# The feasibility and acceptability of Prolonged Exposure Therapy for PTSD at a community trauma centre in Cape Town: a qualitative analysis

by

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## Abstract

South Africa deals with pervasive trauma stemming from its history of political violence, high crime rates, and social challenges, ultimately contributing to a significant burden of trauma exposure and post-traumatic stress disorder (PTSD) among its population. Despite the prevalence of PTSD, evidence-based psychological treatments (EBTs) such as Prolonged Exposure Therapy (PE) remain underutilised, particularly in low-resourced areas.

This study aimed to assess the feasibility and acceptability of PE among social workers at The Trauma Centre for Survivors of Violence and Torture in Cape Town.

This study used a qualitative research design, with special emphasis on Implementation Science. The study used the concepts of feasibility and acceptability to guide the research.

The results revealed several key themes. Social workers' pre-implemetation themes included the perceptions around PE and implementation in South Africa, with three sub-themes emerging. First, the impact of South African socioeconomic and political factors on The Trauma Centre. Second, perceptions surrounding the implementation of PE. And finally, the improvements and feasibility of PE; the social worker's post-intervention findings focused on the feasibility and improvement of PE, post-treatment views, and the hurdles and limitations to implementation. The client's post-intervention findings explored refugee struggles, associated psychological distress, with two sub-themes of self-worth and suicidal ideation, and second, a lack of support and helplessness, loneliness, and isolation. The final theme looked at the experiences of PE, more specifically the positive client experiences with PE, and the challenges of PE.

The implementation of PE at The Trauma Centre revealed both successes and challenges. Findings from this study suggest that PE can be effectively administered through task-shifting in low-resource settings. However, this study also highlighted significant challenges in the feasibility of implementing PE long-term in this context. Clients revealed ambivalent feelings regarding PE. Those who experienced positive outcomes demonstrated the potential for PE to be utilised in resource-limited settings. Those who did not find PE beneficial, highlight the need for future research to adapt PE to be culturally specific and feasible for a resource-constrained setting.

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# Chapter 1

# Introduction

## Psychological Trauma in South Africa

South Africa stands out globally, due to its history of political violence, as well as elevated levels of criminal activity, domestic violence, and accidental injury (Edwards, 2005). As a result, trauma survivors make up a significant portion of the population. Similarly, post-traumatic stress disorder (PTSD) is an intricate issue in South Africa, which is a reflection of the nation's complex history and ongoing social and political challenges (Edwards, 2005). Comprehensive studies on prevalence are lacking, particularly in low- and middle-income countries (LMICs), resulting in a large disparity in study results.

While political violence characterised the apartheid era, it is no longer a common feature of South African society. The Truth and Reconciliation Commission (TRC) exposed the extent of political violence during apartheid, encompassing torture, murder of activists, and destruction of property (Kaminer & Eagle, 2010). Although the extremes of apartheid violence are in the past, South Africa still struggles with political violence, partly rooted in its historical struggles (Kaminer & Eagle, 2010).

Altbeker's 2007 study highlighted South Africa's position in worldwide violent crime statistics (as cited in Kaminer & Eagle, 2010). According to the South African Stress and Health Study (SASH) survey, 56% of respondents experienced more than one trauma, and 16% experienced four or five (Kaminer & Eagle, 2010). The country's history of apartheid-state brutality has resulted in a perceived culture of violence, in which violence is considered a primary means of dealing with problems.

Among the few studies conducted, Atwoli et al. (2013) analysed the SASH and found a trauma exposure prevalence rate of 73.8% in a sample of 4 315 adults. Moreover, Koenen et al. (2017) identified a global lifetime PTSD prevalence rate of 3.9%. According to the SASH research, the prevalence of any mental health disorder among South Africans is 30.3%, with PTSD having a lifetime prevalence of 2.3% (Herman et al., 2009), and the majority of the participants (55.6%) reported witnessing or experiencing multiple traumas (Williams et al., 2014). Men were more vulnerable to criminal-related traumas, such as assault or torture,

whereas women reported more traumas associated with intimate relationship violence, such as sexual assault (Williams et al., 2014). As a result, numerous studies have identified PTSD as a substantial public health concern in South Africa (Atwoli et al., 2013; Edwards, 2005; Kagee, Bantjes & Saal, 2017; Koenen et al., 2017; Williams et al., 2014).

If untreated, PTSD can become a chronic and incapacitating disorder, frequently co-occurring with major depression, anxiety, and substance abuse disorders (McLean & Foa, 2011). Rape and indecent assault rates have become especially concerning in South Africa, and it is widely acknowledged that the actual figures may be significantly higher, due to underreporting of sexual crimes (Edwards, 2005). Overall, South Africa has one of the highest rates of trauma and violence globally, with intimate partner violence against women nearly six times the global average (Seedat et al., 2009). In addition, research findings reveal that most South Africans do not experience a single traumatic event; instead, individuals are frequently exposed to multiple traumas (Williams et al., 2014).

The shortage of evidence-based psychological treatments (ESTs) for PTSD and other mental health issues in LMICs highlights a major concern in global mental health. Many LMICs experience a treatment gap in which a large section of the population in need of mental healthcare does not have access to appropriate treatments (Booysen & Kagee, 2023). This disparity is worsened in these locations by a lack of resources, infrastructure, and skilled mental health providers (Chen et al., 2017; Rossouw et al., 2018). To close the treatment gap, efforts must focus on developing culturally sensitive and contextually appropriate ESTs and enhancing the implementation and dissemination of these treatments inside LMICs. In order to promote mental health equity and ensure that effective interventions reach individuals and communities globally, it is imperitive that these concerns be addressed.

**Psychological Interventions for PTSD**

The history of psychological treatments for PTSD illustrates a changing discipline that has achieved great strides in recent years. Most of the treatment programmes with empirical support, fall under the umbrella of cognitive behavioural therapy (CBT) (Foa et al., 2013). CBT has emerged as a fundamental therapy, with this therapy showing the most evidence of efficacy (Barbui et al., 2020).

Prolonged Exposure Therapy (PE) is a well-established cognitive-behavioural therapy that aims to address and process traumatic memories to reduce their emotional impact (McLean & Foa, 2011). It aims to alleviate PTSD symptoms by addressing avoidance behaviours and facilitating the emotional processing of traumatic memories (McLean & Foa, 2011). PE comprises three phases: in vivo exposure, in which patients confront anxiety-provoking situations related to the trauma; imaginal exposure, in which the patients recount the traumatic events; and finally, processing of the imaginal exposure (McLean & Foa, 2011).

Studies have demonstrated that PE effectively reduces the severity of PTSD symptoms, enhances daily functioning, and improves overall well-being (Foa et al., 2019). Given the prevalence of violence and trauma in South Africa, providing trauma-focused treatments is crucial. However, a shortage of specialised healthcare professionals results in treatment delays and renders treatment less accessible (Roussow et al., 2018). Economic, political, and social factors interfere with the implementation of trauma-focused therapies, particularly in LMICs with sociopolitical instability; limited mental health infrastructure, and personnel problems; insufficient funding; a lack of familiarity with mental health concepts, and low literacy rates (Chen et al., 2017). The limited mental health infrastructure in LMICs frequently limits the ability to deliver evidence-based practices (EBPs) solely through trained mental health professionals (Chen et al., 2017).

Furthermore, emphasis is placed on the difficulties that continue to obstruct the effective treatment of PTSD in developing nations. The World Health Organisation (WHO, 2015) has highlighted the difficulty of managing PTSD in LMICs, such as South Africa, where mental health infrastructure is insufficient and qualified specialists are scarce. Furthermore, treatments in settings characterised by persistent adversities, such as poverty, gender-based violence, and high levels of trauma exposure, provide additional challenges (WHO, 2015). Despite these obstacles, empirically supported psychological therapies have grown in prevalence over the last several decades (Hamblen et al., 2019). The WHO recognises psychological therapies as the primary treatment for common mental disorders (CMDs), including PTSD, in LMICs (Singla et al., 2017).

As previously stated, there is a shortage of trained, specialised mental health workers. Studies have pointed to the effective use of a task-shifting strategy. Neuner et al. (2008) conducted a study demonstrating lay counsellors' successful implementation of narrative exposure therapy in southern Uganda (as cited in McLean & Foa, 2011). Similarly, Rossouw

et al. (2018) conducted a randomised controlled trial in Cape Town that focused on task-shifting in treating PTSD among adolescents, with results showing a significant improvement in PTSD symptoms after PE-A treatment. This said, the feasibility of these treatments needs to be examined, as they are predominantly limited to specialised clinics or research settings (McLean & Foa, 2011). Nevertheless, research indicates that community-based clinicians can effectively utilise PE for PTSD when they undergo training and supervision.

This task-shifting approach was central to the current study. Task-shifting is a method that aims to solve the shortage of specialised healthcare professionals by allocating responsibilities to less-specialised healthcare providers (Roussow et al., 2018; Spedding et al., 2014). Under adequate supervision and assistance, this approach recognises that certain jobs can be safely and efficiently handled by individuals with lower levels of expertise or other professional backgrounds (Spedding et al., 2014).

The few randomised controlled trials (RCTs), such as those conducted by Roussow et al. (2018), are preliminary endeavours to assess the efficacy of ESTs such as PE in LMICs. As a result, it is critical to conduct intervention research that analyses and investigates feasibility and acceptability. According to the findings of Neuner et al. (2008) and Rossouw et al. (2018), evidence-based, trauma-focused therapies (TFTs) can successfully reduce PTSD symptoms in resource-constrained settings. Notably, these studies used a task-shifting technique to train non-specialist health workers (NSHWs) to administer treatment, which increased the feasibility of implementation.

**Problem Statement and Rationale**

PTSD is a global mental health concern with considerable public health implications (Koenen et al., 2017). PE has emerged as an effective treatment for PTSD, yet the feasibility and acceptability of applying PE in LMICs with limited mental health resources, remain unknown (Booysen & Kagee, 2020). LMICs present specific challenges, such as a shortage of mental health experts and inadequate infrastructure, which limits access to evidence-based therapies, such as PE (Chen et al., 2017). As a result, new methods are required to close the treatment gap and increase the availability of effective treatments. Task-shifting, a paradigm that involves training non-specialist health professionals to administer mental health treatments, has shown potential in expanding access to mental healthcare in LMICs and

resource-constrained settings (Spedding et al., 2014). Nevertheless, more research is essential to determine task-shifting's feasibility, acceptability, and effectiveness as an implementation approach for PE in LMICs.

The research rationale focused on the need to address the mental health inequities that exist in LMICs, where the burden of PTSD is high and evidence-based therapies such as PE are underutilised. The project aimed to provide insights into the feasibility and acceptability of task-shifting PE at a trauma centre in Cape Town. The findings may help shape the development of culturally sensitive and contextually relevant mental health therapies, ultimately leading to better mental health outcomes in this context. This study not only broadens our understanding of EBTs in various settings but also has the potential to alter mental health care delivery in resource-limited settings.

## Aims of the Study

This study aimed to assess the feasibility and acceptability of PE among social workers at The Trauma Centre for Survivors of Violence and Torture (herein referred to as The Trauma Centre) in Cape Town.

## Research Questions

The following research questions guided the study:

- How did the social workers at The Trauma Centre in Cape Town perceive and experience the feasibility of using PE as a treatment for PTSD?
- What are the perspectives and experiences of the social workers at The Trauma Centre in Cape Town, regarding the acceptability of using PE as a treatment for PTSD?
- How did the clients receiving PE for PTSD perceive and experience the acceptability of this treatment?

## Significance of the Research

The importance of this study stems from its investigation of the feasibility of adopting PE for PTSD at The Trauma Centre, where mental health resources are limited. By addressing this gap, the research intends to provide important insights into the implemention of PE.

Furthermore, the study's emphasis on task-shifting as a method of delivering PE in a resource-constrained context is significant. Task-shifting is a technique used for closing the treatment gap in LMICs. The absence of research addressing task shifting for PE in these resource-constrained settings emphasises this study's novelty and importance. The findings of this study have the potential to influence mental health interventions in these settings, by providing insight into the feasibility and acceptability of task shifting in the implementation of ESTs. Furthermore, this study paves the way for further research, exploring the feasibility of PE in a South African context.

In essence, this research is significant because it addresses the challenges faced by The Trauma Centre in providing adequate mental health care for individuals with PTSD. The study looks for ways to provide more accessible and culturally relevant mental health treatments in environments where they are desperately needed. Ultimately, the significance of this research goes beyond academic enquiry, intending to guide future studies in this topic.

## Thesis Outline

Chapter 1 introduces the context relevant to this study, the problem statement and rationale, the study aims and research questions, and ends with the significance of the research.

Chapter 2 consists of the literature review. This chapter focuses on PTSD, mainly in the South African context. It focuses on prevalence rates and challenges to trauma treatment. Next, this chapter explores exposure treatments, with a focus on PE for PTSD. It investigates the implementation of treatments into LMICs and the challenges faced with this task. Finally, this chapter interrogates task-shifting and how this technique can close the treatment gap. It further explores the challenges of task-shifting.

Chapter 3 details the methods used in the study, including the research design, research questions, research site, sample, recruitment, and inclusion criteria. Then follows an explanation of the data collection and analysis process.

Chapters 4 and 5 present the findings of the research questions and interview analysis. Chapter 4 focuses on the findings from the social workers, and Chapter 5 looks at the client's findings. Chapter 6 discusses the findings found, as laid out in the previous two chapters.

Finally, Chapter 7 explores any recommendations and limitations and concludes the study.

**Chapter Summary**

The above chapter is an introductory chapter that presents the current study by providing the research context, problem statement and rationale. It additionally detailed the aim of the study, which was to investigate the feasibility and acceptability of implementing PE at The Trauma Centre. Furthermore, this chapter emphasised the significance of the study, with the hopes that it will guide future research.

# Chapter 2

# Literature Review

## Chapter Overview

This chapter provides a review of the existing literature that focuses on prolonged exposure therapy (PE), post-traumatic stress disorder (PTSD), and the concept of task-shifting. A systematic approach was used to ensure that all pertinent papers were included in the literature review, focusing on those papers relevant to low- and middle-income countries (LMICs).

The literature was searched for using Google Scholar and the Rhodes University library. Furthermore, the reference lists of relevant articles were searched, for further literature.

This chapter begins by providing a thorough review of PTSD, including the clinical tools used for diagnosis. Next, it explores the prevalence of PTSD in South Africa, drawing on various studies that have documented this information. Subsequently, it explores risk factors for PTSD, followed by an examination of cultural nuances, such as the experiences of refugees on the disorder's presentation. Lastly, it addresses the obstacles that come with treating trauma.

The chapter then focuses on PTSD treatment strategies, with a special emphasis on PE. It examines the development of exposure therapy, offers an in-depth overview of PE, including all of its methods and processes, and examines its efficacy. The chapter further looks at PE implementation and dissemination, emphasising the adaptations required to account for cultural diversity and the unique challenges that come with it.

The final section of the chapter examines the concept of task-shifting in PTSD treatment. It addresses the treatment gap that is particularly pronounced in LMICs. Furthermore, it discusses the efficacy of task-shifting and the challenges and considerations involved in implementing task-shifting approaches in diverse cultural and resource-limited settings.

## 2.1 PTSD Definition

'Trauma' refers to extreme and often catastrophic events that pose a sudden threat to life or physical integrity (Edwards, 2005). Kaminer and Eagle (2010) state that a person must have experienced a traumatic event that involved some form of physical threat and must have elicited a reaction of intense fear, helplessness, or horror. A PTSD diagnosis includes re-experiencing, avoidance and heightened sympathetic arousal, and according to the DSM, a person must experience at least one re-experiencing symptom, three numbing and avoidance symptoms and two sympathetic arousal symptoms (Edwards, 2005). PTSD consists of intrusion, avoidance, arousal, negative cognitions, and mood (Greene et al., 2016). It is characterised by symptoms of recurrent and intrusive distressing recollections of the event, avoidance of stimuli associated with the trauma and increased arousal (Seedat, 2013). It is associated with impaired functioning, high comorbid disorders and physical problems (Greene et al., 2016). PTSD is a disabling condition, and symptoms often result in impaired interpersonal relationships, serious consequences for work, relationships and health, interpersonal and social problems, as well as diminished quality of life and poor health outcomes (Edwards, 2005; Foa et al., 2013). PTSD can be difficult to diagnose, as it is highly comorbid with other mental disorders, evidenced by a survey that found 88% of men and 79% of women with chronic PTSD meet the criteria for at least one other psychiatric diagnosis (Greene et al., 2016). Foa et al. (2013) found comorbid rates between 62%-92%. PTSD has been called a 'lifetime sentence' because of its association with increased risk of chronic disease, accelerated ageing, and premature mortality (Koenen et al., 2017).

## 2.2. Explanations for PTSD

The development and persistence of PTSD are mediated by negative cognitions, such as the belief that "the world is dangerous" and "I am weak and incompetent" (Foa et al., 2019). These cognitions foster avoidance that prevents disconfirmation; effective PTSD treatment should address and correct these negative cognitions by introducing new information (Foa et al., 2019).

Kaminer and Eagle (2010) discuss various factors related to the development of PTSD in trauma survivors. Notably, research outside South Africa indicates that PTSD affects a minority of trauma survivors, with estimates generally not exceeding 25%. Various theories

attempt to explain why certain individuals develop PTSD. Early psychoanalytic theorists proposed that re-experiencing symptoms represents a form of repetition compulsion, an unconscious attempt to achieve mastery over the traumatic event. Others use the concept of 'schemas,' internal cognitive structures, to explain how traumatic experiences may be too alien to be assimilated into existing mental frameworks, resulting in disorganised memories. Cognitive theories find support in brain imaging studies, suggesting that during trauma, high emotional arousal may hinder the proper evaluation and categorisation of information by the hippocampus. Traumatic memories may be stored as fragmented sensory experiences, rather than integrated wholes.

Kaminer and Eagle (2010) also explores factors influencing the risk of developing PTSD, such as the type of trauma. Studies consistently show that violent assault, especially sexual assault, carries a higher risk of PTSD than accidents or natural disasters. Female gender is identified as a significant risk factor, with women being at least twice as likely as men to develop PTSD after trauma. The passage suggests potential explanations for this gender difference, including biological, environmental, and coping-related factors.

Furthermore, Kaminer and Eagle (2010) note differences in brain structure and functioning observed in trauma survivors with PTSD, compared to those without PTSD. Brain imaging reveals a smaller hippocampus and an excessively activated amygdala in PTSD sufferers. There is an ongoing debate about whether these neurobiological features are inherited vulnerabilities predating trauma or develop because of long-term exposure to high stress levels. In conclusion, the passage highlights the complex interplay of psychological, cognitive, and neurobiological factors contributing to the development of PTSD in some trauma survivors.

### 2.3. Prevalence of PTSD

PTSD is a deeply intertwined issue in South Africa, reflecting the country's complex history and ongoing social and political challenges (Edwards, 2005). Comprehensive studies on prevalence, result in varied rates, particularly in low- and middle-income countries (LMICs), resulting in largely inaccurate prevalence rates.

The prevalence of mental health concerns in LMICs is a global issue, as indicated by various studies (Koenen et al., 2017; Yatham et al., 2018). Atwoli et al. (2015) reported a lifetime traumatic event prevalence of 73.8%, while Peltzer et al. (2007) found that 86.2% of their sample experienced at least one traumatic life event, with an average of 3.5 traumatic events per person. In another study, Seedat et al. (2004) revealed that over 80% of 2041 respondents reported lifetime exposure to at least one trauma, with common traumas including witnessing community violence (63%), being robbed, or mugged (35%) and witnessing a family member being hurt or killed (33%). Kaminer and Eagle (2010) noted that 75% of respondents had experienced a traumatic event, with over half facing multiple traumas. In a South African rural setting, a study found that 67% of children had either directly or vicariously encountered a traumatic event, and another study reported that 95% had witnessed violent events, with 56% experiencing violence themselves (Rossouw et al., 2018). This collective evidence underscores the widespread impact of trauma exposure on mental health in LMICs.

Atwoli et al. (2015) identified a lifetime prevalence of 2.3% for PTSD in South Africa. Edwards (2005) conducted a study during the 1990 violence outbreak in Kwa-Zulu Natal and reported notably high PTSD rates, including 87% showing symptoms consistent with PTSD during that period. In addition, 56% of Port Shepstone residents testifying at The Truth and Reconciliation Commission (TRC) still suffered from PTSD a decade or more later, and 35% of domestic violence survivors were diagnosed with PTSD (Edwards, 2005). The reason for the high prevalence could be that these studies focused on the worst trauma, not a random event, where the "focus on the worst traumas overestimates the probability of PTSD associated with the entire class of PTSD-level traumas" (Atwoli et al., 2015, p.4). Greene et al. (2016) reviewed studies with prevalence rates ranging from 2% to 39.1%, with 12.4% meeting PTSD criteria (Peltzer et al., 2007). A study on South African and Kenyan students reported that South African students displayed higher scores across re-experiencing, avoidance, and hyperarousal symptom clusters than Kenyan respondents (Seedat et al., 2004). The South African group (4.9%) showed more PTSD symptoms than their Kenyan counterparts (2.3%), with 22% diagnosed with full PTSD, while 5% of the Kenyan sample received such a diagnosis (Seedat et al., 2004).

In areas affected by political violence and displacement, PTSD prevalence averaged 30.8% (Singla et al., 2017). Estimates in conflict zones varied widely, ranging from 0.2% to

87% (Yatham et al., 2018). According to Seedat (2013), PTSD had one of the highest proportions of severe cases among anxiety disorders, with 36% of individuals with PTSD considered severely ill.

More than 80% of individuals with mental disorders are situated in LMICs (Yatham et al., 2018). Surprisingly, LMICs exhibit lower prevalence rates, compared to some higher-income countries. South Africa, for instance, reported a PTSD prevalence rate of 2.3%, notably lower than rates of 8.8% in Ireland (Atwoli et al., 2015). Atwoli et al. (2015) emphasise that the variation in trauma exposure rates and the prevalence of specific traumatic events globally, is influenced by historical, cultural, and political factors that differ across regions. Further explanations for the cross-national differences in PTSD prevalence could be "the impact of the PTSD diagnostic criteria requiring avoidance of traumatic reminders. The public nature of political and criminal violence in South Africa may have made avoidance difficult, thereby attenuating our estimates of PTSD prevalence" (Atwoli et al., 2013, p. 8).

In a South African survey, the conditional risk of PTSD was found to be 3.5% (Atwoli et al., 2015). On average, an individual exposed to a Potentially Traumatic Event (PTE) experienced approximately 4.3 occurrences, leading to 13,700 PTEs among 4,315 respondents (Atwoli et al., 2013). Another study found that the conditional risk for PTSD ranges across PTE classes, from 1.4%-8.3%, and varies across specific PTEs, with the highest being purposely injuring, torturing, or killing someone (32.9%) (Atwoli et al., 2013).

Addressing PTSD as a public health concern requires multifaceted interventions at various levels (Edwards, 2005). The study by Koenen et al. (2017) highlighted a significant disparity in seeking treatment between people in high-income countries (HIC) and those in LMICs. In HICs, individuals were twice as likely to seek treatment (53.5%), while in LMICs, only 22.8% sought help, with a mere 3.2% of respondents receiving treatment.

### 2.3.1. Predictors of PTSD

In South Africa, predictors of PTSD are significantly influenced by physical violence and witnessing traumatic events happening to others, which are prominent contributors to lifetime traumatic events (Atwoli et al., 2015). The conditional risk for PTSD is notably elevated for those who witness traumatic events; a pattern attributed to the historical context

of political and criminal violence in the country (Atwoli et al., 2015). The most frequently reported PTEs in South Africa include the unexpected death of a loved one (39.2%); physical violence (37.6%); accidents (31.9%), and witnessing a trauma (29.5%) (Atwoli et al., 2013). Rates of domestic violence, criminal violence, rape, and indecent assault are high in South Africa, with rape figures estimated to be 2 to 3 times higher than reported (Edwards, 2005). Bruce et al. (2001) found the strongest predictors of PTSD to be rape and unwanted sexual contact. In contrast, McQuaid et al. (2001) found that assaultive trauma was reported as the most distressing experience (as cited in Greene et al., 2016).

Post-Apartheid South Africa faces challenges of high rates of violent crime, sexual violence, and domestic abuse, with the country ranking at the top globally, for murder and armed robbery rates (Kaminer et al. 2008). South Africa's homicide rate exceeds the global average by more than five times and is 30% higher than that of other Sub-Saharan countries (Kaminer & Eagle, 2010). In a 1995 Human Rights Watch report, the country earned the designation of “rape capital of the world” (Kaminer & Eagle, 2010).

### 2.3.2. Cultural Variations

PTSD rates vary among racial and ethnic groups, with African Americans reporting a prevalence of 9.1%, compared to 6.8% among European Americans (Williams et al., 2014). These disparities are influenced by historical, cultural, and political factors affecting trauma exposure rates (Atwoli et al., 2015). In South Africa, the prominence of witnessing events in PTSD cases is linked to the cultural philosophy of *ubuntu*, emphasising group solidarity, compassion, and collective unity (Atwoli et al., 2015). Non-Western individuals may not articulate PTSD symptoms in conventional terms, due to cultural variations in expressing emotional states, known as 'idioms of distress' (Edwards, 2005). Overemphasis on single traumatic events may overlook contexts where people face cumulative trauma (Edwards, 2005).

Developed primarily in Western countries, assessment tools might lack linguistic, psychometric, and cultural adaptation (Yatham et al., 2018). Williams et al. (2014) highlight differences in cognitions about self, others, and overall safety across racial groups, emphasising the importance of mental health practitioners assessing historical perspectives

that could influence patient mistrust of healthcare, potentially perpetuating substandard health outcomes.

The conceptualization of trauma has been heavily influenced by Western frameworks. In these contexts, PTSD is often seen as an individual, medicalized disorder, characterized by specific symptoms such as flashbacks, hypervigilance, and avoidance, stemming from exposure to extreme events like war, sexual assault, or accidents (American Psychiatric Association, 2013). This perspective emphasizes the individual's psychological response to trauma, with a focus on symptom-based diagnosis and treatment, primarily through modalities like cognitive-behavioral therapy (American Psychiatric Association, 2013). However, when the PTSD model is applied to Southern Hemisphere contexts such as South Africa, it becomes challanging due to differing cultural understandings of trauma and collective experiences of violence and systemic oppression. In South Africa, trauma is often seen not just as an individual challange, but as a communal and historical phenomenon, where the impacts of apartheid, socio-political violence, and intergenerational trauma are deeply embedded in the collective memory (Edwards, 2005). In order for trauma care to be culturally relevant, there is a need for additional sensitivity to the individual healing process and the collective cultural impacts of trauma consequences in the community (Im & Swan, 2021). In contrast, western framework focus solely on the individual's functioning (Moodley, 2005). The diagnosis assumes a universal application of psychiatric concepts, often applying Western therapeutic methods to non-Western contexts, overlooking the broader impact on communities and overlooks the ways people make menaing of their trauma (Moodley, 2005). The expression of PTSD, therefore, may be experienced differently across cultures, with more collectivist societies placing emphasis on the social and collective impacts of trauma, while individualistic societies focus more on individual symptoms and recovery. Despite these differences, literature ultimately agrees on the idea that trauma shares core psychological and physiological components. Studies show that trauma's impacts, such as hyperarousal, avoidance, and intrusive thoughts, are evident across both Northern and Southern contexts, suggesting that while cultural expressions may differ, the psychological effects of trauma are universally experienced (Patel & Hall, 2021; van der Kolk, 2000).

