# From the 'here and now' to the there and then: The evaluation of the effectiveness of Ehlers and Clark's model for treating PTSD in a rape survivor

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May you realise that you are 'the loved one'

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# CHAPTER I

# Setting the Scene

The purpose of this research is to document the response of a rape survivor to a treatment based on Ehlers and Clark's (2000) therapy model and to use the material to evaluate the effectiveness of this kind of therapy in the South African context. In so doing, the specific local cultural and contextual factors, which may affect the overall effectiveness of the treatment, will be highlighted and discussed. In order to understand how this study fits into the broader context of existing research, a brief overview of the relevant literature will be discussed. The format of this report is based on the model conceptualised by Fishman (2005), one of the leading founders of the journal *Pragmatic Case Studies in Psychotherapy* (PCSP). In this model the introduction deals broadly with setting the context for the case study including the motivation for the research and introducing the participant of the case study. The second chapter provides reviews of the guiding conception of the participant's presenting problem and previous research while the third chapter discusses both the clinical and research methodology. Chapter four presents the results – both qualitative and quantitative – of the assessment as well as the therapy phase of the treatment. The last chapter discusses the interpretation of the data providing a bridge between the practice of the therapy and the existing literature.

However, before embarking on this journey, a brief explanation of the terms to be used and the general motivation for this research will be provided together with an introduction to the participant on which this research was based.

## 1.1. Definitions

### 1.1.1 Trauma

According to Edwards (2005a), in psychiatric and clinical psychology settings, the term trauma refers to extreme and often disastrous events that pose a threat to a person's life or physical integrity. Although there is a consensus about the criteria of a traumatic event, there is diversity in an individual's subjective experience of that trauma. As a person's reaction is often the benchmark of whether a trauma occurred, it is sometimes difficult separating out the event criteria from the experience.

### 1.1.2 Posttraumatic stress disorder

The diagnosis and even existence of post-traumatic stress disorder (PTSD) is a contentious and often debated issue (Brewin, 2003). However, for the purposes of this research, PTSD will be defined as a severe response to a traumatic event in which the person felt their personhood under threat and experienced intense fear, helplessness or horror (American Psychiatric Association, 2000). It is characterised by heightened arousal and susceptibility to startle, re-experiencing of the traumatic incident (which could take the form of intrusive images), emotional numbing, and avoidance of stimuli associated with the trauma. Not all people go on to develop PTSD after exposure to a traumatic event, which demonstrates the complex and reciprocal relationships between stressors, resilience and distress (Kaminer, Seedat, Lockhat, & Stein, 2000). However, those that do can experience the debilitating effects for years or even decades afterwards (Edwards, 2005a).

According to Brewin and Holmes (2003), PTSD is associated with disturbances in a myriad of psychological processes including memory, attention, cognitive-affective reactions, beliefs, coping mechanisms, and social support. In the aftermath of trauma, trauma-related emotions are typically powerful and beliefs distorted. Due to the avoidance of the unbearable material, these beliefs and feelings often remain unreality-tested and unmediated and are frequently the main cause for the chronic nature of the symptomology of PTSD (Resick & Schnicke, 1992).

Regehr, Marziali and Jansen (1999) state that rape survivors often report emotional reactions of grief, generalised fears, self blame, emotional lability and emotional numbing, as well as cognitive reactions of flashbacks, intrusive thoughts, blocking of significant details of the assault and difficulties with concentration. They highlight that social withdrawal and avoidance of social interaction also occur post rape and are often exacerbated by the fact that many survivors change jobs or locations. They note further that physical problems are also commonly reported even if the rape involved little or no physical injury.

## 1.2 Motivation

In South Africa, violence has reached pandemic proportions, the expression of which, according to McDermott (2004) includes a range of contexts: structural (abject poverty and inadequate housing); criminal (assault, robbery and murder); sexual (rape, molestation and forced prostitution); and physical well-being (HIV/AIDS, malnutrition and substance abuse). The climate of violence is such that even though a single event may cause the traumatic

reaction, it is often against a background of traumatic events that invariably increases vulnerability. Although South Africa has moved away from the State- sanctioned atrocities of the 80's and early 90's, her people are still facing human suffering on a day-to-day basis.

Edwards (2005b) demonstrates through a review of specific clinical and epidemiological literature that PTSD and its related conditions are a significant public health dilemma in South Africa and Africa at large. For example, at a primary health care clinic in Khayelitsha, it was found that 94% of adult respondents, ranging in age from 15 to 81 years, had experienced at least one severely traumatic event in their lifetime (Carey, Stein, Zungu-Dirwayi, & Seedat, 2003). Furthermore, in a sample of Pretoria Technikon students, it was found that a significant number of the students had been exposed to traumatising events such as unwanted sexual activity (10% of the female students), witnessing serious injury or death (19%), being victim to violent robbery (13.5%) and physical assault (8%). Of those who were exposed to trauma, a high proportion reported PTSD symptoms (Hoffman, 2002). This reiterates the findings from a study of victims of violent crime, which found that 25% of the sampled population had significant PTSD symptoms (Peltzer, 2000). However, Edwards' (2005b) conclusion that PTSD is a significant public health concern is not only based on the prolific occurrence of PTSD in South Africa, but also on its debilitating effects which has a marked impact on different areas of functioning.

According to the South African Police Service (2005), 55,114 rapes and 10,123 indecent assaults were reported for 2004/2005 thereby indicating the severity and significance of this particular health problem in South Africa. The most recent available statistics on the incidence of rape and indecent assault can be seen as a gross underestimation of this crime, as there are so many factors that limit both the reporting of the crime and the recording of the data. As rape is significantly associated with the production and maintenance of PTSD, the fact that rape statistics are so high in this country warrants a considerable amount of attention.

## 1.3 The participant

The participant chose her own name at the end of the therapy process in order to protect her anonymity. 'Oratilwe' is a Sotho name meaning 'the loved one'. She presented at Fort England Hospital for treatment in response to a poster put up by the clinician/researcher advertising free therapy for survivors of sexual assault and/or abuse. She is a 21-year-old

black woman who lives in Grahamstown with her parents and works as a shop assistant in town. She has her Matric and is planning on furthering her studies through correspondence.

Oratilwe was raped at the end of 2003 by Ken who had been her boyfriend for a year. She was a virgin at the time and had made it clear to him that she was not ready for sex. She did not tell anyone about the rape until she came to see the clinician in October 2005. After the rape, she reported that she had intense feelings of the world not being real and herself not really being in the world. On presentation, she met full criteria for major depression and posttraumatic stress disorder, was experiencing intrusive images approximately three times per week and reported having difficulty sleeping and eating. She stated that she felt sad most of the day every day and would cry for seemingly no reason. She also reported intense feelings of anger that would occur 'out of the blue' and could be directed at anyone. Oratilwe was seen for a total of 15 sessions varying in length from an hour to an hour and a half. The first 5 sessions were part of the assessment process and focussed on gathering information in order to formulate an effective and individualised treatment plan.

Literature will next be reviewed that provides the conceptual background to the way in which the case was formulated and the nature of the treatment process.

# CHAPTER II

# Literature Review

## 2.1 How PTSD is caused and maintained

### 2.1.1 A brief overview

PTSD is a debilitating disorder, which not only affects a variety of domains of functioning but also in itself is a result of a combination of an individual's psychological factors and processes. As it is not possible to outline all the existing theory of how PTSD is initiated and maintained, this review will focus mainly on the cognitive theory put forward by Ehlers and Clark (2000) as it formed the basis of the treatment program used with the participant.

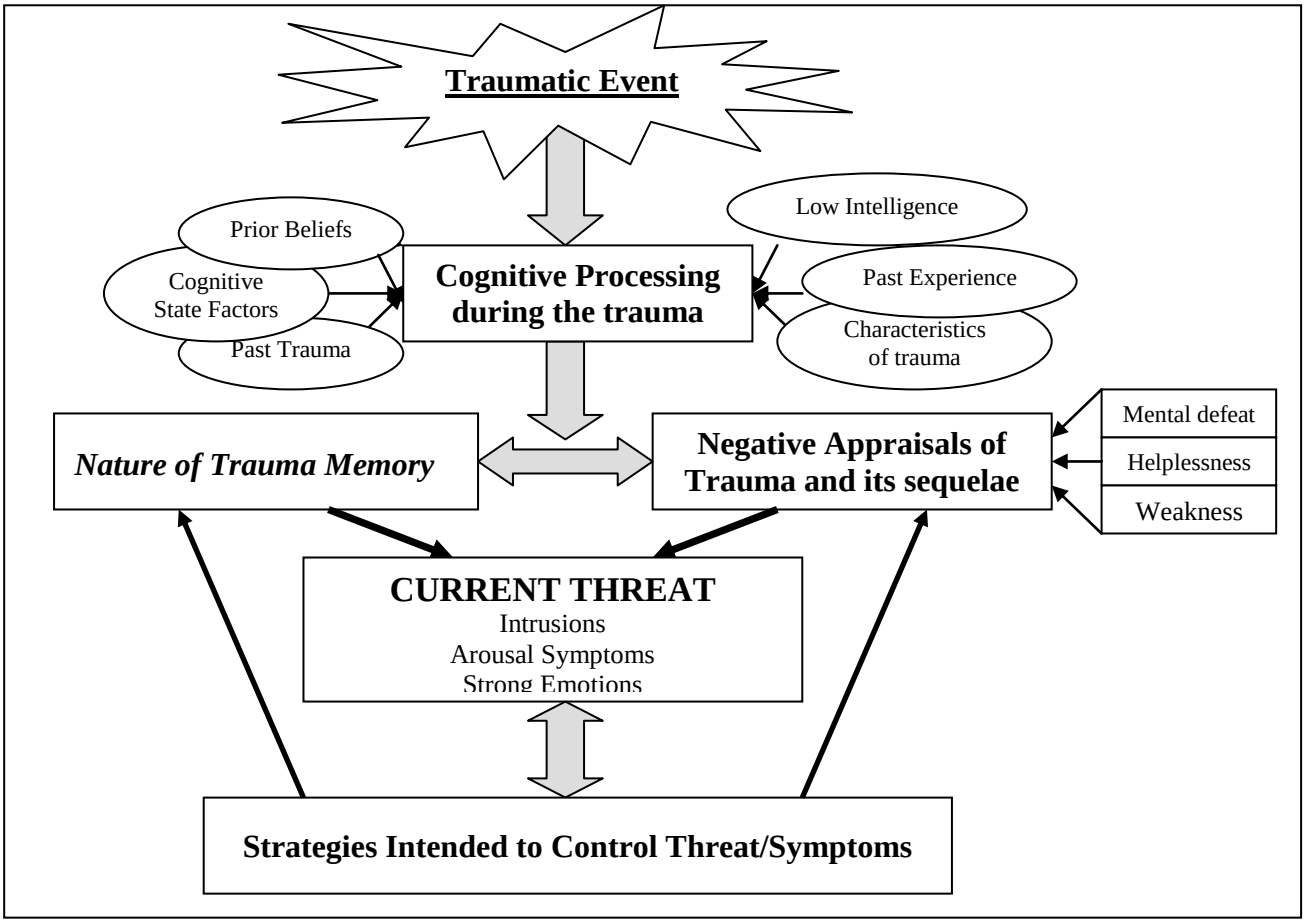
According to Ehlers and Clark (2000), PTSD is a unique anxiety disorder as the anxiety felt is not primarily a result of an appraisal of impending threat as in other anxiety disorders but rather, it is a reaction to a memory for an event that has already happened. Ehlers and Clark's (2000) basic premise – which is based on an incorporation of different cognitive theory, literature and research spanning many years – is that the traumatic event is cognitively processed in a specific way that produces a sense of serious *current* threat by means of two key processes: (1) the appraisal of the trauma and its sequelae and (2) the nature of the memory for the event and its link to other autobiographical memories. These two processes have a reciprocal relationship, which further detracts from the individual's ability to see the trauma as a time limited event that does not have global negative implications for their future.

As can be seen in Figure 2.1 below, the cognitive processing of the traumatic event is dependent on a variety of factors such as prior beliefs, cognitive state factors (such as intoxication at the time of the trauma), the actual characteristics of the trauma, intellectual functioning and past experience (specifically prior traumatisation) to name a few. The way the trauma is then processed has a direct effect on both the trauma memory and the appraisals of the trauma and its sequelae. As stated above, these two processes result in symptoms such as intrusions, hyperarousal and other strong emotions, which produce an intense sense of being in danger in the present. This perceived threat also prompts a sequence of behavioural and cognitive reactions that are intended to reduce the resultant anxiety and suffering in the short term, but have the negative effect of preventing any kind of psychological processing thereby

maintaining the disorder. In order to understand the workings of this model and other relevant theory, the psychological processes are discussed comprehensively in the sections that follow. These are cognitive appraisals, memory, cognitive coping strategies, cognitive-affective reactions, dissociation, schemas and beliefs, and social support.

**Figure 2.1**

*A Cognitive Model of PTSD*




(Adapted from Ehlers & Clark, 2000, p. 321)

### 2.1.2 Cognitive appraisals

Ehlers and Clark (2000) argue that there are several types of appraisal at the time of the traumatic event that can create a sense of present threat. Firstly, there is a tendency to overgeneralise a sense of danger from the event that could result in even normal activities feeling dangerous. This is linked to a feeling of an exaggerated probability of further horrendous events happening specifically to them. Secondly, the individual can have a negative appraisal of their own actions during the actual trauma, which could have long-lasting complicating consequences. There are also different types of appraisals of the trauma

sequelae that produce a sense of current threat. These include interpreting the initial PTSD symptoms as proof that one is permanently changed or at risk, interpreting other people's reactions in the aftermath of the event as rejecting or blaming and negatively appraising the permanence of the consequences of the trauma in other life spheres. In addition, there are factors that increase the likelihood of these negative appraisals. Mental defeat at the time of the trauma and prior experiences of traumatisation, weakness, or helplessness, all increase the risk of appraising oneself as unable to act effectively and as being extremely vulnerable to danger.

### 2.1.3 Memory

The nature of trauma memory is a perplexing phenomenon whereby intentional recall is limited and often fragmented, while involuntary recall (in the form of intrusive memories) is prolific, vivid and emotionally laden (Ehlers & Clark, 2000). This can be understood as a result of the event being "poorly elaborated and not given a complete context in time and place, and inadequately integrated into the general database of autobiographical knowledge" (Brewin & Holmes, 2003, p. 362). Halligan, Michael, Clark, and Ehlers (2003) propose that people who engage in data-driven processing (processing sensory impressions and perceptual characteristics) during the traumatic event and who do not elaborate on the trauma memory are at greater risk of developing PTSD than those who engage in more in-depth complicated processing. According to Brewin and Holmes (2003), systematic studies of patients' memories of traumatic events corroborate that although recall tends to improve over the first few weeks, it tends to be disorganised and contain gaps.

In persistent PTSD where one's self view has been seriously threatened, individuals' general "organisation of their autobiographical memory knowledge base may be disturbed" (Ehlers & Clark, 2000, p. 327). An inability to establish self referential perspective during the trauma due to either dissociation, emotional numbing or a lack of cognitive capacity to evaluate aspects of the event accurately, has a major influence on the processing of the event and therefore on memory (Ehlers & Clark, 2000).

#### *i. Intrusive memories*

Intrusive memories can be understood as unbidden 'film clips' of parts of the trauma consisting of single images, sounds, smells, somatosensory sensations or thoughts (Holmes, Grey, & Young, 2005). When these intrusions feel as if they are happening in the 'here and

now' they are often referred to as flashbacks. These intrusions can guide the therapist to the most disturbing part of the trauma, as they are often the most emotionally laden and distressing parts of the trauma (known as 'hotspots'). In research conducted by Holmes et al. (2005), their data suggest that the hotspots tend to be those in which patients experience a severely negative view of themselves or threat to their physical integrity and not just the commonly accepted emotional responses such as fear, helplessness and horror. Ehlers and Clark (2000) posit that intrusions function as a warning signal and form part of the 'fight or flight' adaptation process. In addition they note that the intrusive memories often stay the same (consist of the original emotions and sensory impressions) even if the person has subsequently acquired new information that contradicts that original impression.

