CONTEXTUAL OBSTACLES TO THE DELIVERY OF EFFECTIVE PSYCHOLOGICAL TREATMENT OF PTSD IN A SOUTH AFRICAN COMMUNITY SETTING

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November 2007

Research report submitted in partial fulfilment of the requirements for the degree of Masters of Arts in Clinical Psychology

The structure of this report is in accordance with the layout prescribed by the Journal *Pragmatic Case Studies in Psychotherapy* and was based on the model conceptualised by Fishman (2005).

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1. CASE CONTEXT

Violence, both political and domestic, and suffering are common features throughout the world (Swartz, 1998). South Africa, however, is a country particularly well-known for its long history of violence, conflict and oppression. It seems, however, that this suffering is not merely related to the past, but is a continuing and ever-present phenomenon in our country. Crime, particularly violent crime, appears to be on the rise and statistics of violent crime indicate that individuals in South Africa have a greater risk of being exposed to violence than do individuals in other countries, excluding those at war (Eagle, 2004). Sexual assault is particularly prevalent in South Africa, and rape and attempted rape make up a significant proportion of the crime statistics in our country. Given the pervasiveness of violence in our country, there is an increased likelihood of being exposed to such incidents and thus trauma has become a common feature of life in South Africa (Edwards, 2005a). From this it follows that the incidence of posttraumatic stress disorder (PTSD), a severe response to a traumatic event, is also high and does, in fact, pose a significant public health concern in South Africa (Edwards, 2005b).

The high rates of violence, trauma and thus PTSD within the South African context suggest that there are a great many individuals in need of psychological treatment. Various treatments for PTSD have been developed in the past decade, with cognitive-behavioural treatments being the most broadly studied (Foa & Rothbaum, 1998), and considerable support for the efficacy of such treatments has been demonstrated. However much of this research has been conducted in the United Kingdom and the United States, while research investigating the transportability of cognitive treatment models for PTSD to a diverse cultural context, namely that of South Africa, appears limited (Edwards, 2005c). Furthermore, there appears to be even *less* research or formal documentation exploring the contextual obstacles encountered when implementing treatment models in such a setting.

The present study presents three individual cases; all three clients had endured a traumatic event, namely rape, and all three met the criteria for PTSD. Despite the fact that each of the clients was initially assessed as being a suitable candidate for psychological treatment, none of the cases proceeded to the therapy phase of treatment. A number of obstacles, both personal and contextual, were encountered during treatment implementation, preventing or limiting a successful outcome of psychological treatment in each case. An examination of these cases highlights a few of the many obstacles frequently faced when delivering psychological treatment to the South African context. In so doing, this research provides an opportunity to consider the possible reasons for the limited documentation of treatment efficacy within the South African context, as well as to enhance our understanding of and sensitivity towards the cultural and contextual factors playing a role in psychological treatment.

2. METHODOLOGY

2.1 Research Questions

There appears to be limited research and formal documentation investigating the transportability of cognitive treatment models for PTSD to a more diverse cultural context, namely that of South Africa (Edwards, 2005c). Thus, the initial aims of this study were to: (1) Document the treatment of a rape survivor who meets the American Psychiatric Association's (2000) *Diagnostic and statistical manual of mental disorders*, fourth edition, text revision criteria for PTSD; (2) Use the information gathered to evaluate the transportability of Ehlers and Clark's (2000) cognitive model for the assessment and treatment of PTSD; and (3) Consider the cultural and contextual factors that may influence the efficacy of the treatment model.

The researcher, and author of this paper, was also the clinician who conducted the assessment and, where appropriate, delivered the treatment. Although not formally trained or certified with the Ehlers and Clark (2000) group, the author/therapist received training in cognitive therapy in her first year of Clinical Psychology Masters. Furthermore, she was closely supervised and mentored by a cognitive therapist accredited with the Academy of Cognitive Therapy. This supervision of the therapist ensured that implementation of the model was in accordance with the

general principles and approach of the Ehlers and Clark's (2000) cognitive therapy model for the treatment of PTSD.

Time and again, however, clients terminated during or soon after the initial assessment, thus failing to engage with the treatment process. The focus of this study therefore shifted and the following new research questions arose: (1) What are the obstacles preventing delivery of the Ehlers and Clark (2000) cognitive therapy model in the South African context? (2) What contextual factors prevent individuals' engagement with treatment and thus hinder the transportability of this treatment model to the South African context?

In order to examine these questions, interviews were conducted with two clinical psychologists with experience in working with these kinds of clients, and the series of cases where clients had either not completed the assessment or had terminated prematurely were examined in depth.

2.2 Clinical Methodology

The model utilised in this study was the Ehlers and Clark (2000) cognitive therapy model. This model is conceptually-driven, and is flexibly applied according to the particular needs of the individual client. According to the recommendations of the model, a thorough assessment was conducted prior to the commencement of treatment. For each of the three cases, the assessment process was systematically carried out and was done so in accordance with the Ehlers and Clark (2000) cognitive therapy model. The assessment comprised a series of interviews and aimed to elicit the following information: the nature of the traumatic event and the way in which this event had impacted on the individual and her life; the key cognitive themes and cognitive appraisals that were to be addressed in therapy; the 'hotspots', intrusive memories and emotional reactions experienced by the individual, and the problematic cognitive and behavioural strategies currently employed by the individual. Finally, the assessment process allowed for the characterising of both the nature of the trauma memory and of the spontaneous intrusions (Ehlers & Clark, 2000). The information obtained throughout the assessment process was subsequently used to make a diagnosis or diagnoses, as well as to conclude the client's suitability for this study.

2.3 Research Methodology

2.3.1 Research Design

The present study employed two distinct research designs. The first was a semi-structured interview, conducted with two clinical psychologists who served as informants on the basis of their experience in the field. The first psychologist had two years' experience, while the second had seven years' experience working with clients with PTSD. This type of interview uses an interview schedule, or an outline of key issues or topics, to be covered during the interview (Durrheim & Wassenaar, 1999). This provides some guide and direction for the interviews, but at the same time allows individuals to freely share their feelings and experiences.

The second research design was a case-based design. This particular type of research implies a lack of rigid distinction between quantitative and qualitative methods, but rather a combination of the two (Edwards, Dattilio, & Bromley, 2004). This study made use predominantly of case narratives, but these were complemented by quantitative data in the form of scores on self-report scales. According to Edwards et al. (2004), a case-based research design, or a case-based study, facilitates the refinement of clinical treatment models in addition to the testing and refinement of the theory on which these models are based. This type of research is predominantly longitudinal in nature, allowing for the examination of the detailed unfolding of events over time. Furthermore, case-based research focuses on intra-subject rather than inter-subject variation, thus looking closely at individual experience (Edwards et al., 2004).

The methodology for each design is quite different and will thus be described separately.

2.3.2 Participant Selection

(i) Semi-structured interviews

The selection of psychologists was based on the following inclusion criteria: (1) she was to be working as a clinical psychologist at a hospital or clinic within a community setting, and (2) she was to have had experience working with clients/patients suffering from PTSD, or individuals who had been exposed to trauma. These were, therefore, a convenience sample. Two local female psychologists were selected; one a White, English-speaking woman aged 28 doing her

community service, and the other a Black, Xhosa-speaking woman aged 40 with 7 years experience, who was also fluent in English.

(ii) Case-based research

The selection of an appropriate client/participant was based on the following inclusion criteria: (1) she was to meet the full DSM-IV criteria for PTSD, (2) the PTSD was to be in response to either rape or attempted rape, (3) she was to be South African, and (4) she was to consent to the course of assessment and treatment, as well as for the case material to be used for this research study. In addition to these inclusion criteria, a number of exclusion criteria were also applied, namely: (1) current substance abuse, and (2) severe personality pathology.

2.3.3 Confidentiality and Ethical Aspects

(i) Semi-structured interviews

Each interviewee provided her verbal consent, following a detailed explanation of the study, including the aims and the nature of this particular study. Furthermore, in order to maintain confidentiality and to protect their clients' privacy, no client names were provided during the interviewees' discussion of the case examples.

(ii) Case-based research

Since all three clients were minors, consent was obtained from the legal guardians as well as the clients themselves. This was done by means of a consent form, which included a description of the aims and nature of the study. Furthermore, all names and identifying data have been changed in this report, in order to protect the clients' privacy.

2.3.4 Data Collection Methods

(i) Semi-structured interviews

Both interviewees were interviewed on one occasion by means of a semi-structured interview. An interview guide was utilised and included questions enquiring about the psychologists' experiences and views of the challenges to treatment implementation. Each interview took place at Fort England Hospital and was 60 to 90 minutes in length. Both interviews were tape recorded and detailed notes were made after each interview.

(ii) Case-based research

The clinical setting in which the data was collected, was that of Fort England Hospital. Data was collected by means of assessment interviews, which took place on an outpatient basis for the first two clients and on both an inpatient and outpatient basis for the third client. Interviews were conducted with the index client as well as with relatives. Each assessment interview was between 90 and 120 minutes in length, but the number of assessment interviews varied according to the client.

All sessions, including those with the clients as well as with third parties, were tape-recorded and detailed session records were made after each session. Supervision notes, namely records of discussions and reflections regarding the case, were made on at least a weekly basis. Additional data was obtained through the use of psychometric assessment instruments, namely self-report scales. The following self-report scales were administered during the assessment interviews: Beck Depression Inventory II (Beck, Steer, & Brown, 1996); Beck Anxiety Inventory (Beck & Steer, 1993); Posttraumatic Cognitions Inventory (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999); Posttraumatic Stress Diagnostic Scale (Foa, Cashman, Jaycox, & Perry, 1997); and the Children's Revised Impact of Events Scale (Perrin, Meiser-Stedman, & Smith, 2005).

2.3.5 Data Reduction Methods

The data collected was used to develop the following data reduction steps:

(1) A thematic summary of the interviews with clinicians was developed, focusing on particular themes that emerged during the two interviews.
(2) Information obtained during the assessment interviews was summarised to provide a case history and presenting problem.
(3) Depending on the amount of available information, a case formulation was developed. This was based on the information regarding the presenting problem, as well as on the available family and personal history of the client.
(4) A case narrative focusing on each individual client's experience of the assessment process, as well as factors related to each cancellation or lack of attendance, was constructed.

2.3.6 Interpretation of Data

The data was subsequently interpreted using a hermeneutic reading method (Edwards, 1998). This interpretative method was discovery-driven, focusing systematically and pragmatically on the meaning of the material from each individual case. This method allowed careful attention to be paid to each individual's personal context and experience (Fishman, 2005). The first step in the interpretation of data was to identify the factors that the clinical psychologists believed to be important which might be relevant to these cases. After this, a case by case exploration was carried out in which the focus was on identifying factors that served as obstacles to the delivery of treatment. In this process, the researcher looked for the factors identified by the clinicians as well as any additional factors suggested by the case material. Following this, a cross-case comparison was employed in order to examine the differences and similarities between the cases.

3. GUIDING CONCEPTION AND RELEVANT RESEARCH

This chapter will provide a discussion of the theoretical concepts relevant to this particular study, as well as to the cases included. Since trauma and PTSD were common to all cases in this study, this section will commence with defining or conceptualising both PTSD and trauma. Consideration will then be given to the history of PTSD as a psychiatric disorder, to the causal and maintaining factors, and to the treatment of this disorder. Following this, attention will be paid to the efficacy and transportability of the treatment of PTSD in the South African context, and finally to the cultural and contextual factors influencing treatment efficacy and transportability.

3.1 Conceptualising Trauma and PTSD

Given that PTSD is a common response to trauma (Ehlers & Clark, 2000), it is necessary to first understand what is meant by the term 'trauma' *before* conceptualising PTSD. It has been noted that the meaning of the term 'trauma' differs according to the context in which it is used (Edwards, 2005a). In this study, the term will be used as it is used in psychiatry and clinical psychology, that is, that it refers to extreme events that are frequently catastrophic and that create a sudden threat to life or physical integrity (Edwards, 2005a). PTSD is defined as a severe

response to a traumatic event during which an individual experiences his/her personhood, or the personhood of another, as being under threat. The individual's response includes intense fear, helplessness or horror. PTSD is characterised by the re-experiencing of the traumatic event in the form of recurrent and intrusive recollections or dreams of the event, the persistent avoidance of stimuli associated with the traumatic event, and increased arousal in the form of insomnia, irritability or hypervigilance (American Psychiatric Association, 2000).

3.2 History of PTSD: A Brief Overview

The study of psychological trauma has a somewhat intermittent history, characterised by periods of active investigation alternating with periods of nothingness (Herman, 2001). The periods of absence in the investigation of trauma are, however, not due to lack of interest, but rather to intense controversy provoked by the subject of trauma.

Post-traumatic Stress Disorder (PTSD) was first included as an official diagnostic category in the American Psychiatric Association's third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) in 1980 (Weathers, Litz, & Keane, 1995). Reports documenting a particular pattern of psychological problems among war veterans played a significant role in the American Psychiatric Association's inclusion of this disorder. The authors thus observe that war-related trauma, and the study thereof, appears to have formed the basis for the study of other types of trauma-related stress. However, since war has long been a part of human existence, the adverse psychological effects of war and thus the symptoms characteristic of PTSD have been observed for some time prior to its formal classification. Despite this fact, prior to World War I, the adverse effects of war particularly on psychological functioning were largely ignored by the medical profession (Weathers et al., 1995).

According to Weathers et al. (1995), the systematic investigation of war-related stress was motivated by the atrocities of World War I. It was during this war that the diagnosis of 'shell shock' was coined. Shell shock referred to the physical symptoms experienced by soldiers as a result of constant exposure to artillery shells (Joseph, Williams, & Yule, 1997). In due course, the psychological nature of the symptoms of this diagnosis was identified, and shell shock came to be viewed as a form of neurosis (Weathers et al., 1995). This interest in war-related stress faded with

the end of World War I and it was only during World War II that interest was reignited. It was the emergence of insights and literature regarding the phenomenology and treatment of war-related stress, which became the basis of contemporary research on PTSD (Weathers et al., 1995).

While a variety of terms have been used to describe the psychological effects of war-zone stress, namely 'shell shock', 'traumatic neurosis', 'war neurosis', 'combat exhaustion', and 'nostalgia', there appeared to be a lack of recognition of the division between acute and chronic stress reactions. It was only with the inclusion of PTSD in the DSM-III that the possibility of the persistence of symptoms of traumatic stress was acknowledged (Weathers et al., 1995).

3.3 Causal and Maintaining Factors in PTSD

PTSD is a common and well-recognised reaction to traumatic events (Ehlers & Clark, 2000; Clark & Ehlers, 2005). Many people experience at least some of the symptoms of PTSD immediately after a traumatic event and, while a large proportion of these individuals recover in the months following this event, a significant minority does not. In such individuals, symptoms may persist for up to years after the event (Clark & Ehlers, 2005). Thus, the question has been raised as to why it is that PTSD persists in some individuals and not others. A number of theoretical bases for the development of PTSD exist (Foa & Rothbaum, 1998), however this section will focus on one particular model, namely the cognitive model of PTSD as proposed by Ehlers and Clark (2000).

PTSD presents somewhat of a conceptual puzzle in that unlike other anxiety disorders, which are seen as the result of appraisals relating to impending threat, the anxiety experienced in PTSD is the result of appraisals relating to that which has already occurred (Ehlers & Clark, 2000). These authors propose to resolve this dilemma by suggesting that PTSD persists when a traumatic event is processed in such a way that it leads to a sense of serious, current threat. It is stated that this sense of threat is the result of (1) excessively negative appraisals (or personal meanings) of the trauma and/or its consequences as well as (2) a disturbance of autobiographical memory, frequently characterised by poor elaboration and contextualisation, strong associative memory, and strong perceptual priming.

The perception of current threat is frequently accompanied by re-experiencing symptoms, symptoms of arousal, as well as anxiety and other emotional responses (Ehlers & Clark, 2000). It is suggested that a series of behavioural and cognitive strategies or responses develop as a means of reducing the distress resulting from the perceived threat. However, while these strategies may achieve a short-term reduction of distress, they prevent long-term cognitive change and thus serve to maintain the disorder (Clark & Ehlers, 2005). The key processes in the causation and maintenance of PTSD will now be discussed in detail.

3.3.1 Cognitive Appraisals

The sense of *current* threat experienced in PTSD is the result of a number of problematic appraisals of the traumatic event (Ehlers & Clark, 2000). It is stated that an individual may overgeneralise from the traumatic event, perceiving ordinary activities or events as more threatening than they in fact are. The probability of further catastrophic events may be exaggerated, and the experience of trauma may be taken as evidence to support negative appraisals. Such appraisals are likely to result in situational fear, as well as avoidance behaviour, which in turn serve to maintain this overgeneralised fear. An individual may also have negative appraisals regarding how he/she felt or behaved during the traumatic event and such appraisals may, too, have long-term negative implications (Ehlers & Clark, 2000).

The meaning that individuals assign to the sequelae of a traumatic event may further contribute to persistent PTSD (Clark & Ehlers, 2005). While some individuals view their symptoms as part of the recovery process, others experience these as a sign that they are 'going crazy' or that they have permanently changed for the worse (Ehlers & Clark, 2000). It has been proposed that such negative appraisals may explain the persistence and maintenance of symptoms as these negative appraisals determine the extent of the distress caused by these symptoms, as well as the extent to which an individual engages in strategies to control the symptoms. Such strategies may prevent an opportunity to correct the meaning of the trauma or the symptoms (Clark & Ehlers, 2005).

Negative appraisals of other people's responses have also been found to predict persistent PTSD (Clark & Ehlers, 2005). A trauma victim may perceive others' responses or actions as an indication that no one is there for him/her, or that others feel that the event was his/her fault.

According to Ehlers and Clark (2000), such perceptions may result in the individual distancing him/herself from others, thus directly resulting in the production of certain PTSD symptoms. Furthermore, such interpretations may prevent the individual from discussing the trauma with others, therefore reducing the opportunity for therapeutic reliving or for receiving corrective feedback from others.

A traumatic event may have long-term negative consequences in various domains of an individual's life, for example physical health, occupation, and financial status (Ehlers & Clark, 2000). An individual's appraisal of these particular consequences, for example that these difficulties are an indication of permanent change, may further contribute to the continuation or maintenance of PTSD symptoms (Clark & Ehlers, 2005).

The appraisals of the trauma *sequelae* determine the emotional responses experienced by an individual, which in turn contribute to persistent PTSD (Ehlers & Clark, 2000). Individuals with PTSD frequently experience a range of negative emotions, namely guilt, depression, shame, or anxiety. The particular emotion experienced depends on the appraisal that is activated, for example, appraisals of perceived responsibility for the traumatic event are likely to lead to feelings of guilt (Ehlers & Clark, 2000).

3.3.2 Memory of the Traumatic Event

Ehlers and Clark (2000) describe the somewhat puzzling nature of the trauma memory in PTSD, namely the difficulty with *intentionally* retrieving or recalling an organised, complete memory of the traumatic event, while at the same time *involuntarily* reexperiencing elements of the event in a vivid and emotive way, in the form of intrusive memories. It is suggested that the pattern of retrieval, as well as the intrusions characteristic of PTSD, are a result of the way in which the traumatic event is encoded and laid down in memory. The features typical of the trauma memory in PTSD will now be discussed and explained.

(i) Intrusive Memories

Intrusive memories are described as spontaneously triggered, unwanted memories consisting predominantly of brief sensory fragments of the trauma (Ehlers, Hackmann, & Michael, 2004).