#### *2.3.1.1. Refugees*

Refugees are a diverse group but share exposure to organised violence and threats arising from religious, cultural, and political differences or territorial disputes (Reed et al., 2011). Socioeconomic adversity and exposure to violence in their origin countries, followed by migration and resettlement into a new context, expose them to risks to their physical, emotional, and social development (Reed et al., 2011). Refugees resettling in LMICs are often exposed to ongoing threats to their security and welfare, and most reports show a higher prevalence rate of psychological problems in refugees, especially PTSD (Reed et al., 2011). There is evidence in a study that reports 75% of 331 displaced children in Southern Darfur met the criteria for PTSD; another study showed 11% of children in the systematic reviews had PTSD; and a systematic review of 181 studies of adults who experienced conflict and displacement, showed a prevalence of more than 30% for depression and PTSD (Reed et al., 2011).

The impact of trauma and compounded stressors are moderated by the loss of relatives and support networks, a lack of basic health needs, displacement, parental psychopathology, and socioeconomic adversity, which are often exacerbated in refugee settings (Cohen & Yaeger, 2021).

## 2.4. Challenges to PTSD Treatment

The enduring impact of political conflict and repression trauma may persist for generations, with ongoing incidents of violence, accidents, and disasters affecting individuals daily (Edwards, 2005). A significant number of PTSD cases remain undiagnosed, and among those diagnosed, many individuals either delay seeking treatment or do not seek it at all (Greene et al., 2016). Individuals with PTSD often visit primary care clinics for physical and mental health concerns, but the condition is frequently overlooked (Greene et al., 2016). This oversight is that those with PTSD may primarily focus on physical symptoms, avoiding discussion of trauma or psychiatric issues during primary care visits (Greene et al., 2016). Furthermore, patients in primary care settings may refrain from pursuing a PTSD diagnosis, due to a lack of awareness about the connection between trauma exposure and their symptoms, stigma, or a practitioner's potential lack of confidence or knowledge regarding PTSD symptoms (Greene et al., 2016).

In economically developing nations, such as South Africa, financial constraints often restrict the provision of mental health care (Kaminer et al. 2008). Despite more than 80% of the global population residing in LMICs, only 6% of mental health research originates from these regions (Patel, 2007). Limited knowledge exists on the efficacy and generalisability of treatments in LMICs, with affordability and feasibility dependent on utilising locally available health resources (Patel, 2007). Over 90% of global mental health resources are concentrated in HICs, where the number of psychiatrists is 200 times greater than in LICs, which have approximately 1800 psychiatrists serving 702 million Africans (Patel, 2007). Studies reveal a mean ratio of 1.1 mental health professionals to every 100,000 patients, and some African LMICs have fewer than one psychiatrist per 200,000 people (Yatham et al., 2018).

In Africa, over half of the countries allocate less than 1% of their total health budgets to mental health, with most resources concentrated in urban, affluent areas and psychiatric hospitals (Yatham et al., 2018; Patel, 2007). The availability and access to mental health services in LMICs are severely limited, leading to gross inadequacy, and the use of culturally non-adapted assessment tools contributes to wide variability (Yatham et al., 2018). Moreover, 85% of individuals with serious mental illness in developing countries receive no treatment, due to restricted access to services and poor mental health awareness (Yatham et al., 2018). In LMICs, the scarcity of opportunities for treatment is exacerbated by persistent problems related to the availability of Evidence-Based Psychological Treatments (ESTs) and trained professionals (Booysen & Kagee, 2020). Many South Africans face the challenge of lacking a post-trauma period to process or adapt to their experiences before encountering subsequent traumas (Kaminer & Eagle, 2010).

Several challenges hinder the expansion of interventions into real-world primary care settings. These challenges include low recognition rates of mental disorders among primary care doctors; insufficient utilisation of evidence-based medications; reliance on non-evidence-based medications; stigma; limited mental health literacy, and a shortage of available psychosocial interventions (Patel, 2007). The scarcity of mental health specialists contributes to treatment delays and a perception of inaccessibility (Rossouw et al., 2018). In LIC African American communities, obstacles to obtaining treatment encompass transportation issues; service costs; family disapproval; unfamiliarity with treatment; stigma, and discrimination (Williams et al., 2014).

LMICs face specific challenges, including the need for training; fidelity checks; supervision, and monitoring (Barbui et al., 2020). Concerns about cultural and social acceptability, infrastructure and resource feasibility, and limited treatment opportunities exacerbate the situation (Barbui et al., 2020). Persistent obstacles related to the availability of ESTs and trained professionals further limit treatment options in LMICs (Booysen & Kagee, 2020). Providers encounter barriers, such as clinic structures that do not allow sufficient time; lack of supervision; absence of organisational support; low provider confidence, and resistance to specific evidence-based treatment approaches for PTSD, along with concerns about potential treatment complications perceived by providers and patients (Borah et al., 2013).

While the feasibility and cost-effectiveness of delivering culturally adapted mental health interventions in resource-poor contexts have been demonstrated, their uptake is impeded by the uneven distribution of human and financial resources (Vally & Abrahams, 2016). Poor coverage of psychological treatment is attributed to reliance on a limited number of specialists, the use of highly specific disorder-based treatment packages, and the stigma associated with mental disorders (Singla et al., 2017).

## 2.5. Development of Exposure Techniques

### 2.5.1. Development of Exposure Therapy

The pathological fear structure central to PTSD, involves extreme responses and pathological interpretations rooted in two cognitive distortions: erroneous beliefs about safety in the world and doubts about self-efficacy and competence because of behaviours and physiological reactions during the trauma event (Booysen & Kagee, 2020). Fear and anxiety are core components of fear structures and trigger symptoms of post-traumatic stress when activated; therefore, activating this fear structure is crucial to altering these erroneous beliefs (Booysen & Kagee, 2020). Exposure therapy is grounded in principles of fear learning, parallel to methods used in extinction training (McLean & Foa, 2011). This therapeutic approach systematically exposes individuals to feared thoughts, images, objects, situations, or activities without the feared trauma event happening again, thereby reducing fear, anxiety, and associated symptoms (McLean & Foa, 2011). Unlike other methods of ‘unlearning’ or

‘forgetting’ feared associations, exposure therapy involves creating new inhibitory learning and forming new associations to foster a change in response (McLean & Foa, 2011).

According to the theory of Emotional Processing Therapy (EPT), fear exists in memory as a cognitive structure made up of details regarding the fear-inducing stimulus, the associated fear reactions, and the meanings connected to each. These components interact to create a cohesive fear structure that can be triggered by inputs that resemble any one of the components (McLean & Foa, 2011). According to McLean and Foa (2011), flawed associations that cause fear responses to generalise to safe contexts and stimuli are indicative of a disordered fear structure. When the fear structure is repeatedly triggered without anticipated negative consequences, natural recovery takes place. PTSD is more likely to develop in people who avoid interacting with traumatic memories and related stimuli (McLean & Foa, 2011).

PE has emerged from the adaptation and extension of EPT, which emphasises the critical role that effective processing of traumatic memory plays in reducing symptoms of post-traumatic stress disorder (PTSD) (Foa et al., 2019). According to EPT, emotional processing requires two conditions: (1) the fear structure needs to be activated for it to be modified, and (2) new information needs to be integrated into the fear structure (Foa et al., 2019). This new information is encoded during exposure and changes the fear structure, which in turn causes a general pattern of decreased negative affect when the same or similar stimuli are encountered, which in turn, reduces symptoms (Foa et al., 2019).

### 2.5.2. PE for PTSD

In PE, patients are given skills to cope with posttraumatic responses, which consist of psychoeducation, breathing techniques, imaginal exposure, in vivo exposure, and emotional processing (Booysen & Kagee, 2020). The aim of in vivo and imaginal exposure is to enhance emotional processing by helping the patient face the trauma memories and reminders (Foa et al., 2019). PE corrects erroneous associations in clients’ fear structure, which allows sufferers to view the trauma event as a one-time point in the past and not a continuing concern at all times (Williams et al., 2014). Exposure aims to modify the pathological fear structures (Hembree et al., 2003).

McLean and Foa (2011) detail the process of PE. This current PTSD treatment programme consists of 8 to 15 individual 90-minute sessions. In the first meeting, the clinician explains the rationale for exposure therapy, emphasising that PTSD is sustained by avoidance of trauma-related thoughts and reminders, as well as distorted beliefs developed post-trauma, thus PE aims to alter these beliefs through exposure. The first session involves selecting the "index trauma" for focus, teaching a relaxation technique, and laying the groundwork for exposure. The second session covers common trauma reactions, introduces in vivo exposure, and constructs a hierarchy for exposure homework. The third session introduces imaginal exposure, followed by post-exposure processing. Subsequent sessions involve ongoing exposure exercises and homework review. The remainder of the sessions include a review of progress and a plan for maintaining gains by shifting from avoidance to confronting trauma reminders.

#### *2.5.2.1. Psychoeducation*

Psychoeducation and controlled breathing exercises play a secondary role in PE. Psychoeducation comprises a discussion about what maintains PTSD and the reactions that commonly follow a trauma (Foa et al., 2013). Controlled breathing training is specifically crafted to reduce an individual's baseline anxiety level, addressing any elevation that may result from rapid and shallow breathing (Foa et al., 2013).

#### *2.5.2.2. In vivo Exposure*

According to Foa et al. (2013), in vivo exposure is a methodical and deliberate process that encourages people to interact with people, places, and circumstances that they have been avoiding. The dysfunctional and unrealistic expectations of harm are challenged and disproved by repetitive exposure to these stimuli, which lowers the corresponding fear response (Foa et al., 2013). Key processes by which in vivo exposure promotes recovery, include the activation of the fear structure and the correction of erroneous probability assessments of harm (McLean & Foa, 2011). By providing opportunities for habituation, this treatment strategy enables people to alter their adverse beliefs and avoids reinforcing avoidance behaviours (McLean & Foa, 2011). By initiating direct contact between clients and

stimuli reminiscent of the trauma, in vivo exposure helps dismantle avoidance patterns and negative beliefs (Williams et al., 2014). As clients engage in assigned exposures, they come to realise that confronting feared stimuli is instrumental in rectifying maladaptive thoughts (Williams et al., 2014).

#### *2.5.2.3. Imaginal Exposure*

To facilitate emotional engagement with the trauma memory, imaginal exposure entails revisiting the memory in the mind and narrating the traumatic event, followed by processing this experience (Foa et al., 2013). According to McLean and Foa (2011), it is easier to distinguish between remembering a trauma and becoming retraumatised, when the trauma is repeatedly relived in the mind. Furthermore, imaginal exposure helps people distinguish between the traumatic event and similar stimuli that have come to be connected with the trauma (McLean & Foa, 2011). Moreover, it helps one's ability to distinguish between real risks and cognitive representations of threat, such as trauma memories (McLean & Foa, 2011).

The primary result of imaginal exposure is the extinction of conditioned fear reactions, which is accomplished by habituation (McLean & Foa, 2011). Patients' erroneous beliefs are corrected by this reduction in anxiety, which was previously associated with the trauma memory (McLean & Foa, 2011). Through habituation, imaginal exposure helps in reducing anxiety without resorting to unhelpful avoidance behaviours (Williams et al., 2014). According to McLean and Foa (2011), deliberately addressing the trauma memory stops avoidance tactics from being negatively reinforced. Negative perceptions about self-efficacy and self-control are altered through this therapeutic learning process (McLean & Foa, 2011).

#### *2.5.2.4. Processing*

Processing offers patients the chance to analyse their beliefs associated with the traumatic memory and acquire a fresh perspective on the trauma (McLean & Foa, 2011). Processing is a less structured process that happens after imaginal exposure and involves discussing the experience of revisiting the trauma memory, with an emphasis on new perspectives and altered beliefs (McLean & Foa, 2011). Processing the exposure promotes corrective learning, which improves treatment outcomes by facilitating patients' understanding of the lack of feared consequences that occur (McLean & Foa, 2011). It

provides an opportunity for patients to communicate and incorporate new knowledge and understanding into their memory, assisting in the recognition of erroneous ideas and perceptions, while strengthening their sense of self-control and personal competence (McLean & Foa, 2011).

A solid foundation for PE should include conveying that PE has been found highly effective and that the therapist is knowledgeable about the use of PE; forming a strong therapeutic alliance; providing a rationale for PE; tailoring the treatment to promote trauma processing, and overcoming avoidance while retaining flexibility (Hembree et al., 2003).

Booysen and Kagee (2023) investigated the views of patients undergoing PE and identified the following outcomes. Participants expressed satisfaction with PE's structured approach, finding it alleviated anxiety and offered support for processing stressors. They valued the clarity of PE and what was expected of them. They found that doing *in vivo* tasks provided them with a different experience and insight related to their perceptions of exposure and the ability to engage with feared situations. Similarly, findings from Sripada et al. (2022) indicated positive responses from treatment participants. All individuals engaging in treatment found it beneficial and expressed a willingness to recommend it. Patients reported reduced anger, fear, and edginess, fewer nightmares, increased calmness and relaxation, enhanced assertiveness, and decreased avoidance. Some participants suggested a desire for longer treatment to address multiple traumas.

PE is recommended for individuals with PTSD symptoms that are distressing and interfering with daily functioning and individuals with intrusive symptoms connected to a specific memory of a traumatic event (Foa et al., 2019). Moreover, PE should not be used if there is a threat of suicide or homicidal activity; significant self-injurious behaviour; ongoing psychosis, or a current high risk of assault (Foa et al., 2019).

The benefits of PE include its robust and flexible efficacy, which has consistently been demonstrated in studies, which mostly affirm its ability to alleviate PTSD and related issues (Foa et al., 2019). PE provides a route for significant improvement, helping people take control of their lives and escape the hold of PTSD (Foa et al., 2019). However, PE may have adverse effects, such as discomfort and emotional distress when confronted with situations, memories, or pictures that cause anxiety, and may result in a temporary worsening of PTSD, anxiety, and depression (Foa et al., 2019).

### 2.5.3. Efficacy of PE

PE is a highly effective, flexible, and robust treatment, capable of safely addressing even the most intricate patient presentations and comorbidities (Foa et al., 2019). Strong evidence supports the efficacy and effectiveness of PE in alleviating PTSD symptoms, as demonstrated in diverse settings, such as America, Israel, Poland, and Japan (Booysen & Kagee, 2020). The effectiveness of PE extends to diverse populations, including female survivors of sexual assault, male combat veterans, and individuals with various traumatic experiences (Hembree et al., 2003).

Foa et al. (2019) detail the PE's progress over several studies. The first study took place in 1991 with 45 female rape victims who had been diagnosed with chronic PTSD. After undergoing nine sessions of PE, stress inoculation training (SIT) or supportive counselling, the subjects were compared to a wait-list control group. The results showed that individuals receiving PE showed a notable and sustained improvement. Subsequent research involved 97 female survivors, encompassing both rape and nonsexual trauma, with chronic PTSD. They received PE, SIT, or a combination of both, and the outcomes were compared to a wait-list control group. Post-treatment, 35% of PE, 42% of SIT, and 46% of SIT/PE participants retained a PTSD diagnosis. Notably, more PE recipients exhibited good end-state function, showing remission in PTSD, general anxiety, and depression. These positive results were consistent at a one-year follow-up. In a relapse analysis by Resick et al. (2012), only 6% of PE remitters relapsed, compared to 21% of CPT remitters. In addition, research investigating the temporal sequence of change, demonstrated that reductions in negative trauma-related cognitions preceded decreases in PTSD symptoms during PE.

Rossouw's study (2018; 2022) discovered notable improvements in PTSD symptom severity for both the Prolonged Exposure Therapy for Adolescents (PE-A) and supportive counselling (SC) groups from baseline to the 12- and 24-month follow-up assessments. Furthermore, the PE-A group demonstrated consistently greater improvements in PTSD symptom severity, compared to the SC group at the 12- and 24-month follow-ups. Significantly, more participants in the PE-A group achieved a 'good response,' compared to the SC group at the 12-month follow-up. Both PE-A and SC groups exhibited significant reductions in self-reported symptom severity from baseline to the 12- and 24-month follow-ups, with the PE-A group experiencing a greater reduction in PTSD symptom severity. The

remission of PTSD diagnosis was sustained in both groups at the 12- and 24-month follow-ups, with 96% and 83% in the PE-A group and 52% and 58% in the SC group.

When one studies the results of large, controlled trials, there is no evidence that PE is associated with a relative increase in adverse side effects, and PE is not associated with symptom exacerbation (Foa et al., 2013).

### 2.5.4. Ongoing adversity

Regarding PE for people who have experienced several traumas, the approach involves ranking the memories according to how intrusive and distressing each memory is (Hembree et al., 2003). Owing to time and practical constraints, only two memories are typically addressed during the imaginal exposure phase (Hembree et al., 2003). In this process, starting with the highest-ranking memories on the hierarchy is recommended, with the expectation that benefits will generalise to other related memories (Hembree et al., 2003). By deliberately concentrating on the most distressing memories, imaginal exposure can be applied more precisely and effectively, maximising its therapeutic effects within the specified time frame (Hembree et al., 2003).

### 2.5.5. Dissemination and Implementation of PE

Limited information exists regarding the application of PE in LMICs (Booysen & Kagee, 2023). Most PE studies are concentrated in high-income regions, emphasising the need to assess and implement PE in the global south, within LMIC contexts (Booysen & Kagee, 2020). Edna Foa reported that a crucial aspect of the future of PE and the effective treatment of PTSD is to develop “ways to disseminate and implement our evidence-based treatments into community clinics around the world” (Booysen & Kagee, 2020, p.2).

Effectiveness trials are crucial to determining whether a treatment, such as PE, can be effectively taught to mental health professionals; implemented amid ongoing adversity and disruptions; executed inexpensively, and delivered in a manner that minimises risks to survivors (Foa et al., 2013). For widespread access to effective PTSD treatments, various systems must collaborate, including graduate training programmes; government agencies;

insurers; professional organisations; healthcare delivery systems; clinical researchers, and public education systems (Foa et al., 2013; McLean & Foa, 2011).

An analysis of dissemination trials for depression treatment in diverse settings, including Pakistan, India, and Uganda, highlighted key conditions for successful dissemination. These include, recruiting counsellors from local communities; adopting participatory training programmes; tailoring treatment programmes to match the skills of local counsellors; providing supervision for ongoing skills development, and implementing proactive strategies to reduce stigma and encourage help-seeking (Foa et al., 2013). This underscores the importance of context-specific adaptation and community involvement in disseminating mental health interventions in LMICs.

#### *2.5.5.1. Cultural Adaptations*

Aspects related to culture in trauma-focused therapy need to be considered if ESTs like PE are to be adopted in LMICs (Booysen & Kagee, 2020). A case study by Booysen and Kagee (2020) found that irrespective of the contextual factors of community violence and the increased likelihood of trauma exposure, treatment could still be implemented with positive outcomes, and presents a hopeful impression regarding the feasibility of ESTs in contexts of ongoing adversity. In saying this, clinicians must be cognisant of contextual factors and consider how they might affect the treatment process and outcome (Booysen & Kagee, 2020).

However, effective dissemination may face cultural barriers. For example, in strict Islamic regions, such as Aceh, seeking treatment can be restricted by the belief in accepting one's fate, an essential component of the Muslim religion (Foa et al., 2013). Therefore, therapy and revisiting traumatic experiences could be seen as a sign of not accepting one's fate. Islamic societies may see trauma as a test of faith and attribute it to Allah; therefore, prolonged suffering could be interpreted as an indication that one is rejecting Allah's will (Foa et al., 2013).

Therapists should posses a basic level of cultural sensitivity and knowledge before working with any cultural group, either obtained by formal education or previous interactions with members of the target group (Williams et al., 2014). Understanding the client's culture is critical to avoid the misattribution of symptoms to stereotypes about their race or

culture (Williams et al., 2014). Consequently, therapists must perform a cultural assessment, considering elements including ethnic identity, racism-related stresses, and religious views (Williams et al., 2014). If cultural differences are not addressed, it may be detrimental to the therapeutic partnership (Williams et al. 2014).

#### *2.5.5.2. Challenges to Dissemination and Implementation*

Multi-level upscale initiatives may be necessary for the successful implementation of PE, due to the following factors: limited resources and acceptance of ESTs in LMICs; antagonistic attitudes towards ESTs within the professional culture; inadequate resources for effective dissemination; limited opportunities for clinician training that impedes the adoption of first-line treatments; restricted access to training for health professionals, and inadequate infrastructure and resources at the primary healthcare level (Booysen & Kagee, 2020). According to the World Health Organisation (WHO), managing PTSD cases in LMICs is challenging, due to ongoing adversity, poverty, gender-based violence (GBV), and escalating levels of trauma exposure (Booysen & Kagee, 2020).

Some clinicians are reluctant to use PE, which may be related to concerns that exposure therapy may exacerbate patients' symptoms, apprehensions about the distressing nature of the treatment, and a belief that PE would lead to higher dropout rates (Borah et al., 2013). Addressing these misconceptions regarding potential harm is crucial, emphasising the importance of enhancing provider readiness and willingness to employ PE (Borah et al., 2013).

In LMICs, hindrances to implementation are often associated with economic, political, and social factors that extend beyond the organisation itself, encompassing issues, such as socio-political instability, limited mental health infrastructure, insufficient funding for social services, and low literacy rates (Chen et al., 2017). Recommendations to overcome these challenges involve simplifying language; tailoring examples to be culturally specific; removing technical jargon, and replacing written handouts with oral and visual explanations (Chen et al., 2017).

One common problem facing dissemination is that its supporters might not be aware of, or familiar with an organisation's culture and structure. Furthermore, rather than being adaptable and willing to compromise, supporters might strongly advocate their chosen

therapeutic format, which could result in opposition to evidence-based treatments (EBTs) (Foa et al., 2013). Further barriers to dissemination include a lack of support for EBTs in the professional culture; insufficient clinician training in EBTs; restrictions on commonly used dissemination strategies, and related costs (Foa et al., 2013). Dissemination-specific issues in developing countries, include limited resources; exacerbated psychological impacts of traumas and disasters in non-western countries, and the neglect of mental health needs as a result of variables such as political unrest or poverty (Foa et al., 2013).

The collectivist nature of many non-Western settings presents a challenge for PE dissemination in diverse cultural contexts, as highlighted by Foa et al. (2013). In contrast to Western societies, which often value individual viewpoints and identities, non-Western cultures usually identify within a collective group, such as their ethnic community or village. This cultural difference has several effects on the dissemination of PE. First, formal one-on-one treatment sessions are unfamiliar and could be impractical in non-Western cultures, due to the predominance of group-oriented interactions. Introducing individual therapy models could be unfeasible and conflict with cultural norms. In a group context, asking patients to recount their traumatic experiences individually, may be distressing, particularly for those who are suffering from severe and chronic PTSD.

Given the public health and societal costs associated with PTSD, the efficiency of care delivery and the dissemination of EBPs present some of the greatest challenges for the field (McLean & Foa et al., 2011).

## 2.6. Task-Shifting

### 2.6.1. Treatment gap

The approach in the global community towards caring for those afflicted with mental health disorders ranges from being woefully underdeveloped to nonexistent (McInnis & Merjver, 2011). Despite mental, neurological, and substance abuse disorders contributing to over 10% of the global burden of disease, with three-quarters affecting individuals in LMICs (Mendenhall et al., 2014), the treatment gap is alarmingly high, exceeding 75% worldwide (Beck et al., 2016; Mendenhall et al., 2014). In LICs such as Ethiopia, the mental health treatment gap can be as high as 90% (Mendenhall et al., 2014). Similarly, De Kock and Pillay

(2018) report that worldwide, the treatment gap for mental health disorders is undeniable, with 85% of people in LMICs and between 35% and 50% of people in HICs living with severe mental disorders not receiving treatment.

Approximately 75% of South Africans who require treatment for severe mental illnesses do not receive the necessary care (Vally & Abrahams, 2016). This significant gap in mental health treatment in South Africa may be due to a lack of qualified mental health professionals in these areas, and the focus of financial resources on more pressing issues, such as managing the HIV epidemic and infectious diseases, such as tuberculosis (Vally & Abrahams, 2016).

A significant portion of individuals grappling with mental health issues, lack access to psychological treatments. Those in dire need of mental health services often find private treatment financially unattainable, and state health services typically lack the capacity to meet the growing demand for treatment (Beck et al., 2016). According to world mental health surveys, the rates of minimally adequate mental health services in LMICs are strikingly low, estimated at 3.7% for major depressive conditions, 2.3% for anxiety conditions, and 1% for substance use conditions, whereas HICs show significantly higher rates at 20%, 13.8%, and 10.3% for the respective conditions (Bolton et al., 2023). Part of the reason for the inadequate availability of mental health care services, is the low level of public funding. According to estimates, the median annual government spending on mental health in LMICs is $0.08 per capita, substantially less than the $0.37 in MICs and significantly lower than the $52.72 in HICs (Bolton et al., 2023).

The rural population in South Africa relying on Primary Health Care (PRPHC) facilities is estimated at 17,143,872 individuals (De Kock & Pillay, 2018). In these health centres, there are seven psychiatrists; 63 mental health-dedicated medical doctors; 81 clinical psychologists, and 116 mental health nurses, which translates to rates per 100,000 population of 0.03, 0.37, 0.47, and 0.68, respectively (De Kock & Pillay, 2018). Notably, South Africa has 762 registered psychiatrists, with 39.6% (302) practising in the public sector and a mere 0.9% (7) in PRPHC areas (De Kock & Pillay, 2018). Among the 2,786 clinical psychologists in the country, 43.5% (1,213) work in the public sector, with national rates of 2.6 per 100,000 population and 0.47 in PRPHC areas (De Kock & Pillay, 2018). Comparatively, LICs and LMICs report a median of 1.4 and 3.8 mental health workers per 100,000 population, whereas HICs have substantially higher rates at, 62.2 (Bolton et al., 2023).

If unaddressed, the global burden of mental health disorders poses a serious threat to the well-being of populations lacking resources, as well as the economic development of entire communities (McInnis & Merjver, 2011). To address the substantial treatment gap and respond to the need for mental health interventions in impoverished communities, there has been a recent push for the adoption of task-shifting in mental health care (Vally & Abrahams, 2016). In this regard, global mental health researchers developed innovative strategies to bridge psychological treatment gaps. These include offering interventions in easily accessible settings, including primary care and community settings and using Non-Specialist Health Workers (NSHWs) to increase the availability of human resources (Singla et al., 2017).