Halligan, et al. (2002) argue that intrusions are the result of faulty processing whereby the encoding of the material is sensory driven rather than conceptually driven, due to the extreme arousal of the situation. The result of this is that a wide range of stimuli can trigger those fragments of memory, as there is not a strong semantic relationship between the fragments and the autobiographical memory. According to Brewin and Holmes (2003), there is strong perceptual priming but reduced perceptual threshold for the trauma related stimuli resulting in the frequent occurrence of these intrusions.

### *ii. Poor retrieval*

Autobiographical events are stored through a process of association with thematically and temporally related experiences within the autobiographical memory base. Elaboration of these memories increases the number of such associations and facilitates the individual's intentional retrieval of memories through higher order search strategies while simultaneously blocking direct, lower level retrieval which occurs through sensory cuing (Halligan et al., 2003)

Ehlers and Clark (2000) explain that there are two routes to retrieval of autobiographical information – higher order meaning-based retrieval strategies and direct triggering by stimuli that were associated with the event. As the information is not adequately integrated into its context in time and place, subsequent and previous information and other autobiographical memories, the first route of meaning based retrieval strategies cannot access the information. This leaves only the second route of direct triggering available (intrusions) which creates the fragmented memory sequence. In turn, this effects the person's appraisals of the trauma and its sequelae. For example, the person may feel that not remembering means something even

worse occurred or an inability to remember the correct order of events may lead to feelings of responsibility for the trauma, as they would be unsure whether their behaviour preceded or followed the behaviour of others.

### 2.1.4 Cognitive coping strategies

In persistent PTSD, the person tries to control the feelings of threat and the other PTSD symptoms by a range of strategies that may decrease the distress in the short term but maintain the disorder in the long term. There are three main mechanisms by which this happens (Ehlers & Clark, 2000):

1. Directly producing PTSD symptoms (for example, staying up late to avoid dreaming about the trauma increases problems in concentration and fatigue).
2. Preventing change in negative appraisals of the trauma and or its sequelae (for example, thought suppression about the trauma is a safety behaviour which stops a person from finding out that they will not go mad if they allow themselves to think about the trauma).
3. Preventing change in the nature of the trauma memory (avoidance of reminders of the trauma).

These mechanisms are enacted by a range of cognitive strategies such as thought suppression, selective attention to threat cues, safety behaviours (behaviours that are created in order to protect against feeling anxiety), avoidance of thinking about the event, avoidance of reminders of the trauma, self-medication (i.e. with alcohol), giving up or avoiding activities that were important, rumination (different from intrusive thoughts but may provide internal retrieval cues and intrusive memories) and dissociation. According to a retrospective study of assault and motor vehicle accident victims, there is a link between greater avoidance and higher PTSD symptom levels (Dunmore, Clark, & Ehlers, 1999). Furthermore, prospective studies have shown that the cognitive strategies of avoidance and thought suppression are related to a slower recovery from PTSD (Dunmore, Clark, & Ehlers, 2001).

### 2.1.5 Cognitive-affective reactions

Patients suffering with PTSD often report a range of intense emotions, which can be explained by negative appraisals at the time of the trauma or in the aftermath (Ehlers & Clark, 2000). For example, the perception of danger could lead to fear; the violation of personal rules and unfairness by others could lead to anger; one's own violation of internal standards could lead to guilt; perceived loss could result in sadness. According to Holmes et al. (2005) it

is imperative to look at a range of emotions when dealing with trauma as the research indicates that shame, sadness, guilt and anger play an integral part in the creation and maintenance of PTSD (Andrews, Brewin, Rose, & Kirk, 2000; Ehlers & Clark, 2000; Lee, Scragg, & Turner, 2001) as well the more well documented emotions of fear, horror and helplessness.

### *i. Shame*

Shame is a complex and often disabling affective reaction and if not dealt with directly in therapy, can seriously disrupt the therapeutic effects of imaginal exposure (Lee et al., 2001). It can be experienced at the time of the event, in response to one's own behaviour or reactions at the time, or the patient could feel ashamed of their emotions as they emerge during therapy. As it affects the experience of the self in relation to others as well as affects help-seeking behaviour, shame can contribute significantly to later psychopathology. It therefore needs to be differentiated from humiliation that occurs when a person has been in a powerless situation where they have been ridiculed or abused and yet does not feel that their self-esteem has been damaged by the actions of the other. In therapy, revealing traumatic events will undoubtedly reactivate shame and memories of humiliation and therefore an awareness of the two separated processes needs to be present (Lee et al., 2001).

Lee et al. (2001), explain the difference between internal and external shame and the implications both can have on a therapeutic process. External shame is caused by feelings related to the experience of being unworthy or devalued in relation to society and is closely linked with models of social anxiety. Internal shame, however, is related to feelings of being devalued in one's own eyes in a way that is destructive to the perception of the self. Both internal and external shame can be activated via attributional processes in the aftermath of a traumatic event. "Intense experiences of shame (whether internal or external) give rise to typical behavioural patterns of submission, desire to escape, hiding and concealment, labelled by Clark and Wells (1995) as 'safety behaviours'" (Lee et al., 2001, p. 453).

In order to deal effectively with shame or guilt- based PTSD, it is important to understand how these affective-cognitive systems are formed and maintained. Lee et al. (2001) describe two pathways to the development of shame or guilt based PTSD – either through schema congruence or schema incongruence. With the development through schema congruence, the meaning of the traumatic event matches a deeper meaning about the self, which acts to

confirm or reactivate core shame schemas. Consequently, when a person tries to process the trauma, high levels of shame are activated which results in avoidance and hiding of the shaming identity. However, in schema incongruence, shame may result if a positive self-identity is broken and if the new beliefs formed are shame-based. According to Lee et al. (2001) it is very important to distinguish between internal shame, external shame and humiliation as they require different paths of cognitive challenging.

### *ii. Guilt*

As opposed to shame, guilt is a self-conscious affect in response to the belief that one is responsible for causing harm to others (Lee et al., 2001). There are four cognitive components of guilt: (1) violation of personal standards of right and wrong; (2) perceived responsibility for causing the event; (3) perceived lack of justification for action taken and (4) false beliefs regarding hindsight bias (Kubany & Manke, 1995). In treatment- seeking rape victims, it was found that trauma related guilt was more strongly associated with depression than with PTSD (Bennice, Gubaugh, & Resick as cited in Nishith, Nixon, & Resick, 2005) and that the guilt cognitions could result in the depressive mood states (Kubany et al., 2004). Therefore, the fact that guilt and not PTSD predicted depression in rape victims further highlights the importance of examining trauma related guilt (Nishith et al., 2005). In addition, Kubany and Manke (1995) hypothesize that when restitution is blocked as frequently occurs with survivors of rape, memories of the trauma are so emotionally distressing that greater avoidance reactions are often the result, which has significant implications for the treatment of PTSD.

According to Lee et al. (2001), "pervasive feelings of guilt can arise when the meaning of the traumatic event conveys a violation or departure from standards of behaviour and/or a feeling of responsibility for causing harm to others" (p. 461). These standards or rules for living are often part of a person's 'conditional rules for living' which have been set up to avoid activation of underlying maladaptive core beliefs (Beck, 1976). According to Young (1994), schemas of unrelenting standards and an overly developed sense of responsibility are often responsible for these dysfunctional assumptions.

### *iii. Anger*

Several studies have documented a relationship between anger and posttraumatic stress disorder even though the nature of this relationship is not completely understood (Cahill, Rauch, Hembree, & Foa, 2003). Riggs, Dancu, Gershuny, Greenberg, and Foa (as cited in

Cahill et al., 2003) propose that non-fear emotions that follow a traumatic experience such as anger are similar to fear emotions whereby they are represented in memory as cognitive structures which include stimulus, response and meaning elements. These 'anger-structures' may have several stimulus elements in common with the fear structures resulting in the same stimuli activating both fear and non-fear structures. Individuals may even learn coping strategies whereby they activate anger structures in response to trauma-related material in order to avoid feelings of anxiety and/or fear thereby preventing the processing of the trauma related material.

The concept of high levels of anger predicting a slower recovery from PTSD (Brewin & Holmes, 2003) was contradicted by Cahill et al. (2003) who found that pre-treatment anger did not reduce the efficacy of CBT treatment for PTSD. In addition, although it was previously thought that exposure therapy alone increased levels of anger in individuals suffering from PTSD, in Cahill et al.'s (2003) study, they found that anger was significantly reduced by using exposure therapy.

#### *iv. Sadness/Depression*

Not only does depression frequently co-occur with PTSD in rape survivors (Resick & Schnicke, 1992), survivors of sexual assault with comorbid depression appear to have poorer outcome following treatment than individuals with PTSD alone (Resick 2001). Thus any treatment with a rape survivor needs to directly address aspects of depression within the therapeutic process.

### 2.1.6 Dissociation

'Dissociation' can be defined as any kind of temporary break in what is commonly regarded "as the relatively continuous, interrelated processes of perceiving the world around us, remembering the past, or having a single identity that links our past with our future" (Spiegel & Cardeña as cited in Brewin & Holmes, 2003, p. 342). Symptoms of dissociation include emotional numbing, derealisation, depersonalisation and out of body experiences. It is often related to the severity of the trauma, fear of death and feelings of helplessness (Brewin & Holmes, 2003). Peritraumatic dissociation has been found to be associated with disorganised narratives of the trauma and to predict subsequent symptomatology (Harvey & Bryant, 1999) partly due to the fact that the trauma memory is not being incorporated fully into the autobiographical memory. Furthermore, dissociation that occurs while individuals are

recalling the trauma, hinders their emotional and cognitive processing of the trauma (Halligan et al., 2003).

### 2.1.7 Beliefs and Schemas

Beliefs are a product of our life experiences and often shape how we think, feel and act. Some beliefs are irrational and are based in our perception of a reality that may no longer be true. The research shows that what people believe before a trauma occurs has a profound impact on whether they develop PTSD. There are two ways in which beliefs impact on the development and maintenance of PTSD. The first way is if the traumatic event shatters the person's basic beliefs and assumptions (Brewin & Holmes, 2003). Janoff-Bulman's argument (1992) is that human beings with a reasonably normative upbringing have three core assumptions about the operation of the world and about themselves: (1) the world is benign, (2) the world is meaningful (implying controllability, predictability and justice) and (3) the self is worthy. Associated with these concepts is the notion of the self as invulnerable. Traumatic events often shatter one or more of these assumptions rendering the person's existing schema or blue print to living, useless. In order to return to functional living the new information needs to be assimilated and incorporated into the existing schemas so that the world can be made sense of again (Resick & Schnicke, 1992). According to Horowitz (2001), trauma related information needs to be matched with schematic representations of the world, which carry meaning about the self, world and others.

The second way that pre-existing schemas can have an impact on the development of PTSD is if there is schema congruence with the traumatic event. For example, if before the trauma, a woman believed that she was ultimately unworthy of love, the traumatic experience of being raped and degraded would offer further evidence that the underlying core belief was true.

Regehr et al. (1999) found an association between a woman's PTSD responses to the rape experience and her perceptions of self and other which predated the rape. Negative self-schemas which reflect disrupted attachment with significant others or other childhood traumas such as sexual abuse can result in mistrust of others and uncertainty about the power of the individual to ensure safety. These women who had previously been abused, maintained negative self- schemas that interfered with the ability to activate adaptive coping mechanisms and were less effective in using support when it was available. Consequently, there was disappointment when others were unable to meet their needs for safety and support.

### 2.1.8 Social Support

Lack of social support has been found to be one of the most significant risk factors for PTSD (Brewin & Holmes, 2003). As one of the symptoms of PTSD is that of feeling separated from self and others, a person suffering from PTSD may find it harder to access their support network than for other psychological distress. Several recent investigations have also considered negative aspects of support such as indifference or criticism and it has been found that a negative social environment is a stronger predictor of PTSD symptomatology than lack of positive support (Ullman & Filipas, 2001; Zoellner, Foa, & Bartholomew, 1999). Furthermore, it was found that in violent crimes, not only was negative support more prevalent for women than it was for men but that the relationship between negative support and PTSD was stronger for women than for men (Brewin & Holmes, 2003).

### 2.1.9 Summary

As can be seen from the different aspects explained above, the cycle creating and maintaining PTSD is multifaceted and therefore a comprehensive treatment is needed to break this complex sequence. The following section looks specifically at Ehlers and Clark's (2000) treatment model and the evidence from past studies that has supported the efficacy of this model.

## 2.2 Cognitive Therapy for PTSD

### 2.2.1 Ehlers and Clark's Model

One of the advantages of using Ehlers and Clark's (2000) model for the treatment of PTSD is that each case is individually formulated as a basis for planning the specifics of the intervention. This formulation is based on identifying the relevant appraisals, memory characteristics and triggers, and behavioural and cognitive strategies maintaining the client's PTSD (Ehlers et al., 2005). The treatment includes a variety of components such as psychoeducation, trauma reliving, cognitive restructuring and behavioural experiments (Ehlers & Clark, 2000). There are three main goals for the treatment: (1) to modify markedly negative appraisals of the trauma and its sequelae, (2) to reduce re-experiencing by elaboration of the trauma memories and discrimination of triggers, and (3) to change dysfunctional behaviours and cognitive strategies (Ehlers et al., 2005). These objectives are achieved through a variety of different therapeutic techniques that will be discussed below.

Firstly however, the process of assessment needs to be highlighted as it informs the direction of the treatment program.