While it is not uncommon for intrusive memories to have more than one sensory component, visual sensations are considered most common. Intrusive memories are seen as lacking one of the key features of other memories of specific events (episodic memories), namely the awareness that the content of the memory belongs in the past. In addition to this, the emotions accompanying the intrusive memories are the same as those emotions experienced at the time of the trauma. It is these features of intrusive memories that create a sense of current threat that accompany these memories. Finally, intrusive memories are described as being resistant to change, and frequently experienced in a stereotyped and repetitive manner (Ehlers et al., 2004). Ehlers and Clark (2000) propose that intrusive memories are a result of the way in which the trauma is encoded and laid down in memory. It is the inadequate elaboration and integration of the trauma memory that is said to result in the problematic nature of this memory, thus leading to the experience of intrusive memories.

(ii) Poor Retrieval

Ehlers and Clark (2000) discuss two routes to the retrieval of autobiographical information, (1) through higher-order meaning-based strategies and (2) through direct triggering by stimuli associated with the event. Autobiographical memories are typically processed in such a way as to reduce the ease with which memories of past experiences are unintentionally retrieved. Ordinarily, autobiographical events are integrated into an autobiographical memory knowledge base organised in terms of themes and time periods. Thus the first retrieval route is enhanced, while the second is inhibited. As mentioned previously, one of the fundamental problems in persistent PTSD is the poor elaboration and inadequate integration of the trauma memory into its context in time, place, previous and subsequent information, as well as other autobiographical memories. It is this poor elaboration and inadequate integration that leads to the poor retrieval typical of the trauma memory in PTSD (Ehlers & Clark, 2000).

3.3.3 Maladaptive Coping Strategies

Individuals with PTSD frequently employ a number of behavioural and cognitive strategies as a means of relieving their distress. While these strategies achieve temporary relief and reduce

distress in the short-term, they frequently prevent cognitive change and thus serve to maintain PTSD in the longer-term (Ehlers & Clark, 2000).

Research indicates that avoidance behaviour, or simply avoidance, plays a central role in the maintenance of PTSD (Clark & Ehlers, 2005). Cognitive avoidance (avoiding thinking about the trauma) and situational avoidance (avoiding people, places, conversations or other such stimuli that serve as reminders of the trauma) are commonly employed in order to control or reduce distress experienced by an individual. Situational avoidance includes the avoidance of social situations as a means of avoiding perceived negative responses or actions of others. 'Safety behaviours', more subtle avoidance behaviours, are also commonly employed by victims of a trauma and so, too is the use of alcohol or medication. Such methods are frequently used as a means of controlling anxiety or reducing distress, but in fact contribute to the maintenance of PTSD (Ehlers & Clark, 2000).

In addition to avoidance behaviours, a number of cognitive responses have been found to play an important part in the maintenance of PTSD (Ehlers & Clark, 2000; Clark & Ehlers, 2005). The first of these cognitive responses is that of thought suppression, a mechanism employed to suppress or eradicate any thoughts of the trauma. This mechanism, has, however, been found to have the opposite effect, namely to increase rather than decrease the frequency of thoughts of the trauma (Ehlers & Clark, 2000). Rumination about aspects of the trauma is a further maladaptive cognitive response style seen as contributing to the maintenance of PTSD. This is due to the fact that it serves to strengthen problematic appraisals of the trauma, prevents the formation of an organised, integrated memory, and frequently increases negative emotions (namely anxiety, hopelessness or dysphoria) (Clark & Ehlers, 2005). Another cognitive process linked to the maintenance of PTSD is selective attention or attentional deployment. This selective attention is to cues representing threat, or stimuli that serve as reminders of the traumatic event, and is likely to increase the frequency of reexperiencing symptoms (Clark & Ehlers, 2005).

While the abovementioned strategies attempt to reduce or control the distress or symptoms experienced by the individual, they in fact serve to maintain PTSD by: (1) directly producing

PTSD symptoms; (2) preventing change in negative appraisals of the trauma and/or its sequelae; and (3) preventing change in the nature of the trauma memory (Ehlers & Clark, 2000).

3.3.4 Problematic Emotions

According to Edwards (2005c), a number of painful emotions are associated with a traumatic event, as well as with the memories of such an event, namely fear, disgust, shame, humiliation, anger, guilt, and grief. Active avoidance is commonly associated with these emotional states, preventing or disrupting the accommodation of new information into existing schemas. The avoidance of these emotions contributes to the development or maintenance of PTSD in the following ways: (1) by interfering with emotional processing of the event; (2) generalising of negative emotions to other situations, thereby creating the view that nowhere is safe; (3) by actively avoiding thoughts of the event, thus increasing the likelihood of this; and (4) assuming of inappropriate responsibility (Edwards, 2005c).

3.3.5 Dysfunctional Beliefs and PTSD

It has been proposed that traumatic events 'shatter' or 'challenge' the basic beliefs and assumptions held by individuals (Janoff-Bulman, 1995). The author states that people's assumptions regarding the world and themselves are generally not challenged or questioned. For the most part, people are said to operate on the basis of three basic assumptions: (1) the world is benevolent; both the world and people in the world are good, (2) events in the world have meaning or make sense, and (3) the self is positive and worthy, deserving of good things (Janoff-Bulman, 1995). When an individual experiences a traumatic event, however, these core assumptions or beliefs are severely challenged or threatened and can no longer be relied upon to make sense of this experience.

It is suggested that a change in beliefs about the self, others and the world, or the breakdown of an individual's assumptive world, is at the heart of psychological trauma (Janoff-Bulman, 1995). Furthermore, negative beliefs have been found to contribute both to the development and maintenance of PTSD (Brewin & Holmes, 2003; Clark & Ehlers, 2005). Victims of traumatic events commonly believe that they have been betrayed or let down by others, and a failure to believe in the good intentions of others is a common consequence of such an event (Brewin &

Holmes, 2003). Furthermore, PTSD is frequently associated with the belief that the traumatic event has resulted in negative, permanent change in the self and the possibility of achieving goals. Not only is PTSD associated with the 'shattering' of positive beliefs, but it is frequently related to the confirmation of previously held negative beliefs (Clark & Ehlers, 2005). According to Edwards (2005c), such dysfunctional beliefs evoke or exacerbate negative emotions which, as mentioned previously, contribute to the development and maintenance of PTSD.

3.3.6 Social Support

Edwards, Sakasa and Van Wyk (2005), in their article focusing on resilience and vulnerability to PTSD, consider the importance of social support as a protective factor against the development of PTSD. Social support may take the form of emotional support, as well as practical assistance addressing the immediate concerns of an individual. It is stated that the value of social support is dependent on the extent to which it is consistent with an individual's needs. Social support, particularly emotional support, allows an individual to talk about and thus work through emotions relating to the trauma. Without this type of support, an individual lacks significant means of emotional processing, thus increasing vulnerability to the development of PTSD and the maintenance of symptoms.

Social support, or the lack thereof, is further discussed by Brewin and Holmes (2003) as one of the strongest risk factors for the development of PTSD. Ullman and Fillipas (2001) give consideration to negative support, namely criticism or lack of concern, as well as to positive support. It is noted that negative support is a greater risk factor in the development of PTSD than is the absence of positive support. Furthermore, negative appraisal of others' attempts at support may also contribute to the development of PTSD (Brewin & Holmes, 2003). Finally, it has been noted that in violent crimes, negative support is frequently more common for female than for male victims, and there appears to be a stronger relationship between negative social support and the development of PTSD in females than in males (Brewin & Holmes, 2003).

3.3.7 Summary

It is evident from the above discussion that there are a number of factors playing a role, not only in the production of PTSD symptoms, but also in the persistence of these symptoms and in the maintenance of this disorder. Furthermore, the abovementioned factors are likely to influence an individual's engagement with both the assessment and the treatment process, which may further serve to maintain PTSD. A treatment intervention thus needs to address this combination of factors and symptoms and to assist an individual in the many areas of difficulty experienced.

3.4 Treating PTSD

Over the past decade various therapeutic approaches for the treatment of PTSD have been developed and utilised. Some of these include hypnotherapy, psychodynamic therapy, pharmacotherapy and cognitive-behavioural therapy. Of these, cognitive-behavioural interventions have been the most vigorously studied (Foa & Rothbaum, 1998).

A commonly-used set of cognitive-behavioural techniques for the treatment of PTSD is that of exposure, which is described as a patient's gradual confrontation of the feared situation (Foa & Rothbaum, 1998). Exposure techniques involve exposure to the trauma memory (either by writing a trauma narrative or by imagining the event) and *in vivo* exposure to the actual places or situations avoided by the individual since the traumatic event (Ehlers, Clark, Hackmann, McManus, & Fennel, 2005). Resick and Schnicke's Cognitive Processing Therapy (CPT), another cognitive approach used for the treatment of trauma, combines exposure and cognitive techniques in that it elicits memories of the traumatic event and subsequently confronts maladaptive beliefs about the event (Resick & Schnicke, 1996).

Ehlers and Clark's (2000) cognitive model not only looks at the persistence of PTSD, but it provides a framework for the cognitive-behavioural treatment of PTSD and it draws on elements and concepts of other models, namely the abovementioned exposure techniques and CPT. According to Clark and Ehlers (2005), this model specifies three goals for therapeutic change. The first of these goals is to reduce intrusive reexperiencing by elaborating and integrating the trauma memory into the individual's preceding and subsequent experience. The elaboration of the trauma memory assists the client in developing a coherent narrative of the event and may be achieved through the writing out of the event, through imaginal reliving of the event, or through

visiting the scene of the trauma (Clark & Ehlers, 2005). The second goal, to modify problematic appraisals of the trauma and its *sequelae*, is facilitated through careful questioning around the moments of particular distress within the trauma memory (the 'hotspots'). These 'hotspots' may also be identified by exploring the content of intrusions or by probe reliving. After identifying an alternative appraisal that is acceptable to the client, this appraisal is integrated into the trauma memory by means of writing or by insertion during a reliving (Clark & Ehlers, 2005). The third goal stipulated by the Ehlers and Clark (2000) model is to eliminate dysfunctional behavioural and cognitive strategies that serve to exacerbate or maintain symptoms. This goal is achieved through the discussion of the problematic outcomes of the existing strategies, as well as encouraging the dropping or reversal of the strategy by means of a behavioural experiment (Clark & Ehlers, 2005).

3.5 Transportability

There appears to be considerable support for the efficacy of cognitive therapy models in treating PTSD. However, research demonstrating the efficacy of these models has taken place predominantly in the United Kingdom and the United States of America, while research focusing on the extent to which similar findings may be gained in more diverse contexts, such as that of South Africa, appears limited (Edwards, 2005c). Schoenwald and Hoagwood (2001) refer to this type of effectiveness research as 'transportability'. Chorpita (2003) elaborates, stating that this particular research is termed 'transportability' as it considers whether a particular intervention may be effectively delivered in a true practice setting.

Schoenwald and Hoagwood (2001) state that even within the context of first world countries, treatment manuals that have proven effective in research settings, may have limited transportability, and are often less effective when applied to a clinical setting. These authors propose that problems with transportability may result from the following sources: (1) inadequate training of those delivering treatment; (2) insufficient resources at the point of intervention; (3) providing a treatment to patient populations for whom the treatment was not designed; and (4) failure to take contextual and cultural factors into consideration.

While Schoenwald and Hoagwood (2001) accurately propose that research on the transportability of treatments is a significant and necessary area, and one that should be further pursued, several studies to date have investigated the transportability of cognitive treatment models for PTSD. According to Edwards (2005c), there is substantial evidence indicating that the fundamental elements of PTSD treatments are indeed transportable from one context to another. One such study conducted by Gillespie, Duffy, Hackmann and Clark (2002) demonstrated the transportability of the Ehlers and Clark (2000) cognitive therapy model to a community setting in Northern Ireland after the 1998 terrorist bomb blast in Omagh. Results of this study indicated a significant reduction of PTSD symptoms, as well as depression, for those individuals who were treated with the model. A study by Kubany et al. (as cited in Edwards, 2005c), provides further evidence of the effectiveness of cognitive treatment interventions implemented in an alternative context. This particular study took place in Hawaii, and many of the women included in the study were from ethnic minorities, while a number of the therapists had no professional-level psychological or psychiatric-counselling training. Such studies illustrate that treatment models may prove effective when implemented in varying and more diverse contexts, thus suggesting the transportability of such treatment models.

A number of studies conducted in South Africa provide further evidence for the transportability of cognitive therapeutic interventions for the treatment of PTSD. Such studies illustrate that PTSD interventions may in fact be successfully implemented in more diverse cultural contexts than initially intended. Several of these studies will now be discussed.

A case discussion by Eagle (2004) illustrates a therapeutic intervention with an attempted rape survivor. The therapy involved the young woman's retelling of the traumatic event as well as the construction of a coherent trauma narrative; the identification of problematic appraisals of both her symptoms and her behaviour during the trauma; psychoeducation; guided imagery; and the reframing of her interpretation and her attribution of responsibility. Eagle (2004) proposes that the success of this particular intervention was largely due to the therapist's respect towards and acceptance of her client and her client's traditional beliefs. The successful outcome of this intervention illustrates the transportability of this intervention, as well as the techniques of which the intervention was comprised, to the South African context. This case further demonstrates that

a successful therapeutic outcome is quite possible despite differing cultural backgrounds of client and clinician.

Straker (1994) demonstrates the importance of acknowledging, and incorporating both Western and African views when providing therapeutic interventions cross-culturally. She illustrates the success of this integrated approach in her treatment of three sisters displaying significant psychological distress following the violent death of their father during the South African civil war. The symptoms displayed by the three girls could be understood from both a traditional Western framework, namely the characteristic features of PTSD, as well as an African framework. It was this integrative approach to treatment that allowed for catharsis and healing, and thus a positive outcome. This study again shows that with an attitude of acceptance and respect on the part of the therapist, and some adaptation of a typical treatment intervention, the transportability of a PTSD intervention to an alternative cultural context is feasible.

A phenomenological case study by Karpelowsky and Edwards (2005) describes the treatment of a 21-year-old Black student suffering from PTSD, due to a series of motor vehicle accidents affecting both him and his family. These authors discuss the use of cognitive therapy techniques, namely the use of guided imagery, in the reduction of the client's PTSD symptoms over the course of 22 sessions. The successful outcome of the treatment again demonstrates the transportability of this particular PTSD intervention to the South African context.

It should, however, be noted that despite the success of the abovementioned intervention, a number of challenges were encountered throughout its implementation (Karpelowsky & Edwards, 2005). The first challenge faced by the client, and thus the therapist, was the client's experience of prior trauma. This factor was discussed as playing a role in the severity of symptoms with which the client presented, and is further discussed by Edwards (2005a) as frequently serving to complicate the symptom picture. This may, in turn, complicate treatment. A further and somewhat significant complicating factor discussed by Karpelowsky and Edwards (2005) was the client's lack of social support. This client was studying some distance away from home; it was indicated that his family, and thus his primary source of support, were 1500 kilometres away. Furthermore, the client's father had encouraged him to forget the pain that he

was experiencing and to simply ‘move on’. This apparent lack of support created difficulty for the client’s true expression of his emotions and thus posed challenges to the healing process. Therefore, while this particular case study demonstrates the transportability of this treatment intervention, it illustrates that the effectiveness of this intervention was not without challenges or complicating factors.

Davidow (2006) explores and documents a 21-year-old Black South African rape survivor’s response to the Ehlers and Clark (2000) cognitive therapy model for the treatment of PTSD. The significant reduction in PTSD and depressive symptomatology throughout the treatment process again illustrates the efficacy of the model, providing further support for the transportability of this treatment model to an alternative and more diverse cultural context.

Once again, however, the success of this treatment intervention was accompanied by various obstacles. Davidow (2006) describes the client’s initial ambivalence engaging in the therapeutic process and the challenge this posed to the author, and therapist, with the initial implementation of treatment. The client’s difficulty with disclosing her experience of rape to anyone in her family (apart from her mother), and the resultant limited social support, was discussed as a further challenge needing to be addressed. Finally, Davidow (2006) describes her client’s reluctance to be tested for HIV as an additional and significant complicating factor in the implementation of this treatment model. Thus, while transportability of this particular intervention is demonstrated, some of the difficulties encountered during treatment implementation are acknowledged.

A study by Payne (2006) further demonstrates the transportability of the Ehlers and Clark (2000) treatment model to the South African context, while again recognising that challenges are frequently encountered throughout this process. Payne (2006) describes the treatment of a fifteen-year-old Black female who had been raped twice by the same perpetrator. The client displayed significant PTSD symptoms, namely flashbacks, nightmares and feelings of isolation, and it was through the implementation of the cognitive therapy techniques posited by the Ehlers and Clark (2000) model, that a reduction of symptoms was achieved. Furthermore, this study demonstrated that treatment gains can be made despite differing cultural backgrounds of clinician and client (Payne, 2006).

Payne (2006) discusses the apparent failure of the criminal justice system to arrest the perpetrator, and the increased levels of anxiety experienced by the client as a result of this. Another significant difficulty encountered during the therapy was the client's discovery of her positive HIV status. Such challenges are not uncommon in the South African context and play a major role in the outcome of a therapeutic intervention as well as a client's healing process.

While the above studies provide support for the transportability of interventions for the treatment of PTSD, they form part of only a limited number of such studies and thus, further investigation is warranted (Edwards, 2005c). Furthermore, several of these studies illustrate a number of challenges that may be encountered when working in a diverse context such as South Africa. These challenges were discussed only briefly, and will be explored further in the following section. It appears, however, that the implementation of treatment interventions in South Africa may not always be smooth and without complications, and thus transportability may not always be easily achieved. The original aim of this study was to investigate the transportability of the Ehlers and Clark (2000) cognitive therapy model for the treatment of PTSD to the South African context thus contributing to the body of existing knowledge in the South African context. However, given the complications encountered with a number of cases and the constant failure of clients to engage with the treatment, as well as the abovementioned and previously documented difficulties encountered in therapy, the focus of this study shifted to the investigation of the obstacles and contextual factors preventing treatment delivery and thus treatment effectiveness.

3.6 Factors Influencing Transportability of Treatment

As mentioned previously, the above studies demonstrate both the efficacy and transportability of PTSD treatments in the South African context. Such studies in South Africa are, however, minimal (Edwards, 2005c). This raises the question of what exactly determines the success of one treatment intervention and the failure of another. When investigating treatment effectiveness and transportability, it is essential to consider the many factors that may influence treatment outcome. Such factors may be personal, that is, related to either client or clinician, or they may be culturally or contextually bound. These factors, and how they impact on the treatment of PTSD in South Africa, will now be discussed in detail.

3.6.1 Personal Factors

'Psychotherapy is first and foremost a human endeavour' (Goodheart, 2006: 41). It is thus a complicated and complex process that cannot simply be reduced to a mechanistic enterprise (Goodheart, 2006). This author discusses several key factors contributing to treatment or therapeutic outcomes, which include factors relating to both the client and the therapist.

(i) Client-related personal factors

The first client-related personal factor is that of motivation (Goodheart, 2006). Motivation determines the level of commitment to, and engagement in, the therapeutic process. Without sufficient motivation, the client may terminate prematurely or complete the course of therapy with limited emotional engagement. In both cases, however, a positive therapeutic outcome is unlikely.

Goodheart (2006) proposes a number of additional client-related personal factors influencing the therapy process and thus the therapeutic outcome. Such factors include a client's biological predisposition, personality structure, developmental level, psychological functioning and personal preferences. Individual variations in personality and how these influence the therapeutic process and outcome are further discussed by Horowitz (2001). Similar to motivation, these characteristics in combination with one another play a role in determining how a client engages with and responds to a particular therapeutic intervention, thus influencing treatment outcome or efficacy.