### 2.6.2. Evidence for Task-shifting

Owing to the severe lack of human resources in South Africa's public health care system, innovative approaches to problem-solving are required, such as bridging traditional, professional boundaries through integrating knowledge from various health disciplines into its practice (De Kock & Pillay, 2018). People living in rural, frontier, remote, or isolated areas with workforce shortages, frequently depend on an informal healthcare system involving the broader medical community and assistance from friends, family, and spiritual leaders (Hoeft et al., 2017). Research indicates that task delegation can enhance access, coverage, and the quality of health services, often at comparable or lower costs than traditional delivery methods (Lehmann et al., 2009).

Given the scarcity of specialised healthcare services in LMICs, experts and practitioners propose redefining the responsibilities and functions of psychiatrists, psychologists, and psychiatric nurses. Rather than simply delivering clinical services, they should assume leadership positions within public mental health initiatives (Mendenhall et al., 2014). According to Mendenhall et al. (2014), this new role entails developing and managing mental health treatment plans; enhancing clinical skills in primary care settings; supervising healthcare teams; ensuring the quality of mental health services; and setting up efficient networks for referral and consultation.

Task-shifting is assigning tasks to professionals with less specialised or narrower expertise and is practical, successful, safe, and cost-efficient in the mental health field (De

Kock & Pillay, 2018). Redistributing tasks allows individuals with less training to assume roles outside their initial scope of practice (Leong et al., 2021). Task-shifting has been shown to improve mental healthcare in underserved areas; a concept made prominent by the HIV/AIDS epidemic (Hoeft et al., 2017). According to Mutamba et al. (2013), individuals who receive specialised training to perform clearly defined tasks, can be deployed faster than their highly trained counterparts and can substantially contribute to complementing and supporting the services offered by other health workers. The effectiveness of task shifting relies on political and financial investments, demanding careful consideration of health services organisation, structure, and resourcing (Lehmann et al., 2009). Implementing effective governance systems is imperative to guarantee the success of any task-shifting initiative (Leong et al., 2009).

Task-shifting offers an innovative approach to increasing access to mental health services, saving time and cost, and reducing disparities (Mendenhall et al., 2014). It aids in reducing stigma, preventing the worsening of mental health conditions, and improving medication adherence (Mendenhall et al., 2014). In addition, integrating locally recognised leaders, such as faith and traditional healers into existing mental health service frameworks can enhance service delivery (Mendenhall et al., 2014). Some argue that lower-level workers providing mental healthcare in resource-limited settings, may offer superior care compared to highly trained professionals (Swartz et al., 2014). This is largely because community members trained to deliver these services, are more likely to share cultural, linguistic, and social backgrounds with those they serve (Swartz et al., 2014).

For task-shifting programmes to be effective, partnerships with communities are essential to ensuring that plans are tailored to the local environment and meet fundamental needs (Hoeft et al., 2017). The involvement of community health workers or lay health workers in the delivery of healthcare can significantly improve community involvement, particularly when these non-professional workers authentically represent their communities and give a voice to health systems (Lehmann et al., 2009). Low- and middle-income countries (LMICs) can develop accessible therapists with relatively low-cost interventions by training local health workers in manualised techniques and providing ongoing supervision from more highly trained colleagues (Beck et al., 2016).

In a large clustered, randomised controlled trial conducted in LMIC settings, Beck et al. (2016) demonstrated that CBT, delivered by NSHW, effectively halved rates of depression in a rural sample of pregnant women at high risk of depression. Moreover, task-shifting to nurses, reportedly improved access to care and was non-inferior to clinical management measures, such as asthma control, AVR therapy provision, and cardiometabolic disease management (Leong et al., 2021). Martinez et al.'s review revealed that patients returning for consultations with nurses outnumbered those with physicians, leading to more face-to-face contact time and higher patient satisfaction scores (as cited in Leong et al., 2021). Furthermore, Anthony et al. estimated that task-shifting roles to nurses for common minor ailments were cost-effective, compared to general practitioner care, allowing for greater utilisation of healthcare resources and improved access to healthcare (as cited in Leong et al., 2021). Several reviews reported better job satisfaction among healthcare workers, due to feelings of empowerment, ability to address local health needs, and social recognition by the communities (Leong et al., 2021). Recipients of care reported they experienced better engagement, due to the increased time spent on a consultation, as well as the possible removal of social and physical barriers that may exist with physicians (Leong et al., 2021).

A Cochrane review summarising this body of research indicates that task-sharing mental healthcare in LMICs may improve the clinical outcomes for depressive disorders, PTSD, alcohol use disorder, and dementia (Mendenhall et al., 2014). Some studies highlight the significant benefits of peer-delivered services, demonstrating improvements in symptomology, quality of life, self-empowerment, hope, self-esteem, and perceived stigmatization (Vally & Abrahams, 2016).

A Ugandan study demonstrated the successful delivery of IPT by community-based workers to people with depression (Peterson et al., 2012). Furthermore, Chatterjee et al. used trained community-based facilitators in India to successfully run a monthly community-based rehabilitation programme (as cited in Peterson et al., 2012). Gillepsie, Duffy, Hackmann and Clark (2002) found community therapists who received training in cognitive therapy for PTSD and ongoing supervision, effectively administered treatment, as well as Neuner et al. (2008) who showed narrative exposure therapy was effectively delivered in Uganda by lay counsellors chosen within the refugee community (as cited in McLean & Foa, 2013). Similarly, community-based therapists achieved positive outcomes in the delivery of PE for PTSD in Japan and Israel (Foa et al., 2013).

### 2.6.3. Challenges to Task-shifting

Several obstacles impede the development of therapies in LMICs. According to Beck et al. (2016), they include the underfunding, marginalisation, and disorganisation of many health services, the difficulty of enacting change, and the lack of emphasis placed on diagnosing and treating mental health concerns within these services.

Beck et al. (2016) describe several obstacles encountered. First, service-related barriers exacerbate the situation, with patients often required to travel from remote areas to major cities for treatment. Second, public sector hospitals struggle with patient volumes, since they are usually overcrowded and underfunded; these problems are worsened by the lack of a referral mechanism. Third, barriers associated with therapists include low salaries, a decline in the morale of mental health practitioners, and inadequate facilities for supervision and training. Next, patients also encounter barriers, such as low literacy rates; stigmatisation; a preference for medication over therapy; the perception that they have physical health issues because of somatic symptoms, and the influence of religious and spiritual leaders. Finally, one major challenge in the therapeutic process is the restricted availability of supervision.

Referral pathways for accessible mental health services are often informal and face significant challenges that prevent patients from receiving help, such as stigma, financial constraints, and geographical isolation (Bolton et al., 2023). Moreover, the ability to assist refugee populations is constrained in LMICs, causing refugees to depend on non-governmental organisations (NGOs) that provide mental health services financed by short-term grants, with ongoing sustainability issues, following the intervention (Cohen & Yaeger, 2021). Further barriers include cultural and linguistic differences; a lack of information; unfamiliarity with public systems; costs, and social stigma, all of which can make it difficult for people to obtain support in new environments (Cohen & Yaeger, 2021).

Task-shifting might encounter difficulties with maintaining professional boundaries, ensuring confidentiality, preventing burnout, and managing staff turnover (Hoeft et al., 2017). In a research project involving social workers delivering home-based CBT, agencies reported severe understaffing; high caseloads for staff; limited time for additional activities, and

significant challenges in establishing boundaries (Lehmann et al., 2009). Furthermore, national governments must demonstrate significant leadership to truly embrace task-shifting. These governments must garner support from various stakeholders who play a role in, and are impacted by the restructuring of tasks (Lehmann et al., 2009). When there is a lack of commitment, task-shifting could be relegated to the fringes of the formal health system, where it is vulnerable to changes in funding and policy, thus making it fragile and unsustainable (Lehmann et al., 2009). Government-related obstacles include poor staff coordination; a low skill set; inadequate support and recognition, and insufficient financial incentives (Leong et al., 2021).

The field of global mental health is acutely concerned with the lack of resources for mental healthcare in LMICs (Swartz et al., 2014). A key challenge to task-shifting is the socioeconomic inequalities between lay providers and employed health professionals (Wall et al., 2020). Beyond economic impacts, the four most common areas of concern regarding lay provider experiences are motivation; self-efficacy; stress; and burnout, which are concerning, as they might reduce the quality and effectiveness of interventions (Wall et al., 2020). Compassion fatigue is a further challenge.

Suggestions for addressing challenges in task-shifting mental healthcare involve integrating counsellor support; providing training to help counsellors navigate stressors; offering ongoing supervision for coping and problem-solving; fostering connections with peers for mutual support, and providing incentives and compensation (Wall et al., 2020).

## Chapter Summary

The literature emphasises the high prevalence rate of PTSD and trauma exposure, especially in countries, such as South Africa, highlighting the critical need for effective psychological interventions. However, access to EBTs such as PE, is often limited in resource-constrained areas. To address these challenges, task-shifting has emerged as a strategy. Several studies have shown the feasibility and effectiveness of task-shifting.

# Chapter 3

# Research Design and Methodology

## Chapter overview

The study aimed to investigate the feasibility and acceptability of implementing Prolonged Exposure (PE) therapy at The Trauma Centre in Cape Town. This qualitative study focused on gathering the experiences and perceptions of social workers and their clients involved in implementing PE. Qualitative methodologies are considered essential in the field of implementation research because of their ability to provide intricate insights into complex issues, such as the factors influencing implementation success or failure, as well as the varied experiences of patients and healthcare professionals (Hamilton & Finley, 2020). It is important to emphasise that this study was part of a larger research study, intending to gather preliminary data to serve as the foundation for future research. By concentrating on qualitative aspects, the study aimed to provide significant insights into the current environment of PE implementation, and inform and guide future research endeavours within the broader spectrum of mental health intervention and implementation studies.

## 3.1. Research Design

### 3.1.1 Qualitative Research

Qualitative research involves gathering, interpreting, and analysing non-numerical data to gain insight into the deeper meanings of human experiences and behaviours (Renjith et al., 2021). This type of research provides detailed and rich descriptions that allow for a more in-depth comprehension of the subject (Flick et al., 2004). Furthermore, qualitative research is often characterised as action research, since it employs observation and interview techniques and is motivated by inductive reasoning (Al-Busaidi, 2008).

Qualitative research establishes concepts for understanding social phenomena in natural settings, emphasising participants' meanings, experiences, and perspectives (Al-Busaidi, 2008). This approach is ideal for recording individual's lived experiences and determining the meanings they attribute to events, processes, and structures in their lives (Al-Busaidi, 2008). According to Munhall (2012), qualitative research entails asking broad

questions about human experiences and realities, spending time with people in their natural settings, and collecting detailed, descriptive data to understand these experiences better (as cited in Renjith et al., 2021).

Qualitative research typically uses a more open and immersive approach, compared to other research approaches that rely on large quantities of data and strict standardisation (Flick et al., 2004). This openness enables a more in-depth analysis of the phenomena under investigation (Flick et al., 2004). For example, through guided interviews, biographical narratives, or ethnographic descriptions of everyday life, researchers can gain a more concrete and vivid understanding of what it is like to live with a chronic illness, from the perspective of those involved (Flick et al., 2004). This technique differs from standardised surveys, which may give more objective data but may lack the depth and richness of qualitative methods (Flick et al., 2004).

Quantitative methods focus on the "when," "what," and "where," whereas qualitative inquiry aims to explain the "how" and "why" of decision-making processes (Renjith et al., 2021). Moreover, qualitative research is a set of interpretive procedures aimed at understanding the meaning, rather than the frequency, of naturally occurring events in the social world (Al-Busaidi, 2008). It is a way of capturing the essence of human experiences, sometimes called viewing lifeworlds 'from the inside out' (Flick et al., 2004). This method aims to comprehend social reality by concentrating on the perspectives of those involved (Flick et al., 2004). The goal is to investigate, describe, and explain occurrences to make sense of the intricacies of reality. Ultimately, qualitative research seeks to understand the complexities of human behaviour (Renjith et al., 2021).

Rather than simply depicting reality, qualitative research seeks to uncover the underlying processes, patterns of meaning, and structural aspects that shape it (Flick et al., 2004). Instead of sensationalising or romanticising other people's experiences, it seeks insights through unexpected elements (Flick et al., 2004). These insights act like a mirror, reflecting the unknown in the known and the known in the unknown, possibly leading to new understanding and opportunities for researchers and participants (Flick et al., 2004). By engaging closely with individuals and their experiences, qualitative research can provide insights beyond surface-level observations, resulting in a more nuanced understanding of complex events (Flick et al., 2004).

Patton (2002) identifies numerous characteristics conducive to qualitative research, including investigations into people's experiences and the meanings they derive from them and the study of individuals in their social context (as cited in Al-Busaidi, 2008). Similarly, qualitative description could be a prerequisite for qualitative research, particularly in areas with little prior investigation (Al-Busaidi, 2008). This is particularly relevant in PE, an emerging concept in South Africa that has not been thoroughly examined for effectiveness in this environment. As a result, qualitative methodologies are necessary to investigate PE treatment in this setting, thoroughly. They enable a descriptive examination of the treatment's implementation, providing useful insights for future research.

Qualitative research is commonly used in healthcare to understand patterns of health behaviours; describe lived experiences; develop behavioural theories; study healthcare needs, and design interventions (Renjith et al., 2021). Furthermore, using qualitative methods in health research has allowed for a better understanding of health professionals' perspectives on incorporating laypeople in care and identifying barriers to implementing change in healthcare practices (Al-Busaidi, 2008). This aspect is critical to the current study investigating the feasibility of social workers implementing PE. Using qualitative methodologies enables a thorough investigation of social workers' viewpoints, potential challenges, and the feasibility of incorporating PE into their current practices. This technique can provide useful insights into effective implementation strategies and address identified barriers.

Flick et al. (2004) summarised the essential theoretical assumptions of qualitative research. First, social reality is considered a collective creation, emerging from the meanings individuals attribute to their experiences. Next, the premise is that social reality is dynamic, constantly evolving, and involves a reflexive relationship. Objective aspects of life, such as events or situations, are understood in the context of the subjective interpretations assigned to them by individuals. Finally, social reality is considered communicative, meaning people build their perception of the world via communication.

Qualitative research enables a thorough examination of social workers' experiences, perspectives, and opinions and their clients' participation in this implementation and task-shifting study. It reveals the complexities of implementing PE in this environment, such as practical challenges, attitudes, and cultural context, which are essential for understanding the intervention's feasibility and acceptability. Furthermore, qualitative approaches are well-

suited to capture the nuanced features of how PE is viewed and experienced by clients undergoing therapy, offering valuable insights regarding its acceptability at The Trauma Centre.

### 3.1.2. Implementation Science

The study is embedded within the methodology of Implementation Science. Implementation Science encompasses various models, theories, and frameworks guiding research findings into practice. The proposed study will be guided by feasibility and acceptability as concepts. Feasibility evaluates the suitability of an intervention for further testing, helping researchers understand its applicability and viability (Bowen et al., 2009). These studies indicate the modifications needed to research methods and protocols and how these changes can be implemented (Bowen et al., 2009). Furthermore, acceptability refers to stakeholders' perceptions of whether a particular innovation is agreeable or satisfactory (Hamilton & Finley, 2020). Using these two conceptual frameworks, the gathered data will be analysed, with feasibility and acceptability as the guiding constructs for the analysis.

It has been widely reported that EBPs take, on average, 17 years to be incorporated into routine general practice in healthcare, with only about half of them ever reaching widespread clinical usage (Bauer & Kirchner, 2020). Implementation science is the study of methods to promote the systematic uptake of research findings and evidence-based practices into standard practice, aiming to enhance the quality and efficacy of healthcare services (Bauer et al., 2015). It is more comprehensive than standard clinical research, concentrating not only on the patient but also on the provider, organisational, and policy levels of healthcare (Bauer et al., 2015). It is fundamentally multidisciplinary and transdisciplinary, involving health services researchers, economists, sociologists, anthropologists, organisational scientists, administrators, frontline physicians, and patients (Bauer et al., 2015; Wilson & Kislov, 2022). Implementation science often starts with an underutilised EBP and recognises and addresses quality gaps at provider, clinic, or healthcare system levels (Bauer et al., 2015). Implementation strategies are critical for changing healthcare organisations, professional behaviour, or the utilisation of health services; they serve as the "how to" of initiatives to change (Wilson & Kislov, 2022).

### 3.1.3 Goals for Implementation Science

The objective of implementation science is to bridge the gap between research and application. It aims to expedite the transition of research findings into clinical practice by examining the techniques and procedures that facilitate or hinder the utilisation of EBPs in routine healthcare settings (Chen et al., 2017). It encourages systematically integrating evidence-based procedures into routine care to improve healthcare quality and efficacy (Bauer et al., 2015; Yapa & Bärnighausen, 2018). It involves investigating the methods and strategies used to integrate treatments within specific settings, such as processes, adaptability, fidelity, and behavioural effects (Brownson et al., 2018; Wilson & Kislov, 2022).

Recognising the complexities of this process, Bowen et al. (2009) emphasise the importance of a comprehensive approach that includes the careful selection, adaption, and assessment of intervention studies. Implementation research actively encourages using evidence-based healthcare approaches in routine care (Brownson et al., 2018). It aims to improve healthcare quality by developing generalisable knowledge that can be applied beyond the scope of research (Bauer et al., 2015).

Qualitative methods are invaluable in implementation research as they help answer and understand complex questions and describe what is happening and why (Hamilton & Finley, 2020).

### 3.1.4 Implementation Science in LMICs

Implementing and maintaining any treatment, including PE, is a complex undertaking, as described by Bauer et al. (2015). Implementation techniques are frequently complex and multifaceted and need considerable thought and adaptation to suit the local context. Furthermore, implementation occurs in settings which involve numerous interacting levels, such as patients, providers, teams, and service units, with substantial variance between settings. Without an in-depth understanding of the context, an EBP may be adopted or implemented in a modified form, jeopardising its integrity, due to contextual constraints. Theory must be used consistently and collectively to manage this complexity and create knowledge about what works, where, and why.

When comparing research efforts in high-income countries (HICs) versus low- and middle-income countries (LMICs), it is clear that the clinical context and available resources, such as organisational funding and healthcare infrastructure, influence the types of implementation barriers that arise (Chen et al., 2017). In HICs, obstacles are frequently defined in terms of characteristics that are unique to the organisation where the intervention is being implemented, whereas, in LMICs, implementation challenges are frequently linked to economic, political, and social variables that impact institutions beyond the organisation (Chen et al., 2017). These issues include sociopolitical instability, a lack of mental health infrastructure, insufficient funding for social services, a lack of familiarity with mental health concepts, and low literacy rates (Chen et al., 2017). In implementation science, there is a growing recognition that effectively implementing and maintaining evidence-based treatments require awareness of the climate, culture, and social environment (Chen et al., 2017).

In LMICs, a lack of mental health infrastructure makes it challenging to depend purely on qualified mental health practitioners to offer evidence-based practices (EBPs) (Chen et al., 2017). Several studies have looked at the feasibility of training primary care personnel or paraprofessionals to administer EBPs, with some showing efficacy (Chen et al., 2017). The limits on human and physical resources experienced in resource-limited nations and communities will likely encourage progress in health implementation science (Yapa & Bärnighausen, 2018). In these environments, routine healthcare is frequently delivered by nurses and community health workers, who may lack access to basic medical equipment and operate in primary care clinics or homes with unreliable referral mechanisms to higher-level treatment (Yapa & Bärnighausen, 2018). These limits and the significant gaps between ideal and real-world healthcare delivery in such settings, provide a climate conducive to innovation (Yapa & Bärnighausen, 2018). This is due to the requirement for increased creativity to successfully incorporate scientific developments in routine healthcare practices (Yapa & Bärnighausen, 2018). In LMICs, evidence-based procedures are adapted by reducing technical jargon; customising language and examples to be culturally relevant; eliminating specific protocol components, and utilising oral and visual explanations instead of written handouts (Chen et al., 2017).

### 3.1.5 Feasibility and Acceptability

The nature of the intended change, as well as a careful analysis of how and why a certain approach is expected to be effective in each environment, is likely to impact the implementation method chosen (Wilson & Kislov, 2022). Theory provides an important lens through which we predict, identify, and define the major aspects driving change (Wilson & Kislov, 2022). The application of theory helps to define the nature of the desired change and considers the larger system, process, and contextual characteristics that must be addressed, if implementation plans are to be effective (Wilson & Kislov, 2022). The concepts of feasibility and acceptability have guided this research.

As a conceptualisation framework, feasibility is crucial in assessing an intervention's suitability, compatibility and trialability for further testing and implementation (Bowen et al., 2009; Brownson et al., 2018). It involves meticulously evaluating the intervention's applicability and viability in real-world contexts, providing valuable insights for researchers to understand the practicality of moving forward with the intervention (Bowen et al., 2009). Feasibility studies also illuminate the necessary modifications to research methods and protocols, offering a guideline for refining the intervention and optimising its potential impact (Bowen et al., 2009). Perceived feasibility is critical to the early adoption of interventions, as it determines if a new programme or policy can be implemented within a certain organisation, environment, or population (Brownson et al., 2018).

Furthernmore, the study was guided and conceptualised by acceptability, which revolves around stakeholders' perceptions of whether a particular innovation is agreeable or satisfactory, based on their knowledge or direct experience (Brownson et al., 2018; Hamilton & Finley, 2020). Understanding the acceptability of an intervention is crucial in gauging its potential success and uptake within the target community or setting. Acceptability can refer to various factors within a healthcare context, such as interventions, procedures, technology, and services (Brownson et al., 2018). It should be assessed using stakeholders' knowledge or experience with various aspects of the intervention, such as its content, complexity, or usability (Brownson et al., 2018). Stakeholders, such as administrators, payers, providers, and consumers, may offer acceptability insights, which will likely evolve with time and experience (Brownson et al., 2018). Ultimately, conclusions of acceptability can vary depending on the implementation stage, such as pre-implementation and during the implementation process (Brownson et al., 2018).

The gathered data were systematically analysed using these two conceptual frameworks - feasibility and acceptability. Feasibility and acceptability guided the analysis process, allowing for a nuanced exploration of the intervention's practicality and stakeholder reception. This methodological approach ensures that the study not only assesses the theoretical effectiveness of the intervention but also addresses the real-world factors that influence its implementation and acceptance within the specified context.

### 3.1.6 Research Questions

The following research questions guided the proposed study:

- How did the social workers at The Trauma Centre in Cape Town perceive and experience the feasibility of using PE as a treatment for PTSD?
- What are the perspectives and experiences of the social workerst at The Trauma Centre in Cape Town regarding the acceptability of using PE as a treatment for PTSD?
- How did the clients receiving PE for PTSD perceive and experience the acceptability of this treatment?

## 3.2 Research site: The Trauma Centre

The Trauma Centre for Survivors of Violence and Torture Trust is a registered Non-Profit Organisation (NPO) and Public Benefit Organisation (PBO) in South Africa. They aim to foster a non-violent society that respects human rights and addresses trauma through inclusive healing processes. The centre aims to achieve this by providing evidence-based healing practices to restore the mental health of survivors of violence and torture, offering capacity-building for laypersons; frontline workers; and communities in trauma healing; fostering local and global partnerships to strengthen interventions, and delivering services through community-based clinics in various locations. As part of their work, they operate a Child Protection Clinic, a community clinic and provide violence prevention services. The study will involve social workers from The Trauma Centre implementing PE with clients in Cape Town.

## 3.3 Sampling strategy

### 3.3.1 Sample

There are two sample sets in the proposed study. The first is the social workers working at the Trauma Centre. The primary investigators trained twelve social workers, with nine completing the preintervention interviews and four remaining in the study until the end. Because the proposed study is part of a broader investigation, this training took place in July 2022.

Clients receiving PE comprise the second sample of participants. There were five clients, with each social worker treating one and one social worker treating two.

Like the larger trial, this proposed study used purposive sampling, and the social workers administering PE to participants were already employed at The Trauma Centre. Purposive sampling is a common qualitative research approach that involves selecting individuals who meet the criteria relevant to the research topic (Renjith et al., 2021). This strategy strengthens the study's credibility by ensuring the selected participants exhibit characteristics or experiences applicable to the phenomena under examination (Renjith et al., 2021). Sampling in qualitative research aims to find distinct groups of individuals who have certain qualities or live in conditions relevant to the subject, thus allowing for a thorough examination of attitudes and behaviours (Al-Busaidi, 2008).

### 3.3.2 Recruitment

Initial contact was made with the Director of The Trauma Centre to obtain gatekeeper permission and their consent to do the study at The Trauma Centre. Once that was obtained, the employees were made aware and informed about the study that would be taking place. Next, the PI made contact with The Trauma Centre and set up an initial online presentation meeting with them to introduce himself to everyone. Based on this meeting, participants were then given time to consider whether they would want to be part of the project or not. Several Trauma Centre employees decided not to participate in training, due to work load issues.

Furthermore, the clients that were recruited were all refugees. This was not intentional, but rather happened organically based on the clients who agreed to participate. The Trauma Centre's existing referral process was followed to recruit clients. Suitable participants were then selected using predetermined inclusion and exclusion criteria. For example, clients who willfully sought out services at the Trauma Centre were informed about the project, or clients who are referred to The Trauma Centre by an external agency, such as the South African Police Services, were notified. All potential referrals to the study were identified by the administrative staff of the Trauma Centre. Eligibility of participants was based on the inclusion and exclusion criteria and the posttraumatic stress disorder checklist for DSM5 (PCL-5). The use of the PCL-5 is an easy to administer self-report measure to determine a positive PTSD diagnosis (cut-off is 33). Potential clients were contacted telephonically by staff members of the Trauma Centre to see if they wanted to participate.

The training consisted of two separate trainings. The PI (Dr. Booysen) did a general CBT training with The Trauma Centre staff that ran over one day, and then Dr. Rossouw and Dr. Booysen did a two day training with the staff focusing on PE. After the training, the staff were interviewed and those who wanted to take part and participate followed through with the implementation.

Participation was voluntary throughout, which is why some people decided not to participate.

### 3.3.3 Inclusion and Exclusion Criteria

Inclusion criteria for the social workers were that they must have been registered with the South African Council for Social Service Professions (SACSSP).

Inclusion criteria for the trauma clients included males and females (South African and Non-South African) aged between 18 – 65 years. Participants must have received PE at the Trauma Centre for a minimum of three sessions to be included. Participants must have been able to speak English and Afrikaans or English and isiXhosa or isiZulu. Clients were required to reside in Cape Town. Participants would be excluded from the study if they were younger than 18 years of age and if they were actively suicidal or homicidal with clear intent.

### 3.4 Ethical Considerations

A qualitative study must be grounded in the principles of beneficence, non-maleficence, autonomy, and justice (Renjith et al., 2021). Beneficence refers to the objective of seeking to do good; non-maleficence is doing no harm; autonomy is allowing participants to make their own decisions; and justice refers to acting in fair and equitable ways (Pope et al., 2020).