### *v. The assessment phase*

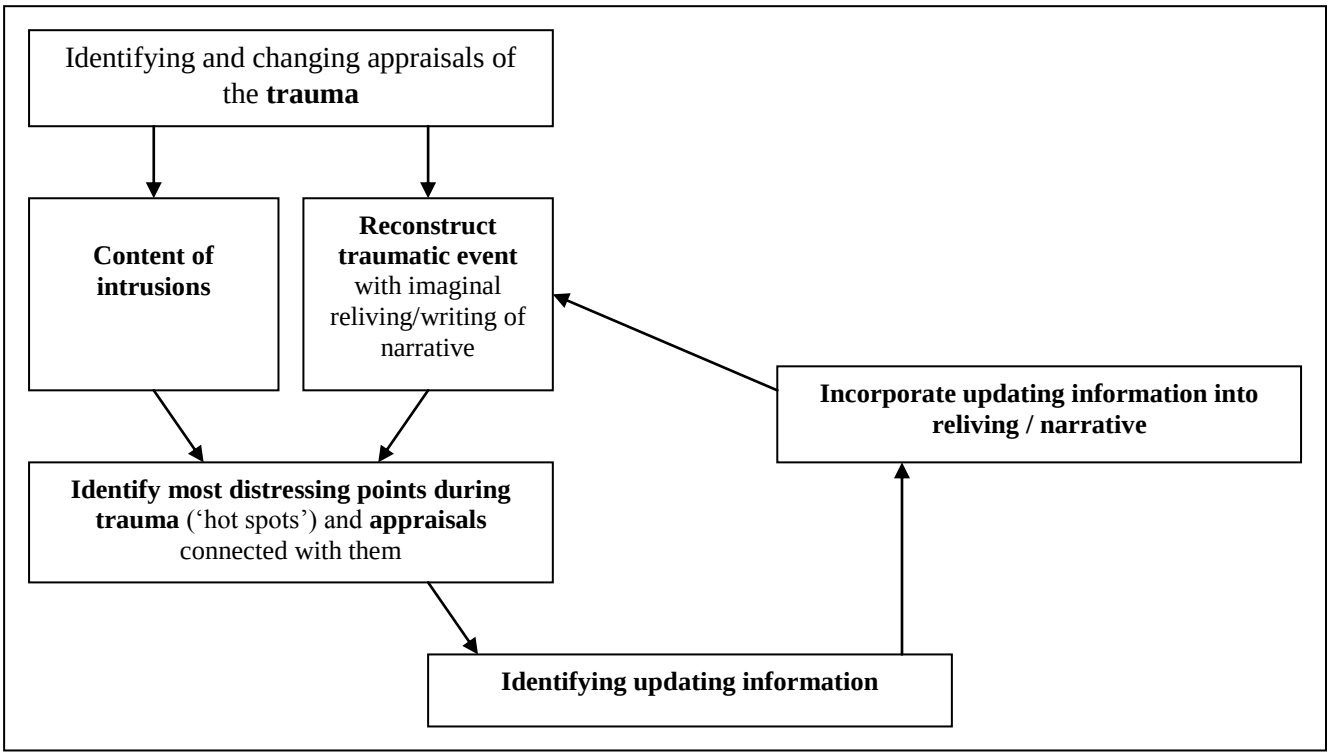
The main aim of the assessment is to identify the main cognitive themes that will be addressed in therapy (Ehlers & Clark, 2000). The 'hotspots' need to be identified to help rectify the related appraisals and reduce the re-experiencing. This can be done through questioning around the worst part or most painful part of the trauma, conducting a preliminary reliving of the trauma or writing a narrative of the trauma. It is necessary for the development of an individualised treatment that the nature of the client's predominant emotions (i.e. guilt, shame, anger) is identified (Ehlers & Clark, 2000). In order to detect problematic appraisals of the trauma sequelae, the clinician should explore a person's particular difficulties since the trauma and their beliefs regarding (1) their symptoms, (2) their future and (3) other people's reactions. Enquiring about their ways of coping is a helpful way of finding out about possible cognitive strategies that may be maintaining the PTSD. Lastly, the clinician needs to start to characterise the nature of the trauma memory and spontaneous intrusion by paying attention to the gaps in memory, the confusion of memory sequences and the extent to which memory has a "here and now" quality or strong sensori-motor components (Ehlers & Clark, 2000).

### *vi. Goal 1 – Appraisals*

Once the negative appraisals regarding the trauma and its sequelae have been identified in the assessment phase, Socratic questioning and other standard cognitive and behavioural techniques can be utilised to change them (see Figure 2.2). When a new, more adaptive and acceptable appraisal has been identified, it can then be incorporated into the existing narrative – either by adding it to the written account (Resick & Schnicke, 1992) or by inserting the new appraisal into subsequent reliving. An example Ehlers et al. (2005) provide is that of a woman who was raped and told by the rapist that she was ugly before being turned over onto her stomach so he could not see her face while he raped her. This had been one of her 'hotspots' and since the rape she had felt unattractive and began to engage in casual sex in an attempt to prove her attractiveness. Through Socratic questioning, an alternate appraisal was identified which was that the rapist had chosen her because of her attractiveness and that his comment was due to the fact that he could not become aroused without humiliating and abusing women. This new appraisal was then incorporated into a subsequent reliving where she stood up and said this to the rapist at the point where he verbally abused her.

**Figure 2.2**

*Cognitive Therapy for PTSD – Goal 1*




(Adapted from Ehlers et al., 2005)

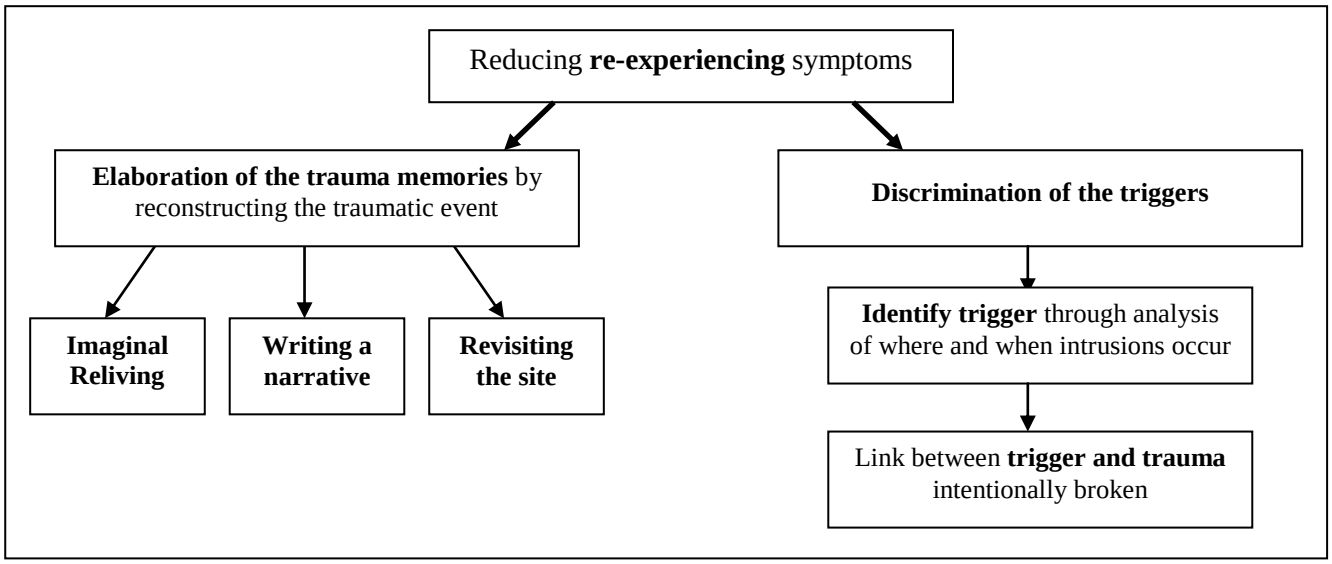
Due to the nature of the trauma memory, it may be difficult for people to recall distressing elements of the trauma and access subsequent information that corrects the impression they had at the time of the trauma (Ehlers et al., 2005). For example, a person who at the time of the traumatic event thought that their life was over might need to be reminded that their life has continued.

### *vii. Goal 2 – Reducing re-experiencing*

In order to reduce the re-experiencing of traumatic material, there are two separate steps (see Figure 2.3). The first is to elaborate the trauma memory by reconstructing the traumatic event thereby helping the patient develop a coherent narrative account which places the trauma in sequence, in context, and in the past (Ehlers et al., 2005). This can be done through imaginal reliving, writing of a comprehensive narrative and/or visiting the place where the trauma took place. Secondly, discrimination of the triggers needs to take place in two ways: by identifying the triggers and then determining the link between the trauma memory and the trigger and intentionally separating them (Ehlers et al., 2005). This dual approach promotes the reduction of intrusive images as well as the incorporation of the trauma memory into existing autobiographical memory.

**Figure 2.3**

*Cognitive Therapy for PTSD – Goal 2*




### *viii. Goal 3 – Changing dysfunctional behaviours and cognitive strategies*

After locating the dysfunctional coping strategies in the assessment phase, the clinician needs to educate the patient as to how their strategies are worsening or even creating their symptoms. The strategy is then changed in the context of a behavioural experiment and cognitive restructuring (Ehlers et al., 2005). For example, an individual who uses thought suppression to deal with the overwhelming nature of intrusive thoughts would be asked to allow him/herself to remember these memories and engage with them rather than avoid them.

## 2.2.2 Evidence of treatment efficacy

As resources are limited within many of our settings, it is not enough just to provide treatment. It is our duty to ensure that the treatment provided is well researched, has demonstrated effectiveness in our specific context and is based on available resources.

"In a meta-analysis of controlled and uncontrolled studies, van Etten and Taylor (1998) concluded that CBT for PTSD is effective" (Ehlers et al., 2005, p. 414). Due to the scope of this paper however, only those studies directly relating to the use of the Ehlers and Clark model (2000) or to the treatment of rape survivors or those on which the model was based, will be reviewed.

### *ix. The efficacy of the Ehlers and Clark (2000) model*

Ehlers et al. (2003) conducted a study on motor vehicle accident survivors to assess whether cognitive therapy or a self-help booklet given in the initial aftermath of a traumatic event is more effective in preventing the development of PTSD than repeated assessments. The participants of the research were requested to monitor their symptoms for three weeks and to report them on monitoring sheets. All those who did not recover during this phase (n=85) were randomly assigned to receive cognitive therapy (CT), a self help booklet based on cognitive behavioural therapy (SH) or repeated assessments (RA). CT participants received 2 to 12 weekly sessions and 0 to 3 booster sessions with the sessions initially lasting 90 minutes but decreasing to 60 minutes. SH participants were given a structured introduction to the self-help booklet by a clinician. The RA group did not receive any 'treatment', and were given the rationale that research was unclear regarding the length of time necessary to wait before starting treatment. The results showed that CT is an effective intervention for recent-onset PTSD as only three people out of 28 (11%) still had PTSD at follow up, while a self-help booklet was shown to be ineffective as only twelve percent of patients recovered.

Another study which further supports the efficacy of the Ehlers and Clark (2000) model is the research conducted by Gillespie, Duffy, Hackmann and Clark (2002) with survivors of the 1998 terrorist bomb blast at Omagh in Northern Ireland. In a series of 91 consecutive cases, generally treated with between 5 and 30 sessions, symptoms of PTSD and depression were found to be significantly reduced. No patients were worse after treatment – 3% showed no improvement and 97% showed varying degrees of improvement with most common improvements being in the 70% and 90% range. This paper focused on the transportability (how effective a proven treatment is in one context when applied to a completely different context) of this kind of therapy to a frontline clinical service and positive results were found of CT previously reported in more restricted settings appear to generalise well.

Lastly, in a paper by Ehlers et al. (2005), two separate studies were completed using cognitive therapy (CT) for posttraumatic stress disorder. In study one, a consecutive case series, 20 patients treated with CT showed marked improvements in symptoms of PTSD, depression and anxiety. In study two, a randomised controlled trial, CT (n=14) was compared to a waiting condition (n=14) and the results indicated a marked reduction in PTSD symptoms,

disability, depression and anxiety. In both studies the treatment gains were maintained at a six-month follow up.

### *x. Studies dealing specifically with rape survivors*

Foa, Rothbaum, Riggs and Murdock (1991) compared the efficacy of prolonged exposure therapy (PET), stress inoculation training (SIT), supportive counselling and a waiting list control group on PTSD among raped or physically assaulted women. Foa's PET includes four components in this particular order: education-rationale, breathing retraining, behavioural exposures, and imaginal exposures. The therapy also includes homework assignments and a systematic desensitisation with the exposure techniques based on the client's subjective units of distress (Resick, Nishith, Weaver, Astin, & Feuer, 2002). Although at posttreatment, they found that all four groups had improved significantly, SIT was better than supportive counselling and the waiting list and slightly better than PET. However, at a three month follow up PET was found to be slightly better than SIT. In a later study Foa et al. (1999) compared three different treatment conditions to a waiting list in the treatment of sexual and physical assault survivors with PTSD. The three treatment conditions were PET, SIT and a combination of PET and SIT. The treatments consisted of nine sessions lasting 90 minutes each. Although all three treatments were found to be superior to the waiting list, with no difference between them on most measures, PET was found to be the best on end state functioning.

In a further study conducted by Resick et al. (2002), two well-researched and documented treatment programs were compared. The study compared cognitive-processing therapy (CPT) with PET and a waiting condition. The CPT treatment manual written by Resick and Schnicke (1992), includes education about PTSD, the treatment, and the relationship between events, cognitions and emotions. The exposure component of the therapy takes the form of a written detailed narrative, which is processed throughout the therapy. Maladaptive thoughts and beliefs about the traumatic event are challenged and homework assignments are used throughout the process to practice the skills and techniques learnt in the therapy sessions. In this way, both PTSD and depression symptoms can be targeted. In this study, the participants were randomly assigned to one of the conditions and the two active treatments were completed within six weeks. CPT and PET were conducted twice weekly for a total of 13 hours of treatment. Approximately one third of the participants in each treatment group failed to complete the course of treatment but of those who did, about 80% no longer met the criteria

for PTSD at the nine-month follow up. Although there was no significant difference between the effectiveness of the active treatments on PTSD, CPT had a marked impact on symptoms of depression (less than 5% were depressed at nine month follow up) compared to the PET condition (15% were still depressed at follow up), which is significant as many rape victims suffer from comorbid depression. Both treatment conditions were shown to be superior to the waiting condition.

In a continuation of this study, Nishith et al. (2005) revisited findings to examine whether the results that CPT had better outcomes than PET for certain aspects of trauma related guilt and if the effect was a function of improvement in a subset of participants with both PTSD and major depression. Nishith et al. (2005) found that CPT was as effective in treating "pure" PTSD and PTSD with comorbid depression in terms of guilt and that CPT was more effective than PET in reducing certain trauma related guilt cognitions.

It can be seen that different variations of cognitive therapy have been found to be effective for a wide variety of individuals suffering from PTSD. It would seem that both Ehlers and Clark's (2000) as well as Resick and Schnicke's CPT (1992) have yielded significant results in proving the efficacy of their respective treatments. The relevance of reviewing the effectiveness of CPT is that Ehlers and Clark (2000), in developing their model, drew on certain pertinent aspects of Resick and Schnicke's (1992) treatment manual.

## 2.3 Transportability

From these studies, it can be seen that there are effective ways of treating PTSD, specifically in rape victims. However, the question of how applicable these studies are in the South African context has to date not been answered. Schoenwald and Hoagwood (as cited in Edwards, 2005c) refer to this question as the issue of transportability. It is suggested that transportability problems surface from four causes: insufficient training of the therapist, insufficient resources, poorly selected patient populations and failure to consider cultural and contextual factors. Therefore, the aim of this research is to investigate the transportability of Ehlers and Clark's (2000) cognitive therapy model and the factors that need to be considered when applying a proven treatment in the South African context.

# CHAPTER III

# Methodology

## 3.1 Clinical Methodology

The treatment programme was based on the Ehlers and Clark (2000) model. As the model is conceptually driven, it was applied flexibly in response to the needs of the client and the progress of therapy. As in accordance with the model, the first step was to conduct an assessment of the patient which in this case spanned five sessions ranging from 40 to 90 minutes each in length. The assessment was conducted in order to find out pertinent issues, which would shape and create the treatment program (Ehlers & Clark, 2000). Such issues as: (1) what the effects of the trauma had been on the individual's life, (2) relevant family history, (3) analysis and content of the intrusions, (4) key appraisals at the time of the trauma; (5) key beliefs uncovered thus far and (6) the maintaining factors which would need to be targeted in the treatment plan. This information was then formulated in order to produce a comprehensive treatment plan designed for the individual. Specific cognitive and behavioural techniques were discussed in supervision which formed an intricate part of the treatment plan. A list of therapy goals was then created in conjunction with the patient, based on the treatment plan and a verbal contract was made to attend therapy twice weekly for approximately six weeks. Once the therapy was underway, the goals for therapy were divided into a hierarchy based on importance and were dealt with systematically according to the patient's needs.

The author of this paper, who administered the treatments, received training in her first year of Clinical Psychology Masters in Cognitive Therapy. She was taught and closely supervised during the treatment of this case by a cognitive therapist accredited with the Academy of Cognitive Therapy who was able to ensure that the intervention followed Ehlers and Clark's (2000) model for treating PTSD.

## 3.2 Research Methodology

### 3.2.1 Research Design

This research takes the form of a case-based design, in which a case narrative in combination with repeated quantitative measures are used (Edwards, Dattilio, & Bromley, 2004). Fishman (2005), in his introduction to the journal Pragmatic Case Studies in Psychotherapy (PCSP), describes the Pragmatic Case Study (PCS) method of research. This is a systematic way of

ensuring rigorous quality in a predominantly qualitative study. A single unit of analysis has been used in this design, which will add to a database of knowledge regarding the treatment of PTSD. The participant, Oratilwe, provided informed consent for both the method of data collection as well as the use of the material for research purposes.