(ii) Therapist-related personal factors

The therapeutic relationship is recognised by many different schools of psychology as a central factor in the therapy process, and thus treatment outcome (Comas-Diaz, 2006). Herman (2001) further proposes that recovery cannot occur in isolation, but only within the context of a relationship. Thus it is necessary to consider not only client-related factors, but also therapist-related factors that assist in the development of a positive working alliance or relationship, and in turn increase the likelihood of therapeutic change and treatment efficacy.

A therapist's capacity for empathy, which is described as 'the recognition of the self in the other' (p.96), is a key factor contributing to a positive psychotherapeutic outcome (Comas-Diaz, 2006). In addition to empathy, clients from most cultures expect mental health providers to demonstrate genuineness, availability, respect, warmth, congruence and connectedness. Such personal therapist-related qualities are likely to facilitate the development of a working alliance, or a collaborative therapeutic relationship, and it is within this collaborative relationship that a positive treatment outcome may occur. Thus, it may be said that a therapist's personal qualities are a significant factor in determining treatment efficacy (Comas-Diaz, 2006).

3.6.2 Cultural and Contextual Factors

While personal factors are central in determining therapeutic outcome or efficacy, these factors are largely determined by the cultural context of both the therapist and client. Clients and clinicians negotiate their relationship according to their world views, as well as in terms of cultural variables infused by subjective and contextual meanings (Comas-Diaz, 2006).

(i) Differing world views and belief systems

Until recently few patients would have sought the assistance of therapists from across the cultural divide; traditionally, Black patients would choose to receive help from African healers and White patients would seek help from White therapists of a traditional Western orientation (Straker, 1994). This, however, is no longer the case. The establishment of a multi-cultural therapeutic relationship thus implies the merging of differing world views and belief systems, which may pose additional challenges to a therapeutic intervention, as well as to the efficacy of the intervention. In her discussion of a clinical case (see section 3.5), Straker (1994) illustrates contrasting views or frameworks and how these different views, namely Western and African, determine a client's understanding of a psychiatric illness (such as PTSD), as well as its symptoms and origin. Within a Western framework, or belief system, the clients' symptoms could be understood as an expression of PTSD, while within an African framework these same symptoms could be perceived as being due to outside forces, namely communication from the ancestors. Swartz (1998) elaborates on this issue of differing belief systems stating that two individuals from two different contexts may perceive similar conditions, symptoms, or experiences quite differently.

How a client perceives his/her symptoms plays a significant role in determining the perceived need for or compliance with treatment. Comas-Diaz (2006) further discusses how differing cultural beliefs may lead to miscommunication between client and clinician, as well as to treatment non-compliance. The case of an Indian immigrant suffering from social phobia, and her previous experience of therapy is described. After a failed trial of systematic desensitisation, this woman approached the author for assistance. She discussed her previous therapist, a White woman, as having been too 'technical' and more concerned with 'following a treatment manual' than with the client's unique experiences. Furthermore, this client described the difficulty that she had experienced with measuring her emotions numerically (on a rating scale) and the anger she had felt toward her previous therapist who encouraged her 'to keep trying'. It was the client's feeling of discomfort with the 'Western' therapy approach and the perceived lack of respect and flexibility on the part of the therapist that led to her premature termination. Thus it is evident that a client's belief system, which is largely influenced by his/her culture, is a major contributing factor to treatment efficacy.

(ii) Language

Swartz (1998) discusses another challenge that is constantly faced when working with individuals of varying cultures, that of language. In a multicultural, multilingual country such as South Africa, it often happens that a client and clinician do not speak the same language and interpreters are required to assist. Given the lack of resources in our country, trained interpreters are not always available and the clinician may have to call upon nursing staff, cleaning staff, or even relatives of the client to translate. Swartz (1998) raises a number of important issues regarding the use of interpreters in the assessment and therapy process. Firstly using relatives and ward cleaners as interpreters raises the issue of confidentiality; secondly, when interviews are translated, there is the risk of information or responses being distorted and relayed in a manner that is not entirely accurate or reliable. Finally, the addition of a third person, the translator, may impact on the therapeutic process. When an interview or therapy session is being translated, it is not always possible to convey empathy and understanding in the way in which it is intended. The therapeutic relationship may no longer be perceived as an intimate, two-person relationship, but as a somewhat administrative, rigid process (Swartz, 1998). This may hinder the establishment of rapport, which may ultimately affect the therapy process and the therapeutic outcome. Thus it is

evident that while the obstacle of different languages may be overcome with the use of an interpreter, using an interpreter brings additional challenges, which may affect the therapeutic relationship and process and thus the therapy outcome.

The issue of language has additional implications. Swartz (1998) compares two approaches to language, namely the empiricist approach (that language is simply used for labelling) and the hermeneutic approach. The latter approach views language as playing a role in the construction of meaning and the creation of reality, including our emotional realities. Swartz further states that certain emotions are better described or expressed in some languages than in others, and that different systems of emotional vocabulary are developed by different languages. Thus not all emotions can be adequately expressed in all languages and when emotional language is translated, an individual's emotional reality may be distorted. This may pose a challenge when working therapeutically with clients of different cultures as their true emotional experience may not be adequately understood and may thus not be appropriately empathised. This in turn may affect the therapeutic relationship and therefore treatment efficacy.

(iii) Societal conditions

The rates of violence and trauma in South Africa are high (Eagle, 2004; Edwards, 2005b) and thus the likelihood of being exposed to a traumatic event in South Africa is also high. Edwards (2005a) discusses the exposure of individuals, particularly individuals in the Third World, to cumulative trauma. This chronic or pervasive presence of trauma in South Africa may create challenges for treatment and the long-lasting effects thereof. While individuals suffering from PTSD and other psychological disorders clearly require individual attention and assistance in the form of psychotherapy, sending a recovered individual back into a society characterised by violence and trauma is likely to affect that individual's permanent recovery and render him/her vulnerable to further psychological difficulty. Thus, while psychotherapeutic interventions are indeed beneficial and necessary, long-term treatment efficacy may be hindered by traumatic societal conditions. Edwards (2005a) proposes that in order for trauma to truly be addressed, the conditions within our society that result in traumatic events should be transformed.

When considering the impact of societal conditions on treatment efficacy, the chronic poverty and deprivation in South Africa should be mentioned. Strous (2003) discusses the lack of adequate mental health services within the public health sector, stating that mental health professionals are frequently located in urban areas that are not accessible to much of the population. It thus appears that individuals from community settings often do not receive the treatment that they so desperately require. Furthermore, private practitioners are said to have minimal training with regards to working with individuals from disadvantaged communities and lack experience related to particular cultural, social and language contexts (Strous, 2003). Therefore when treatment *is* provided for individuals of such contexts, it may not always be adequate and thus long-term treatment efficacy may be limited.

Terre Blanche (2004) gives further consideration to the impact of poverty within South Africa and explores the challenges, psychological and other, that are encountered by individuals living in environments characterised by poverty and deprivation. Children who grow up in such environments are frequently forced to take on parental responsibilities thus causing them to miss out on important developmental tasks and opportunities. Furthermore children growing up in overcrowded environments, a common feature of poverty, are likely to endure greater stress and may be at increased risk of physical and sexual abuse. It has been found that children raised in conditions characterised by poverty and deprivation are more likely to witness or be victims of crime and violence. Thus it again follows that these children or individuals are at greater risk of developing PTSD or other psychological problems (Edwards, 2005b). Since poverty has a negative effect on individuals' mental, as well as physical wellbeing, individuals growing up in such environments may have a greater need for mental health care and psychological intervention, but at the same time have no access to or be unable to afford such care or intervention. Mental health services are less accessible to poor individuals; such individuals frequently live in areas that are completely lacking in health facilities or, at least, lacking in *adequately* resourced health facilities, while other individuals may simply be unable to afford those facilities that are provided (Terre Blanche, 2004).

(iv) HIV

Davidow (2006) and Payne (2006) highlight an additional contextual factor that frequently complicates psychological treatment of trauma, in South Africa, that of HIV. Davidow (2006) discusses the high incidence of HIV in South Africa and thus the increased risk of individuals exposed to sexual assault for contracting the virus. Given this high risk within our country she states that sexual trauma, namely rape, takes on a different dimension in that the risk to an individual's life is no longer time-limited, but may in fact be ongoing. Existing feelings of shame, anger or dirtiness resulting from the trauma may be exacerbated by this possible risk and thus need to be worked with during therapy, as well as feelings regarding uncertainty and reality of living with HIV (Davidow, 2006).

The impact of HIV on psychological treatment interventions is further discussed by Payne (2006). In her study, Payne describes her client's discovery of her positive HIV status and how this altered or influenced the therapy process. The focus of therapy shifted from trauma work to exploring and validating the client's fear of having contracted HIV, exploring her thoughts and feelings related to being tested, and finally to containing her feelings when her status was discovered.

Thus HIV poses an additional challenge to the implementation of psychological treatment of PTSD in the South African context and may be seen as playing a role in influencing treatment efficacy.

(v) Social support

Social support is described as one of the major protective factors against the development of PTSD (see section 3.3). However, in a country such as South Africa, social support is often minimal and cannot be taken for granted. Swartz (1998) discusses South Africa's long history of violence, conflict and repression and the effect that such occurrences have had, and continue to have. Communities are disrupted, families break up and children are orphaned or abandoned. The AIDS epidemic has, similarly, disrupted society. With this significant disruption and loss of life, social support may be limited. This lack of social support in South Africa may therefore render an individual vulnerable to the development of a psychological disorder or the maintenance of

symptoms of a psychological disorder (Brewin and Holmes, 2003; Edwards et al., 2005). Tarrier and Humphreys (2003) consider the implications of a lack of, or a perceived lack of, social support for effective long-term therapeutic outcomes. Individuals who appear to be lacking in social support frequently do not engage with, or respond to, psychological treatment. Thus lack of social support is not only a risk factor in the development and maintenance of PTSD, but a lack of social support within the South African context may limit long-term effectiveness of therapeutic interventions.

From this section, it is apparent that there are a multitude of factors that may influence treatment effectiveness. These factors may be personal and related specifically to a client or a clinician and thus are likely to be present in any context. There are, however, a number of cultural factors, specific to the South African context. Such factors pose unique challenges to the effective implementation of treatment interventions.

4. INTERVIEW WITH CLINICIANS

This section presents a thematic summary of the interviews conducted with two clinicians, both of whom have had much experience working with traumatised individuals, particularly individuals from community settings. Both clinicians work within the government system, Clinician 1 working for community-based clinics and Clinician 2 for Fort England Hospital. These interviews explored the numerous challenges or obstacles encountered when working with individuals from such settings, and the possible reasons for clients' lack of engagement with therapy. Such difficulties appear to be related to both the client and the therapist, and these, as well as numerous cultural and contextual factors playing a role in clients' engagement with the therapeutic process, will be discussed. The majority of themes summarised below were identified by both informants. Where only one of them mentioned a factor, this will be explicitly stated.

4.1 Client-Related Factors

4.1.1 Motivation

A large number of clients are referred for therapy by teachers, doctors, or other referral sources. These individuals may therefore not be attending therapy by choice, but do so simply because they have been *told* to see a psychologist. A lack of motivation is common amongst such clients and given the necessity of motivation for the commencement and continuation of therapy, a successful therapeutic outcome is often unlikely.

Additionally, clients are frequently unaware of the nature of therapy and the fact that therapy is a process, often due to a lack of psychological education and understanding. Thus it was discussed that when clients do not feel better immediately and they discover that therapy is to involve a number of sessions and therefore more time than originally assumed, the motivation required to continue with this process is often lacking.

Clinician 2 also noted that some clients gain something by maintaining their 'sick' role. Certain symptoms or difficulties may in the past have provided them with the care and attention that has otherwise been lacking in their lives, thus there has been some secondary gain. Such clients may thus not be motivated to change and are therefore unlikely to engage with the therapeutic process.

4.1.2 Avoidance

Most individuals who have endured a trauma find it exceptionally difficult to talk about the incident and often put off talking about it for as long as possible. Many clients feel that they will not be able to tolerate the intensity of the memories and feelings elicited by therapy and thus choose to avoid therapy altogether. Individuals frequently talk about wanting to 'forget about' the incident, 'move on' with their lives, and 'leave the past in the past'. Such views or desires, as well as the belief that therapy will be unbearable, prevent individuals from engaging with therapy. Clinician 2 stated that individuals often do not wish to be labelled, for example as a 'rape victim', and attending therapy would mean, for many, acknowledging and accepting this label and thus their own vulnerability.

4.2 Therapist-Related Factors

4.2.1 Cultural background

The cultural context of the therapist was discussed as directly influencing a client's engagement with the therapy. Clients often request to see a therapist of a particular race or culture. Most often, it appears that African clients prefer to be seen by a non-African (particularly White) therapist for various reasons. African clients belonging to a particular community are frequently afraid of other community members discovering their stories, and thus request a therapist of a different race, or if of the same race, of a different language or community setting. Some clients may fear that a therapist of the same culture or community setting will know too much about them or their cultural background and may therefore find it difficult to trust this therapist. In these cases, clients choose confidentiality and trust over being fully understood in terms of their language and culture.

Clinician 2, who is in fact Xhosa-speaking, stated that in her experience African clients often prefer to see a White therapist as they are concerned that an African therapist is less knowledgeable than a White therapist. They may feel that an African therapist will be unable to help in the same manner that a White therapist might. Therefore, upon discovering that their therapist is of a particular race or cultural background, clients might not commence with, or return to therapy.

Alternatively, however, many clients prefer a therapist of the same language and culture as this allows them to feel understood. In such cases, therapy with a clinician of a *different* language or culture may be experienced as frustrating and uncontaining, frequently leading to premature termination.

4.2.2 Therapeutic approaches or boundaries

Clinician 2 stated that clients often do not like, or feel comfortable with, a particular approach used by a therapist. If this cannot be discussed or negotiated with the therapist, often due to a therapist's own inflexibility, a client may choose not to return to that therapist. Clinician 1 discussed the fact that a number of her clients lived far away from the clinic where therapy took

place and had to walk a long way to therapy. Some clients would thus ask for a lift home and when this request was denied, due to boundary issues or for ethical reasons, the therapeutic relationship was, at times, negatively affected. According to this clinician, clients might perceive the therapist's refusal of their request as going against their cultural idea or belief of helping others, thus impacting on the therapeutic relationship.

4.3 Cultural and Contextual Factors

4.3.1 Lack of psychological education and understanding

Both clinicians made frequent mention of the lack of psychological understanding or education of many of their clients, particularly those clients from community settings. These clients frequently lack the knowledge or the understanding of what exactly a psychologist does, and what therapy entails. They view an appointment with a psychologist as similar to a trip to the doctor or their local clinic. Thus there is often the expectation that they will be seen for therapy immediately, without making an appointment. Furthermore, individuals are frequently *referred* for therapy; they are told that since they have experienced a certain trauma they should see a psychologist. Such clients may therefore be unaware of the role of a therapist or of the process of therapy. A therapist may be seen as a doctor and clients may therefore expect to receive medication, which will help them to feel better. Many clients come to therapy with the hope of a 'quick fix'. It is hoped that one or two sessions is all that is required for relief of their symptoms and it is seldom understood that therapy is a *process* that takes time. When clients do not feel better immediately, they frequently become frustrated or despondent and do not wish to continue with therapy.

Both clinicians felt that clients are often unaware that therapy involves working through the traumatic experience and that experiencing intense emotions is part of the healing process. Thus they may not be prepared for the intensity of the emotions elicited, which may cause them to withdraw from the process. This is illustrated by the following case: a young girl, who had been raped, was brought to therapy by her caregiver. When the therapist attempted to explore, from her client, the reasons for her coming to therapy, the girl was said to have started sobbing exceptionally loudly, without ever saying what had happened to her. Despite the clinician containing and validating her client's feelings throughout this session, the client's caregiver

continually told the girl to 'stop crying'. A second session was arranged for the following day, but the client's caregiver did not bring her that day, or ever again. It appeared that the client's caregiver had had little understanding of the nature of therapy and thus had not understood that crying is merely part of the healing process. The intense emotions experienced by the client during the session are likely to have been experienced as foreign and frightening, or perhaps as harmful, by the caregiver and thus the concept of therapy or continuing with this process may have felt too threatening.

On the other hand, when clients begin to experience some relief from their symptoms, for example sleeping through the night for the first time in months, they feel that they do not need to continue with therapy. Clinician 2 discussed a case that stood out for her and one that illustrates this point. A four-year-old boy, who had witnessed his mom being axed to pieces by his father, was referred to the clinician for play therapy. This little boy had reportedly not cried or spoken throughout the incident or up until his mother's funeral. He attended therapy for two years; the first year he never said a word throughout each session, but simply sat on the floor. The following year, he began speaking during sessions saying first, 'I want to go home' and after several sessions, 'I'm sleepy'. Following these words, he would sleep on the clinician's lap. After a few such sessions he asked 'can I play cards?' The clinician stated that they had played cards and marbles and that, during one session, the boy laughed for the first time. Soon after he began talking again, his caregivers stopped bringing him to therapy as they thought he was healed.

Since clients frequently lack the knowledge or understanding of psychotherapy, they are unlikely to recognise its importance for their own healing or psychological well-being. Clinician 2 pointed out that psychologists may simply assume that everyone understands psychology and what it is all about. We seldom take into account that psychology is, in fact, a relatively new and unknown process for many individuals or communities.

4.3.2 Language

As noted in section 4.2.1, clients frequently choose to be seen by a therapist of a different culture. A therapeutic process with a therapist and client from differing cultural backgrounds implies a process conducted in a language other than the client's first language. While some clients may be

able to speak the therapist's language, this ability may be limited, therefore limiting the true expression of experiences and emotions. Other clients may not be able to speak the same language as the therapist and thus an interpreter is required. In these cases, interpreters are essential in translating for both client and therapist and in assisting understanding of the spoken language of both parties. However, Clinician 1 stated that interpreters may affect the therapeutic process in that much of what an individual says may be missed or distorted during the process of translation. Furthermore, the process of interpretation or translation may hinder the natural flow of the therapy and thus lead to feelings of frustration for both client and therapist. Such feelings of frustration may also be experienced when a client and therapist speak different dialects of the same language. Clinician 2 discussed the differences in colloquial language amongst Xhosa-speaking individuals living in different regions and how such differences may create significant difficulties in following conversation or understanding emotions. She stated that in these cases, one is continually forced to clarify words or phrases to ensure an adequate understanding of the client. The client may feel misunderstood and become frustrated by this process, and may respond by prematurely terminating therapy.

Clinician 2 described the apparent difficulty experienced by clients from African cultures in the verbal articulation of emotions. She stated that clients from such settings and environments often lack the words or vocabulary necessary to express their emotions. In some cultures, there is often one word used to describe many different feelings, thus the clinician always needs to explore exactly what is meant by a particular word, rather than simply accepting what is said at face value. Furthermore, in certain communities or cultures, talking about emotions is not something that is considered relevant or important. Clients are used to going to doctors and traditional healers, telling their stories and describing their symptoms and subsequently receiving medicines or solutions. Individuals are seldom asked how they feel and thus when this question is put forward during therapy, clients often appear surprised. Clients frequently assume that by listening to their story, a therapist should *know* how they feel and consequently a therapist's questioning regarding their feelings may be experienced as frustrating and irrelevant. A client may feel that he/she is not understood and such feelings may contribute in a client's lack of engagement or willingness to engage with therapy.

