per night, and she had not experienced further intrusions or nightmares. Sessions 13 and 14 saw a steady decline in both the BDI and BAI scores.

At session 15 there was a slight increase on both the BAI (23) and BDI (6) scores. This appeared to be directly related to Zanele's knowledge that she would be doing the second reliving during this session. During the following session her scores on

both indices had decreased even further. The decrease in scores can be partly ascribed to the second reliving. However, it should be noted that during this time the perpetrator was apprehended and held in custody for a second time, which had a positive influence on Zanele's feelings of personal safety.

Zanele's scores on the BDI (4), BAI (14) and PDS (2) decreased further by session 17. This suggested that her knowledge that the perpetrator was in custody, and that she was not likely to come into contact with him, served to alleviate her symptoms further. Session 18 saw a further decrease in her symptoms of anxiety, but slight increase in her depressive symptoms (6). Whilst the reason for this was unclear initially, the reason emerged during the subsequent session when Zanele reported that they had been discussing sexually transmitted diseases and HIV in their life skills class.

Zanele's score on the BAI (14) had risen by session 19. She was afraid that she had contracted HIV or an STD. She had spoken to her mother about accompanying her to the clinic but this had not occurred. Her anxiety about not knowing what was wrong with her in light of the symptoms she was experiencing around her genital area served to exacerbate her symptoms of anxiety further. In addition their attempt to obtain information about the perpetrator's whereabouts failed.

Session 21 saw a decrease in Zanele's BAI score (9). This was surprising as she knew that she would be receiving the test results during the session. However, her BDI score (6) had increased by two points. It is possible that Zanele might have expected the results of the tests she received, or she may have internalised certain information discussed during session 19 about the pros of knowing one's HIV status. During the session it emerged that the increase in her BDI score was related to fears about her future if she tested HIV positive. In addition the clinician consulted the BDI qualitatively. The question on eating habits had been answered differently to the times it had been administered previously. This would account for an increase of 2 points on the BDI score.

At session 23 Zanele's scores on the BDI (6) and BAI (9) remained the same as in session 21. I was surprised by this as I anticipated an increase in her scores on the

BAI and/or BDI after hearing that she was HIV positive. However, she reported feeling relieved that she no longer had to bear the burden of her HIV positive diagnosis alone, and felt that she had her mother's support. In addition, she reported that she had read the material I had given her and had come to the realisation that her life was not over.

7.2 Trauma-Related Guilt Inventory (TRGI)

The trauma related guilt inventory (Table 2) was administered twice during the course of assessment and therapy, thus a lengthy interpretation of these scores is not possible. However it should be noted that on the TRGI two of the scale scores had decreased. The distress scale score remained unchanged. Two of the subscale scores decreased. However, the lack of justification scale score increased. This was possibly due to her suspicion that she had been infected with HIV or an STD and her difficulty processing this. The day before session 17 when this self-report scale was administered, Zanele had learned about HIV and STD's at school. It was at this point that Zanele realised that there could be a connection between the discharge and an STD. It should be noted, however, that Zanele found it difficult to understand some of the items. For example, on the TRGI (Item 7: 'I did something that went against my values') she said she should have told her parents after she was raped for the first time.

Table 2

Trauma-related Guilt Inventory Scale and Subscale Scores

Scales and Subscales	*Assessment 3*	*Session 17*
Global Guilt Scale Score	1.25	0.75
Distress Scale Score	2.17	2.17
Guilt Cognitions Scale Score	1.64	1.59
Hindsight-Bias/Responsibility Subscale Score	1.57	0.71
Wrongdoing Subscale Score	2.6	2.2
Lack of Justification Subscale Score	0	2.75

7.3 Posttraumatic Cognitions Inventory (PTCI)

The posttraumatic cognitions inventory was administered twice during the course of assessment and therapy. A lengthy interpretation of these scores is therefore not possible. Her score on the PTCI on the second administration decreased, indicating a decrease in PTSD symptoms as well as more adaptive cognitions regarding the traumatic events. However, it should be noted that Zanele required assistance in completing this scale and certain items needed to be simplified using examples. Despite this, this self-report scale provided useful qualitative information and prompted further questions and areas of enquiry. For example, a systematic enquiry regarding item 10, *the event has ruined my body/parts of my body*, revealed that Zanele thought she had contracted HIV or an STD.