Protecting the participants was paramount, and the greatest care was taken while collecting data from a vulnerable research population (Renjith et al., 2021). The clients in this study could be seen as a vulnerable population. They were individuals who were experiencing PTSD symptoms, emphasising a traumatic past or present, that was significantly affecting their lives. PE, although shown to be effective, involves a client retelling their trauma narrative and confronting places, activities or people, that elicit a trauma response. Because of this, ethical considerations were vital to this study to ensure no harm was done to the participants.

Ethical approval was obtained prior to me joining the project. The PI submitted ethical approval and the project was approved by the psychology department ethics committee and the Rhodes University Ethical Standards Committee (RUESC) in 2022.

With regards to consent, the PI's conducted presentation at The Trauma Centre, which allowed the staff to ask any questions and clarify concerns about the training and implementation of PE. Those who chose to participate were invited to sign a consent form to be trained in PE and to implement PE. Importantly, the social workers and staff of the Trauma Centre were informed that their participation was voluntary.

For the trauma clients (18 years and older), during the screening meetings with referred and prospective clients, they were provided with information pertaining to the research study. Clients who declined to participate were referred to the existing services of the Trauma Centre. If a client agreed to participate, they read and indicated that they had understood what was enclosed in the consent form. Clients were informed about the research process. For example, clients were informed that they would complete brief assessment measures before the intervention started, during treatment, and once treatment was completed. All assessments (i.e., baseline, during intervention, and post-intervention) were managed and conducted by the treating social worker.

Regarding the ethical integrity of the proposed study, all researchers and staff involved maintained and implemented ethical principles such as written informed consent, confidentiality, anonymity, discontinuance, beneficence, and non-maleficence (Renjith et al., 2021). Working collaboratively with the Trauma Centre, all client-identifying information was stored at the Trauma Centre as part of their existing administrative processes. All identifying information, such as names and contact details, was removed and replaced with a code (e.g., Participant 4; Client 2). Any identifying information was also removed and anonymized at conference presentations. Lastly, all personal information collected was managed according to the POPIA regulations.

The data was anonymized and stored on a private and password-protected Google Drive storage account owned by the PI. Basic client information about the clients was also stored by the Trauma Centre as part of their existing administrative processes. The data was made available to any appropriate person or authority.

Due to the nature of the research project, the psychological safety of participants was prioritized throughout the study. First, excluded participants were eligible for services at the Trauma Centre or any other available organizations of their choice in the Cape Town area. Participants who decided to withdraw for any reason were informed about service providers in the Cape Town area, should they need to try a different treatment or re-start treatment at a later time. Clients who decided to decline participation in the study were not treated unfairly and were invited to make use of the services at the Trauma Centre.

Any adverse events or emergencies during the study were managed by the PI and the director of the Trauma Centre. The PI checked on a weekly basis during case consultations to assess whether any adverse events had occurred and if any participants were at risk.

Risk related to the social workers as participants was considered minimal, as they were trained and registered health professionals. However, the progress and potential difficulties of the social workers were monitored and discussed during the weekly consultations.

Demonstrating rigour or quality in research is crucial regardless of the method used. Lincoln and Guba (1985) introduced criteria for evaluating qualitative research, often referred to as ‘standards of trustworthiness’, as stated by Renjith et al. (2021). These criteria include

credibility, transferability, dependability, and confirmability. Credibility is about ensuring the "truth value" of the data and their interpretation. Transferability assesses how findings can be applied to other settings or populations. Dependability refers to the repeatability or replicability of the study findings. Confirmability, the fourth criterion, concerns the extent to which study findings can be confirmed by others. To enhance trustworthiness, qualitative researchers should ensure rigour in their studies and report measures taken to enhance trustworthiness.

This study recognised trauma clients' vulnerability and emphasised the significance of safeguarding their well-being throughout the research. To minimise harm and exploitation, precautions were taken, including the ongoing monitoring of participants' experiences during the trauma treatment and evaluation of PTSD symptoms.

In the event of an adverse incident or an emergency, the study's lead investigator and the Trauma Centre director managed the situation. Participants' well-being was monitored regularly, and the Rhodes University Ethics Committee was notified if needed, to guarantee transparency and guidance.

While the risk to social workers as participants was considered low, due to their training and registration, their progress and any issues were monitored and discussed in weekly meetings. The social workers participated in weekly supervision with the PI, where they could bring up any challenges or adverse effects they were dealing with because of the research process.

### 3.5 Data Collection

The study adopted a qualitative research approach, employing semi-structured interviews as the primary data collection method. This methodology involves conducting interviews before and after the implementation of the PE, offering a dynamic and comprehensive perspective on the participants' experiences.

Semi-structured interviews are chosen due to their effectiveness in eliciting in-depth insights into individuals' thoughts, perceptions, and experiences regarding a novel idea or its implementation (Al-Busaidi, 2008; Hamilton & Finley, 2020). Semi-standardised interviews offer valuable opportunities for exploring situational meanings, motives for action, everyday

theories, and self-interpretations in a detailed and open manner (Flick et al., 2004). This approach allows for a discursive understanding through interpretations, providing a platform for applying action-theory ideas in sociology and psychology (Flick et al., 2004). The research aimed to create a conducive environment where individuals felt invited to share their perspectives openly, by engaging participants in one-on-one conversations. The interview questions were carefully crafted to be inviting, accessible, and analysable, ensuring that the responses gathered were rich in detail and contributed meaningfully to the research objectives. The client interview guide had to be altered, as a participant struggled with the language chosen, expressing that technical jargon made it difficult to understand and answer the questions. The revised interview guide included simpler English for everyone to understand. Outside interviewers and I conducted the interviews. The interview questions guided the interviewers in asking questions relevant to the study objectives and allowed each participant to tell their narrative and express their opinions.

Using qualitative procedures in social research has highlighted the advantages of semi-structured interviews over more restricted standardised questioning methods (Flick et al., 2004). Semi-structured interviews align with the principles of discovery and exploration, emphasising the creation of meaning through reflective dialogue with participants (Magaldi & Berler, 2020). By embracing semi-structured interviews, the study aimed to interrogate the lived experiences of social workers and their clients, capturing nuanced insights beyond the scope of quantitative data. Conducting these interviews one-on-one with social workers and their clients is a deliberate choice to facilitate a personalised and intimate exploration of their experiences. This was achieved by allowing for flexibility and for the participants to guide the interview, leading to an exploration of their experiences and attitudes (Al-Busaidi, 2008). This flexibility allows for the production of richer data (Al-Busaidi, 2008).

This approach aimed to uncover a comprehensive understanding of the participants' perspectives and to identify recurring themes in their discourse. Through these qualitative interviews, the study aimed to illuminate the dynamics surrounding the implementation of PE therapy, ultimately contributing to the broader field of Implementation Science and informing future mental health interventions in similar contexts.

Despite the many advantages of semi-structured interviews, several challenges and disadvantages exist. This type of interviewing can sometimes reduce the researcher's control over the interview process and it can take longer to conduct and analyse (Al-Busaidi, 2008).

### 3.5.1 Interview Guideline

The interview guides (Appendix D and E) had been formulated by the time I joined the research team. However, I reviewed both guides. I changed the client's interview guide due to technical jargon, which made it difficult for participants to understand and answer the questions in rich, descriptive detail. In doing this, I made the existing questions easier to understand.

Burgess (cited in Taylor, 2005) defines qualitative research interviews as "conversations with a purpose" (p. 39). As a result, an interview guide is necessary to facilitate this conversation and generate answers from participants that are spontaneous, in-depth, unique, and vivid (Kallio et al., 2016). According to Patton (2002), an interview guide is a series of topics or questions the interviewer is open to exploring and probing with the interviewee (as cited in Al-Busaidi, 2008). Moreover, the guide outlines the themes, topics, or scenarios to be explored within the interview and may include phrases to prompt the discussion (Taylor, 2005). These form a loose guide to the conversation, allowing the participants to explore issues that are relevant to them, rather than discuss aspects that may reinforce the researcher's preconceptions (Taylor, 2005). A significant advantage of having an interview guide is that it aids the interviewer in asking the same basic lines of inquiry with each participant, while managing the interviews in a systematic and comprehensive way (Al-Busaidi, 2008).

The interview guide's quality affects the interview's implementation, and the analysis of the collected data (Kallio et al., 2016). Ultimately, the aim is to understand the world from the participant's perspective (Taylor, 2005), emphasising that the answers reflect the interviewee's personal feelings and narratives, allowing new concepts to emerge from the interview (Kallio et al., 2016).

### 3.5.2 Interview Procedure

The interview aims to explore the 'insider perspective' and capture their thoughts, perceptions, feelings, and experiences (Taylor, 2005). Thus, while interviews can be carried out in several formats (face-to-face, over the telephone or via the Internet), the tone of the

interview is generally informal and conversational, reflecting a two-way process, where the researcher and participant engage in a dialogue to explore the topic at hand (Taylor, 2005).

This study involved two cohorts of participants. The social workers were involved in two interviews: pre-and post-intervention. The clients took part in one set of post-intervention interviews.

The pre-intervention social worker interviews took place over three days in 2022. Nine participants were interviewed on 22 July, 5 August or 9 September. An external interviewer conducted these interviews, and each interview was done face-to-face at The Trauma Centre. These interviews were conducted before I was part of the larger research team.

From July 2023, I started scheduling post-intervention interviews with the social workers and the clients. By this time, there were four social workers still providing PE. An external interviewer conducted three social workers' post-intervention interviews via Zoom, and I conducted one in-person interview at The Trauma Centre. The interviews were conducted on 7, 14 and 19 September and 13 October 2023.

In addition, I set up interviews with the clients and the external interviewer. These interviews were conducted from August to December of 2023.

Using a qualitative interview format, enabled participants to provide detailed descriptions of their experiences and offer their perspectives and interpretations of these experiences (Taylor, 2005). The relevant interviewers had the opportunity to discuss and explore topics and questions with the participants and probe further, if necessary (Taylor, 2005). Each interview allowed the participant to describe their experience, beliefs, and attitudes. This individualised approach is crucial as it acknowledges the uniqueness and humanity of each participant, aligning with the researcher's goal of capturing diverse and subjective accounts (Taylor, 2005).

### 3.6 Data Analysis

### 3.6.1 Thematic Analysis

Implementation Science incorporates diverse analytical methods, and this study employed thematic analysis (TA) as its chosen analytic method. Thematic analysis is a systematic process that involves identifying and organising patterns of meaning, commonly known as themes, across a dataset to extract meaningful insights (Braun & Clarke, 2012).

Thematic analysis is independent of theory and epistemology (Campbell et al., 2021). This independence from a specific theoretical framework permits a broad and flexible application of the analytic approach (Campbell et al., 2021).

TA is the researcher's thoughtful engagement with the data and analytic process (Braun & Clarke, 2019). Terms, such as 'developing', 'constructing' and 'generating' define this process (Braun & Clarke, 2019). It is important to understand its purpose and approach, to improve thematic analysis practice. Braun and Clarke (2019) point out several points that aid in this understanding. First, it is important to be explicit, thoughtful and intentional when applying the method and theory of thematic analysis. Second, recognising that assumptions and perspectives are inherent in qualitative research is imperative. It is necessary to unpack these assumptions, and it is good practice to reflect on and identify your assumptions for a particular project. Third, acknowledging the existence of different approaches to thematic analysis - which may not always align - can help avoid confusion and ensure consistency in concept and practice. Furthermore, selecting a thematic analysis approach that aligns with one’s research purpose and analytical sensibility is essential. Last, emphasising the importance of quality and understanding the reasons behind one’s actions are crucial for conducting effective, reflexive thematic analysis.

### 3.6.2 Analysis Procedure

The study's analysis will follow a comprehensive six-step process for thematic analysis, as outlined by Braun and Clarke (2012):

#### *3.6.2.1. Familiarisation:*

This step involves immersing oneself in the data to deeply understand its content (Campbell et al., 2021). Actions within this step include transcribing data, note-taking,

reading and re-reading the data set, and preliminary searching for patterns and meanings (Campbell et al., 2021).

This step was achieved by listening to the interview recordings several times. I listened to the social workers' pre-intervention interviews, post-intervention interviews, and client interviews. Once I had done this, I read through each transcript. I then read the transcripts while listening to the recordings to ensure I was reading the tone and meaning correctly. By listening and reading simultaneously, I could also check the accuracy of the transcripts and make edits where necessary, thereby increasing the reliance and validity of the transcripts.

This step involved a conscious knowledge of reflexivity. According to Campbell et al. (2021), reflexivity is a process of self-examination, revealing ourselves as individuals and researchers, while understanding how our personal biases may influence the research process. This ongoing process calls for the researcher to situate themselves within the analytic process, considering several factors such as age, race, ethnicity, and gender identification (Campbell et al., 2021).

#### *3.6.2.2. Coding*

This step involves the systematic coding of data to identify meaningful units (Braun & Clarke, 2006). This entails organising the data to formulate initial codes, achieved by labelling and organising the data into groups (Campbell et al., 2021). Codes are the fundamental building blocks to developing themes and involve assigning codes to identify important statements, experiences, and reflections (Braun & Clarke, 2006).

Following the familiarisation process, initial codes were generated. This was done using Atlas, with access provided to me by Rhodes University. The codes generated are narrower than the themes identified next (Campbell et al., 2021). A few words represented each code, but they were descriptive and represented extracts from each interview that presented valuable information in answering the research questions.

The pre-intervention with the social workers' coding resulted in 48 codes across the nine transcripts, with 212 quotations highlighted. The post-intervention with the social workers' coding resulted in 39 codes and 219 quotations across four transcripts. Finally, the client's analysis revealed 12 codes, with 265 quotations from five transcripts.

#### *3.6.2.3. Generating (Initial) Themes*

The next step involves sorting codes into initial themes and identifying the meaning and relationships between the initial codes (Campbell et al., 2021). This can be achieved by diagramming, mind mapping or writing themes and their defining properties (Campbell et al., 2021). According to Braun and Clarke (2019), themes do not emerge from the data since they are not 'in' the data. Rather, they are interpretive stories about the data produced through the researcher's theoretical assumptions, their analytic resources and skills, and the data themselves.

I did this step manually. I wrote out each code in a notebook for the pre-intervention interviews with the social workers. Then, I started gathering codes with similar or connected meanings and rewrote all those codes together. I had a symbol for each group of codes that seemed related, which resulted in ten groups of related codes. I then analysed these ten groups to find emerging themes and numbered each group one, two and three – for the three emerging themes. Next, I organised the codes within each theme according to similarities or alikeness.

I followed the same process for the post-intervention interviews. This process resulted in six groups of codes, which were then organised into four themes.

For the client's post-intervention interviews, fewer codes were found in the analysis procedure. Based on the codes that generated the most information from the clients, I generated the themes on Atlas.

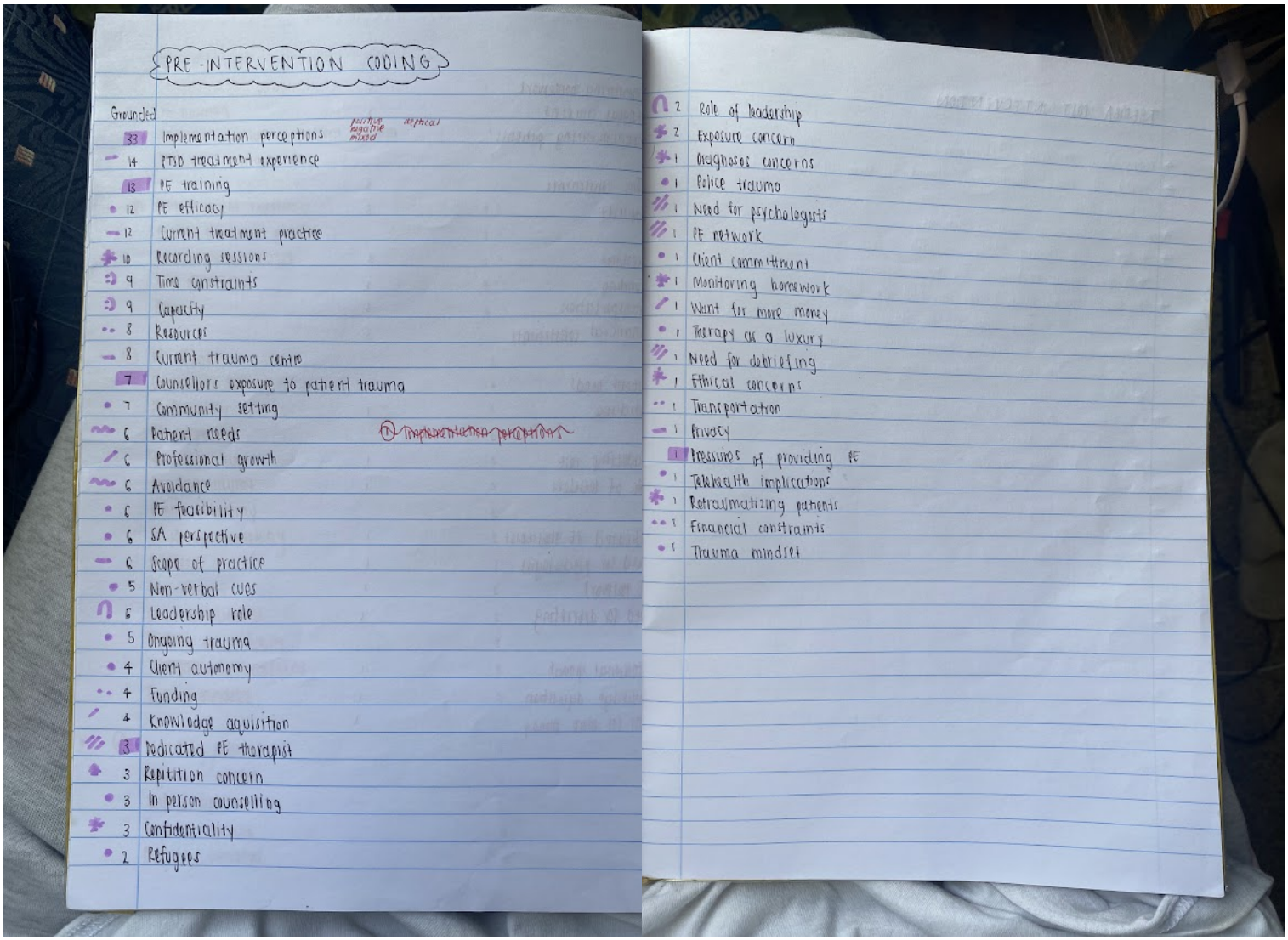


*Figure 3.1:* Initial codes from social workers' pre-intervention interviews (own photo)

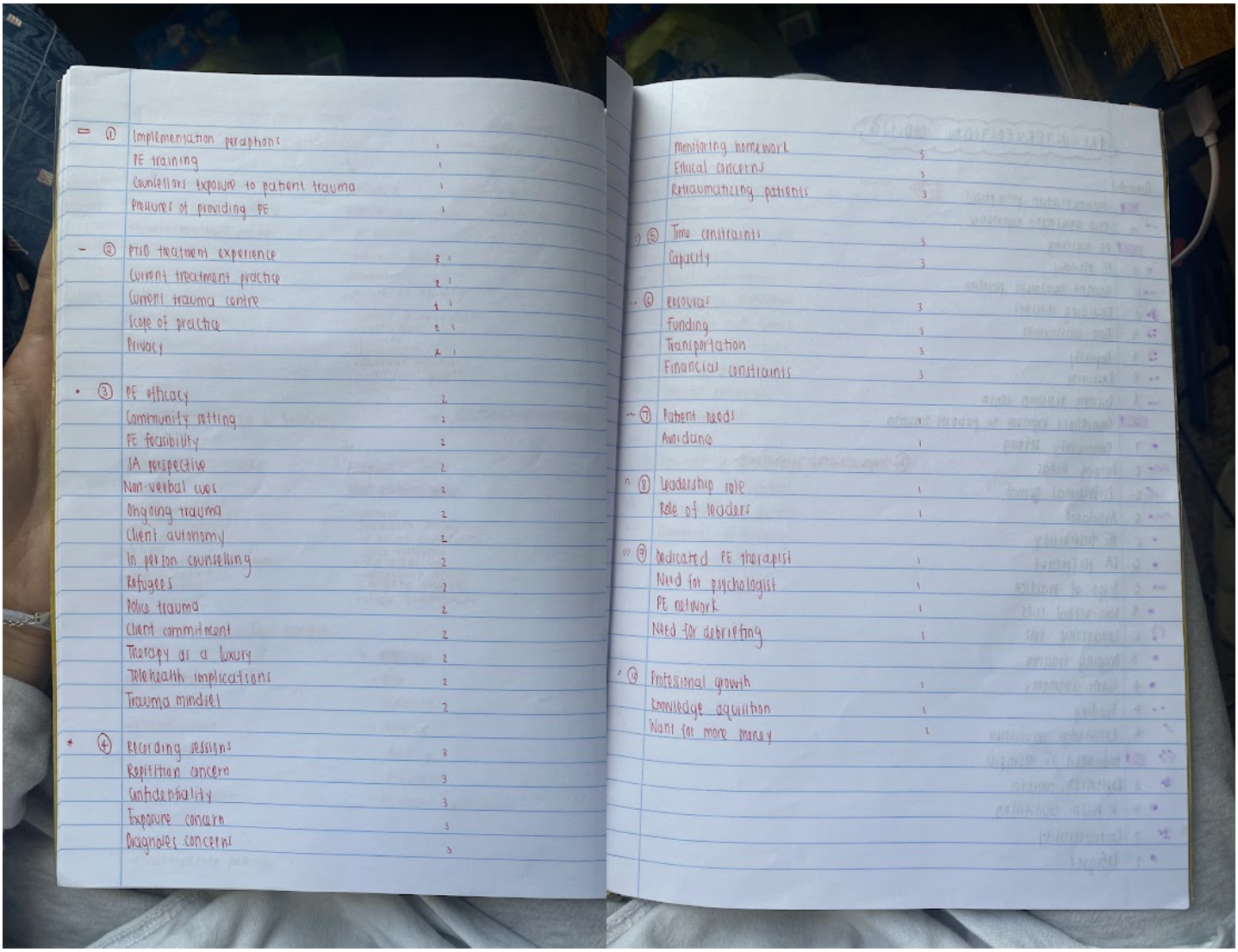


*Figure 3.2:* Grouping of codes from social workers' pre-intervention interviews (own photo)

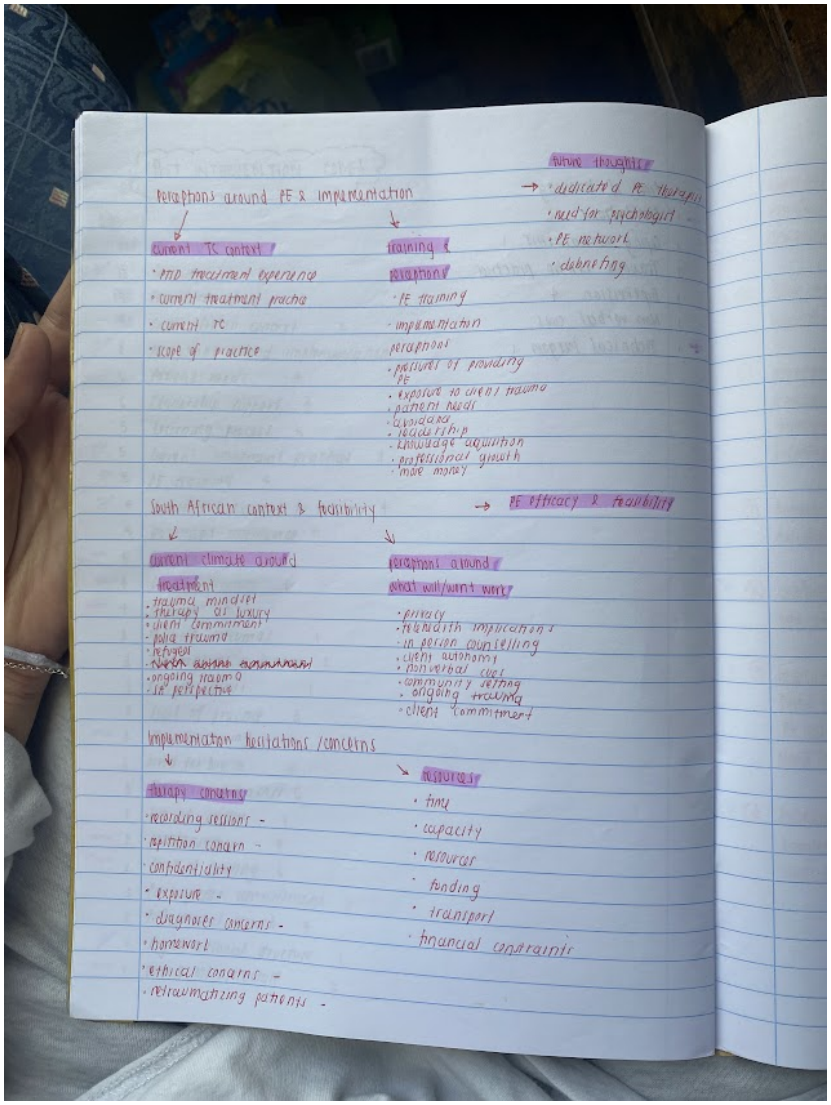


*Figure 3.3:* Formulation of themes for social workers' pre-intervention findings (own photo)

#### *3.6.2.4. Reviewing and Defining Themes*

Braun and Clarke (2006) describe the two-level process of reviewing and defining themes. First, the coded data extracts are reviewed to determine if they form comprehensive patterns for each theme. The researcher can proceed to the next level if the themes fit well. If not, the researcher must analyse the themes to determine if they are problematic or if some data do not fit, thus leading to the reworking, recreation, or elimination of a theme. The second level involves reviewing the entire dataset to ensure the validity of the individual themes and the overall themes in reflecting the data's meaning. This also involves coding any data within themes that were previously missed.

This phase was an ongoing process that I kept returning to, even after completing subsequent steps. The initial list of themes is not what is shown in this paper today.

Throughout the writing process, I would make edits to my themes, such as adding or removing information or whole codes that were either deemed irrelevant or important to the research questions. My supervisor guided me during this process, and we had several meetings or conversations about my themes and any edits or changes I needed to make. In Table 3.1, 3.2 and 3.3, the iterative process of refining the themes can be seen, where the red font represents my thought process and sections that were removed or edited.