4.3.3 Social support

Both clinicians emphasised the role of social support, or the lack thereof, in clients' engagement with the therapy process. It appears that a client's family, or primary support group, frequently influences a client's commencement or continuation with therapy. At times a client may wish to come to or continue with therapy, but that the family will not allow this (often due to a lack of psychological education or understanding). As mentioned previously, there is often a lack of understanding within African cultures of the *importance* of therapy. Very often the client's family does not view therapy as necessary or as a priority and thus they do not allow the client to continue with a process that has begun, or to begin this process at all. This was discussed as being particularly problematic with child clients. Given the apparent lack of psychological understanding amongst many individuals and communities, should an individual be involved in a difficult and intense therapeutic process, that individual is unlikely to receive the emotional support necessary for engagement of the process. Clinician 2 commented on the implications of the patriarchal nature of many African families and how in such families, the father or male in the family makes the final decisions. Thus if he does not see the importance of therapy or of attending therapy sessions regularly, the therapy process often cannot proceed.

Clinician 1 described how young children often below the age of three, who had been raped or sodomised, were frequently admitted to the paediatric ward of a general hospital and subsequently referred for play therapy. Many of these children come from single-parent families where there is alcohol and other substance abuse and the parents of these children frequently cannot engage with the idea of their child needing treatment. Thus, despite the clear need for a therapeutic intervention, the lack of social support within these communities prevents such interventions from taking place.

4.3.4 Poverty and lack of resources

A common obstacle encountered when implementing psychotherapy interventions within the South African context is that of poverty and a lack of resources. Many of the clients seen at Fort England and at community-based clinics are from community settings and frequently from underprivileged backgrounds. Both clinicians stated that clients are often unable to get to therapy, as they may be living far away from the facilities where therapy takes place and cannot afford the

transport required to take them there. Furthermore, clients may begin therapy with the idea that this will be a once or twice-off event and thus might pay for transport initially. However, upon realising that therapy is a longer process than was originally thought, clients often terminate, largely due to financial reasons.

Clinician 1 also described the lack of available resources in the settings where therapy takes place, and the influence that this has on therapeutic interventions. There is no playroom facility in the clinics where she works, which thus limits the age of clients that may be seen. She described a case of a five-year-old boy for whom play therapy was indicated. However, given the fact that there was no playroom facility in this setting, the client had to be referred elsewhere. Both clinicians discussed the limited number of Xhosa-speaking therapists in the settings in which they work. This means that clients frequently have to wait for some time to be seen by a therapist who is able to speak their language. Such factors thus directly impact on the therapeutic process and on the provision of psychotherapy within these settings.

4.3.5 Multiple traumas

Both clinicians acknowledged the high incidence of crime and trauma in our country and the fact that many individuals, particularly individuals within certain settings, are exposed to abuse or trauma on a daily basis. Violence and abuse have become such a part of our lives, that they are frequently experienced as 'the norm'. The psychological impact of such experiences is often not acknowledged and the importance of working through such events to facilitate healing is not recognised, thus individuals frequently do not seek therapy. Clinician 2 discussed how in many cases individuals only choose to seek therapy when a physical condition, namely HIV, comes to the fore. She elaborated on this, saying that for many individuals treatment for that which cannot be seen, namely a psychological or psychiatric problem, seems 'pointless'.

Both clinicians observed that although many clients are referred for therapy for one particular trauma, it may soon become apparent that there are 'layers of trauma' in the clients' lives. This often complicates the therapy as both the client and therapist may feel overwhelmed by this multitude of traumas. Furthermore, while a client may seek therapy following a trauma, this

particular incident may be experienced as ‘just another bad thing that has happened’ and he/she may not fully engage with the therapeutic process.

An additional complicating factor is that of HIV. The high incidence of HIV in South Africa means that individuals exposed to sexual trauma are frequently at risk for contracting HIV. Both clinicians discussed how this impacts on the therapy process within our context. Being tested positive is undeniably traumatic and thus an individual is faced with this additional trauma, as well as a loss of their previous healthy status and a loss of a part of themselves. Both clinicians described the shifting of the focus of therapy, saying that therapy becomes about containing the client’s feelings of loss and helplessness. Also, clients frequently choose to speak more about their status and living with their status than about the traumatic incident. For many clients their positive HIV status resulting from an experience of rape is more traumatic than the rape itself. Furthermore, clients may not wish to talk about the traumatic incident at all, as it reminds them of their HIV status and this in turn elicits strong emotions. Clients’ resistance to HIV testing, and their avoidance thereof, was discussed by both clinicians. Clinician 1 stated that individuals frequently do not wish to go for testing, and that therapy thus becomes about exploring this difficulty and the feelings related to this.

4.3.6 The criminal justice system

When asked about the impact of the criminal justice system, if any, on the therapeutic process, both clinicians stated that weaknesses in the South African criminal justice system often serve to exacerbate the trauma and thus complicate the therapy. Clinician 1 discussed the fact that individuals are often reluctant to report an incident of rape or another trauma because of their awareness of the slow legal process and the significant length of time taken for perpetrators to be caught, as well as their fear that the perpetrator will not be caught at all. Clinician 2 confirmed this saying that given the length of time taken for perpetrators to be taken into custody or arrested, individuals are often at risk for re-victimisation at the hands of the perpetrator. These individuals are likely to be living in a constant state of fear and anxiety, making it difficult to engage in everyday activities and in a therapeutic intervention, thus complicating the therapy process.

4.3.7 Cultural beliefs and views

Clinician 2 described the influence of cultural beliefs on the therapy process. She stated that within African cultures various events, for example traumatic incidents are often believed to be the result of evil spirits or bewitchment and so, too, are symptoms relating to these traumatic incidents. This clinician discussed the impact that such beliefs might have on implementing a therapeutic intervention within this context; it was stated that given some individuals or families' belief that traumatic events or PTSD symptoms are caused by evil spirits, the importance or relevance of therapy may not be recognised. Such individuals feel that their attention should be focused on 'chasing away' the evil spirits, rather than on processing or working through the trauma that they have endured. Thus individuals fail to seek or engage with a therapy process.

4.3.8 Summary

From the interviews conducted with these two clinicians, it is evident that there are numerous difficulties or obstacles encountered when implementing therapeutic interventions in the South African context. Such difficulties may be both personal factors, related to the client and the therapist, as well as factors related to the context in which the therapy takes place. These obstacles or challenges appear to influence an individual's engagement with the therapeutic process, either directly or indirectly, and thus may be seen as influencing the therapeutic outcome.

5. THE CLIENTS

This section will provide a systematic discussion of the three cases included in this study. Each client will be introduced and background information provided. Background information will include the circumstances leading to the client's presentation for treatment, the presenting problem and history of the presenting problem, as well as additional relevant history. Since all three cases presented in this study terminated prematurely, thus failing to engage with treatment, a detailed discussion of the assessment process and a narrative of this process for each client will be provided. Finally, each case will be formulated in terms of the Ehlers and Clark (2000) model, as well as with regards to particular obstacles that may have prevented each individual's engagement with the therapy process.

5.1 Case One

5.1.1 Background Information

Marie, a fifteen-year-old Coloured female scholar from Grahamstown, was referred to Fort England Community Psychiatric Services for an assessment following a recent suicide attempt. Marie was assessed by a psychologist and was subsequently referred to Ward A-Neuro at Fort England Hospital. According to collateral information, Marie's suicide attempt appeared to have been in response to feelings of intense anger that were evoked when an acquaintance spoke poorly of her deceased mother. Marie described her suicide attempt as having been her way of trying to 'get away from the world'.

On admission, Marie reported feeling stressed and angry, particularly with regards to the loss of her mother in 2005. According to hospital notes, she denied current suicide ideation or experiencing a low mood, and was not objectively assessed as suffering from clinical depression. Upon further enquiry, Marie reported having been raped the previous year. She spoke little about this event, appearing somewhat reluctant or avoidant, and the diagnosis of posttraumatic stress disorder was, at this point, considered. Nine days later, Marie was discharged and was referred by the multidisciplinary team on Ward A-Neuro to the author for outpatient psychotherapy.

Despite describing feeling 'fine' during her initial outpatient interview, Marie discussed numerous difficulties or symptoms that she was experiencing. At this time, she met the criteria for major depression as well as for PTSD. She reported feeling most concerned about her difficulty sleeping, particularly her difficulty falling asleep. Although she initially denied feeling sad, Marie described feeling irritable much of the time. She further stated that she had lost her appetite, was having difficulty concentrating and remembering things, and that she no longer felt like doing anything that she had previously experienced as positive and pleasurable, namely singing, dancing or running. When asked when she last took part in such activities, Marie reported that she had done so in 2006, prior to having been raped.

Marie described having been raped in Port Elizabeth and stated that the perpetrator had been someone known to her. She was reportedly living with her father at the time, but had moved to Grahamstown shortly after the incident. Marie described this move as having been a way of

‘getting away’, and an attempt to ‘move on’ with her life and ‘forget about everything that had happened’. She stated that she had not since returned to Port Elizabeth and that she would ‘never’ return as this would bring back too many painful memories. Marie described feeling ‘nervous’ and ‘upset’ when thinking about the event and acknowledged avoiding thoughts or conversations of this event. She further discussed reexperiencing the event in the form of frequent nightmares and described symptoms of increased arousal, namely irritability, difficulty falling asleep and an inability to concentrate. Marie’s initial scores on the BAI (49) and the BDI-II (36) were classified as severe and placed her in the clinically significant range for anxiety and depression respectively.

As the assessment interview progressed, it became apparent that Marie’s early and current home environment was somewhat chaotic. Her parents were never married and, until recently, Marie had never met her father and had been unaware of his identity. While Marie was growing up, she lived with her mother, her mother’s boyfriend and their child (Marie’s younger half-sister). Her mother’s boyfriend reportedly abused alcohol and drugs, and he and Marie were said to have had a rather distant relationship. Marie’s mother, with whom Marie had been very close, died in 2005, reportedly as a result of a spider bite. It was only after this time that Marie met her father and subsequently went to stay with him in Port Elizabeth. Collateral information indicates that Marie’s father abused substances and that he has been ‘in and out of prison’ for charges of rape, murder and attempted murder. Marie describes their relationship as ‘fine’, but stated that she has not seen or spoken to her father since she moved to Grahamstown.

Since moving to Grahamstown, Marie has been living with her great-aunt, great-grandparents, cousins, and another married couple. Collateral information indicates that Marie’s current home environment is characterised by much conflict, and little understanding or communication. However, it was Marie’s great-aunt who became concerned about Marie’s recent changes in behaviour. Furthermore, after Marie’s suicide attempt, it was her great-aunt who requested that Marie be seen by a psychologist, which in turn led to Marie’s hospital admission.

5.1.2 The Assessment Process

(Sessions 1 – 5)

Initial contact

My initial contact with Marie was one week after her discharge from Ward A-Neuro. She sat alone in the waiting room of the Intern House, cross-legged on a chair and tightly hugging a large teddy bear that belonged to the waiting room. She appeared timid and slightly anxious as I showed her into my office, and she remained quiet until I enquired about her feelings. Marie described feeling nervous and, as the session progressed, she appeared sad and confirmed that this was how she felt. Not long into the session, however, Marie's mood shifted. She began to play on her cell phone, avoiding eye contact and looking bored and distracted. At these times it was difficult to determine whether this way of interacting was an expression of a lack of interest, of her previously-reported difficulty concentrating, or of avoidance. I was soon to discover that Marie's initial manner of relating would become a pattern and a common thread throughout our relatively brief period of contact.

Despite providing a fair amount of information during our initial assessment interview, Marie spoke in a detached and somewhat disengaged manner of her past traumatic experience, namely having been raped the previous year, as well as of her current difficulties. Furthermore, at one point during the interview, Marie abruptly excused herself to go to the bathroom. This sudden exit from my office followed my attempt to explore the nightmares that she had acknowledged experiencing. Despite having proceeded with the interview process in what I had perceived to be a slow and gentle manner, I wondered at this point whether my questioning had been slow and gentle *enough* for my client. Upon her return to my office, I reflected these thoughts to Marie, suggesting that she may have experienced these questions as difficult and upsetting, and that she may have wished to avoid answering. She denied experiencing the questioning and exploration as such, stating that she had simply 'needed the bathroom' and I thus did not pursue this any further.

Reluctance to engage

Marie's lack of engagement continued into our second assessment session. She discussed having gone to the clinic after recently experiencing some symptoms in her genital area. She reported having been told that she 'might have a sexually transmitted disease' and that she had been given

medication, which did not seem to be working. Some time was spent discussing these symptoms and Marie's feelings relating to these. Furthermore time was taken to motivate Marie to return to the clinic and to inform the doctor that the prescribed treatment was not helping. Although she described feeling concerned about these symptoms and what they might mean, Marie related this information in an unemotional and disengaged manner. At times during the session, Marie appeared to be in pain and stated that she was experiencing cramps. At other times she displayed no evidence of pain and appeared bored and distracted.

During this second session, Marie described the loss of her mother and how much she missed having her mother around. She discussed her relationship with her father and described him as 'a horrible person'. While talking, Marie again played with her cell phone and when asked certain questions she did not answer, at times appearing not to hear these questions. Marie abruptly excused herself to go to the bathroom on two occasions during the session and after returning the second time she described having cramps. She appeared to be in pain as she crouched over her knees and held her stomach. I felt concerned about Marie and cut our session short, again encouraging her to return to the clinic for a check-up. Marie's aunt was contacted and informed that Marie was not well and transport was arranged to take Marie home. Despite my concern about her physical condition, I wondered about some of the other happenings that had occurred, as well as Marie's behaviour during our session. Again it was difficult to gauge whether Marie's way of relating was a means of avoiding difficult feelings and thoughts relating to the content of this session, or whether it was due to other factors, namely difficulty concentrating, or a lack of interest or motivation.

Risk assessment and ethical considerations

During our third, and what would be our final, outpatient assessment session, Marie's mood appeared significantly more depressed. This was confirmed by her subjective account of her mood as well as by her score of 59 on the BDI. Marie described feeling 'stressed' and 'depressed' and stated that she was unable to stop thinking about killing herself. She discussed missing her mother and wishing that she was still alive. She reported feeling 'so alone', stating that no one understands her and that 'there is no point' to anything. I spent some time trying to explore and validate Marie's feelings, but at the same time I was aware of my ethical

responsibility as a therapist and felt it essential to assess for suicide risk. While she did not appear to have an active suicide plan, Marie acknowledged that if given the opportunity and the means to 'do it', she *would* kill herself. Earlier in this session, Marie described having felt understood and contained during her admission to Ward A-Neuro. It was thus during my assessment of her suicide risk that this statement was revisited. The option of readmission to Fort England was explored and recommended in order to ensure Marie's safety, and this was positively received by both Marie and her aunt. I contacted Ward A-Neuro and was informed that there was sufficient space for Marie to be admitted that same day. When informed of this, Marie stated that she would prefer to come the following day. I was struck by her sudden change in affect and behaviour. She appeared calm, contained and cheerful when only a few moments before she had been completely despondent and somewhat desperate. I commented on her apparent change in mood and Marie described feeling relieved by the knowledge that she was to return to hospital.

Premature termination

Marie and I had agreed that we would continue to meet while she was in Ward A-Neuro. Thus the following day, the day of her readmission, I met briefly with Marie to see how she was doing and to arrange a time for our next session. Marie described feeling 'better' and 'safer', and stated that it was nice to be with people who understood her and her 'problems'. It was with much the same words that our subsequent session in Ward A-Neuro began. Marie reported that she felt 'much better' and stated that she no longer wished to die. She described wanting to go home soon in order to 'carry on with things'. When asked about this change, Marie stated that talking to and sharing her problems with other patients in the ward, had made her feel 'better'. She discussed having realised that there *are* people to talk to and people who understand her and that this makes her feel less alone.

Two days later, it came to my attention that Marie was to be discharged from Ward A-Neuro at the end of the week. I thus went to see her in order to make arrangements for the continuation of our therapy process. Marie appeared cheerful and excited, and described looking forward to her discharge. We spoke about how she thought things might be when she returned home and how she could perhaps cope with the potential stressors. Marie described recognising the importance of communication and stated that she was going to try hard to share her feelings and difficulties

with her aunt, rather than avoiding these. She further stated that she realised the importance of therapy and requested that we continue therapy twice a week after her discharge. I immediately agreed, feeling moved by Marie's apparent motivation to work through her difficulties, and times were set up.

The day of our first session arrived, but Marie did not. When contacted during our session time, she stated that she was 'not feeling well'. This pattern was repeated for the following three sessions and it was during our telephone contact that took place during her fourth session that Marie acknowledged feeling uncertain whether she wished to return to therapy. I attempted to reflect her feelings of confusion and uncertainty and encouraged her to attend one further session simply to talk about these feelings and the factors making it difficult for her to attend therapy. Marie agreed to this, but never returned, thus concluding our brief period of contact.

Collateral assessment interviews

Marie's aunt, also her guardian, presented for two collateral interviews. These took place after sessions one and three with Marie and, similar to the intake interviews with Marie, these sessions were between 60 and 90 minutes in length. It was during these sessions that Marie's aunt discussed her concerns about Marie's current behaviour, which she described as 'wild' and 'very up and down'. She stated that her niece had started drinking alcohol approximately two months earlier and that this was something that she had 'never touched' before. She also reported, with apparent surprise and confusion, that Marie constantly sought out male company and frequently tried to 'draw attention to herself' when in such company. According to her aunt, it often appeared that Marie was 'not herself' and that she seemed to withdraw at times. It was further reported that Marie 'does not listen to the adults' in their house and that she simply 'does her own thing'.

Marie's aunt reported that although she and Marie have a 'good relationship', and that Marie is able to communicate with her, she does not talk about having been raped. Marie's aunt stated that it was only when she brought Marie to see another psychologist earlier this year that she discovered what had happened to her niece. She further confirmed her niece's avoidance symptoms stating that Marie not only refuses to talk about the incident, but she refuses to return

to Port Elizabeth (where the incident occurred). As she described her feelings of helplessness and her apparent inability to connect with her niece about this traumatic event, as well as her current difficulties, I was reminded of my own feeling of helplessness and the difficulty that I had experienced while attempting to engage with Marie during our initial session.

Marie's aunt confirmed that Marie and her mother had shared a close relationship and that Marie had been devastated when her mother died. She described Marie's mother as a quiet, gentle person who 'did anything for anyone', while her father was described as 'a bad man' and a criminal'. She reported that Marie's mother had been treated as an outpatient at Fort England many years ago for 'migraines and stress'. She further stated that there was a history of mental illness on Marie's paternal side, but was uncertain of any details with regard to this. Marie was reportedly an unplanned and unexpected baby and according to her aunt, Marie's parents were in no way ready for parenthood.

During our second collateral assessment interview, Marie's aunt reported that Marie was no longer staying with her, but that she had spent the last two nights at her grandparents' house. She said that Marie had started smoking cannabis and that she had been 'very drunk' and 'snuck out' to a shebeen over the weekend. Her aunt reported having confronted Marie about this behaviour and stated that she had attempted to discipline her niece by 'grounding her'. Marie had responded by moving out of her aunt's house and in with her grandparents. Her aunt discussed having suspected that Marie had not been happy living with her as there 'were too many people' in the house. Furthermore, the people in the house had reportedly spoken to and treated Marie badly.

Marie's aunt again discussed her growing concerns regarding Marie's current emotions and behaviour. She stated that Marie's moods change very quickly, frequently shifting from being tearful and quiet to extremely angry and aggressive. She further reported that Marie had recently stated that she wished to die. Marie's aunt described feeling 'scared' and 'worried' that Marie would attempt suicide again, particularly given her recent mood swings and substance abuse. I acknowledged the potential suicide risk and attempted to validate her feelings of concern and anxiety. Together we discussed possible ways of managing this potential risk, and Marie's aunt described feeling that it would be safer and within Marie's best interests to be readmitted to Fort

England. I stated that this was indeed something to be considered and agreed to address this with Marie in our next session the following day. However, as mentioned previously, Marie herself raised the idea of suicide and discussed Fort England as being somewhere that she felt ‘safe’ from harming herself.