Table 3
Posttraumatic Cognition Inventory Scores

PTCI-Short Form	***Assessment 2***	***Session 17***
Score	107	86

The graphical displays and tables above illustrate Zanele's scores on the self-report scales at the start of assessment and during the treatment process. During the screening interview all the scores fell within the clinically significant range. By session 23 her anxiety, and depressive symptoms had reduced significantly. By session 12 she no longer met the criteria for PTSD (Beck & Steer, 1993; Foa et al., 1997; Foa et al., 1999).

7.4 Information obtained from the Independent Research Interview

The interview was tape-recorded and the information obtained regarding Zanele's experience of the intervention was extracted. The tape recording was made available to the author after the 23rd therapy session. Zanele reported that she had felt afraid about coming to the hospital for the first time as she did not know what to expect. She reported that she felt shy initially but that this changed over time. She reported that she had noticed a number of changes since the start of therapy. She said that she had not been able to sleep and frequently woke up during the night.

This had changed, as she was now able to sleep better. She reported that she no longer experienced nightmares or flashbacks. In addition, her levels of energy had increased and she was able to engage in previously enjoyed activities with her friends. She reported feeling surprised by the changes that had occurred in her life and said that it was unlikely that these changes would have occurred had she not attended therapy. She reported that the changes were extremely important to her and believed that they were the result of the therapeutic process and the clinician's experience, and the support that she received from her maternal grandmother.

When asked what she found particularly useful she said that working with triggers and imagery transformation techniques used to change her dream endings was especially beneficial in alleviating her symptoms. She found the reliving technique the most difficult aspect of the therapy, but stated that she found it helpful. She reported that she did not have any suggestions on improving the therapeutic process, and added that she felt there was nothing that the intervention lacked.

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

This section of the report focuses on the evaluation of the effectiveness of the treatment intervention, and the benefits of using the Ehlers and Clark (2000) model in this particular case. Following this, the transportability of this treatment intervention is discussed. The report concludes with a section on research limitations, conclusion and recommendations.

8.1 Evaluation of Effectiveness of Treatment Intervention

There are a number of ways to ascertain the effectiveness of this treatment intervention. First, to compare the extent to which the goals of therapy were achieved at the outcome of therapy. Second, to analyse the quantitative scores obtained from the self-report questionnaires. Third, to investigate the qualitative report or therapy narrative as it unfolded during the therapeutic process. Fourth, to explore whether there were any contextual issues which threatened the transportability of the Ehlers and Clark (2000) model to the South African context.

8.1.1 Goals of Therapy and Therapy Outcomes

It was hypothesised that the degree to which the therapeutic intervention achieves the goals set out at the start of the therapy, the more effective the intervention. That is, a good therapy outcome or reduction in symptoms implies 'treatment utility' (Persons & Tompkins, 1997). The treatment goals and the extent to which these were achieved is discussed below.

8.1.1.1 Goal 1 - Modifying negative appraisals.

The negative appraisals were identified using various cognitive techniques such as Socratic questioning, imagery techniques, and identification of hotspots. These appraisals were modified during reliving sessions where cognitive restructuring was included in the reliving procedure.

8.1.1.2 Goal 2 – Reducing re-experiencing.

Zanele reported suffering from intrusions of being assaulted, flashbacks of the perpetrators face and nightmares of the traumatic events. These difficulties were targeted using techniques such as working with triggers, imagery transformation and changing dream endings, and writing detailed narratives of the traumatic events in a therapy journal. By session 13 all the re-experiencing symptoms had dissipated.