**Table 3.1**

*Example of Initial Themes and Edits made to the Social Workers' Pre-Intervention Themes*

| **Subordinate themes** | **Sub-themes** |
|---|---|
| Subordinate theme 1: Perceptions around PE and implementation. | Theme 1: Current Trauma Centre context |
| | Theme 2: PE training and perceptions (cut down) |
| | Theme 3: Future directions |
| Subordinate theme 2: South African context | Theme 1: Current climate around treatment |
| | Theme 2: Perceptions on what will and will not work. (keep parts around efficacy and feasibility) |
| | Theme 3: Efficacy and feasibility (combine theme 2 and theme 3). |
| Subordinate theme 3: Implementation concerns | Theme 1: Therapy concerns (drop this theme and put nb info in the previous theme). |
| | Theme 2: Resources (drop or keep?) |

**Table 3.2**

*Example of Initial Themes and Edits made to the Social Workers' Post-Intervention Themes*

| **Subordinate themes** | **Sub-themes** |
|---|---|
| Subordinate theme 1: Perceptions of implementation (keep but cut down) | Theme 1: Post-treatment views |
| | Theme 2: Hurdles and limitations to treatment |
| Subordinate theme 2: South African context | Theme 1: Trauma Centre culture (repetition of pre-intervention themes, so should I remove it completely?) |
| | Theme 2: South African mindset of mental health (keep but cut down) |
| Subordinate theme 3: Feasibility | |
| Subordinate theme 4: Resources | |

**Table 3.3**

*Example of Initial Themes and Edits made to the Clients' Post-Intervention Themes*

| **Subordinate themes** | **Sub-themes** |
|---|---|
| Subordinate theme 1: Perceptions of trauma experiences | Theme 1: Isolation and loneliness |
| | Theme 2: Fear |
| | Theme 3: Lack of support and helplessness |
| | Theme four: Unworthy/no value/useless |

| | |
|---|---|
| | Theme 5: Suicidal ideation |
| | Theme six: Resilience |
| Subordinate theme 2: PE perceptions | Theme 1: Positive experiences |
| | Theme 2: Critiques on PE |
| | Theme 3: Relationship with the therapist |
| | Theme 4: Ongoing trauma/refugees/South African context<br>(Combine with next theme) |
| Subordinate theme 3: Refugee struggles | |

#### *3.6.2.5. Producing the Report*

This step involves presenting a concise account of the narrative told by the data. It entails writing a compelling argument that addresses the research questions and writing beyond the simple description of the themes (Campbell et al., 2021). This step involved my laying out the themes in a format that made sense. I had many conversations with my supervisor during this stage to get feedback at each point and ensure that I was presenting the data as best I could.

I worked through Atlas in this step and continuously referred to the transcripts to extract the quotations essential to the research questions.

## Chapter Summary

This chapter provided a comprehensive overview of the methodology and research design used in this study, to gather and analyse data relevant to the research questions. A

qualitative approach was used, which was influenced by implementation science. This chapter details the process of the research, including the used sample, the development of an interview guide, and the process of data collection and analysis. It also explored the ethical considerations that are critical to qualitative research and addressed the ethical considerations taken in this study.

# Chapter 4

# Findings – Social workers

## Chapter Overview

The next two chapters outline the results obtained through the analysis procedure to address the research questions regarding the feasibility and acceptability of implementing PE as perceived by social workers and their clients.

Chapter 5 comprises two sections: Findings related to the pre-intervention and post-intervention interviews. In the pre-intervention findings, one superordinate theme was identified, comprising three sub-themes. These findings arose from the analysis of nine social worker interviews. Post-intervention, three superordinate themes emerged from the interviews with the remaining social worker participants, which included four social workers.

To support these findings and ensure data trustworthiness, quotations from the interview's transcripts are included as textual evidence. Participants are represented by an abbreviation of social worker in the form of 'SW'.

The following table represents the themes in the next chapter:

**Table 4.1**

*Pre-intervention Social Worker Findings*

| **Superordinate theme** | **Sub-themes** |
|---|---|
| Superordinate theme: Perceptions of Prolonged Exposure Therapy and Implementation in South Africa | Sub-theme 1: Impact of South African Socioeconomic and Political Factors on The Trauma Centre |
| | Sub-theme 2: Perceptions of the Implementation of Prolonged Exposure Therapy |
| | Sub-theme 3: Improvement and Feasibility of Prolonged Exposure Therapy |

**Table 4.2.**

*Post-intervention Social Worker Findings*

| **Superordinate themes** |
|---|
| Superordinate theme one: Feasibility and improvement of Prolonged Exposure Therapy |
| Superordinate theme two: Post-treatment views |
| Superordinate theme three: Hurdles and limitations to implementation |

**Social Worker's Pre-intervention Findings**

## 4.1 Superordinate Theme One: Perceptions of Prolonged Exposure and Implementation in South Africa

### 4.1.1 Sub-theme one: Impact of South African socioeconomic and political factors on The Trauma Centre

South Africa is diverse, with a complex tapestry of languages, cultures, races, and religions. This diversity greatly impacts people's worldviews, perspectives, beliefs, morals and understanding. In such a context, it becomes critical to consider these aspects while implementing any treatment modalities. The societal perceptions of disorders and mental health, impact the effectiveness and acceptance of these treatments. As a result, it is crucial to avoid a one-size-fits-all approach and acknowledge the distinct cultural and individual differences that may influence treatment outcomes in South Africa.

South Africa is *"a country that has trauma every day"* (SW 1), and many people classify South Africa as *"a nation that is traumatised"* (SW 1). As a result, the need for trauma treatments in South Africa is widely acknowledged by the Trauma Centre's social workers. They acknowledge South Africa's history of widespread trauma and violence stemming from apartheid, political unrest, and high levels of crime. Thus, a significant portion of the population has been left grappling with the psychological impact of trauma. Moreover, social workers at The Trauma Centre deal with a significant number of refugee clients who come from past trauma into an environment with ongoing trauma. The growing recognition of the long-term consequences of untreated trauma, as well as a greater awareness

of mental health in the country, is leading to a greater demand for accessible and effective trauma treatments.

SW 6 reflected on the PE training, saying*:*

*Most of it is from a Westernised perspective and not a South African perspective. They don't take into account us as South Africans; we have poverty, cultural background, religious background, all of those things, so I just … can't see it working in a South African context for me. Personally, I just can't see it happening...*

Furthermore, the mindset around trauma, mental health and treatment differs across cultures, which is echoed by SW 6, who emphasises:

*Before I started working at the Trauma Centre, I would think therapy is for white people, and now that I'm here I can understand therapy is for everyone, but the people out there when we introduce therapy to them they like "No I don't want that, that's not what I want"... so maybe take into account, like South African perspective.*

SW 6's reflections highlight a gap in the applicability of Western forms of treatment to a South African context, which emphasises the need for culturally sensitive treatments that consider the diverse socio-economic and cultural realities of its targeted sample.

A prevailing sentiment among social workers is a lack of PTSD knowledge and experience in treating PTSD, due to a limited scope of practice. These social workers were trained differently from psychologists and their training focus is not on disorders and diagnosing disorders. Despite their training not focusing on the treatment of diagnosed disorders, such as PTSD, they end up working in the field of traumatic stress. Many participants stated that while they encounter clients with trauma and symptoms, suggestive of PTSD, they feel unequipped to address these issues and consequently, refer such clients to psychologists. For instance, SW 8 highlighted this by stating, *"... We have been exposed to clients that ... say ... this is post-traumatic stress disorder but because we are not um, trained to deal with that or believe that way so we usually would refer them to a psychologist."* Similarly, SW 5 mentioned, *"Well, I haven't had any work with PTSD; we work with trauma, but um, I haven't actually counselled anyone with PTSD,"* indicating a gap in knowledge and capability when dealing with PTSD cases. Despite PTSD being outside a social worker's

scope of practice, the high prevalence of this disorder sheds light on the need for further training and education for social workers dealing with such mental health difficulties.

Regarding the current treatment practices employed by social workers at The Trauma Centre, there is a consensus that they utilise a basic and unstructured form of Cognitive Behavioural Therapy (CBT). Several participants expressed that they were never formally trained in any specific treatment modality, leading to a basic understanding of CBT or other evidence-based treatments. SW 5 illustrated this, stating: *"... I've never been trained in a specific model to actually give therapy in, so, ... as social workers, we are eclectic. We use, we take from different places."* She also mentioned, *"I've learnt a lot in practice, but none of us actually been trained in it."*

SW 1 summarised this situation by describing social workers as a *"Jack of all trades, masters of none."*

The interviews highlighted the social workers' reluctance to address their clients' trauma. They appeared hesitant and almost fearful to engage with their clients' stories, and subsequently, their therapeutic approaches focused on practical elements and breathing techniques. This reluctance could stem from being overwhelmed by the number of clients requiring therapy and the lack of training in the assessment of traumatic stress and relevant treatment. SW 4 described their therapy approach as *"Basically a sausage machine because people come through one after the next..."* The interviews repeatedly revealed a difference in specialised training for social workers at The Trauma Centre, where their treatment approach was largely eclectic or rooted in CBT. This ultimately led social workers to be reluctant to engage with their clients' trauma and rather focus on practical elements of treatment.

SW 2 added:

*Sometimes it doesn't even involve the victim telling the story because we believe that this person has already told the story at the police station... This person has told the story to the nurse or the doctor, and they come to me, and they just come in for support. I've read the referral note, and then if a person cannot talk on that day, it's okay. That therapy says that keeping quiet sometimes healing on its own.*

This lack of active engagement with the trauma narrative led several participants to express dissatisfaction with the effectiveness of the current treatment practices. SW 1

remarked, *"It's not very effective when you look at that".* As evidenced above, the social workers largely focus their sessions on practical strategies to address trauma while avoiding their client's trauma narrative. This approach inadvertently reinforces the avoidance cycle that is essential to PTSD, leading to the perpetuation of the trauma cycle, without being effectively addressed or alleviated.

The primary reason for the lack of PTSD understanding and the use of unstructured trauma treatments among social workers can be attributed to their scope of practice. Social workers are restricted in the types of clients they can treat, and individuals diagnosed with PTSD fall outside of their scope. As a result, they often refer these clients to hospitals or psychologists because social workers possess only a basic knowledge of trauma-focused treatments. SW 4 explained this, stating, *"Many of the clients that might be um, benefiting from this treatment, we … refer them because we find ourselves in a position of saying no, we are not psychologists, and we cannot um, diagnose clients so we do referrals".* Furthermore, SW 9 stated, *"Within my scope of practice and profession, I'm not allowed to diagnose PTSD."*

Their limited scope of practice has led some participants to question their ability to provide PE to clients, as they were never permitted to treat PTSD previously but are now being encouraged to do so. SW 2 expressed this uncertainty, saying, *"Now it's presented to me as if I'm capable of doing it. Am I capable or not? I think I am, but my scope of work does not allow me to step into that boundary."*

It is evident that South Africa's rich diversity significantly influences individuals' worldviews and approaches to mental health. This complexity necessitates a nuanced understanding when implementing treatments, as societal perceptions of mental health and trauma impact the acceptance and effectiveness of these treatments. Social workers at The Trauma Centre are acutely aware of the need for tailored trauma interventions but face challenges in addressing trauma, due to gaps in their training and experience with PTSD. This lack of specialised knowledge in PTSD needs to be addressed if task-shifting is to be widely used in the future. Addressing this is essential for improving the effectiveness of trauma treatment and ensuring that it is widely implemented and aligns with the diverse and complex realities faced by those in South Africa.

### 4.1.2 Sub-theme two: Perceptions of the Implementation of Prolonged Exposure Therapy

Participants expressed a variety of perspectives regarding the implementation of PE, spanning a wide spectrum of thoughts. Some participants felt uncomfortable with the therapy, due to ethical concerns and a fear of causing more harm than good. Others had mixed feelings, acknowledging the potential benefits and challenges of implementing PE. On the other hand, some participants had very positive feelings about PE. They saw it as a valuable and effective therapeutic approach, *"That is long overdue that should have been … incorporated or presented a while ago"* (SW 8). These diverse perspectives indicate the complexity of introducing new interventions, such as PE and highlight the importance of considering individual attitudes and concerns in the implementation process.

Participants expressed varying degrees of scepticism towards implementing PE and hesitancy regarding its suitability for their clients. SW 6 did not believe the Trauma Centre clients would take well to that form of therapy since *"We work on the Cape Flats and people, they don't want exposure therapy, they feel that's not for them, they looking for more quick solution."* The time-consuming nature of this therapy was a major concern for many participants, which will be discussed further in theme 3. SW 3 believed this treatment is tailored for upper-middle-class people and would not necessarily work in a South African context, unless it was *"improved"*.

The social workers at The Trauma Centre are accustomed to a more spontaneous and unstructured therapy method, where they address each session as it arises, without following a formal treatment plan. As a result, the structured nature of PE is unfamiliar to them and elicited mixed reactions.

SW 3 found an issue in the lack of autonomy this treatment allows, stating, *"The prolonged exposure therapy doesn't give you the space to be yourself; you just have to follow the process … you can't be like a robot"*. SW 2 found an issue with the fact that she believed she could not provide a rounded form of therapy because of the structured guideline, mentioning that:

*It stops me from … giving a holistic support in terms of other systems that are affecting the person because my focus is on those two things, the imaginary and the*

*behaviour, but it leaves everything else out that, as a social worker, I'm supposed to be supporting this person with.*

Contrary to this, SW 1 sees PE as a form of therapy whereby:

*You can stick to it and see how that works, so it's something that if I use, I can safely say, look I've used it, and it has worked. I can't corrupt with using other styles because the guideline is very to the T of what somebody is supposed to do, so it's … exciting.*

SW 2 expressed adverse feelings towards the implementation of PE. Their main sentiment was feeling uncomfortable, whereby she stated*, "If there's anything that I'm very uncomfortable with, it's two things: the recording and that repetitiveness. I need to get it in my head that it works. I don't think it does".* She feels the repetitive element *"sounds a little bit unethical for me as a social worker to do this part".* These concerns are valid and need to be addressed. Despite the efficacy of PE in the global north, the idea of repeatedly recounting and recording trauma narratives is unfamiliar and contradicts the beliefs or experiences of many qualified practitioners. Therefore, it is crucial to educate and expose individuals to the successes of this therapy, in order to foster a more open-minded approach toward novel treatments.

The concept of avoidance as a central component to sustaining PTSD was frequently discussed, with SW 5 describing avoidance as *"The engine room of trauma".* This notion is elaborated by SW 8, who said, *"By confronting the trauma memory, clients can come to the realisation… that it's not actually happening again it's just a thought."* This remark highlights the fundamental objective of PE therapy: eliminating the avoidance behaviours that maintain trauma's control of an individual and encouraging a re-evaluation of traumatic memories as thoughts, rather than present reality.

Although social workers recognise the therapeutic importance of guiding clients through their trauma narratives, there is still hesitation surrounding this. The director of The Trauma Centre expresses this concern, stating:

*The Trauma Centre staff is very sensitive people, … very empathetic. I think some of them will find it hard to do this simply because we have to see the person … not wanting to do it, and that goes a little bit against the culture of the organisation in itself.*

This statement reflects a larger organisational culture that has traditionally prioritised preventing re-traumatisation to protect their clients—and themselves—from additional distress. This reluctance to delve into trauma narratives is underscored by fears that such interactions may cause more harm. SW 5 acknowledged her apprehension, saying, *"I am dreading it a little bit, you know, just kind of sitting with the trauma."* She believed this would be especially difficult, given her mindset: *"I'm a nurturer, and all I want to do is make it better, so in that moment you're tearful, you're crying, and why would I take you through that you know, it's gonna be really hard for me."*

Contrary to these views, when considering the effectiveness of PE in meeting patient needs, SW 4 highlighted its potential to liberate individuals from their traumatic experiences, stating PE would *"Help people to move on to be able to be free from … the burden of … this thing that happened to them"* and it empowers them to *"Become a survivor and not to be a victim anymore."* This sentiment underscores the power of confrontation, rather than evading one's trauma narrative—an important lesson learnt from PE training.

SW 9 believed that PE would *"Be invaluable to our clients here"*, especially for their refugee clients who *"Have a lot of intense trauma."* SW 8 believed this treatment would be *"Beneficial to the clients, so we were able to deal with it more holistically".* As previously mentioned, these participants had a rudimentary knowledge of PTSD treatment; therefore, SW 8 believed the knowledge gained from the PE training would provide social workers with a more comprehensive understanding of how to deal with patients with this disorder. SW 4 also expressed positive feelings, highlighting, *"It will add to the … tools we can use to help various clients."* She believed implementing PE would allow staff, *"To deliver a more professional services to our clients."*

Implementing PE and subsequent training, brings significant knowledge acquisition and professional growth advantages. Numerous social workers expressed enthusiasm about acquiring new skills through this process. The training not only deepened their understanding of PTSD but also equipped them with the necessary skills to assist clients with PTSD. Furthermore, this training would enable staff, *"To deliver a more professional service to our clients"* (SW 4) and would aid social workers *"In terms of my own personal professional growth"* (SW 5). This indicates the broader positive effect of the training on service quality and the ongoing professional advancement of social workers in their field.

### 4.1.3 Sub-theme Three: Improvement and Feasibility of Prolonged Exposure Therapy

The participants gave their perspectives on the effectiveness of PE and provided insights into the feasibility, effectiveness, and challenges of adopting PE. Their views were invaluable, given their firsthand client experience and a deep understanding of the factors that lead to effective therapeutic outcomes in this context.

SW 9 expressed the benefits of PE for their clients, noting, *"Prolonged exposure would really be beneficial to those clients to help them to work through the trauma but to also be able to cognitively assist them with not reliving that trauma every day",* whereby *"people can start to now accept that this is something that has happened, but it's not happening … now"* (SW 8).

SW 9 further stated:

*People will start to face that thing that they've been trying to avoid for so many years or for so long, and they can actually realise it. Okay, I can actually deal with this thing, I can actually face this thing and I will be okay.*

It is evident that several social workers believed in this treatment's efficacy and that it would aid their clients in healing. SW 4 spoke about the efficacy of PE; how this treatment helps clients with their PTSD symptoms and gives the social worker confidence in knowing they are providing a treatment that works and will help their client: *"You almost feel like, oh wow, I'm not just … seeing this sea of people and nobody feels better; we could actually have a tool that is proven to get people better on the other side."*

SW 3 emphasised the need to adapt PE to fit the South African context, stressing the importance of cultural sensitivity. They mentioned the need for a more simplistic version:
SW 3: *It needs to be simplified.*
Interviewer: *Simplified, in what way?*
SW 3: *Like you, less technology gadgets because most of these people do not have these things, the cell phone to record and the space to store the data when they collect, and ja, it*

*needs to be simplified in a very big way because for now it's bit complicated. Not only for the clients but even for me.*

A significant portion of The Trauma Centre's work takes place in community settings, where the framework of therapy sessions is inherently flexible to meet the needs and convenience of the clients. These sessions often occur in environments that lack privacy, thus posing problems. The adaptation necessary in these community settings has raised concerns among numerous participants, regarding the feasibility of successfully implementing PE in such circumstances. SW 5 highlighted these concerns: *"You know we work in the communities. It's quite fast-paced you know; sometimes we running queues outside. So, I don't know. I don't think we would be able to do it in the communities."* In a similar vein, SW 3 shared apprehensions about the feasibility of implementing such a complex and nuanced therapy with clients who are primarily seen in the field, stating:

*I feel like it would be a good thing for those clients who come here, but mostly 90% of our clients they are on the field, so for them, it's gonna be quite tricky. It's a very complicated process, very complicated treatment and I don't think it would actually … work on the field….*

These expressions of concern underscore the necessity of reconsidering how PE therapy could be adapted to fit the less structured and often unpredictable context of community-based interventions. SW 8 commented on the time-consuming nature of PE, noting, *"The amount of time a session takes, like when we are in the field, … would not always be something that would be possible."* Another significant concern raised regarding the community context is privacy. SW 5 expressed doubts about the level of privacy that could be maintained during therapy sessions conducted in community settings, stating:

*I don't know how private it's going to be because if I'm seeing a client a lot of the time in the container, the doors are open, or I have people coming in and out a lot of the time, and that's not really going to be conducive.*

Another problem that could hinder the effective implementation of PE is client commitment. Several participants noted that clients often fail to attend or attend only a few sessions. Since PE is a lengthy treatment, client commitment is crucial for success. SW 4 noted*, "Our client base it's not always reliable to turn up, already so to add this challenging therapy, might be an obstacle."* Similarly, SW 3 said, *"It's impossible"* for a client to come to ten or more sessions, as *"the nature of our situation is that clients … only come once or*

*twice."* Another significant issue is the presence of interpersonal violence in the lives of women clients, where partners may observe communication between them and their social worker, potentially leading to further violence. As mentioned earlier, the recording of sessions poses a significant concern in such environments, as the discovery of recordings or the fact that therapy is taking place, might escalate the violence. SW 2 emphasised this: *"Most clients don't come back to the second session because the husband saw the phone, the WhatsApp between the social worker and the client."* These challenges highlight the complex dynamics and practical obstacles that can influence the successful implementation of PE therapy in community settings. Strategies to address these issues may include increasing the flexibility in session scheduling, enhancing confidentiality measures, and providing additional support for clients to ensure their safety and commitment to the therapy process.

Similarly, the ongoing nature of trauma in countries, such as South Africa, presents a significant challenge to the successful implementation of PE. Many of the clients seen by these social workers are refugees or survivors of Gender-Based Violence (GBV), who live in violent and traumatic environments. Several SWs have highlighted the impact of environments on therapy's effectiveness. SW 6:

*Those women are in the household where … the abuse is taking place, and even if they do come for exposure therapy or they … love exposure therapy, they still going back to that environment every day, and so the therapy won't really be working because they just exposed again to … the trauma and the same with like gang violence; you doing exposure therapy but you going back to the community.*

This is supported by SW 1, who said, *"It might be difficult to implement prolonged exposure because they constantly in the traumatic environment."* This ongoing exposure to trauma can hinder the effectiveness of PE therapy, as clients might struggle to process past traumas when they are constantly confronted with new traumatic experiences.

Heavy caseloads, time constraints, and limited resources, characterise social work in South Africa. Social workers are already under tremendous strain, due to service demand, sometimes rushing through therapy to accommodate more clients. Introducing PE may add to the stress on these social workers. Multiple participants raised concerns about capacity and time constraints. SW 5 highlighted this issue, stating:

*It's quite an investment of your time … and already we are up against the clock as it is, … so for me … time and capacity … would probably be my biggest concern about how we gonna be able to do this.*

This sentiment was reiterated by SW 5, who emphasised the need for social workers to adjust their schedules to accommodate the demands of PE: *"I don't think our social workers … have the capacity at the moment …".* While there is enthusiasm for implementing PE, participants are wary of the practical problems and adjustments required to incorporate it into their already demanding schedules.

PE is acknowledged as a resource-intensive treatment that requires funding and organisational readiness for successful implementation. SW 1 highlighted PE's potential financial strain on clients, particularly those from disadvantaged communities: *"So that's eight sessions of somebody who comes from a poor community, takes three taxis to come here, might not have the money. So monetary wise it can be of financial strain on the patient."* This raises concerns about the accessibility of PE for individuals who may struggle to afford transportation to and from sessions. Furthermore, SW 4 spoke on the need for more funding and hoped that providing specialised care, such as PE would attract more funders and aid in disseminating PE. She stated, *"So hopefully we will be able to be productive and see more people and … get funding for more therapists, that that would be the idea."*

The data discussed above reflect views collected during the post-training phase, before the actual intervention. The following section will provide a detailed analysis of the results obtained from interviews conducted after the intervention was implemented.

**Social Workers Post-Intervention Findings**

As reported in the pre-intervention themes, the participants raised many of the same sentiments, specifically regarding The Trauma Centre culture and climate. Participants again focused on the traumatic nature of the South African context and how ongoing violence and trauma create challenges to treatment. Furthermore, participants reiterated the unstructured nature of treatment practices at The Trauma Centre and how they were largely ineffective in treating clients.

Clients had positive views regarding the efficacy of PE, now that they had provided the therapy. In contrast, however, their viewpoints around feasibility were less favourable. The following superordinate theme will discuss the social workers' perspectives on the efficacy and feasibility of PE. Following this theme will be superordinates 2 and 3, which were notable findings from the post-intervention interviews, namely participants' perspectives and hurdles and limitations to treatment.

### 4.2 Superordinate Theme One: Feasibility and Improvement of Prolonged Exposure Therapy

SW 1 expressed strong confidence in PE, asserting that it provides a sense of certainty regarding its efficacy. She said it is *"Guaranteed after the ten weeks that they'll be fine."* Furthermore, SW 1 highlighted the value of monitoring stress levels during PE sessions, pointing out, *"With PE, because you monitor things and you measure the stress levels, you can know if it's working or not."*

The interview with SW 3 revealed her belief in the efficacy of PE. She recounted several instances where PE had yielded remarkable results, noting, *"The outcomes of a couple of our patients or clients that have been through … this have been amazing, you know, have been actually quite incredible."* She emphasised that even her client who opted out of treatment early, still experienced positive changes. She recounted a client's journey, pointing out the positive impact of PE on his life: *"Just listening to the positive impact that it has had on his life, I can't imagine that anyone couldn't be happy about that for him; you know it was because of PE."*

SW 2 shared a compelling case study where a client experienced significant improvement in their mental health and quality of life through PE:

*When we met during PE, the signs and symptoms of depression and anxiety was still there and actually very high, but during PE processes … she started to, to feel better. And then she started to sleep at night … and then she started not to use the medication. She was struggling to go in public in front of the people in church, because she thought that everyone will talk about her because … she had one leg and she's disabled. So she was scared to go out, and during the PE process, she started to go out more. She was even scared to to even look at the soldiers because where she comes from, she comes from Burundi. She was chased*

*away and raped by the soldiers and almost killed by the soldiers, and the soldiers killed the entire family, her family, so she couldn't even look at the picture of a soldier. And then during the PE process, she was able to actually look at the picture of the soldier. So you can see that there is a progress in client's life.*

Moreover, SW 2 highlighted the power of storytelling and self-reflection in the PE process, stating, *"Telling my story, and sometimes listening using the recording you listening to your own voice is, I think that's where the power lies in."* According to SW 2, this aspect of PE is crucial in helping clients develop a healthy relationship with their past traumas. In order to properly process the trauma, clients must *"confront the beast."* This is significant, as SW 2 was one of the participants who expressed the most scepticism surrounding this treatment and the recording of sessions. He believed it to be unethical and something that challenged his moral beliefs. Overall, SW 2 viewed PE as a highly effective treatment, describing it as *"One of the best",* and emphasised that its benefits outweigh potential disadvantages.

SW 4 shared several compelling examples of the positive outcomes of PE. For example, *"One client, I had ... never spoke to her children ... because of them reminding her of the trauma, they were born out of the trauma and then she then she started talking to them."* After just four sessions, another client experienced significant improvements in her ability to perform daily tasks, such as walking down the street. The effectiveness of PE was further evidenced by a client who offered to pay for the therapy, recognising its value and impact on his life, which SW 4 interpreted as a testament to the therapy's efficacy:

*One of the clients actually also asked one of our social workers lady who asked her at the end of it what do I owe you in financially because we never talk about that. But he felt that because it was such a good therapy, it made such a difference; it couldn't be a free service.*

Participants were less positive about the feasibility of PE. The efficacy of the treatment they witnessed was undeniable. However, this does not automatically mean the treatment was feasible, especially in an LMIC setting. The social workers made similar remarks regarding the feasibility of the pre- and post-intervention interviews. Their post-intervention views also reflected a concern for the community setting and infrastructure, and whether this treatment could be successfully implemented in such environments. In addition, the issue of multiple and ongoing trauma was mentioned and emphasised as a barrier to the

feasibility of PE. SW 2 raised the use of task-shifting in aiding in the successful implementation of PE in community settings, highlighting the importance of using people close to the communities, both in proximity and culture.