When examining these collateral sessions, it appears that some of my own confusion and difficulties that I had experienced during my brief contact with Marie were reflected in her aunt’s experiences. These collateral sessions thus provide some insight into Marie’s seemingly chaotic yet lonely world and serve to explain possible factors that led not only to Marie’s current presentation of symptoms and difficulties, but also to her lack of engagement with the therapy process. These factors will now be discussed.

5.1.3 Case Formulation

(i) Understanding of current presentation

While Marie’s family psychiatric history is not entirely clear, there does appear to exist the presence of mental illness (on both the maternal and paternal side) suggesting a genetic vulnerability to developing a psychiatric disorder. While this vulnerability does not *guarantee* the development of a psychiatric illness, it may certainly be considered a risk factor (Sadock & Sadock, 2003). Marie’s inherent vulnerability combined with her early childhood experiences and environmental factors provides insight into, and understanding of, the predisposing factors that may have informed her current presentation of PTSD and major depressive disorder.

Marie’s parents were never married. She was an unplanned and unexpected baby and neither of her parents were prepared for parenthood or for the responsibility this entails. Marie grew up without any knowledge of her father, and it was only after her mother’s death in 2005 that Marie met her father for the first time. Marie grew up living with her mother (who, at some point, was treated as an outpatient for ‘stress’), her mother’s boyfriend (who abused substances) and their daughter (Marie’s younger half-sister).

Such a chaotic and unstable early home environment is, according Edwards et al. (2005), a well-known predisposing factor in the development of PTSD. Given the absence of consistent

nurturance within the family system, it is probable that Marie was never able to develop a secure attachment to her primary caregivers and that her emotional needs were never consistently met. Such early life experiences may have been perceived by Marie as frightening and may have led to the development of certain core beliefs, for example, 'the world is an unpredictable and threatening place', and 'people cannot be trusted'. The development of such beliefs is likely to have resulted in a wariness of the world and an anxious way of relating to others. Furthermore, it appears that Marie's mother suffered from anxiety symptoms and thus Marie's own anxious personality style may have been shaped through the modelling of her mother's anxious behaviour and way of relating.

The death of Marie's mother in 2005 was a significant loss and major life event. Recent stressful life events have been viewed as an additional predisposing factor in the development of PTSD (Sadock & Sadock, 2003). Marie's recent loss of her mother may have reinforced her existing core beliefs, namely that the world is unpredictable, which in turn reinforced her existing anxious personality style, rendering her vulnerable to the development of an anxiety disorder, namely PTSD.

The precipitant of Marie's current symptoms appears to have been the traumatic incident that occurred in 2006, namely having been raped. While her mother's death was discussed as a predisposing factor, it is also likely to have precipitated Marie's depression, perhaps even before her development of PTSD. The loss of her mother the previous year and her seemingly distant relationship with her father, as demonstrated by her complete loss of contact with him since her move to Grahamstown, suggests a lack of emotional support. Marie's recent move from her aunt to her grandmother's house, due to her unhappiness experienced while living at her aunt's house, suggests that she experienced this environment as unsupportive. Thus the trauma of having been raped, compounded by her perceived lack of support and her resultant feelings of loneliness and isolation may have precipitated the development of Marie's current symptoms.

A number of factors may be seen as playing a role in the maintenance of Marie's symptoms. As mentioned above, Marie's mother is no longer alive and Marie and her father no longer communicate with one another. Furthermore, while Marie's aunt appears to be concerned about,

and supportive of her, Marie's recent move from her aunt's house suggests that she did not experience her home environment or her aunt as such. Marie described feeling misunderstood and alone, and stated that she did not feel supported by anyone. This perceived lack of support is likely to have resulted in her isolating herself and prevented her from confiding in anyone about her experiences and emotions. Marie thus lacked the opportunity to process such emotions and experiences associated with the trauma, which thus contributes to the maintenance of her PTSD symptoms.

Marie's avoidance of conversations, thoughts, and people or places relating to the trauma, as well as her recent use of substances (a possible attempt to avoid emotional pain), together serve to maintain her current symptoms. Such avoidance behaviours or strategies are likely to prevent Marie from receiving social support from others, correcting faulty beliefs, and again may prevent an opportunity to work through or process emotions relating to the trauma. Thus her symptoms of PTSD remain.

(ii) Understanding Marie's lack of engagement with therapy

While this was never openly discussed or addressed, it is apparent that a number of factors contributed not only to her current presentation of symptoms, but also to Marie's lack of engagement with the therapy process.

During the assessment process, Marie discussed her feelings of loneliness and of not being understood by anyone. Her overt expression of such feelings, as well as her covert expression by moving out of her aunt's house, clearly demonstrates Marie's perceived lack of social support within her current environment. Social support has been discussed not only as one of the key factors in the development and maintenance of PTSD symptoms, but also as an important variable influencing a client's engagement with and response to psychological treatment (Tarrier & Humphreys, 2003). As mentioned previously, it appears that Marie's perceived lack of support rendered her vulnerable to the development of PTSD and contributed to the maintenance thereof. However, her chaotic home environment and her perceived lack of support within this environment may also have contributed to her inability to engage with treatment.

Marie described finding it difficult to talk about the trauma of being raped, and her aunt confirmed this stating that Marie 'never' speaks about it. Her aunt further stated that it was only when she brought Marie to therapy this year that she discovered what had happened. Marie reported that she had not returned to PE and did not wish to do so. Furthermore, she discussed having had no contact with her father in PE, with whom she had been staying at the time of the rape. It is evident from Marie's behaviour that she prefers to avoid all reminders of the traumatic event and thus it follows that she would choose to avoid a therapy process that may trigger memories or emotions associated with the trauma. This desire to avoid painful emotions and memories associated with the event may thus have been an important contributing factor in Marie's difficulty engaging with the therapy process and her resultant premature termination.

Marie's recent abuse of alcohol and cannabis, as reported by her aunt, may be seen as a further method of avoiding painful thoughts or emotions. While literature shows that such methods of avoidance are ineffective in the long-term (Clark & Ehlers, 2005), they may certainly assist individuals in the short-term by dulling or numbing some of the ever-present pain and anxiety. Marie's abuse of substances may have allowed her to temporarily forget about the painful memories and thoughts associated with her traumatic experience and thus therapy may have been perceived as unnecessary at present. Her use of alcohol and cannabis, an additional avoidance mechanism, may thus have been a further contributing factor in her failure or lack of desire to engage with treatment.

It was during our second intake interview that Marie discussed the possibility that she may have contracted a sexually transmitted disease. Her recent discovery of these symptoms is likely to have been experienced as frightening and stressful by Marie and exacerbated her current feelings of sadness and anxiety. An additional source of stress such as this may have temporarily taken precedence over other aspects of her life, including the therapy process, and may thus have played a role in Marie's lack of engagement with this process.

At times during the assessment process, Marie appeared bored, disinterested and reluctant to engage. During these moments, it was difficult to ascertain whether this behaviour was due to a lack interest or motivation, whether this was simply an avoidance strategy, or perhaps a

combination of the two. This avoidant pattern of relating may further be viewed according to Young, Klosko and Weishaar's (2003) schema modes as the 'Detached Protector' mode. Schema modes refer to the 'moment to moment emotional states and coping responses – adaptive and maladaptive – that we all experience' (p. 37). The 'Detached Protector' mode is described as a dysfunctional coping mode and individuals employing this particular mode withdraw psychologically from pain by maladaptive means (Young et al., 2003). Marie's current pattern of relating with the world, expressed in her avoidance of communicating with others, as well as her abovementioned substance abuse, may be viewed as a way of avoiding or withdrawing from the emotional pain elicited by reminders of the trauma. Marie's acknowledgment that she no longer wished to continue with therapy, and her subsequent failure to attend the following three sessions, may be seen as an expression of her lack of motivation or lack of desire to continue, or as an expression of the 'Detached Protector mode'. Thus Marie's current way of relating was an additional factor hindering, or preventing, her engagement with the therapy process.

From the above information, it appears that there was no *one single* factor, but rather a combination of factors that together contributed to Marie's lack of engagement with the therapy process and her resultant termination.

5.2 Case Two

5.2.1 Background Information

The next client, Sibongiseni, made an even briefer appearance and thus background information was, in this case, even more limited. Sibongiseni, a nine-year-old Xhosa-speaking female scholar was referred to Fort England in May 2007 by Linda, a worker at the Raphael Centre in Grahamstown. Linda was also Sibongiseni's caregiver and had been since December 2006. It was reported that Sibongiseni had been raped on two occasions, by two different perpetrators, both incidents occurring in 2006.

The first incident took place early in 2006; the perpetrator was the sixteen-year-old son of her mother's boyfriend and was thus someone known to Sibongiseni. This incident occurred while she and her mother were spending the night at her mother's boyfriend's house in Grahamstown. The boy had reportedly gone into the room where Sibongiseni was sleeping and had forced her to

have intercourse with him. The second incident, also in Grahamstown, took place in a forest near the township where Sibongiseni and her mother were living. The perpetrator in this case was a man living in the same community, and was again someone known to Sibongiseni. He is reported to have approached Sibongiseni while she was playing on the street with her friends. Sibongiseni described having gone to him when he called her and stated that he then took her to the forest and demanded that she have intercourse with him. She reportedly screamed and he responded by threatening her with a knife, and subsequently raped her. Although both rapes occurred in 2006, Sibongiseni only disclosed information regarding the incidents in May 2007 and it was only information regarding the second rape that was, at that time, provided. She related this information to her teacher who then referred her to the Raphael Centre, a centre for people diagnosed with HIV, for HIV testing and counselling, and it was here that Sibongiseni was referred to Fort England for therapy.

Although Sibongiseni volunteered little information regarding her feelings or symptoms, she did acknowledge finding it difficult to talk about the incidents of rape and reported preferring *not* to talk about these events. Sibongiseni further stated that she did not wish to be anywhere near where the incidents had occurred. Persistent avoidance of stimuli associated with the trauma was thus evident. Despite Sibongiseni describing that she felt ‘good’ and relating few problems or concerns, information elicited from the ‘Children’s Revised Impact of Event Scale’ (CRIES), a brief screening instrument for children at risk for developing PTSD (Perrin et al., 2005), indicated a number of current difficulties and symptoms of PTSD. Symptoms of increased arousal were apparent, namely difficulty paying attention or concentrating, exaggerated startle response, and hypervigilance. So too were reexperiencing symptoms evident, namely recurrent thoughts of the incidents. According to Linda, Sibongiseni had recently been behaving in a hypersexual manner; such behaviour in children is often indicative of re-enacting the sexual trauma (Mash & Wolfe, 2002). Thus while Sibongiseni did not describe, or *appear* to be feeling particularly distressed, information obtained from additional sources, namely from the CRIES and from her caregiver, was indicative of PTSD. It was Linda’s concerns regarding Sibongiseni’s behaviour (to be discussed) that led her to seek psychotherapy for Sibongiseni.

5.2.2 The Assessment Process

(Sessions 1 – 2)

Brief contact

Prior to the commencement of the assessment, Linda had informed me that Sibongiseni was unable to understand or speak any English. However, she was deeply concerned about Sibongiseni's past and current difficulties, and stated that she would be willing to assist with translating throughout the assessment and therapy process. Despite some reservations in implementing a therapeutic process by means of a translator, I felt eager to explore whether the Ehlers and Clark (2000) model *could* be implemented in an entirely different context from that in which it was originally implemented. Thus began our assessment process.

During our first session together, which would also be our last, Sibongiseni said very little and appeared somewhat affectively disengaged. Although she answered questions when asked, Sibongiseni volunteered very little information spontaneously and it was difficult to get a true sense of her feelings and experiences, or to ascertain specific symptoms and her current level of functioning. While Linda took time to translate, ensuring that all information was interpreted with care and accuracy, this initial interview felt rather stilted and awkward at times. It was not always possible to immediately reflect or validate certain feelings expressed by Sibongiseni, as these first needed to be translated. While this by no means *prevented* reflection, exploration or validation of feelings and experiences, the delay resulting from translating between Sibongiseni and myself created some difficulty in truly connecting with Sibongiseni.

Sibongiseni stated that Linda had informed her of our session, but reported that she had never before been to see a psychologist and that she was unsure of what a psychologist does. I explained that psychologists help people who are feeling sad and hurt, and who have had some difficult or horrible things happen to them. When I asked how it felt for her to be here, Sibongiseni described feeling 'very good'. I then asked if she would be able to tell me why she thought she might be here, and she related both incidents of rape that had occurred in 2006. While she became sad at times, her sadness appeared less intense than I had imagined it might be, and she seemed to discuss these traumatic events with relative ease.

Sibongiseni described the abovementioned events in a distant and detached manner. She provided a very brief account of both events, and few details were described. I was, at this point, aware that this was our first session together and that talking about such experiences with anyone, least of all a stranger, was likely to be difficult and uncomfortable. I reflected this and she agreed. I was also aware of the fact that Sibongiseni and I were not only from completely different cultural backgrounds, but we were unable to understand one another without assistance. I thus reflected on the possible feeling of discomfort resulting from having to share her experiences and then listen to these being translated. Sibongiseni, however, stated that this felt 'fine'. Despite her lack of acknowledgement of these factors, it is likely that these played a role in Sibongiseni's ability to engage openly and comfortably with the assessment process. I did, however, wonder if there was perhaps more to Sibongiseni's lack of emotional engagement, and what was beneath her current presentation. I hoped to explore this further and a second appointment was scheduled.

Following this session, I took my concerns about Sibongiseni's apparent lack of emotion regarding these traumatic incidents, as well as her inappropriate sexual behaviour, to supervision. There it was discussed that Sibongiseni's current presentation was a commonly observed pattern exhibited in individuals with a history of abuse or those raised in a context of inappropriate sexualisation. I thus planned to explore her early history and the possibility of early abuse.

Collateral assessment interview

Linda, Sibongiseni's caregiver, presented for one collateral interview. This was scheduled for a few days after my initial session with Sibongiseni, but only took place after two weeks as Linda did not arrive for two consecutive sessions. My initial session with Linda was, similar to the first assessment session, 90 minutes in length. Linda related the incidents of rape discussed in the previous session, clarifying a number of details, as well as how this information had come to light. She stated that Sibongiseni had reported the second incident to her teacher who had referred her to the Raphael Centre, where Linda works, for HIV testing. A colleague of Linda had subsequently taken Sibongiseni into her home in order to remove her from her abusive and unsafe home environment. Linda became acquainted with Sibongiseni and aware of her difficult home environment and, when Linda's colleague left town, Sibongiseni went to stay with Linda.

She remained here from December 2006 to the present time and was described as being happy and settled in her new environment.

Linda reported that Sibongiseni's mother was not contactable at present and would therefore be unable to provide collateral information regarding Sibongiseni's developmental or family history. However, the information provided by Linda gave a glimpse into Sibongiseni's erratic home environment (prior to living with Linda's superior and subsequently with Linda). She described Sibongiseni's mother as 'irresponsible', stating that she abused alcohol and that she had, on numerous occasions, engaged in sexual activities in the presence of her daughter. She further stated that she was 'rude' and appeared to have little interest in Sibongiseni's life. In the initial intake session, Sibongiseni reported that her mother had reprimanded and beaten her for discussing one of the incidents of rape. Linda confirmed that she had been aware of this, but said that she was unsure whether Sibongiseni had been exposed to previous or subsequent abuse.

During this collateral interview, Linda stated that although she and Sibongiseni get along 'very well', she had recently become concerned about Sibongiseni's behaviour. She described Sibongiseni as 'very naughty', saying that she refuses to do her homework, steals money from Linda's wallet, and that she goes out of the house for hours at a time, without informing anyone of her whereabouts. She further reported that Sibongiseni had recently started to behave in a sexually inappropriate towards boys and men, including Linda's boyfriend. Finally, she confirmed Sibongiseni's preference to avoid talking about having been raped, as well as avoiding reminders of these incidents. Linda discussed feeling worried and confused by this behaviour and although she very much wanted to help Sibongiseni, she did not know how. I attempted to validate her feelings of confusion and anxiety, while at the same time providing some psychoeducation regarding Sibongiseni's current behaviour. I stated that Sibongiseni's behaviour was a common reaction to a traumatic event, as well as to inappropriate sexualisation and that while this was distressing to observe, it made sense in the context of all that Sibongiseni had experienced.

During this session, I again asked Linda how she had felt interpreting our previous session as well as how she feels about continuing to interpret throughout the assessment and therapy

process. She replied that this was 'fine' and reported no problems or difficulties experienced during the prior session. She did, however, appear somewhat reserved in answering this question and I wondered whether she had, in fact experienced the process of interpreting as difficult, but that she felt unable to share these with me. I thus stated that we could continue with this process of translating, but that should problems or difficulties be experienced or encountered we could certainly find an alternative solution for this process. This was agreed upon and a second assessment interview with Sibongiseni was set up.

Sibongiseni and Linda did not arrive for Sibongiseni's second session. I contacted Linda during our session time and was informed by her that she had been busy at work and was thus unable to bring Sibongiseni. The provision of transport to and from Fort England was offered, but Linda declined this saying that ordinarily transport would not be a problem and that it was just that particular day. Another appointment was thus set up. Prior to this session, however, Linda called to cancel her session. I returned this call not only to set up another time, but also to gauge whether there was something preventing Linda from keeping our appointment times. During this telephone conversation, Linda stated that she was in fact not feeling happy about translating our sessions. She described having felt uncomfortable interpreting for Sibongiseni, and discussed feeling particularly concerned about the possibility that Sibongiseni may not be as open with Linda as she might be in the presence of an unknown interpreter. I acknowledged these feelings and was reminded of my initial reservations, one of which was the issue that was raised by Linda. Linda stated that she wished for Sibongiseni to continue with therapy and said that she would provide a translator for the continuation of this process. We set up another appointment and Linda emphatically stated that the person to assist with interpreting would accompany Sibongiseni to this next session.

Sibongiseni and the interpreter did not arrive for the following two sessions. On both occasions, I telephoned Linda who informed me that no one was available to translate. When Sibongiseni did not arrive for our subsequent session, I again contacted Linda. She informed me that Sibongiseni was not staying with her at present, but that she had gone to stay with some relatives outside of Grahamstown. I emphasised the importance of Sibongiseni receiving therapy and stated that should she return to Grahamstown, Linda was welcome to contact me and we could continue

with our process. I had no further contact with either Linda or Sibongiseni and our process, which had not in fact even started, thus ended abruptly.

5.2.3 Case Formulation

(i) Understanding of current presentation

Due to unavailability of collateral sources, little information regarding Sibongiseni's developmental history and early childhood experiences was obtained. However, the information that *was* elicited provides some understanding of the predisposing factors that may have contributed to Sibongiseni's current symptoms.

Sibongiseni's mother, with whom she was living up until December 2006, is described as an 'irresponsible' parent. She is reported to have abused alcohol and to have had a number of boyfriends with whom she engaged in sexual activities in the presence of Sibongiseni. Sibongiseni's acknowledgment that her mother scolded and beat her for disclosing information about having been raped suggests the possibility of previous abuse or inappropriate methods of discipline.

The above information provides an image of an unstable, inconsistent and abusive home environment with limited social support. Such an environment is, as mentioned in the previous case, a well-recognized predisposing factor in the development of PTSD. It appears that Sibongiseni lacked consistent parental care and nurturance, and it is likely that no primary caregiver was available for secure attachment. Furthermore, it is unlikely that Sibongiseni's emotional needs were ever consistently met, but that she was punished either verbally or physically for the expression of her needs. The development of certain core beliefs, for example 'the world is a threatening place' and 'people cannot be trusted' is likely to have resulted from such early life experiences and environmental factors. These core beliefs may, again, have resulted in a sense of guardedness and a wary or cautious way of relating to others and to the world.