8.1.1.3 Goal 3 – Changing dysfunctional behaviours and coping strategies.

Zanele reported that she avoided going to sleep to avoid having nightmares, she fled from the classroom when she experienced flashbacks and she avoided speaking to people about the traumatic events. These difficulties were targeted by addressing the triggers, providing psychoeducation on the consequences of these strategies, and increasing her social support by sharing her experience with family members, the social worker and volunteer. At the time of writing the report Zanele's sleeping pattern had normalised, she no longer experienced flashbacks and she was able to speak about the traumatic events in a more contained manner than at the start of therapy. In addition she has started to increase her social support network by befriending a nurse at the local clinic who gave Zanele the medication to treat the STD's she had been infected with.

From the therapy goals set out above, and the resolution of the reported difficulties in terms of the strategies set out by Ehlers and Clark (2000), the therapeutic intervention was assessed to be effective.

8.1.2 Quantitative Measures

The quantitative measures provide a visual representation of the resolution or change in symptom severity over the course of therapy. If these measures can be attributed to treatment effect, they can be strong indicators for the effectiveness of this treatment. Whilst it is not possible to exclude extraneous factors altogether, the fact that Zanele's symptoms persisted for four months prior to therapy commencing provides evidence that without treatment her symptoms of PTSD and depression would probably have remained the same or similar. The administration of the self-report questionnaires and the quantitative measures obtained enable tracking of the

symptoms which provides evidence of the effectiveness of the techniques used as the therapeutic process unfolds. For example, after working with triggers in session 6 the flashbacks of the perpetrator's face remitted, and there was an associated decrease on the PDS score, thus suggesting that this strategy was an effective intervention. Zanele's scores on the BDI-III, the BAI, PDS and PTCI all reduced significantly over the course of the intervention. By session 12 she no longer met the diagnosis for PTSD. Thus, the consistency between the quantitative results, the client's qualitative experience, and the clinician's understanding of the therapeutic process, provide strong evidence that this treatment was effective.

8.1.3 Therapy Narrative

Section 5, Course of Therapy, outlines the treatment intervention as well as Zanele's experience of the techniques used and the efficacy of these in reducing her levels of distress and PTSD symptoms. In summary, by session 11 Zanele no longer met the criteria for PTSD. She reported sleeping seven to eight hours per night, she no longer experienced nightmares, intrusions or flashbacks. In addition she frequently wrote about her experience of therapy in her journal, which she shared with the clinician at various points during the intervention (see Appendix).

8.1.4 Evaluation of Status of Therapy at the time of Writing Report

At the time of writing this report the therapeutic process was still underway, with the following areas requiring further intervention: to establish social support structures and to identify relevant institutions and support groups to assist Zanele in adjusting to living with HIV; continued psychoeducation; exploring her future plans; and follow up enquiries and further reports to the police station.

8.1.5 Summary

In light of the information above it appears that the therapeutic intervention played a significant role in Zanele's recovery. The case narrative, visual displays, her therapy journal, and the information obtained from the independent interview suggest that her gains cannot be attributed to spontaneous recovery. It appears that the

reduction of symptoms and levels of distress expressed, the changes in daily functioning are related to her response to treatment.

9. EFFECTIVENESS OF EHLERS AND CLARK'S (2000) MODEL IN THIS INTERVENTION

9.1 Prescription vs Flexibility

The use of manualised treatments is surrounded by controversy, and is frequently a topic of debate. Some practicing clinician's argue that manualised treatments oversimplify the therapeutic process, which may result in misuse or rigid application of techniques (Najavits, Weiss, Shaw & Dierberger, 2000) or limited or no involvement of the clinician. Others advocate their use, and argue that they encourage clinician's to utilise a broader range of intervention strategies, improve training whilst also standardising treatment, and increase the validity of research studies. Najavtis et al. (2000) investigated 47 cognitive-behavioural therapists' views on treatment manuals. Overall their findings suggested that 75% of the therapists held manuals in high regard and utilised them with few concerns. Findings indicated that the 'ideal' manual offered practical advice, focused on techniques and theoretical rationale, and identified difficulties frequently encountered.