### 3.2.2 Participant

The participant was selected by means of a poster located in a central part of town (see Appendix A). The poster offered free therapy in exchange for being part of a research project. From the respondents to the poster one female participant was selected based on the following inclusion criteria: (1) she met the full DSM IV criteria for PTSD, (2) the PTSD was in response to a rape, (3) she was Xhosa speaking, and (4) she was willing to give consent for the course of treatment to be used for the purposes of this research. As was advertised in the poster, the researcher, through funding provided by the Rhodes University Joint Research Committee Grant to Professor David Edwards, paid for the cost of her transportation.

### 3.2.3 Data Collection

The following data collection methods were employed: (1) an in depth history of the presenting problem as well as the participant's own history was gathered by means of a semi-structured interview (Ehlers & Clark, 2000) consisting of 5 sessions lasting altogether 3 hours and 40 minutes and a reliving session (Foa & Rothbaum, 1998), (2) all assessment sessions as well as therapy sessions were audio-tape recorded, (3) detailed session records were written after every session, (4) records were kept of all written in-session and homework exercises, (5) notes were kept from weekly supervision as well as from ongoing reflection regarding the significance of the material from each session, (6) psychometric tests namely the Beck Depression Inventory (BDI: Beck, Steer, & Brown, 1996), Beck Anxiety Inventory (BAI: Beck & Steer, 1993), the Posttraumatic Diagnostic Scale (PDS: Foa, Cashman, Jaycox, & Perry, 1997) and the Posttraumatic Cognitions Inventory - Revised (PTCI: Foa, Ehlers, Clark, Tolin, & Orsillo, 1999) were used at intake sessions 1 and 5 and therapy sessions 2, 3, 6, 7 and 10 (roughly once per week).

### 3.2.4 Data Reduction

Four forms of data reduction were used:

(1) A summary of the assessment material based on a case history format from Hackmann (2005) was written and formed the basis of the formulation.

(2) A case formulation using Ehlers and Clark (2000) and Young, Klosko, & Weishaar (2003) was developed. It was based on the participant's family and personal history and presenting problem with the emphasis being on developing a deep understanding of the maintaining factors keeping the PTSD in place. It is discussed in the next chapter.

(3) Based on the qualitative data, a selective thematic case narrative was written that focussed on the experiences of the participant as she moved through the treatment. The themes were chosen through a process of phenomenological hermeneutic enquiry (Smith & Osborn, 2003) and are presented in the following chapter.

(4) The self-report scales were scored and the repeated measures were displayed graphically.

In keeping with the humanistic endeavour of this research, most of the story of Oratilwe's therapy is told in the first person. The researcher, therapist and first person "I", all refer to the author of this paper.

### 3.2.5 Interpretation of Data

A hermeneutic reading method (Edwards, 1998) was used to interpret the selective narrative. There were two types of interpretive questions used to interrogate the data. Firstly, there were questions that arose directly out of the research questions such as: (1) how effective is the assessment and formulation and does it helpfully guide the clinician to what is significant for treatment? (2) how effective is Ehlers and Clark's (2000) model in treating PTSD in a rape survivor? (3) what issues are there in transporting this treatment to a South African context?; and (4) what local cultural or contextual factors have influenced the overall efficacy of the treatment? Secondly, further questions were generated through the development of the narrative itself.

# CHAPTER IV

# Oratilwe's Story

It would be impossible to provide a step-by-step description of my therapy with Oratilwe that took place over 12 weeks, thus a selective thematic narrative has been developed which includes both the qualitative and quantitative results. To clarify, the narrative is a summary of the main occurrences in the therapy session by session leaving out repetition within sessions, specific details regarding her relationship with her current boyfriend, the discussions around organisation of transport and the scheduling of appointments. The narrative looks specifically at aspects within the therapy process, which demonstrates the workings of the Ehlers and Clark (2000) model encompassing themes such as anger, guilt, shame, HIV/AIDS, social support, core beliefs and avoidance. Most importantly, this narrative endeavours to capture the essence and flow of the therapy as well as the interpersonal process that was so fundamental to both her and my experience. Therefore, first person narrative will be used when referring to the author/therapist/researcher

## 4.1 Phase 1: Assessment

I stood by the window looking out anxiously for any sign of the young woman I had spoken to on the phone. I was trying to keep my desperation at bay – I needed her more than she needed therapy – and I knew this was not a good thought to keep my anxiety under control. She was the fourth possible participant for my research and with the end of the year looming closer and closer I could not afford for her not to come. Finally I caught sight of this neatly dressed, attractive black woman walking anxiously towards the intern house. This waiting, seeing and breathing again with relief was to become a familiar ritual in our course of therapy.

Oratilwe came into the room with an air of confidence. Although her anxiety was clear, there was a sense of self-possession about her that was both a relief (she had some internal resources) as well as disconcerting. As we started the familiar dance of therapy beginnings, my own sense of anxiety started to dissipate but was quickly replaced by confusion. Even though I could feel an instant empathy for this young woman in front of me, I had a strange feeling of disbelief as she spoke about the fact that she had been raped two years previously. There were no overt signs that she was making this up (as well as no real reason) yet she spoke with so little emotion or feeling regarding this heinous experience that the discrepancy

was jarring. As she progressed with her story, she appeared more emotional about the fact that an ex-boyfriend had been unfaithful to her than about being raped.

I took this anomaly to supervision, as I knew that I believed her but was struggling with the fact that there was a part of me at the time that did not. My supervisor so rightly pointed out that what I was experiencing was the level of her dissociation – I was the first person she was telling her story to in two years and what I was responding to was the part of her that was desperately trying to believe that it did not happen. Thus began our therapy process that lasted only 12 weeks but redirected the course of this young woman's life.

The assessment process consisted of five sessions lasting between 40 and 90 minutes. The first three of those sessions focussed on gathering information regarding the difficulties she was experiencing at the time, her family history, her current coping strategies, her beliefs about rape before and after the trauma and the way she believed the rape had affected her life (see assessment results in Section 4.1.1). Throughout this process, I provided Oratilwe with information regarding the presentation and mechanisms of PTSD and depression, which seemed to have a strong normalising effect.

The continuity that was set up in the first three sessions was soon to be undermined. Oratilwe called and cancelled what was to be our fourth session and then cancelled the make up session. Although she said it was due to illness, I had my suspicions that she was coming up hard against her age-old pattern of avoiding that which felt unmanageable.

As our third time planned fourth session drew closer my anxiety built. My standing-by-the-window ritual again came into play but the sigh of relief came when she appeared on time walking calmly into the intern house. Although I felt that Oratilwe's missing of sessions could be due to more than illness, I did not focus on it more than to just reflect how maybe part of her found it really difficult to come to the last sessions. In this session, I provided Oratilwe with an explanation of Ehlers and Clark's (2000) theory on PTSD. I also demonstrated, by asking her to close her eyes and telling her not to think about a pink elephant (she could not help but think of it), how her coping strategy of trying to stop herself from thinking about the trauma was creating and maintaining some of the symptoms discussed earlier in the paper. In addition, I started preparing her for the reliving that was going to take place in session five and to explore some of her fears around talking about the trauma.

Oratilwe arrived late for session five. She appeared visibly anxious and stated that although she felt like she did not want to do this retelling, she also felt anticipation in sharing the story with someone else. We again looked at her fears regarding talking about the rape. As her biggest fear was that she would commit suicide if she allowed herself to think about it, I provided her with my cell phone number and we verbally contracted that should she ever feel that desperate during the treatment process, she would call me before acting on it.

Due to her apparent high levels of anxiety, I conducted a relaxation exercise, which resulted in her looking calmer and more centred. The following is an extract from the account that she provided me with, with very few prompts.

O: It was just near Christmas… he called and asked if I would go over to him to his aunt's place here in town… ya… so when I got there he was watching cricket… so after the cricket …. We watched some other programs – it was a concert. He started umm fondling me like and we had done that before so there was nothing wrong with that…

T: How did you feel when he started touching you?

O: Since he wasn't really touching my private parts he was just touching my face and tried to kiss me I was comfortable with that... So he went to take a bath…. And came back… so… he asked me to go in the room. So I followed him as well.

T: Were there other people around?

O: No it was just me and him in the house. Umm… when he was there, he had already undressed um… he already had his underwear on. He started kissing me again while we were standing up there and …. He placed me on the bed… okay so… I tried to get him off and told him I don't want to do this. You know … I'm not ready for it. He said, no I understand – I'll just do it on top….

T: How were you feeling when he said that?

O: A part of me trusted him but a part of me didn't but I must say 75% I trusted him. (long pause) Okay so…. We started stripping and I told him I wasn't comfortable with this whole thing – even if he was just going to be on top without taking any underwear off…. But he managed to convince me to take my clothes off. So we kissed and all of a sudden he just overpowered me and took my underwear off… I tried to kick him, I tried to scream but the room that I was in, it was behind, so the people on the other side of the street couldn't hear me….

T: What were you thinking when you tried to kick him off?

O: Just please get off me I'm just not ready to do it. When he forced me I was just like, my future is now over… as I was kicking he… he got a chance to hold my legs and entered me. I kept on saying just stop just stop…. (crying)

T: He just wouldn't stop (long silence – crying)

Afterwards we discussed what she was thinking and feeling now that she had shared the details of her story with me. Although she was able to engage with her guilt around being at his house, her shame at having trusted him and her feelings of hopelessness regarding her future, she could articulate but not connect with the anger that she felt for Ken. I, on the other hand, felt rage building inside me towards this man. Thoughts of 'how dare he betray her that way' and 'what made him think it was okay to hurt someone like that' were spurring on my feelings of anger. I reflected to her that although she was saying she was angry (she stated that she wanted him to hurt as badly as he hurt her and if she could destroy him she would), I could not see it in her face but I could feel it in me. She seemed taken aback by the fact that I felt her anger and I could feel the impact that my words had on her and our relationship in general. Even though the intensity of the anger abated after I had reflected it, the memory of it was firmly planted. At the end of the session I broached the question of whether he wore a condom during the rape and whether she knew if she was infected with HIV or not. She stated that she thought she saw a condom in the bathroom after the rape but was not sure. She admitted that this had been a major worry for her and that she was too afraid to go for an HIV test.

At the end of session five, Oratilwe remarked how good it felt to tell someone she could trust about the rape. Looking at the quantitative measures, between intake one and intake five, there appeared to be a slight increase in Oratilwe's level of depression (Figure 4.2) and her traumatic symptomatology (Figure 4.3) whereas there was a decrease in her levels of anxiety (Figure 4.4) and in the intensity of her posttraumatic cognitions (Figure 4.5). It is hypothesized that the normalising of her experience and psychoeducation might have had a positive effect on the intensity of her cognitions and her overall anxiety. However, due to the fact that the memory of trauma had up till now been actively avoided, the talking about the traumatic material seems to have brought Oratilwe's feelings of depression and the traumatic symptomatology up into consciousness.

### 4.1.1 Assessment Results

Oratilwe met the DSM-IV criteria for PTSD on the basis of a clinical interview and this was consistent with her scores on the Beck Anxiety Inventory (BAI: Beck & Steer, 1993), the Posttraumatic Diagnostic Scale (PDS: Foa et al., 1997) and the Posttraumatic Cognitions Inventory - Revised (PTCI: Foa et al., 1999). She was also suffering from a major depression at the time of presentation, which was diagnosed from a combination of her presenting symptomatology as well as her scores on the Beck Depression Inventory (BDI-II: Beck et al., 1996). Her affect was restricted and sometimes dissociated while her mood was reported to be between good and very bad. The assessment consisted of five intake sessions varying in length between 40 and 90 minutes with one session devoted to a reliving.

#### *xi. Family History*

Oratilwe's parents are still married and live together with two of their daughters and two of their grandchildren in Grahamstown. Oratilwe's mother, Julie, was described as a sweet, talkative, empathic and short-tempered – a person acutely aware of social opinion. She is currently unemployed and looks after her grandchildren during the day. Oratilwe reported that she never felt loved by her mother and always felt like she was a disappointment because she knew her mother wanted to give her father a son (she is the sixth girl). She said that she remembers her mother as always being angry with her and punishing her severely for little things she did wrong. She admitted that she felt as if she was never good enough. Oratilwe stated that although she was never close to her mother growing up, they now had an understanding between them, which allowed them to communicate about surface level happenings.

Oratilwe's father, Wilson, was described as very kind and a person who likes to laugh a lot. He is retired and spends his time helping his daughters with their yards and house maintenance. Oratilwe stated that he was very angry when she was younger and that she was quite scared of him. He would often take his anger out on her for no reason. In addition, she said that he used to be very stingy with money and did not like them to ask him for anything when he got paid. She reported that her father was better than her mother because he would still give her compliments such as "you are as strong as a boy". She admitted that he is less aggressive now but said that they too have a superficial relationship where they can talk and laugh about unimportant issues.

Oratilwe described a punitive and rigid upbringing whereby she was punished severely for not adhering to sometimes unreasonable expectations. For example, Oratilwe related an incident when she was 16 years old where she was beaten for coming home after seven at night from her sister's home even though she had let her parents know where she was. She stated that she was not allowed to play sports at school because it would mean that she might come home late. Both Oratilwe's parents are strict Jehovah Witnesses and have forbidden Oratilwe to date outside of the religion despite her three older sisters having married out. As stated above, Oratilwe is the youngest of six sisters and she explained that the older sisters often parented her as well.

### *xii. Personal History*

Oratilwe reported that although there were no problems or complications with her mother's pregnancy, she was a breach birth and therefore was born through caesarean section. She reached all her milestones timeously and there were no neurotic symptoms in childhood reported (except for a phobia of worms). She said that she had been a self-sufficient child and was very outgoing until going to school at the age of six. She reported that this shyness lasted until grade 10 where she began to interact with others in her class. She matriculated from school with average marks and has been studying through correspondence while working. She stated that she drinks alcohol very seldom and will only have one drink when she does. She suffered from Tuberculosis at the end of 2004 and subsequently is often ill with chest pains. In addition she has stomach ulcers, which are currently under control.

Oratilwe has had three significant intimate relationships with men in her life. She started seeing her first boyfriend, Ken, when she was 18 years old. They maintained a long distance relationship for a year as he lived in Cape Town and only came home to Grahamstown during university vacations. She has not had formal contact with him since he raped her at the end of 2003. She started seeing her second boyfriend, Lonwabo, six months after the rape. After seeing each other for a few months, he moved to Johannesburg and they tried a long distance relationship. A few months after that he broke off their relationship as he told her he had heard that she was cheating on him. The next year, she found out that he had a child of five years old and had originally gone to Johannesburg to marry the mother of his child. Her third and current relationship started in June of 2005 with Sipho. As he lives in Port Elizabeth, they only see each other approximately once a month. Although she said she loves him, she

expressed ambivalence regarding the way that he treats her and how she feels about herself when she is with him.

### 4.1.2 Formulation

A significant predisposing factor in Oratilwe's current presentation is that she did not receive consistent nurturance and love as a child. Whether this was due to being the sixth child born into an authoritarian and rigid family system, or because she was the disappointing 'non-son', it is clear that a cold, conditional and rejecting early environment made a significant contribution to her current presentation. It would seem, judging from her description of her relationship with her eldest sister, that she received nurturance and acceptance from her during childhood, which could have offset some of the punitive and harsh treatment she received from her parents.

These early childhood experiences set up unconditional schemas (earliest schemas that do not waver) of mistrust or abuse, emotional deprivation of nurturance and defectiveness or shame (Young et al., 2003). These schemas led to Oratilwe's expectations of being hurt, humiliated or abused by others, that her needs for nurturance and attention would not be met and feelings that she was defective, bad and unlovable to significant others. According to Young et al., (2003) children often develop alternative strategies to get their needs met and avoid activation of unconditional schemas. These conditional schemas (not as fixed as unconditional schemas) then develop as ways to protect the child and get some sense of self from a limited and uncontrollable environment. Oratilwe's excessive focus on the desires, feelings and needs of others at the cost of her own can be seen as a conditional schema by which she received some sense of avoiding feelings of shame and defectiveness. This subjugation of both her needs and emotions was set up early in her childhood as she was taught that in order to survive she had to do what her parents required of her in the way that they required it. Through her self-sacrificing and approval seeking, Oratilwe was able to gain conditional acceptance from her parents at the cost of developing her true and authentic self.

The trauma of being raped by someone she knew, loved and trusted, activated Oratilwe's core schemas of mistrust, abuse and defectiveness which were evident in the assessment phase of the treatment. Her feelings of worthlessness, powerlessness, shame and hopelessness prompted her to try and forget about the event by keeping it a secret and actively pushing thoughts of it out of her mind. In this way she both created and maintained the PTSD

symptoms as she never allowed herself to process and share the horror of what she had experienced.

### *xiii. General effects of trauma on the patient's life*

Oratilwe described her life as difficult since the rape but said that she just tried to follow the advice "fake it till you make it". She said that she used to be a talkative person but since the rape she felt as if she did not want to talk at all. In addition to having problems with her eating and sleeping, Oratilwe felt cut off from herself and from others. She reported that she could not trust men, especially her current boyfriend, and constantly struggled with being intimate with him. She stated that her dreams for her future have ended and that she would never be the same again.

### *xiv. Analysis of the contents of the re-experiencing, and of voluntary recall*

At the beginning of the assessment, Oratilwe reported having only one intrusion but by the end of the assessment phase another two had emerged.

1. Lying on the bed with him on top of her and her trying to kick him off. Him then catching her leg and penetrating her.
   *Possible meaning: in trying to protect herself she became more vulnerable.*
2. Him smiling while penetrating her.
   *Possible meaning: her pain excited him.*
3. Him telling her to "clean up your mess" and her washing the blood off the sheets in the bathroom.
   *Possible meaning: Further evidence of her degradation and worthlessness.*

Oratilwe stated that she tried to suppress intrusive thoughts by locking her door and playing her music very loud. She reported that she felt that if she allowed herself to think about them, she would commit suicide because it was proof that she is not worthy of love. In addition, she stated that her memory for the event was completely clear and she could remember every detail. This was corroborated through her lucid and systematic recall of the trauma during the reliving exposures.

### *xv. Key appraisals at the time of the trauma*

- She believed that her body's uncomfortable feeling when she was taking off her clothes was a warning that the rape was going to happen.

- She thought to herself when she was washing away the blood from the sheets that she was washing away all her dreams and hopes.

***xvi. Key beliefs uncovered during assessment***

- It was my fault it happened – I must have done something or acted in a way that made him treat me like that
- I am unworthy of love
- Men cannot be trusted
- The rape was punishment for disobeying my parents
- I could have done something to prevent it
- I am a helpless person
- My future is over

### 4.1.3 Treatment Plan

The original plan for treatment was to have 12 to 16 sessions of 90 minutes each twice per week.

**Table 4.1**
*Treatment Plan based on the Ehlers and Clark (2000) model*

| Maintaining Factor | Intervention |
|---|---|
| Distorted peri-traumatic appraisals:<br>▪ She could have run away or hit him with something.<br>▪ In defending herself she made herself more vulnerable.<br>▪ It was her fault it happened.<br>▪ The rape was a punishment for disobeying her parents.<br>▪ Her whole life and future was destroyed. | ▪ Verbal challenging of beliefs through Socratic questioning and reality checking.<br>▪ Use other cognitive techniques such as, thought records and evidence-based arguments to target issues such as guilt, anger and trust. |
| Fragmented narrative, appraisals never updated | ▪ Repeated reliving of hotspots.<br>▪ Organising the narrative.<br>▪ Verbal challenging of distorted appraisal.<br>▪ Inserting corrective information verbally, and through image transformations. |

| Maintaining Factor | Intervention |
|---|---|
| Suppression/avoidance of intrusions | ▪ PTSD psychoeducation<br>▪ Thought suppression demonstration<br>▪ Image transformations and manipulations: the meaning she gave to those images does not reflect reality: what she thought happened did not occur |
| Dysfunctional assumptions<br>▪ I am helpless in my life<br>▪ I am unworthy of love<br>▪ I am HIV positive and therefore my future does not exist | Help locate and target these assumptions through cognitive restructuring and specific behavioural interventions. |
| Limited social support | Get supportive person from her world involved by disclosing the rape. Use therapeutic space if necessary. |

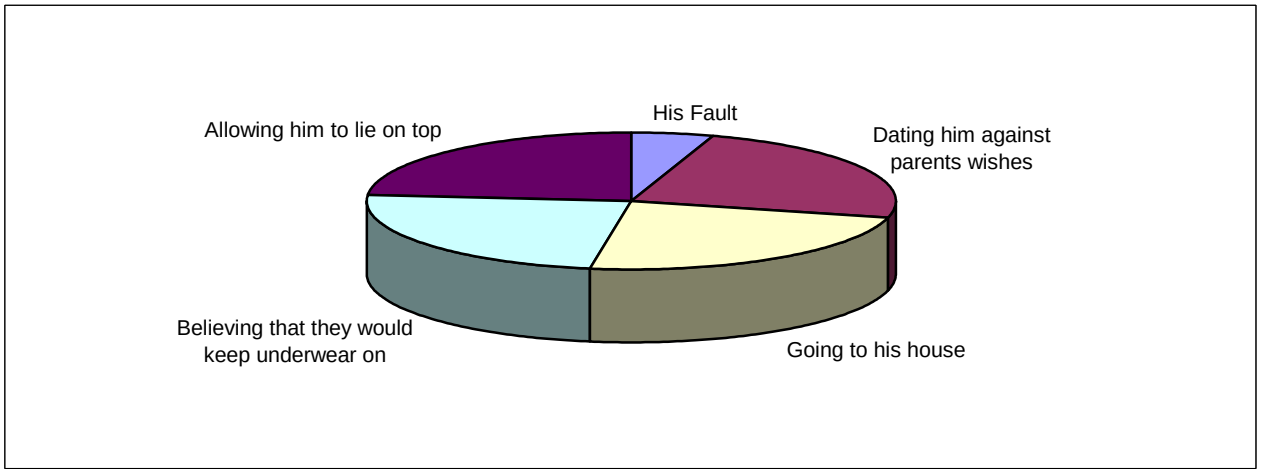
## 4.2 Phase 2: The Therapy Begins

**(Therapy sessions 1 – 3)**

Our first session of therapy was spent discussing the goals for the therapy and then starting to deal with her feelings of guilt. Even though Oratilwe 'knew' that she was not responsible for the rape, she said that she still felt like it was 95% her fault. Through using a guilt pie graph (Figure 4.1) – we went through all the different aspects that she felt 'caused' the rape to happen. Once we had been through all the different aspects of her guilt, I systematically challenged them through a combination of Socratic questioning and logical reasoning focusing specifically on the belief that the rape had been a punishment for disobeying her parents. By the end of the session I drew up a new pie graph which depicted the reality of the division of responsibility – 100% his fault. Although she was able to engage with the points one at a time as we went through them, she struggled to believe at that point in the therapy process that the rape was completely his fault.

Figure 4.1

*Guilt Pie Graph*




Oratilwe cancelled our second session twice as she said she was ill. When she arrived at the session her face appeared swollen and her affect was obviously depressed. She started the session by stating that she had attempted suicide that weekend by drinking a bottle of cough mixture as she had felt like her life was over and her future hopeless. Although she had told her mother the next day about the suicide attempt, there was still no-one else in her world that knew about the rape and could therefore understand what she was going through. We spent most of the session looking at the hopelessness that prompted her to try and take her own life. I attempted a dual approach whereby I validated her feelings of utter loss and hopelessness yet challenged the reality of these perceptions. For example, Oratilwe believed that if she was HIV positive there would be no way for her to have children and therefore fulfil her dream of having a family of her own. I reflected and held how desperate that thought must make her feel but disputed the logic that being HIV positive (*if* that was the case) meant that she could never have children. At the end of the session, I stressed the importance of someone else in her world knowing what she was going through and encouraged her to think about telling a family member about the rape. I offered that we could tell the person together here in the therapy room if that would feel more manageable. As can be seen in Figures 4.2, 4.3, and 4.4, there were marked increases in Oratilwe's anxiety, depression and posttraumatic symptomatology between the last intake session and therapy session two.

My immediate response after the session was one of responsibility – that I, through incompetence, had made her worse and was doing her harm rather than helping her. My supervisor helped me to see that I could not save her from experiencing the pain that she was

going through which left me feeling a profound sense of powerlessness in the face of such suffering. This feeling was not unlike the helplessness that Oratilwe had experienced during the rape and was still dealing with in her everyday life.

My supervisor's words rang true in the third therapy session where Oratilwe presented more centred, less anxious and less depressed than she had since we began this process. In this session, due in part to the lifting of her general mood, she was able to engage deeply with the loneliness and isolation she experienced on a daily basis. We explored how the burden of keeping this secret to herself was adding to her feeling of being cut off from the world around her as well as maintaining her avoidance of challenging her appraisal of the trauma's sequelae. For example, by not telling her parents about the rape they could never disconfirm her belief that she was being punished for disobeying them.

We also looked more in depth into the issue of her HIV status and explored how the 'not-knowing' was affecting her life. She told me that she had decided that she would just live as if she was HIV positive until she was ready to find out. In that way, she would be prepared if the results turned out to be positive. I pointed out the benefit in terms of safety of living an HIV positive life but also that it was forming part of the cycle that was maintaining the PTSD and adding to how bad she was feeling inside. I reflected the hardness that would come if she found out that she was HIV positive but that she would survive the finding out – even if she felt like she would not – in the same way she was able to survive the retelling of the details of the rape. In addition, we discussed how possibly living like she was HIV positive with the added uncertainty of not knowing was worse than actually knowing and that knowing did not change the *fact* of whether she was sick or not. I suggested setting a deadline which we could work towards, in order to combat the avoidance that she was demonstrating. She showed visible anxiety around this suggestion so we looked at her fears and I questioned how knowing her status would be different from just thinking it.

Anger featured again in this session. I tried a technique to get her in touch with her anger whereby she filled in two pieces of paper – "I am angry with Oratilwe because…" and "I am angry with Ken because…". She engaged well with the task and we were able to get to the content of her anger. For example, she stated: "I am angry with Oratilwe because I shouldn't have trusted him with all my heart". We then worked through all the points and I challenged her again on points such as "I should not have gone there" and "I should not have allowed

him on top of me" by pointing out the normality of such actions within the context of him being her boyfriend at the time. Although Oratilwe was engaging with the task, I could feel that she was cut off from her anger – not just in her lack of affect but also in the boiling rage in the pit of my own stomach. Interestingly, it was accompanied by the sense of powerlessness that I had experienced after our second therapy session. This time, however, I was able to recognise it for what it was – hers and not mine. It felt like it was time to start shifting the anger from impotent rage to empowering action.

We looked at the point "I should have told someone immediately so he could be punished" and "I am angry with Ken because he is living a happy life while I am suffering" in terms of what could still be done for him to face the consequences of his actions. She was against going to the police as she felt that due to the passing of so much time, nothing would come of it except the embarrassment and powerlessness of having people not believe her and that he would win again. I suggested that there might be another way, through telling his family of what he did, that he might be brought to some kind of justice albeit in a more subtle way. Oratilwe found this idea to be most empowering as she felt that it was something she could do to practically change something that she was feeling. This point led onto the fact that she needed to tell someone in her own family so that she could have practical support in this type of confrontation.

## 4.3 Phase 3: The Turning Point

**(Therapy sessions 4 – 6)**

Oratilwe arrived at session four stating that she had told her eldest sister, Nomhle, that she had something to tell her and had asked her to accompany Oratilwe to her next session. We spent the session preparing for the disclosure by looking at Oratilwe's fears and deciding what my role in the telling would be. We discussed how much she wanted me to disclose and how I could ask her in the session if I was not sure. We then role played the actual telling and decided where her sister would sit in the room. I brought up the fact that it might be strange or even invasive for her having someone else in our space and she engaged well with how she could be feeling afterwards. The following are a list of what she wanted us to bring up and address with her sister: (1) fear of being judged for dating a person outside the religion (and that the rape was therefore a punishment for this), (2) disappointment that she was not a virgin anymore, (3) disappointing her parents (and that again the rape was a punishment), (4) being

held responsible for the rape because she went to his house, (5) being blamed by her sister for not telling her sooner, (6) fear that her sister will not believe her, (7) confidentiality (discuss with her sister who she can tell in order to get support for herself - can be either her husband or her younger sister Noluthando) and (8) the possibility that she might be HIV positive.

Oratilwe arrived with Nomhle for session five looking anxious and pale. Her disclosure occurred with very little affect on her part and her sister's reaction was in line with the way she was telling it. Throughout the session, despite being obviously overwhelmed, her sister was both supportive and engaging and kept on reiterating how she had known that something had happened that December because "Oratilwe was just not the same Oratilwe". I found the sadness in the room at points to be totally overwhelming as it was not just one person's sadness but two.

We discussed all the issues that Oratilwe and I had planned to which had a multiple effect of lessening Oratilwe's anxiety, providing her sister with more information and providing me with clarity regarding certain issues. For example, Nomhle stated that she did not think Oratilwe should find out her status because it was well known that a person often died as soon as they found out that they were HIV positive. I was able to better understand Oratilwe's difficulties regarding finding out her status as well as challenge the logic of such a belief. In addition, Nomhle stated that she felt their parents would not blame Oratilwe and would understand that it was not her fault. This seemed to be an important disconfirmation of a central belief that only someone in her family could provide.

As half an hour of the session still remained after the disclosure process, Oratilwe decided that we should use the rest of the session as a therapy session and that her sister should wait outside. This gave us an opportunity to reflect on the success of the session and to look at anything that may have bothered Oratilwe during the disclosure. She felt as I did that the telling had been a success. We decided to spend the last twenty minutes talking about the intrusive images she was still having. It was at this point that Oratilwe disclosed an aspect of the story that she had never articulated before.

O: The first one (intrusive memory) I was saying yes… yes he can do it on top of me its fine. I was saying it … I say it with trust and confidence, you can just do it on top.

T: I wonder something in that is…. That you were wanting that…. I know we spoke a little about this before but sexually… not that you were wanting sex… but that you were wanting that physical feeling and that intimacy with your boyfriend

O: It was curiosity

T: And a very natural feeling to be excited to have that feeling

O: That is what I was scared for telling people and reporting it to the police. Cause if they hear that part that I said no you can do it just on top. They would think I was asking for it. How could a person think an older person would just do it on top. How could I expect that an older person would be happy with just doing it on top. And in that way … I thought he could have changed the statement to yes you can do it. So in other words I allowed him.

T: Okay so, is some of the flashback, is some of it around how you were feeling in your body, in terms of excitement and feeling guilty about that?

O: Ya, I feel guilty for actually being that excited. And feel stupid for saying you know you can do it just on top. So the fact that I said you can do it – sounds as if I said you can do whatever you want. I feel guilty just for saying those words.

As can be seen from this extract, Oratilwe had both strong guilt (in that she felt responsible for possibly causing the rape) and shame (that she felt such strong sexual desire) reactions to the memory of telling him it was alright for him to 'do it' on top. The intensity and nature of this emotion prevented her from telling me about it before and it was only with the deepening of the therapeutic trust and connection that Oratilwe was able to risk sharing it.