### 4.3 Superordinate Theme Two: Post-Treatment Views

In their pre-intervention interviews, participants expressed mixed feelings about implementation, which persisted in their post-intervention perceptions. Despite this, all four participants expressed positive feelings about the use of PE. SW 1 mentioned, *"I feel happy about it being delivered,"* a sentiment echoed by SW 2 and SW 3, who described it as *"great"* (SW 2) and something *"We could use … at The Trauma Centre"* (SW 3). SW 4 also praised the therapy, noting *"It's amazing that we have the … tools to really provide evidence-based support to victims of PTSD."* She further stated, *"We can actually help clients who have PTSD who can't work, can't function anymore properly."*

The reflections from SW 3, SW 2, and SW 4 on their experiences with PE underscore significant professional growth and a deepening of their knowledge base. This was highlighted by SW 3, who stated, "*It's been a great experience, and the knowledge that I've gained has been invaluable."* SW 2 spoke to growth, not just on a personal level but as a clinician, by pointing out that it *"made me grow as a … professional"* and mentioning that the experiences and the supervision provided a space for development. SW 4 elaborated on how the knowledge acquired through PE had been beneficial not only to individual staff members but to the entire organisation, indicating an enhancement in the competency in dealing with PTSD. She stated, *"The knowledge that we have of PE at The Trauma Centre is really helping the staff here."* Her gratitude towards the training underscores gaining invaluable skills that form a lasting part of one's professional identity. She emphasised this sentiment by saying*, "I'm grateful because no one can take this away from me, and I got the skills … and it's nice for me … to know the value."*

These findings show that learning and implementing PE promoted the development of clinical skills and personal and organisational growth. The supervision and communal learning experiences suggest that the development that resulted from PE training is both an individual and collaborative experience. It is one that enriches practitioners' professional lives and improves the overall quality of care The Trauma Centre provides.

SW 2's reflections illustrate the professional competence and growth in confidence derived from utilising a well-defined therapeutic framework. The structured nature of PE allows therapists to navigate each session with clear direction, reducing the uncertainty for both practitioner and client. This clarity, as SW 2 suggested, not only enhances the therapist's confidence but also instils hope during the counselling process, knowing there is a guided pathway toward healing:

*And … you know exactly what … you are going to do from first session up until the last session. So there is no way that in between you … as a therapist, you are confused on what to do or you don't know what to do; in PE you know exactly what to do.*

In contrast, the participants expressed some less favourable views on PE and its implementation. SW 2 reflected on the process, emphasising, *"It's a daunting process … it's a very difficult one sometimes to follow. It's not easy also for us as a therapists to … follow that particular process."* As previously mentioned, the structured nature of PE is a new concept to these practitioners, and this experience pushed them out of their comfort zones. This suggests that getting used to PE may require time, practice, and more experience to feel comfortable and confident in delivering the therapy. SW 2 exclaimed, *"I wish most of our colleagues participated because I see PE as … the perfect treatment, but in an unperfect environment."* This suggests that adaptability is necessary to make PE the perfect treatment in the perfect environment.

The participants expressed their feelings on sitting with clients through their retelling of trauma memories and being exposed to the trauma. They revealed the emotional and psychological challenges they faced by working with PTSD patients through PE. SW 1 articulated social workers' challenges, stating, *"It is not easy to be dealing with a lot of issues that people bring,"* highlighting the emotional toll such work can take on counsellors. SW 2 elaborated on this sentiment by describing the challenge of maintaining professional composure, while engaging empathetically with the client's traumatic experiences. He explained:

*It's difficult. It's one of the most challenging things ever, not only for the participants to sit and tell their stories but also for you to … be able to listen to the stories over and over again, … you have to put a straight face and be a therapist and but at the same time be sensitive and empathical … to another human being.*

SW 2's reflection captures the delicate balance therapists should strike between professional compartmentalisation and empathy, especially when faced with narratives that are, as he puts it, *"scary".*

Similarly, SW 4 touches on the personal impact of clients' stories on therapists, many of whom have their trauma histories, noting, *"I think a lot of staff honestly has had personal trauma. And then you hear about somebody else's trauma, and it triggers your own."* She further elaborated on the need to debrief or take a moment to find composure, after a difficult session. This is highlighted by her saying:

*Even at the beginning, my client used to cry intensely; she still does … when she tells the story, she still cries. It was very bad; I used to leave the office and go for a drive because this is intense to just continue to the next… sessions.*

These reflections paint a picture of the significant emotional toll involved in PE therapy for PTSD, not only for the clients but also for the therapists. They emphasised the necessity of support mechanisms, such as debriefing and therapy for therapists.

The dynamics of leadership support and practitioner avoidance within the implementation context, offer an insight into organisational behaviour and its impact on implementing and disseminating evidence-based treatments. SW 4's reflections highlighted a readiness to address PTSD and embrace new treatments. She emphasised the need for leaders to encourage practitioners to step out of their comfort zones in treating trauma. As shown, these social workers did not have much PTSD experience and avoided dealing with trauma narratives, as evidenced by SW 4 stating, *"We tend to think 'ah I'm not ready yet', but they will never be ready because of this PTSD."* Therefore, these social workers need to be encouraged to go against their tendency towards avoidance, and leadership is essential for encouraging engagement with novel therapeutic approaches. The interviews with SW 1 and SW 2 further illuminated the complexity of leadership involvement, where strong support can have positive and negative consequences. SW 1 acknowledged the *"100% support"* from leadership, facilitating a smooth implementation of PE, which contrasts with SW 2's observation that overly enthusiastic endorsement by leadership might lead to perceptions of PE as exclusively a leadership role, leading to the alienation of other staff members and fostering a sense of resistance towards the initiative. This suggests that while leadership

support is crucial, there is a delicate balance in ensuring it does not lead to counterproductive outcomes.

### 4.4 Superordinate Theme Three: Hurdles and Limitations to Implementation

Participants expressed a common concern regarding their current capacity. Owing to PE being a long form of therapy, these participants noticed they could not keep up with the demand. SW 1 pointed out the relationship between the volume of trauma cases and the structured time allocation for PE, stating, *"There's so much trauma, unfortunately, that the two hours and nature of the programme is difficult to meet everybody."* She suggested that a solution lay in increasing the number of trained social workers, arguing that a larger team could significantly enhance service delivery: *"If the whole organisation of 15 … were trained to do this, then it would be brief... it can be brief if there is increased capacity of the people delivering the service."* SW 3's comments provide another perspective on these capacity challenges, highlighting, *"Normally, I would see clients for about six sessions. But … that's a lot. You know, I don't … even have the opportunity to see most of my clients for that period … that's an absolute luxury at the moment."* She pointed out the impracticality of adhering to PE's session requirements, labelling it *"A luxury that I'm not afforded."*

The need for increased capacity is not simply about numbers but also about integrating PE into the organisational policy to ensure new social workers are trained and prepared to deliver these services as part of their role at The Trauma Centre; as SW 3 suggested, *"It would need to really be part of the actual policies and procedures so that when … new social workers start that they already aware that this is part of what they will be doing. So it's in the contract."* According to SW 3, *"The way we set up at the moment, I can't see it, you know, yeah, we need more capacity in order to do that."* This notion was supported by SW 2, who queried, *"Is there a time … for trauma centre counsellors to be involved in PE, and how can we make time for that?"* indicating the need for a broader organisational shift to accommodate the demands of PE.

Building on this, the issue of burnout among social workers emerged as a significant concern. Their shared experiences highlighted the demanding nature of their roles and the mental and emotional strain they endured. SW 1 expressed a feeling of being overwhelmed and frustrated:

*Yet sometimes we complain that the work is a lot and … at the end of the day … we still complain … that the work is a lot, and that the government is not doing enough and we can't do enough.*

This issue is exacerbated by an organisational culture that, seemingly unintentionally, contributes to burnout. SW 1 added, *"I think the company culture is just that people sometimes end up having burned out from doing a lot of trauma work that they … not keen to try new stuff."*

SW 3's comments provide a personal insight into the lives of those providing trauma therapy. While she shared her passion for her work, she also recognised a lack of energy, stating, *"So I'm quite excited, but you know, our energy is very low."* Her straightforward comment*, "I'm feeling tired,"* highlights the emotional and physical toll that working in trauma therapy can take, emphasising the importance of implementing support systems to alleviate burnout. The participants' involvement with this research reflects a process influenced by various factors. Initially, there was an eagerness and interest among the social workers, as evidenced by SW 3's observation that *"people were curious, they were interested..."* This initial enthusiasm led to most of The Trauma Centre's social workers being involved; however, over time, there was a decline in participation for various reasons. This is demonstrated by SW 1, stating, *"When we began, I think we were about 15 and now, … only four remained."* One reason for this decline comes from SW 3, who emphasised, *"People didn't really … feel they had the capacity … to do it."*

Participants expressed the lack of compensation needed to sustain employment. SW 4 underscored this point, noting that the nature of their organisation being an NGO with limited financial resources, meant that social workers often sought better-paying opportunities elsewhere:

*Some of the social workers who were trained also left. So because in a nature of being a NGO … we are on bottom of the range in salary. So people are looking for government jobs to improve, other jobs to improve … their remuneration...*

This external pressure contributed to the high turnover rate, with social workers leaving the programme for more affluent positions.

Forming a dedicated PE team is one way to combat the lack of participant commitment to implementing PE. The interview with SW 4 highlighted her desire to establish a dedicated PE team within The Trauma Centre. She envisioned the potential of such a team, stating, *"If we can … start building a team that we can have a PE unit, and then we can take referrals from all over Cape Town because, I mean, the need is there."* She believed this initiative aligned with the centre's vision and could provide a unique and valuable service. She noted, *"That would be wonderful if we can build that kind of a unit that's a niche and unique because we are The Trauma Centre. I think it's, it's appropriate; it's within the our vision to provide that service."* However, SW 4 recognised the challenges of creating this team, particularly in size and capacity. She acknowledged the need to train more people to ensure continuity and to prevent overburdening of existing staff:

*I think we really need to train more people because if one of the other leave, then we basically have one full-time practice, and the one social worker who has been trained now in PE is working with children. So in her work life she can't really use it."*

SW 4 also expressed concerns about retaining staff due to the organisation's financial challenges, noting that staff with trauma experience are sought after by other organisations that offer better salaries:

*I think the challenge … we will lose the staff … if you have a bit of trauma experience, you are very much wanted by other organisations because of our experience and working with trauma victims, we are grabbed, sucked up other organisations pay more.*

This highlights the competitive nature of the job market and the importance of offering competitive compensation to retain staff. In light of these challenges, SW 4 suggested that providing incentives for staff could help address retention issues: *"But I think, knowing staff if there is a bit of an incentive because its hard work, PE is hard work let's face it."* This suggests that while dedication to the work is present, financial considerations significantly motivate staff to remain engaged in PE therapy.

**Chapter Summary**

This chapter examined the pre-intervention and post-intervention findings from the social worker's interviews. Concerning pre-intervention views, the data revealed perceptions

around PE and its implementation, within the South African context. Moreover, the current South African and Trauma Centre context and climate were detailed, using direct quotations from each social worker. Next, the social workers' perceptions regarding PE were highlighted, and last, the social workers' perspectives on the feasibility and efficacy of PE were examined.

The post-intervention findings revealed the perceptions of the feasibility and improvements found post-PE implementation. Next, the social workers' views on PE were discussed, after they had experienced providing the treatment first-hand. Last, the hurdles and limitations to implementation were discussed.

# Chapter 5

# Findings – Clients

## Chapter Overview

Chapter 5 focuses on the results from the clients' interviews. Between the four social workers, they saw five clients. This chapter comprises three superordinate themes. Within superordinate theme two, two sub-themes exist; within superordinate theme three, there are also two sub-themes.

Furthermore, this chapter details the clients' trauma backgrounds to provide context to their perceptions and experiences with PE. By examining their histories, we can better understand how past traumas influence their views and responses to treatment.

**Table 4.3**

*Clients' Post-intervention Themes*

| **Superordinate themes** | **Sub-themes** |
|---|---|
| Superordinate theme: Refugee struggles | |
| Superordinate theme: Associated psychological distress: | Sub-theme 1: Self-worth and suicidal ideation |
| | Sub-theme 2: Lack of support and helplessness, loneliness, isolation |
| Superordinate theme: Experiences of Prolonged Exposure Therapy | Sub-theme 1: Positive client experiences with Prolonged Exposure Therapy |
| | Sub-theme 2: Challenges of Prolonged Exposure Therapy treatment |

## 5.1 Superordinate Theme One: Refugee Struggles

Client 1 provided extensive insights into his experiences and challenges as a refugee. He recounts the moment his life took an especially traumatic turn, stating, *"And xenophobia came in 2012. It's where my life start to be messed until now."* He describes the brutality of the xenophobic attacks he endured, where he was violently beaten:

*When they catch me there, they didn't ask question. They start to beat me. They beat me too much … They didn't see the value of my body. They didn't see if I'm a human being … they were using stick, beating me. And I don't know, it was something like a hammer. They beat me in the leg, and my left leg, it was broken.*

His attackers expressed anger and hatred towards him, accusing him of stealing South African citizens' jobs, opportunities and women. The words these attackers spoke at Client 1 had a psychological effect on him, which is evident in the fear he expressed in his interview: *"And I was just crying saying, sorry, forgive me. I'll leave your country. But they say, we have to kill you one by one. You must leave our country. So, I was there down, crying, bleeding ...."* This interview allowed Client 1 to express all the times he was targeted for being a refugee. His story reveals ongoing attacks on him and his business in everyday spaces, such as taxis or churches.

Client 1's struggles as a refugee in South Africa were deeply rooted in feelings of insecurity and a lack of safety. Despite the efforts of his therapist to provide comfort, he found it difficult to feel safe in a country where he faced constant discrimination and violence. He expressed the following, *"She try all her best to make me to feel comfort. Yeah. But the situation of the country where I live is not giving me that … safety."* Client 1 describd a sense of hope that therapy provided but stated that that hope was quickly diminished, asserting*:*

*Sometimes, when I'm with her talking about therapy, I'll feel like, no, I can be okay again. I can have a good life again in future. But, problem, they just come … I feel like I'm nobody. I'm rejected. Yeah. I feel like I'm dying. There's no assistance.*

This constant state of fear and violence impacted Client 1's commitment to therapy. He expressed a fear of using taxis and mentioned that if he decided to walk to therapy, he would end up running out of fear: *"I will be walking, like, running, because I don't know if they will attack me, so I feel difficult to come here."* Furthermore, he would not speak, out of fear of revealing his foreign identity when using public transport. He mentioned*:*

*Even when I'm in My City, I don't move, I just enter, I don't talk, even if my phone can ring, I don't answer, because I don't want people to know I'm from where, or I'm doing what, or I don't want people to understand if I'm foreigner.*

Ultimately, the state of fear that Client 1 lived in influenced his sense of identity and belonging, leading him to conceal his status as a foreigner. Client 1 summed up his reality perfectly, saying, *“Because I'm a foreigner, they don't value me.”*

Client 2’s experiences were similar. Despite feeling relief during her therapy sessions, the harsh realities of her situation quickly undid the progress made. She described, *"I'm gonna have my session, I feel better. But I reach at home … I break down again.”* This cycle of temporary relief, followed by the reality of living in poverty and experiencing constant stressors, is further exacerbated by the ongoing trauma she faced in her daily life. Client 2 recounts experiences of being attacked and robbed on her way home, leading to a continuous cycle of re-traumatisation:

*I can come from here, I reach there by the road, they attack me. They beat me. I go again, stretching to re-traumatise again. They beat me like last time, they beat me, they take everything. Yeah. You understand what I mean? I get treatment, but I find myself, I'm back again. I'm re-traumatised again.*

Client 2’s traumatic experiences included being physically attacked and robbed, as evidenced in her statement, *"I was being attacked. They did beat me. They did break me. They did break my artificial leg. They did take my phone. Everything I was there with, they did take it.”* She also suffered the traumatic experience of being raped, along with her mother, illustrated in her mentioning, *"They raped me in front of my mother. My mother was being raped in front of me."* These traumatic events have left her feeling vulnerable and targeted, as she described the common occurrence of such violence in mundane situations, such as taking a taxi. This constant violence leaves someone, such as Client 2 in a constant state of fear, where survival becomes a major priority. Someone, in this situation, has been stripped of their basic rights and lives in a state of fight or flight. This takes a toll on a person mentally and physically, and a person cannot try to process their past trauma, if they are facing trauma almost every day.

These clients’ experiences highlight the complex interplay between therapy, ongoing trauma, and the socio-economic challenges faced by refugees in South Africa, suggesting that without addressing these external factors, the efficacy of treatment may be hindered. Client 2 described the harsh reality of life in the country, where being a refugee means facing ongoing

xenophobia and attacks. Despite seeking therapy to cope with these traumas, Client 2 felt trapped in a cycle of violence and re-traumatisation.

Furthermore, living with the effects of trauma had a huge impact on Client 2's life, leading her to feel overwhelmed by fear and hopelessness. She described the experience as a *"living hell,"* highlighting the intense emotional and psychological toll it has taken on her. Client 2 expressed how constant fear impacted her life, highlighting, *"We are living with fear. You understand? All dream is gone. All happiness is gone. So, you try like to find a little bit of peace, like I don't know how to say, but you never find that peace."*

Client 5 recounted her experiences as a refugee and highlighted the constant struggle, fear and trauma that dictated her daily life. Throughout the refugee participant's interviews, they highlighted the constant violence and discrimination they were subjected to. This led to a feeling of helplessness and hopelessness as participants felt as if there was no point in confronting their past trauma when it just kept reoccurring. Client 5 described an incident in which she had to leave her home: *"Violence is a lot, is a lot as I was telling you this time the landlord, he hit my son when I interfere, he chased us in the house."* A person's house should be a safe space to relax, but unfortunately for many refugees, this is not the case, leading to their living in a constant state of high alert. Her experiences involved being attacked by a group of boys, recounting, *"I was going to Pick n Pay to buy my baby meal, 45 boys come the chase me. I tried to run; I fell down. When I fell down, they remove my jacket; they started beating me."* This quotation emphasises how everyday tasks can turn into traumatic experiences for refugees. These traumatic incidents not only highlight the physical dangers refugees face but also the psychological toll of living in constant fear and uncertainty.

Client 4's experiences as a refugee in South Africa, underscore the challenges many face in similar situations. Despite living in the country long-term, she and her son lacked proper documentation*: "For 21 years, I'm in South Africa; I don't have a proper document. And the boy who was left with me is 20 years, no document."* This lack of documentation not only limits their access to basic services but also aggravates their vulnerability to exploitation and abuse. Client 4's frustration was palpable when she described the indifference she encountered at government offices: *"Then when you go to home affairs with people, they don't even care about you,"* again echoing a sense of marginalisation and hopelessness among refugees in South Africa.

These participants ' narratives explicitly show the harsh reality of living as a refugee in South Africa. The ongoing trauma they endure adds an another layer to determining the feasibility of a treatment intervention. Furthermore, these individuals are dealing with fear from their previous traumas and their current living situations. This combined weight of fear often interferes with their healing process and prevents them from confronting their traumatic memories.

## 5.2 Superordinate Theme Two: Associated Psychological Distress

### 5.2.1 Sub-Theme One: Self-Worth and Suicidal Ideation

This theme encompasses feelings experienced by participants who were related to their traumatic stress and symptoms, specifically a lack of self-worth and suicidal ideation.

Client 1's experiences deeply impacted his sense of self-worth and security, leaving him feeling lost and devoid of happiness. This experience is commonly found in emotional processing theory of PTSD. He expressed, *"And really, my life was disappointed. And I feel like I don't have joy anymore. I don't have peace. I don't have happiness in my life."* This disappointment led him to question his own value, stating, *"Because to me, I feel like I don't have value,"* and *"I feel like I'm nobody. I'm rejected. Yeah. I feel like I'm dying."* Several times throughout her interview, Client 2 expressed feelings of worthlessness. One example was seen through her expressing, *"I'm still useless to society, you know when you disabled, you know sometimes life is tough. I'm useless."* Furthermore, she detailed how she avoids crowds and gatherings because she felt *"I'm nothing."* Her disability was largely the reason for some of these emotions because it led to her experiencing prejudice and marginalisation, ultimately alienating her from society. In addition, Client 3's reflections on her trauma reflected a sense of worthlessness, as evidenced in her admission, *"I couldn't see my value then."*

Client 4 expressed a lack of self-worth, stating, *"I'm useless"* and *"I can't do anything. I'm alive, but I can't do anything."* Her suffering was clear in her expressing, *"My life does not have sense anymore,"* which illustrated her perception of a loss of meaning and direction following the death of her son. Furthermore, she highlighted her suffering, explaining, *"It's*

*just like they killed me, actually they just, they killed me, not him, because he is in peace where he is, but he's not happy because I'm not happy, you see, and I'm not in peace."*

Client 2's traumatic stress manifested in suicidal thoughts. This isn't a new concept, as traumatic stress has associated mental health comorbidities, such as depression, anxiety, suicide ideation and substance abuse. These comorbid aspects of PTSD were mentioned several times throughout the client's interviews. Client 2 expressed a desire to escape her suffering. She recounted an incident where her suicidal ideation took over: *"When I cross the road, I just, I give up … I stay in the middle of the road. I'm just hear 'beep beep beep'."* It became clear that her mental suffering had a major impact on her daily function, leading to her regularly contemplating suicide. Furthermore, she emphasised, *"I was in trauma; I was traumatised, so there's many things I was not able to understand,"* which encapsulated her mental state before starting treatment. The trauma that Client 2 endured led to several debilitating consequences. She detailed feeling disorientation to the point where her basic personal care was affected. She said, *"I was wearing shoes different colour, and I cannot realise. I was … not bathing."* This neglect of self-care is indicative of her mental state, when she explained, *"For me, I was depressed."*

Furthermore, Client 4 and Client 5 highlighted the reality of suicidal ideation and a lack of self-worth among individuals dealing with severe trauma. Client 4 described her reality by stating, *"I feel like running away. I don't know, I must go hide myself. I don't know where ... Maybe I must go far. Maybe that's gonna help me."* This emphasised her longing to escape her reality and her suffering. She stated, *"My mind here is not working well,"* which highlighted her cognitive disorientation triggered by her trauma. Client 5's interview blatantly revealed her suicidal ideation, when she said, *"It is difficult for me many days and many times I'm just feel to kill myself because of the flashbacks and the nightmares, and it a lot of things, depression (crying)."* This quotation emphasised the ongoing suffering that trauma survivors endure as a result of their trauma symptoms, demonstrating how this can lead to thoughts of suicide.

The above extracts from client 1 to 5's interviews clearly emphasised a sense of diminished self-worth and suicidal ideation linked to their traumatic stress. Each individual expressed profound feelings of worthlessness and a desire to escape their suffering, which manifested in depression, self-neglect and suicidal ideation. As stated, this is common in

individuals suffering from PTSD, as this disorder is commonly associated with comorbid disorders.

### 5.2.2 Sub-Theme Two: Lack of Support, Helplessness, Loneliness, and Isolation

This theme explores the individuals' sense of isolation and loneliness. As they dealt with their trauma, numerous participants' narratives revealed a recurring sense of being alone in their struggles.

Client 1 escaped a war-torn country to seek refuge at a young age, and his experience was revealed to be challenging and lonely. His mother decided that he should leave to avoid military conscription. Even after reaching the relative safety of Cape Town, he faced survival challenges. He mentioned, *“I used to eat in the bin looking for food so I can feed myself because I didn't have mother or uncle, anyone. So, I really struggled there.”* This highlighted a deep sense of isolation and loneliness, as a result of his physical isolation from familiar surroundings and family, as well as the mental isolation resulting from the task of surviving in an unfamiliar and often hostile environment.

In her interview, Client 2 told her story of losing a leg, which deeply impacted her life and her place in society. Her internal struggle was evident as she described how her thoughts and emotions were *"killing me inside."* She further stated that she avoided seeking help or confiding in people because *“People like us, disabled, don't have nothing to share. People reject us. So, you can go tell a person how you hurt. They'll mock you. They'll use that same story to mock you, to traumatise you, to bully you.”* Ultimately, this led to Client 2 living a largely isolated life from society, as she did not feel accepted by those around her.

Client 5 also shared feelings of isolation and loneliness, which impacted her relationships and emotional well-being. She admitted that her inclination to withdraw from people stemmed from her traumatic experiences, stating, *"It affects me because most of time I don't talk to anyone."* Despite having a supportive husband who was *“always understanding,"* she still felt great solitude: *"I got no one. I don't have anyone to talk to."* This feeling of loneliness also led her to self-isolation, when she expressed, *"I just feel like locking myself in the room and not talking."* This led Client 5 to live in a cycle of feeling isolated from society, therefore self-isolating herself.

Client 1's experiences highlighted a sense of helplessness and a lack of support he faced when seeking assistance from the authorities, after being attacked. Despite reporting the incident to the police often, he received little help and was left without any resolution or justice: *"I went to the police … they say, Okay, we're gonna give you paper, case number. But there's nothing we can do for you."* This lack of intervention led to him quitting his job and losing confidence in finding work, showing that the incidents influenced his perception of security and well-being. Client 1's interview explicitly highlighted the ongoing cycle of xenophobic violence that he had endured over the years. His narrative encapsulated a series of setbacks, followed by his resilience and attempts to rebuild, only to face further violence and loss. This cycle deeply affected him, leading to feelings of helplessness and despair, ultimately affecting his trust in others, especially South Africans.

Client 4's narrative similarly captures a sense of helplessness and a lack of support following an incident involving her son and his school, when he went on a school trip and passed away for reasons unknown to her. She expressed frustration over the school and educational authorities' handling of the situation, stating, *"I don't get a closure from the school. And nobody helps me,"* highlighting her struggle in seeking justice and understanding surrounding her son's death. Client 4's grief was apparent as she continued to suffer deeply from the death of her son 12 years after his passing, emphasising her continued pain and unresolved trauma by stating, *"My child was not sick. I let my child to go with the school. But that things happen, it's what is eating me till today. That things is not gonna heal yet. Because it's stuck."*

Client 4's story revealed her frustration with believing that human rights protect a person. She felt disappointed and overlooked, stating, *"But they always say that there's a human right, there's a human right. There's no human right. Because they killed him, but they killed me, actually."* Her narrative highlighted how the system can fail people, showing a lack of empathy, and how staying silent and ignoring issues makes things worse for those trying to find closure and justice. This lack of support can be attributed to not only a PTSD diagnosis but also by being a refugee in Cape Town and experiencing the challenges that come with it.

## 5.3 Superordinate Theme Three: Experiences of Prolonged Exposure Therapy

### 5.3.1 Sub-Theme Three: Positive Client Experiences with Prolonged Exposure Therapy

Client 1 reflected on his experience with receiving PE, showing a journey that led to healing and understanding. He shared, *"When I start with her, my pressure was very high. And by talking, by repeating my story, I'll calm down."* As indicated in the previous theme, Client 1 experienced a lack of value and worth, where he believed, *"I'm nobody",* and receiving PE allowed him to regain a sense of self-worth and confidence. He further noted, *"I find the therapy was good,"* and through these sessions, he understood, *"I'm normal and they make me to understand ... I'm not crazy, I'm okay..."* This realisation was vital for Client 1's healing and allowed him to embrace his 'negative' perceptions and emotions related to his trauma to confront his narrative and allow for healing, as echoed in his sentiment, *"I'll feel like ... I can be okay again. I can have a good life again in future."*

Client 2's experiences with PE reveal a journey of recovery and resilience, characterised by a significant shift in her mental and physical health. Client 2 acknowledged the importance of courage in seeking help, expressing, *"The person who is sick, you must have that courage to search for the doctor. You must have that courage first. I want to heal."* This highlighted the importance of a client wanting to heal and have a better quality of life. Furthermore, Client 2 described PE's impact on her and how it gave her a newfound purpose in life and a will to live. She emphasised, *"This treatment it really helped because, for me, I was close to my grave here."* She spoke of several improvements, not just in her mental state, but her physical state as well, stating, *"Now, after the therapist, if I go to a hospital ... my BP also start to work,"* and, *"it's working because I see some change. I was not also sleeping, I was not sleeping, and I need to take the pills to sleep. Yeah. But I start to sleep..."* It is clear in Client 2's narrative that sleep alone influenced her quality of life and gave her some motivation and hope, with her saying, *"Today I sleep. Wow, today I sleep well. So I was excited to come again to my, to my session. I was, I was having that courage to come."* Importantly, Client 2's therapy sessions instilled a sense of self-acceptance and the courage to engage with life more fully, *"My therapist teach me to accept who I am. And accept the situation how it is. Now sometime I can go to church, which I was not doing before."*

Client 3 reflected positively on her experience with PE. She stated, *"This therapy I got from Marguerite, it changed my mind, my outlook, it changed my mind and I'm busy picking myself up,"* highlighting the valuable impact the sessions had on her mental state and overall well-being. Initially resistant and used to avoiding her trauma memories, Client 3 recounted how her experience evolved:

*In the beginning of therapy, I ran away. But as therapy progressed, I could stay. And I could stay longer than 45 minutes in that, until my body told me, oh, okay, nothing happened. You're still here. That … you were avoiding, it didn't happen. You're safe, you're okay.*

This therapy allowed her to realise that her trauma memory was in the past and not something happening at that moment and that, ultimately, she was safe and in control. Her recovery and resilience were evident as she explained the outcomes of her treatment:

*It took me from hiding, from not even existing, from living in a dark hole. It took me from there where I can now independently go shopping; I can go to the parade, I can go to mosque, I can walk outside.*

Moreover, Client 3's showed a newfound sense of self-awareness and emotional regulation: *"What is my feelings? How am I feeling? Am I anxious? Do I have anxiety? And yes, in the beginning, I had a lot."* PE gave Client 3 the skills to think critically and understand her emotions and trauma reactions, more deeply. Her overall reflection on the therapy was encapsulated when she said, *"This has increased my awareness so much. I apply myself in every moment, and I use the same principles that I've learnt here,"* as well as her stating, *"My perception on life and my outlook has changed, and this therapy helped me because this therapy, I can apply to other things that happened in my life as well."* Client 3 acknowledged that healing is not linear but a lifelong journey; one on which she is grateful and excited to be.

A major theme in Client 3's experience is the rediscovery of her self-worth, which developed during her sessions. She reflected:

*I put myself first now. I couldn't do that for years. I'm putting myself first. And this also emerged from this therapy. I've recognised, and I've realised throughout this therapy, I am so worthy. I couldn't see my value then. And I'm not being emotional. It's just all this gratitude. This is tears of joy. It's just all this gratitude.*

Client 3's positive experience with PE led to her advocating the benefits of this therapy. She said, *"I want people to know that trauma is not the end of the road. It's not the end of the world. There's life after that."* She reflected on her treatment, noticing a difference in how she was pre-treatment, compared to post-treatment: *"In the beginning, it was hard ... But when I look back, I see myself, man, coming here, sitting in the corner there, and I couldn't even speak. And now I can. I advocate this programme."*

Her narrative captures the impact that therapy can have on an individual's life, enabling them to face past traumas and move forward with resilience and renewed self-awareness. To summarise her experience perfectly, Client 3 reflected, "*I'm starting to live now."*

Client 4's reflections on her therapeutic experience conveyed positive perceptions of her treatment. She found comfort in specific techniques used during therapy, particularly highlighting, *"The breathing ... helped me."* Engaging in structured breathing exercises provided her with a tool to manage her anxiety and triggers more effectively. Furthermore, Client 4 expressed gratitude for the interpersonal aspects of her therapy, noting the benefits of simply being in a therapeutic environment, emphasising, "*Coming here for you to take your time, to speak to you, yeah, it helps, seeing other people's faces, you know? It helps, yeah, for me to leave my home to come here. It's helping*." This shows the importance of social interactions and having a support system.

### 5.3.2 Sub-Theme Four: Challenges of Prolonged Exposure Therapy Treatment

Client 1 expressed some doubts about the effectiveness and feasibility of PE being implemented with refugees, due to ongoing trauma and xenophobic attacks, stating, *"If they're in this country, I don't think ... it's gonna ... help."*

It is evident that Client 3 had many positive experiences with PE; however, she also detailed some hard moments and challenges during her treatment journey. She explained her difficulty engaging in the imaginal exposure, stating, *"God, that was the pits. In the beginning, it was difficult, it was hard, it was complicated ... I wanted to run away, wanted to hide."* This reaction may have been seen as normal, as many of these participants had spent years avoiding their trauma. For the first time, they were confronting their trauma narrative head-on, which would inevitably, be a hard process. Client 3 further detailed the challenging

nature of this therapy, mentioning, *"There was a lot of unlearning. Unlearning is still part of the process. Yeah. It's been ... Horrible ... It's been horrific. I had to face it. It's been brutal. I had to face it."* Client 3 spoke to avoidance and how facing her traumas for the first time was extremely difficult:

*When all the fears and the hiding and the sadness and the grief, when that started to open up that I had to face them, that was the horrible part of this, the initial stages where you see it for what it is, but when you're in that closed up, you don't see it then.*

However, confronting her trauma allowed her to process these memories and allowed for her trauma symptoms to be alleviated. Ultimately, Client 3 trusted this process, and because of that, she reaped the benefits and was living a life she never imagined. She was aware of that, as she said, *"Seriously. If you're not committed, it's not going to work."*

Client 4's experiences with PE highlighted a largely, negative view. Despite her initial attempts to remain strong, the sessions began to take a negative toll on her. She expressed, *"At the beginning, I tried to be strong, you know? But as I was coming every Tuesday, it was painful for me. Like, the wound was opening again."* These sessions impacted her entire week, affecting her functioning: *"So from Tuesday until the week finish, I'm sad."*

Client 4's experience with PE can be summarised by her stating, *"I don't like this because ... it's breaking me."* Client 4 found the imaginal exposure to be particularly hard, having to retell the story of her son's death. She mentioned, *"When I come, they will ask me to tell how did it happen ... when my boy was in the morgue. So, I must explain. So, when I explain, like I'm bursting, you see?"* This imaginal exposure led to her wanting to stop therapy, stating, *"So, I was like, no, I need to stop this because this putting me very down."*

While Client 4 acknowledged some benefits from the social interaction the therapy sessions provided, they commented, *"I don't have friends; I need people to speak to me, in which way, yes, it helped me,"* these did not compensate for the emotional toll this process had on her.

It seems apparent that Client 4's inability to fully process the death of her son stems from a lack of closure. Client 4 not only had PTSD but also traumatic grief, which complicated her process. Client 4's narrative captured PE's complexity and potential

drawbacks, particularly for individuals with deeply embedded traumatic experiences and comorbid variables.

Client 5's account of her experiences with PE revealed a perception of ineffectiveness and emotional difficulty. Throughout her interview, she cried and struggled to answer the questions. She was hesitant to recommend PE to others, which highlighted her scepticism about the benefits of this treatment. When asked whether she would suggest therapy to those who had suffered similarly, she responded, *"I don't know because, with myself, I can say it didn't change,"* expressing her hesitation to advocate for a treatment that had not benefited her. The process of recounting her traumatic experiences during therapy felt to her, like reliving the trauma, as she expressed, *"When I was talking to her, I was feeling like it's happening again."*

The main challenge for Client 5 centred around a large component of PE – speaking about her trauma memory. She did not find any relief in confiding in her therapist and indicated that talking to her therapist *"was difficult".* This difficulty suggested that the therapy, rather than alleviating her psychological pain, perhaps deepened it.

Although Client 4 and 5 reported inadequate progress with their PE treatment, their situations revealed additional complexities and nuances that must be acknowledged. Client 4's profound grief, which was evident throughout her interview, significantly hindered her ability to engage with the PE process effectively. Moreover, Client 5 demonstrated ongoing issues with dependency. Despite attending over eight sessions, she reported not experiencing significant benefits from the treatment. These factors highlight broader comorbid issues and social challenges that affect treatment outcomes. Addressing these underlying issues is important, as they are integral to understanding and improving the overall effectiveness of therapeutic interventions.

**Chapter Summary**

This chapter examined the findings obtained during the interviews with the social workers' clients. The data revealed the many struggles refugees face, which are detailed in this chapter. Furthermore, this chapter discussed the psychological distress experienced by the participants. These included a lack of self-worth; suicidal ideation; lack of support;

helplessness, and loneliness. Last, the data revealed the participants' experiences of PE – both positive experiences and treatment critiques.

# Chapter 6

# Discussion

## Chapter overview

The study aimed to investigate the feasibility of implementing Prolonged Exposure therapy (PE) in a resource-constrained organisation in Cape Town. This study focuses on two important viewpoints: the social workers providing the treatment and the clients receiving the treatment.

In this chapter, I start by focusing on the findings related to social workers. I discuss the South African context and organisational dynamics, shedding light on how these factors influence the feasibility and acceptability of implementing PE. Next, I explore the hurdles and limitations the social workers expressed.

Concerning the clients, I discuss the associated mental health distress they experience and how it has a significant impact on their daily functioning. Next, I focus on the client's experiences of receiving PE, capturing their perspectives and feedback, concerning the acceptability of implementing PE. Last, I discuss the unique challenges refugees face, and explore how their experiences add an extra layer of complexity to the attempt to implement a novel treatment, such as PE.

## Social Workers

### 6.1 South African Context and Organisational Dynamics

Studies conducted in LMICs, particularly in the context of South Africa, repeatedly highlight the prevalence of trauma exposure and the complex challenges related to delivering effective treatment (Rathod et al., 2017; Wainberg et al., 2017). PTSD and trauma are deeply embedded in South African society, due to the country's history of violence, both past and present (Edwards, 2005). As a result, psychological treatments are of critical importance. Professionals, such as the social workers at The Trauma Centre, support the need for psychological treatments, stating that trauma has a profound impact on South Africa. Their

observations reflect the literature, stating that South Africa is often referred to as a 'traumatised nation'.

In a complex context, such as South Africa, implementing effective treatment requires the consideration of multiple contextual factors. Unfortunately, LMICs are often neglected in research undertakings (Patel, 2007). Typically, innovative treatments are developed and implemented in Western countries, leading to a significant gap in treatment-seeking behaviours between individuals in high-income countries (HIC) and those in LMICs (Patel, 2007). Studies show that individuals in HICs are twice as likely to seek treatment, with 53.5% doing so, compared to 22.8% in LMICs, with a mere 3.2% of those in LMICs receiving treatment (Koenen et al., 2017). Moreover, mental health disorders in LMICs are predominantly diagnosed and treated in urban psychiatric hospitals and specialised clinics, with community health centres and primary care services, often insufficiently equipped (Wainberg et al., 2017). Therefore, access to care is severely limited for many individuals. This issue is evidenced by the experience of participants in this study who had to travel significant distances to reach The Trauma Centre for their PE sessions. These individuals would not have been able to obtain the same level of care at nearby primary care clinics, highlighting the substantial disparity in treatment accessibility between specialised facilities and local health services.

The social workers at The Trauma Centre emphasised the critical need for culturally appropriate treatments adapted and tailored to the South African context. They highlighted some challenges, including technical jargon during the PE sessions, which hindered complete comprehension for some clients. Furthermore, the social workers also expressed concerns about feasibility, due to prevailing attitudes towards mental health in South Africa, which are influenced by a complex interplay of cultural, socio-economic, and religious factors. Greene et al. (2016) have shown that many individuals with PTSD delay seeking treatment or do not seek it at all. In the South African context, this reluctance may stem from cultural perceptions that perceive therapy as something predominantly reserved for white individuals, thus reflecting a stigma about mental health that may discourage people from seeking the help they need.

Furthermore, the social workers expressed their concerns about their organisation's resources and whether it would be feasible to implement PE in a context with little infrastructure, resources, and funding. This lack of resources is a pressing concern in South

Africa, and research has shown that over half of the countries in Africa allocate less than 1% of their total health budgets to mental health, with most resources concentrated in urban, affluent areas and psychiatric hospitals (Patel, 2007; Yatham et al., 2018). This leads to a lack of mental health services and the use of culturally non-adapted assessment tools (Yatham et al., 2018). Owing to a lack of mental health services, social workers experience a massive caseload, and treatment is often rushed or done in environments not conducive to effective therapy. The Trauma Centre's social workers described providing therapy in containers in communities with long queues of people waiting to be helped. This often leads to a rushed therapy session that focuses on only practical and legal elements of the issue. Most therapy is not done in a quiet, private space; rather, people are continually walking in and out, which is not conducive to effective therapy. Social workers expressed the need to provide PE at The Trauma Centre, where privacy can be maintained.

While the feasibility and cost-effectiveness of delivering culturally adapted mental health interventions in resource-poor contexts have been demonstrated, their uptake is impeded by the uneven distribution of human and financial resources (Vally & Abrahams, 2016). Within The Trauma Centre context, social workers expressed a lack of knowledge of disorders and mental health treatments. This lack of knowledge is evidenced by Patel (2007), who describes several challenges that impede the expansion of interventions into real-world primary care settings. These include low recognition rates of mental disorders among primary care doctors; insufficient utilisation of evidence-based medications; reliance on non-evidence-based medications; stigma; limited mental health literacy, and a shortage of available psychosocial interventions. This literature strongly relates to the current study's findings, where the social workers have a limited knowledge base of PTSD and have not been trained adequately in evidence-based treatments. This has led them to provide treatment mainly focusing on legal elements, practical factors, and breathing techniques. Social workers expressed their desire for a form of therapy they could be trained in and which provided effectiveness.

Moreover, social workers expressed concern about the feasibility of providing effective treatment in the context of ongoing violence and trauma exposure. The existing literature reports on the trauma exposure rates and the frequency of individuals being exposed to more than one trauma (Peltzer et al., 2007; Kaminer & Eagle, 2010). The findings from this research emphasise this reality as a concern for the feasibility of implementing PE

successfully. Social workers pointed to the fact that many of their clients live in traumatic environments and questioned how PE would be effective in these cases. Similarly, many of the social workers' clients are refugees who live in environments of ongoing violence and are constantly exposed to xenophobic violence. In this situation, therapy requires versatility and flexibility, where the therapist considers each client's needs, resources, and ongoing stressors, and monitors their progression and recovery (Ursano et al., 2003).

In addition, Ursano et al. (2003) state that working with one's family and community is important, instead of intervening alone or in specialised settings, where the therapist should focus on clients' strengths and resourcefulness. The findings in this study have highlighted the intricate nature of dealing with multiple traumas, as social workers had to deliver PE to clients who were living in contexts of ongoing violence. These clients often arrived at each session with a new traumatic experience. This ongoing exposure to trauma and violence meant that the social workers had to constantly adapt their approach, addressing not only the clients' past traumas but also their more recent traumas that were happening between sessions. This evolving nature of the client's experiences highlights the need for a flexible therapeutic strategy, to effectively treat and support these individuals living in violent and traumatic environments.

Ultimately, the social workers felt ambivalent, regarding the feasibility of implementing PE within a South African context. While acknowledging the necessity for a treatment, such as PE, they expressed scepticism regarding its practical implementation and the challenges inherent in working within a resource-constrained environment. Implementing and maintaining treatments, such as PE, is a multifaceted challenge, especially when used and adapted to a resource-constrained setting. These challenges include managing various levels, including patients, healthcare providers, and service units (Chen et al., 2017). In resource-constrained settings, the implementation process is often hindered by broader economic, political, and social issues, such as political instability; insufficient mental health infrastructure; limited funding, and low literacy rates (Chen et al., 2017). The shortage of qualified mental health professionals and limited resources, complicate effective implementation in these settings. In this study, challenges encountered in training providers in a novel treatment, included social workers' reluctance to step outside of their comfort zone and try new treatment methods, insufficient commitment to training, inadequate organisational readiness, and mixed feelings among the leadership at The Trauma Centre

about the implementation of PE. This, in turn, affected the engagement of other social workers.

### 6.2 Hurdles and Limitations to Implementation and Treatment

The social workers' lack of capacity and the resulting burnout they experience, are of major concern. They all spoke to their overwhelming caseload, which does not allow for long-term therapy or long sessions. This is particularly problematic for implementing PE, which demands substantial time and resources due to its lengthy and intensive nature. The challenge of limited capacity is widespread, especially in LMICs, where mental health resources are disproportionately concentrated in HICs. Over 90% of global mental health resources are allocated to HICs, where the number of psychiatrists is 200 times greater than in Low-Income Countries (LICs), which have approximately 1800 psychiatrists serving 702 million Africans (Patel et al. 2007). Studies reveal a mean ratio of 1.1 mental health professionals to every 100,000 patients, and some African LMICs, have fewer than one psychiatrist per 200,000 people (Yatham et al., 2018). This disparity exacerbates the challenge of implementing comprehensive therapies, such as PE, as the shortage of professionals and resources limits the capacity to provide adequate and sustained care.

Moreover, social workers are easier to access than psychologists, resulting in their handling a large portion of mental health cases. This often leads to each social worker being assigned an unmanageable number of clients. This high caseload is frustrating to social workers, who enter the field of mental health intending to provide meaningful support and facilitate clients' healing processes. However, the demanding nature of working in this industry in South Africa, impedes their ability to offer effective services to their clients. While the social workers in this study support incorporating PE into their practice, they have reservations about the long-term practicality and feasibility, given their current constraints. They acknowledge the treatment's benefits and transformative nature but are concerned about whether it can be integrated into their already overloaded schedules and limited resources.

These abovementioned statistics and the social workers' concerns, highlight the need for task-shifting in resource-constrained settings. Studies have shown that task-shifting can address healthcare resource shortages, allow physicians in primary care to provide more complex care, and expand healthcare capacity (Leong et al., 2021). By training social

workers at The Trauma Centre in PE, they were able to provide a nuanced treatment to patients that aided in the alleviation of their trauma symptoms. This notion was not a reality previous to this research. In saying this, The Trauma Centre social workers felt overwhelmed by incorporating PE into their work. This could be due to several factors, including limited participation and the complexity of PE. Only four participants completed the study, leading to the social workers questioning whether this treatment can be effectively implemented long-term. PE's complex and demanding nature may be too daunting for these practitioners, as it requires specific skills and time that these social workers might not have, in addition to their usual responsibilities.

Furthermore, the social workers expressed feelings of burnout and a lack of energy. Burnout leads to reports of career dissatisfaction and the intention of leaving the profession, as well as increased errors and reduced time devoted to providing care (Dubale et al., 2019). One participant highlighted her excitement about implementing PE, highlighting its value and potential benefits. However, this enthusiasm was clouded by feelings of exhaustion, emphasising a common struggle at The Trauma Centre, where social workers are motivated and passionate to provide quality services but feel their capacity is limited. Moreover, the potential for an increased workload contributed to the fear of burnout. The social workers already felt overwhelmed with their caseload, and the prospect of taking on new tasks, such as PE was daunting, which could be why several participants dropped out of the study.

Some participants alluded to broader systemic issues, attributing the problem of burnout to both organisational shortcomings and government policies. They expressed frustration with the government’s efforts to address mental health concerns, stating that they are not doing enough. This challenge is compounded by an organisational culture that seemingly unintentionally, fosters burnout in practitioners. Burnout leads to a lack of motivation and enthusiasm towards their work and a reluctance to try new treatment approaches. For task-shifting to be successful, governments need to take on a leadership role and garner support from various stakeholders, who play a role in restructuring tasks (Lehmann et al., 2009). If governments do not show this commitment, task-shifting may not get the attention it needs in the healthcare system, thus rendering it ineffective and unsustainable, and ultimately, returning to the former health system approach (Lehmann et al., 2009).

A further concern raised was limited finances. The Trauma Centre director discussed the organisation's financial limitations. NGOs rely on grants, donations, and limited funding sources, which can directly impact the organisations' ability to offer competitive salaries and compensation. She further emphasised the importance of adequate compensation in retaining staff members. Since this is an issue at The Trauma Centre, practitioners leave the organisation, searching for positions with higher compensation.

In addition, it is difficult to retain employees because other organisations pay higher salaries and practitioners with trauma experience are highly sought after in South Africa. This has broader implications for the quality of care and organisational stability. Frequent staff turnover can impact the quality of care provided to clients. If The Trauma Centre is a revolving door for staff, clients cannot build rapport and relationships with therapists over time. Furthermore, a high turnover disrupts the effectiveness of the organisation. Committed and consistent staffing is important for maintaining an organisation's unified culture and delivering quality care.

## Clients

### 6.3 Client Experiences

Several clients detailed the revolutionary results they experienced from PE, highlighting this treatment's efficacy and acceptability.

A noticeable theme emerging from the participants' reflections, is the concept of resilience. Research has begun to examine the interplay between resilience's psychosocial and biological underpinnings. It is recognised that resilience is not only an innate trait but is significantly influenced by personal characteristics, such as emotional regulation; the ability to confront fears; personality traits; effective coping strategies, and the ability to seek and utilise social support (Horn et al., 2016).

Several of the study's participants showed these resilience-related traits. Each person's resilience manifested itself differently. One participant, for example, expressed how her experience with PE had given her the capacity to regulate her emotions. She gained critical thinking abilities from this treatment, which allowed her to explore and comprehend her emotional and trauma-related reactions. Furthermore, the skills she has gained from PE have

not only aided her in comprehending her trauma reactions on a deeper level but have also enabled her to apply these skills to other aspects of her life. This use of resilience techniques in a variety of situations, points to PE having a transformative impact on her overall approach to managing subsequent trauma.

As Horn et al. (2016) report, personality traits play a significant role in resilience. In this study's cohort, certain clients exhibited a mindset that was characterised by persistence, even after years and years of trauma and struggle. For example, one client attributed her resilience to her faith. She described her faith as a guiding force throughout her trauma journey, providing her with a sense of purpose and allowing her to believe in a larger plan for her life. This left her feeling reassured and in control of her circumstances.

Similarly, participants describe their enhanced ability to confront their fears after PE sessions. This treatment has allowed them to reconceptualise their memories as elements in the past, over which they now have control. This is central to the theory of PE, where exposure aims to modify pathological fear structures. Two conditions are necessary for effective treatment: (1) exposure should activate the fear structure that is targeted, and (2) the exposure experience should include corrective information that will be incorporated into the fear structure (Hembree et al., 2003). Ultimately, this corrects erroneous associations in clients' fear structure, which allows sufferers to view the trauma event as a one-time point in the past and not a continuing concern for all times (Williams et al., 2014).

Clients also elaborated on improvements in their physical well-being, due to PE, including blood pressure and sleep quality. These physical improvements had a ripple effect on their mental health. As their sleep quality improved, so did their motivation to persist with sessions. This improvement in their physical well-being also instilled a sense of hope regarding the potential for a better quality of life. Furthermore, clients noticed changes in their self-worth and confidence, which proved crucial for changing their outlook on life. They detailed how these changes gave them a sense of purpose and will to live, and expressed excitement about their healing journey. Receiving PE not only improved their physical well-being but also gave them the skills and confidence to confront fearful situations they were previously avoiding. This confidence facilitated a sense of freedom and reduced the persistent impact of fear and isolation on their lives. As these clients progressed through their treatment,

they reported feeling increasingly able to confront their fears and embrace their lives with a sense of liberation and optimism for the future.

In contrast to this, several clients reflected on their critiques of PE. The feasibility of this treatment was questioned, due to the ongoing traumas experienced by refugees. The efficacy and feasibility of PE are challenged by the continuous exposure to trauma that refugees often endure, which may impact the potential benefits of PE. Addressing the complexities and challenges inherent in complex cases is important, as these clients' experiences involve multifaceted issues that complicate the treatment process. One participant elaborated on a crucial component for successful treatment: clients must be fully committed to their healing process. The treatment efficacy will be compromised if a client is not ready to heal or engage with their challenges.

A debate has been had surrounding exposure therapy, particularly within refugee populations. Concerns have been raised about whether exposure therapy increases a client's distress, rather than alleviating it, as discussing their trauma memories may lead to re-traumatising (Nickerson et al., 2011). This risk of re-traumatisation was evident in the experiences of two clients who reported a deterioration in their condition, following the sessions. These clients described an increase in their distress and a sense of feeling overwhelmed, which persisted throughout the week. For these clients, PE did not provide them with symptom alleviation as hoped, but rather worsened their suffering, leading them to describe themselves as feeling 'broken' after their sessions. These two clients presented with unique comorbid factors that impacted the efficacy and success of their treatment. The first client presented with severe grief, which ultimately overwhelmed her capacity to engage fully in the PE sessions. The unresolved nature of her grief made it difficult for her to focus on the goals of the treatment and hindered her capacity to process her trauma.

Moreover, the second client displaced issues with dependency. These issues prevented the client from fully engaging in the therapeutic process and affected her commitment to treatment. This client displayed issues with emotional regulation, preventing her from facing her trauma memories and processing these memories. Moreover, this client demonstrated emotional distress during each session, as evidenced by her persistent crying. This expression of her distress emphasised her emotional state and highlighted the complexities involved in her therapeutic experience.

Despite the concerns raised by Nickerson et al. (2011) regarding re-traumatisation, it has been evidenced that exposure therapy does not result in more adverse effects, compared to other therapeutic approaches and strategies. However, these findings should be viewed in a critical light, as the nuances of treating individuals who have experienced prolonged and ongoing trauma necessitate a more comprehensive understanding of how these factors influence outcomes. It is important to recognise the unique contexts of clients. For this study's clients, the impact of PE varied, and their responses to this treatment might be concluded to be more complex than those observed in contexts with less chronic trauma exposure. Therefore, tailoring treatment to consider these nuances is imperative in addressing the full spectrum of a client's needs.

### 6.4 Refugee struggles

This study's sample predominantly included refugees, which brought complexities to the treatment process that were more intricate than initially anticipated. Refugees resettling in LMICs are often exposed to ongoing threats to their security and well-being. Research consistently shows that refugees experience higher prevalence rates of psychological disorders, particularly PTSD (Reed et al., 2011), a trend that was reflected in the findings of this study. Among the participants, four individuals detailed their experiences with trauma, both past and present. They had escaped from violent and unsafe countries, seeking refuge in South Africa with the hopes of a better life. Despite escaping their violent pasts, they encountered continued violence and trauma in South Africa, mainly due to xenophobic attacks.

These clients' experiences highlight the dynamic interplay between therapy, ongoing trauma, and the socio-economic challenges faced by refugees in South Africa. The findings of this study suggest that treatment efficacy is significantly influenced by the external conditions faced by refugees, emphasising the importance of addressing these factors to improve therapy outcomes. This was evidenced in this study as providing PE to refugee clients brought about complications and limitations, due to the ongoing nature of their trauma. Despite most clients reporting improvements in their emotional state after sessions, these feelings were sometimes short-lived. The benefits of therapy were frequently overshadowed by the reality of their lives, which were characterised by ongoing exposure to

trauma, hopelessness, and fear. This continued exposure to trauma hindered their progress, leading to a pattern where therapeutic progress was impacted by the realities of the clients' external contexts. Ultimately, while PE may offer valuable tools for managing trauma, its efficacy and feasibility can be hindered if the broader socio-economic and contextual problems are not addressed.

When working with refugee samples, it is important to provide therapeutic interventions that are culturally sensitive and adaptable to the client's needs. Refugees often come from various cultural and religious backgrounds and may have unique ways of understanding, expressing and processing their trauma. For instance, some individuals may be reluctant to talk about their traumatic memories but may find other methods, such as writing, painting, dancing, or singing, to be more appropriate and accessible ways of exploring their trauma (Schick et al., 2018). In the context of PE, the writing component raised challenges for the refugees. Clients struggled with this aspect of treatment due to a language barrier or limited literacy, finding this task complicated. This area may need to be adapted to be culturally appropriate and easier for those non-English speaking clients. By adapting treatment to be more culturally relevant and linguistically appropriate, practitioners can better support clients in navigating their trauma.

For some clients, ongoing exposure to trauma may lead to their still meeting the diagnostic criteria for PTSD, even after receiving trauma-focused psychotherapy (Schick et al., 2018). This ongoing exposure can lead to significant, functional impairment or comorbid, psychiatric disorders (Schick et al., 2018). Some clients in the study evidenced this. Two clients continued to experience psychological distress and turmoil after receiving PE. One client struggled with unresolved trauma, resulting in a lack of closure and ongoing emotional distress. Another client faced ongoing violence and trauma exposure, which heightened their distress. These external factors could not be mitigated or changed, making PE perceived as ineffective for these two clients.

The treatment of refugees is significantly complicated by their exposure to ongoing violence, ultimately leading to a sense of complexity in the treatment process. The persistent threat of violence, results in refugees experiencing feelings of constant stress and fear, exacerbating their mental health challenges. This unpredictable nature of violence can disrupt the therapeutic process, making it hard for refugees to engage fully in their psychological treatment. For example, refugees may miss their therapy sessions because of elevated anxiety

levels about travelling to The Trauma Centre. This was evident in the study, where a participant wanted to cancel sessions because of fears associated with public transport, due to past traumatic experiences. This participant would walk to his sessions but often felt unsafe while walking, so he would end up running to avoid further attacks.

To treat the psychological consequences of continuous violence, specialised treatments are needed that consider the larger socio-political environment, in addition to the client's urgent mental health needs. To reduce the adverse effects of ongoing violence on the mental health and general well-being of refugees, psychological support must be given, in addition to measures to enhance safety, stability, and resilience.

**Chapter Summary**

This chapter describes and interprets the study's research findings from the perspective of social workers and their clients. This chapter explored the significance of the findings and the meanings derived from the collected data. This chapter centred on the social workers' perspectives on the feasibility and acceptability of PE implementation and revealed insights related to a South African context and organisational dynamics. It further detailed the hurdles encountered by social workers on implementing PE.

The discussion of the clients' perspectives revealed mixed feelings regarding the treatment. Clients highlighted the ongoing trauma they faced, which impacted their treatment success. While PE can be transformative, its feasibility may be limited by these clients' socio-economic and contextual challenges. It is suggested that these external factors should be addressed to enhance the overall efficacy of trauma-focused treatments.

# Chapter 7

## Limitations, Recommendations, and Conclusion

### Summary

Using a task-shifting approach, this study investigated the feasibility and acceptability of implementing Prolonged Exposure Therapy at The Trauma Centre in Cape Town, South Africa. Through qualitative methods, the research explored the perspectives of social workers and clients in a resource-constrained setting. It focused on three main areas. First, it examined how social workers view the feasibility of adopting PE. Second, the study explored the social workers' opinions on the acceptability of PE as a treatment for PTSD, and last, it looked at the clients' experiences and perceptions of PE. The study addressed gaps in implementing evidence-based treatment (EBTs) in resource-constrained settings. It highlighted that, despite various challenges, PE can be delivered in low-resource environments through task-shifting.

### 7.1 Limitations of the Study

This study's generalisability is a noteworthy limitation, stemming from a small and specific sample. Although this sample size was suitable for this study's objectives and did not hinder the analysis of data or the discovery of valuable insights, the small sample size does restrict the finding's broader applicability to a larger and more diverse population. Moreover, the study primarily focused on a refugee population, further narrowing the study's capacity to be generalised to non-refugee populations. Consequently, caution must be taken when extending these findings outside of the demographic characteristics and contexts of the sampled group, since they may not accurately represent the experiences and results of larger, more varied populations. Future research should aim to include a wider participant demographic to enhance the external validity of the findings and offer a more comprehensive understanding of the phenomena being studied across different population groups.

A further limitation is participant attrition, particularly concerning attendance during the training sessions. The training occurred over several days; however, not all participants attended every session. While some participants engaged with the training material enthusiastically, expressing excitement in acquiring new knowledge and skills, others were

less committed and either did not show up or attended sessions only occasionally. This variability in attendance impacted the overall readiness of participants. Leaders who opted out of the training, unknowingly influenced the motivation and involvement of other social workers, leading to reduced involvement in the training and subsequent study. This inconsistency in attendance reflects varying levels of readiness and interest among the participants regarding the study and training material. The inconsistent participation of social workers in the training presented challenges for the training to be consistent and comprehensive, which could impact the overall quality and reliability of the collected data. This said, the four social workers who participated in this study attended all training sessions. Therefore, the quality and reliability of the collected data were not diminished, due to the lack of training attendance. However, future research will benefit from strategies to increase participant and organisational readiness, ultimately increasing participant involvement and commitment to training.

Last, and most importantly, there were limitations regarding planning and readiness, specifically the lack of comprehensive pre-implementation planning and organisational assessment. Implementation science highlights the significance of selecting a suitable framework, such as Reach, Effectiveness, Adoption, Implementation, and Maintenance (ReAIM) or Promoting Action on Research Implementation in Health Services (PARIHS) before the start of a study. These frameworks offer structured methodologies for identifying potential barriers and evaluating organisational structure, which are essential for effective implementation. This early adoption of such frameworks meant that the researchers could have better anticipated the complexities and challenges that arose during the study. Furthermore, this could have enhanced readiness, allowing for a more seamless implementation. Incorporating thorough pre-implementation planning and framework selection are essential to maximise the success and impact of similar research undertakings.

### 7.2 Recommendations for Future Research

Considering the implications of this research's findings, several critical areas emerge that warrant attention in future research endeavours. Firstly, there is a need to broaden the participant samples beyond the specific refugee category. Next, the evaluation of resources needs to be considered to support the implementation of feasible, effective, and successful research projects in resource-constrained settings, such as South Africa. Finally, it is

imperative to include thorough pre-implementation planning and an organisational readiness assessment before the start of the research.

### 7.2.1 Sample

The current study focused on evaluating the feasibility of PE with a sample mainly comprising refugees. However, to understand its applicability and efficacy in various socio-cultural contexts, a wider range of demographic groups must be considered within and beyond refugee communities. Andrade (2020) states that for the results generated from study samples to apply to the broader population, they must accurately represent the group that is the subject of the study. This study's findings are limited to their applicability within refugee populations. Including a more diverse sample comprising individuals from varied socioeconomic backgrounds and ethnicities in future research endeavours, would facilitate a better assessment of the generalisability and scalability of task-shifting strategies for PE (Andrade, 2020).

### 7.2.2 Resources

PE is undeniably resource-intensive, necessitating private space to conduct sessions; time and capacity for sessions; and financial resources for recording equipment and client transport. These requirements pose significant challenges in resource-constrained organisations, such as The Trauma Centre, where infrastructure and financial means for sustaining these resource-intense therapies are limited. In the past, social workers have had to fund some of their clients' transportation expenses, personally. While this may be feasible in the short term, this is unsustainable, as social workers cannot indefinitely cover these costs. Moreover, scaling up PE implementation faces additional hurdles, particularly securing funding for essential recording devices for imaginal exposure. Relying solely on governmental or external funding may not always be viable or successful in addressing their resource gaps. Therefore, future research should explore alternative approaches requiring fewer resources, necessitating innovative problem-solving and creative thinking to adapt PE delivery methods, without compromising therapeutic effectiveness. By brainstorming and

implementing innovative strategies, researchers can explore sustainable ways to task-shift PE in resource-constrained contexts.

### 7.2.3 Pre-Implementation Planning and Organisational Readiness

The final recommendation emphasises the importance of pre-implementation planning and organisational readiness assessment. As highlighted in the discussion of limitations, this study lacked the utilisation of an implementation framework during its research planning phase. Future studies should adopt a framework that can effectively guide the research process, anticipating and addressing potential barriers and challenges. As noted in the limitations, some social workers did not attend the PE training sessions or did not fully commit to the process. During their interviews, participants revealed that certain social workers felt a lack of transparency from the research team and did not fully grasp the objectives and goals of the training, resulting in reduced commitment and involvement. This issue could have been mitigated through comprehensive pre-intervention planning, particularly involving The Trauma Centre. This would have shed light on organisational culture and prepared the trainers and researchers for potential reactions from social workers, regarding introducing a new treatment approach.

Furthermore, it became evident that social workers at The Trauma Centre possessed limited knowledge of PTSD and had a narrow scope of practice in this area. Future research should, therefore, address this knowledge gap among mental health workers regarding PTSD and explore strategies to enhance their expertise. Moreover, conducting thorough pre-intervention planning would have provided the researchers with deeper insights into the organisation's readiness, enabling more effective preparation. Even after the training sessions, the participants' interviews revealed ongoing gaps in their understanding of PTSD.

Last, social workers expressed the need for cultural adaptation of the treatment to suit the South African context. While cultural adaptation is crucial and a potential focus for future research, evaluating the therapy's efficacy and feasibility is essential before proceeding with cultural adaptations. This approach ensures that any cultural adaptations are based on solid empirical evidence and align with the specific needs and contexts of the local population.

## 7.3 Conclusion

The implementation of PE at The Trauma Centre revealed significant challenges and valuable insights. First, it can be deduced that social workers generally regarded PE as an effective treatment for PTSD. They reported significant personal and professional growth from their engagement with PE and emphasised its transformative impact on some clients. Despite these positive observations, there was scepticism regarding the feasibility of sustaining PE in the long term. The social workers expressed mixed feelings about the feasibility of PE acknowledging its potential benefits, while simultaneously questioning whether it could be successfully implemented, given the ongoing challenges they face.

Furthermore, while most clients reported positive outcomes and healing from PE, two clients reported that it did not effectively alleviate their PTSD symptoms and trauma symptoms. These clients' cases highlighted additional challenges, such as grief and dependency, which may have influenced their responses to the treatment. In these instances, the feasibility of the treatment did not come into question, but rather the acceptability and efficacy of it. Despite the mixed results from the clients, it can still be concluded that the treatment was feasible overall. The study demonstrated that PE can be delivered in resource-constrained settings, making meaningful improvements for several clients.

Not without its challenges, the implementation of PE resulted in the successful alleviation of several clients' PTSD symptoms, thus rendering the treatment acceptable. On the other hand, two clients did not find the treatment acceptable. Further research may need to consider the efficacy of PE in complex environments, to understand better how it can be optimised.

Overall, this study provided significant insights into the feasibility of task-shifting PE at a trauma centre, offering valuable guidance for future research. It emphasised the importance of acknowledging and addressing the barriers encountered in this study and advocated systematically using an implementation framework throughout the research process. By incorporating these insights, future studies can enhance their approach to implementing PE and further explore its effectiveness in diverse cultural and socio-economic contexts.

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# Appendices

## Appendix A

## Rhodes University Ethical Approval

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**Rhodes University Human Research Ethics Committee**
PO Box 94, Makhanda, 6140, South Africa
t: +27 (0) 46 603 7727
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https://www.ru.ac.za/researchgateway/ethics/

06 September2023

Dr Duane Booysen
Department of Psychology
Rhodes University

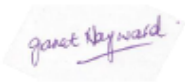
Dear Dr Booysen,

Re: Implementation of Prolonged Exposure Therapy for PTSD at a community trauma centre in Cape Town: A feasibility trial

This letter confirms that the RU-HREC has reviewed the proposed changes to your research protocol and approved your request to conduct interviews with clients who have received Prolonged Exposure Therapy for PTSD after they have received the therapy has been approved.

Approval number: 2021-5257-6490

Sincerely,



Dr Janet Hayward
Chair of Rhodes University Human Research Ethics Committee

# Appendix B

## Written Informed Consent Form – Social Worker Version

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**PARTICIPANT INFORMED CONSENT**
**INFORMED CONSENT DECLARATION**
**(Mental Health Provider)**

Project Title: Implementation of Prolonged Exposure Therapy for PTSD at a community trauma centre in Cape Town: A feasibility trial (ref: 2021-5257-6385).

Dr Duane D. Booysen from the Department of Psychology, Rhodes University, Dr Jaco Rossouw (Stellenbosch University, Department of Psychiatry), and Prof Ashraf Kagee (Stellenbosch University, Department of Psychology) has requested my permission to participate in the above-mentioned research project.

The nature and the purpose of the research project and of this informed consent declaration have been explained to me in a language that I understand.

I am aware that:

1. The purpose of the study is to explore whether it is feasible to train mental health providers (MHPs) in prolonged exposure therapy (PE) for the treatment of post-traumatic stress disorder (PTSD) and depression at a primary care level in the Cape Town area.

2. Rhodes University has given ethical clearance to this research project, and I have seen/may request to see the clearance certificate by contacting ethics-commitee@ru.ac.za

3. By participating in this research project, I will contribute the understanding of whether effective trauma therapies such as PE are feasible to be implemented at a primary care level. In addition, my participation would also contribute to the dissemination and implementation of evidence-based practices at the Trauma Centre for the treatment of PTSD.

4. I will participate in the project by completing three assessments (baseline, during therapy, and post-intervention). I will also complete a minimum of 10 sessions of PE therapy on a weekly or bi-weekly basis, but I know that I can withdraw from therapy whenever I see fit to do so.

5. My participation is entirely voluntary and should I at any stage wish to withdraw from participating further, I may do so without any negative consequences. I also know that if I decline or withdraw from the study, I could still access the usual services of the Trauma Centre.

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14. By signing this informed consent declaration, I am not waiving any legal claims, rights or remedies.

15. A copy of this informed consent declaration will be given to me, and the original will be kept on record.

I, ....., have read the above information / confirm that the above information has been explained to me in a language that I understand and I am aware of this document's contents. I have asked all questions that I wished to ask and these have been answered to my satisfaction. I fully understand what is expected of me during the research.

I have not been pressurised in any way and I voluntarily agree to participate in the above-mentioned project.

..... .....

**Participants signature** **Date**

Rhodes University, Research Office, Ethics
Ethics Coordinator: ethics-commitee@ru.ac.za
t: +27 (0) 46 603 7727 f: +27 (0) 86 616 7707
Room 220, Main Admin Building, Drostdy Road, Grahamstown, 6139

/d.booysen@ru.ac.za).

# Appendix C

## Written Informed Consent Form – Client Version

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### PARTICIPANT INFORMED CONSENT
### INFORMED CONSENT DECLARATION
**(Trauma Client)**

Project Title: Implementation of Prolonged Exposure Therapy for PTSD at a community trauma centre in Cape Town: A feasibility trial (ref: 2021-5257-6490).

Dr Duane D. Booysen from the Department of Psychology, Rhodes University, Dr Jaco Rossouw (Stellenbosch University, Department of Psychiatry), and Prof Ashraf Kagee (Stellenbosch University, Department of Psychology) has requested my permission to participate in the above-mentioned research project.

The nature and the purpose of the research project and of this informed consent declaration have been explained to me in a language that I understand.

I am aware that:

1. The purpose of the study is to explore whether it is feasible to receive prolonged exposure therapy (PE) for the treatment of post-traumatic stress disorder (PTSD) and depression at a primary care level in the Cape Town area.

2. Rhodes University has given ethical clearance to this research project, and I have seen/may request to see the clearance certificate by contacting ethics-commitee@ru.ac.za

3. By participating in this research project, I will contribute the understanding of whether effective trauma therapies such as PE are feasible to be implemented at a primary care level. In addition, my participation would also contribute to the dissemination and implementation of evidence-based practices at the Trauma Centre for the treatment of PTSD.

4. I will participate in the project by completing three assessments (baseline, during therapy, and post-intervention). I will also complete a minimum of 10 sessions of PE therapy on a weekly or bi-weekly basis, but I know that I can withdraw from therapy whenever I see fit to do so. I will also be invited to participate in a post-intervention interview to explore my perceptions and experiences of PE for PTSD.

5. My participation is entirely voluntary and should I at any stage wish to withdraw from participating further, I may do so without any negative consequences. I also know

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that if I decline or withdraw from the study, I could still access the usual services of the Trauma Centre.

6. The project will form part of the routine clinical services of the Trauma Centre, therefore, I will not be compensated for participating in the research.

7. I am also aware that due to the dual nature of the project providing training to MHPs on a voluntary basis and the project also being a research project, the MHPs that would provide PE to me could withdraw from the project. I acknowledge that this will require that I re-enter services at the Trauma Centre with a different MHP using the usual services of the Trauma Centre (i.e., supportive counselling).

8. The following risks are associated with my participation: the risk is high as I will complete questionnaires that will explore aspects related to my trauma related experiences. Additionally, I will also be invited to participate in PE therapy for a minimum of 10 sessions. PE will solely focus on my trauma related experiences and difficulties, which could result in some levels of distress during therapy. For example, PE requires that I talk about my traumatic experience(s) and engage in practically safe activities outside of therapy to further my trauma recovery. In addition, I am also aware that I can contact the PI (DB) or my the Trauma Centre about any emergency regarding my trauma therapy.

9. I am aware that the MHPs will participate in weekly case consultations with Dr Booysen (PI) and Dr Rossouw to discuss the process of treatment. The consultations will also serve to assist MHPs with any difficulties during treatment and to further their learning of implementing PE for PTSD.

10. The researchers intend to publish and presenting the research results in the form of journal articles and at national and or international research conferences. However, confidentiality and anonymity of records will be maintained and that my name and identity will not be revealed to anyone who has not been involved in the conducting of the research, ***unless I indicate to the contrary/recognize that as a public figure my identity will inevitably be/become known.***

11. I have been informed that the data obtained in the current study will be used in future research projects to inform the dissemination and implementation of PE for PTSD at the Trauma Centre and any other relevant organizations who provide mental health services.

12. I will have the right to request feedback in the form of a summary report regarding the results obtained during the study.

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13. Any further questions that I might have concerned the research, or my participation will be answered by Dr Duane D. Booysen (0781676607 / 0466038507 /d.booysen@ru.ac.za).

14. By signing this informed consent declaration, I am not waiving any legal claims, rights or remedies.

15. A copy of this informed consent declaration will be given to me, and the original will be kept on record.

I, ....., have read the above information / confirm that the above information has been explained to me in a language that I understand and I am aware of this document's contents. I have asked all questions that I wished to ask and these have been answered to my satisfaction. I fully understand what is expected of me during the research.

I have not been pressurised in any way and I voluntarily agree to participate in the above-mentioned project.

..... .....

**Participants signature** **Date**

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Room 220, Main Admin Building, Drostdy Road, Grahamstown, 6139

## Appendix D

## Social Worker Interview Guide

### MHP Interview Guide

**Please keep in mind that the interviewee has completed training and implementing PE.**

**Introduction**
- What is your title and role?

**Characteristics of Individuals**
Knowledge & Beliefs about PE
- Are you familiar with Prolonged Exposure (PE)?
    - *If necessary, provide brief description of PE-PC*
- How do you feel about PE being delivered at the Trauma Centre?

**Outer setting-related factors**
Patient Needs & Resources
- How well do you think PE meets the needs of patients in your organization?
    - In what ways does it meet their needs?
    - Reduced wait times? Offering services in a preferred setting? Offering brief rather than longer services?

**Intervention-related**
Relative Advantage
- How do you have the implementation improved standard care for clients with PTSD?

Adaptability
- What kinds of changes or alterations would be needed to make PE work effectively in your at the Trauma Centre in the long run?
    - What would be the best way to deliver the treatment? In person or by telehealth?

**Inner Setting-related factors**
Leadership Engagement
- How has leadership/management at the Trauma Centre been involved or supported the implementation of PE?
    - How receptive, enthusiastic or involved were they?
    - How did that influence the success of the implementation, in your opinion?

Implementation Climate: Tension for Change
- Is there a strong need for additional PTSD treatments like PE at the Trauma Centre?
- How do you feel about current practices and process for treating PTSD at the Trauma Centre?

Implementation Climate: Compatibility
- How well do you think PE fits with the existing work processes and practices at the Trauma Centre?
    - What issues or complications might arise if this were implemented on a larger scale?
        - What ideas do you have to overcome some of these barriers?

Leadership Engagement
- What kind of support or actions from supervisors or leaders in your organization would help make PE implementation successful?

Culture

- How do you think the Trauma Centre's culture (general beliefs, values, assumptions that people embrace) will affected the implementation of PE?

Available Resources

- Do you expect to have sufficient resources to implement and administer PE with existing providers in the future?

**Summary Questions**

1. Overall, what do you see as the **key strength or benefit** of PE for treating PTSD at the Trauma Centre?
2. Overall, what do you see as the **key limitation or weakness** of PE for treating PTSD at the Trauma Centre?

Any other comments or suggestions?

## Appendix E

## Clinet Interview Guide

**Draft Interview Guide**

**Interview Orientation**

My name is _____ and I am a researcher assistant working on the PE for PTSD project at the Trauma Centre.

Before we begin, I would like to take a minute to explain why I am inviting you to participate in this interview today and what I will be doing with the information you provide to me. Please stop me at any time if you have any questions. After I've told you a bit more about this interview, you can decide whether or not you would like to participate.

We are conducting interviews with patients who participated in the PE programme. The purpose of this interview is to help us understand your experience of the programme and to hear any suggestions you may have about how to improve it. I am interested in hearing about the things that you especially liked about your treatment and also any particular ways you think treatment could have been improved. There are no right or wrong answers. Your input will help us to evaluate PTSD treatment and improve it for other patients.

Participation is purely voluntary. If you agree to participate in this interview, you will be asked questions related to your experiences in the PE programme. We will NOT ask you any questions about your trauma specifically, rather, we are only interested in your experiences with the treatment you received. The interview should take approximately 30-45 minutes and will be audio taped so that we do not miss anything that you have to say.

If at any time and for any reason, you would prefer not to answer any questions, please feel free not to answer. If at any time you would like to stop participating, please tell me. We can take a break, stop and continue at a later date, or stop altogether. You will not be penalized in any way for deciding to stop participation at any time. In addition, your counsellor is not listening to this, nor will they have access to the audio recording of this interview.

Any information you provide will be handled in a confidential manner. Only people working on this study will use the interview recordings. We will take steps to ensure your answers stay confidential. Your name will not appear on any of the transcripts. The interview transcript will be labeled only with a study ID number and any personal references that would identify any individuals will be removed.

We may be required to break confidentiality if we believe that there is a risk of harm to yourself or someone else (for example, you may harm yourself, someone else, or someone is harming you, or in cases of child or elder abuse). This means that we may be required to inform the authorities to protect you or others. As with any research study, there may be other risks that are unforeseeable at this time. As mentioned before, if at any time you would like to stop participating, please tell me. We can take a break, stop and continue at a later date, or stop altogether.

Are you interested in participating in this study?

*If the participant agrees to participate, start the recording and begin the interview. Interviewers please make a note to probe for the title of any person mentioned by the interviewee but discourage the use of individual names. In addition, please state your name, the participant's ID number, and the date of the interview at the beginning of the recording.*

**Introduction**

1. Can you tell me what it's like for you dealing with PTSD?

**Intervention-related Questions**

2. Please talk about the therapy you got from (insert social workers name):
    a. Share what you did in the therapy, any homework, and how often.
    b. If you missed any sessions, can you explain why? What stopped you from going?
3. Did you think this treatment helped you?
    a. If yes, how did it help you?
    b. If no, what didn't work for you?
4. Would you tell others who went through tough times to try this treatment?
5. What could make this treatment better or work more?
6. Did this treatment change the way you think about talking to someone about your feelings or getting help for your mental health?
    a. If yes, how?

**Specific Questions Related to Beliefs**

Many things can get in the way of patients going to treatment. We're going to ask you about some potential problems, and we'd like you to tell us which ones have or could get in the way of you coming to your therapy sessions. Some of these may or may not apply to you.

1. Making Appointments
    a. Can you share your experience with setting up appointments for your treatment?
2. Feeling Judged
    a. Do you worry about what others might think because you have PTSD or are getting treatment for it?
        i. If yes, could you explain why?
    b. Have you ever felt like you had to keep your PTSD a secret from others?
        i. Why did you feel that way?
3. Challenges in Getting Help
    a. Has not having enough time ever been a problem for you in getting treatment?
    b. Has money been a problem for you in getting treatment?
    c. Has transportation been a problem for you to reach your treatment?
    d. Has finding someone to take care of your child while you attend treatment been an issue for you?
4. Other Issues
    a. Can you tell me about any other problems or obstacles you faced, like ongoing difficult situations such as community violence?

**Potential Interventions/Ways to Address Barriers**

Based on what you've been through, we'd like to know if you have any ideas to help other patients who are also going through a tough time with PTSD. Can you share any suggestions for:

1. How your clinic can make it easier for patients to start PTSD treatment?
2. How your clinic can support patients to continue and not give up on PTSD treatment?

**Summary Questions**

1. Is there anything else that you'd like to add?

**Thank you for participating in this interview.**