The Ehlers and Clark (2000) model has not been formulated into an official manual. However, it offers practical guidelines on the assessment and treatment of PTSD within a cognitive framework. As mentioned previously this model incorporates a more comprehensive understanding of PTSD and draws on a various therapy techniques with the main objective of targeting difficulties based on an individualised case formulation. The guidelines advocated by the Ehlers and Clark model proved to be both effective and beneficial in this study. In addition the flexibility in the application of the proposed guidelines was advantageous for a number of reasons. These aspects are discussed in more detail below.

9.1.1 Assessment

The assessment procedure advocated by Ehlers and Clark was particularly useful for a number of reasons. Firstly, the line of enquiry and specific questions asked enabled the identification of a number of predominant cognitive themes and problematic appraisals. In addition the patient was asked to think about the event and identify the worst things or the most painful moments. This was useful in identifying possible hotspots and possible meanings associated with these. In addition it was possible to identify the ways in which the client had been coping with the trauma prior to attending treatment sessions.

In addition, Ehlers and Clark (2000) advocate that reliving is an essential component of the assessment phase. The client in this particular case felt that she was not able to complete the reliving during the assessment, as she felt that it would be too anxiety provoking at that particular point. However, she was willing to provide an account of what had occurred during both traumas. The reliving component of the intervention took place during sessions 11 and 15. Whilst Ehlers and Clark's model provides practical guidelines, they encourage flexibility and clinical decisions regarding individual cases to be dealt with on a case-by-case basis. The flexibility of the model was useful in this case as it allowed the client to move at a pace that she felt comfortable with, and this served to strengthen the therapeutic alliance as the she felt that she was a part of the therapeutic process.

9.1.2 Formulation

The information obtained during the assessment phase is carefully organised into various categories of difficulties, thus aiding in the clarity of the conceptualisation and allowing a more focused application of cognitive therapy techniques. In addition, the flexibility inherent in the Ehlers and Clark (2000) model allows an extension of the initial formulation. For example, information obtained at a later date is used to update the formulation where necessary, thus enabling a deeper and more comprehensive understanding of the client. This is consistent with propositions advocated for effective cognitive behavioural case formulation techniques (Persons & Tompkins, 1997). The formulation-driven approach allows for flexibility by allowing

clinicians to use their clinical judgment to make decisions which are guided by theory and continuous assessment (Persons, 2006).

9.1.3 Treatment Intervention

The individual case formulation informs the treatment plan, thus assisting the clinician in identifying appropriate techniques for tackling particular difficulties the client experienced. In order to increase the empirical foundation of 'case formulation-driven psychotherapy, the therapist [uses] a hypothesis testing approach to each case, [relies] on evidence-based nomothetic formulations and therapies as templates for the idiographic formulation and treatment plan' (Persons, 2006) and utilises empirical findings to formulate individual cases, in developing the treatment intervention and to guide clinical decision making. In addition, the flexibility allowed for reliance on principles rather than rigid application of interventions (Najavits et al., 2000). These aspects of flexibility and constantly linking the assessment and intervention are core components of the Ehlers and Clark (2000) treatment model. For example, in session 1 the focus of the intervention was working with triggers. Whilst the client reported that the flashbacks of the perpetrator's face stopped, they had returned by session 4. The flexibility of the model allowed the clinician to rely on her clinical judgment, it was thus decided that the focus of intervention during session 6 would be working with triggers.

In my experience working with this model for the first time, I found that the guidelines proposed by Ehlers and Clark were useful in the assessment, individual case formulation and treatment for PTSD. There was sufficient flexibility inherent in this model to allow for the clinician's own clinical judgement. Thus it does not represent a 'cookbook' approach (Najavits et al., 2000 p. 404), with all the instructions laid out for anyone's application. An adequate knowledge of cognitive therapy is required, as is training and supervision if the model is to be applied effectively.

9.2 Techniques most Beneficial in this Treatment

Ehlers and Clark (2000) offer specific techniques such as psychoeducation, working with triggers, imagery rehearsal techniques, using a therapy journal, and reliving which proved to be particularly beneficial in this treatment intervention.

9.2.1 Psychoeducation

Psychoeducation was an important component in the treatment of this case. Zanele reported feeling more at ease after she received information about PTSD. She realised that her symptoms were not a sign that she was going crazy, but rather a reaction to the traumas she had endured. During this time, psychoeducation about the rationale for treatment was discussed. As previously noted, there was a dramatic reduction in the scores on the BDI, BAI and PDS following the screening interview, which Zanele ascribed to psychoeducation. During the therapeutic process the clinician continued to provide information about the various strategies that were to be employed, which put Zanele at ease as she knew what to expect during the sessions when the were used. During sessions 18 and 19, Zanele was provided with information about HIV and STD's, and was given reading material on these topics. Before this occurred, the clinician explored her knowledge on these areas. Her limited understanding of HIV and STD's left her feeling afraid that she may have been infected with something she did not understand. After she received the information she frequently used phrases such as 'I know my life is not over' and 'I still have a future, although it may be different from the one I planned'. This demonstrates the importance of increasing one's knowledge and the effects this has on one's way of thinking.

9.2.2 Working with triggers

Working with triggers during the therapy session (where Zanele was asked to identify the differences and similarities between the perpetrators face and the face of another black male) allowed the patient to establish a time perspective and differentiate between harmless stimuli from dangerous stimuli encountered during the traumatic events (Ehlers & Clark, 2000). During this time she was encouraged to

drop safety behaviours (e.g. avoidance), which she felt able to do in the contained environment during the session. Her realisation that the experience was frightening but tolerable allowed her to generalise these strategies to other contexts, with the result that the flashbacks and intrusions dissipated.

9.2.3 Imagery rehearsal techniques

Zanele reported suffering from chronic nightmares of the traumatic events she had experienced. Imagery techniques were useful in elaborating and changing the meaning of the trauma memory (Ehlers & Clark, 2000). Zanele continued practicing the imagery techniques she learnt in therapy and used these to alter the dream endings for homework. These techniques proved to be beneficial in this treatment as Zanele's nightmares decreased from nearly every night to twice or three times a week. In addition, the dreams were different. She no longer dreamt about being raped, as she managed to escape, defend herself or receive assistance from other individuals. Krakow and colleagues (2001) postulated that decreased nightmares were associated with decreased anxiety, improvements in sleep, and an increase in energy levels during the day, which facilitated in coping with other difficulties. This was evident in this study. As Zanele's sleeping patterns normalised, she was more able to tolerate anxiety-provoking material such as the reliving.

9.2.4 Therapy Journal

Zanele used her therapy journal to record her nightmares and the changes she made to these, as well as documenting her experience of the therapeutic process and her feelings about the techniques used during sessions. This enabled further elaboration of the trauma memory into her autobiographical memory.

The above-mentioned strategies, namely working with triggers, imagery rehearsal techniques and the therapy journal, can be understood as graded exposure from less anxiety-provoking information to more emotionally laden information. This demonstrated that Zanele had more resources at her disposal to deal with the reliving.

9.2.5 Reliving

Ehlers and Clark (2000) advocate that reliving is an essential feature of the assessment phase. As mentioned previously, the client reported that she did not feel ready for the reliving during this phase of the intervention. Thus, the reliving procedure was therefore put on hold until sessions 11 and 15. This enabled a deepening of rapport between the clinician and the client and the client experienced this as confirmation of her role in her recovery process. Again, this highlights the importance of flexibility, and the resultant treatment gains when the client is mutually included in the treatment process.

The reliving procedure enabled the identification of hotspots of the trauma and its sequelae. This proved to be beneficial as Zanele was exposed to extremely anxiety provoking material which, during the course of the session, resulted in habituation and integration of the trauma memory into her autobiographical memory. The reactivation of trauma memories and cognitive restructuring within the reliving allowed rehearsal of specific cognitive re-appraisals to update the trauma memory, thus allowing optimal change of these peri-traumatic hotspots (Brewin et al., 1996; Ehlers and Clark, 2000). It is important to note that there was a remission in nightmares and intrusions following the first reliving session.