Sibongiseni's physical and verbal punishment in response to her discussing her experience of having been raped suggests the possibility of similar reactions in response to her previous

expression of other emotions or experiences. Such experiences may well have reinforced Sibongiseni's existing core beliefs, namely that people cannot be trusted or that the world is unpredictable. Furthermore, these reactions are likely to have been experienced by a child as traumatic. Such early experiences of trauma are said to be a further predisposing factor in the development of PTSD and other negative mental health outcomes (Anda et al., 2006; Sadock & Sadock, 2003). Sibongiseni's mother's engagement in sexual activities in front of Sibongiseni, may also have been experienced as confusing and traumatic, further strengthening Sibongiseni's core beliefs and in turn reinforcing her wariness of the world. Such factors in combination are likely to have predisposed Sibongiseni to the development of an anxiety disorder, namely PTSD. Her mother's inappropriate display of sexual activities may, however, have come to be viewed by Sibongiseni as normal, influencing her own inappropriate and premature sexual behaviour through the modelling of such inappropriate behaviour.

The precipitating factor in the development of Sibongiseni's current presentation appears to have been having been raped on two separate occasions, by two different perpetrators. The emotional unavailability of Sibongiseni's mother, as demonstrated by her punitive response to Sibongiseni's discussion of the incident as well as by her preoccupation with her own life, implies a lack of emotional support. Thus the trauma of having been raped twice, exacerbated by a lack of support, appears to have precipitated the development of Sibongiseni's current symptoms.

Various factors may be viewed as playing a role in the maintenance of Sibongiseni's symptoms. Sibongiseni's physical and verbal abuse resulting from her disclosure of information about her trauma is likely to have limited any further disclosure for fear that she will again be punished or hurt. Furthermore, while Sibongiseni's temporary home environment appeared more stable than previously, her primary caregiver was not available at that time. While Linda had openly expressed her concern and her desire to help Sibongiseni, Sibongiseni may not have felt able to communicate with Linda and may have felt that she lacked the support of the one person she needed. Sibongiseni's fear of talking about the incidents of rape, as well as her perceived lack of support is likely to have prevented her from confiding in anyone about her experiences and emotions. This further prevented an opportunity for the processing of such emotions and

experiences related to the trauma, which in turn contributes to the maintenance of Sibongiseni's PTSD symptoms.

The avoidance of talking about the incidents of rape, as well as visiting the areas in which these two incidents occurred is, again, likely to prevent an opportunity to work through difficult feelings associated with the traumas. Furthermore, Sibongiseni's avoidance serves to strengthen her core beliefs as she is not provided with an opportunity to challenge these. Therefore her PTSD symptoms are maintained.

(ii) Understanding Sibongiseni's lack of engagement with therapy

This particular case presents somewhat of a dilemma. Here was a client with a clear need for therapy; a client who has endured a great deal in her relatively short life and who would undeniably benefit from a therapeutic intervention. Yet the implementation of this intervention was not possible. Various factors appear to have limited Sibongiseni's ability to engage with the therapy process, thus preventing the implementation of treatment. Some of these factors may have been directly related to Sibongiseni, while others may have been external factors.

Sibongiseni's erratic home environment appears not only to have been a predisposing factor in the development of her current symptoms, as well as a maintaining factor, but also appears to have played a direct role in the premature termination of treatment. Sibongiseni's sudden move to family outside of Grahamstown meant that we would be unable to continue with the assessment or therapy process. It thus appears that Sibongiseni's lack of a stable and supportive environment was a major contributing factor in the prevention of treatment implementation.

Related to this, a significant challenge encountered in this case, and one that proved to be fundamental in Sibongiseni's lack of engagement with the therapeutic intervention, was the absence of a responsible adult who could in fact take responsibility for Sibongiseni. Sibongiseni had moved from one caretaker to another and while Linda appeared extremely concerned about and motivated to help her, she turned out to be only a temporary caregiver. It thus appears that there was no *one* person who was permanent in Sibongiseni's life; no *one* committed, motivated person who could take responsibility for her and the various aspects of her life, including her

mental wellbeing. Since no one was able, or available, to ensure her regular attendance of therapy appointments, regardless of where she was staying, it was not possible for Sibongiseni to engage with any therapeutic process.

Another undeniable factor influencing the implementation of this intervention was that of language. While it is not impossible to implement a psychological treatment by means of an interpreter, the use of an interpreter brings with it a number of challenges. In the case of Sibongiseni, Linda acknowledged her feelings of discomfort with the translation process, as well as her concerns that Sibongiseni was limiting the information she chose to disclose because of Linda's presence. While Sibongiseni never expressed similar feelings, it is not unlikely that she, too, may have felt uncomfortable with her expressed feelings and experiences being translated in her presence. Furthermore, the idea of discussing such experiences and emotions in the presence of her caregiver may well have influenced her ability to engage openly and may have influenced the content of the information Sibongiseni felt able to provide. Although these feelings and possibilities were acknowledged by Linda and an alternative arrangement was made, the additional obstacle of a lack of availability of a translator appears to have further hindered the therapy process.

Not only did the therapeutic intervention come to an abrupt ending, but during its very brief implementation it appeared that Sibongiseni's engagement was limited. This may be explained by a number of possible factors. The punitive reaction of Sibongiseni's mother to her discussion of having been raped is likely to have influenced Sibongiseni's ability or desire to confide in anyone about her experience. Her possible fear of similar reactions from others in response to expressing her feelings or discussing the incident may have contributed to Sibongiseni's limited emotional engagement noted during the assessment process.

Sibongiseni's own acknowledgment of finding it difficult to talk about her traumatic experiences and that she does not like to go near the places where the incidents occurred, as well as Linda's confirmation that Sibongiseni seldom speaks about these, suggests a preference to avoid reminders of her traumatic experiences. This tendency to avoid is thus likely to have played a

major role in Sibongiseni's limited engagement with the assessment process, thus preventing the effective implementation of a therapeutic intervention.

There were thus a number of factors that together played a role in preventing treatment implementation in this case. While some of these could perhaps have been resolved, and were thus not primary factors in preventing implementation, other factors were more central and had a direct influence on Sibongiseni's limited engagement with, and therefore the implementation of, a therapy intervention.

5.3 Case Three

5.3.1 Background Information

Bulelwa, an eighteen-year-old Black scholar, was admitted to Ward D (a locked ward) at Fort England Hospital early in 2007 due to 'strange' and 'inappropriate' behaviour observed by her family, namely laughing for no apparent reason, talking irrelevantly and walking through the streets half naked. Her thought content was, at this time, described as delusional. On admission, Bulelwa provided no complaints, but described feeling 'very happy'. Upon further enquiry, it was discovered that she had been gang-raped in the township in Grahamstown four weeks prior to her admission.

Bulelwa remained in Ward D for six weeks. At the time of her discharge, she was reported to be symptom-free. Approximately two weeks later, however, Bulelwa was readmitted to Ward D. She was observed to be restless, talkative and agitated, and her thought content was again described as being delusional, with predominant grandiose delusions. She was diagnosed with Bipolar I disorder, most recent episode manic, severe with psychotic features and was placed on treatment for this disorder. After three months in this ward, Bulelwa was stable enough for a transfer to an open ward, A-Neuro. It was in this ward that she was referred to the author for psychotherapy. She remained in this ward for just under a month and, after her discharge, continued therapy as an outpatient.

Collateral information provides a picture of a chaotic and unstable early home environment. Bulelwa's parents were never married and did not have a good relationship. Her father lives in

Port Elizabeth and has a history of mental illness; he was hospitalised at Fort England in the past with a diagnosis of schizophrenia. Bulelwa and her mother have a poor relationship and have not lived together since 2002. Her mother is unmarried and currently lives with her boyfriend. She has three children (including Bulelwa) aged eighteen, eight, and ten months, all of whom have different fathers. Furthermore, Bulelwa's mother abused, and continues to abuse, alcohol. From the time of Bulelwa's birth, her mother would disappear for days at a time, leaving Bulelwa with her maternal grandmother and would return home drunk and verbally abusive. Collateral information further indicates that Bulelwa was afraid of her mother and would scream and cry upon hearing her voice. Bulelwa's mother and grandmother were physically abusive towards Bulelwa and her younger sister and it was in 2002 that both girls were removed and placed in the foster care of their maternal aunt who lives in the township in Grahamstown. However, Bulelwa reportedly became unhappy with the way in which her foster care grant was handled by her aunt, and it was this conflict that resulted in Bulelwa moving from her aunt to her paternal grandmother's home. This move took place in 2006 and it was later this same year that Bulelwa was raped. After her discharge from Fort England, her maternal uncle took Bulelwa in to live with him, out of the township, and into the suburbs of Grahamstown. He felt that it would be safer for Bulelwa to be living in the suburbs, as the perpetrators were reportedly out on bail and were thus roaming freely in the township.

During her initial inpatient interview, Bulelwa stated that she was feeling 'fine'. As the interview progressed, however, Bulelwa acknowledged experiencing a number of difficulties and symptoms. Despite her relatively low scores on the BDI and BAI self-report scales, it was apparent that Bulelwa met the DSM-IV criteria for posttraumatic stress disorder. This appeared consistent with her score of 36 on the PDS, which is in the severe range. She described reexperiencing the gang rape in the form of recurrent, intrusive recollections of the event, as well as psychological distress at exposure to cues resembling the event. She further stated that she does not like to be reminded of the incident and described trying to avoid thinking or talking about it. In addition to this, Bulelwa discussed wanting to move to Port Elizabeth, saying that Grahamstown reminds her of the incident. Avoidance symptoms were thus apparent. Finally, Bulelwa reported symptoms of increased arousal, namely an inability to concentrate,

hypervigilance, and exaggerated startle response. Bulelwa later stated that perhaps she was 'not fine' and acknowledged her need for psychotherapy.

5.3.2 The Assessment Process
(Sessions 1 – 3)
Inpatient contact

My initial contact with Bulelwa was towards the end of her stay in Ward A-Neuro. The commencement of psychotherapy had been discussed and agreed upon with Bulelwa during a ward round, however, when I approached her in the ward to set up an appointment time, I was met with some resistance. Bulelwa stated in a somewhat detached manner that she was 'feeling fine now' and that she did not think that she 'needed therapy'. I responded to this by saying that while she might feel 'fine' at present, she had been through a great deal and that perhaps it would be helpful to talk through some of her feelings relating to these experiences. Bulelwa thus agreed to meet with me and I felt somewhat concerned that I had forced her into this decision. Another part of me, however, was aware that her resistance and apparent detachment may well have been an expression of her avoidance. This initial contact and pattern of interaction was to become a familiar and routine pattern throughout our contact.

During our first inpatient intake session, Bulelwa described enjoying Ward A-Neuro saying that she likes 'being busy'. When this was explored, Bulelwa stated that she prefers to be busy because when she is not, she thinks about 'that thing that happened' and that when she does so she feels sad. She described methods used to distract herself, namely watching television and sleeping. However, she acknowledged having thoughts about the incident of rape despite her efforts to avoid this. As mentioned previously, Bulelwa met the DSM-IV criteria for PTSD, exhibiting not only symptoms of avoidance and reexperiencing, but also of increased arousal. Bulelwa related these symptoms and experiences with little emotion and it was only when asked what *she* was experiencing as *most* distressing, that Bulelwa became tearful. She described feeling saddened by the fact that she and her mother do not get along and that although her mother lives in Grahamstown, she has not seen her for more than a brief while since 2002. I reflected that while she had initially described feeling 'fine', it appeared that there was a great deal happening in her life and a great many emotions that she appeared to be feeling. At this point

Bulelwa acknowledged that although she *says* she is 'fine', she is 'not really fine'. I validated these feelings, saying that given all that she has experienced, it was perfectly normal to *not* be feeling 'fine'. I further emphasised the importance of therapy explaining that it would provide her with an opportunity to talk about, and work through, her emotions and experiences. Bulelwa stated that talking about these things 'would be a great thing' and thus a second appointment was set up.

Prior to our second appointment, the team on Ward A-Neuro evaluated Bulelwa and concluded that she was stable and doing sufficiently well. Thus the possibility of discharge was considered. This was discussed with Bulelwa who described wanting 'very much' to be discharged. Our following two sessions thus focused on Bulelwa's feelings relating to her pending discharge, possible difficulties to be encountered, as well as her plans after discharge. Bulelwa described feeling 'tired of being in hospital' and stated that she felt 'glad' to be leaving. When asked how she was feeling at present compared to how she had felt prior to her admission, she reported having felt 'safer' in hospital as there were many people in the ward. She stated that she therefore felt less afraid at night and was more able to sleep. Together we explored how she might feel after her discharge; Bulelwa acknowledged that she may again feel afraid and unsafe at home as, although she was to be living in the suburbs away from the location, she was to be living with only a few people, namely her aunt, uncle and her young cousin. She further stated that she was unsure what had happened to the men who had raped her, but that she thought that they were living freely in the township in Grahamstown. Bulelwa thus described feeling afraid of leaving hospital and of once again living in Grahamstown. Her feelings and concerns were validated and I informed her that I would look into the status of the police investigation and find out what was happening with the case.

During these two sessions, Bulelwa discussed her plans for the future. She stated that while school was very important to her and that she really wanted to complete her schooling, she had 'been thinking' and had decided to continue the following year. When asked what she was planning on doing with her time after her discharge, Bulelwa stated that she did not wish to be bored and discussed her plan of asking her aunt, who has her own shop, if she could perhaps help in the shop until returning to school.

Bulelwa's feelings regarding the therapy process and the continuation thereof were explored. She stated that she was feeling 'fine' about the process thus far and that she felt 'good' about continuing. The continuation of outpatient therapy was discussed and a regular session time was agreed upon. At this point, I felt slightly lost and wondered about the assessment process thus far. However, upon discussing these feelings in supervision it was made clear to me that while the assessment process had indeed begun, this process could only move at the client's pace. Furthermore, these three sessions had been spent containing my client and were focused on preparing her for discharge, which was at that point, what she required. Thus a *formal* assessment had, at this point, not been conducted.

Resistance

Bulelwa did not arrive for our first outpatient session. I was unable to contact her during this session as the only number on which I was able to reach her was her uncle's cell phone and upon calling him, he informed me that he was not at home at that time and thus was not near Bulelwa. When I eventually reached Bulelwa and enquired about our session, she stated that she 'forgot'. We rescheduled for the following day, but again Bulelwa did not arrive. I was only able to reach her three days later and it was during this telephone conversation that Bulelwa reported that she was 'feeling fine' and that she did not think she 'needed' therapy. I responded by saying that she may indeed *feel* 'fine', and that perhaps this made it difficult for her to *want* to come to therapy and to talk about things that might make her feel 'not so fine'. I further stated that she had been through a great deal in the past year and that it was important to talk about these experiences in order for these to be processed. Bulelwa stated, with little emotion, that she 'will come', but that it is 'very far'. Despite having previously declined the offer of transportation, stating that she would prefer to walk to Fort England, transport was again offered and was subsequently accepted. Another appointment was set up and transport was arranged, and I began to wait in anticipation. Again I felt concerned that I had pushed Bulelwa into agreeing to continue with therapy and that in providing transport for her, I was in a sense forcing her to come. At the same time, however, I was aware of Bulelwa's obvious need for and the importance of continuing therapy, and that perhaps her hesitation or reluctance was simply a sign of avoidance.

(Sessions 4 – 5)

Emotional disengagement

During session four, our first outpatient session, Bulelwa described feeling 'fine' and stated that since her discharge things had been 'going well'. Upon further exploration, however, Bulelwa acknowledged feeling 'bored' and 'lonely'. She discussed spending most days alone at home, saying that both her aunt and uncle work and that she never goes out of the house. She described feeling afraid when she is home alone and reported spending much time checking to see that the doors are locked, the windows are closed and that no one is outside of the house. Bulelwa further stated that she tries to keep busy so as to avoid thinking about having been raped as this makes her feel sad and angry, but stated that there is 'not much to do' at home. I attempted to validate her feelings of loneliness, fear, sadness and anger, while at the same time normalising these feelings and her desire to avoid thinking about the incident. Some time was taken to psychoeducate Bulelwa about the trauma and its effect on her life, as well as to motivate her to continue with therapy, particularly in light of her current symptoms. When asked how she was feeling about this session and how she felt about continuing with therapy, Bulelwa appeared positive stating that she felt 'relieved' and that continuing with therapy would be 'a good thing'. Despite her verbal expression of feeling positive and motivated to continue, her affect appeared somewhat incongruous as she displayed little emotion. I then stated that while we had seen one another several times, we had not yet spoken about her traumatic experience. I asked Bulelwa how it would be for her to talk about this incident during our next session and she replied, again with little emotion, that this would be 'fine'.

Bulelwa began our next session by again saying that she felt 'fine'. When asked what it means for her to feel 'fine', Bulelwa smiled and repeated that it means that she is 'fine'. Similarly, when asked how she would feel about telling the story of her rape she replied that this would be 'fine'. To my surprise, Bulelwa began talking immediately saying, 'Ok, it was like this…'. She related the entire story relatively quickly in a factual and somewhat detached manner, appearing affectively disengaged. I was struck by her seemingly emotionless description of an event as traumatic and frightening as the one that she had experienced.

When she had finished speaking, I asked Bulelwa how she was feeling and how it had been for her to talk about what had happened. She stated that it made her ‘sad’ as it made her think about, and reminded her of what had happened. She further stated that it was something that she tried *not* to think about as she wanted to ‘move on’ with her life. While attempting to validate her desire to ‘move on’ with her life, I explained that the only way to truly move on is to process her experience and her feelings relating to this experience. At the suggestion of my supervisor, I used a metaphor to explain the importance of working through and processing these emotions and experiences in order to truly move on. I explained that her attempt to avoid thinking about this traumatic event and the resultant emotions, and locking these emotions and thoughts away is similar to someone throwing a pile of clothes into a cupboard and closing the doors. While the cupboard may remain closed for a time, eventually the doors will open and the clothes will come falling out. Thus the clothes need to be folded and neatly packed away in order for the doors to remain closed. Similarly, her emotions and experiences relating to the trauma need to be expressed and processed in order to allow healing and long-term relief. Bulelwa responded by saying that this ‘makes sense’ and that she realised the importance of talking.

During these sessions, I was repeatedly struck by Bulelwa’s distant and disengaged manner of relating and her limited expression of emotions when describing difficult experiences, namely having been raped. I also wondered about the fact that Bulelwa acknowledged feeling bored, lonely and afraid during her numerous days spent alone at home, but at the same time appeared not to engage with such feelings. I took these observations and feelings of confusion to supervision and related the difficulties I was experiencing connecting with Bulelwa, simply in the sense that at times it felt as though she was not present. It was discussed that Bulelwa’s disengaged pattern of relating appears similar to Young et al.’s (2003) ‘Detached Protector’ mode. Bulelwa’s shift into this particular emotional state or coping response, or ‘mode’, was at this point seen as a way of her detaching emotionally in order to avoid the psychological pain associated with her recent trauma.

(Sessions 6 – 8)

Lack of communication and support within the family system

At the beginning of our next session, Bulelwa again described feeling 'fine'. Similarly, when asked how she had felt after the previous session during which we had discussed the rape, she responded that she had had 'no feelings' and that she felt 'fine'. Again I attempted to explore her feelings and her apparent inability to express these, asking what feeling 'fine' means to *her*. Bulelwa smiled saying, 'You always ask me how I'm feeling'. She stated that she had never before been asked about, or encouraged to express, her feelings and said that at home 'nobody speaks about feelings'. She further stated that talking about feelings was therefore something strange and new to her. I reflected that therapy must feel rather strange and perhaps difficult at times, but that part of our work together would be about learning to label and express emotions and that in time it might feel a little easier.