The quantitative results at session six showed a marked decrease in Oratilwe's anxiety (Figure 4.4) and her posttraumatic symptoms (Figure 4.3) but an increase in her depression scores (Figure 4.2) and in the intensity of posttraumatic cognitions (Figure 4.5). It may have been that with the lifting of the anxiety and traumatic responses, Oratilwe's sadness and hopelessness were beginning to become more pronounced. This could also in turn have influenced her thinking which would be reflected in the scores from the PTCI. Another possibility is that in overcoming the avoidance and confronting the material there was some habituation of the emotion and less uncontrolled intrusion but at the same time the underlying meaning which was so painful became more accessible.

The purpose of session six was to deal directly with the intrusive material through reliving, imagery rescripting, and by looking at the affect and appraisal associated with them. She started the narrative at the same point she had before with a lot more detail than the narrative she offered in session 5 of the assessment (see Appendix B for summary of the reliving). She engaged well with this reliving and allowed herself to feel all the emotions that were coming to her. When she was finished, I reflected how the feelings of powerlessness and worthlessness were coming out clearly in this retelling and she was able to connect with this statement. I asked her to start again but that this time I was going to ask her to imagine things differently. When she got to the part in the narrative of him holding her arms tightly at her sides, I asked her what she wanted to do at this point and she said she wished she could push him off her and shout at him. I suggested she do this in her imagination and to tell me what was happening in her minds eye. We then went back into the narrative and tried to change what she said when he told her that it was her mess to clean up but she could not access the words. At this point the anger was boiling again inside me and I said in very strong words: "My mess? No this is your mess that YOU need to clean up!". She started sobbing at this point and the relief that her anger had been articulated was palpable. At the end of the reconstruction I reiterated that the reconstruction was not meant to deny what happened but rather to give her a feeling of power in the face of such helplessness.

We then looked at the feelings of worthlessness and powerlessness and the thoughts associated with them. Through a process of arguing for and against the two beliefs (I am completely powerless; I am completely worthless), she was able to see that these specific feelings were being generalised from the trauma and that there parts of her that did not believe it (see Appendix C). She was also able to verbalise how her current boyfriend intensifies her feelings of worthlessness and powerlessness in that he does not listen to her needs within the relationship and does not show her the love that she feels she needs. She made the connection between these feelings and the current loneliness she was feeling stating, "I depend too much emotionally on my boyfriend and that is why I land up feeling so lonely".

## 4.4 Phase 4: Endings

**(Sessions 7 – 10)**

In session seven, Oratilwe stated that she was feeling hurt and disappointed in Nomhle as she (Nomhle) had told her other sister Noluthando about the rape even though they had agreed that she would only tell her husband for support. We discussed the various ways that she

could handle this upset in order to regain the tentative support system she had been starting to create. Even though the quantitative results showed marked improvements in all four measures indicating a reduction in both traumatic and depressive symptomatology, I felt as if we had taken a major step backwards and undone the good work achieved thus far. It was only with a gentle reminder from my supervisor that I was again able to re-see the therapy for what it was, a continuous process.

In this session and in session eight we revisited her HIV status and the irrational beliefs surrounding the finding out of her status. She verbalised her greatest fears in finding out were that she would not be able to handle it and that she would die as soon as she found out. Again, I highlighted that knowledge of something could not kill you and that it was the decision of what to do with that knowledge that determined health. I also put words to the fact that knowing did not create the virus and that if she was HIV positive, that would be there whether she knew about it or not. Oratilwe seemed able to connect with what I was saying in a way that she could not on previous occasions. At the end of session eight we rated her anxiety regarding being tested for HIV on a scale from 1 to 100. She stated that when she first came to see me it was 99.9 and but that on that day it was 55. We explored what went into the rating such as heart rate, the way her body felt, and the images in her head. I asked her for the exact images and she said it was a person with full-blown AIDS. I suggested that she find out about possible support groups for people living healthy lives with HIV and to speak to someone who is healthy with HIV.

Sessions nine and ten were a combination of preparing for termination, consolidating the process thus far and re-authoring the narrative through a combination of reliving exposures. Oratilwe arrived 15 minutes late for session nine looking anxious and pale. She reported that she had seen Ken on Saturday and even though he did not see her, she felt like she was spinning out of control again. She had been in a shop in Grahamstown and saw him out of the window crossing the street. He was smiling at the time and she stated that the intrusive image that had haunted her before, of him smiling while he penetrated her, was back and could not be stopped. She landed up drinking a bottle of wine by herself that night and stated that she just wanted to stop thinking about it. She also had no one to talk to about it because she did not trust Nomhle to keep it quiet. She described some faulty thinking that seemed to be maintaining the intrusions which were, “If I get emotional about it, it means that I have gone backwards and I am undoing all the hard work I have done”. She therefore tried to avoid

thinking about it because it made her emotional. This blocking however was resulting in the intrusive images. We did some cognitive restructuring regarding thought blocking and how this was similar to how she had been coping when she first came to see me.

In order to deal with the intrusive material directly we did another reliving focusing specifically on the hotspot that had been activated by seeing him smile – that of Ken smiling when he penetrated her. What became clear in this reliving was that all the thoughts she had described having had such as "my future is ruined forever" and "how could I have been so stupid to go there" were still in place even though she had challenged them in therapy. After the reliving, I commented on this fact and suggested that although the next session was our last session, we should incorporate some re-authoring of the narrative.

We ended the session looking at the anger that had been evoked during the reliving. I asked her to close her eyes and to try and tell him what she wanted to tell him. She was not able to do it straight away so I started for her saying things like "How dare you hurt me in that way?" and "What gave you the right to hurt me like that?". After a while she was able to engage in the exercise and could tell him that he had no right to hurt her like that, which was the first time in my presence that she had truly connected with the deep anger sitting inside her.

Oratilwe arrived for her last session on time appearing slightly cut off and restricted. She commented that she had not had any flashbacks since our last session and she was starting to feel more in control of herself again. Her scores on all four measures (Figures 4, 5, 6, and 7) indicated the further abating of her symptoms. She reported that she had cleared up the issue with Nomhle by text messaging her that she (Nomhle) was not supposed to tell Noluthando and therefore if Noluthando had any questions about the rape, she needed to ask Nomhle and not Oratilwe. She said that although she felt hesitant to engage fully with her, she felt better about the situation.

We started the reliving again but this time I actively commented at points when her new ways of thinking needed to be integrated. She was somewhat cut off in the telling and although accepted the points, did not engage with the emotionally laden material. I commented on this vacancy to her and she admitted that she was finding it difficult to get into it because she knew it was our last session. I could feel my own panic rising – we had so much still to do, she was not finished, just a few more sessions were needed. I had to consciously bring my

focus back to the point that this was a process that I had to, for practical reasons, pass on to someone else. We then spoke about the difficulty of ending when things were feeling unfinished and her anxiety around seeing someone else the next year. We also reflected on her worst parts and best parts of therapy and she stated that they had been the same – telling her story and having someone listen and understand. I was filled suddenly by an overwhelming awe for this young girl. For her to acknowledge that that had been the most helpful part was a testament to her inner resources and soul's knowledge. Although we did not know her HIV status, and some of the cognitive distortions of the rape were still in place, I felt as if we had travelled this part of her journey together successfully and that however her life unfolded from here, it would be better for what had happened.

## Figures 4.2 – 4.5

## Oratilwe's responses on the self-report questionnaires

**Figure 4.2**
*Beck Depression Inventory*

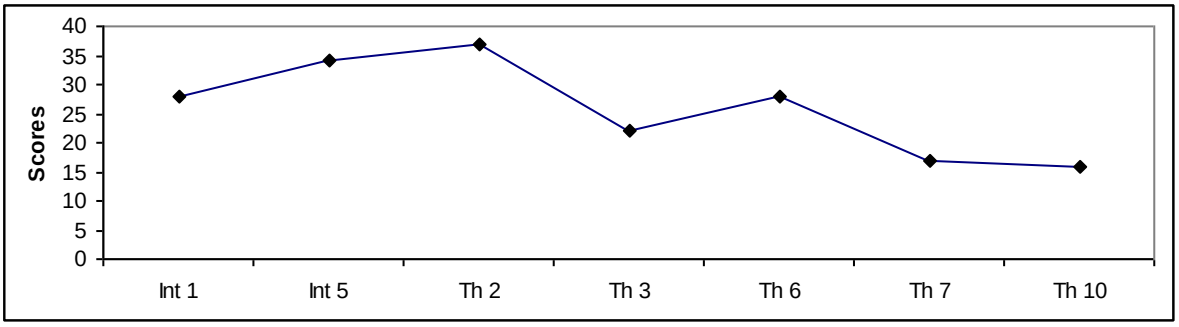



**Figure 4.3**
*Posttraumatic Diagnostic Scale*

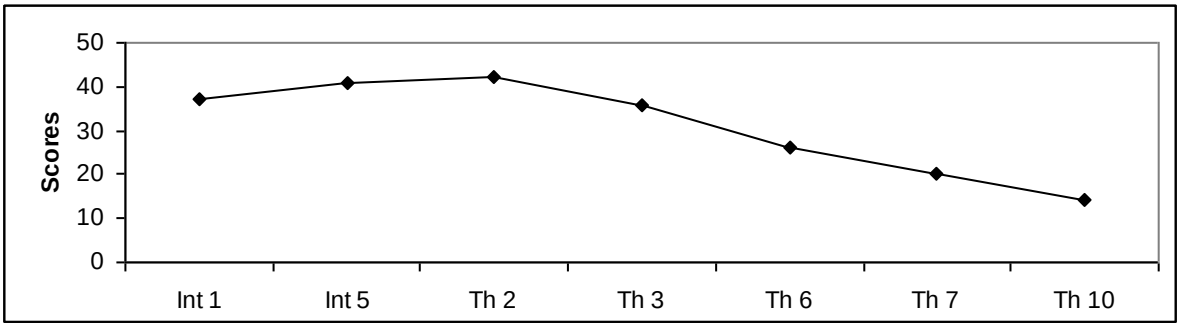



**Figure 4.4**
*Beck Anxiety Inventory*

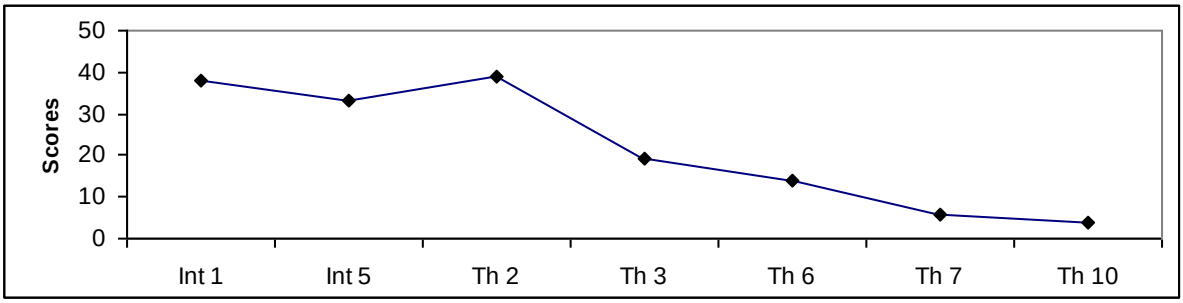
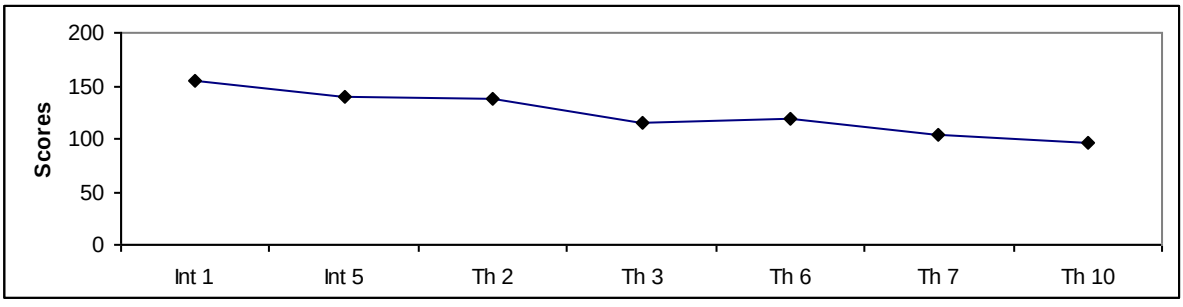



**Figure 4.5**
*Posttraumatic Cognitions Inventory*



# CHAPTER V

# Interpretation and Discussion

As my therapy with Oratilwe was a full and rich experience, so too was the ensuing material I analysed. Through the use of an interpretive phenomenological process of analysis (Smith & Osborn, 2003), the narrative was interrogated with the following questions, to provide a sound and comprehensive interpretation. Firstly, the overarching question regarding the effectiveness of the Ehlers and Clark (2000) model for treating PTSD in a rape survivor can be broken down into the following sub-questions: (1) Do the procedures for assessment offer anything different from other standard procedures? (2) What is the benefit of the model in terms of conceptualisation and formulation? (3) How does the material from the therapy process inform one's understanding of the model's effectiveness? (4) What issues (if any) came up in the course of the treatment that could have affected the transportability of the model? Secondly, questions regarding contextual factors that could hinder effectiveness were developed enquiring specifically into issues such as the HIV/AIDS epidemic in South Africa, language barriers and cultural diversity. Lastly, possible limitations in both the clinical and research methodology were sought after in order to comment on the generalisability of the conclusions made in this study.

## 5.1 The Assessment Procedure

Ehlers and Clark's (2000) model offers two components to the assessment procedure which makes it unique, namely the line of enquiry and the reliving exposure. The primary focus on formulating the case resulted in asking specific questions regarding the appraisal of the trauma, current coping mechanisms, beliefs about self and/or the trauma and hotspots of memory rather than just on family background and relationship history. For example, questions such as "What are the worst things about the trauma or the most painful moments?" or "What do you think is the best way of coping with the trauma?" shed light on important aspects that would be dealt with in the treatment process.

The reliving that occurred in the assessment phase proved to be very useful to the treatment as a whole. Not only were there huge amounts of information gleaned from the process, but also it significantly impacted on the therapeutic alliance, Oratilwe's own feelings of being heard and my own feelings of understanding her experience before officially starting the therapy. In

addition, it provided an important behavioural experiment to test one of her appraisals that she would go mad or die if she thought about the rape in that much detail (Ehlers & Clark, 2000).

## 5.2 Formulation

A primary component of Ehlers and Clark's (2000) model for treating PTSD is the way in which the case is formulated in order to generate an individually specific treatment plan. Strong evidence for the comprehensiveness of the formulation is in the fact that the treatment plan developed after the assessment, did not deviate substantially throughout the treatment process. There was, however, a process of extending the initial formulation in terms of deepening an understanding of both the precipitating and maintaining factors.

The way Ehlers and Clark (2000) set out the formulation of the case is both practical and flexible as the therapist is given a guide to frame the conceptualisation, and also various techniques to meet this end. For example, dividing the assessment information into the different headings (see section 4.1.2) allows one to challenge specific appraisal and target the underlying beliefs. It is also important to note that the strategies suggested by Ehlers and Clark (2000) are standard Cognitive Therapy techniques but they can be used more specifically due to the clarity of the conceptualisation. The following is an extension of the formulation written after the assessment and includes all information gleaned from Oratilwe and the process as a whole.

### 5.2.1 Predisposing Factors

The understanding of the predisposing factors did not change significantly in the course of our therapy. It was still thought that Oratilwe had unconditional schemas of mistrust or abuse, emotional deprivation and defectiveness or shame due to her harsh, cold and often punitive early childhood experiences. Her conditional schemas of subjugation and excessive compliance gave her strategies to avoid activating the unconditional schemas and acquire some sense of self. This culminated in a life strategy of denying her own feelings and needs and suppressing unwanted emotions such as anger in order to gain acceptance and most importantly, guard against feelings of shame, emotional deprivation and abuse.

Further evidence was added to this understanding through her description of two significant relationships – with her current boyfriend and her eldest sister Nomhle. In both of these relationships, Oratilwe demonstrated that she believed their needs were more important than

her own and that showing any negative emotion (such as anger) would result in the loss of their love. When questioned what it would mean to her if they were unhappy with her she stated that it would be further evidence that she was unworthy of love. An added component to her relationship with her boyfriend was the difficulty she was experiencing in trusting him. Although this fitted with her belief of 'men cannot be trusted' it would also seem from her relationship history that she was choosing men that provided 'proof' for her core schema of mistrust or abuse and that he could in fact be cheating on her.

### 5.2.2 Precipitating Factors

Although the rape was the main precipitating event, it was the particular events within it and the related appraisals that served to create and maintain the PTSD. Thus, this part of the formulation evolved with the gaining of understanding throughout the therapy process.

During the rape, Oratilwe had four main faulty appraisals: (1) her feelings of excitement in her body she perceived as a warning that the rape was going to happen, (2) by saying "you can do it… on top" he might have thought she was giving him permission, (3) by trying to protect herself (by kicking him) she allowed him to penetrate her, and (4) she thought that she had no future now that she had been raped. These faulty appraisals resulted in feelings of internal shame, guilt and hopelessness and tapped into her core schemas mentioned above. Beliefs such as "It was my fault it happened – I must have done something or acted in a way that made him treat me like that" and "I am unworthy of love" can be seen as a result of the defective schema, while "Men cannot be trusted" and "The rape was punishment for disobeying my parents" is part of the mistrust or abuse schema. The conditional schemas of subjugation and excessive compliance would account for her beliefs that she could have done something to prevent what had happened and that she was a helpless person.

### 5.2.3 Maintaining factors

The question that needs to be asked at this point is how does one understand the fact that Oratilwe developed chronic PTSD? It is argued that the combination of avoidance of the trauma material for two years, the resultant lack of social support, feelings of hopelessness, the reactivation of maladaptive schemas and the faulty appraisals she held of the event all added to the creation and maintenance of her PTSD. Although some of these factors were known at the end of the assessment process, the understanding of the cycle of creation and maintenance deepened during the therapy, examples of which will be discussed below.

### *xvii. Social Support*

The strength of these maladaptive schemas can be seen by the fact that she did not report the rape to the police nor tell anyone for two years. The risk of showing her perceived defectiveness and the core belief that this was what she ultimately deserved lead to her extreme avoidance and denial of what had really happened. This avoidance developed and maintained her PTSD in two ways. Firstly, by avoiding thinking about the rape and therefore not processing it for two years, she kept the memory unelaborated and inadequately integrated into her autobiographical memory which, as Brewin and Holmes (2003) explain, results in involuntary recall. Secondly, by not telling anyone about the rape, she not only created her own isolation, she denied herself any kind of social support which increases one's risk for developing PTSD (Brewin & Holmes, 2003).

After the assessment, the isolation that Oratilwe was living with was clear. She not only felt different to how she used to feel but she also felt radically different to her peer group. This resulted in her having very little social interaction with others on a superficial basis which left her feeling lonely and intensified feelings of worthlessness. It was formulated that her social isolation was primarily causing and maintaining her depression, which in turn intensified her PTSD symptomatology. However, at this point no direct link was evident. It was only around the time of the third and fourth therapy session that I realised how the lack of social support was directly creating and maintaining her PTSD. We were working with two separate maintaining factors – her uncertainty around her HIV status and her sense of powerlessness regarding seeking justice for what Ken did. In strategising how we could deal with these two aspects, it became apparent that in order to do the things she would need to do – go for an HIV test or tell his parents about what he did – she would need a very strong network of support. As no one in her world knew about the rape, this need had no way of being met. It therefore became essential for her to tell a supportive other person, in order to move the therapy forward and start breaking the cycle of isolation that was maintaining the PTSD.

### *xviii. The permanence of change*

After the assessment, my understanding was that her negative appraisal of the permanence of the trauma's consequences, that she was "not the same Oratilwe", added to her feelings of hopelessness and depression. My strategy for dealing with this was to challenge the truth of this perception and to generate alternative statements that would reflect a more realistic perspective. This plan of action however was brought into question in the sixth session of

therapy. When she told Nomhle, her sister, that she had been raped, her (Nomhle's) reaction was that she had known something had happened because after that December "Oratilwe was just not the same Oratilwe". It was only then that I appreciated the fact that Oratilwe's feeling of being a different person was not just an internal feeling of being changed but was to some degree an external reality. I subsequently saw the futility in trying to challenge the appraisal that she was different. The reality was that she was different – the challenge therefore was to grow from the adversity (Joseph & Williams, 2005) rather than to stay in this place of in between who she was and who she could be.

### *xix. Past experience, maladaptive schemas and the trauma material*

As mentioned above, one of Oratilwe's maladaptive schemas was of mistrust and abuse stemming from the harsh and often abusive treatment she received from both her father and mother. Oratilwe related an experience during the intake assessment of her father beating her for breaking his new radio when she knew that it had been bought broken. She reported that she knew if she argued with him or told him what she thought it would only make it worse so she just submitted to the beating. In the reliving part of the assessment, Oratilwe described how Ken had caught her leg and thus penetrated her, and how she felt that by trying to protect herself she had caused him to hurt her. This fits in with her maladaptive schema based on her past experience as she equated protecting herself with initiating more hurt. Although both of these pieces were known after the assessment phase, it was only when the hotspot came up again in session five that the way they interacted became clear. This points to the need to continue the process of formulation throughout the course of therapy, even without incoming new material, as it is possible that one misses certain levels of connection.

## 5.3 The Treatment Process

The analysis of the treatment process with Oratilwe (Smith & Osborn, 2003) yielded a number of significant themes, which need to be explored in this section. Firstly, broad issues such as the debate around using manualised treatments and the usefulness of Ehlers and Clark's (2000) model in making decisions will be discussed, drawing on pertinent points from the relevant literature. Secondly, aspects regarding the use of imagery will be discussed, further demonstrating the strength of the model. In addition, factors surrounding the process of taking the step to return to normal functioning will be discussed with a view to plotting out what direction the therapy could have taken should it have continued. Lastly, some issues

regarding the interpersonal dynamics within the therapy process will be highlighted and explored in more depth.

### 5.3.1 Prescription versus Flexibility

A pertinent debate exists in the literature regarding the use of manualised treatments and the possible limitations that they might have (Edwards, 2006). In its worst form, manualised treatments can be a prescriptive formula or "cookbook" approach that is applied verbatim with little or no involvement of the clinician, rendering it inflexible and limited (Addis as cited in Najavits, Weiss, Shaw, & Dierberger 2000). This, however, is a shortcoming of both the specific manual as well as the clinician applying it. In its best form, manuals can provide a guideline and a set of possible tools to aid the clinician in applying the skills that he/she has been trained in, to provide a well-researched and effective treatment. In their study researching cognitive-behavioural therapists' view of using treatment manuals, Najavits et al. (2000), found a very positive view of manuals existed and that they were extensively used with few concerns. In addition they found that the 'ideal' manual had practical advice, had more of it rather than less and had features that made it user friendly (such as illustrations).

In this therapy process, the Ehlers and Clark (2000) model was found to be a flexible guide to dealing with PTSD. Although it has not been formulated into an official manual, it draws on an eclectic mix of different therapy techniques from existing manuals such as Resick and Schnicke's CPT, Foa and Rothbaum's manual and many other individual cognitive practices in order to deal with the material targeted through the comprehensive assessment process.

Following on from the point above, is the way in which the model or any manual for that matter is applied. It was my experience that although the model provided guidelines, the clinical decisions that needed to be made regarding the specifics of the case had to occur through supervision and the therapist's own reflective process. The answers to most of these questions were not in the manual pointing to the fact that it is not just a 'cookbook' of instructions that anyone can apply and that adequate training and supervision is needed in order for the therapy to be effective.

### 5.3.2 Reliving and the use of imagery

Ehlers and Clark (2000) offer specific techniques regarding the use of imagery such as shortened reliving focussing specifically on hotspots and rescripting of certain hotspots.

### *xx. Hotspots*

Using shortened reliving exposures focusing specifically on the hotspots of the trauma, as suggested by Ehlers and Clark (2000), proved to be beneficial in this case in two ways. Firstly, the exposure to extremely anxiety provoking material is limited thus the reliving is made more manageable and less overwhelming. Oratilwe's comment in reflecting on the best and worst parts of the therapy shows the benefit of the manageable exposures as she reported, "it was the hardest part but also the most helpful". Another benefit of short focused reliving is from a time perspective. Reliving the whole narrative could take up a full session thereby leaving little time to process it and focus on the appraisals and emotions of the important hotspots. In this case, we were able to get through the underlying meaning of two or three hotspots in one therapy session thereby increasing both the speed of processing as well as efficiency of the treatment.

### *xxi. Rescripting*

The reliving provided an opportunity to use imagery rescripting and reconstruct some of the narrative thus altering the generalised beliefs of worthlessness and powerlessness, which the trauma had activated. This type of technique is suggested by Ehlers et al. (2005) and the significance of such a strategy can be seen in phase 3 of the therapeutic process. By therapy session six, Oratilwe's intrusions were still occurring two to three times per week and were impacting significantly on her functioning. As the reliving and processing of the session before did not seem to be making a significant difference, the clinical decision was made to deal directly with these intrusions through a focused reliving and to try imagery rescripting to alleviate her pervasive feelings of powerlessness and worthlessness. Oratilwe was able to imagine pushing the rapist off her and protecting herself with both her actions and her words. This self-empowering and nurturing image did not change the fact that she had been in a powerless position, rather, it gave her a *feeling* of her existing power and worth. In so doing, both the trauma material as well as her core maladaptive schemas were challenged (Smucker, Dancu, Foa, & Niederee, 1995). By getting in touch with the emotions through image rather than cognition, she engaged on a different level of processing the traumatic experience, which helped to eliminate those particular hotspots (Edwards, 1990).

### *xxii. Shame and guilt*

Another important issue that emerged during the course of therapy was the need to work directly with Oratilwe's feelings of guilt and internal shame. Lee et al. (2001) caution that

there is a risk in doing reliving with an individual whose underlying emotions are those of shame and guilt as the exposure often activates these emotions thereby inhibiting processing. The example from the narrative, of Oratilwe's guilt and internal shame over being sexually excited and saying that Ken could "do it", adds further support to Lee at al.'s (2001) argument that the therapist needs to deal directly with emotions of shame and guilt in order to resolve PTSD symptomatology. It was only when she was able to articulate her guilt at having said those words and have me, as her expert-mentor tell her in no uncertain terms that it was not her fault, that Oratilwe could begin to resolve that particular hotspot. Oratilwe's shame was more difficult to deal with as she felt that the excitement in her body was evidence of her defectiveness rather than a normal reaction to her boyfriend touching her. Through normalising her reaction in terms of separating her sexual excitement from what happened afterwards, Oratilwe was able to release that specific hotspot. After this reliving, this particular hotspot was eliminated. It is hypothesized that a strong therapeutic relationship is needed in order to hold these kinds of emotions and so perhaps the deeper layers of guilt and shame may not come out in the assessment phase but only during the progression of therapy.

### 5.3.3 'Reclaiming one's life' with uncertainty

Ehlers and Clark (2000) argue that after a trauma, individuals struggling with the 'here and now' sense that intrusions create, often feel as if their life is stuck at the time of the trauma. In addition, the person may give up social interaction or other significant activities that are important to them due to either feeling disconnected from the world around them or as in Oratilwe's case, feeling the burden of the 'dirty secret'. Ehlers and Clark (2000) therefore propose that part of the therapeutic endeavour is to provide the patient with active strategies in order to reengage in the world around them thus reclaiming parts of their former self. This is a unique part of this model as it takes an active step in confronting not just the internal components maintaining the PTSD but looks further into the external world of the patient.

Oratilwe made an important step towards reclaiming her life when she told her sister about the rape. In doing so, she took a firm stand against her own avoidance of the truth of the situation and bravely confronted someone in her world knowing her darkest secret. Thus, she took her first step out of her self-created isolation and back into the world that 'the old Oratilwe' inhabited.

This reclaiming of one's life, however, is made more complicated when there is uncertainty around an individual's HIV status. Oratilwe's strategy of living her life *as if* she were HIV positive served to reinforce feelings or hopelessness and therefore intensified her feelings of depression. Her PTSD symptoms, which were maintained in part by her social isolation, then increased resulting in more distress. The difficulty however is in the fact that if she was HIV positive and was *not* living safely, her health as well as her partner's could be compromised. This uncertainty thus provided a stumbling block in the progression of reengagement, for she was unable to reclaim her life without knowing what kind of life she would have to reclaim. It is suggested that should the therapy have continued for another six sessions, Oratilwe's avoidance of finding out her HIV status could have been overcome as well as her fear of disclosing the rape to the rest of her family thereby aiding her reclaiming of her own life.

### 5.3.4 Interpersonal Dynamics

Although it is difficult to separate the therapy process from that of an interpersonal one, there are aspects that one can tease apart in order to further explain the importance of this case.

#### *xxiii. The relationship*

In writing about the therapeutic alliance, Safran and Muran (2000) argue that an 'alliance' provides a guide to develop an understanding of what a particular therapeutic task means to a particular patient in a given moment rather than using "an inflexible and idealized criterion such as therapeutic neutrality" (p. 14). In all therapeutic work the type of alliance that is formed is of the utmost importance to the success of the intervention (Safran & Muran, 2000). However, in trauma work specifically, due to the fact that the individual's sense of who they are in the world is often in flux (Eagle, 2004), the therapist needs to find a balance between being a strong authoritative mentor and at the same time empower the individual to lead their own life.

In my therapy with Oratilwe, I sometimes found it difficult to balance these two sides as the guilt and shame that she was dealing with (or avoiding) on a daily basis activated deeper core beliefs of powerlessness and worthlessness. This therefore created a situation whereby the authoritative expert could play into her beliefs of her own helplessness and serve to reinforce them rather than disconfirm them. For example, when I suggested that we set a deadline for her to go for an HIV test she appeared anxious, scared and above all trapped. In addition to

exploring her anxiety around finding out her status, I also questioned specifically how she felt about me making that suggestion thereby opening the space for her to voice any feelings of being threatened by me. I felt in that instant that this was not the time to use my authority with her, as she had no social support and therefore the action would increase her dependence on me and possibly lead to more feelings of powerlessness. Instead, a strategic decision was made to create a support outside of the room and make the decision regarding checking her HIV status empowering rather than traumatic.

### *xxiv. Using the self as an instrument*

It is widely accepted that the therapist's own feelings in relation to the therapeutic relationship can provide valuable information regarding the patient's experiences as well as provide a sound therapeutic tool to deal with difficult emotional content (Safran & Muran, 2000). In this case, it was through this interpersonal process that Oratilwe was able to get in touch with and articulate her anger thereby turning it from a helpless rage into an empowering force. As was stated in the narrative, although Oratilwe could share the content of her anger quite easily, she had difficulty accessing the emotive quality of her rage. I, however, felt the full force of it and although it may have been partly my own response to someone having been hurt, the extent to which I felt it was not my own.

With reflection and the supervision process, I was able to slowly feed this anger back to Oratilwe with a shape and form that she was unable to give it. This started in the assessment reliving where I reflected for the first time how I felt anger when she spoke even though she did not seem to be feeling it. In the third therapy session, anger featured in me again but this time it was combined with a powerless feeling. It cued me to suggesting a way for her to start expressing her anger in an empowering way helping her to see the positive benefit of anger and to possibly reframe it. In therapy session six the reliving and rescripting brought up the anger in me again although she was unable to get in touch with it. I asked her to access that anger when confronting him in her imagination but she needed me to put words to it as it still felt too difficult. Finally in session 10, when the anger welled in me after the reliving, she was able, with a bit of prompting from me, to finally get in touch with her anger and say to him that he had no right to hurt her in that way. In this process, we changed her unexpressed rage from helpless to powerful.

The last point which I wish to reflect on in terms of the therapist's self as a tool, has to do with the writing up process of this therapy. As mentioned in the narrative section, on first presentation, Oratilwe was completely dissociated from the horrifying emotions of her trauma. Even though I found this disconcerting at first, there was also a part of me which felt relief that I did not have to feel the deepest aspects of her pain just yet. Although the therapy progressed and she became more in touch with her emotions and I, as her witness, felt her pain, terror, and shame in equal force, I still felt able to hold it and tolerate it. However, when transcribing some of the sessions in this writing up process, the pain of her experience and the utter sense of betrayal she felt threatened to overwhelm me. My first feeling was horror - that someone she loved could have done this to her. My next was the physical pain she must have felt and lastly I was left with the powerlessness and helplessness she felt when her strongest and most powerful words of "I hate you" and "Please stop - I don't want to do this" did not work.

There are two possible hypotheses to explain this occurrence. Firstly, it is possible that what I was feeling was my own and was being evoked by her but was primarily about how I was feeling. As this did not happen in the room and nothing significant had changed between the time of the therapy and the writing up process this hypothesis seems unlikely. The second possibility is that the pain and horror that she felt at the time was too difficult for her to bear and that through a process of projective identification (Edwards & Jacobs, 2003) I began to carry it. The fact that I did not feel the full intensity in the room could have to do with her need for me to not get in touch with the full horror and that my feelings in listening to it afterwards, are an indication of work that is still needing to be done. Another component to this is the fact that I had just found out that Oratilwe was not continuing with therapy. My worry for her well-being and the unfinished nature of our therapy could therefore have compounded my own feelings of pain for this woman.

This phenomenon has implications for the research and clinical methodology of this study. In the normal course of a therapy I would not necessarily have had the experience of re-listening to parts of it after the completion of the therapy and would therefore not have picked up the unfinished 'stuff'. The question that needs to be asked is "Did I miss it within the course of the therapy because of my own fear of being witness to such pain or was it a necessary part of the process that would have eventually been picked up should the therapy have continued?"

The answer to this question is inconclusive which does not invalidate the need to ask this important question.

## 5.4 Evaluation of the model's effectiveness

There are three ways in which this model's effectiveness could be evaluated, namely through looking at the qualitative material, mapping out the quantitative results and exploring any problems with transportability. As the previous sections focus specifically on the qualitative material, this section will deal with both the quantitative results and the transportability of the model to show the effectiveness of the Ehlers and Clark (2000) treatment. Furthermore, it is important at this point to discuss the fact that the therapy was incomplete and to explore what implications this may have had on measuring the effectiveness of the model.

### 5.4.1 Quantitative measures

The quantitative measures give some graphic indication of the resolution of certain symptoms which, if attributed to treatment effect, can provide strong evidence for the effectiveness of the model. Dealing directly with treatment effect, although one can only hypothesize about external factors, the fact that her symptoms did not remit in two years is strong evidence for the fact that without this treatment her levels of depression and PTSD would be similar to her starting levels if not the same.

#### *xxv. PTSD Symptomatology*

As can be seen in the graphical representations (Figures 4.3 – 4.5), Oratilwe's scores at the start of the assessment, on the PDS, BAI and PTCI are all in the clinically significant range (Beck & Steer, 1993; Foa et al., 1997; Foa et al., 1999) and yet by the end of therapy, her anxiety, posttraumatic stress disorder symptoms and cognitions had reduced to such an extent that she no longer met the paper criteria for PTSD. This reduction cannot conclusively be attributed to the treatment alone, but due to the fact that her quantitative results were in line with qualitative experiences, the evidence is sufficient to draw this conclusion.

The graphs indicate that there were two significant points in the changing of her PTSD symptomatology in the course of treatment. The sharp increase, reflected most prominently in the BAI, was seen between the last assessment session and the second therapy session. It is argued that the process of confronting such difficult material after it had been avoided for so long increased both the awareness of the symptoms as well as the resultant anxiety. An

anomaly in this representation is the decrease in her PTCI scores which could be explained by the cognitive working through of guilt related material that took place in therapy session one. The next significant point is the reduction in scores from therapy session two to therapy session three. The dramatic decrease in her BAI scores may indicate a lowering in general anxiety symptoms rather than the specific PTSD symptoms which seem to decrease at a more gradual pace. It would seem that the containment she received in the session after her suicide attempt provided a holding enough experience to allow herself to confront and start to process some of the traumatic material.

#### *xxvi. Depression*

As with the PTSD symptoms, Oratilwe's depression scores (Figure 4.2)were in the significant range indicating severe depression symptomatology (Beck et al., 1996). They increased steadily over the course of the assessment and then again between the last intake session and the second therapy session. The dramatic reduction that can be seen between therapy session two and three is again argued to be due to the containment that session two offered. In addition, the abatement of symptoms could be due to the fact that the session dealt specifically with such issues as hopelessness and social isolation which were serving to maintain both aspects of the depression and the PTSD. Unlike the PTSD measures, the depression scores increase again between therapy sessions five and six. This is a slightly unexpected phenomenon as one would imagine that with the disclosure of the rape to her sister, her feelings of isolation and loneliness would decrease and therefore the overall scores would indicate this. However, this difference can be explained by the reliving that occurred after the session with her sister. In engaging with the trauma material, although habituating to the anxiety component, the deeper meanings of loss and sadness were accessed and thus felt to a greater extent. After session six, although the depression scores decrease, they never reach below significance (Beck et al., 1996) therefore indicating that Oratilwe was most likely still suffering from depression.

### 5.4.2 Evaluation of the status of therapy at termination

As stated previously in this study, at the point of termination, the therapy with Oratilwe was unfinished due to the clinician's internship coming to an end. However, a benefit of the model is that due to the focus on formulation, another therapist taking over would be able to quickly grasp the complexity of the case and carry on with the existing treatment plan. The following

were issues that still needed to be resolved and possible ways in which they could be dealt with:

- *Social support:* The rest of the family needed to be told about the trauma to facilitate in the reduction of other maintaining factors (such as clarifying HIV status)
- *HIV status:* This needed to be clarified and the necessary steps taken in the therapy is she found out that she was HIV positive. This could have comprised of a combination of psychoeducation as well as an extension of the challenging of the faulty appraisals surrounding this situation.
- *Intrusive thoughts:* As they were still occurring once a week, more work needed to be done in specifically targeting any remaining hotspots and adding in a further element of exploring the related triggers.
- *Lack of integration of new appraisals into trauma memory:* Further integration needed to take place in order to ensure longer lasting results of the abatement of symptoms.
- *Linking past experiences, maladaptive schemas and trauma material:* Although this was started in the therapy process, more work needed to be done regarding the dealing with maladaptive schemas.
- *Dysfunctional relationship patterns:* Oratilwe's choices regarding intimate partners appeared to be questionable and therefore more time was needed to explore the root of these choices and work on changing the existing patterns.
- *Depressive symptoms:* Although this could have decreased organically through dealing with the other factors listed above, a continuation of challenging negative appraisals and focusing on maintaining factors of hopelessness needed to be done to further decrease the depressive symptomatology.

Although the premature termination had clinical implications for this case, it is not a limiting factor in terms of the research as there was enough material from the therapy that did take place to effectively evaluate the model.

### 5.4.3 Transportability

The transportability of the Ehlers and Clark (2000) model to other settings and countries has not been widely researched. The study conducted by Gillespie et al. (2002) on the treatments with the Omagh bombing survivors, seems to be one of the only published articles which looks specifically at how this model can be applied out of a research setting into a frontline clinical service. Although completely different in design, this case study adds further evidence

that the Ehlers and Clark (2000) model can be applied efficiently and effectively in different settings and in fact in different countries. The results from this treatment process therefore, add weight to the findings cited in the current literature and provides further evidence of the effectiveness of Ehlers and Clark's (2000) treatment model (Ehlers et al., 2005; Gillespie et al., 2002).

Schoenwald and Hoagwood (as cited in Edwards, 2005c) mentions that transportability problems surface from four causes: (1) insufficient training of the therapist, (2) insufficient resources, (3) poorly selected patient populations and (4) failure to consider cultural and contextual factors. The fact that these were not factors in this research adds further evidence to the transportability of the model. As the issue of cultural and contextual factors is more complex, it will be discussed in more detail in the following section.

## 5.5 Contextualising the Research

An important aim for this research was to examine the contextual factors that could possibly affect the effectiveness of this treatment. The following are a result of interrogating the data with this question in mind.

### 5.5.1 HIV/AIDS

Although HIV/AIDS is not unique to South Africa, according to N. Ridgard (personal communication, January 26, 2006) this country is one of the top two contenders for the highest incidence (actual amount) of people suffering with HIV/AIDS in the world. In a study conducted by the HSRC (2005) it was found that approximately 10.8% of our population are HIV positive and that women were four times more likely to be HIV positive than their male counterparts. In addition, they stated that the largest increase in HIV infections were in women between the ages of 15 and 24. Kalichman and Simbayi (2004) investigated the factors related to risks for sexually transmitted infections including HIV, among South African women with a history of sexual assault and found that not only were women who had been sexually assaulted at high risk for contracting the disease *during* the assault (involvement of blood increases risk) but that they were often at risk for HIV in their current sexual relationships.

With this disease in mind, the trauma of rape takes on a new dimension as the risk to the individual's life and future well-being is not time limited but possibly ongoing. This type of

threat adds a slightly different slant to PTSD theory as the threat to one's safety is neither a perceived risk nor an external danger. It is a real threat to one's very health and way of being in the world. Added to this is the knowledge that this possible 'time-bomb' was planted by the rapist which can serve to intensify feelings of dirtiness, shame and/or anger. Therefore, the awareness of the risk for HIV infection as well as the focus of dealing with both the uncertainty and the reality of this disease, need to be significant components of any treatment with a rape survivor – specifically in a country with so many at risk.

### 5.5.2 Language and Culture

Another factor, which needs to be taken into account when working in our multilingual society, is the possibility of the therapist speaking a different language to his/her patient. Due to its cognitive emphasis, this type of therapy requires a certain level of verbal fluency on the part of the patient and therefore differences in language can pose a problem. Fortunately, this was not the case with Oratilwe as her proficiency in English allowed for more than adequate processing and understanding.

Linked to this possible obstacle, is the issue of cultural diversity. In contemporary South Africa, many clients presenting for counselling with Western trained black and white psychotherapists, have been African people whose worldviews reflect subscription to aspects of traditional African cosmology despite simultaneous engagement with Western healing services (Eagle, 2004). Eagle (2004) discusses the dilemma that conventional African wisdom, as understood by the clients presenting for trauma counselling, appears to be counterproductive for their recovery in terms of western intervention principles. She concludes that although there seems to be a dilemma, with understanding of the issues involved and cultural sensitivity, these aspects and worldviews can be worked with explicitly in the therapy. In my experience with Oratilwe, our cultural differences had negligible bearing on the therapy process. This may indicate that the process of assessment, formulation and treatment that Ehlers and Clark (2000) set up is not culturally biased and can be applied within a range of different frameworks and worldviews.

## 5.6 Research Limitations

As this is only one study standing alone, the findings from it cannot be applied liberally to all situations. What can be said, however, is that the conclusions made can add to a database of knowledge, which can in turn make the findings more generalisable. An important conclusion

to clarify is that of one's culture impacting on the therapeutic process. Although research has shown that culture can have major implications on therapy in general and trauma treatment in particular (Eagle, 2004; Straker, 1994), this research shows that there are people for whom culture has a negligible effect. It is therefore suggested that further research be conducted applying Ehlers and Clark's (2000) model in the South African context to confirm the hypothesis that this model has particular strengths in dealing with cultural diversity.

## 5.7 Conclusion

Through the information discussed above, even though the therapy was not finished, the Ehlers and Clark (2000) model can be seen to be both effective and transportable to the South African context taking into account factors such as the HIV epidemic, language differences and cultural diversity. It is hypothesized that the assessment and formulation intrinsic to this model, which pays such close attention to the phenomenology of the client's experience, renders this a sound and transportable model.

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**APPENDICES**

**Appendix A**

# Are you a survivor of a sexual assault or rape?

## Are you still suffering from some of these symptoms:

- ❒ **Flashbacks or dreams of the incident**
- ❒ **Feelings of being overwhelmed**
- ❒ **Problems with sleeping and/or eating**
- ❒ **Feeling numb or cut off**
- ❒ **Feeling anxious a lot of the time**

***If you answered yes to these questions and you would like someone to help you deal with these feelings please contact:***

**Amy (an Intern Psychologist)**
**at Fort England Hospital**
**046 622 7003 (ex 260)**

[As the treatment is contributing to research, there will be no charge for treatment and transportation costs can be covered]

## Appendix B

It was after Christmas and he asked her to go over to his aunt's house. They were sitting in the lounge watching cricket and then started watching a music concert. He started fondling her – touching her face and wanting to kiss her and she said that it was okay because that was something that they had done before. He then went to have a bath and came back with just a towel on. He went into his bedroom and then told her to come in because he did not want her to think that he was neglecting her. He continued fondling her and tried to take off her top. She said that she did not want to have sex and he said that they would just do it on top. She said okay we can do it on top and he undressed her. As they were lying on the bed kissing, he started becoming rougher and held her hands at her sides. She asked him what he was doing but he did not answer her. He then took her underwear off and she started to get worried. She tried to push him off her but he seemed to get even stronger and when she tried to kick him off he penetrated her. She begged him to stop and to get off but he continued. While she was crying and saying that she hated him and that he must stop he smiled at her and seemed to enjoy himself even more. He tried to fondle her breasts and kiss her and when she begged him to stop towards the end he whispered to her: "please baby, just let me ejaculate. Eventually when he was finished, she was able to push him off. He wiped away her tears tried to kiss her again but she would not let her. She felt something wet coming out of herself and saw that she was bleeding. When she told him that she was bleeding he replied in a disgusted manner "just clean up your mess" as there was blood on the sheets. He then went to go and bath again and after a few minutes she took her clothes and the dirty sheet and went to bathroom. She had a quick bath and then washed the sheets. As she was watching the blood wash off the sheets she felt that that was her life and all her dreams just washing away. She dressed and went to hang the sheet inside. She could not leave the house without him letting her out so she had to ask him to open the door. On the walk home, all she could think about was how excited she had been to go and be alone with him and how she regretted it so much now. She thought about going to the police but realised that she had washed away all the evidence and did not think that they would believe her. When she got home she went into her room and went to sleep trying to pretend that it never happened. She reported that for months afterwards she felt cut off from what was going on in the world around her as well as herself saying that she did not feel real. She said that she saw him a week later and he seemed so proud of himself – he brushed his private parts when he saw her.

## Appendix C

Powerlessness

We went back to how she felt powerless with her current boyfriend and I reflected how the powerlessness she felt from the rape was being brought into her present relationships. We then went through the proof for and against the fact that she was powerless in her life.

| For | Against |
|---|---|
| She is not taken seriously (by her boyfriends) | Everyone else takes her seriously |
| Plans that she makes do not work out | She is taking short courses and ultimately has made decisions regarding her future |
| She cannot control how late she goes out etc. | She is choosing to respect her parents |
| | She is confronting things that are hard |
| | She is coming to therapy |

Worthlessness

We looked at when the feeling of worthlessness felt the most intense during the rape:

→ when he was looking at her with cold eyes

→ when he told her to clean up her mess

We then discussed the proof for against the fact that she is indeed worthless in her life:

| For | Against |
|---|---|
| Boyfriend (and men) does not show her love and respect | Family and friends love and respect her |
| The rape | She is helpful |
| | Able to love |
| | There is part of herself which does not feel as if she is worthless |