As a training psychologist this was my first encounter with reliving as a therapeutic intervention. I initially had some reservations, specifically with regards to how Zanele would cope with such an intense focus on the traumas she had experienced. In addition, I wondered whether I would be able to provide sufficient containment at the end of the reliving. However, during the sessions that we worked on triggers, her journal enabled me to put this into perspective as I realised that Zanele's resources for coping with such anxiety provoking material had increased substantially during the course of therapy. In addition, I realised that the gains obtained following the reliving exercise outweighed the distress Zanele experienced during the reliving process, which was consistent with her reports that she felt 'more calm'.

9.3 Transportability to South African context

The treatment intervention highlighted in this report provides further evidence to suggest that the Ehlers and Clark (2000) treatment model is transportable to the South African context. First, the guidelines advocated by these authors were utilised in a therapeutic intervention at a clinical outpatient setting at a psychiatric hospital in Grahamstown, thus fulfilling the criteria that the model is transportable from a research setting, where it evolved, to a routine clinical setting. Second, the model was implemented in a third world setting in the treatment of PTSD with a 15 year old black Xhosa speaking adolescent from an underprivileged community, fulfilling the second criteria that the model is transportable from one cultural setting to another, as well as providing evidence that this model is not only effective in treating adults but adolescents as well. The results obtained from this treatment process also provide evidence for the effectiveness of the Ehlers and Clark (2000) treatment model (Davidow, 2005; Ehlers et al., 2005; Gillespie et al., 2002).

Schoenewald and Hoagwood (2001) highlighted a number of factors which threaten to impact on transportability: First, insufficient training of the clinician; second, insufficient or inadequate resources; third, poorly selected client populations and fourth, insufficient attention paid to contextual and cultural factors. These factors were considered prior to and during the therapeutic intervention. In this particular case, the first two factors were not considered significant. The third and fourth were given considerable thought. Zanele is a Xhosa speaking black South African female living in an underprivileged location. Therefore, she is a suitable representative of the larger society living within South Africa and was a suitable candidate for the research. In addition, she did not have access to resources such as psychotherapy and it was largely due to research funds that she was able to fund her transport costs. This is a significant factor considering the vast majority of the population find themselves in a similar predicament.

The fourth aspect, cultural factors, was also given consideration. This includes the differences in culture and languages spoken. This topic was explored at various points during the intervention. This allowed easy and open conversation about the therapeutic relationship. Initially, Zanele reported that she had not spent much time

with a white person and thus had to get used to the way that the clinician spoke. From the start of therapy until the time of writing the report Zanele was encouraged to inform me if she did not understand what I was saying. She did this on many occasions, which appeared to strengthen the therapeutic alliance as she felt that she was able to do this. In addition, her reflections in her therapy journal suggest that working with a therapist from another culture was not a limiting factor in this intervention (see Appendix: excerpts from Zanele's journal).

10. RESEARCH LIMITATIONS

10.1 Self-report Questionnaires

Zanele found it difficult to understand certain items on the PTCI and the TRGI. Whilst these self-report questionnaires were useful in obtaining qualitative information, the clinician was required to provide additional explanations of various items. It appears that the validity of these measures, within the South African context, would improve if the scales were translated into the other official South African languages.

10.2 Single Case Study

This is the second study, with Davidow's (2005) study being the first, in a series of case studies to be conducted. Therefore, the findings of this study cannot be applied to all situations. However, this study will form part of a larger project with the aim of generating a series of 20 cases. This would enable generalisation based on replication on a case-by-case basis (Edwards, Bromley & Dattilio, 2004).

11. CONCLUSION

Although the therapeutic intervention will continue, the therapeutic gains achieved thus far have been beneficial to the client, taking into account the scores from the self-report questionnaires, the independent interview, and the client's accounts. The information discussed in this report provides evidence that the Ehlers and Clark (2000) treatment model for PTSD is both effective and transportable to the South African context.

This report concludes on a positive note. Increased pressure has been placed on parliament to pass the Sexual Offences Bill, which places increasing emphasis on the rights of women and children. This includes a more comprehensive focus on the intervention and treatment for survivors following sexual assault (Tlelima, 2006).