This session, as well as the following two sessions, focused largely on Bulelwa's current home environment and her apparent lack of appropriate support. When asked what she had been doing with her time since our last session Bulelwa replied, 'nothing'. She stated that she spends her days alone watching television or sleeping and consequently discussed feeling bored and lonely. Bulelwa described this loneliness as 'sad', but stated that this was 'a usual feeling' and something that she had experienced most of her life. She said, however, that this feeling had never bothered in the past; never before had she felt sad about having no one to talk to, and never before had she felt afraid when alone. Bulelwa discussed disliking being alone, saying that it is when she is alone that she thinks 'so many things' and worries about 'what might happen'. I attempted to validate and normalise these feelings of sadness and fear and discussed how her being alone and doing very little with her time is likely to exacerbate such feelings.

During these sessions I attempted to explore possible ways in which Bulelwa could occupy her time. She appeared unable to provide any suggestions or ideas of her own and when I put forward various options, for example returning to school on a part-time basis, getting involved in church or charity activities or looking for a job, these were met with little enthusiasm. After some consideration, Bulelwa stated that perhaps she *could* look for a job as it would be nice to have some extra money. She was, however, uncertain how to go about this and some time was spent

discussing options and ways of looking for work. She then stated that she was unsure whether her uncle would 'allow' her to get a job. It was at this point that I raised the idea of having a family session, which would include Bulelwa, her aunt and her uncle. I stated that it was important for her family to be aware of how lonely and isolated she had been feeling and how detrimental this was to her recovery. I informed Bulelwa of the importance of her family's support in assisting the healing process and said that perhaps a family meeting would be a useful way to gain the support and understanding she needed. Bulelwa stated that this would be 'very helpful' and together we discussed a number of possible days and times so that these could be offered to her uncle.

The primary goal of a family session was, at this stage, to psychoeducate Bulelwa's family about what was required to enable her to engage with treatment. Furthermore, in having a family session, I hoped to make her family aware that at present, Bulelwa's life appeared to be on hold and that this was unlikely to assist her in the future, but rather that it may be setting her up for disaster later on.

After a number of telephone calls, I made contact with Bulelwa's uncle and set up an appointment. The day of our family session arrived, but Bulelwa and her family did not. I contacted her uncle during the arranged session time only to be informed that he was out of town for the day and that his girlfriend, Bulelwa's aunt, was working. Another appointment was thus set up. I felt, however, that it would be unfair on Bulelwa that our session be cancelled and organised transport to bring her to Fort England. Bulelwa arrived, stating that her uncle had not informed her that I had contacted him or that they were to attend a family session that day. When asked how it felt that she had not been informed and that the session had not taken place, Bulelwa simply shrugged and stated that it was 'fine'.

A similar sequence of events occurred during our following three family session times. When asked, on the third occasion how this felt for her, Bulelwa responded by saying that she felt 'sad' and 'hurt' that her family was 'not trying to help'. She further stated that she did not think that having a family session 'would make a difference anyway'. I was struck by this apparent lack of communication with regard to the family session, and wondered about the extent of communication within the family in general. It seemed that if there was no communication about

something as seemingly simple as a session time, there was unlikely to be communication regarding other aspects, such as feelings and experiences. Bulelwa confirmed that there was little communication within her family and stated that everyone in their home simply 'does their own thing'.

Despite describing this lack of communication within her family as 'a usual thing', Bulelwa acknowledged feeling 'sad' and 'lonely', and discussed a time in her life that she had felt similar to this. Bulelwa spoke of her childhood, saying that she and her sister were physically and verbally abused by both her mother and her grandmother. She described having run away with her sister to their aunt's house, but stated that although her aunt had taken them in, Bulelwa had never felt wanted by her. She further stated that she had never felt wanted by her mother, and said that she wished that her mother cared for her and that they could once again be a family. She cried openly, for the first time, as she related these experiences and it was during this session that I felt truly able to connect with Bulelwa. It occurred to me then that Bulelwa's trauma of having been raped, while something horrendous and terrifying to me, may not be the most problematic feature in her life. For Bulelwa it was her feelings of isolation, loneliness and abandonment, which had in fact been with her for as long as she could remember, that were most troubling for her. It appeared, therefore, that the trauma endured by Bulelwa in 2006 was merely another awful occurrence in her lonely and difficult life.

(Sessions 9 – 10)

Avoidance

Despite the previous session having been an emotional and difficult one for Bulelwa, I felt that it had been somewhat of a turning point as this was the first time that she had openly expressed her emotions and the first time that I felt able to truly connect with her. I thus felt motivated to continue with the assessment process and ultimately with therapy, and hoped that the previous session might have opened up a new way of relating. To my frustration, however, Bulelwa again appeared distant and disengaged. She began this session by stating that she was feeling 'fine' and 'normal' and that 'nothing' had happened since the previous week. She described having been spending her days alone 'doing nothing' and when asked how this had been for her she replied that it was 'very lonely'. I mentioned that we had spoken previously about how she might try to

fill her time and asked if she had given these options, particularly looking for a job, any more thought. Bulelwa stated that she had not done so as she ‘forgot’.

The following session followed a similar pattern, only this time when Bulelwa was asked how this ‘doing nothing’ was for her, she replied with little emotion that she was ‘used to it’. It appeared that despite her previously expressed feelings of boredom, loneliness and frustration, Bulelwa was unable to motivate herself to change her situation. Furthermore, it seemed that she had come to accept this way of being. While I felt confused and frustrated, largely with myself, it occurred to me that both Bulelwa and her family’s way of relating with me was indicative of their way of relating with one another. Bulelwa’s apparent passivity and emotional disengagement within our sessions, largely prevented our moving beyond the assessment phase and collaboratively proceeding with the treatment plan.

Confusion and lack of progress in the criminal justice system

In working with a rape survivor, it is important for both psychologist and client to know the status of the police investigation and whether criminal charges have been, or will be, laid against the perpetrator/s. However, throughout my contact with Bulelwa, it was extremely difficult to obtain any clear information about this. For some time during her admission to Ward A-Neuro, and after her discharge, it appeared that there was little movement with regard to Bulelwa’s case. She was uncertain about what was happening with the case and remained uncertain after her discharge. She did, however, state that as far as she knew the four perpetrators who had raped her were out on bail and were thus living freely in the township. This created feelings of frustration, confusion and anxiety, which would have implications for Bulelwa’s recovery. As no information was forthcoming from Bulelwa or her current caretakers, it fell on me to make my own enquiries, something that proved difficult and extremely frustrating at times. Not only was there a significant delay in the process of gaining any information regarding the case, but it appeared that there was frequently miscommunication between those involved in the case. At one point it was made clear to me by a colleague at Fort England, who was involved with Bulelwa’s case and had been in touch with the investigating officers, that Bulelwa had been interviewed at her house following her discharge, and taken to identify the perpetrators in a line-up. Upon discussing this with her, however, Bulelwa informed me that this was not the case. After further investigation, it

appeared that there had been some misunderstanding and miscommunication and that my client had in fact been interviewed by the investigating officer while in hospital, and had identified the perpetrators in the location *prior* to her hospital admission. Furthermore, there was the additional delay of sending samples outside of Grahamstown for DNA testing. These had been obtained immediately after the rape while Bulelwa was in hospital. Thus while investigations regarding the case were underway, these were characterised by much confusion and delay, which served to exacerbate Bulelwa's current feelings of fear and anxiety.

Collateral assessment interview

After numerous phone calls, several family sessions that never materialised, and Bulelwa's acknowledgement that she would prefer for me to meet with her uncle and aunt alone, I was finally able to meet with her uncle. He stated that Bulelwa was doing 'better than before', but described her as being 'lazy', saying that she does nothing but watch television and sleep. He expressed wanting very much to help Bulelwa and discussed having attempted to encourage her to 'move on' with her life, but appeared concerned and confused by her passivity and her apparent inability to do anything. I attempted to validate his feelings of confusion, but simultaneously tried to psychoeducate Bulelwa's uncle about the effects of trauma and how Bulelwa's behaviour was a common response to a traumatic event. I further discussed the detrimental effects of Bulelwa's current inactivity and isolation on her mental wellbeing, and emphasised the importance of his and the rest of the family's support in facilitating Bulelwa's recovery.

During this session, it became apparent that Bulelwa's uncle was concerned about his niece's safety and wellbeing and that he truly wanted to help her. It seemed, however, that he was simply unsure of *how* to go about this.

5.3.3 Case Formulation

(i) Understanding of current presentation

Collateral information indicates the presence of psychiatric illness on both the maternal and paternal side of Bulelwa's family; Bulelwa's father has, in the past, been hospitalised with a diagnosis of schizophrenia and her mother is said to have abused alcohol since before Bulelwa

was born. The presence of mental illness in Bulelwa's family might therefore suggest a genetic vulnerability to the development of a psychiatric disorder. While it is difficult, in Bulelwa's case, to know what is genetic and what is environmental, it may be said that Bulelwa's genetic vulnerability, in combination with her early environment and experiences, provides insight into her current presentation and the predisposing factors that may have informed this presentation.

Information provided from collateral sources, as well as from Bulelwa herself, indicates a confused and unstable early home environment. Bulelwa's parents were never married and they separated soon after her birth. Her father was unemployed and suffered from 'mental problems', and thus took little responsibility for his daughter. Bulelwa's mother was said to have had little time for her children. She abused alcohol and regularly disappeared from home, leaving Bulelwa in the care of her maternal aunt and grandmother, and upon her return was frequently drunk and verbally abusive. This chaos and instability continued and in 2002, due to ongoing verbal and physical abuse at the hands of their mother and maternal grandmother, Bulelwa and her younger sister were removed from their home by social services and placed in the foster care of their aunt.

This erratic and abusive early home environment is, as mentioned previously, a well-recognised predisposing factor in the development of PTSD, as well as other psychiatric disorders. Such traumatic childhood experiences have been found to have a pervasive and profound impact on the functioning of individuals (van der Kolk, 2005). This type of multiple, chronic trauma has been termed 'complex trauma' and is said to frequently give rise to multifaceted symptomatology in children. However, rather than viewing these symptoms as separate and providing an individual with various comorbid diagnoses, for example depression, anxiety and PTSD, a new diagnosis of 'developmental trauma disorder' is suggested to encompass these symptoms and difficulties (van der Kolk, 2005). This diagnosis considers affective dysregulation as well as the organisation of behaviour to prevent the recurring effects of trauma. Thus Bulelwa's traumatic early environment was a major predisposing factor of her current presentation, namely her passive behaviour and disengaged manner of relating.

In view of her early environment it may be said that Bulelwa's mother and father were physically and emotionally unavailable, and thus were never available for secure attachment or to meet the

emotional needs of their daughter. Bulelwa's early childhood experiences are likely to have been experienced as traumatic and frightening and, similar to the previous cases, may have resulted in the development of particular beliefs about the self, others and the world (core beliefs). Such a negative early environment and resultant core beliefs are, again, likely to have led to a distrust of her environment and, in turn, an anxious way of relating to the world.

Bulelwa's mother's abuse of alcohol, as well as her mother and maternal grandmother's physical and verbal abuse of Bulelwa and her sister, suggests that there was little communication or appropriate expression of emotions within the family. There was thus no opportunity for Bulelwa to learn the appropriate expression or regulation of emotions through the modelling of such behaviour. Furthermore, this abuse as well as the infrequent physical or emotional presence of both parents implies the absence of support within Bulelwa's family. This lack of social support is an additional factor rendering an individual vulnerable to the development of a psychiatric disorder, in this case PTSD with a coexisting mood disorder.

The precipitant of Bulelwa's mood disorder, as well as her current symptoms of PTSD, appears to have been her traumatic experience of having been gang-raped by four of her neighbouring community members in 2006, exacerbated by having come into contact with the perpetrators near her home in Grahamstown. Bulelwa's poor relationships with her family, particularly with her mother and grandmother, as well as her limited contact with her father, suggest a lack of emotional support. Thus the trauma of having been gang-raped, exacerbated by the fact that there was little support in her life, appears to have precipitated Bulelwa's current presentation.

Various factors appear to be maintaining Bulelwa's current symptoms. Bulelwa acknowledged feeling saddened by her loss of contact with her mother; she reported feeling as though her mother has never cared for her, but stated that she longs for them to one day be a family again. Her relationships with her maternal grandmother and aunt are described as poor, and her father, with whom she reportedly gets along well, lives in Port Elizabeth and thus her contact with him is limited. It appears, therefore, that Bulelwa lacks the social support that she so desperately needs to facilitate her recovery. Furthermore, while she acknowledges getting along with her maternal uncle and his girlfriend, with whom she now lives, Bulelwa confirms the lack of communication

and expression of emotions within this environment. She further reports that her uncle and his girlfriend are seldom at home and that she thus spends most of her time alone at home. This social isolation and lack of appropriate social support suggests that Bulelwa is unable talk about her experiences and emotions relating to the trauma. This in turn prevents an opportunity for the processing or working through of these emotions and experiences, thus contributing to the maintenance of her PTSD symptoms.

Bulelwa's preference to avoid thinking or talking about the trauma that she endured in 2006 is again likely to prevent an opportunity to process emotions relating to this experience. Furthermore, such avoidance behaviours do not allow for the correction of faulty beliefs, but rather serve to maintain Bulelwa's problematic beliefs and thoughts and in turn serve to maintain her PTSD symptoms.

Bulelwa's lack of engagement with the world and her apparent lack of motivation to do anything may be seen as an additional avoidance strategy. Similar to her avoidance of thoughts and conversations relating to her trauma, Bulelwa's complete lack of engagement may further serve to maintain her current symptoms. So long as Bulelwa is not engaging with the world, she is unlikely to be exposed to triggers that serve as reminders of the event. Thus emotions are unlikely to be aroused and cannot be appropriately and therapeutically processed. Therefore, while Bulelwa's avoidance of the world and of life may assist her in the short-term, this is unlikely to assist her healing process, but in fact serves to maintain her symptoms.

(ii) Factors preventing treatment implementation

It appears that there were numerous factors contributing to Bulelwa's lack of engagement with the therapeutic process and, in turn, preventing the collaborative implementation of treatment.

One of the initial obstacles encountered was that of contacting Bulelwa. Bulelwa did not have a cell phone and there was no landline in her home, thus the only method of contacting her was on her uncle's cell phone. The seemingly simple task of contacting Bulelwa was thus experienced as extremely difficult due to the fact that her uncle was, as discussed previously, seldom home and therefore seldom in the presence of Bulelwa. This frequently resulted in delays in contacting

Bulelwa, which in turn hindered our ability to meet for appointments. Thus, a relatively small factor such as a telephone did in fact play a large role in preventing the implementation of treatment.

The second, and possibly *most* significant, obstacle encountered in this case was the lack of an appropriate support system in Bulelwa's life. During the assessment process, Bulelwa discussed her problematic family relationships as well as the lack of support within her previous home environment, and she expressed her resultant feelings of loneliness and isolation. Bulelwa's current home environment appears significantly more stable and supportive than her early environment, and her uncle has expressed his concern regarding his niece as well as his desire to assist and support her. However, his failure to arrive for numerous sessions, his frequent absence at home, and his apparent lack of understanding regarding Bulelwa's current behaviour, suggests a limited psychological understanding and perhaps a lack of awareness of *how* to support Bulelwa or what *kind* of support she requires. Thus while Bulelwa is not necessarily without support, there appears to be a lack of *appropriate* support in her life. Furthermore, knowing that therapy was likely to arouse certain difficult or unpleasant emotions or thoughts, and that returning home to an empty house after sessions would mean being alone with such thoughts and emotions, is likely to have made it difficult for Bulelwa to *want* to engage with therapy. It thus appears that a lack of social support plays a role not only in the development and maintenance of PTSD, but also in the treatment process or rather a client's engagement with and response to this process (Tarrier & Humphreys, 2003).

Bulelwa has acknowledged the lack of communication and expression of emotions within her home environment, saying that neither of these is, or ever has been, encouraged in her family. This pattern of relating within Bulelwa's family appears to have influenced her own way of relating, and provides insight into her apparent difficulty with expressing and connecting with emotions. This difficulty communicating and expressing her emotions in general, is likely to have influenced her lack of communication and expression of emotions within the therapeutic context, thus limiting her ability to engage with treatment.

While Bulelwa's lack of emotional engagement may certainly be a result of environmental influences and social learning, it may also be seen as an avoidance strategy. Bulelwa stated that she does not like to think or talk about the trauma of being raped and, at one point, stated that she would prefer to move away from Grahamstown as it reminds her too much of the incident. It is clear that Bulelwa wished to avoid all reminders of the incident and, since therapy was to involve talking and thinking about the incident, it is likely that she would also choose to avoid the therapy process. Bulelwa's attempt to avoid all emotions, thoughts and memories associated with the trauma thus appears to have contributed to her lack of engagement with this process.

During our initial contact, as well as at other times during the assessment process, Bulelwa appeared to lack the motivation or interest necessary for the commencement or continuation of a therapeutic process. This apparent lack of interest or motivation may have been just that, a lack of interest or motivation, or it may have been an additional avoidance strategy. It was discussed earlier, that Bulelwa's way of relating may have been a method of avoiding or coping with psychological pain, particularly the pain related to her trauma. Thus her shift into her 'fine' mode or way of being, may have been a shift into the 'Detached Protector' mode (Young et al., 2003), an emotional state or coping response facilitating the avoidance of, and escape from, difficult emotions. However, regardless of the explanation of or reasons for her disengaged or seemingly disinterested pattern of relating, Bulelwa's manner of relating was an additional factor preventing or hindering the implementation of treatment.

The assessment process began while Bulelwa was an inpatient at Fort England Hospital and continued on an outpatient basis after her discharge. Given her long hospital admission, Bulelwa's move out of hospital and into her uncle's home was a significant one. Some of our time together was thus spent exploring and working with her feelings regarding this change. In addition to this, several family sessions were set up throughout our period of assessment, but never took place and it was therefore important to explore how this was experienced by Bulelwa. Legal complications and confusion regarding the case against the perpetrators of the rape required time to be taken to discuss details of this case and gain clarity on the legal proceedings thus far. Such occurrences and difficulties throughout our period of contact meant that many of our sessions were focused on aspects *other* than the treatment of PTSD. While these sessions

were by no means unimportant, and such issues or aspects are not necessarily separate from treatment per say, they did impact on the implementation of treatment, frequently hindering this process.

As mentioned above, the case against the perpetrators was characterised by a number of complications. Information regarding the status of this case was extremely difficult to obtain and it seemed that little progress was made with regards to the case throughout our period of contact. Bulelwa acknowledged feeling angry about the fact that the perpetrators were not yet in prison and further stated that it makes her feel afraid to stay in Grahamstown. This anxiety and fear aroused by her knowledge of the fact that the men were living freely in the community was counter-therapeutic and is likely to have played a role in undoing any therapeutic gains made, which may in turn be seen as playing a role in preventing treatment implementation.

Bulelwa's intense reaction to the trauma that she endured resulted in a significantly long stay in hospital. During her admission, she was diagnosed with Bipolar I disorder, most recent episode manic, severe with psychotic features and was prescribed the appropriate treatment for this disorder. Given her severe Axis I disorder in addition to her diagnosis of PTSD it was, at times during the assessment process, difficult to determine whether some of Bulelwa's symptoms and way of relating were indicative of avoidance characteristic of PTSD or whether these were the expression of her Axis I diagnosis. Furthermore, Bulelwa's mood-stabilising medication may have played a role in her engagement with the therapy process. It thus appears that Bulelwa's other Axis I diagnosis may have served to complicate the implementation of this psychotherapeutic intervention.