12. RECOMMENDATIONS

This study highlights the importance of a multi-disciplinary approach (van Wyk & Edwards, 2005) in working with trauma survivors, and the identification of factors which threaten to impede the recovery process including cases being thrown out of court and granting of bail to perpetrators. A multi-disciplinary approach should aim to include medical personnel (to conduct medical examinations and provision of post-exposure prophylaxis in sexual assault or rape cases), members of the police force and criminal justice system (to obtain sufficient information regarding cases to increase the apprehension of and charges against perpetrators, and reduce the number of bail applications), psychologists (to offer psychotherapy to trauma survivors and their families), and social workers (to assist in more active dissemination of information about sexual abuse, rape, and the risk of infection of HIV and/or STD's).

It is recommended that policies are developed which focus on providing psychotherapeutic interventions to individuals living in impoverished communities. A further recommendation is that individuals working with trauma survivors should receive ongoing support and engage in their own personal psychotherapy. Training clinicians should be supervised with a two-dimensional focus in mind, namely a focus on the therapeutic process with the client and a focus on the impact of working with trauma on their lives.

In conclusion, further research, particularly randomised controlled studies, on the effectiveness and transportability of the Ehlers and Clark (2000) model to the South African context is necessary.

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PROVINCE OF THE EASTERN CAPE

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CONSENT FORM

I, _____ give consent that my treatment at Fort England Hospital may form part of research aimed at identifying effective treatments for individuals who have experienced trauma.

I understand that my participation in research will not compromise the therapeutic process and professional standards of my therapy.

I give consent for sessions to be audiotaped and understand that they will be listened to by psychology professionals bound by the standard regulations on confidentiality.

In the event that the research is published, I understand that a pseudonym will be used and all identifying data will be changed to protect my anonymity.

It has been explained to me and I understand that I may withdraw my consent to participate in the research at any time, without any prejudice to my continued treatment.

_____
Client
Date:

_____
Charmaine Payne
Intern Clinical Psychologist
Date:

_____
Prof. Dave Edwards
Supervising Clinical Psychologist
Date:

My first time in fort england hospital

When i first to the fort england hospital think that i was going to be left in dark with no lights or people to talk to. I was so ____ to go the but I met a wonderfull person her name is (charmaine) she was so carring and loving the same time.

The Resourn why I first came to fort england hospital I was r two times January, february with the same man, I didn't anyone about both times.

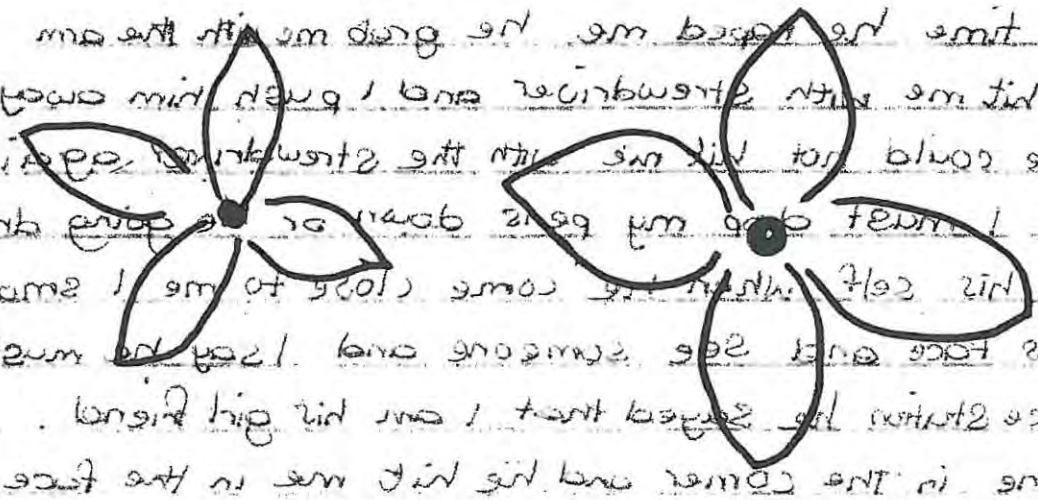
Maybe (you will ask me how my parents find out about wha pered)? my uncle girl friend traped me and sayed that she here people in the taxi sayed that I was biteed up an Raped and I say yes. (You will ask me why I didn't tell an because he sayed that he is going to kill me if I say som to anyone. (You will ask where did he raped me)! The fir time he rape me in the street corner, The second time her me at his home in his room. (You will ask me why did not screem)! because I was so scared of him. (You wil why did I not diffend my self when he raped me)! be I was so wick and so scared to screem. (You will ask that was not ushamed of what happened to me)! I first but now I am not ushamed of anything or anyone talk about it when I think to talk about it.

You must not say that you are not going to be rap you will be raped if your time comes and you mus not be ushamed of it you must tell your parents or y Neibour or you Mother's friend if you are scared t tell your parents your self. I learn a lesorn, to t my parents what happen to me.

THANK You!

'You are not responsible for being down, but you are responsible for getting up'

Jesse Jackson (20th Century American political leader)



Revenge

I want revenge but I don't want one I know that he will get what he wants!

We are your girls what do you want from us
WE will give you what you deserve for what you are going to us

[redacted]

I have not lost hope but I know that he will be in jail for what he did to me.

If a men hit a women.
you Stroke a women you Strike a Rock

All about me not you!

I dream about what happened to me
when he hit me with the strewdriver and he sayed that
I must not even say that to anyone or else.
And then he say that I must drop my pens down and
he hit me until I drop them and he raped in grass and
he say he is going to kill me if I tell anyone that he
raped me.
The second time I remember when he hit his girlfriend
to home in her stomuc and she was droping blood
and he sayed I must come in to his room he sort
out the problem! The problem was his girlfriend. He sayed
that I must drop ~~must~~ my pens and I sayed I will not
do that I want to go home he hit me in the face
and he drop my peas down and he rape me..
I hate him for what he did to me!

The first time he raped me he grab me with the arm
and he hit me with strewdriver and I push him away
so that he could not hit me with the strewdriver again
he sayed I must drop my pens down or he going drop
them buy his self when he come close to me I smack
him in his face and see someone and I say he must
call a police station he sayed that I am his girl friend.
he push me in the corner and he hit me in the face I
ekick him on his legs and he trow me down in the
grass I ticked and kicked him for as long as I can so
that he could not drop my pens as I kick him someone
showd up and say hey what are you doing he sayed that
I am his girlfriend and that person let go of her at last
I ran away and nothing happen to me!

My sation on Tuesday 11 July 2006

I was so scared about my sation Tuesday but I did go there and talk about what happened to me, I tell charmaine everything about those both rapes.
I was so scared my body was remembering what happened to me and I was swetting my body was filling hot and shaking all the same time. when we finish our sation she g me how do I fill about the sation and she ask n about what I am going to do at home.

Thank you

My sation on friday 14 July 2006

Our sation was to short but we did talk about things we discuss eh obout our sation on Tuesday 11 July. We talk about what I fill or what i did feel when i was telling her about what i did tell her about my first rape. we discuss that i am going to tell her about my second time when i was roped by

Thank you
for your time and
energy

my sation on Tuesday 18 July 2006

We talk about everything

Years ago me and my sister we did live life like others we didn't eat lunch and the moring we didn't have enough clothes.
Between 1999 and 2000 My mom find a job at
And me and my ~~sis~~ sister we live a normal life.

Stand your ground

Don't every let down your feelings!

You are a strong girl; Strong women, Strong person don't let a men or a boy bully you Stand your ground

God knows why he$ make us who we are!

We are strong
Don't every anyone
let down you.
feeling i know this by my experience!

9 August 2006
is a women's day

even if I dont know what
happend in the past but I know
that women role this land of
Africa. Women Role this world.
We are the Rock of this world.
~~Da~~ we as women we don't want
to be abuse by our Mens or our
childrens So we want our
freedom.

Don't rape us
Don't Abuse us
Just Love us
As we love u.