Bulelwa's home environment (prior to living with her uncle) is described as chaotic, abusive, and lacking in nurturance and support. When asked during the assessment process what *her* main concern was, Bulelwa stated that it was the fact that she and her mother do not speak and that her mother does not care for her. It was during these times that Bulelwa openly expressed her feelings of sadness and loneliness, feelings that were seldom expressed when talking of anything else including the trauma of being raped. It appears that much of Bulelwa's life was characterised by abuse and emotional abandonment, and thus trauma. Therefore the trauma of having been

raped may not have been perceived by Bulelwa as of primary importance, which in turn may have hindered her engagement with the therapy process and thus prevented the implementation of treatment.

It is therefore evident that there was no single reason or obstacle preventing the implementation of treatment, but rather a combination of factors may be seen as *together* having played a role.

6. DISCUSSION

This study investigates the difficulties or obstacles encountered when implementing a therapeutic intervention, in this case the Ehlers and Clark (2000) cognitive therapy model, for the treatment of PTSD in the South African context. While a multitude of research articles documenting the successful outcome of various treatment interventions have been published, it is seldom that those cases that were *not* successful or *did not* proceed to treatment are discussed or considered. Thus it was the aim of this particular study to explore the many obstacles encountered when delivering treatment in the South African context, those that frequently prevent a successful therapeutic outcome, and furthermore, to document these.

All three of the cases included in the study failed to proceed to the therapy phase of treatment and it was for various reasons that this was so. A number of obstacles or challenges were encountered during each process and, while some of these were unique to a particular case, many of the challenges were in fact common to all cases. The thematic summary of the interviews provides further evidence for the difficulties repeatedly faced when working therapeutically in the South African context. Certain challenges described by the interviewees were not encountered in the three cases, however, many of them *were* faced time and time again. This section will consider those obstacles or difficulties that appeared to be less common and that were encountered infrequently, but that are undeniable factors influencing treatment delivery in the South African context. Attention will then be paid to obstacles that were common to all cases, those that may be seen as significant and consistent problems faced when implementing therapeutic interventions in this context. Finally, this section will provide recommendations regarding the structure of psychological services for individuals and communities.

6.1 Infrequently Encountered Obstacles in this Study

6.1.1 Language

The obstacle of language was discussed by both clinicians as a considerable one when implementing treatment in the South African context. African clients often request to be seen by non-African clinicians (for reasons mentioned previously) and thus the issue of language is frequently encountered. Although there are ways around this obstacle, namely the use of translators or interpreters, this creates additional challenges. The presence of a translator and thus a third person may affect the natural flow of the therapy process causing reflections and validation of feelings and experiences to feel stilted, and may create some difficulty in truly connecting with the client. The process of translation may lead to frustration for both client and therapist and such feelings may lead to a reluctance to engage, or to premature termination.

While this particular challenge was encountered in only one of the three cases, namely the case of Sibongiseni, it was a significant one and one that served to complicate the implementation of the psychological intervention.

6.1.2 HIV and other sexually transmitted diseases

It is a well-established fact that the incidence of HIV and STDs in South Africa is high. The likelihood of coming face to face with this complication during the therapy process is therefore also high. Although HIV was not encountered in the cases included in this study, the possibility of having contracted a sexually transmitted disease was discussed in the case of Marie and the focus of treatment shifted to explore her feelings relating to this.

Both clinicians acknowledged HIV as a major obstacle in the delivery of psychological treatment of PTSD in the South African context. It was stated that HIV is more than a mere complication or obstacle, but is in fact an additional trauma, which serves to exacerbate the effects of the trauma for which the client is referred. A client's discovery of his/her HIV status frequently requires the focus of the therapy to shift in order to provide the client with much-needed containment, and the traumatic experience may not be the point of focus for the client. Such a client is therefore unlikely to be able to engage fully with a therapy process.

While this particular complication, namely the possibility of contracting a sexually transmitted disease, was encountered in only one of the three cases, HIV and other STDs should be acknowledged as having a profound impact on the implementation of psychological treatment of PTSD within the South African context.

6.1.3 Failures in the criminal justice system

An additional obstacle encountered in this study was the confusion and lack of progress in the criminal justice system. While this appears to have been experienced as problematic for only one of the three clients, namely Bulelwa, it was acknowledged by the clinicians as a significant difficulty that is often encountered when implementing treatment for PTSD in the South African context. Both clinicians discussed the long length of time that is frequently taken to arrest or convict perpetrators in our country. The effect that this has on clients is more than mere frustration at nothing being done. The length of time taken for justice to be served implies that perpetrators are frequently roaming around freely and thus the client (or the victim) is at risk for re-victimisation. This is likely to lead to feelings of terror and helplessness, which impact profoundly on both an individual's life and on the therapy process.

6.1.4 Cultural beliefs

This was not an obstacle encountered in this study, but was described by one interviewee in particular as a significant challenge encountered when implementing psychological interventions in the South African context. It appears that clients belonging to certain cultures have differing explanations and beliefs regarding events, and psychological symptoms. In African cultures, traumatic events and their associated symptoms are frequently viewed as the work of evil spirits or the result of bewitchment. Psychotherapy is therefore not deemed necessary. As mentioned previously, how clients perceive their symptoms plays a significant role in determining their perceived need for treatment (Comas-Diaz, 2006). Therefore individuals from these cultures may not seek psychological treatment at all, or they may commence with treatment, but fail to engage openly with this process, thus impacting on effective treatment implementation.

6.2 Frequently Encountered Obstacles in this Study

6.2.1 Social support

Possibly the most significant obstacle encountered consistently throughout each case was a lack of social support. While each of the clients was living in an environment that was much improved from their previous home environment, there was an absence of primary caregivers in each client's life. There did appear, in all three cases, an alternative source of support, however at times the support provided was not the type of support that was needed to facilitate the client's recovery. This was illustrated in the case of Bulelwa where her uncle had taken her into his home in an attempt to ensure her safety and well-being. However, while he was able and willing to provide practical support or assistance, Bulelwa's uncle appeared unaware of the importance of emotional support or how to go about providing this kind of support for his niece. This was evident in his apparent inability to keep scheduled family sessions, as well as in Bulelwa's reports that he was seldom home. In the case of Sibongiseni, there was evidence of a lack of a responsible and consistent adult in her life; there was no one to bring her regularly to therapy and in so doing ensuring that her need for psychological intervention was met. With regards to Marie, her aunt expressed her concerns regarding Marie, as well as her desire to support her. However, Marie's move from her aunt's house indicates that she was unable to accept this support such as it was. As mentioned earlier, the value of social support depends on how consistent it is with an individual's needs (Edwards et al., 2005). Thus it appears that while all three clients were indeed receiving support from their current caregivers, this was not the kind of support required to facilitate their healing.

Both clinicians who were interviewed, further discussed the lack of social support as a major obstacle with which they were frequently faced when implementing therapeutic interventions. It was said that social support not only influences clients' (particularly children's) ability to attend therapy sessions, but also influences individuals' ability to engage with an intensive therapy process. Tarrier and Humphreys (2003) confirm that social support, or the quality thereof, is an important contributing factor to an individual's engagement with or response to psychological treatment, and thus to effective long-term therapeutic outcomes.

The lack of support, or *appropriate* support, discussed in the three cases as well as the clinicians' acknowledgement of this particular challenge provides evidence that a lack of social support is indeed a significant, and frequently-faced, obstacle to the delivery of effective psychological treatment for PTSD in the South African context.

6.2.2 Emotional expression

While this obstacle was, to some extent, encountered in every case, it was most apparent in the case of Bulelwa. Bulelwa's difficulty expressing her emotions and her explanation that talking about her feelings was not something she had ever been encouraged to do was confirmed by information obtained during the interviews. Both clinicians described a lack of emotional expression as an obstacle with which they were frequently faced. It was said that in certain cultures, namely African cultures, emotional expression is not encouraged and is in fact considered to be irrelevant and unimportant. Consequently clients of these cultures experience difficulty articulating their feelings, and they may find this meaningless and unnecessary. Such views frequently result in frustration with the therapy process, a process emphasising emotional expression, leading ultimately to a discontinuation of the therapy process.

This particular difficulty may be seen as related to the abovementioned obstacle of social support, since learning to verbalise and express emotions takes place in supportive relationships. Given the lack of support, or *appropriate* support, within the South African context, it follows that the difficulty with emotional expression is another commonly-occurring obstacle and one that poses a major challenge to the implementation of psychological treatment within this context.

6.2.3 Lack of psychological understanding

A lack of psychological education and understanding is another major challenge that is consistently encountered when implementing psychological interventions in the South African context. Both clinicians described how clients frequently attend therapy simply because they have been 'told' to and thus appear to know very little about psychology and psychotherapy when arriving for their initial appointment. Clients often appear surprised to discover that therapy is a *process* involving more than one or two sessions, that this process will involve talking about the trauma in depth, or that therapy is unlikely to alleviate their emotional pain or eliminate their

symptoms immediately. The clinicians discussed clients' apparent lack of understanding that the only way to truly 'move on' is to process the trauma, which will entail working through and speaking of the trauma. A lack of psychological understanding frequently leads to a lack of engagement with the therapy process, as well as to premature termination. The clinicians stated that this is due to the fact that clients experience immense frustration when they become aware of what the process of therapy entails, and often do not wish to continue with this process.

This lack of psychological education and understanding discussed by the clinicians was demonstrated time and again in all three cases. Sibongiseni was unaware of what a psychologist is, or does, and in the cases of Bulelwa and Marie, there was little understanding of psychotherapy as a *process*. Both Bulelwa and Marie discussed wanting to 'move on' and put the trauma behind them and both clients, at some point, described feeling 'fine' and discussed not needing therapy. Furthermore in the case of Bulelwa, limited psychological understanding within her family was apparent. All three clients were somewhat reluctant to talk about the traumatic incident and appeared, at times, not to understand the relevance of this to the therapy process. While this may be considered an expression of the clients' avoidance, it also demonstrates a lack of understanding of the process of psychotherapy as well as its importance to individuals' wellbeing and serves to hinder the implementation of psychological treatment.

Despite this being a challenge frequently encountered in the South African context, a lack of psychological education and understanding may well be a factor characteristic of other contexts, implying that there is in fact a universal need for psychoeducation.

6.2.4 Lack of resources

As discussed in section 3.6.2, poverty, deprivation and thus the lack of resources in South Africa has major implications for the mental health of individuals living in this context. A lack of resources is a key factor preventing or hindering the implementation of psychological treatment, and was discussed by the clinicians as another frequently-faced obstacle in their own therapeutic work. Mental health facilities are often located some distance away from clients' homes and transportation is required to bring these clients to therapy. However, individuals from underprivileged homes are frequently unable to afford the cost of transport and are thus unable to

begin or continue with a much-needed therapy process. Furthermore, a lack of available facilities or resources, for example playroom facilities or Xhosa-speaking therapists, in certain clinics or healthcare settings was said to influence the clients that may be seen and thus the availability of treatment interventions for those individuals in need.

A lack of resources and the resultant challenges was discussed in all three cases, but was perhaps most notable in the cases of Bulelwa and Sibongiseni. Bulelwa's inability to afford transport or a phone meant that she not only had difficulty getting to therapy, but that it was also extremely difficult to contact her when necessary. This significantly affected the implementation of treatment or, at that point, the assessment process. This challenge further appears to have been significant in the case of Sibongiseni, since in a less impoverished environment, a more stable fostering arrangement might have been made by social workers thus increasing the likelihood of an effective therapeutic process.

These cases, as well as the clinicians' discussion of the challenges associated with the lack of resources, indicate that poverty, and therefore the lack of resources, is a major challenge and one that is consistently encountered in the delivery of effective psychological treatment in the South African context.

6.2.5 Multiple traumas

All three clients included in this study came from chronically abusive or neglectful environments. Bulelwa and Sibongiseni, in particular, discussed previous instances of emotional and physical abuse and thus trauma that had occurred in their lives. It appears, therefore, that these clients endured much trauma prior to the traumatic event/s for which they were referred. Furthermore, these cases suggest that abuse and neglect within a South African community setting is not uncommon. This was confirmed by the clinicians who discussed, from their own experience, the high incidence of violence, abuse and trauma in their clients' lives. It was said that trauma has become such a 'normal' part of our existence in South Africa that many individuals fail to recognise the importance of psychological treatment following a trauma, and thus therapy is frequently not sought.

The presence of chronic neglect and abuse, and thus multiple traumas, has further implications for the mental health of individuals, and their capacity to emotionally engage with treatment. Such adverse experiences, particularly in childhood, are a well-known predisposing factor for the development of PTSD and other psychiatric disorders or symptoms (Edwards et al., 2005; van der Kolk, 2005; & Anda et al., 2006). The term 'developmental trauma disorder' has been suggested for the multifaceted symptomatology resulting from these experiences. Furthermore, such traumatic childhood experiences have a pervasive and profound impact on individuals' development of self and therefore their functioning and the way in which they engage with the world (van der Kolk, 2005). As discussed in section 5.3.3, developmental trauma disorder gives rise to a passive, distant, or detached manner of behaving and relating to others, which suggests that such individuals are unlikely to effectively engage with a therapeutic intervention.

The presence of chronic abuse and multiple traumas in South Africa thus creates distinct difficulties and is a significant obstacle in the implementation of psychological treatment in this context.

6.2.6 Avoidance

Both clinicians who were interviewed discussed clients' avoidance as a frequently-faced challenge when delivering psychological treatment, particularly treatment focusing on trauma. It was discussed that this avoidance is commonly a way of avoiding emotional pain or avoiding acknowledging one's own vulnerability, as well as an attempt to 'move on' with one's life.

This particular obstacle was faced time and again in each case and was expressed in the clients' preference to avoid all reminders of the traumatic event, as well as in an avoidance of, or lack of engagement with the therapy process. This was particularly prominent in the cases of Marie and Bulelwa, both of whom at times did not wish to attend or continue with therapy at all, while at other times attended therapy, but did not engage with this process. This lack of engagement with or avoidance of the therapy process, may further be explained as an expression of Young et al.'s 'Detached Protector' schema mode, which serves the function of coping with or withdrawing from psychological pain (see sections 5.1.3 and 5.3.3). In the case of Sibongiseni, avoidance was expressed simply in her acknowledgement that she found it difficult to talk about the traumatic

incidents and that she preferred not to. The clients' preference to avoid the therapy process altogether and their reluctance to engage with this process during sessions, regardless of their reasons, created much difficulty in the implementation of psychological treatment in all three cases.

While it is likely that most individuals find it difficult to engage with reminders of a traumatic experience thus implying that avoidance may not be specifically related to the South African context, the lack of social support in the South African context may increase the likelihood of avoidance and therefore creates an additional challenge to treatment implementation.

6.2.7 Motivation

Another consistently-encountered obstacle to the implementation of effective psychological treatment is a lack of motivation on the part of the client. A lack of motivation was clearly demonstrated, and became a routine pattern of interaction, in the cases of Marie and Bulelwa. Marie's somewhat bored and disinterested manner during the assessment process, as well as her acknowledgment that she no longer wished to continue with therapy, may be viewed as an expression of her lack of motivation. Bulelwa, on the other hand, displayed a lack of motivation in her initial resistance to commencing with treatment, as well as her passivity and lack of engagement throughout the assessment process. While it should, again, be noted that this apparent lack of motivation may have been the clients' attempt of coping with or avoiding emotional pain (as noted in sections 5.1.3 and 5.3.3), it was experienced as a significant challenge to the implementation of treatment.

Motivation, or a lack thereof, was confirmed by the interviewees as a major difficulty faced when working therapeutically in the South African context. Both clinicians stated that while a client's lack of motivation might be due to other factors, for instance being referred by someone else for therapy or a limited awareness of the nature of therapy, this lack of motivation frequently prevents the delivery of psychological treatment.

Again, while it should be noted that a lack of motivation is not necessarily associated with any one context, certain factors related specifically to the South African context, namely a lack of

psychological education, may increase clients' lack of motivation and thus the difficulty implementing psychological treatment.

6.3 Summary and Recommendations

It appears that numerous obstacles are encountered when implementing psychological interventions for PTSD. While many of these are related to the individuals involved in the therapy process (both client and therapist) and thus are likely to be encountered in any context, a number of challenges are very much culturally embedded and appear unique to the South African context.

A fundamental obstacle to effective treatment implementation is a lack of psychological education, and thus a lack of or limited psychological understanding or awareness. This particular obstacle may be seen as the basis for other obstacles or challenges also frequently encountered in South Africa, namely a lack of appropriate social support, limited emotional expression, avoidance of or lack of engagement with the therapy process, and motivation. It seems that if individuals were sufficiently educated with regards to the process of psychotherapy, as well as its importance for their psychological wellbeing, they may feel more motivated and less inclined to avoid such a process. Furthermore, psychoeducation of communities as a whole would imply a greater understanding amongst community and family members and thus an increased awareness of the importance of social support, as well as how to provide the quality of support necessary for psychological healing. In psychoeducating communities, an acceptance of psychology and the necessity of psychological treatment would be facilitated, thus facilitating parents' or caregivers' acceptance of responsibility of engaging their children in this process. Thus it appears that there is a great need for psychoeducation for the community as a whole, as well as for individuals, and this is recommended to facilitate effective psychological interventions.

Poverty and the resultant lack of resources are an additional and significant challenge to treatment implementation within the South African context and frequently prevent an effective therapeutic outcome. Thus the provision of resources and appropriate facilities that are accessible to all communities is needed.

Finally, a positive therapeutic outcome is unlikely should individuals be continually forced to return to an abusive and unsafe environment. Edwards (2005a) discusses the effects of living in a society characterised by violence and trauma and states that while psychotherapeutic interventions are necessary and beneficial, long-term treatment efficacy may be hindered by such conditions. Thus it is proposed that in order for trauma in South Africa to be addressed and for long-term therapeutic gains to be made, the conditions within our society resulting in traumatic incidents need to be transformed.

7. CONCLUSION

As discussed previously, there appears to be limited research and formal documentation investigating the transportability of cognitive treatment models for PTSD to a diverse cultural context, namely the South African context (Edwards, 2005c). Furthermore, there appears to be even less research or documentation investigating or exploring the difficulties encountered when implementing treatment models in such a context. This study provides evidence that there are, indeed, numerous challenges or obstacles that are frequently encountered when delivering psychological treatment in the South African context. In highlighting, exploring and documenting such challenges it is hoped that a richer understanding of these difficulties might be gained. This understanding may further enable clinicians to be more sensitive and better prepared when implementing therapeutic interventions within this context, thus enhancing the likelihood of a successful outcome of treatment delivery in the South African context.

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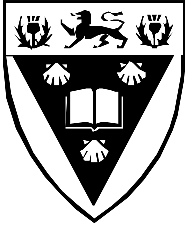
Appendix A: Consent forms



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CONSENT FORM FOR GUARDIAN

I/We, ____, consent to __________________________'s engagement in the therapeutic process and research study with Kerry Swartz in the treatment of Post-traumatic Stress Disorder.

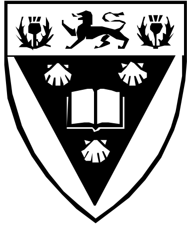
I/We understand that:

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

Signed on (Date):

Parent/guardian:

Researcher:



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PARTICIPANT CONSENT FORM

I, ______________________________, consent to engage in the therapeutic process and research study with Kerry Swartz in the treatment of Post-traumatic Stress Disorder.

I understand that:

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

Signed on (Date):

Participant:

Researcher: