The Acceptability of Prolonged Exposure Therapy for Primary Care (PE-PC) for the treatment of PTSD in a low resourced community in the Eastern Cape

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"*Do not be anxious about anything, but in everything, by prayer and petition, with thanksgiving, present your requests to God. And the peace of God, which transcends all understanding, will guard your hearts and your minds in Christ Jesus*." Philippians: 4: 6-7.

Declaration

I, Lerato Leboho, hereby affirm and declare that the following is my work, and it has not been copied or plagiarised from any source without the appropriate reference. I hereby declare that no harm, to the best of my knowledge, has come to any of the participants of the study as a result of their participation. All reasonable steps have been taken to ensure that no such harm, either personally or otherwise occurred or will occur in the future to the integrity and wellbeing of the participants and South African society.

Date: 15-11-23 Signature: L. Leboho

Dedication

This thesis is dedicated to all the PTSD patients and participants of prolonged exposure therapy for primary care, who willingly shared their personal experiences and lives in order to produce data that addressed the research topic and questions. I am sincerely grateful for your participation in this study, despite its vulnerable and sensitive nature. I believe the information obtained will contribute significantly, not only to the knowledge gap in the existing literature on the discussed and highlighted phenomena in the clinical psychology field, but also to the improvement and enhancement of the mental healthcare systems and services in Makhanda society, South Africa and in low- and middle-income countries at large. I truly honour and appreciate you.

Abstract

Post-traumatic stress disorder (PTSD) is a global mental health concern, especially in low-resourced communities that are characterised by limited access to health professionals, limited healthcare infrastructure, and limited access to evidence-based mental healthcare at primary care level. Over the last decade, several psychological trauma-focused therapies (TFTs), such as prolonged exposure therapy (PE) have been developed to treat PTSD. In the context of the existing literature, studies done in HICs have explored the implementation and acceptability of prolonged exposure therapy at primary care level (PE-PC) as a first-line treatment for PTSD. Contrary to this, there is little to no implementation studies done to date that have examined the acceptability of empirically supported treatments (ESTs), such as PE in low-resourced countries, such as South Africa.

Using the Implementation Science framework, ten participants were recruited to be interviewed, using semi-structured interviews, about their experiences and perceptions of PE-PC as a treatment for PTSD, and to also share their experiences of living with PTSD. The interview data was analysed using the reflexive thematic analysis (RTA) method to determine whether PE-PC is an acceptable treatment for PTSD that can be administered at community level and highlights the importance of integrating mental health within primary healthcare practice. Based on the analysis four superordinate themes were identified, namely, lack and absence of social support; factors preventing trauma survivors from accessing EBTs; lack of knowledge regarding mental health literacy, and adaptation of a brief trauma-focused therapy in a low-resource community.

The evidence this study shows that some of the factors that hinder the acceptability of trauma-focused therapies (TFTs) at community level, include stigma and discrimination, the absence of social support, limited resources, and inadequate knowledge on mental health and illness. Therefore, it makes sense of the urgency to implement evidence-based treatments (EBTs) in LMICs. Findings of this thesis suggest that (a) PE-PC should be adopted at community level, and that (b) PE-PC is an acceptable treatment for PTSD in low-resourced communities.

Key words: post-traumatic stress disorder, trauma-focused therapies, Prolonged Exposure therapy at primary care level, acceptability, low-resourced community.

List of abbreviations

ADC	Assumption Development Centre
CBT	Cognitive Behavioural Therapy
CPT	Cognitive Processing Therapy
CMD	Common Mental Disorders
DSM	Diagnostic and statistical manual for mental disorders
EPT	Emotional processing theory
EBP	Evidence-based practice
EBTs	Evidence-based treatments
ESTs	Empirically supported treatments
HICs	High-income countries
ICD	International Classification of Mental and Behavioural Disorders
IS	Implementation Science framework
LMICs	Low- and middle-income countries
PE	Prolonged Exposure Therapy
PE-PC	Prolonged Exposure Therapy for Primary Care
PC-led	Peer Counsellor-led intervention
PCL-5	Post-traumatic stress disorder checklist for DSM-5
RTA	Reflexive Thematic Analysis
RPERC	Rhodes University Research Projects and Ethics Review Committee
RUESC	Rhodes University Ethical Standards Committee
TAU	Treatment As Usual
TFTs	Trauma-focused therapies
WHO	World Health Organisation

Brief glossary

Acceptability	Refers to a multi-faceted construct that reflects the extent to which people delivering or receiving a healthcare intervention consider it to be appropriate, based on anticipated or experienced cognitive and emotional responses to the intervention (Casale *et al.,* 2023).
Avoidance	Refers to an act or practice of avoiding or withdrawing from something (Celik *et al,* 2023).
Emotional Processing	Is the confrontation with and expression of trauma-related thoughts and feelings in order to incorporate corrective information into trauma-related fear structures (Alpert, 2023).
Imaginal exposure	Is the repeated and systematic approach to the trauma memory and related thoughts and feelings (Whiteside, 2023 & Morgan-Mullane 2023).
In-vivo exposure	Is the repeated and systematic approach to objectively expose people to real life safe situations, activities, places, and objects that are avoided because they remind individuals of their trauma (Williams *et al.,* 2023).
Reflexivity	The process of critical self-reflection on one's biases, theoretical predispositions, and preferences, as well as an acknowledgement of the inquirer's place in the setting, context, and social phenomenon they seek to understand and a means for a critical examination of the entire research process (Versey, 2024).
Trauma	The challenging emotional consequences that living through a distressing event can have for an individual, causing dissociation and avoidance (Ahmadi *et al.,* 2023).

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Chapter One: Concept and Background

1.1 Introduction

The objective of this study examined the acceptability of a brief, modified version of prolonged exposure therapy (PE) as a treatment for post-traumatic stress disorder (PTSD) in the low-resourced community of Makhanda. This chapter will describe the rationale for the importance of conducting this study and provide an outline of the thesis. The chapter also describes the specific research problem and questions. Lastly, the chapter will present an outline of the structure of the following chapters.

1.2 Background to the Research Problem

According to Kayiteshonga *et al*. (2022) an estimate of 450 million people suffer from mental and behavioural disorders across the globe, with an estimate of 7.4% of the global burden of disease attributed to mental disorders. PTSD has become a global mental health concern in the contexts of ongoing adversities, such as the COVID-19 pandemic, as a result of the high prevalence of trauma exposure (Koenen *et al*., 2017). A study conducted by Yunitri *et a*l. (2022) estimated the prevalence of PTSD at 17.52% post COVID-19, globally. In addition, the World Health Organisation (WHO) recently declared the global rapid increase and worldwide spread of post-traumatic stress disorder (PTSD) as a result of the effects of the Covid-19 pandemic among vulnerable populations (WHO, 2022). Covid-19 patients experienced feelings of trauma as a result of job retrenchments, which resulted in the worsening of the socio-economic state of many countries; lockdown restrictions; stigmatisation; grieving the death of family and friends, and a lack of stable social support. Yunitri *et al*. (2022) uses the population exposure model to demonstrate how the Covid-19 pandemic continues to physically and psychologically expose individuals to traumatic events which negatively impact the psychological and overall well-being of individuals and communities. Furthermore, healthcare professionals experienced trauma due to a shortage of self-protection gear and medication, isolation from their family and friends, work overload, and witnessing deaths of their colleagues (Saragih *et al*., 2021; Yunitri *et al*., 2022).

Over the last three decades, studies and the literature have demonstrated a vast number of effective treatments used in western high-income countries (HICs) to treat mental disorders, such as PTSD, and an overrepresentation of white people as the dominant population having access to psychological treatments for mental illness. This is discussed in detail in the literature review chapter. Psychologically based interventions for mental disorders at primary care level are already being administered in HICs, including community-based interventions, and therapy

delivered by non-specialists (Soltan *et al*., 2022; Verhey *et al.,* 2020). Notwithstanding, there is limited literature on the use of trauma-focused therapies (TFTs) for PTSD in LMICs, particularly at community level, thus portraying injustices within institutions and healthcare systems at the expense of the disadvantaged minority groups.

Similarly, the availability of effective TFTs has been largely limited to HICs and at a specialty care level in HICs and some LMICs (Thornicroft *et al.,* 2023). This projects the disproportionate distribution of resources in LMICs, underutilisation, and limited accessibility to people residing in low-resourced communities. In addition, despite the scarce attempts made to provide treatment in resource constrained communities, much of the population have limited access to trauma-focused therapies for PTSD. The existing body of literature on PTSD in LMICs indicates that research regarding the prevalence and causes of the disorder, and its treatment, is still inadequate, especially the acceptability of TFTs at a community-based level. Thus, the study focuses on examining how prolonged exposure for primary-care (PE-PC) was perceived and experienced in a low-resourced community.

This study aims to address one of the main objectives of the larger project, which is to ascertain whether clients who receive PE-PC for PTSD in a low-resourced setting, perceive the treatment to be an acceptable TFT for PTSD. It is imperative to note that the results and findings of the current study will attempt to prove part of the hypothesis of the larger study that predicts that the implementation and use of PE-PC for PTSD in a low-resource context characterised by ongoing adversity and increased triune exposure will result in symptom improvement for PTSD, Depression, and Quality of Life compared to Treatment As Usual (TAU). Therefore, this study contributes to the overall larger project by addressing the notion of the acceptability of PE-PC within a low resourced community.

1.2.1 The Concept of Acceptability

The implementation concept of acceptability was used to conceptualise this research study. The multifaceted concept was used to investigate how the PE-PC treatment was received by the PTSD patients. It allowed the researcher to examine how clients engaged with the content of the intervention. It can be accessed by investigating elements of participants' responsiveness and adherence to the intervention. The former is evident through participants' willingness to accept the responsibilities asked of them by the intervention; for instance, the writing and reading activities within the PE-PC treatment, with the latter being portrayed through the participants' continuance and how often they frequented treatment (Casale *et al.,* 2023).

1.2.2 Prevalence of Trauma in South Africa

Surveys have shown that people residing in low- and middle-income countries (LMICs) are prone to developing mental illnesses and disorders; however, only a small percentage receive any form of professional help (Koenen *et al.*, 2017). South African society has a long-standing history of physical, political and psychological trauma (Dithlake, 2019), dating back to the apartheid era. Although South Africa has made substantial progress since 1994 post-apartheid, a large portion of its current population of approximately 60.14 million, are still subjected to the debilitating traumatic effects and consequences of apartheid. In contemporary South Africa, PTSD is a major public health concern, evident through a lifetime prevalence of 2.3% across all age groups (Swain *et al*., 2017). Thus, the challenge of encouraging people to accept and access psychological interventions include the perception that treatment is expensive, time consuming, and not effective. Therefore, researchers have focused on conducting mental health campaigns to educate communities and address these misconceptions. Mental health campaigns were a prominent element in phase 1 of the larger study, where researchers were educating the Makhanda communities on PE-PC treatment and encouraging them to engage.

Swain *et al*. (2017) suggests that high levels of trauma in South Africa stem from discrimination, abuse, and socio-economic disproportion which result in long-term social and emotional consequences in vulnerable groups. However, the literature has highlighted that much of the population of South Africa do not engage with psychological evidence. Limited access to evidence-based treatments (EBTs) can be attributed to the increasingly limited resources in South Africa, including poor health systems, limited healthcare professionals, and the absence of psychoeducation on trauma and PTSD treatments in South Africa. This is reflective of the urgent need for acceptable and accessible treatments, and an appeal to the South African government to integrate and decentralise mental health services within primary healthcare practice (Wakida *et al.*, 2019; Padmanabhanunni, 2020). According to Edwards (2005) those accountable for resourcing mental health must engage in strategic planning; the literature review chapter will unpack these challenges in detail. Thus, understanding how the historical factors have persisted within LMICs and how they further influence people's experience of psychological treatments, is critical. This will help the researcher build premises and develop arguments to determine whether participants who received PE-PC accept it as a treatment for PTSD.

The research problems prompting this study are summarised in three broad categories that will be referenced and resonate throughout this study including, obstacles faced by adults while accessing trauma-focused therapies (TFTs) in low-resourced settings that could influence the outcome of acceptability. These include, stigma and discrimination, and the perception that one needs money or insurance to afford therapy or counselling, and a lack of awareness and limited knowledge on mental healthcare and the availability of psychological interventions (Docrat *et al*., 2019). These perceptions have contributed significantly to why the number of people accessing TFTs is very low in low-resourced settings, when the number of people with severe symptoms and diagnosed with PTSD is constantly increasing, and how these perceptions will negatively impact their experience of evidence-based intervention.

In addition, factors contributing to the prevalence of PTSD in resource-constrained settings, including the challenge of insufficient numbers of healthcare professionals adequately equipped to administer psychological treatments and assessments, and limited infrastructure. The implementation process of the larger study had to account for the training of non-specialised healthcare workers who would be able to administer assessments and the PE-PC intervention for PTSD. Docrat *et al.,* (2019) referred to the inefficiencies and constraints within mental health resources, medication supply and infrastructure is evidence of the impairments in South Africa's progress in mental health policies, which might have implications for the implantation of acceptability.

Lastly, the existing poor mental health systems in South Africa, also contribute to why the targeted population might not consider any form of psychological treatment acceptable. That is, despite having a global commitment to include mental health amongst health and development priorities, represented by the inclusion of mental health in the Sustainable Development Goals (Docrat *et al*., 2019), many LMICs, such as South Africa, still do not prioritise mental healthcare, despite the increasing burden of mental disorders. Very little of the national budget is allocated to improving and enhancing mental healthcare systems and policies in South Africa. Docrat *et al*., (2019) indicated that in 2017, only 5.0% of the overall public health budget was assigned to South Africa's public mental health expenditure, with most of it being spent on inpatient care occurring at psychiatric hospital-level. Because nothing has been done to improve outpatient care at community level, there is a need for the government to assign more of the public health budget to outpatient mental healthcare at primary care level. Thus, if the results of this study indicate that PE-PC is an appropriate and acceptable treatment option for PTSD, findings will be used to assist PTSD patients on a larger scale.

1.3 Rationale of the study

There is a high prevalence of trauma exposure and PTSD in South Africa, with various implications on different age groups. The researcher poses the predicament that, if there is no effort made by mental health professionals to enhance mental health services in under-privileged communities, people residing in low-resourced communities will continue to not have access to cost effective trauma-focused therapies (TFTs). As a result, they will continue to be traumatized and continue to experience psychological distress that interfere with their day to day lives. Therefore, justifying the imperative need to conduct a study that examined the acceptability of an evidence-based trauma-focused therapy through a cultural lens of an under-privileged population within the Makhanda community. The purpose of this dissemination and implementation study is to highlight the importance of enhancing mental health systems by ensuring that they are accessible and cost-effective treatments within the primary healthcare, considering the limited knowledge around mental health services and interventions available for PTSD in LMICs, the misconceptions and inadequate knowledge and exposure to treatment. Results of this study will also provide a concrete foundation for future research on the topic of integrating mental health services at a local level. This, therefore, forms a groundbreaking direction for the future of clinical psychology, the acceptability of psychotherapy for PTSD in low-resourced settings, and how mental health systems operate across different communities.

1.4 Research questions

The central focus of the research study was to explore the acceptability of PE-PC as a treatment for PTSD in a low-resourced community in the Eastern Cape. The proposed study aimed to provide insights relevant to the contextual considerations (i.e., acceptability) when disseminating and implementing. The research questions for this study are:

- How do adult clients seeking trauma counselling perceive and experience PE-PC as a treatment for PTSD in a low-resourced community?
- What are the contextual facilitators and barriers that adult clients experience when seeking trauma therapy in a low-resource community?

The objectives of this study were to (1) understand the experiences of the participants of the PE-PC treatment for PTSD; (2) examine the obstacles and facilitators, as well as the contextual and cultural determinants that are faced by adults seeking treatment for PTSD in a culturally diverse context; (3) determine whether or not the PE-PC was acceptable as a treatment for PTSD in a low-resourced community, such as Makhanda, using the information obtained from

the interviews conducted with participants who had at least two sessions of the PE-PC treatment; (4) investigate if their symptoms were reduced after receiving the PE-PC intervention.

1.5 Significance to the field

Subsequently, this study raises awareness on the significance of culturally adaptive treatments within non-Western settings, and demonstrates the successful implementation of acceptability of primary care level accessible treatment for post-traumatic stress disorder in a low-resourced community. The findings of this research will encourage researchers to further examine other treatments that have been proven effective in treating common mental disorders in HICs. Furthermore, the study aims to examine how these interventions can be modified into culturally adaptive and cost-effective treatments that can be used in LMICs, particularly in low-resourced settings. In addition, the goal is to contribute towards improving the knowledge base of acceptable psychotherapy for PTSD, to benefit people residing in low-resourced communities in LMICs, who have had to travel long distances to access psychological mental healthcare treatments. The study also shows that offering EBTs within primary healthcare practice will enhance the emotional, social, mental and overall well-being of vulnerable populations, helping to educate people on the importance of accessing psychological treatments and support systems to minimise symptoms of mental illness. Moreover, how absence of social support can contribute to the rapid increase in the prevalence of mental illnesses. Lastly, the study also illustrated that despite the lack of knowledge among people in low-resourced communities in LMICs, much of the population are more willing to learn and discover the treatments stipulated in other research. It highlights how the majority of policy makers in LMICs do not prioritise mental health systems, hence promoting future mental health policy, governance and administration.

The research can be considered an appeal to governments in LMICs to take on the initiative to enhance the mental health systems and policies in a manner that benefits the resource-constrained areas, as well as appeal to the populations in these areas to access and accept psychological treatments for mental illness. Furthermore, the utilisation of NSHWs to administer PE-PC can also be perceived as a generation of employment to unemployed people in low-resourced communities.

1.6 The structure of the thesis.

This thesis is sectioned into six chapters. Chapter one reviews the background and rationale of the study. Chapter two establishes the theoretical framework underpinning the study. Chapter three presents the literature review focusing on significant themes that appeared during the literature review and examining their effect on the current study. Chapter four demonstrates the research design used for this study, and how the methodology provides justification for the selected designs, including how samples were recruited, how data was collected using semi-structured interviews, and analysed using reflexive thematic analysis (RTA) principles. It also presents issues pertaining to the validity and reliability of the study. Lastly, ethical considerations are discussed. In light of this, the last chapter consolidates the findings and several elements concerning participants' experiences and perceptions of PE-PC as a treatment of PTSD, in order to establish if it is an acceptable treatment for PTSD in a low-resource community. Limitations and recommendations of the current study are also considered and suggestions for future research studies are provided.

1.7 Chapter summary

This chapter provides the reader with an introduction to the current research study by describing the research context and rationale of the study. It provides justification for the reasons why (despite the rapid increase in the prevalence of PTSD of people residing in resource-constrained settings who are at high-risk of developing the disorder), very little is being done by those who are responsible for providing access to psychological trauma-focused treatments. The chapter introduces the possibility that the outcome of acceptability can address several disparities within mental health care in South Africa that perpetuate inequalities, as well as enhance access to treatment that is not dependent on a person's race and socioeconomic status.

Chapter Two: Theoretical Framework

2.1 Introduction

This chapter will discuss the implementation of the scientific theoretical concept of acceptability. The researcher will also describe how this research study falls into the context of implementation science, and provides a succinct understanding of the several theories, frameworks and models found in implementation science. The researcher will proceed to examine how the notion of acceptability is understood in other fields, so as to provide a background of the underpinnings of the concept. This will be followed by the rationale of why the IS concept of acceptability is the focus of the study; why and how it was used to conceptualise the study, and how it is used as a lens to help the researcher conceptualise the interview data. Lastly, this chapter will deliberate on emotional processing theory as a psychological theory of PTSD.

2.2 Implementation Science

According to Prathivadi *et al.* (2022) implementation science (IS) is used to refer to empirical methods used to embrace and integrate evidence-based health interventions into community and clinical settings to enhance individual progress and ensure the sustainability of population health. It focuses on enhancing the quality needed to minimise the evidence-practice gap. The present study was prompted by identifying an evidence-practice gap within the existing literature, as well as the absence of studies on the acceptability of psychotherapies for PTSD in low-resourced communities. Thus, the researcher attempts to examine the implementation of an evidence-based intervention, that is, a brief modified version of prolonged exposure therapy (PE) that can be integrated within primary care practice, and ensure the sustainability of the health of the population in Makhanda.

IS provides tools that allow for the study of complex implementation while understanding facilitators and barriers that might negatively affect the implementation outcomes. IS focuses on presenting evidence on affordability, scalability and sustainability (Kemp *et al.*, 2019) and aims to enhance the health of the population by taking advantage of interdisciplinary strategies to promote the uptake and dissemination of effective, underused interventions in LMICs. Implementation Science is appropriate because there is no existing literature on the acceptability of prolonged exposure for primary care in a South African context.

According to Prathivadi *et al.* (2022), there are strategies that provide a rationale for this study falling within the context of IS. These recommendations include: (i) the importance of considering the historical, economic, cultural and socio-political contexts of the community in which the research is being conducted; (ii) in addition, the researcher must seek to collaborate and work with stakeholders and end-users of PE-PC. This strategy improves the conduct of primary care research in that it ensures the in-depth and meaningfulness of the research findings, and more importantly, ensures the longevity of the intervention in primary care practice; (iii) lastly, Prathivadi *et al.* (2022) recommends that ensuring successful implementation and improvement of the conduct of primary care studies is achieved through exploring, understanding and applying theory.

The benefit of using the IS framework for this study is that it allows for the findings and results to be incorporated into routine healthcare in clinical and other applicable contexts; that is, it allows for knowledge obtained from studies to be put into practice and prompt future research to be conducted (Wensing, 2015). IS focuses on the premise that research results that are generated in a particular setting and population, for example a clinical trial, can be generalised and applied to similar settings and populations elsewhere (Wensing, 2015). However, this does not automatically mean PE-PC will be successful in other primary care practices with different context-dependent factors compared to Makhanda. Furthermore, the IS framework focuses on the outcomes of interventions for patients, which is the appropriate framework for assessing the outcome of acceptability of PE-PC by interviewing participants who received the intervention. Thus, their perceptions and experiences can be used to address the research questions.

According to Breen and Moulin (2022), IS is a multidisciplinary field that promotes the development of evidenced-based interventions, such as PE-PC. It examines how interventions are adopted and whether or not they are sustainable in practice through the integration of research findings into healthcare policy and practice to enhance quality and effectiveness. The above-mentioned authors state that IS also focuses on the prevention of disease and promotes health in populations, taking an interest in the organisation and processes of healthcare delivery that addresses broader organisational and societal issues. Therefore, the IS framework is used for this research as it seeks to make provision of evidence-based solutions to bridge research and mitigate the prevalence of common mental disorders, thus enhancing patients' outcomes (Breen & Moulin, 2022). Moreover, IS is an appropriate framework for this study as the strategies allow for adjustment in order to fit the target population, settings and study aims for

improvement; if the findings of the study indicate high acceptability, then researchers and healthcare professionals will need to expand the scale of the findings.

2.3 Implementation Science: Theories, Frameworks, and Models

Implementation Science emphasises the significance of establishing a theoretical underpinning of implementation and strategies. Wensing (2015) demonstrates that there are several theories, models and frameworks used in IS within different fields. The literature suggests that there has been an increase in the use of theoretical approaches in IS, for the purposes of equipping users with an improved explanation and understanding of how and why implementation fails or succeeds (Nilsen, 2022). Implementation theories are a distinct category of theoretical approaches that seek to understand and explain what influences the implementation outcomes. For the purpose of selecting appropriate approaches for this study, the researcher familiarised themselves with how approaches in IS differ and overlap.

In IS, theory refers to the predictive capacity, or the extent to which variables predict changes in other variables; theories also attempt to explain the causal mechanisms of IS that are applicable when evaluating implementation processes in healthcare (Nilsen, 2022). While models are used to describe and guide the process of translating research into practice, Frameworks, on the other hand, have the descriptive purpose of illustrating factors that influence implementation outcomes. Evidently, the three broad aims of models, frameworks and theories used in IS include: (i) describing and guiding the process of research into practice; (ii) understanding and explaining what influences implementation outcome, and (iii) evaluating implementation (Nilsen, 2022).

In order to address these aims, IS uses theoretical approaches that are expressed through five different categories: process models; determinant frameworks; classic theories; implementation theories, and evaluation frameworks. Implementation theories differ from process models that focus on outlining and guiding the process of translating research into practice, by addressing barriers and enablers to implementations; determinant frameworks provide support on how to carry out implementation efforts; classic theories and evaluation frameworks aim to evaluate implementation (Nilsen, 2022). This study adopts the comprehensive aim of understanding and explaining what factors and contextual determinants influence the implementation outcome of acceptability of PE-PC in a low-resourced setting.

Consequently, given that this study seeks to assess whether or not PE-PC is an acceptable treatment for PTSD in a low-resourced community, the relevant theoretical

approach for this study is the evaluation framework, on the grounds that it aims to understand and explain influences on implementation outcomes and seeks to examine how barriers (hindrances, impediments) and enablers (facilitators) influence the implementation outcome of acceptability. The study will employ the IS RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) framework in public health which highlights aspects of implementation that require evaluation. Nilsen (2022) argued that there are eight distinct outcomes that have potential for evaluation to determine the success of an implantation; these include: sustainability; acceptability; adoption; feasibility; penetration; appropriateness; fidelity, and costs. This study focuses only on the outcome of acceptability. In addition, evaluation frameworks acknowledge that implementation is a multidimensional phenomenon that has multiple interacting influences (Nilsen, 2022). Therefore, it is important to note that theories, frameworks and models from the other four categories can be employed for the purposes of evaluation as they also put emphasis on constructs and concepts that can be measured and operationalised.

Furthermore, Nilsen (2022) avers that IS was prompted by the inclination to address challenges that are associated with translating research into achieving more evidence-based practice (EBP) in areas of professional practice and in healthcare, while paying attention to the theoretical underpinnings of implementation. Using poor theoretical underpinning makes it challenging for the researcher to explain the success or failure of implementation, and further restrains the opportunity to identify elements that predict the possibility of successful implementation. This denies the researcher the opportunity to develop and employ enhanced strategies to achieve more success within implementation (Nilsen, 2022).

IS promotes the notion of assimilating the research findings into routine practice to enhance the quality and efficacy of healthcare and services. Therefore, making use of relevant theories, models and frameworks in IS for this study, allows the researcher a clear perspective into the mechanism by which implementation is most likely to succeed (Nilsen, 2022). That is, if the findings of this study indicate a high acceptability of PE-PC then the IS allows for the incorporation of this treatment into primary care practice. Therefore, the IS evaluation framework will be employed to operationalise the IS concept of acceptability and show how it was used in this study, by illustrating how the elements of acceptability determine the success or failure of an intervention.

2.4 Implementation Science: acceptability

The study used acceptability as an implementation science (IS) concept to conceptualise its aim and address the research questions (Riddle *et al*., 2020). The goal of IS is to identify processes, methods and factors that can successfully establish evidence-based treatments (EBTs), such as PE-PC in policy and practice to enhance and sustain population health (Bauer & Kirchner, 2020); hence, the emphasis on ensuring the success of implementation by assessing the acceptability of interventions. However, there is limited evidence on how to assess and conceptualise acceptability when evaluating healthcare interventions (Sekhon *et al.,* 2017). Sekhon *et al*. (2017) defines acceptability as a multifaceted IS construct that reflects the extent to which people delivering and receiving healthcare interventions consider them appropriate. In this study, the theoretical concept of acceptability will assess participants' anticipated or experienced cognitive and emotional responses to PE-PC. This research examines both an individual perspective (treatment acceptability) and a collectively shared judgement about the nature of PE-PC (social acceptability) (Sekhon *et al*., 2017).

Casale *et al*. (2023) argued that the concept of acceptability continues to gain traction within the health sector, and has become a prominent consideration in the evaluation and implementation of healthcare interventions. The authors opine that the notion of acceptability is considered a crucial condition in the assessment of the successful implementation and evaluation of healthcare interventions (Casele *et al*., 2023). Therefore, the acceptability of PE-PC will be assessed through a combination of how participants' behaviour (dropout rates), affect (feelings), cognition (perceptions), and barriers that participants experience while seeking psychological treatment (Sekhon *et al*., 2017), by examining participants' interaction with the intervention, their attendance and satisfaction, and their programme adherence. If PE-PC is considered acceptable, patients will more likely adhere to treatment recommendations and benefit from the outcomes.

According to Lewis *et al.* (2015) reviews conducted in IS have indicated that no studies have focused on the implementation outcomes instruments. To unpack the construct of acceptability, Sekhon *et al.* (2017) conducted an overview of reviews that attempt to theorise and measure the acceptability of healthcare interventions. The findings of this study showed that there were reviews that managed to explicitly define or theorise acceptability. However, Sekhon *et al*. (2017) emphasised those measures used to determine the acceptability of healthcare interventions' focus on recipients' behaviour (e.g., dropout rates), affect (i.e., feelings), cognition (i.e., perceptions), or a combination of these.

Alternatively, Sekhon *et al*. (2017) proposed that the construct of acceptability can be assessed from an individual viewpoint 'treatment acceptability' and examined from a collectively shared judgement about the nature of an intervention 'social acceptability' (Sekhon *et al*., 2017). According to Sekhon *et al*. (2017) the former is dependent on the patients' attitude towards the intervention options and their judgement of perceived acceptability prior to experiencing the intervention. The latter refers to patients' assessment of the acceptability, effectiveness, adequacy and suitability of the care and treatment. Patients' perceived acceptability is determined by the treatment's appropriateness in addressing the clinical problem, convenience, suitability to individual lifestyle, and the effectiveness in managing the clinical problem (Sekhon *et al.*, 2017), whereas treatment acceptability is conceptualised by assessing patients' willingness to participate in an intervention and their decision to complete treatment. Therefore, perceptions and attitudes of acceptability may change after patients have experienced the treatment.

Evident from above, acceptability is a conceptually distinct outcome for evaluation (Nilsen, 2022). The theoretical framework of acceptability (TFA) comprises seven component constructs that include self-efficacy (participant's confidence that they can perform the behaviour(s) required to participate in the intervention),; affective attitude (how the recipient or deliverer feels about the intervention); intervention coherence (participant's level of understanding the intervention and how it works); perception of effectiveness (the level at which the intervention is perceived as likely to achieve it purpose); opportunity costs (the extent to which benefits, values or profits must be relinquished to engage in the intervention); burden (the perceived amount of effort that is required to participate in the intervention, and ethicality (the extent to which the intervention is a good fit with an individual's value) (Sekhon *et al.,* 2017; Ortblad *et al.*, 2023). Therefore, the TFA is used to assess the acceptability of healthcare interventions from the viewpoint of intervention recipients and deliverers. However, the findings of this thesis focus on examining the acceptability of PE-PC by assessing the participants' experiences.

Ortblad *et al.* (2023) argue that though acceptability is a significant indicator of effective treatment, it is not the only factor that needs to be examined in order to make mental healthcare accessible in Low-resource communities. As discussed above, the definitions of acceptability vary and many of them fail to comprehensively represent the constructs in the existing acceptability frameworks (Ortblad *et al*., 2023). According to Ortblad *et al.* (2023), the TFA highlights that researchers and healthcare professionals need to design and implement

interventions that are acceptable to the population for whom they are intended, in order to maximise the prospective impact of new evidence-based treatments and approaches to mental health. The process of using the TFA, explains patients' positions on elements that impact adherence and engagement. Thus, findings obtained by the researcher from using the TFA will also provide information regarding adoption, the extent of success of the implementation, as well as the scale-up potential of the intervention. Thereby it portrays how the investigation of acceptability evolves over time.

In addition, the TFA posits that the multi-factorial construct of acceptability centres on participants' perception of a particular intervention and the delivery strategy, with particular attention paid to their environmental, social and cultural context (Ortblad *et al.*, 2023). This thesis, however, focuses only on the individual's perceptions to examine whether PE is an acceptable treatment for PTSD in primary care practice. Therefore, the TFA indicates the extent to which participants receiving PE-PC consider it to be an appropriate intervention for PTSD, considering their anticipated and/or experienced emotional and cognitive responses to the treatment (Ortblad *et al.*, 2023). Hence, if PE-PC is considered an acceptable treatment for PTSD, the results of this study should indicate that patients more likely adhered to PE-PC treatment suggestions and will show that they benefited from enhanced clinical outcomes.

According to Sekhon *et al*. (2017) the acceptability of healthcare interventions to recipients is a crucial matter to address in the development, implementation and subjective evaluation periods of healthcare interventions. Thus, Sekhon *et al*. (2017) attempted to theorise the construct of acceptability, in order to fully understand the concept and its components within IS. The focal point of the IS theoretical framework of acceptability is embedded in the difference between prospective and retrospective acceptability. With the premise that before healthcare professionals and patients experience an intervention, they already make judgements based on the information they have about whether they expect the intervention to be acceptable or unacceptable. This anticipated acceptability before engaging with an intervention allows for the modification of the intervention to increase participation and acceptability, and has been found to be prone to change following an experience of the treatment (Sekhon *et al.,* 2017). Therefore, it requires that the researcher be direct about the intention of acceptability assessments at certain points of the study.

Consequently, implementation acceptability is accounted for by, but not circumscribed to, measuring elements that include: participant's responsiveness; quality of delivery;

participant's adherence to the intervention; exposure to the dose or number of sessions attended, and programme differentiation (Carroll *et al.,* 2007). Implementation acceptability is used to highlight the extent to which an intervention or treatment is received by the population as intended. Measuring and understanding whether a modified version of PE therapy is acceptable at primary care level (PE-PC) will allow researchers to fully comprehend whether this treatment is effective in mitigating the prevalence of PTSD and limited access to trauma-focused therapies within low-resourced settings. Findings will also allow the researcher to examine the limitations of the study in order to make recommendations to other researchers for further research on the implementation acceptability of PE-PC.

It is imperative that the concept of acceptability is adopted in several other disciplines to depict whether people receiving healthcare interventions find them to be reasonable, appropriate and fair (Klaic *et al.,* 2022). A cancer management study on post-deployment assessments in home settings, illustrated that acceptability is understood as patients' and caregivers' perception of treatment as helpful and of low-burden (LeBaron *et al.,* 2022). Casale *et al.* (2023) reinforces the lack of consistent definitions and measurement tools for acceptability. The above-mentioned authors conducted an interdisciplinary review on acceptability studies and the lack thereof and attested that. Their findings conceptualised the notion of acceptability. With reference to TFA by Sekhon *et al.* (2017), Casele *et al.* (2023) conceptualised intervention acceptability as an alignment of the social and cultural practices and norms that permeate young people's communities and context, and the broader perceived positive effects of an intervention beyond the achievement of its intended purpose. This implies assessing acceptability based on the positive consequences of the intervention and how patients consider the intervention to be relevant to their needs and lived experiences (Casele *et al.,* 2023).

Casele *et al.* (2022) adopts a social-ecological approach and draws from gender and social norms theory to understand the concept of acceptability. This approach contextualises acceptability as a notion dependent on how relationships, structures and norms influence individual behaviours and attitudes at different levels, as well as how these factors influence the success of an intervention. In contrast, political economy analysis understands social and political acceptability from the perspective of who benefits from an intervention and what influences their attitudes towards an intervention (Casele *et al.,* 2022). On the other hand, the community-based approach highlights acceptability based on the quality and duration of end-

user and stakeholder engagement. This is evident in the different ways that acceptability is employed in other fields.

2.4.2 Debates regarding acceptability

As illustrated above, acceptability is a key consideration in examining the various interacting components of healthcare interventions; however, it is not enough to determine the effectiveness of an intervention. In order to measure the successful implementation of a healthcare intervention, we must analyse the acceptability of the intervention to both intervention recipients (e.g., patients) and intervention deliverers (e.g., health professionals or researchers) (Sekhon *et al*., 2017). Therefore, this justifies why the larger research project does not only assess the outcome of acceptability but also examines the effectiveness and feasibility of PE-PC. In addition, the lack of a clear definition of acceptability and the absence of evidence to operationalise the construct of acceptability, shows how difficult it is for intervention developers to assess acceptability for those receiving and delivering healthcare interventions (Sekhon *et al*., 2017).

Furthermore, most studies and reviews have focused primarily on the operational definition of acceptability that pays attention to observed behaviour (e.g., treatment discontinuation, drop-out and withdrawal rates). However, it is not enough to make conclusions on the acceptability of an intervention based on observed behaviour. Klaic *et al.* (2022) argued that other authors dismiss this premise of observed behaviour on the grounds that people drop out for different reasons that cannot be objectified into making conclusions regarding whether an intervention is acceptable. Sekhon *et al*. (2017) argued that the construct of acceptability is sometimes confused with the construct of satisfaction. This is reflected through studies that have assessed acceptability using satisfaction measures. However, the difference is that acceptability, unlike satisfaction, can be measured before participants engage in an intervention (Sekhon *et al*., 2017). This is possible by considering factors that include participants' attitudes towards the intervention, perceived effectiveness, suitability, and the convenience and appropriateness of the intervention that can be measured and considered as an indicator of treatment acceptability (Casele *et al*., 2023; Yardley *et al.*, 2015).

2.4.3 Acceptability as a lens to help the researcher understand the interview data

Consequently, using the IS concept of acceptability highlights the need to ensure that the findings of the research increase the impact of health services. This is evident through the process of modifying and enhancing the effectiveness of the PE clinical intervention by

allowing it to focus on the population to which it is being administered and other determinants, such as the settings, that might have implications and significant influences on how patients receive it. Notwithstanding the complexities and multilevel processes involved in implementation, this research focuses only on examining the outcome of acceptability which will provide future directions on whether or not the PE-PC intervention is acceptable and sustainable in primary care practice in resource-constrained settings. In addition, acceptability is deeply embedded in the sociocultural and structural context in which people live, and it is able to predict and explain key outcomes of interest, such as intervention uptake, retention and efficacy, which is relevant when research is interpreting findings and analysing interview data (Perski & Short, 2021; Casele *et al.,* 2023). Therefore, this study will use the TFA to measure acceptability using the seven constructs discussed earlier in this chapter.

Chapter summary

This chapter conceptualises implementation science, by briefly discussing the theoretical approaches in five categories within IS, and assessing the principles of acceptability as a conceptually distinct outcome for potential evaluation. It also provides a succinct discussion on how the notion of acceptability is understood within clinical settings, which is relevant to how the researcher will use the concept as a lens to aid the understanding of interview data. The chapter also examines how acceptability is understood in other fields and debates around the phenomenon. The next chapter provides a detailed review of the existing limited literature on the notion of acceptability of TFTs in low-resourced settings.

Chapter Three: Literature Review

3.1 Chapter Overview

This chapter provides an outline of themes that stood out during the review of the existing literature, with a detailed unpacking of the various themes and connecting them to the notions presented in this dissertation. The chapter will examine PTSD as a psychiatric disorder with reference to the emotional processing theory; elaborate the prevalence of PTSD in SA and similar LMICs; investigate the trauma-focused therapies used for PTSD, and lastly examine the acceptability of treatments, such as PE and an abbreviated TFT for SD in a low-resourced setting.

3.2. Literature Search Strategy

The literature was searched across various relevant databases at Rhodes University, including PubMed, Google Scholar, MEDLINE, ResearchGate and Scopus. The review focused on the SA literature; however, international literature was also briefly reviewed in order to establish the prevalence of PTSD and the acceptability of treatments. When attempting to examine whether a modified version that is culturally adaptive, non-time-consuming and cost-effective, can also be adopted as a first-line treatment for PTSD in LMICs, particularly in low-resourced settings.

The key words used to source research studies related to this study include: (i) trauma-focused therapies; (ii) post-traumatic stress disorder; (iii) low- and middle-income countries; (iv) South Africa; (v) low-resourced communities, and (vi) acceptability. From these keywords, a list of synonyms and related terms were created and then extensively searched.

3.3 Conceptualisation of post-traumatic stress disorder

The concept of trauma is defined depending on the context, and in this study, the notion is used of clinical psychology and psychiatry, referring to extreme events that are continually catastrophic, causing an immediate threat to a person's life or physical integrity (Swarts, 2007; Cromby *et al.,* 2013). In other words, re-experienced direct or indirect trauma causes severe stress, which becomes PTSD. There have been several disagreements concerning the definitions and constructs of PTSD; whether to focus on symptoms that occur following trauma or on the phenomena of the trauma memory (Bryant, 2019). However, there are two substantial definitions of PTSD. Firstly, the DSM-5 definition focuses on fear responses and emotional reactions to trauma, with the prerequisite that an individual experiences or witnesses a traumatic event (exposure to actual or threatened death, serious injury or sexual violence) (Criterion A). In addition, if a person has experienced a traumatic event, they need to present

four symptom clusters for more than a month after trauma exposure. These include dissociative flashbacks; intrusive distressing memories; intense or prolonged psychological distress when exposed to reminders of the trauma, and recurrent distressing dreams (Criteria B). Moreover, a person is expected to have active avoidance of internal (e.g., thoughts, memories) and external (e.g., conversations) reminders of the trauma (Criteria C). Furthermore, a person needs to present alterations in mood and cognition; that is, an inability to remember certain aspects of the traumatic event, having consistent distorted cognitions and negative thoughts as a result of the event (Criteria D). Lastly, one needs to have at least two arousal symptoms, including irritable behaviour and angry outbursts; reckless or self-destructive behaviour; exaggerated startle response; problems with concentration, and sleep disturbance (Criterion E) (Bryant, 2019).

Secondly, the International Classification of Diseases (ICD) adopts a simple approach to psychiatric diagnoses compared to the DSM-IV, in order to reduce the burden on the diagnosticians in low-resource settings, who are unable to administer long assessments to individual patients (Bryant, 2019). The ICD-11 diagnostic guidelines for PTSD focus on re-experiencing traumatic events, avoidance of reminders, and perception of heightened current threat (Bryant, 2019). A diagnosis can also be made when there are persistent symptoms of increased arousal; for instance, difficulty falling or staying asleep; irritability or outbursts of anger; difficulty concentrating; hypervigilance, and exaggerated startle response. The other factors that determine the diagnosis of PTSD include: when the duration of the disturbance is more than 1 month, and when the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas or functioning.

3.3.1 Emotional Processing Theory

Emotional processing theory (EPT) conceptualises PTSD as an inability to effectively process traumatic memories as a result of extensive avoidance of trauma-related thoughts and images (Alpert *et al.*, 2021). As a result, EPT acknowledges fear as a mechanism used to avoid or escape perceived danger. Alpert *et al.* (2021) established that empirically supported psychological treatments that aim to minimise fear, for example PE, are able to meet their aim through emotional processing where an individual learns to adopt accurate information to the fear structure (Edna, 2011; Alpert *et al.,* 2021). This new learnt information does not replace the already existing fear; however, the PE therapy will help the individual retrieve the modified structure which is realistic, and helps them disconfirm information when the person's fear structure is activated and able to rationally differentiate what they expect to happen and what

actually happens. Therefore, the EPT accounts for how the use of trauma-focused therapies such as prolonged exposure and PE-PC effectively minimises pathological emotions that cause the development of PTSD and maintain its symptoms (Alpert *et al.,* 2021).

In addition, the emotional processing theory of PTSD depicts how exposure treatments need to focus on matching the exposure to the disorder-specific fear structure, in order to effectively minimise fear and promote emotional engagement (Alpert *et al.,* 2021). That is, a person suffering from PTSD has a traumatic memory structure where they associate objects and situations with real danger; for instance, a rape survivor might fail to trust the opposite sex because of their traumatic memory which is instantly activated when they perceive their close approach. According to Alpert *et al.* (2021), a patient's representations of their actions during and post trauma and the diagnosis of PTSD is relatively connected with how they perceive themselves as incompetent and unable to cope in similar traumatic environments. Therefore, EPT focuses on minimising related emotions and reactions within the fear structure, which are directly linked to the traumatic memory in PTSD patients that can potentially be a barrier towards emotional processing (Alpert *et al.,* 2021).

3.4 Prevalence of PTSD in SA and similar countries

Consequently, some of the contextual factors that depict the prevalence of PTSD in SA include: the impact of the apartheid era; the rape culture; Covid-19 pandemic; gender-based violence, and high crime rates. As with many other countries that have been colonised, South Africa is known for its prevailing history of violence, crime, conflict and oppression, that manifest as physical, political and psychological trauma (Dithlake, 2019; Richardson *et al.,* 2022), not only as a result of the repercussions of the apartheid era but also because of the persistent current circumstances. During the apartheid era, a system of institutionalised racial segregation and discrimination were enforced, and Black South Africans were exploited and forced to adapt to destructive colonial operations. This history still has a considerable impact with regard to how Black South Africans respond to psychological treatment. Seemingly, much of the population residing in low-resourced communities in SA and similar countries, are faced with adversities that include: poverty, inadequate resources, and a lack of social support (Cromby *et al.,* 2013). This signifies that the population residing in South Africa has a significant chance of being exposed to many forms of violence, compared to people residing in other countries, excluding those at war (Swarts, 2007). Consequently, they are susceptible to developing psychological disorders, such as PTSD. In addition, Kaminer *et al.* (2022) assert that South Africa has a high rate of child maltreatment and community violence, and that the

majority of the adolescent population in low-resource settings are exposed to multiple forms of violence as they grow up. Moreover, trauma exposure creates high risk for PTSD among South African youth. However, despite the increase in the number of mental health difficulties and the high rates of trauma exposure among children and adolescents, there is still not much evidence available on trauma interventions among people living in low-resource settings.

The pervasiveness of gender-based violence (GBV) and the rape culture in South African institutions (i.e., churches, families, universities, and communities), is an indication of the prospect and plausibility of people being exposed to rape in environments they believe to be safe in (Manomano, 2023; Geldenhuys, 2023). This results in victims suffering from PTSD or experiencing a greater chance of developing it. Furthermore, the Covid-19 pandemic was a crucial contributor to the spike in the prevalence of PTSD in the country and similar parts of the world. Countries have heightened challenges within the healthcare systems in most LMICs, where mental illness is already considered a burden (Lombard *et al.,* 2022). Lombard *et al*. (2022) make use of a case study of anaesthetists' susceptibility to Covid-19 in SA, and how it made them vulnerable and prone to developing substance abuse, and common mental disorders, such as PTSD. The authors argued that frontline workers were overwhelmed by the increase in the demand for their services, and their exposure to the virus put them at high risk of death, which caused severe trauma.

In addition, the Covid-19 pandemic in South Africa and similar countries, had a high rate of comorbidities, and many people living in disadvantaged or resource-constrained communities (i.e., townships and rural communities) were unable to practise proper hygiene (i.e., sanitation), and social distancing because it was made impossible by over-crowding and a lack of resources (Andrews, 2023). As a result, this put the population at high risk of experiencing PTSD from witnessing the death of many from the devastating effects of the pandemic within institutions and communities (Walsh, 2020). Thus, the uncertainty and fear of the global Covid-19 pandemic had an adverse psychological impact on healthcare professionals and the general population, through the repeated exposure to trauma, which was evident in the spike of research studies on COVID-19-related PTSD.

Furthermore, sociodemographic statistics suggest that much of the population in SA is directly or indirectly exposed and witness to a traumatic event at least once in their lifetime, as a result of the high prevalence of HIV rates, teenage pregnancy, child marriage, gender-based violence and unsafe abortion (Manomano, 2023; Geldenhuys, 2023). This has made the

prevalence of PTSD unacceptably high among South Africans, particularly individuals who lack social support and have pre-existing mental health conditions (Lombard *et al.,* 2022). Moreover, victims of racism, rape, homophobia and xenophobia in South Africa, continue to be at high risk of developing PTSD (Musisi & Kinyanda, 2020). As a result of constantly being subjected to stigmatisation and discrimination in the communities they consider their own. This maintains feelings of inadequacy in these victims and also reflects the absence of much needed social support in settings that already expose them to different forms of harshness.

Similarly, Rwandans experienced the catastrophic genocide against the Tutsi where more the one million people were killed over a period of 100 days, with survivors being exposed to traumatic events, which had negative impact on their psychological well-being (Hoppen *et al.,* 2021). This period for Rwandans in 1994, was permeated by extreme levels of psychological and physical violence, making them vulnerable to developing psychological disorders, such PTSD (Kayiteshonga *et al.,* 2022; Musanabaganwa *et al*., 2020). Kayiteshonga *et al.* (2022) argued that women were more susceptible to developing PTSD than men. The authors found that even though more than half (61.7%) of the population in Rwanda is LMIC, citizens are not aware of mental health services; only 5.3% report to having accessed the existing mental health services (Kayiteshonga *et al.,* 2022). The study showed a high prevalence of substance abuse disorders, PTSD, panic disorder, and major depressive episodes, yet the utilisation of available mental health services was significantly low. Kayiteshonga *et al.* (2022) indicated that only 14.1% were recorded to having utilised mental health services. Despite this, the government of Rwanda prioritises mental health by ensuring that services are accessible within communities and engage in frequent training programmes with medical professionals, as well as raising awareness about mental health (Kayiteshonga *et al.,* 2022).

More so, the prevalence of violence against Pakistani women is alarming, indicating a high risk to the health of the victims and their families, which make them vulnerable to mental health problems. Statistics show a high rate of PTSD and depression among Pakistani women who experience domestic violence (Latif *et al.,* 2021). According to Yatham *et al.* (2018), other determinants contributing to significant psychiatric morbidity and a high prevalence of PTSD in LMICs include: environmental stressors, poverty, and civil conflict. The above-mentioned authors added that though there is a high prevalence of PTSD in LMICs of up to 87% among young adults, research on mental health is still scarce.

As mentioned throughout this thesis, studies demonstrating the acceptability of TTFs within primary care practice at community level have been conducted predominantly in HICs, such as the United States of America and in the United Kingdom (Western countries). Conversely, studies paying attention to similar findings in more diverse settings for instance, South Africa are minimal. It is important to consider several factors that are responsible for the implementation outcome of acceptability, including personal factors, cultural and context-related factors that may hinder the acceptability of PE-PC. With as much as 73.8% of the South African population having been exposed to at least one traumatic event, the country has the highest incidents of murder, assault, rape, robbery, and intimate partner violence, worldwide Topper *et al.* (2015). Thus, Topper *et al.* (2015) argued that the extent and severity of trauma exposure in South Africa contributes significantly more to the overall burden of disease, as compared to other countries. Yet, the majority of people with PTSD and related mental disorders in South Africa fail to seek healthcare as a result of barriers that manifest from fears and distorted cognitions (Topper *et al.*, 2015).

3.4.1 Determinants and Causes of PTSD

Despite research stipulating that the occurrence of PTSD is the most common in South Africa as portrayed in chapter 1, researchers also echo that this area of research remains under-explored and that it is not considered in health policies (Bouchard *et al*., 2023). It is evident in the existing literature that some of the determinants and causes of PTSD within low-resourced communities in South Africa can be attributed to the impact of devastating natural disasters, internal migration, and effects of apartheid such as inequality (Bouchard *et al*., 2023). Despite the apparent consequences of these factors, there are no factors put in place to ensure that the concerned people receive any form of after care, instead they are just ignored. In addition, Davies *et al*, 2023 presented the impact of COVID-19 as one of the recent catastrophic determinants of the rapid increase of PTSD in South Africa, the authors findings mainly project how the pandemic related measures and restrictions negatively strained the accessibility of mental health services, which resulted in the exacerbation of the existing gaps and challenges in mental health service provision in South Africa. Therefore, this study aims to respond to researchers' recommendations in the existing literature, to increase mental health resources in South Africa.

3.5 Trauma-Focused Therapies of PTSD

According to Swartz (2007) research on the acceptability of trauma treatments has been conducted largely in HICs; however, there is limited research that examines whether or not

some effectively proved interventions in HICs can be accepted and applied to culturally diverse contexts, (i.e., South Africa) and similar LMICs. Swarts (2007) avers that there is limited documentation of treatment efficacy in SA and similar countries for common metal disorders (i.e., anxiety, depression, and PTSD). Although a sum of 85% of the world's population resides in the 153 countries currently classified as LMICs, many of these, regardless of income class, have an insufficient number of psychiatrists to cope with the demand, as well as lacking specialised services (Alzaghoul *et al*., 2022). Thus, many people in LMICs are at risk of developing long-term mental health conditions that will go unidentified and untreated, as a result of the unavailability or inaccessibility of mental health services. Therefore, although Tay and Carlsson (2022) acknowledge that recent studies have discovered the positive effects and outcomes of brief interventions as treatments for CMD in LMICs and humanitarian settings, there is still not enough published research on the acceptability of TFTs within culturally diverse settings that have been studied prior to this research study.

The literature suggests that trauma-focused therapies seek to encourage people to individually reflect on their traumatic experiences in order to get rid of the self-blame, anger and guilt that causes victims to feel responsible for the traumatic event(s) that happened to them or that they witnessed and prevent them from accessing EBTs. Alzaghoul *et al*. (2022) identified three group-based interventions: notably teaching recovery techniques, writing for recovery, and advancing adolescents, all of which focus on the improvement of social skills and a statistically significant reduction in PTSD score in children and adolescents. According to Namy *et al*. (2022) common methods used to treat acute trauma include: Cognitive Processing Theory (CPT) which makes use of cognitive restructuring strategies to mitigate the state of being hopeless that develops as a result of traumatic experiences; Prolonged Exposure Therapy (PE) which is used to decrease stress by habitually exposing patients to internal and external stimuli intended to remind them of their traumatic event; Cognitive Behavioural Therapy that targets the cognition pathways to alter negative patterns of thinking that evoke distress (Swarts, 2007), and Interpersonal Therapy (IPT) which is used to improve social interactions.

In addition, some of the psychological/trauma-focused therapies which mitigate the prevalence of PTSD include: Narrative Exposure Therapy (NET) which is a short-term treatment for PTSD patients involving emotional exposure to the memories of traumatic events and the reorganisation of these memories into a coherent, chronological narrative, developed for use in LMICs (Robjant & Fazel, 2010); Behavioural Activation treatment (BA)

that focuses on using behaviours to activate pleasant emotions (Walsh *et al*., 2022); Eye Movement Desensitisation and Reprocessing (EMDR) which points directly on the trauma memory and attempts to change how it is stored in the patient's brain (Motta, 2020); Thought Field Therapy (TFT) which focuses on the reduction of psychological distress by manipulating how energy flows in the patient's body (Callahan & Callahan, 2022), as well as trauma or general supportive counselling. Therefore, the literature is of the view that psychological therapies substantially reduce endpoint PTSD symptoms, compared to control conditions (Purgato *et al*., 2018).

Consequently, Bryant (2019) attests that although Trauma-focused Cognitive Behavioural Therapy (TF-CBT) has been previously considered the most effective intervention for PTSD, its efficacy has declined over the past decades, considering that only two-thirds of PTSD patients respond positively to it. Thomas *et al.* (2022) investigated whether TF-CBT that is considered a standard treatment in Western countries for childhood PTSD, can be as effective in treating children and young adults affected by conflict and war in LMICs. They discovered that cultural considerations were of great significance in terms of ensuring the TF-CBT treatment met the needs of local populations, which also meant translating and validating measures and instruments for local use. Their findings indicated that TF-CBT is an effective treatment for trauma-related symptoms and improving psychosocial functioning in children and adolescents in LMICs. Thomas *et al*. (2022) further suggested that considering the limited number of published literature available in this area of study, there is need for further research in order to conclude when and for whom trauma-focused interventions are most relevant. Therefore, it prompts the researcher to investigate the acceptability of cost-effective and accessible TFTs for PTSD in low-resourced countries.

Similarly, Kaminer *et al*. (2022) developed a brief eight-session version of trauma-focused cognitive behavioural therapy (TF-CBT), which they conducted with 10 adolescents and their caregivers, focusing on assessing the acceptability and tolerability of the abbreviated TF-CBT model. Findings showed that some of the most effective components of the TF-CBT were that they created a solid foundation for trauma processing, made adequate time for clients to practise coping skills. The feedback from participants was that the abbreviated trauma-processing component was difficult but tolerable (Kaminer *et al*., 2022). Results of the study indicate that following completion of the treatment, PTSD symptoms were reduced over the course of treatment for all participants.

Clemans *et al.* (2021) conducted implementation research on a modified version of group cognitive processing therapy (CPT) comprising 10 sessions, to determine the acceptability, feasibility and effectiveness of the intervention for female adolescents (between the age of 14 and 19), survivors of commercial sexual exploitation in Cambodia. According to Clemans *et al*. (2021) LMICs have more often established human trafficking operations with the majority of victims of commercial sexual exploitation being children and women. Treatment acceptability was measured using an eight-item Client Satisfaction Questionnaire-8 Khmer Version (CSQ-8), which was used to assess a client's experience of attending the group CPT and their perception of its usefulness. The instrument allowed for local language translation, making it culturally sensitive (Clemans *et al*., 2021).

Kaysen *et al.* (2020) further assessed the acceptability and effectiveness of Cognitive Processing Therapy (CPT), which is a trauma-focused therapy, used to reduce psychological symptoms in sexual violence survivors residing in a region with a history of chronic conflict, such as in the eastern part of the Democratic Republic of Congo (DRC). Kaysen *et al.* (2020) examined the degree to which exposure to different levels of ongoing insecurity, influence the effectiveness of an evidence-based, trauma-focused psychotherapy for sexual violence survivors. The results showed that women exposed to greater insecurity reported higher initial symptoms, compared to women residing in relatively more secure sites. Most women who participated in the study reported a significant reduction in psychological symptoms over time. Therefore, the findings of the study support the effectiveness and acceptability of trauma-focused therapies when provided in a well-structured and well-supervised programme, even in low-resource settings with ongoing conflict and violence (Kaysen *et al.,* 2020).

However, these TFTs discussed above, are currently offered only at speciality care level (i.e., psychiatric hospitals and facilities) in SA and other similar LMICs, which limit accessibility to much of the population in low-resourced settings. In addition, there are fewer studies conducted or quality evidence that indicates that psychological therapies have large or moderate effects in reducing PTSD in adults living in low-resourced settings in LMICs. Purgato *et al.* (2018) alluded to the fact that they identified few studies that looked at the effectiveness or acceptability of psychological therapies for PTSD in LMICs. Latif *et al.* (2021) attest that there are no studies on culturally adaptive TFTs in LMICs. Therefore, more research is needed to investigate if psychological therapies are more effective than control conditions, in reducing symptoms of mental disorders (i.e., PTSD) in people of all ages, gender, or religion, amongst people residing in LMICs that are subjected to humanitarian crises.

Consequently, Ryan *et al.* (2021) conducted a review on lay-delivered talk therapies for adults affected by humanitarian crises in LMICs. Notably, the mental health GAP Action Programme Humanitarian Intervention Guide (mhGAP-HIG), recommends the use of brief versions of structured psychological interventions for people experiencing symptoms of CMDs such as PTSD. The mhGAP-HIG recognises the increase in evidence that suggests that these brief interventions can be delivered by lay workers to people subjected to humanitarian crises in LMICs; however, Ryan *et al.* (2021) posited that there has not been any review and much evidence on this. As portrayed in the introductory chapter of this thesis, the larger research study also focuses on training non-specialised healthcare workers to administer PE-PC intervention for PTSD in Makhanda.

Furthermore, Verhey *et al*. (2020) conducted a review on the implementation outcomes (i.e., acceptability, appropriateness, feasibility, and sustainability) of NSHW-delivered CBT treatments addressing common mental disorders and substance abuse in LMICs. Verhey *et al*. (2020) argued that the advantage of having NSHWs deliver TFTs is that they are expected to deliver brief and straightforward treatment and that the use of NSHWs also increases the accessibility and availability of mental healthcare at community level. The results on the acceptability implementation outcome indicated that some of the issues that hindered the acceptability of the NSHW-delivered CBT intervention include: women's lack of autonomy; stigma; resistance to change in sociocultural hierarchies; cultural barriers, and a lack of engagement that Verhey *et al*. (2020) and several other determinants discussed earlier. The findings of the review also suggested that CBT-based interventions delivered by NSHWs can be acceptable in resource-constrained settings. Nevertheless, it was also stipulated that there is a need to conduct more research to better assess psychological trauma-focused interventions under different implementation outcomes, as well as addressing key gaps in the literature on the acceptability of TFTs.

Furthermore, the researcher reviewed the literature on interventions led by peer counsellors (PCs) for adults with common mental disorders, especially targeting depressive and/or anxiety disorders or PTSD in LMICs. The overall effectiveness and key implementation outcomes (acceptability, feasibility, cost, fidelity, sustainability), were scrutinised. Triece *et al.* (2022) proposed a solution of task shifting, where tasks are reallocated among health workers, especially giving more duties to less qualified care providers in order to optimise their efficiency. The results of the review indicated high acceptability, feasibility, and fidelity, but cost and sustainability outcomes were underreported in the included papers. PC-led

interventions seemed to show initial promise in terms of effectiveness, acceptability, feasibility, cost, fidelity, and sustainability. Triece *et al.* (2022) indicated that peer counsellor-led interventions were described as acceptable to both clients and peer counsellors in LMICs. Triece *et al*. (2022) suggested that future research should focus on standardising measurements of implementation outcomes to facilitate cross-study analysis.

Moreover, according to Namy *et al*. (2022) alternative treatments for PTSD include meditation, mindfulness and stress management. These are used for trauma-sensitivity and inclusivity, focusing on decreasing the heart rate and blood pressure, in order to release stress-reducing neurotransmitters such as serotonin, which helps with the downregulation of the sympathetic nervous system. In addition, studies conducted using a veteran population found that military-based trauma-focused yoga treatment was effective in reducing PTSD symptoms, such as avoidance, re-experiencing, hyper-arousal and numbness. Yoga as a TFT, enhances mindfulness and decreases symptoms of insomnia, anxiety and depression. Namy *et al*. (2022) stated that trauma-informed yoga programmes report high attendance rates and that the participants were willing to recommend yoga to others. Therefore, TFTs, such as yoga have shown an effective reduction of trauma-related mental health disorders in populations, such as veterans and survivors of sexual violence. The increase in this evidence is encouraging, considering yoga as a cost-effective trauma-focused intervention which is easy to implement, especially in low-resourced settings.

In addition, Carter *et al.* (2021) reviewed studies on the detection, diagnosis, prevention, treatment and/or management of a broad range of mental disorders in LMICs, using digital mental health treatments. Carter *et al.* (2021) reported that most reviewed studies indicated feasibility and acceptability of digital mental health treatments to treat common mental health disorders, such as PTSD, depression and anxiety, as indicated by participant satisfaction and programme adherence. Studies show that digital interventions show an improvement in depressive symptoms, quality of life, treatment adherence, and recovery (Carter *et al.,* 2021). Considering the limited mental health resources and the lack of professional healthcare workers, effective digital health innovations present an opportunity to address the global discrepancy in mental healthcare provision. Therefore, the implementation of digital and online services is acceptable in LMICs, because it presents an opportunity to enable the individual to access adequate mental healthcare in communities where mental health services may not be otherwise available. However, it might not be beneficial to people residing

in resource-constrained environments, who might not have access to the internet or computers to access digital mental health services.

On the other hand, there have been several challenges noted within the process of delivering TFTs in South Africa and similar countries. These challenges include: patients' unwillingness to follow through on a referral to specialty mental health services, and hesitation to commit to long treatment sessions across several weeks by patients with complexities and severe symptoms (Rauch *et al.,* 2017). Therefore, the provision of brief modified EBTs within primary care practice may be significantly beneficial to patients residing in low-resourced settings, in a manner that is not emotionally exhausting for patients. Another challenge in LMICs with delivering TFTs is the shortage of mental health professionals who can administer treatments in resource constrained settings. This is evident through how the available service in PC settings is limited to the provision of supportive contacts and over-the-counter medication. It does not include any form of psychotherapy courses of action for patients who present mental illness symptoms (Rauch *et al.* 2017). Hence, the focus of this research is to interrogate the acceptability of same-day mental health service within primary care practice. Evidently, though TFTs remain restricted in terms of availability, there are nevertheless several challenges faced by healthcare professionals when attempting to administer it to patients.

3.6 Acceptability of TFTs, such as PE and PE-PC in LMICs

Given the above, it is imperative that we acknowledge that though the literature portrays several trauma-focused therapies that have been developed to treat PTSD, there is still an extensive knowledge gap regarding whether or not trauma patients consider TFTs acceptable for PTSD in low-resourced settings (Booysen & Kagee, 2023). To our knowledge there are no studies done on the acceptability of a modified version of prolonged exposure therapy (PE-PC) and similar treatments in low-resourced settings that emphasise coping and safety strategies to enhance young people's resilience to ongoing violent or violence triggering environments (Kaminer *et al*., 2022). However, Kaysen *et al*. (2020) argued that most psychological interventions discussed earlier, that have demonstrated the effectiveness in HICs, can be difficult to deliver to patients subjected to mass conflict and displacement, due to ongoing exposure to trauma and other major stressors. This reflects how there is insufficient literature on the implementation of PE and similar trauma treatments in LMICs.

Tay and Carlsson (2022) noted that even though there have been significant results showing the effectiveness and benefits of psychosocial interventions in treating common

mental disorders (CMD), such as PTSD, there are still some notable variations that require large scale studies to be conducted to further investigate the effectiveness, feasibility, and acceptability of PE and similar TFTs in South Africa, and within humanitarian crisis settings in LMICs. Therefore, there is a need to examine the social and cultural factors that potentially influence how patients perceive their symptoms and how they engage with a specific treatment in culturally diverse settings. Consideration should be given to advocating culturally adaptive TFTs that might increase the chances of the acceptability of TFTs in low-resourced settings. According to Verhey *et al*. (2020) expectations, cultural values and norms contribute significantly to the acceptability of a treatment. Therefore, appropriate language and cultural issues surrounding mental disorders should be taken into account, in order to increase the acceptability of the intervention. Booysen and Kagee (2023) attested that the findings of their study suggested that PE is an acceptable trauma therapy in a contextually diverse setting, such as the Eastern Cape, South Africa. Though this present study will hopefully be a significant contribution to the literature on the acceptability of a TFT in a South African setting, there are no other studies that suggest the acceptability of trauma-focused treatments within contextually diverse settings in LMICs. This is because some available traditional treatments, such as pharmacological approaches and talk therapy are connected to poor adherence and low remission rates and may be stigmatised and not be culturally accepted in some contexts (Namy *et al*., 2022).

Namy *et al*. (2022) conducted a study in Uganda to examine the effectiveness of healing and resilience after trauma (HaRT), using Yoga, a twelve-week psycho-social, group-based intervention for women and girls who had been trafficked. Human trafficking survivors become vulnerable to cycles of economic marginalisation, social stigma, and re-exploitation (Namy *et al*., 2022), as well as being more susceptible to depression, PTSD, and general anxiety disorders, and are at a heightened risk of suicide. The purpose of HaRT Yoga is to create a nurturing environment where participants can strengthen their inner resilience, build a supportive community, and overcome the long-term physical and psychological effects of trauma (Namy *et al*., 2022). The intervention is an integration of yoga poses with breathwork, visualisations, theme-based discussions and mindfulness practices. The findings of this study showed that the HaRT Yoga low-cost programme was acceptable and feasible to implement in a shelter-based setting, with participants experiencing reductions in depression symptoms, and self-rated emotional and physical health (Namy *et al*., 2022).

In addition, Latif *et al.* (2021) argued that culturally adapted trauma-focused CBT-based guided self-help (CatCBT GSH) was feasible and that the intervention was acceptable to Pakistani women who experienced domestic violence. It also suggested that this TFT focused on identifying and changing negative thoughts, challenging them and finding alternative thoughts, which would be helpful in improving symptoms of PTSD, depression, anxiety and the overall functioning in this population. However, Latif *et al.* (2021) depicted that the availability of CBT in LMICs remains low, despite the evidence that it is an effective trauma treatment, particularly within low-resourced settings. Moreover, Latif *et al.* (2021) noted that their study was the first to report a culturally adapted GSH intervention for victims of trauma from LMICs to their knowledge; this highlights the gap in studies done on the implementation outcome of acceptability of trauma-focused therapies (TFTs) in LMICs, particularly in low-resourced settings. Thus, there is need for more studies on TFTs because, despite the strong evidence of the acceptability and effectiveness of TFTs, they remain under-utilised in LMICs.

According to Clemens *et al.* (2021) results of their implementation study indicated that the modified group (CPT) trauma-focused therapy appeared to be feasible and received a high acceptability rate, evident through a significant decline in PTSD and depression symptom severity over time. There was also a high mean of client satisfaction with the group treatment at posttreatment. Clemans *et al.* (2021) argued that it is important to examine the reasons for the dropout rate as another dimension of acceptability but not as a factor that measures acceptability. For instance, the patient who dropped out during this study was because of a conflict with her work schedule, and not because they did not find the group CPT a useful intervention. Clemans et al. (2021) depicted that these treatments are largely underutilised internationally, regardless of the strong evidence of the effectiveness of the TFTs. This is as a result of a lack of available, qualified providers and knowledge or awareness regarding the availability of treatment programmes (Clemans *et al*., 2021). Similarly, though Booysen and Kagee (2023) noted that there had been an increase of attention paid to PTSD treatments over the last three decades, most researchers who examine implementation acceptability of TFTs indicate that their study is the first on a particular group in a LMIC. Thus, there is a critical gap in the literature regarding our understanding of the psychological needs PTSD patients in LMICs, which prompts an increase in efforts to minimise mental illness and more calls for the implementation of EBTs in low-resourced communities.

Consequently, some determinants and facilitators that have hindered the implementation outcome of the acceptability of TFTs, such as PE and PE-PC in LMICs include

stigma and discrimination. PTSD patients will not access TFTs as a result of the fear of being negatively stereotyped, labelled and isolated in their respective communities. This deepens health disparities and has the potential to drive population mortality and morbidity into a power imbalance (Kemp *et al.,* 2019; Puspitasari *et al.,* 2020). In addition, negative perceptions and attitudes also hinder the IS outcome of acceptability as a result of inadequate knowledge on issues of mental health, as well as the misconception that any form of mental healthcare is expensive and accessed only by people who can afford it. This is also reflective of the need to conduct further mental health promotions and campaigns within LMICs communities, to educate people on the availability and accessibility of cost-effective mental healthcare interventions.

Furthermore, the distressing thoughts and behaviours that involve a spiritual dimension can be interpreted differently in LMICs when we adopt Western categories of illness, which might impact participants' experience of a TFT. For example, in non-Western societies, hearing voices and seeing things that other people cannot see can be praised in the isiXhosa culture in South Africa as a communication passage between the ancestral world and living people through a 'gifted' person. In Western societies the same characteristics fit the DSM-5 criteria for schizophrenia (Volkan, 2021; KM & Maluleke, 2021). This illustrates how culture, religion and tradition play a role in people's perceptions of illness and their willingness to accept treatments. That is, most patients who visit psychiatric hospitals express prior hesitation because they come from communities where the mentally ill are considered irrational, unpredictable and dangerous, as a result of prejudice and negative stereotyping (Cromby *et al.,* 2013). This causes patients to feel isolated and might imply how they perceive trauma therapies and how they will experience TFTS, such as PE and PE-PC at community level.

Significantly, the implementation of trauma treatments for PTSD is imperative in order to mitigate the prevalence of PTSD, which has become a global issue and a public health concern. The literature echoes that IS studies have been conducted in Western-European countries, with minimal to none conducted in African countries, such as SA. This makes the availability of TFTs in LMICs scarce. The present study which will hopefully contribute to the literature on the implementation outcome of acceptability of trauma therapies, such as PE, through findings that will highlight the reduction of PTSD symptoms in patients who accessed PE-PC, is a reflection of the acceptability of the treatment in a low-resourced setting characterised by violence, which is evidently a significant contributor to the escalating public health crises.

3.7 Essential Features of PE-PC

The reason why the larger project aimed to ascertain the successful implementation of an abbreviated version of Prolonged exposure therapy, PE-PC which is modified from the mainstream (PE) was to make the treatment more accessible to defined populations within low-resource communities. Some of the elements and aspects of PE-PC that the researchers looked, that justifies the urgent need for implementation of this treatment in a resource constrained context like Makhanda, include the integration of emotional processing theory, psychoeducation of the treatment to participants by the counsellors and explanations of their different reactions to trauma, in vivo exposure – the importance of approaching trauma-related but objectively safe activities, situations or places, and imaginal exposure, all of which are essential in that they help participants establish rational reactions and have an understanding of their reactions and how to continuously deal with them even after their PE-PC sessions, while being cost efficient and accessible.

Chapter Summary

This chapter outlines the concept of PTSD, discusses its prevalence in South Africa and similar countries, investigates the trauma-focused treatments for PTSD, and examines the notion of the acceptability of treatments, such as PE and PE-PC in LMICs. The arguments and themes presented are a reflection of what stood out for the researcher while reviewing the existing literature relevant to the notions presented in the title of this thesis that will assist the researcher to address the research questions effectively. Lastly, the chapter portrays an identified knowledge gap within the mental health systems and policies in South Africa and other LMICs.

Chapter Four: Research Methods

Chapter Overview

This study was part of a larger study that explored the effectiveness, acceptability and feasibility of PE-PC as a treatment for PTSD in a low-resourced community in the Eastern Cape, by examining how participants perceived and experienced the treatment. Participants were recruited via project promotion and campaigns, poster advertisements and referred from counselling centres, the police station and Joza Clinic in Makhanda and at Rhodes University.

This chapter discusses the qualitative research designs and methodology employed to collect and analyse data relevant to the acceptability of a modified version of prolonged exposure therapy (PE) in a resource constrained context. The research will firstly outline the research problem followed by the rationale of why the selected sampling and data collection methods were appropriate for this study; a discussion on the theoretical underpinnings of reflexive thematic analysis (RTA) used to make sense of research finding, as well as set out the ethical considerations relating to the study.

4.1 Research problem

The review of the literature suggested that HICs are developing evidence on the implementation and acceptability of PE and PE-PC as first-line treatments for PTSD, within primary care practice. However, the literature also mentions studies paying attention to similar findings in more diverse settings, for instance South Africa, are minimal (Topper *et al.,* 2015). In addition, Wensing (2015) argued that studies on research knowledge implementation in healthcare has focused mainly on healthcare professionals (i.e., nurses and physicians). Fewer studies have been done on other implementation outcomes by none-specialised healthcare workers (i.e., psychologists), which is evident of the urgent need to research other IS outcomes of TFTs in more diverse settings.

4.1.1 Scope of the Research

The research time frame of this research study was particularly narrow in scope. The study was limited to examining the experience of 10 participants. To the researcher's knowledge, this will be the first study of its kind to examine the acceptability of a modified treatment for PTSD in a low-resource community.

4.2. Aim of the Study

The main aim of this study was to examine the acceptability of prolonged exposure therapy for primary care (PE-PC) for the treatment of PTSD in a low-resourced community in the Eastern Cape.

4.3. Rationale for Using Qualitative research methods

Qualitative research methods (QRMs) were used in this research study, allowing for the exploration of events in their context, and enabling researchers to gain an understanding of the underlying complex factors of participants' experiences through rich descriptions and valuable insight into settings and situations (Saunders *et al.,* 2018). Adeoye-Olatunde and Olenik (2021) state that qualitative research is an umbrella concept for different methods of exploring and analysing phenomena in a real-world setting, allowing for a thorough exploration, and a nuanced understanding of the research material, from an interpretivist approach, with the intention of producing in-depth knowledge of the phenomena (Pathak *et al.,* 2013). Therefore, the current study did not seek to represent the wider population under study nor generalise findings, but focused on gaining an in-depth understanding of PE-PC participants' perceptions and unique experiences in relation to their complex context.

The research aimed to address the following two main questions: "How do clients seeking trauma counselling perceive and experience PE-PC as a treatment for PTSD in a low-resourced community" and "What are the contextual facilitators and barriers that adult clients experience when seeking trauma therapy in a low-resourced community". Qualitative research methods were employed because the data obtained was not numerical in nature; instead, it existed within the inductive and interpretivist approach (Flick, 2004). This indicates the subjective truth of the data as a result of the uniqueness of the participants and the complexities of their contexts. Therefore, qualitative research designs were appropriate for this study as they emphasised the need to understand clients' behaviour within their natural settings, in order to comprehend their experience of PE-PC (Flick, 2004: Pathak *et al.,* 2013). Data for this study was collected using one face-to-face 35 – 45 minute-long, semi-structured interview with participants who had undergone the PE-PC sessions, in order to assess whether they perceived them as an acceptable treatment for PTSD in a resource-constrained community. The interview schedule used by the researcher is attached to this study as Appendix A.

4.4 Research Setting

The study was conducted in the Makhanda community in the Eastern Cape (South Africa. Particular attention was paid to the Joza location at the Assumption Development Care centre (ADC), Joza Clinic, and the Makhanda Police Station. However, the study focus shifted to the Rhodes University setting when considering the challenges faced by the Joza location population to commit to the interview process following completion of the PE-PC sessions. This occurred because of no participants' phones and the anticipated language barrier between the researcher, translator and clients. The Rhodes University Psychology Department setting was selected based on its ability to provide infrastructure to conduct interviews, a closer proximity for the targeted participants. Conduction of SSIs at the Rhodes University Psychology Department location established confidentiality of the interviews and ensured that the environment was safe, secure and conducive for participants to comfortably express themselves.

4.5 Sampling

The study made use of a non-probability form of sampling - purposive sampling, also known as judgement sampling, to recruit participants (Obilor, 2023). This method was appropriate considering its emphasis on strategically matching the sample to the research objectives and aims, thus ensuring and enhancing the rigour of the study and the trustworthiness of the data and findings (Campbell *et al.,* 2020). Campbell *et al.* (2020) proposed that purposive sampling should be employed in a qualitative study when the sample is relatively small, and the aim is to increase the depth of understanding which allows the researcher to gain a detailed knowledge about a specific phenomenon (Obilor, 2023). In addition, purposive sampling is used on participants who are most likely to give relevant information in a manner that effectively uses limited research resources, and to select participants who share similar characteristics within similar contexts. In this case, it is PTSD survivors in a low-resourced setting; Bryman (2012) refers to this as the homogenous sampling technique.

The larger research project recruited participants through advertisements of the project on posters, mental health promotions and campaigns in the Makhanda community, and referrals from the Rhodes Counselling Centre, Assumption Development Centre (ADC), Joza Primary Health Clinic, and the Joza Youth Hub. Purposive sampling was employed because it is cost-effective and time efficient, allowing the researcher to eliminate irrelevant members, and focus on the best-fit participants. These were trauma survivors who scored a certain percentage on

the PCL-5 assessments, and were therefore selected and invited for interviews; thus ensuring relevant results to the research context (Obilor, 2023; Campbell *et al.,* 2020).

Consequently, purposive sampling was appropriate for this study because it allowed the researchers to recruit participants who could provide in-depth and detailed information about the phenomenon under investigation (Pace, 2021); i.e. whether or not they considered PE-PC an acceptable PTSD treatment in context of on-going diversity. The participants who had symptoms of PTSD were able to provide information on their experiences and perceptions of PE-PC. A sample of (n = 10) participants from phase 1 of the larger study, who received at least 2 sessions of PE-PC were invited to participate in face-to-face, semi-structured interviews. Participants were notified by counsellors during the PE-PC sessions that a research assistant would contact them to schedule an interview. The researcher contacted participants using contact information ton a data tracking excel shift with emails and direct phone calls to schedule interviews. Invitations to interviews were sent to all participants who accessed PE-PC, with ten participants responding.

An advantage of using purposive sampling was that it paid attention only to the population of specific interest, which increased internal validity (Andrade, 2021). In addition, purposive sampling allowed for the non-random selection of participants, and ensured that members of the population were selected, based on the researcher's expertise and knowledge of whether they met the criteria stipulated in the following section (Obilor, 2023). This resulted in a truly representative population of people with PTSD in Makhanda. Obilor (2023) also argued that purposive sampling should be employed when the research focuses on sensitive and special skills, behaviour, personality or attributes, which were applicable to the current study. The researcher sought to examine how these individual attributes played a part in a patient's experiences of PE-PC, and whether they had an effect on the acceptability of the treatment.

However, the limitations of using purposive sampling for this study is poor generalisability, considering that the results obtained can be generalised only to the sub-population from which the sample was drawn (Andrade, 2021). Another limitation of using purposive sampling is the strong risk of researcher bias and findings holding limited external validity; that is, the more purposive a sample is, the more the external validity is limited (Andrade, 2021). Furthermore, this kind of non-probability is a source of invalid statistical

inferences, as it is subject to the biases, manipulations and errors of the researcher and might exclude participants who could have been part of the research study.

4.4 Inclusion and exclusion criteria

To direct sampling, the inclusion criteria were as follows: client's selection included adults between 18 and 65 years of age (South African and/or non-South African), and those who reported having directly experienced or witnessed a traumatic event in their lifetime and had a total score of 28 or more on the PTSD Diagnostic Scale for DSM5 (PCL-5) (3 months post- trauma). Clients were included if they spoke English and/or Afrikaans /isiXhosa and those who resided in the Makhanda area. Clients included in this study were those whose characteristics were defined for a purpose relevant to the study.

Clients were excluded from the study if they had a bipolar or psychotic disorder; alcohol dependency; moderate to severe traumatic brain injury; homicidal or suicidal ideation with an apparent intent or plan, and substance use or other disorders warranting immediate emergency attention. Clients on psychotropic medication were required to be on a stable treatment routine at least two-months prior to starting the intervention. Clients who had terminated psychotherapy within the last three months for PTSD were excluded.

4.5 Data collection: Semi-structured interview procedure

Individual, face-to face, semi-structured interviews (SSIs) were selected as an appropriate data collection method for the current qualitative research study as its primary benefit was that they allowed for interviews to be focused while still giving the investigator the autonomy to examine pertinent ideas that might have come up during an interview, thus enhancing the researcher's understanding of the participants' perceptions and experiences of services being offered within the PE-PC project (Adeoye-Olatunde & Olenik, 2021). Furthermore, SSIs were appropriate for this study because they permitted the interviewer to listen to the interviewee talking about certain aspects of their life and experiences, which was a crucial aspect in determining whether or not patients considered PE-PC to be an acceptable intervention for PTSD (Henriksen *et al.,* 2022), thus aligning with the purpose of the study.

The thesis employed SSIs for their flexibility, allowing patients to talk about themselves, as well as assisting the researcher to gain an understanding of the context of the patient's experiences and to adapt questions to the patient's context and narrative (Heriksen *et al.,* 2022). Therefore, the researcher was required to show genuine interest in the patient and in their experiences in order to ensure a good rapport, so that a patient felt safe about disclosing

experiences necessary to examine whether thought PE-PC is an acceptable intervention (Henriksen *et al.,* 2022). If the patient senses that the interviewer is surprised, disapproving, condemning or uninterested, they become unwilling to continue fully expressing themselves. Henriksen *et al.* (2022) acknowledges that empathy is an important characteristic in the way an interviewer relates to the subject. It will create an atmosphere that allows the participants to fully describe how they feel and potentially, to give a frank confession about their experience.

Furthermore, SSIs are an appropriate data collection method for this study because they allow for the use of open-ended questions so that patients can elaborate on their experiences and speak freely, giving them adequate time to reflect on their PE-PC experience. The use of SSIs gives researchers room to ask patients to elaborate and clarify when they need a better understanding. Henriksen *et al.* (2022) maintains that probing is necessary in an interview because a basic affirmative answer of either yes or no, is not enough evidence for whether a symptom is present or absent following a patient's description of their experience, as well as not enough to determine the participant's attitude to PE-PC as an acceptable intervention for PTSD.

Moreover, SSIs are an appropriate method for the data collection process because they were used to examine trauma survivors' experiences as they happened within the context of their personal and social world, which is what the research intended (Englander, 2020; Henricksen *et al.,* 2022). The explorative- and discovery-oriented approach taken by the SSIs allowed for interpersonal interaction between the subject and the interviewer (Henriksen *et al.,* 2022). For instance, it was important that while interviewing the PE-PC trauma survivors that the researcher engaged with them, instead of being simply an observer. Being ethical and mindful of the patient's presence and attitude is important for them to feel comfortable to give an accurate description and feedback on their perception of PE-PC.

In addition, the interviewer was required to not be judgemental, especially when they were addressing a socially vulnerable participant; instead, they must be interested in the patient and have an empathic attitude. Hendriksen *et al.* (2022) describe an empathic attitude as a distinct intentional act that allows us to be mindful and understanding of other people's mental states. This is crucial, considering the focus on a low-resourced community in Eastern Cape and the role, impact and influence that a resource-constrained environment has on post-traumatic stress disorder patients.

Subsequently, face-to-face interviews were arranged at times and dates that were convenient for the participants. An advantage of using SSIs was that the researcher was able to maintain eye contact and read into a client's body language cues which established rapport and allowed the researcher to make noteworthy observations. Participants were also asked to consent to the interview and the recordings prior to the interviews. Participants were also informed of their right to stop the interview at any point if they experienced distress. In addition, the interview schedule (Appendix A) comprised eighteen sub-questions divided into three main following sections: (i) cultural formulation-related questions, which helped the researcher understand how the participant understood their symptoms using cultural knowledge and how their friends and family understood their symptoms prior to PTSD diagnosis, such as "How would you describe your trauma-related difficulties from a cultural perspective?"; (ii) interview-related questions, that focused on understanding the participant's experiences and perceptions of PE-PC as a treatment for PTSD in Makhanda, such as "Would you recommend PE-PC for PTSD to other patients who have experienced stressful life events?"; (iii) and questions related to the participant's beliefs of factors they think had an impact on how they perceived PE-PC, such as stigma, discrimination, as well as resources they had at their exposure, for instance, "Do you worry about what others will think of you because of your PTSD diagnosis or treatment?". The interview guide used flexibility to allow for an interaction between the researcher and the participant; though some questions did not focus on the main research questions, they gave the researcher the liberty to understand, relate and empathise with the participant in order to comprehend their experiences of the treatment.

Furthermore, all interviews were conducted in 2023. Most of the interviews lasted at least 30 minutes, and depended solely on participants' willingness to share their experience of the PE-PC intervention for PTSD with the researcher. In addition, the researcher recorded all interviews that were then transcribed verbatim to ensure that the researcher was able to fully understand the data by re-reading, in order to minimise interviewer bias and increase trustworthiness. The researcher also took notes during each interview to act as visual cues of their primary understanding of the data collected during the interview. Given the extent of detail provided during the interview, there were no follow-up interviews required.

However, the limitation of SSIs as methods of data collection for the current qualitative study is that they require adequate knowledge from the interviewer on phenomena (Henriksen *et al.,* 2022). Another limitation of using SSIs that the researcher experienced during data collection is that patients seemed unsure of how to answer some of the questions because they

considered them too open-ended and had less time between questions to consider their responses, given the duration of each interview, the translation and/or the clarification time. This challenge was evident when some participants asked for clarification of the question, even after much deliberation, to ensure questions and concepts were simplified.

4.6 Rationale for using Reflexive Thematic Analysis

The data analysis method selected for this study was reflexive thematic analysis (RTA), an interpretive analytical method of qualitative paradigms (Campbell *et al.,* 2021). Comparing thematic analysis to other qualitative methods of analysis will further provide insight into why RTA was the most appropriate method. Interpretive phenomenological analysis (IPA) can be considered an appropriate methodology for this study, considering that its guiding theoretical framework focuses on understanding and interpreting how human beings experience and make sense of the world, using interviews to collect a first-person account of personal experience, (Umil *et al.*, 2023). However, IPA unlike TA focuses on the analysis of each case prior to developing themes, which is not relevant for this study, considering the aim is to have an overall understanding of whether PE-PC will be considered an acceptable treatment for PTSD in a low-resourced community in the Eastern Cape. In addition, IPA is usually conducted on a very small sample and tends to be more time consuming, yet relatively determined to produce the same results as RTA, which justifies why RTA was selected for this study. The other reasons that justify using RTA was that this study was not merely focused on participants' experiences and meaning-making process, but the acceptability of PE-PC. The sample was larger than N = 10, and the analytic focus was on acknowledging themes across the data set as opposed to the unique features of individual cases (Braun & Clarke, 2021).

Similarly, grounded theory (GT) like RTA focuses on lived experiences. Braun and Clarke (2021) argued that GT focuses on the creation of meaning and social order through human actions and interaction. However, the decision to use RTA instead of GT for this study was based on many reasons, including that considering the limited time set to carry out this study, RTA is less complex and includes clear and fewer procedures compared to GT, as well as the sample being relatively small and homogenous (Braun & Clarke, 2021). Comparably, discourse analysis (DA) unlike RTA, conceptualises language as a social practice that brings things into reality as opposed to simply reflecting participants' thoughts and feelings. Therefore, the reasons for choosing RTA over DA are justified by the idea that the research aims and questions were not based on the effects of language. Furthermore, DA procedures

unlike RTA are less practical and tend to be based on ideas as opposed to practical guidelines (Braun & Clarke, 2021).

4.6 Data Analysis method: Reflective Thematic Analysis

Braun and Clarke (2019) acknowledge that the thematic analysis approach has since expanded and developed since the early 2000s, when they started writing on the method of analysis. Therefore, this section of the thesis will explore the new developments and shifts that have been identified by Braun and Clarke (2019; 2021) in order to understand RTA. Braun and Clarke (2021) conducted a study to improve the qualitative quality criteria of TA, in order to support researchers and investigators in conducting cohesive and excellent TA and on how they can avoid potential bias while conducting their analysis process. Braun and Clarke (2021) achieved this by utilising ten problematic scenarios and assumptions. For each problematic practice, the authors provide complementary appropriate practices and guidelines for assessing the quality of thematic analysis in the form of critical questions necessary for the evaluation of TA research. This study has covered only a few that are fundamental to understanding the method and its characteristics, in line with why reflexive TA was an appropriate method for this research.

Some problematic assumptions and misunderstandings that were crucial in avoiding bias in this study, include the idea that there was an inadequate engagement with the theoretical assumptions that underpin the procedures with the overall quality of the study discussions. That is, there was the assumption that choosing to conduct TA meant that we emphasised procedures over reflexivity and theoretical sensitivity; where we were dependent on concrete rules, instead of allowing flexibility within the research (Braun & Clarke, 2021). This completely opposes and critiques the intention of sound reflexivity of the researcher. Brauna and Clarke (2021) challenge this assumption that TA prioritises proceduralism, by arguing that theory is a significant part of TA. In order for researchers to successfully implement and carry out procedures, they need to understand the underlying philosophical assumptions, as well as emphasising that simply following the steps in TA does not result in good TA. Therefore, the authors go forward and outline the different forms of TA, which portray thematic analysis as an umbrella term consisting of several methods; for instance, the underlying philosophical assumption of TA, is embedded in the subjective role of the situated researcher in knowledge generation, as examined later in this section.

In addition, there is a misconception that TA is primarily descriptive; that is, assuming that patterns taken from a dataset using TA are simply phrased, summaries and low-level interpretations, in comparison to other theories and methods of analysis; thus justifying the suggestion that TA should be combined with other methods that offer high-level interpretations. Braun and Clarke (2021) discredit this misconception, stating that descriptive analyses require the researcher to be objective and interested in the participant's voice. The reflexivity of the researcher reflects that they are positioned and situated, actively ensuring that they understand and report data from the lens and perspective of the participant's cultural, social, historical and ideological perspective (Braun & Clarke, 2021). Therefore, the researcher is required to remain sensitive by showing empathy to the participant by identifying the power-dynamics and cross-cultural differences that may potentially influence the researcher or the participant. Braun and Clark also challenge the problematic practice that TA is only a data reduction method; that is, the passive voice that is adopted by positivist-empiricists, which appeal to the objective scientist, will take away from their responsibility of interpreting a participant's account. Furthermore, as mentioned above, assuming that TA is a low-level descriptive method hinders the multiple possibilities held by RTA; for example, the ability to give deep interpretations (Brauna & Clarke, 2021). The authors also postulate that the depth of interpretation is determined by the analyst's skills, and not the TA method.

Another problematic practice that can help to understand TA, is the confusion between codes and themes; though the two terms are used interchangeably, the process of coding is explained as a process of assigning data to pre-established themes (Braun & Clarke, 2021). A code is considered a unit of analysis used to create initial themes, and these units of analysis can be grouped by similarity, and form concrete, complex and intricate themes. Therefore, codes and themes play significantly different roles in the process of analysis. Similarly, the other problematic practice that gives a clear insight into RTA is the confusion between themes and topics. Braun and Clarke (2021) conceptualised a theme as patterns of shared meaning that are unified by a central common concept or idea. Topics are simply discussion points on particular phenomena, and themes have a central concept and shared meaning. Thus, it is important to know the distinction between these notions as conducting RTA requires an adequate understanding of how to code and how to develop themes from the codes.

With reference to the above, the researcher has addressed some of the misconceptions that TA is not suitable because it lacks sophistication and that it is an atheoretical descriptive method. Addressing these problems also reflects how quality will be prioritised and bias

avoided in this study. Subsequently, RTA is a revised version of TA that focuses on the reflexivity of the researcher, theoretical assumptions, the guiding of the research question, and flexibility (Terry & Hayfield, 2020; Braun & Clarke, 2021). That is, RTA is a distinct approach informed by certain values and assumptions of qualitative research methodologies that prioritise the significance of the researcher's reflexive engagement with theory, data and interpretation, as well as the subjectivity of the researcher as an analytic resource (Braun & Clarke, 2021). According to Terry and Hayfield (2020), ever-increasing engagement with the data through the lens of a researcher's theoretical perspective, ensures rigour and quality in analysis.

Braun and Clarke (2021) classified TA methods into three broad types. First, coding reliability approaches, where the subjectivity of the researcher is considered as biased and as a potential threat to coding reliability. It can be controlled by several coders measuring the level of agreement and deciding the final coding based on consensus (Braun & Clarke, 2021). Second, the reflexive approaches that focus on later theme development, where themes are developed from codes and identified as patterns of shared meaning. These are based on a common concept, and acknowledge the process of coding as subjective and a way used by the researcher to deepen their understanding of the data. Lastly, the codebook approaches are a combination of the two approaches; it is used neither for the purposes of determining the accuracy nor the reliability of coding but to keep note of the developing analysis (Braun & Clarke, 2021). This study used reflexive approaches to make sense of the data, because they are based on the qualitative values framework that focuses on the subjectivity of the researcher as a significant resource for research, as well as considering meaning and knowledge as partial, situated and contextual (Braun & Clarke, 2021).

Furthermore, Braun and Clarke (2022) argue that RTA's emphasis on the subjectivity of the researcher and of data interpretation is identified as integral to the analytical process and not problematic, as positivists would note (Campbell *et al*., 2021). In addition, emphasis was given to latent (interpretive) level themes instead of semantic (descriptive) level themes. The former was considered appropriate to address research questions and aims, considering its ability to go beyond what is said, and rather depict underlying assumptions, ideas, and conceptualisations, whereas the latter identified and summarised the content of the data and acknowledged surface meaning (Campbell *et al*., 2021). The flexibility of RTA as an analytic strategy reflects how it can be adopted with different theories within the qualitative or interpretivist paradigm.

Subsequently, RTA prioritises the researcher's subjectivity, which is acknowledging the part played by the researcher in the formulation and generation of knowledge (Joy *et al.*, 2023). RTA is robust and accessible for instigating understandings of patterned meaning across a qualitative dataset. Joy *et al*. (2023) further argues that RTA s is used to unpack a dataset in a manner that generates compelling, and deep insights, giving meaning to identified patterns. The central meanings that a researcher discovers will formulate themes to summaries and ideas within the dataset. Unlike the quantitative methods that focus on the positivist idealisation of objective researchers, RTA allows for practice that is informed by the subjective values of a situated and thoughtful researcher who provides contextual data (Joy *et al*., 2023).

Given the above, RTA was an appropriate analytical method for this study on the grounds that it can be established within various conceptual and theoretical frameworks (Joy *et al*., 2023), together with its ability to address a wide range of questions. As mentioned above, researcher subjectivity is a critical notion of RTA; that is, the researcher of this study successfully situated herself in the research, by being a part of phase of the study. Joy et al. (2023) indicated that the researcher's position was far from the distant unbiased observer that is advocated within the positivist paradigm. The emphasis of researcher subjectivity in RTA is consistent with the notion that meaning is contextual and situated. This was apparent as the researcher continuously attempted to test and refine the process that resulted in meaningful, conceptually-driven themes. Thus, Joy *et al*. (2023) alluded to the interrogative process of RTA, which allows researchers to examine what they are contributing to the existing knowledge on certain phenomena, by being critically involved with research choices, values, and processes.

In addition, the notion of reflexivity in RTA was also a strength in the sense that the introspective role of subjectivity of the researcher allowed them to constantly reflect on their values, while recognising, examining and seeking to understand how their social background, assumptions and location affect their research practice. Levitt *et al*. (2017) argue that the concept of methodological integrity, research designs and procedures must be appropriate to address research problems, aims and questions. Thus, RTA was appropriate for this study, as it prioritises the accuracy and reliability of data, which was crucial because the results of the study were based on the verbal feedback of participants' perceptions and experiences of PE-PC.

4.7 Data analysis procedure: Six-phase process of RTA

In order to maintain the integrity of the RTA method, Braun and Clarke (2021) use a six-phase processes to identify and develop patterns of meaning across a dataset and guide researchers in the processes of coding, engaging with data, and developing themes. It is important to note that these phases are not linear, considering their qualities of being fluid and flexible, which makes the analytical procedures recursive (Joy, Braun & Clarke, 2023). That is, the founders of this method encourage the process of going backwards in reflexive TA, as an indication of thoughtful re-engagement.

Evidently, the process of analysing data for this study started when the researcher began to search and identify patterns of meaning, similarities and differences, and elements of potential significance and interest, within the data set; from printed interview transcripts, notes and audio recordings, following the completion of each interview. This reflexive thematic method of analysis allowed room for a more recursive process of constantly moving back and forth between the data set, the coded extracts, and the report, with consideration to the time difference between each interview (Braun & Clarke, 2010). Thus, the theoretical approach adopted by this study required constant re-engagement with the literature, for the purpose of enhancing analysis by sensitising the researcher to nuances and features within the data (Braun & Clarke, 2010).

4.7.1 Data familiarisation and writing familiarisation notes

Joy *et al*. (2023) depicts familiarisation as the process through which the researcher becomes intimately acquainted with the raw contents of their dataset, in order to be familiar with the depth of the content from interviews to gain a holistic viewpoint of the material. According to Braun and Clarke (2021), this phase happens throughout the process of analysing the data; it involves reading and re-reading; reflecting; questioning; imagining; wondering; writing, and noting down initial ideas. Prior to this phase, the researcher had to self-examine and understand how their personal biases may influence or impact the research process (Campbell *et al*., 2021). That is, before engaging with the data set, the researcher acknowledged their positionality, including the location of the Joza community and Rhodes University. Cognisance needed to be taken of the language they intended to employ and the potential use of a translator, as most participants understood only isiXhosa. The iterative process required the researcher to acknowledge these factors and ensure that they practised reflexivity and eliminated any biases or assumptions they held regarding PTSD or PE-PC.

The procedure of becoming familiar with the dataset included the re-reading of transcripts, which allowed the researcher to start looking for patterns and meaning within the data. The researcher, by note making during interviews was able to capture questions and thoughts for significant meaning within participants' accounts. Campbell *et al.* (2021) argues that reflexive discussions must be had throughout to ensure the successful observations of power dynamics and situations of privilege, while going through the dataset. The researcher took notes during each interview and also used printed transcripts to re-read and become familiar with the data and observe emerging patterns.

In addition, in phase 1, the researcher initially had the audio recordings transcribed from the verbal data from the interviews into written form, which she found effective by familiarising herself with the data, while producing verbatim statements to ensure thoroughness and rigour. Going through the transcripts and recordings prior to coding the data was a crucial part of the analytical process, even though it was time consuming. Thus, ideas of potential patterns with the data set started to formulate from simply reading through the first time (Byrne, 2022; Braun & Clarke, 2019). Therefore, before the researcher began to formally code the data set, they started taking notes, making a list of ideas as they came up and highlighting concepts and notions that stood out. Braun and Clarke (2010) attest that the processes of conducting RTA are a combination of interpretative acts from which the researcher created meaning, carefully considering and immersing themselves within the data. Thus, this process allowed the researcher to gain a thorough understanding of the data and was able to begin imagining how the participants' responses would address the research questions.

4.7.2 Systematic data coding

The process of coding was fundamental to the development of themes (Popat & Starkey, 2019). Generating codes at this stage was a way to organise data into discretely identified categories with similar meanings (Joy *et al.,* 2023; Popat & Starkey, 2019). This would usually be in the form of sentences, words, phrases or paragraphs or in the form of succinct, analytically meaningful description of code labels. The codes are used to capture broader meanings that summarise particular notions and ideas. It is fundamental that the researcher continues to refer back to the research question in order to ensure that participants understand what the data set is telling them in relation to their questions. Braun and Clarke (2022) acknowledged that coding in RTA is not merely a process of identifying; instead, it is a process of interpretation which is enhanced by the researcher's subjectivity. Joy *et al.,* (2023) emphasised that the process of coding is open and organic, as it can be refined and enhanced

as the researcher's understanding evolves. The interpretive depth and reflexive theoretical underpinnings of RTA, allow for adequate time to reflect, deep engagement and insight into the data. This results in good quality coding and sound theme development (Braun & Clarke, 2022).

In phase 2, after identifying interesting ideas from reading and re-reading the data set, the researcher began to formulate initial semantic and latent codes to determine which data they could examine in a meaningful way. They coded data by highlighting and making notes while re-reading transcribed data, which they kept referring back to when they were making tables and maps. In addition, they manually made use of sticky notes to illustrate how and what particular data extracts were coded for and how data were organised into meaningful groups. These groups would represent different categories and ideas they found interesting would be mapped, as well as highlighting elements that stood out; this is was done manually. In order to code all data extracts, the researcher copied them from participants' transcripts to ensure that the context was not lost. As will be seen in Appendix B some data extracts were coded more than once under different units of analysis. As will be outlined in the procedure for the third phase, themes that were formulated were theory-driven, on the grounds that the researcher engaged with the data with specific questions in mind that they intended to code the data around. In addition, establishing tables created a systematic method, ensuring that the researcher paid equal attention to the entire data set, thus allowing them to practise the iterative process of referring the data set in order to effectively build, refine and improve interpretations and evaluations made while coding the data. Repeated patterns were sought with the data items that formed base and foundation of possible themes (Popat & Starkey, 2019).

4.7.3 Generating initial themes from coded and collected data

This phase occurs when the researcher actively creates and develops themes, by organising codes generated from the previous phase into themes by generating clusters that are distinctive, yet relevant and interesting. According to Lindgren *et al.* (2020) themes are multifaceted structures that revolve around a central idea that the researcher established in order to address the research questions. In this study, the researcher made use of tables and maps to indicate how initial codes interact with one another, and to illustrate how themes would be generated. The use of tables and maps during the process of developing themes allowed the researcher to acquire clarity and logical order, as well as avoiding being overwhelmed. Consequently, the researcher was able to take time away from the project in between analysis which allowed for ideas to permeate organically, without the pressure of writing, so that the codes could be simply

embraced and revisited. Joy *et al.* (2023) refer to this constructive process as "generative interregnum".

Furthermore, the third phase was where the interpretive analysis of the data took place, when the researcher developed broader themes based on arguments and premises that pointed to the perceptions and experiences of PTSD patients who received PE-PC in Makhanda (Braun & Clarke, 2022). This phase began after the researcher had initially coded all the data into categories that were combined to form overarching themes and the sub-themes. Here, the researcher used thematic maps to provide a visual illustration and to justify how they grouped different codes together and how codes formulated different themes. The thematic maps were created at this point, to consider the relationship and differences between codes as shown in Appendix C. Braun and Clarke (2010) recommend the use of thematic maps as a way of conceptualising the different data patterns and the relationships between them, as well as identifying any accounts that seemed to be significantly different from the dominant concepts emerging from the data during the process of analysis (Braun & Clarke, 2022). It is important to note that there were codes that neither created main or sub-themes which resulted in the researcher creating a temporary theme named 'miscellaneous' for codes that did not fit anywhere. Thus, in this phase the researcher went through a process of combining, refining, separating and discarding themes that did not seem to clearly capture the meaning of the data and those that did not seem to reflect the aims, questions and objectives of the study.

4.7.4 Refining themes

Here the relationships between the initial themes were identified, with the intention of avoiding repetition and dividing themes into overarching themes that provided an overall understanding of the main message for each theme so that they were not duplicated. This was executed by reviewing the coded data, as well as the overall data set using quotations and codes in descriptions to demonstrate the theme content. The process of reviewing themes allowed the researcher to explore the validity and reliability of the information obtained, and examine whether each theme portrayed a compelling narrative about the shared meaning of the data set and research questions (Braun & Clarke, 2022). This process also involved moving in between codes and themes, and mapping the links between the codes, in order to formulate the final themes.

As shown above, the process of generating themes also required the researcher to be iterative; the fourth phase was where potential themes that they had developed in the third

phase were refined by ensuring that the research questions were answered. This process involved discarding themes upon the realisation that there were insufficient data to support or justify the theme. This also involved combining themes that appeared similar and were supported by the same data. Phase four of conducting RTA was for the purpose of reviewing and refining themes, and was done in two distinct levels. Notably, reviewing data at the level of the coded data extracts, meant that the researcher was required to read all the categorised extracts under each theme and observe if they formed a coherent pattern. The second level entailed, that when potential themes did not seem to form logical sound patterns, the researcher needed to examine whether the theme was problematic or merely that the data extracts under it did not fit. Thus, the theme was only valid if it captured the coded data. The refinement of themes is illustrated in table 1 in chapter five.

Most importantly, the process of reviewing themes in phase four is to ensure the validity of each theme in relation to the entire data set (Williams & Moser, 2019). Apart from assessing themes to examine whether they worked in relation to the dataset, this phase also required that the researcher code any additional data within the themes that they had missed in the earlier coding stages. This also emphasised that the reflexive thematic analysis was an ongoing natural process. The process of refining and reviewing maps also led to discovering new themes, which required them to code for these generated themes that emerged as they were making maps.

4.7.5 Defining and naming themes

The last two phases allowed the researcher to refine themes and present arguments. Braun and Clarke (2019; 2021) recommend the use of appealing labels for themes as a way of expressing the core message represented by the theme. It is then the researcher's responsibility to write a detailed analysis that unpacks the descriptive phrases of the data. While some themes were re-done, others were completely rejected on the grounds that they did not project a compelling argument that addressed the research question. Therefore, this stage involved the construction and naming of themes in a way that captured significant aspects of the data set, as well as the themes that represented the data.

Therefore, the fifth phase of conducting RTA was on defining and naming themes. This was when the final refinement and conceptualisation of themes was done. The researcher defined and refined themes they reviewed as appropriate to present for their analysis and engagement in analysing the data within each theme (Braun & Clarke, 2010). The researcher was able to accomplish this by categorising themes into rational accounts supported by a

narrative. The most crucial part of this phase was to ensure that they captured the interesting elements of each theme in a way that illustrated how it tied into the broader story of the participants' perceptions and experiences of PE-PC as a treatment for PTSD; how these included their opinion on whether the treatment should be considered acceptable. The use of sub-themes was also very effective in ensuring that there was structure to complex themes, together with making sure that all elements of the themes that addressed the question were acknowledged. The researcher tried to use attention-capturing names for their themes, so that the reader understood what the theme might have been about without necessarily explaining. It also served the purpose of guiding them when they discussed and provided support for each theme.

4.7.6 Writing the report

The final report would entail giving a full story told by the data, by expanding beyond the basic descriptions and constructing arguments and premises that addressed and answered the research questions. It is also important that the researcher constantly referred back to the tables to ensure that the stories told aligned with the meanings of the themes. Furthermore, the researcher made use of compelling, vivid data extracts from the coded data to demonstrate the different characteristics of the themes in order to support the accounts and present evidence about the data and the meaning attached to them. The write-up was envisaged as a coherent account regarding the dataset that addressed the research question.

Therefore, after having refined themes, the final step was the write-up of the report, which was for the purpose of giving a full account of the complex stories that participants shared during interviews, and to portray how the information they provided helped understand different phenomena from their perspectives. In order to reflect on the validity of the study findings the researcher used data extracts as evidence to indicate a rational and interesting account of the participants' stories across themes and arguments that support how these themes connected to the research questions, thereby ensuring that the report was beyond mere description. This report will be done in the following chapter.

4.8 Limitations of RTA

Juxtaposing, created themes at an early stage of data analysis can result in simplistic categories (Terry & Hayfield, 2020). Braun and Clarke (2021) argued that RTA is not considered a theoretically informed framework, compared to other methodologies, such as GT, IPA, qualitative content analysis (QCA), and DA, which can be considered a limitation.

Though this notion is challenged by dismissing the ideology that TA is lacking in analytical power and sophistication, researchers have the autonomy to select which methodology is fit for their study. Although the study design is coherent because research methods, theoretical assumptions and methods are in alignment, other researchers still have hesitations (Braun & Clarke, 2020; 2021). Moreover, RTA is neither quick nor an easy process, because the need for nuanced analyses in order to develop complex, rich, and non-obvious themes require a lot of time (Braun & Clarke, 2021). There is also a limitation of this analysis method in the subjectivity of the researcher, considering that researcher bias might impact and influence the research findings. As much as there are ways to avoid bias, it is essential to be aware of the possibility of unbiased knowledge construction in RTA (Gan *et al.*, 2021).

4.9 Validity and reliability

As echoed throughout this chapter, the quality of this study was ensured through the different processes of the research. The researcher maintained the validity of the study by pre-testing different formats for interview questions, before they began conducting the research (Silverman & Marvasti, 2010). The researcher was also able to practise respondent validation during the interviews, repeating in a summarised form if they had understood what they said before taking note of it. This was very helpful when they were listening back to audio recordings, which increased the reliability of the interpretations made, and the methods used. The findings of this study were based on sound investigation and not only on a few carefully selected examples. This demonstrates that data were not used only to fit desired conclusions, but instead, addressed the research questions (Silverman & Marvasti, 2010).

In addition, the researcher carefully selected all the methods used to collect and analyse data in a manner that allowed them to evaluate how the selected strategies would best address the aims and questions of this study, in comparison to other methods which might have addressed the questions and aims of the study. This allowed the researcher to ensure that the reliability of the study methods and findings were properly managed. The reliability of this study was also enhanced by ensuring that all personal positions adopted by the researcher were supported by the research literature (Bui, 2013).

4.9.1 Rigour and Transparency

First, the researcher established investigative rigour by persistently engaging in a prolonged examination of the data and by substantiating occurring themes with verbatim quotations from the participants' accounts (Terry & Hayfield, 2020; Finlay, 2021). Second, in

order to provide the reader with clarity, the sections in this chapter have exhaustively provided detailed accounts of the step-by-step processes and procedures conducted by the researcher to collect and analyse data and provide textual extracts from the printed transcripts of participants' accounts of their experiences and perception of PE-PC for PTSD in a low-resourced community, as recommended by Braun and Clarke (2019). In addition, the researcher achieved coherence by employing the RTA, which aligned with the purpose of the study. Moreover, the researcher continuously reflected on the intersubjective dynamics between themselves and the data by submitting a thorough deliberation of their personal involvement in the research. They were also careful to maintain a reflexive position throughout the collection and analysis of the data procedures.

4.10 Ethical considerations

In order to protect the rights and privacy of participants, there are several ethical considerations that were accounted for in this research. That is, the research was carried out in accordance with the guidelines outlined by the Rhodes University Ethical Standard Committee (RUESC) and the study was adaptable to the Rhodes University's Policy on Research Ethics. Therefore, ethical approval was granted by RUESC – the Human Ethics (HE) sub-committee. The researcher only commenced with the study following the approval of the University's Research Proposals and Ethics Review Committee (RPERC) and the Humanities Higher Degrees Committee (HHDC). In addition the conduction of this study was approved by the Rhodes University Human Ethics Committee (RU_HEC) - (2020-1558-4720), letter of approval is attached to the thesis as appendix F. This study involved human participants; therefore, it was marked at a level of 'moderate' risk. The privacy and anonymity of clients was be protected by excluding their names, personal details, locations and any further identifying information, to ensure that participants remained unidentifiable, apart from what they chose to share in relation to their PTSD experience, diagnosis and treatment. As mentioned earlier, the participants' verbal consent was obtained prior to the interviews and consent was received from each participant to record the interview session. The informed consent stipulated the purpose, aims and significance of the research study, as well as informing the participants that their participation was voluntary; withdrawal was acceptable at any point of the interview without penalty. The consent questions informed the participants how the researcher would maintain confidentiality and anonymity and outlined the potential risks.

The 'moderate' risk level of the study required the researcher to pay particular attention to emotion, behavioural and/or cues of distress, such as anxiety, irritability, tears and/or

avoidance, displayed by participants during the interviews. The researcher practised sensitivity and empathy while engaging with the participants during the interviews as a strategy to manage participants' distress levels and help them to feel at ease. In addition, in order to maintain confidentiality, only the researcher, the supervisor and the transcriber had access to the data, which was privately stored on the computer drive, with access limited to the aforementioned persons. Furthermore, the transcripts did not contain information that made the participants identifiable. Lastly, the participants were debriefed after the interview regarding what the information obtained from the interviews would be used for, and the researcher ensured they left the interview feeling optimistic.

4.10.1 Distress Protocol

The sensitivity and vulnerability of the nature of the sample used for this study made it a priority to ensure that there were measures put in place to safeguard and mitigate potential risks to participants throughout the research process, (i.e., causing harm to their emotional well-being). Some of these measures included enquiring about counselors concerns regarding the well-being and safety of participants and having HPCSA registered counsellors in place to mitigate and manage immediate risks. Therefore, if participants advised counsellors that the processes of the treatment were distressing to them, the counsellors would then liaise with Dr Booysen the lead Psychologist on the program, for recordkeeping and additional support and guidance. In addition, the researcher also advised participants to stop the interviews at any point if they feel overwhelmed, as well as their right to access treatment after completion of the intervention and not think that they are not allowed to access treatment due to pending follow-up assessments.

4.11 Adverse event and mitigation

The researcher was responsible for contacting the participants who had received the PE-PC sessions and scheduling interviews at a time convenient for both the researcher and the participant. The researcher used their personal mobile phone as well as the postgraduate library landline to call and schedule participants for interviews. No record of these call was kept nor are they still accessible to the researcher at this point. Some clients simply did not respond to the invitation email, other participants postponed several times, and some responded after the researcher followed up.

An external transcriber was used to transcribe the interview data from audio recordings, however no Artificial Intelligence applications were employed at any point of the research.

Chapter overview

This chapter outlined that the interpretive nature of this study justified the rationale for selecting qualitative research methodology, such as purposive sampling, semi-structured interviews, and reflexive thematic analysis; to recruit participants, gather and collect data and analyse their findings, respectively. The chapter also projected the considerations accounted for, such as validity, reliability, rigour and ethics. The following chapter presents findings of this research study and a discussion section, with arguments and premises presented to make sense of the findings.

Chapter Five: Findings and Discussion

5.1 Introduction

The research topic sought to critically examine the acceptability of PE-PC as a treatment for PTSD in the low-resourced community of Makhanda, by closely investigating trauma survivors' experiences of the intervention. In addition, this chapter will explore possible barriers to PE-PC as an effective trauma-focused therapy in primary care practice. The findings will be synthesised in a manner that addresses the research questions using Braun and Clarke's (2022) Reflexive Thematic Analysis method. It will also discuss how these themes contribute to the existing knowledge gap in the literature on PTSD, regarding the accessibility and acceptability of treatments in low-resourced settings.

5.2 Results and Findings

Table 1 presents a summary of all superordinate themes and sub-themes.

Superordinate Themes	**Sub-themes**		
Lack and absence of social support.	Insensitivity of others towards the mentally ill.	Prevalence and effects of stigma and discrimination.	Loss of Community
Factors preventing trauma survivors from accessing EBTs.	Challenges faced by trauma survivors when seeking EBTs.	Limited resources in low-resourced communities.	
Lack of knowledge regarding mental health literacy.	Lack and absence of mental health promotions and campaigns.	Challenges conceptualising trauma experiences and symptoms from a cultural perspective.	
Adaptation of a brief trauma-focused therapy programme in a low-resource community.	Experiences of PE-PC.	Reduction of PTSD symptoms following PE-PC sessions.	Increased mental health awareness.

Theme 1: Lack and absence of social support

Sub-theme 1.1 Insensitivity of others towards the mentally ill

The insensitivity of the community was a repeated theme during the interviews with the PE-PC participants which was evident through how participants expressed how they constantly felt alienated and isolated in their own respective communities. The researcher discovered this from participants' responses to the interview question on factors that were of a major concern for participants that made their symptoms and experiences with PTSD significantly worse. For instance, when asked what made their PTSD experiences worse, participants responded that whenever they let people know of their diagnosis, they were made to feel inferior, "That makes me feel stupid and unworthy and a failure. It makes me feel really horrible about myself," (Participant 05) and "Most of the time, I feel like they are saying, get over it and that offends me the most because are you trying to say I'm dumb or something," (Participant 05). This is reflective of how their feelings were dismissed because the people they trusted to help them did not consider how difficult it was for them to experience trauma, and instead, made them feel as if it was better to not communicate at all.

Similarly, most of the participants who were interviewed indicated that what worsened their traumatic experience was the lack or absence of substantial support systems. Participant [06] who had been raped at home by her cousin, attested that she "had difficulties relating to people and constantly felt paranoid in anticipation of the same event repeating". They also added that they did not feel as if their families and friends were understanding of their experience and how it affected them. Consequently, this made them unable to open up to them because they felt that their experience was being undermined. The absence of social support is also evident through several expressions made by the participants in response to the kinds of stresses that made their trauma worse. Participant [04] said it was difficult making friends once they discovered they, the participant, had been diagnosed with PTSD or when they witnessed one of their panic attacks. They admitted that opening up about mental illness can "change people's opinions of you very fast". Therefore, Participant (08) who went through consistent emotional abuse in foster care and Participant (10) who witnessed gun violence, expressed having to "hide events that happened to them" because they believed their community would judge them instead of offering support.

Sub-theme 1.2 Prevalence and effects of stigma and discrimination

The results of this study demonstrated that people with psychological disorders are considered irrational, which is evident by how the members of the community are insensitive to trauma survivors. This is further portrayed through interpersonal, structural and intrapersonal stigmatisation and discrimination; characterised by discriminatory behaviour, derogatory labels, ignorance and prejudice at community level.

Furthermore, interpersonal stigmatisation was mirrored through the negative attitudes and perceptions against trauma survivors, which was evident through the accounts given by the PE-PC participants. Participants opined that their families and societies were insensitive towards their PTSD diagnosis and symptoms, because they were constantly feeling misunderstood and not validated. When participants were asked what they thought their family, friends and community members believed was causing their symptoms, with or without knowledge of their PTSD diagnosis, they expressed that most people did not understand and instead misconceptualised their experiences. This was as a result of the stigma and discrimination towards psychological disorders. Some of the responses illustrate that participants experienced stigmatisation and felt that they were not validated, resulting in not seeking treatment earlier. Participant (04) responded that "There was a time when I was veered away from getting help because I just felt like no one fully understood me and what I was trying to tell them; I just felt lost in translation," Participant (05) said "They already got a perception that this person's crazy" and Participant (06) who expressed that "There's always a subsequent labelling that follows" when people learn of their diagnosis. Therefore, the way the participants conceptualised the society's reactions to their symptoms was perceivable of the notion of the other, which was evident of interpersonal stigmatisation and discrimination against the mentally ill. Consequently, several participants alluded to the fact that their PTSD symptoms were also exacerbated by their close family members.

In a review by Kapungwe *et al.* (2010) the authors argued that more often than not, families discriminate against and abuse their relatives who suffer from psychological disorders. This is very disheartening to consider how an environment where they are supposed to receive support and protection, is commonly where their symptoms are heightened and maintained because they are considered a burden with whom families do not want any association. The segregation of the trauma survivors by their family members was evident through the participants' responses to aspects of their background that were of concern to their making a difference to their trauma experience. Participant (03) responded "My parents pretty much

consistently, emotionally abused me" and added that "another thing that would remind me is whenever the holidays would come up, that would mean I have to return home to my family which also stresses me out". Therefore, without EBTs to support trauma survivors within uninterested, uncaring families and communities, participants' symptoms will continue to worsen.

Sub-theme 1.2.1 Structural stigmatisation

In addition, structural stigmatisation and discrimination calls attention to the debilitating state of mental health systems in LMICs, especially in low-resourced communities. As illustrated in chapter one, low-resourced settings are permeated with limited resources, including a lack of enough trained mental healthcare professionals to administer interventions. The neglect of mental healthcare issues by the government, is instrumental to the structural stigmatisation experienced by trauma survivors. Furthermore, structural stigmatisation of trauma survivors is also apparent through conscious and/or unconscious bias, by way of illustration, in showing no interest towards trauma survivors' background, therapeutic pessimism, labelling, and giving inadequate information on the diagnosis or poor-quality psychiatric treatment. Arguably, the delays in diagnosis, overlooking comorbid mental health disorders; unequal distribution of resources for mental health, and the unwillingness to treat physical illness in patients with psychological disorders, also indicate healthcare professionals' structural stigmatisation (Javed *et al.*, 2021). Therefore, this was depicted by participants who expressed that they had not received any form of therapy or counselling prior to PE-PC, despite having severe PTSD symptoms that negatively impacted their quality of life, because people overlooked their experiences, and no one recommended that they seek treatment.

This is evident through some of the participants' responses to the question of their access to TFTs, following their PTSD symptoms. Participant (04) expressed that "I think a lot of communities are damaged because of people not being able to seek the care that they need, when it comes to their mental health" and went on to say "not everyone has that opportunity; not everyone has those resources available to them". Participant (02) also expressed that "There're so many people in low-resource communities who ja, suffer from PTSD, but they can't recognise one, and they don't know how to treat it, and as a result, you just have generations of traumatised people". This signifies that participants residing in low-resource settings experience marginalisation on account of being unable to identify their difficulties and symptoms following exposure to trauma. Moreover, being aware that the communities they reside in, have no resources available to help them, people overlook trauma as not as serious

as other psychological disorders. This is apparent through participant (09) who said "Pretty much most people think it's only acceptable for very extreme forms of mental disorders, not something like trauma or other such things; those are seen as things you must just tough it out."

Subsequently, structural stigmatisation encompasses discriminatory legislations, policies and social structures and inadequate quality of mental health services (Javed *et al.,* 2021). Thus, the minimal government or structural support for mental health disorders in LMICs; the absence of mental health infrastructures within resource-constrained settings, such as Makhanda; the limited funds allocated to mental health per year, and the absence of substantial mental health laws and policies in LMICs, is evident of structural discrimination and stigmatisation of people suffering from psychological disorders. Therefore, this shows structural stigmatisation as governments are failing to equally distribute resources, update laws and policies that are unable to protect trauma survivors' rights, and take advantage of the fact that patients have no direct voice to change the law themselves.

Furthermore, participants' perceptions and understanding of trauma, as a result of the influence of their communities' beliefs, have also shown to be a manifestation of intrapersonal stigmatisation, where participants overlook their symptoms and undermine how exposure to trauma can have significant implications for their life. Intrapersonal stigma refers to stigmatisation at individual level, where a patient internalises stigma and the negative beliefs about themselves and conforms to the stereotypes and shame they are subjected to, based on their psychological disorders. In addition, self-stigmatisation is also a consequence of being terrified by the idea of being an outcast within their respective communities and families because having a psychological disorder is considered taboo (Javed *et al.,* 2021; Mascavano *et al.,* 2015). Intrapersonal stigmatisation can be observed when participant (03) said "I felt like I was gatekeeping my own access to therapy and also for a while, I didn't even consider that I was traumatised". Another trauma survivor said they never thought to seek treatment because they "just didn't think I was traumatised or traumatised enough" (Participant 08), and "assumed that the only way you can really get through is if you acknowledge that it has happened and move on" (Participant 09). Therefore, self-stigmatisation prevented the participants from seeking and accessing treatments.

Topper *et al.* (2015) presented similar findings by highlighting that most trauma survivors who sought help were older people who received a salary, and TB patients who already had a *bona fide* medical condition and did not fear being stigmatised for PTSD

symptoms. This supports the misconception of needing money to access treatment, as mentioned by 7 out of 10 participants from the current study who delayed accessing TFTs due to financial restraints, and participants who expressed prior hesitation to seek treatment for PTSD because they had feelings of shame and feared being stigmatised. Therefore, similar to the findings of Topper *et al.* (2015), participants expressed how concerning it was that financial challenges, stigma and mental illiteracy could reduce the number of people who were likely to seek mental healthcare in low-resourced communities. Thus, this bears testimony to the participant who expressed not accessing treatment because they assumed their symptoms did not require treatment; that they would get better with time, and also acknowledged that it did not stop them from developing PTSD. Sripada *et al.* (2022) also reported that low-income individuals are less likely to receive EBTs, which shows the urgent need to enhance PTSD treatment delivery in underserved areas.

Sub-theme 1.3: Loss of Community

Unlike some Western societies that prioritise individuality, non-western societies are often commended for their collectivist beliefs and sense of togetherness (Khalil, 2024). However, Tran *et al*. (2024) argued that many studies conducted in LMICs, particularly within resource constrained settings, continue to portray the isolation of people with psychological disorders, which is ironic considering that they are the most vulnerable, in comparison to others and require constant emotional support. This is reflective of how these communities have a biased perception and limited understanding of how their negative attitudes impact people with psychological disorders, by maintaining their symptoms and heightening the prevalence of CMDs, such as PTSD (Jana *et al.,* 2023).

Thus, when the participants were asked the kinds of factors that made their exposure to a traumatic event and PTSD symptoms unbearable, participants stated that they constantly felt isolated and alienated in their respective communities; that they had to keep their diagnosis and symptoms to themselves, because of the fear that they would experience loneliness, as their community would start to distance themselves and avoid any association with them. For instance, the participants, when asked if they were concerned about what people would think of them after learning of their PTSD diagnosis, one convincingly exclaimed “Um yes, so I have hidden it, just a fear of judgement and I don’t know, just to seem normal and okay and again to fit in and not have people judge me for that specific thing that happened in my life ja, and

not to be pitied" Participant (07). Participant (09) who was also a rape survivor responded "I thought I had to hide these specific events that happened and what caused them. They're things I barely want to discuss, and I thought I'd be um, judged for my actions during those events."

Many other participants had similar responses, expressing the fear of being judged within their communities as a result of their PTSD diagnosis. This is reflective of how some collectivist communities are not supportive of trauma survivors, which in turn, heightens the prevalence of CMDs, and most importantly, calls for the provision of EBTs to be accessible. Conversations around creating support structures should be initiated, which would encourage trauma survivors to seek and access psychological treatment.

Conversely, a few participants said that they had friends and family members who supported their journey and encouraged them to receive some form of therapy as a way of coping with their traumatic experiences, and were willing to cover the costs. When asked what kind of support made their traumatic experience better, Participant (04) responded "My mom, for example, has made a conscious effort to understand therapy and mental health and um, has gone to therapy herself and taken steps to understand what mental health is in a general sense. So that's somebody who I always know will understand what I mean when I'm not feeling well". Participant (04) responded to the same question saying "I've got a very strong friendship support system, I think. Um, very, very strong, like we've always been like super encouraging to each other I think, in various aspects, like whenever we, whenever we feel that one friend is down, we hold that friend, like we all very caring to that person and when another person's down they get their moment". Thus, this is evident of the impact of social support and the difference it makes to the trauma survivors to consider their PTSD symptoms manageable. In addition, the contrast in the responses of the participants who indicated the absence of social support and stated that they had lost a sense of community, was noticeable. They sadly expressed that not having anyone to encourage them worsened their PTSD symptoms. Those who attested to having their family or friend's support, is an indication of how social support can help minimise PTSD symptoms, whereas the absence thereof prolonged and maintained their condition.

Theme 2: Factors preventing trauma survivors from accessing EBTs

Sub-theme 2.1: Challenges faced by Trauma survivors when seeking EBTs

Subsequently, this sub-theme demonstrates how denial and misconceptions of therapy contributes to low treatment-seeking, among trauma survivors in a low-resourced setting. This

implies that trauma survivors spend a long time in denial and avoid the idea that they have experienced something traumatic, by suppressing any thoughts and stimuli related to their trauma. This difficulty in confronting stimuli maintains the PTSD symptoms, such as social isolation, hypervigilance, self-destructive behaviour and emotional detachment. Thus, failure to confront stimuli delays patients' acceptance or realisation of the need to seek EBTs. Participants' avoidance and difficulty in confronting trauma can be deduced from their responses to the question of what strategies or coping mechanisms they have employed to manage their trauma. Participant (02) said "I've learnt to just completely disengage from… because they can be very distracting for me", and Participant (06) responded "I had been um, struggling with this for some time but just um, not wanting to entertain those feelings. So that that sort of like um, aggravated um, it is sort of like worsened it for me, because then I became even more … even more paranoid". Therefore, the difficulty in confronting trauma or admitting that they experienced something traumatic, is one of the challenges that PTSD patients evidently face when attempting to access TFTs.

In addition, most of the participants also expressed the misconception that therapy is expensive and a lack of knowledge regarding the availability of cost-effect treatments, such as PE-PC also contribute towards why trauma survivors decide to not seek EBTs. Participant (05) said that some of the factors that delayed their access to psychological treatment was "definitely money and the distance because I did want, but then only to find out that therapists are far away from me, and they are really expensive; you find that a session is R800 and I thought, ja, there you go. I can't do this because I don't have money and you know travelling is problem". Participant (06) said they had delayed seeking treatment as a result of "being uninformed and just thinking I have to pay for these services." Similarly, Participant (04) argued that time was a hurdle for them, in that it "made it difficult to like, just do everything that I'd like to do; get help when I say, when I think I need help. I think especially this um, this year being my final year, I feel like there's so much going on," and they had to prioritise other commitments at the expense of compromising their mental health. Moreover, avoidance among many other PTSD symptoms also plays a part in why participants did not seek treatment earlier. Participant (02) reported that attending to their trauma meant they could not attend to other commitments, "I had a lot of commitments last year and it felt like if I entertain this thing (their trauma) that's been bothering me, I'm gonna get into my feelings, and then I won't be able to show up for these things anymore". This shows how their PTSD symptoms worsened by delaying to

confront their trauma. The reference to their trauma as “this thing” is also evident of the element of denial and avoidance.

Sub-theme 2.2: Low-resourced communities

As deliberated in chapter 1, there are limited resources in low-resourced communities, such as a lack of mental health infrastructure and limited mental health professionals, which also contribute to factors that prevent PTSD patients from accessing TFTs. This is evident through Participant (02) who exclaimed “We don't have the best um, space for people with mental health issues”; that is, researchers struggled finding already established structures for mental health during phase 1 of the larger study in the Joza community. Though they were able to use the Assumption Development Care centre (ADC), the Joza clinic and police station to establish stations, from where counsellors could receive referrals, they faced a great deal of challenges as a result of a lack of mental health infrastructure in Makhanda. This was also evident by the limited number of people that the Rhodes University psychology clinic and counselling centre can see per time, with restrictions on the matters they address, and with only eight sessions per person in most cases. Thus, Participant (04) said “Not everyone has that opportunity; not everyone has those resources available to them”. Therefore, a critical gap within mental health practice in LMICs exists, particularly within resource-constrained settings, such as Makhanda.

In addition, there are very few trained and registered mental healthcare professionals in Makhanda, which means that there is always a backlog of people who are contacted to schedule counselling sessions. Participants commented that though they found the scheduling for PE-PC easy and flexible, they had challenges with accessing counselling with the counselling centre. In the worst cases, other patients never filled in forms because they considered their trauma as something not severe enough for the Rhodes Counselling Centre (CC) to schedule them. This is unfortunate considering that the Counselling Centre is the one avenue where students, who happen to be the majority of the Makhanda community, have access to psychological-based treatments, which is within a walking distance and is free.

Therefore, when asked how the process of scheduling PE-PC sessions went, most participants expressed not having any difficulties at all, by acknowledging that they “found the scheduling quite easy. I just mentioned my one free day in the week that I had, and they picked a slot in there that worked for me” Participant (03). Others said that when the sessions clashed

with other commitments, the counsellors were willing to reschedule or patients would prioritise the sessions. For instance, Participant (07) responded “Um, it was okay; it did clash a bit with practicals and so it did happen sometimes at the same time as my practicals, other than that we did change days”. Thus, the participants said that the implementation of a modified version of PE within low-resourced communities in primary care practice, would increase the accessibility and availability of a TFT in Makhanda and reduce the backlog of trauma survivors at the psychology clinic and the Rhodes CC. Participant (09) commented “I realised if I did this (PE-PC) sooner things might have been easier”.

It is imperative to note that the implementation of PE-PC happened within the Rhodes University setting and resources (i.e., the Psychology Department practical rooms were used to conduct interviews). However, the counselling and delivery of the PE-PC treatment did not take place in the traditional or conventional clinic or in the counselling centre, and in various seminar venues that still had privacy. Thus, alternative spaces were used to implement the counselling.

Theme 3: Lack of knowledge regarding mental health literacy

Sub-theme 3.1: Lack and absence of mental health promotions and campaigns

There is an absence of mental health literacy among people residing in low-resourced settings in LMICs, such as in South Africa. The existing psychological facilities in SA lack the capacity to provide the population in these communities with adequate knowledge (Sripada *et al.,* 2022). Though studies have highlighted that PTSD is most often detected in primary care, community mental health providers rarely have training in efficacious PTSD treatments, and community dissemination and implementation efforts have had mixed success. Thus, Sripada *et al*. (2022) emphasise that adapted brief EBTs for PTSD can improve treatment access and efficiency for low-resourced settings. This approach has the potential to improve the scalability of PTSD treatment by minimising the required resources while maximising effectiveness.

Most non-western societies’ populations define psychological disorders using traditional constructs and the dominant cultural explanatory model that influences society members to consider psychological disorders as a result of committing atrocities; self-infliction; being possessed by evil spirits or demons; being cursed, and bewitchment. This can be seen through Participant’s (02) response “I think a lot of people don't realise that they struggle with PTSD because people don't know what PTSD is”. Thus, despite the apparent prevalence of trauma in Makhanda and the increase in mental health conversations, there is

still limited mental health literacy; an absence of political prioritisation of mental healthcare; social marginalisation; low financial investment on mental health, and material poverty. When asked whether mental healthcare has become more common in conversations in low-resourced settings with regard to the creation of spaces and initiatives that allow people to openly talk about mental illness and welcome the idea of accessing EBTs, Participant (10) said "We definitely have not made enough progress; until people can say they need a mental health day, things aren't okay; we have not made progress". This shows that despite the preliminary interests shown by researchers to examine psychological healthcare at community level, there is still not enough knowledge regarding mental health because of the absence of promotions and campaigns to educate people residing in low-resourced communities.

Sub-theme 3.2: Challenges conceptualising trauma experiences and symptoms from a cultural perspective

The conceptualisation of mental illness in non-western communities, particularly in low-resourced communities, depicts limited knowledge and an absence of education regarding mental health and illness. This is apparent through the absence and the lack of positive conversations carried in resource-constrained communities regarding psychological disorders, such as PTSD. As shown under sub-theme 3.1, there are several misconceptions within non-western communities, on what causes mental illness and how to treat it. This could be seen by how participants hesitated and struggled to respond when they were asked to make sense of their trauma-related difficulties from a cultural perspective. For example, Participant (02) said "Our parents are still new to the mental health conversation", indicating how the senior generations, who are the backbone of the communities, still do not fully understand the concept of mental health, Furthermore, some participants acknowledged the lack of terms to conceptualise trauma from a cultural perspective, while others did not understand what the question was requiring them to say. This was evident through their asking for the interviewer to clarify, and still found it challenging to answer. The former is evident from the response from Participants (06) "So, from a cultural perspective, there's not, there hasn't really been um, I have yet to come across discourse where we um, define it in psychological terms and say that this…" whereas Participant (5) said "From my cultural background? ... I don't understand your question," and the latter by "Um, could you explain the question please". Therefore, in different words and phrases the participants echoed that within non-western communities, there are several misconceptions of mental health and illness, characterised by the need to substitute or integrate their notions with new ideas. Therefore, this sub-theme highlights how mental health

is understood across different generations, and how culture is applied to make sense of these experiences. Arguably, it highlighted how the senior generation has a specific lens different from the participants, due to the contemporary times the latter are living in.

Theme 4: Adaptation of a brief trauma-focused therapy in a low-resourced community

Sub-theme 4.1: Experiences of PE-PC

This thesis advocates that the outcome of acceptability is a significant element in the assessment of what determines the success of one treatment, and failure of another. A factor that suggests that trauma survivors accepted PE-PC as an effective treatment for PTSD in a low-resourced community, could be attributed to their willingness to recommend PE-PC to other trauma survivors, and participant satisfaction, as well as their compliance and adherence to the treatment. Some of the responses that fully captured the element and implementation outcome of acceptability, after being asked whether they would recommend PE-PC to other trauma survivors, Participant (05) responded "Definitely, I'd recommend it. I'm thinking of recommending it to someone else, actually. Because ja bra, if these sessions were there in 2021, maybe I would have been far with my journey right now of healing and stuff like that". Participant (05) expressed having wanted to experience such a treatment earlier, as a result of appreciating how their symptoms had significantly decreased. Participants (01; 03) said "I think this should definitely be adopted". In addition, a high compliance and adherence is evident by the participants who completed their sessions and requested additional sessions to the minimal four sessions. They commented that despite finding the re-writing of the trauma memory after every session challenging, most participants acknowledged that PE-PC was very helpful in minimising their PTSD symptoms (i.e., avoidance). Participant (08) illustrated this by remarking "After PE-PC, there was almost no concern; I could freely think about them without any form of guilt or getting upset."

In addition, though all the participants reported an appreciation of the writing activity, some participants expressed finding it challenging and time consuming, in that it appeared repetitive. For instance, Participant (05) said "These sessions are annoying [laughs]. I'm going to be honest, they are annoying but as much as that is the case, they are so helpful in ways that I can't describe you know, because you get to connect pieces of you that never really connected". In addition, Participant (06) also expressed an interest in having the sessions extended when they said "I did want to find out, if um, with the sessions...if there's an option to continue". However, the interviewed participants appeared to have managed to address their prior avoided thoughts as a result of the writing exercises, which indicated how the writing was

beneficial. Individual participants were able to reduce their PTSD symptoms and triggers. Researchers on PTSD treatments and therapies have argued that hesitation during exposure therapies is an indication of trauma and avoidance and can obstruct a trauma survivor's progress which is why counsellors administering treatment must focus on that and emphasise the importance of exposure activities (Van de Water, 2018). This was apparent as participants who said they found the writing annoying, also expressed that the writing allowed them to fully engage with the PE-PC treatment sessions and differentiate reality and trauma stimuli, when asked why the treatment was helpful. Therefore, it was reflective of how the emotional processing theory predicts that participants might initially perceive exposure procedures as distressing (Rauch, 2006).

Similarly, some participants reflected on the duration of the modified TFT, and expressed the wish for sessions to be more than 30 minutes, so as to give them enough time to complete assessments and be comfortable with their counsellor, as well as leave enough time to share their experiences. For example, Participant (02) said "I think we need more time [laughs], I think in almost every session I had with my counsellor, we went over time because 30 minutes is just not enough you know". In addition, Participant (07) also said "Maybe, if it were just a bit longer, just for like, just to get someone settled and comfortable enough to start the session, because, you only start to get comfortable maybe at a later stage and its already almost done". These reflections may be related to the participants' inability to express their vulnerability before feeling safe in an environment and receiving reassurance from the person with whom they are conversing. On the other hand, the same reflections can depict how time, during the sessions, was a barrier for some participants.

In addition, Participant (09) who is a trauma survivor of rape, was asked about what they found helpful from the treatment; they commended the unintentional assignment of a female counsellor to their case, which might be interpreted as a PTSD symptom of avoidance. Booysen and Kagee (2023) found that gender match in psychotherapy female rape survivors and female counsellors was not directly associated with treatment retention. This said, here it appeared to have contributed to the participant's positive experience with PE-PC and their willingness to robustly engage and complete the PE-PC treatment sessions. Moreover, they expressed a sense of safety during the treatment sessions and thereafter. Although this may suggest that gender difference in therapy can measure the acceptability of PE-PC and contribute towards the enhancement of treatment outcome, there is not enough evidence from this study to support that conclusion; it should be noted that Booysen and Kagee (2023) presented similar

findings. Furthermore, Sherwood (2001) found that recovery in therapy occurred when clients felt safe and supported in therapy, which was reflected in Participant 10's statement “gives more people open space to talk about their truth”. Therefore, participants expressed feeling understood because counsellors were closer to their age; consequently, they felt comfortable. Participants expressed symptom reduction as they no longer experienced distress when they relived or visited their trauma-memories.

In addition, in determining the acceptability of PE-PC, in response to how it would fill the critical knowledge gap in research and in practice, one can ascribe the acceptability of PE-PC as a treatment for PTSD in a low-resourced community. A participant excitedly recognised that the NSHWs were just as effective in administering psychological treatments as evident when they (02) said “I did have a like side thought the other day, though that maybe we don't always need the PhD graduates to be counsellors, you know; you guys are masters students [laughs] masters, honours, you know and for me, this was still effective”. Therefore, it appears there was approval of the implementation of PE-PC as an adoptable and acceptable TFT within primary care practice in Makhanda. This is similar to Van de Water’s (2018) findings that trauma-focused treatment procedures, implemented by NSHWs were perceived as helpful, and that warm therapeutic relationships result in the reduction of PTSD symptoms. Participants appeared to have experienced an emotional shift by how they expressed the improvement in their quality of life. Thus, as Booysen and Kagee (2023) argued, participants did not merely experience symptom improvement but also a sense of reclaiming their lives in various ways by having a different perspective on life.

Sub-theme 4.2: Reduction of PTSD symptoms following PE-PC sessions

Most patients attested that they no longer struggled with confronting their traumatic memories, and confirmed a significant improvement, after seeking PE-PC. This was apparent through Participant (02) who said “PE-PC was very helpful in understanding ‘what exactly is it about this thing that triggers me?’… It was also great in desensitising me to my trauma”. In addition, Participant (05) expressed that prior to accessing PE-PC their life “was a mess, especially with the symptoms of depression, sleeping nonstop, having headaches on a daily basis, not having energy”, and having to force themselves to do small day-to-day tasks, such as washing dishes, studying, and/or sleeping. However, after engaging with the PE-PC sessions consisting of *in vivo,* writing exercises and learning how to confront their trauma, their

symptoms decreased significantly. Thus, most participants mentioned that they did not find it as difficult as previously, to talk about their traumatic experience following the completion of the PE-PC intervention sessions. Participant (03) attested that following the PE-PC sessions their trauma "no longer caused me to cringe or to effectively spiral into anything. I could more easily come to terms with the rest of my trauma" and Participant (05) excitedly said that PE-PC "is really helpful. I can't start describing it, I can't, it's just … I'm happy I joined it, you know". Furthermore, Participant (07) also said that PE-PC was helpful because "it felt like I was being listened to for the first time; there was less judgement and more familiarity with my story" and added that "it would be helpful, especially for underdeveloped communities". Therefore, participants' feedback of their experiences with PE-PC indicated that they believed it should be implemented at community level to help other trauma survivors.

Sub-theme 4.3: Increased mental health awareness

Several participants indicated that they had noticed a significant decrease in the use of derogatory language or labels when referring to trauma survivors; that instead of the previously dominating rejection and ignorance, members of the community showed a willingness to understand mental illness. This was evident through the presence of people during phase 1 of the larger study, when researchers were visiting different location areas in Makhanda to conduct mental health campaigns and promote members of this low-resourced community to encourage anyone they knew suffering from PTSD symptoms. As a result of having indirectly or directly experienced a traumatic event, they were stimulated to seek psychological treatment by engaging with the PE-PC intervention. Therefore, the number of people who accessed PE-PC in Makhanda (as depicted in the larger study), reflected that patients were no longer as concerned about discrimination or being stigmatised, because they had developed an understanding that the negative attitudes towards trauma survivors was the result of an inadequate understanding of mental illness and the need to seek EBTs. However, the PE-PC campaigns provided people residing with information about PTSD, as a disorder that results from avoiding and suppressing trauma memories and replacing them with irrational fears, and how PE-PC was going to be used to treat PTSD. Therefore, it is imperative to note that the PE-PC promotions and campaigns were helpful in informing the general public of what PTSD was. This allowed people to add detailed information to their already existing knowledge, as well as help people understand how their fears and negative attitudes towards the people with

psychological disorders, such as PTSD, was a primary factor in the reproduction and maintenance of the stigma.

Correspondingly, although the participants feared stigma and lacked an adequate understanding of TFTs, they appeared to be open to seeking and engaging with PE-PC, a treatment for PTSD in a resource-constrained setting. For instance, one patient added that people should not wait until their symptoms became unbearable, and advised that instead, non-western communities need to normalise seeking therapy or counselling in order to "allow an uninvolved person to help them organise their thoughts and take back control over things that continue to prevent them from living their life" (Participant 10). In addition, patients admitted that they were now more open to seeking psychological treatments because of the mental health literacy that they obtained from the PE-PC project education campaigns. Furthermore, the prioritisation of integrating mental health into primary care in LMICs, such as in South Africa, particularly within low-resourced settings, such as Makhanda, is evident of how researchers are focusing on the implementation of anti-stigma interventions, which contribute to patients' willingness to seek EBTs. Moreover, participants attested that the processes of PE-PC allowed them to feel like co-facilitators of their sessions, referring to the process of writing and re-writing their experiences. They said they found this to be the most effective yet challenging aspect of PE-PC, in that it helped them reduce their PTSD symptoms by finally pushing them to confront their trauma memories. When asked if PE-PC was helpful, Participant (08) answered "These sessions you know, they expose you to your trauma that don't run away from it just think about it, go through it, feel it and accept it, then slowly, let go, you know" and Participant (05) also averred "You get to connect with yourself, the traumatised self of you, you know, in deeper details, not in trying to ignore that girl or that whatever that girl, that guy without running away from it, you know."

Consequently, the participants satisfaction with PE-PC can be identified through the participants' feedback regarding their experience of the intervention and their attesting to how PE-PC improved the quality of their lives, significantly minimised their PTSD symptoms and helped them claim their autonomy by helping them to start confronting places, memories, thoughts and any other stimuli that they were avoiding. Furthermore, patients reported not feeling guilty or blaming themselves for the traumatic event they had experienced and stopped associating every similar situation with their trauma. This was shown through what Participant (02) said "Like you start understanding that this was literally just a life thing that happened, you know, um, it's not my fault um; I don't need to make this now a barrier for the rest of my

life … I can heal from it and still live a full life". Therefore, it shows how treatment adherence also projects how PE-PC participants received this intervention for PTSD in a low-resourced setting. The researcher will use these themes to conclude on how the brief and modified version of PE could be helpful and beneficial, especially in underdeveloped communities.

5.3 Discussion

The main objective of this thesis was to examine the acceptability of prolonged exposure therapy at primary care level as a treatment for PTSD, using the Implementation Science framework, in a resource-constrained community in the Eastern Cape. By understanding how participants perceive and experience the treatment, will determine whether the results of the study suggest that PE-PC is an acceptable trauma-focused treatment for PTSD. Although in this study it can be established why some participants decided to dropout or withdraw from the PE-PC sessions, using dropout rates is a crude measure to determine the acceptability of PE-PC. The use of qualitative research in implementation science allows for interesting observations (Van de Water, 2018).

As was established in chapter 1 of this thesis, little is known regarding factors that hinder access to TFTs in low-resourced communities (Topper *et al.,* 2015). Results from this research depicted that contextual factors, such as stigma and mental health literacy impacted trauma survivors' experience of PTSD and treatment seeking. Participants expressed their fear of being stigmatised and discriminated, and their lack of adequate knowledge regarding mental health and illness contributed to why they delayed seeking treatment. Most of the participants reported that they believed people who are labelled as trauma survivors face negative criticism from their community and at times, family members, thereby isolating them with no social support when they required it most. This notion can also be seen in the context of the existing literature through authors who have investigated how stigma contributes towards a great deal of added issues.

Consequently, the cultural context within which participants and counsellors embed contextual and subjective meanings is also partially responsible for influencing the acceptability of PE-PC as a treatment for PTSD. It is important to note that conducting a research study in Makhanda, meant that participants' African foundation influenced their understanding of PTSD and its symptoms and essentially their willingness to seek EBTs. The study suggested that culture plays a role in how participants understand their experiences of PTSD and the idea of seeking treatment, which was illustrated by the different perceptions that

senior generations and young adults have on mental health and treatments. Mental health literacy among young adults in resource-constrained communities can be further identified by how culture becomes more complex as PE-PC participants view their experiences of PTSD from different cultural perspectives, compared to senior members of their families. This is evident through Participant's (06) response to how they are unable to find a discourse that explains their PTSD symptoms and experiences from a cultural perspective. They moved on to say that their parents were still new to the conversations on mental health and well-being. Participant (02) also indicated that parents are still new to mental health conversations. Similar to the findings of this research, Topper *et al.* (2015) reported that stigma and a lack of knowledge regarding the nature and treatment of mental illness were the most prominent barriers to seeking care.

Consequently, the evidence that PE-PC was experienced to be beneficial within Makhanda, a stigmatised context, reflects the urgency of the implementation knowledge to promote equitable mental healthcare for common mental disorders. Booysen and Kagee (2023) reported that experiences of EBTs are limited and that the overall treatment gap for common mental disorders in LMICs, especially in resource-constrained communities, is significantly high at 93%. Findings of this current study also indicated that the treatment gap in Makhanda and the absence of mental healthcare in LMICs, can be attributed to political instability, contextual and systemic challenges, limited healthcare infrastructure, and limited trained professionals. A participant sadly expressed how there has not been enough progress in South Africa regarding promoting access to mental healthcare for everyone. Therefore, the findings confirmed the effectiveness of using implementation science to increase the acceptability of psychotherapy in low-resourced communities.

Subsequently, in a study conducted by Booysen and Kagee (2023), these authors found that although there have been several TFTs developed to treat PTSD, there are limited studies on how trauma survivors perceive and experience TFTs, such as PE for PTSD, especially in LMICs. Although Booysen and Kagee (2023) found that trauma-survivors perceived and experienced PE to be generally beneficial for the treatment of PTSD, limited studies can be affirmed by the idea that the researcher indicated that, to the best of their knowledge, the current study is the very first to examine the acceptability of a modified trauma-focused treatment for PTSD in a low-resourced community in South Africa.

Participants also indicate that PE-PC was experienced to be beneficial for individual participants. This was evident through the participants' adherence to and satisfaction of the PE-PC treatments. It is therefore imperative to note that trauma survivors can benefit from brief TFTs that are administered by lay counsellors at community level within a stigmatised context. Evidently, considering the limitation of studies on how trauma survivors perceive and experience TFTs, this pilot study will hopefully contribute significantly to the literature on the acceptability of modified TFTs such as PE-PC in a resource-constrained community in South Africa.

Sripada *et al.* (2022) argued that though PE has been adapted for use in primary care settings in the US, to mitigate the challenge of psychological facilities lacking the capacity to provide patients with first-line, EBTs for PTSD, the effectiveness and use of PE-PC in low-resource settings is relatively unknown. Accordingly, feedback from the participants in the current study suggested that the PE-PC intervention was beneficial and filled a critical gap in PTSD services in low-resourced settings. This was evident through the number of participants who sought and attended PE-PC therapy, as well as treatment satisfaction by participants who attested to a significant reduction in their PTSD symptoms. Similarly, findings from Sripada *et al.* (2022) also suggested that PE-PC was a feasible and acceptable intervention for PTSD in low-resourced settings in the US, as a result of high rates of participation. Although PE-PC has demonstrated preliminary evidence of acceptability in a resource-constrained setting, there were certainly participants that reported that they required additional sessions, or more intensive PTSD treatment. This was apparent in participants who expressed that they required more than 30 minutes a session to settle in, and from those, some required an extension of more than the standard 4 sessions.

In addition, the relationship between the counsellors and participants was also a crucial factor in determining the outcome of the acceptability of PE-PC, as some participants stated that they felt at ease talking to counsellors and looked forward to coming to sessions. Thus, a positive working relationship, characterised by a counsellor's personal qualities such as, the ability to be genuine, accommodative, respectful and empathetic towards clients, enhanced the chances of patients' recovery and acceptability of PE-PC. Most of the interviewed participants acknowledged a comfortable relationship with their counsellors, which made their scheduling processes easy and established rapport; most participants said there were no difficulties expressing themselves, as a result of a good relationship with their counsellors. This factor also

contributed to why participants' perceptions and experiences of PE-PC were dominantly positive.

Considering that the purpose of the interviews was to understand participants' experiences and perceptions of PE-PC as a treatment for PTSD, societal conditions are also relatively significant for influencing participants' experiences of the intervention and the acceptability of PE-PC as a treatment for PTSD in Makhanda. The pervasive prevalence of rape culture and the high rates of violence in Makhanda, cause people to be more prone to trauma exposure and the likelihood of developing trauma. Swartz (2007) further stated that persons suffering from psychological disorders, such as PTSD, require individual attention and assistance in the form of psychotherapy before being directed back into society. Some of the societal conditions that might interfere with the PE-PC treatment efficacy and hinder acceptability include: deprivation; lack of adequate mental health services; underbudgeted public health sector; inadequately resourced health facilities; the frequent location of mental health professionals in urban areas; inaccessible mental healthcare for the population in resource-constrained settings, and chronic poverty. All of the above-mentioned have negative effects on people's well-being.

Therefore, although the implementation of modified TFTs, such as PE-PC, within primary care practice in low-resourced communities, such as Makhanda, remains limited. This is as a result of various contextual factors, such as stigma and mental health illiteracy, and may hinder the implementation of acceptable psychological therapies for PTSD. Finally, deriving from the experiences and perceptions of the participants (n = 10), the results of this study will hopefully contribute to the limited literature and knowledge gap on the acceptability of modified trauma-focused therapies for PTSD in South Africa. The findings also suggest that the complexities of culture influence how trauma survivors experience PTSD and how they perceive treatment seeking.

The findings suggest that the reliability of evidence for the implementation outcome of the acceptability of PE-PC was considerably high. The future direction of mental healthcare in low-resourced settings is a good indication of how researchers are interrogating methods to ensure the enhancement of mental healthcare at community level in resource-constrained settings. In order to encourage patients to seek treatments and invite collaborations and the input of Non-profit Government Organisations to invest in building mental health infrastructures, train NSHWs to administer psychological assessments, and provide resources

needed to ensure the availability and accessibility of the accepted interventions, such as PE-PC as a first-line treatment for PTSD. Thus, there is a realisation that public awareness and community sensitisation are effective strategies that should be employed in low-resourced communities to mitigate the prevalence of mental disorders, such as PTSD and encourage treatment seeking and accessing EBTs. This shows that educating people on the EBTs will result in a high acceptance of the EBTs, as shown through Participant (08) who said that if PE-PC was made available to people in resource-constrained settings, it would have the biggest social impact. Thus, in order to ensure the provision of EBTs within primary care practice, the policy makers also need to fully invest in the process of sensitising the general public, and ensuring adequate mental health budget allocation. The promotion of mental health literacy and incorporating inclusive mental health laws and comprehensive policies that are sustainable and culturally sensitive, should be rigorously and urgently undertaken. Most importantly, it is evident that mental healthcare, such as PE-PC is an active extension of a support network for trauma survivors in a resource-constrained setting.

Consequently, although participants attested to having faced numerous challenges while attempting to access TFTs, all ten participants indicated having high levels of treatment satisfaction. They thought that the sessions successfully reduced their symptoms and helped them gain a better understanding thereof, replacing the misconceptions they might have had prior to accessing PE-PC. Moreover, their quality of life improved, as they stopped avoiding their trauma-related stimuli. The limited reference and comparison of this study's results to existing literature, is an indication that there are a few existing studies on the phenomena of the acceptability of TFTs in low-resourced settings.

Chapter Summary

This chapter shows the process of how the researcher made sense of the data in order to determine whether PE-PC is an acceptable treatment for PTSD among adult clients in Makhanda. It also discussed the factors that influenced or hindered the implementation outcome of acceptability. Based on the data obtained from the semi-structured interviews, it can be concluded that the PE-PC intervention is an acceptable treatment option for PTSD in a resource-constrained community.

Chapter Six: Conclusion

6.1 Chapter overview

Chapter six provides an outline of the current study and submits an overview of the central findings. The researcher offers final conclusions, outlines the limitations and implications of the study, and provides recommendations for future research on the dissemination and implementation outcome of the acceptability of EBTs in low-resourced settings.

6.2 Summation of results

The aim of this study was to examine the acceptability of PE-PC as a treatment for PTSD in a low-resourced community in the Eastern Cape. In order to determine whether PE-PC was considered acceptable, the researcher addressed two research questions: How do adult clients seeking trauma counselling perceive and experience PE-PC as a treatment for PTSD in a low-resourced community? and What are the contextual facilitators and barriers that adult clients experience when seeking trauma therapy in a low-resourced community?

The results of the study presented two main findings: (a) the researcher discovered that contextual factors, such as stigma and mental health literacy impacted trauma survivors' experience of PTSD and treatment seeking. There was emphasis on the issues caused by stigma by investigating the different avenues in which PTSD manifests and the impact it has on people; (b) the researcher also outlined that PE-PC was beneficial for individual participants, within the stigmatised context. Participants appeared to have a reduction in PTSD symptoms by not avoiding or finding it difficult to talk about their trauma following PE-PC. The researcher showed that these findings are in line with what the existing literature and studies have reported on what the treatment-seeking experience is like for trauma survivors.

Furthermore, other significant findings from the study were that most participants opined that some factors that hindered them from accessing or seeking treatment earlier, included financial constraints and time. Participants also mentioned that PE-PC sessions were beneficial, as they were free of charge and that the sessions were not protracted, unless the participant requested an extension from the standard four. The findings of the study also reported that denial and misconceptions among trauma survivors and within their respective communities added to low treatment-seeking.

Furthermore, participants' difficulty in conceptualising their PTSD symptoms from a cultural perspective, illustrated how the idea of culture became more complex, as participant

viewed their experience of PTSD from a different cultural perspective, compared to senior members of their families. Therefore, the researcher highlights how mental health is understood across different generations, and how culture is applied to make sense of these experiences. Thus, this might portray that senior generations have a specific lens, and the participants have a different one, due to the contemporary times in which they live.

In addition, it is important to note that using RTA for this study involved the concept of the reflexivity of the researcher, which entails subjectivity, as outlined in the methodology chapter. Therefore, acknowledging the subjective position of the researcher, can be a limitation because it means that data are open to interpretation; different researchers can reach different conclusions when analysing the coded data, leading to inaccuracy and the unreliability of findings. The researcher's own biases are part of the interpretation of the results.

6.3 Limitations

The limitations pertaining to the current study include the notion that it was narrow in scope, considering the limited time set to complete a Master's thesis. Another limitation was the sample size; that is, the researcher found it challenging to schedule interviews with participants who had already completed their PE-PC sessions. Some participants rescheduled several times, while others simply did not respond to the invitations. However, the use of RTA as the method of analysis considered a sample size of ten participants, appropriate for this study's focus on meaning. However, future research may benefit from extended time and more participants.

Another limitation was that although the researcher had proposed conducting the study predominantly within the Joza location in Makhanda, they later had to extend the scope for sample selection to the whole of the Makhanda community, as it was not easy to contact participants, following their completion of the PE-PC. The majority of the participants did not have personal mobile devices; therefore, there was no direct contact numbers to facilitate contact. Thus, communication became a limitation, and the researcher miscalculated this challenge as it appeared to be the case for the broader Makhanda population. This indicates that there was not enough consideration given to the possible socio-economic restraints. Consideration of this insight early on in the study allowed the researcher to modify their inclusion and exclusion criteria to limit the generalisability of the research findings, which in turn, strengthened the reliability and validity of the study.

6.4 Implications of the current study

This study has been hopefully successful, in that it has shown that there has been an increase in mental health awareness within the Makhanda population and an increase in patients' willingness to seek trauma-focused treatments. It has initiated positive conversations around mental illness and any related discussions which allow people to deconstruct pre-conceived myths and misconceptions. It has contributed to the knowledge gap within the field of traumatic stress, regarding the acceptability of PTSD treatments within primary care practice in a low-resourced setting, as well as being deemed significant in the South African context. The study further suggests that EBTs should not be confined to psychiatric hospitals, and that PE-PC can help mitigate the high prevalence of PTSD and comorbid conditions in low-resourced communities, even though the study did not focus on comorbid conditions. The study also portrays the factors that may hinder the acceptability of PE-PC. Despite the limitations of this study, it provides rich and nuanced insights into the experiences of participants who received PE-PC sessions. Thus, the acceptability of PE-PC has been observed from all ten participants. According to the findings of this current study, PE-PC is an acceptable treatment for PTSD in a low-resourced setting, which adds value to the literature for future research.

6.5 Recommendations

According to the researcher's knowledge, this is the first study to examine the acceptability of PE-PC as a treatment for PTSD in a low-resourced community. Therefore, the researcher has several direction recommendations for future research on this notion. First, as a result of the limited scope and a relatively small sample of this study, future research may benefit from a larger sample, considering how it may allow researchers to explore more diverse and distinctive experiences. Fundamentally, the researcher also recommends that researchers adopt an empathetic approach when working with a vulnerable population, in order to build rapport between themselves and their clients.

Second, the researcher further recommends that future research should investigate how to culturally adapt PE-PC within various settings in South Africa. This will be beneficial for its dissemination and implementation as a treatment for PTSD, especially in low-resourced communities.

Third, another area of recommendation for future research includes exploring how the current macro-system, i.e., the government, contributes to the implications faced by mentally ill patients and how the existing regulations do not provide opportunities for everyone. As

shown throughout the thesis, healthcare systems in LMICs do not prioritise mental health. Therefore, the health systems in LMICs need to coordinate and integrate to resolve policy implications that maintain the prevalence of common mental health disorders and examine ways of ensuring the acceptability and sustainability of mental healthcare treatments. Thus, exploring macro-systems include recognising broader systematic and environmental contributors to mental health and distress. That is, researchers should also examine the influence of multi-level intervention, by calling for collaboration between policymakers and other stakeholders, such as the police, university lecturers and school teachers to work together to ensure that mental health is promoted at community and individual level. Moreover, the agenda of making mental health and wellbeing a global priority and decolonising the discipline of psychology into a culturally adoptive discipline, should be urgently implemented.

In addition, as the implementation of EBTS, such as PE-PC is encouraged, the researcher also recommends that researchers should continue to investigate what policies to employ for continuing encouraging trauma survivors to seek treatment; and what structures can be created to help patients to positively regulate their emotions, and avoid relapsing into depressive states, where their trauma is crippling and prevents them from being their whole selves in their community.

It is recommended that mental health literacy be made a standard component of the education curriculums in LMICs, particularly within low-resourced communities, in order to deconstruct misconceptions and myths, thereby replacing them with true notions and normalising mental health conversations. There is a pressing need to normalise the socialisation and training of NSHWs to administer treatments, in order to mitigate the lack of professionally trained mental healthcare workers. Therefore, educating people will increase trauma survivors' proactiveness in accessing TFTs. Lastly, the research recommends that future studies pay close attention to how the nature of the therapeutic relationship can influence the treatment outcome of acceptability.

Although the reflexivity and subjectivity of the researcher is regarded as useful, future research on this topic should attempt to go broader than a mere subjective approach.

Conclusion

Using the implementation science framework and qualitative methodology was an appropriate strategy for obtaining critical insight into the knowledge gap of the acceptability of EBTs in low-resourced communities. This study indicates the contribution made to the

scholarly community on the treatment of PTSD in a low-resourced community in South Africa. It also highlights the progress made within clinical psychology to ensure access to psychological treatment for everyone, providing an understanding of accessing treatment by exploring the challenges faced by trauma survivors and factors that maintain the prevalence of PTSD. Therefore, knowledge obtained from the study can be used to improve understanding the urgency of using TFTs within primary care practice. It may also help researchers to identify how to promote the need to access EBTs and educate people into accessing treatment. Therefore, there is still much that needs to be done with regard to educating people about mental illness and the accessibility and availability of acceptable psychological treatments for common mental disorders in South Africa.

In conclusion, the current pilot study fills a critical gap in the literature regarding PTSD treatments in low-resourced settings. This study thoroughly investigated how the poor health systems in South Africa and the lack of functional mental health structures have contributed significantly to the obstacles faced by adults, when seeking EBTs in low-resourced settings. The findings of the study also indicate that there is an urgent need to decentralise and integrate mental healthcare into broader primary care practice, in order to encourage the active engagement of those who are affected and living with mental disorders, improve the access of psychological treatments, and enhance population mental health. Most importantly, the comprehensive findings of the current study demonstrated valid conclusions, as all ten participants attested that PE-PC was an acceptable treatment for PTSD.

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Appendix A

Interview Schedule

Interview Orientation

My name is Lerato Leboho and I am a student researcher at Rhodes University, working on prolonged exposure therapy for primary care (PE-PC) for post-traumatic stress disorder (PTSD) project, under the supervision of Dr Duane D. Booysen.

Before we begin, I would like to take a minute to explain why I am inviting you to participate in this interview today and what I will be doing with the information you provide . Please stop me at any time if you have questions. After I have told you a bit more about this interview, you can decide whether you would like to participate.

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

Participation is purely voluntary. If you agree to participate in this interview, you will be asked questions related to your experiences in the PE-PC project. We will NOT ask you any questions about your trauma specifically; rather, we are interested only in your experiences with the treatment you received. The interview should take approximately 45-60 minutes and will be audio taped so that we do not miss anything that you have to say.

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

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

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

Are you interested in participating in this study?

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

Introduction

Cultural Formulation-related Questions

1. Defining the problem
    a. How would you describe your trauma-related difficulties from a cultural perspective?
    b. What troubles you most about your problem?
2. Cause and context
    a. What do others in your family, friends, or others in your community think is causing your problem?
3. Stressors and supports
    a. Are there any kinds of support that make you [PROBLEM] better, such as support from family, friends, or others?

b. Are there any kinds of stresses that make you [PROBLEM] feel worse, such as difficulties with money, or family problems?

4. Role of cultural identity
   a. Are there any aspects of your background or identity that make a difference to your problem?
   b. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?
5. Self-coping
   a. What have you done on your own to cope with the problem?
6. Barriers
   a. Has anything prevented you from getting the help you need?
      i. For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?

Intervention-related Questions

1. Have you been in counselling previously ? Tell me about the therapy you received?
   a. Probe for information about activities, homework, and frequency.
   b. If a patient did not attend any sessions, ask why not? What got in the way?
2. Did you find PE-PC for PTSD treatment helpful?
   a. If yes, how?
   b. If no, why not?
3. Would you recommend this treatment to other patients who have experienced stressful life events?
4. What elements of this treatment need improvement to make it better?
5. Did this treatment change your opinions about therapy or mental health treatment in general?
   a. If so, how?
6. Do you think PE-PC should be adopted as a treatment for PTSD at a community level?

Specific Questions Related to Beliefs

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

1. Scheduling
    a. What has been your experience with scheduling appointments for PTSD treatment?
2. Stigma
    a. Do you worry what people will think of you because of your PTSD diagnosis or treatment?
        i. If yes, why?
    b. Have you ever felt as if you had to hide your PTSD from others?
        i. Why did you feel that way?
3. Resources
    a. In what way has a lack of time been a barrier for you?
    b. In what way have finances for treatment been an issue for you?
    c. In what way has transportation to treatment been an issue for you?
    d. In what way has childcare (so you can attend treatment), been an issue for you?
4. Other
    a. What other problems/barriers come up?

Summary Questions

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

Thank you for participating in this interview.

Appendix C

Code Data Extracts

Data Extract	Coded For:
"I think their default was just ah, she is probably busy." "We don't have the best um space for people with mental health issues." "People see me as being dramatic." "I think it's more the outer circle of family but not my core inside family." "I t's very difficult, at the school environment here to be able to make friends." "You think twice about whether or not do you say, that you think that your mental health might hinder you but you could," "Just that opening up about such big things, people can change their opinion of you very fast." "I had difficulty interacting with other people or any anxiety. I assumed everyone else was judging me or I had a much lower self-esteem." "The fact that I am autistic, trans- and bi-sexual, and my family are sort of like in a very conservative Christian cult-like environment. So, they are not happy with	Feeling isolated and/or alienated by friends and family because of their PTSD symptoms.

having a child like me, which definitely made the situation worse, their abuses worse." "I thought I had to hide these specific events that happened that caused them; they're things I barely want to discuss, and I thought I'd be um, judged for my actions during those events."	
"E specially in a country such as ours that there is traumatic experiences happening; people are getting shot every day and kids are seeing that stuff and people are dealing with crime every day and people are seeing that like, there's like so many broken homes and people are having to deal with that, and they're not given, and they don't have and I mean, even like things like going to the mountain, that is traumatic experiences for some men and they don't have anyone to talk to about that, nobody, no one at all. And another thing, it would remind me is whenever the holidays would come up because that would mean I have to return home to my family which also stresses me out." "So, I have a series of unhealthy and healthy coping mechanisms."	Prevalence of trauma in resource-constrained settings.
"So, I've always been concerned that if people find out or know about these things, then their perceptions of me will change for life."	Fear of being stigmatis ed and discriminated against.

“And quite often when people have, or when people develop perceptions about you, um that have negative connotations it’s very hard for people to forget that.” “T here’s always this subsequent labelling that follows. ” “Yeah, I think fear of being judged and also just like fear of people thinking that I might have like a serious mental illness and also fear of like going into therapy space and being told that I might need to go to like a mental asylum, I’ve always feared that because sometimes I do feel like the way that I think will spiral into me needing to go on medication or further assistance with mental illness, so I'm scared of that because there’s not a positive connotation that comes with like being on medication and being in a mental asylum, so I think before that's what I was very scared of and still kind of am.” “My mom doesn't even know so ja, it’s just something I want to keep to myself.” “Um yes, so I have hid it, just a fear of judgement and I don’t know, just to seem normal and okay and again, to fit in and not have people judge me for that specific thing that happened in my life ja, and not to be pitied.”	

“Bro, it's so hard attending therapy; you don’t understand. It is so hard having to go there.” “I always panic about what people have to say.” “No, I just didn’t want to feel stupid around people, you know, because they would have probably like thought, this girl is crazy, is crazy, so I didn’t want to feel stupid, and weak and pathetic, though I felt like that but ke (then). I didn’t want everyone to see it; it’s okay if I’m the only one knowing it.”	
“I think that this definitely opened my eyes to that idea that, it doesn’t always have to be one way, there could always be a different way to look about it.” “Not everyone has that opportunity, not everyone has those resources available to them.” “Just that opening up about such big things, people can change their opinion of you very fast.” “Life is not stopping, because my mental health is not fine. It's still going and so if I don't keep going with life, I'm gonna lose track of where I am.” “Pretty much most people think it’s only acceptable for very extreme forms of mental disorders, not something like trauma or other such things; those are seen as things	Perceptions and misconceptions held by participants prior to accessing PE-PC.

you must just tough it out; I'm gonna use that term." "P haku phaku means is that um, abnormally anxious or um, paranoid or is constantly thinking that something is gonna happen whenever you're in an environment where you associate anything with that incident that occurred." "So, stuff like having depression is usually like things that you need to pray for and not really seek any help for and I can't really talk to my mother about like what I'm going through, so it's just something I hide or keep to myself and so I think I'm gonna sort out for myself." "T here's not a positive connotation that comes with like being on medication and being in a mental asylum." "My mom doesn't even know so ja, it's just something I want to keep to myself."	
"I've just now resorted to uh, we are not telling anybody." "I also struggled with reporting the issue because, I don't know, I just felt like, it was such a grey situation… l ike it wasn't black and white, so I wasn't sure if me reporting it would have been fair." "People see me as being dramatic…or just being distant." "Like we're over it and stuff."	Not feeling understood or validated within their communities and families.

“My family might have like thought that it's adolescent stage and me growing up so being a teenage now I’m being moody and stuff because they didn't know what I was going through.” “I think it's more the outer circle of family but not my core inside family.” “There was a time that I was veered away from getting help because I just felt like no one fully understood me and what I was trying to tell them, but I just felt lost in translation.” “They already got a perception that this means this person's crazy, that this person…” “Just that opening up about such big things, people can change their opinion of you very fast.” “If anything, it’s just been difficult to explain.” “I had difficulty interacting with other people or any anxiety. I assumed everyone else was judging me or I had a much lower self-esteem.” “My parents pretty much consistently, emotionally abused me.” “I thought I’d be judged negatively for my actions during those events.”	

"This is a condition, but it's just, it's just being referred to as just being abnormally paranoid…" "Ja, after I went through a stroke and so with the panic attacks cause, usually I have panic attacks when there's no one there, like the first time I had it in front of my mother; she just thought oh, I just got out of hospital, so it must be like a clinical problem, so I should probably go see the doctor." "And ja, I just want to fit in," "M y mom thought I was lazy; she thought I was lazy and tried comparing me with all her other kids but ke." "And other people felt like I was a rude person, that I'm not talking with them, stuff like that, ja." "Ja, nobody understands into details, but whatever. They will think it's normal stress or whatever, like something which can just get over it."	
"Something bad that happened to you, that you have to deal with and then eventually you get through it and carry on with what's going on in your life." "I think a lot of people don't realis e that they struggle from PTSD because people don't know what PTSD is." "P haku phaku means is that um, abnormally anxious or um, paranoid or is	Understanding of trauma.

constantly thinking that something is gonna happen whenever you're in an environment where you associate anything with that incident that occurred." "This is a condition, but it's just, it's just being referred to as just being abnormally paranoid…" "So, stuff like having depression is usually like things that you need to pray for and not really seek any help for and I can't really talk to my mother about like what I'm going through, so it's just something I hide or keep to myself and so I think I'm gonna sort out for myself." "I t's not something, she wouldn't like automatically like go oh, that's an anxiety attack or we should see a psychologist. There's no understanding of what a panic attack is, in my environment and the people around me."	
"I think a lot of communities are damaged because of people not being able to seek the care that they need, when it comes to their mental health." "I think that's why a lot of the time why kids come to university and this is the first time that they'll ever get therapy; the first time that they're given access to free therapy."	Limited access to mental healthcare in low-resourced communities.

"Not everyone has that opportunity; not everyone has those resources available to them." "Um, that was the only time I had been to therapy or counselling." "Environment, there's no therapist in Bizana, you need to travel for them."	
"Wooh, from a cultural perspective?" "Um, culturally yoh, we don't want mental health issues; we're completely unaware of, or oblivious to um, when people start acting out or somebody's having some kind of mental difficulties." "Our parents are still new to the mental health conversation." "My mom, she has made a conscious effort to like understand therapy and mental health and um, has gone to therapy herself and taken steps to understand what mental health is in a general sense." "I think that this definitely opened my eyes to that idea that, it doesn't always have to be one way; there could always be a different way to look about it." "I think a lot of people don't realis e that they struggle from PTSD because people don't know what PTSD is." "And so, um, when everyone thinks PTSD, people think soldiers that people get shot and so um, that's not necessarily so. I	Lack of knowledge regarding mental illness and treatments in non-western communities, particularly low-resourced settings.

think a lot of the time people don't understand." "T here's a decent chance that they will bring some more of punishment on me, so financial or verbal or perhaps even physical abuse." "Those are the ones you ever read about, so you don't exactly learn that what I was going through was that bad." "Pretty much most people think it's only acceptable for very extreme forms of mental disorders, not something like trauma or other such things; those are seen as things you must just tough it out; I'm gonna use that term." "So, from a cultural perspective, there's not, there hasn't really been um, I have yet to come across discourse where we um, define it in psychological terms and say that this…" "This is a condition, but it's just, it's just being referred to as just being abnormally paranoid…" "Uh, I think it just goes back to being uninformed and just thinking I have to pay for these services." "So, stuff like having depression is usually like things that you need to pray for and not really seek any help for, and I can't really talk to my mother about like what I'm going	

through, so it's just something I hide or keep to myself and so I think I'm gonna sort out for myself." "I t's not something, she wouldn't like automatically like go oh, that's an anxiety attack or we should see a psychologist. There's no understanding of what a panic attack is, in my environment and the people around me." "T here's not a positive connotation that comes with like being on medication and being in a mental asylum." "Well, in terms of traumatic experience um, my mom did understand, but I don't think she understands the part where I'm depressed, where I'm, you know, when I'm down and all those things. I don't think she understands that part." "And other people felt like I was a rude person, that I'm not talking with them stuff like that, ja."	
" I think that learning and unlearning really did help because much earlier on, I wouldn't have sought help." "Education one thing. Um, learning about these things in psychology." "If I had to choose between an exam and therapy, I'd choose therapy, in a heartbeat. If I had to choose between a vacation and	Increased mental health awareness following PE-PC exposure.

therapy, I'd choose therapy over everything,"	
"I t was hectic bra, it was a mess, it was a mess, especially with the symptoms of depression, sleeping nonstop, having headaches on a daily basis, not having energy, you know, having to force myself to go uh, do the dishes, to study and fighting sleep on the other hand; it was all a mess, it was a mess. I'm just, I don't know how I survived."	Reduction in PTSD symptoms after receiving PE-PC sessions.
"We experienced a shortfall in that, in that, the things that make me feel unsafe or the conditions that made me really, really feel like okay I'm anxious, could not be replicated here. For instance, um, couldn't find a place that's dangerous enough for me to hang around and feel like um, maybe in the street yes, but it's nearly, it's not nearly half as um, scary as what I go through when I go home."	Inadequate exposure during PE-PC.
"So, with things like stigmas and stuff, I think I was able to just block out that noise." "I was just put off by like the unprofessionalism… I basically just got an SMS telling me to stop calling you know." "P eople die every day, people go through breakups every day; are you always now going to act out just because you're going through something?"	Insensitivity of others towards the mentally ill patients.

"Does your employer, your future employer look at you like you can't handle things." "Um, most people assumed it was just part of my personality." "T here's a decent chance that they will bring some more of punishment on me, so financial or verbal or perhaps even physical abuse." "This is a condition, but it's just, it's just being referred to as just being abnormally paranoid…" "A lot of people around me have just assumed that I am that person who's just um, confrontational." "Um, I think negatively there are some aspects. Um, when I consider how I struggled with delinquency earlier on in my life and being in and out of reformatories…I think that just um, sort of worsened it because then everyone expects that I'm going to be that person. Um, when, when I, when I know that deep down, I'm just scared." "T here's not a positive connotation that comes with like being on medication and being in a mental asylum." "When I share that little, you'll hear a person saying 'we all have stress, you know',"	

“Most of the times I feel like they are saying, get over it and that offends me the most because are you trying to say I'm dumb or something.” “That makes me feel stupid and unworthy and a failure. It makes me feel, it makes me feel really horrible about myself when I hear people say, get over it. ”	
“From a cultural perspective?” “So, from a cultural perspective, there's not, there hasn’t really been um, I have yet to come across discourse where we um, define it in psychological terms and say that this…” “This is a condition, but it's just, it's just being referred to as just being abnormally paranoid…” “Um, could you explain the question, please? ” “So, stuff like having depression is usually like things that you need to pray for and not really seek any help for and I can't really talk to my mother about like what I'm going through, so it's just something I hide or keep to myself and so I think I'm gonna sort out for myself.” “From my cultural background? ... I don’t understand your question.”	Difficulty conceptualis ing trauma experience and symptoms from a cultural perspective.
“The first main factor is I just didn't think I was traumatis ed or traumatized enough.”	Reasons for not accessing any form of EBTs.

	“I felt like I was gatekeeping my own access to therapy and also for a while, I didn’t even consider that I was traumatis ed.” “I believe those were the only things that were keeping me from getting help. Not realis ing that I needed it and financial troubles.” “I'm going to be specific and say with my experience of um, posttraumatic stress disorder; um, I had always assumed that the only way you can really get through is if you acknowledge that it has happened and moved on, um, which is something that I did for a while; I kept on acknowledging that these things happen and I’m not responsible for those things that happened.” “Uh, I think it just goes back to being uninformed and just thinking I have to pay for these services.” “Um, so, I, I'm coming from a home where like most of the people don't talk about what they're going through and so that's sort of what I've become as well.” “So, stuff like having depression is usually like things that you need to pray for and not really seek any help for and I can't really talk to my mother about like what I'm going through, so it's just something I hide or keep to myself and so I think I'm gonna sort out for myself.”	

“I think being a black woman who's a foreigner in South Africa, makes things a bit more difficult.” “So, ja, I felt like I had to keep moving instead of coming and sitting and talking to someone about my problems because there’s things waiting for me to be done.” “Definitely money and the distance because I did want, but then only to find out that therapy, therapists are far away from me and they are really expensive you find that a session is R800 and I thought, and I thought, ja, there you go. I can't do this because I don't have money and you know travelling is problem.”	
“Dealing with that is now the newest hurdle.” “I've learnt to just completely disengage from because they can be very distracting for me.” “How do I continue whilst still sorting out this thing that I went through … I just cried.” “I had got to the point where um, like, I couldn't control myself anymore.” “I sleep and avoid thinking about it.” “Will have panic attacks and not know that they’re having panic attacks and everything.”	Difficulties confronting trauma stimuli or anything closely related to it.

“I had been um, struggling with this for some time but just um, not wanting to entertain those feelings. So that, that sort of like um, aggravated um, it is sort of like worsened it for me, because then I became even more, even more paranoid.” “Whenever I experience anxiety, I’ll suppress it.” “My tendency to want to violently react to incidents that don't warrant any violence. But because I’ve just, I’ve been exposed to so much violence, that I just assumed that this situation warrants violence on my end.” “I think being around men, make um, triggers me a lot. Um, and my uncles trigger me. I don't really feel safe around them, just because I don’t feel safe around men in general and group settings where I don’t know people specifically.” “So, I just didn’t think about it and just lived life, though it bothered me somehow, somehow, but I just ignored it and lived life until I couldn't ignore it anymore.”	
“I do think there are social aspects that helped me get the help that I need.” “I thought she wouldn’t understand.” “I never spoke to other family members beside my mom.” “Um, support? No, other than the initiatives from the Psychology D epartment, w	Not receiving any form of or enough support from people around them.

hich I must say, I wouldn't have had access to it, had I not been within the university space. So back home, my community, no." "Even people who even say, I understand mental health wara wara wara; dude they don't, they don't."	
"This person is going through a thing, leave them right now they'll figure it out." "The culture here at school is very exclusionary." "T here's always this subsequent labelling that follows." "Yes, sometimes I think it bothers me because I don't want people to identify me for my trauma. I don't want them to look at me and think about that when I'm interacting with them." "Makes me feel stupid and unworthy and a failure. It makes me feel, it makes me feel really horrible about myself when I hear people say, get over it. "	Community and society's attitudes and their possible effects on a mentally ill person.
"With like back roll at the counselling centre and everything over there, it did take a couple of days." "I had a lot of commitments last year and it felt like if I entertain this thing that's been bothering me, I'm gonna get into my feelings, and then I won't be able to show up for these things anymore."	Service users challenges and difficulties (cultural, social or financial) when attempting to access evidence-based treatments.

“Ja, it's finance and like I once told my mom that I think I need to, to go to therapy and she was like no, you're gonna have to talk to my friend. ” “I couldn't go cause of financial reasons.” “Um, finding a therapist here is actually really difficult in private practice.” “I feel like time has definitely made it difficult to like just do everything that I'd like to do, get help when I say, when I think I need help, I think especially this um, this year being my final year, I feel like there's so much going on.” “ I think sometimes I just compromise my mental health for the fact of school.” “I think money was actually an issue for me.” “D idn’t have much way to afford that form of therapy, until I found out that this, um, what do you call it? ... this programme was free, in which case I wanted immediately and joined in.” “Money.” “Definitely, financial constraints, um, because I am only able to access um, these amenities at this kind of treatment here at university. Before that, I had no access to that um, and the only kind of help that I had access to I had to pay for and that wasn’t easy for me cause I had people to take care	

of; I had myself to take care of so that wasn't easy." "I think being a black woman who's a foreigner in South Africa, makes things a bit more difficult." "T he local place where I live is not near but it's not too far as well, and it was R500 per hour and I live with a single mother and I didn't have a job as well, so we couldn't afford that." "I would have to take public transport so, ja that does also get in the way."	
"Other people decide to or just happen to adopt unhealthy coping mechanisms." "I might be triggered by something and I'll have seizures and all the time people think I'm a sangoma." "Um, most people assumed it was just part of my personality."	Beliefs on causes of mental illness.
"Because like the judging, like mm, okay we can't do certain things to her cause they trigger like they won't be the same as they were before." "T here's always this subsequent labelling that follows."	Stereotyping and prejudice against people with mental disorders.
"I couldn't speak to my father about any of it… u m, and my brother as well." "When this happened, it felt like a betrayal of sorts."	Feelings of loss and embarrassment.

"I felt like there was little judgement." "Yes, sometimes I think it bothers me because I don't want people to identify me for my trauma. I don't want them to look at me and think about that when I'm interacting with them."	
"My dad neh, very, I don't want to say traditional, but he's your typical , black father, you know, no boys, we don't talk about that, I don't want to see you around any men." "I t was causing stress to me that I couldn't talk to her about it and then … c ause I couldn't confide in her."	Societal expectations and norms that makes PTSD patients hesitant about sharing their traumatic experiences.
"Journaling helps. Um, I also meditate. Ja, meditation, yoga." "I sleep and avoid it." "I think a very positive aspect um, is my religion, I feel like I've turned to God for a lot of things." "I've been able to look to religion to be my guiding force, in terms of trying to figure out how I'm feeling or when I'm struggling." "Um, I started journaling and that became like a part of like um, my experiences. I am able to write down how I feel in the moment…and u m, I used to gym as well." "Distract myself with any form of work or perhaps entertaining activities, such as	Alternative strategies used by trauma survivors to cope with PTSD.

reading or video games or something along those lines and consumption of some form of sugar, so if I get particularly stressed, I'll buy myself an energy drink and perhaps even a chocolate or some form of sweet." "It was at church, my local church, it was a, I think it's called biblical counselling."	
"When I started therapy, it was because this thing is really getting in the way of me doing certain things." "I feel like if I had gone through therapy before like earlier, I would have maybe moved on earlier too." "Before, um, before I didn't have a coping mechanism." "Um, but simply accepting it wasn't enough; I had to do um, continuously experience that or at least feel like I'm experiencing that or relive it um, for me to come to, to actually come to terms with it." "Um, frequent panic attacks." "And being unable to understand, like some of the anxieties that I have, like general anxiety."	Reasons why PTSD patients seek EBTs.
"We definitely have not made enough progress, until people can say they need a mental health day; things aren't okay, we have not made progress."	Future direction of mental healthcare in low-resourced settings.

“I t gives more people open space to talk about their truth.”	
“I went to all of these sessions and I felt like oh my gosh, I'm in a much better space.” “Having that time every single week to focus on this um, memory and how it affects me, that was really helpful.” “Like you start understanding that this was literally just a life thing that happened, you know; um, it's not my fault; um, I don't need to make this now a barrier for the rest of my life.” “I can heal from it and still live a full life.” “I did have a like side thought the other day, though that maybe we don't always need the PhD graduates to be counsellors, you know; you guys are M aster’s students [laughs] M asters, H onours, you know and for me, this was still effective.” “I think I never realis ed how many different ways there are for people to deal with traumatic experiences.” “You never realis e that there’s so many different ways that you could deal with traumatic experiences.” “It did help me realise that therapy can be easier to attain than I thought it was.” “I found it helpful, in that it equipped me with um, coping mechanisms or tools through which I can um, cope and um, come	Perceptions of therapy post experiencing PE-PC.

to terms with everything that's happened, and curb um, the symptoms that I get."	
"PE-PC was very helpful in understanding 'what exactly is it about this thing that triggers me?'… It was also great in desensitis ing me to my trauma." "It was, helpful. Like um, I'd say I was encouraged to face the other trauma and showed me how to tackle and sometimes how to deal with it and I got to talk about it and get it off like my shoulders." "Because it was, it was helpful for me and then I believe that it could help them too." "Very helpful, yes." "I found the treatment quite helpful." "They no longer caused me to cringe or to effectively spiral into anything. I could more easily come to terms with the rest of my trauma." "I would recommend this treatment if they want something fairly quick or cheap, then it's very helpful and for getting through memory of any traumatic event." "I think I would recommend it, depending on the kind of trauma that they went through. Um, and I say this um, because we experienced sort of a shortfall when it came to um, implementing some um, of this prolonged exposure."	Reasons for recommending PE-PC to other trauma survivors.

"So, depending on the kind of trauma that, that person experienced and whether I believe those conditions um, could be replicated here, then uh uh, to would I recommend or not recommend." "Um yes, I did. I think I found it helpful because it felt like I was being listened to for the first time and it felt easier to do it with someone that's closer to my age and also in my circumstance, being at Rhodes." "It felt good to kind of release it in some kind of way." "I think I would recommend for someone with a similar experience, just for the way that it helped me be able to articulate what had happened to me, because I think that's important because I hadn't before, and if you in a space where you're able to be a completely vulnerable and let like your tears out or let the story out for the first time or even repeatedly, I think it can be helpful." "I feel that the programme would benefit them to be able to articulate the things that are going on at home for their mental health and also for their family's mental health." "As I said, I would recommend it to a person in a heartbeat because it's really helpful, it's really helpful, it's really helpful, it is really helpful. I can't start	

describing it, I can't, it's just … I'm happy I joined it, you know."	
"So, I think half an hour just is not enough time." "I feel like ja, it might be a good idea to make it more flexible in terms of the duration of the therapy." "Mm [pause], I think maybe the duration because I know it's 30 minutes to 45 minutes and I'm not sure how long um, counselling sessions usually go for, but maybe if it were just a bit longer just for like, just to get someone settled and comfortable enough to start the session because when it goes by so quick, you only start to get comfortable maybe at a later stage and then it's already almost done or done and you just started to um, let yourself be able to engage in the programme. If it was longer, I feel like maybe then you'd have that time to be uncomfortable and get into comfortability of actually engaging and like taking part in the programme. Ja, so just time." "Definitely, I'd recommend it. I'm thinking of recommending it to someone else, actually. Because ja bra, if these sessions were there in 2021, maybe I would have been far with my journey right now of healing and stuff like that. Because some	Changes or improvements to PE-PC.

stuff I only talked about them this year on those papers.”	
“Mm definitely, like you said to increase availability.” “If this kind of treatment was made available to those people, it would have the biggest social impact.” “So, if we have this, at least we, ja you increase treatment for the people who need it.” “I think it’s a really good structure in the way in which it goes about everything for you to deal with what's going on.” “I think it's like really important that we have clinics or places that people can speak to someone,” “Until when I found out this, that this programme existed and that it was free, then I could access it.” “I found the treatment quite helpful.” “After PE-PC , there were almost no concern; I could freely think about them without any form of guilt or getting upset.” “They no longer caused me to cringe or to effectively spiral into anything. I could more easily come to terms with the rest of my trauma.” “I think this should definitely be adopted.”	Adopting PE-PC as a treatment for PTSD at community level.

“I think it is something that could be offered at local clinics.” “And I found that very helpful, so I'm taking that on for when I'm, like, feeling down or when I think about it too much, I write it out exactly as it is and it's helpful to sort of write it, and it's not in my head. So, it's not like I'm making it up or and it's not real, because usually feels real if I'm thinking about it. But if I write it, then it just feels distant so ja, I've been doing that to cope I think, ja.” “Um yes, I did. I think I found it helpful because it felt like I was being listened to for the first time and it felt easier to do it with someone that's closer to my age and also in my circumstance, being at Rhodes.” “So, I think it would be helpful, especially for underdeveloped communities. So ja, I do think that it's important.” “Definitely, I’d recommend it. I'm thinking of recommending it to someone else, actually. Because ja bra, if these sessions were there in 2021, maybe I would have been far with my journey right now of healing and stuff like that. Because some stuff I only talked about them this year on those papers.” “These sessions you know, they expose you to your trauma that don't run away from it, just think about it, go through it, feel it and accept it, then slowly, let go, you know.”	

"You got to connect with yourself, the traumatis ed self of you, you know, in deeper details, not in trying to ignore that girl or that guy without running away from it, you know. You get to just be face to face, man to man or woman to woman, whatsoever." "I don't really celebrate myself but when I joined the sessions, I celebrated. "	
"Mine actually fit in perfectly." "I think that becomes like really difficult to just try to set your schedule and figure out time." "I felt so overwhelmed with everything, like trying to schedule life, trying to schedule school, trying to schedule your therapy, trying to put everything on one calendar feels, like overwhelms you so much." "You never wanna miss anything that's going on in terms of your school work. " "Found the scheduling quite easy. I just mentioned my one free day in the week that I had, and they picked a slot in there that worked for me." "I think it was fairly easier." "I think it was fairly easy; it was just email [] 'how you doing, today, can we confirm today' then we just confirm it." "Um, it was okay; it did clash a bit with practicals and so it did happen sometimes at	Accessibility in relation to scheduling sessions for PE-PC.

the same time as my practicals; other than that, we did change days sometimes. ”	

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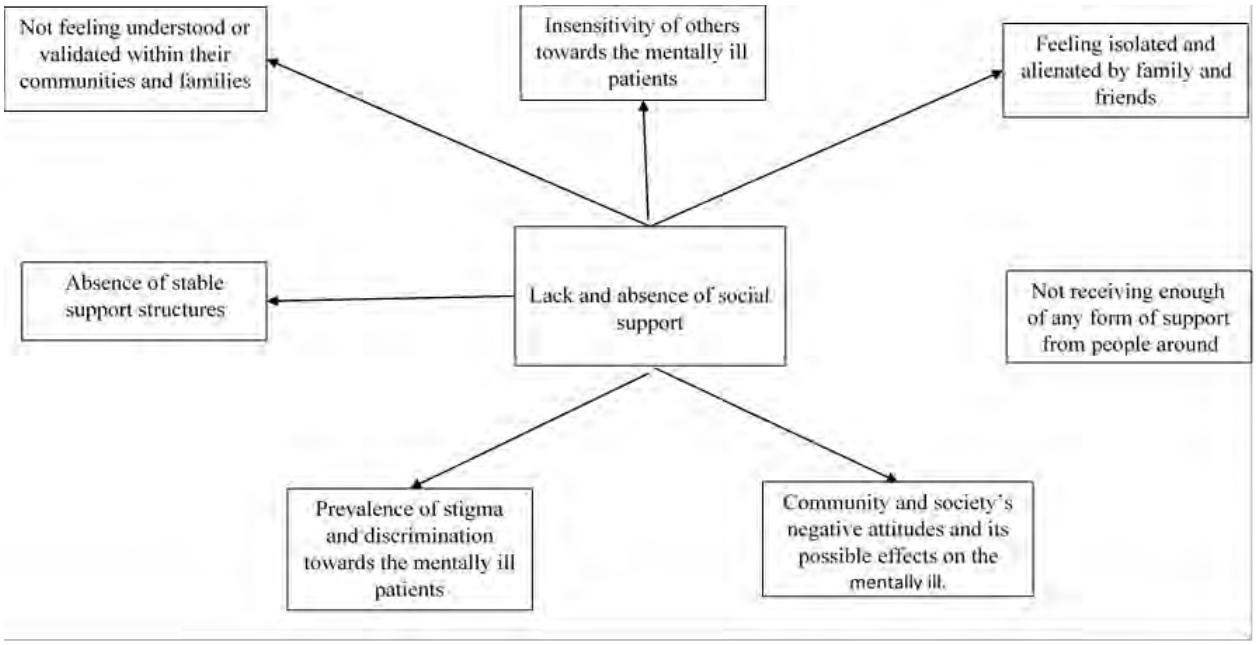
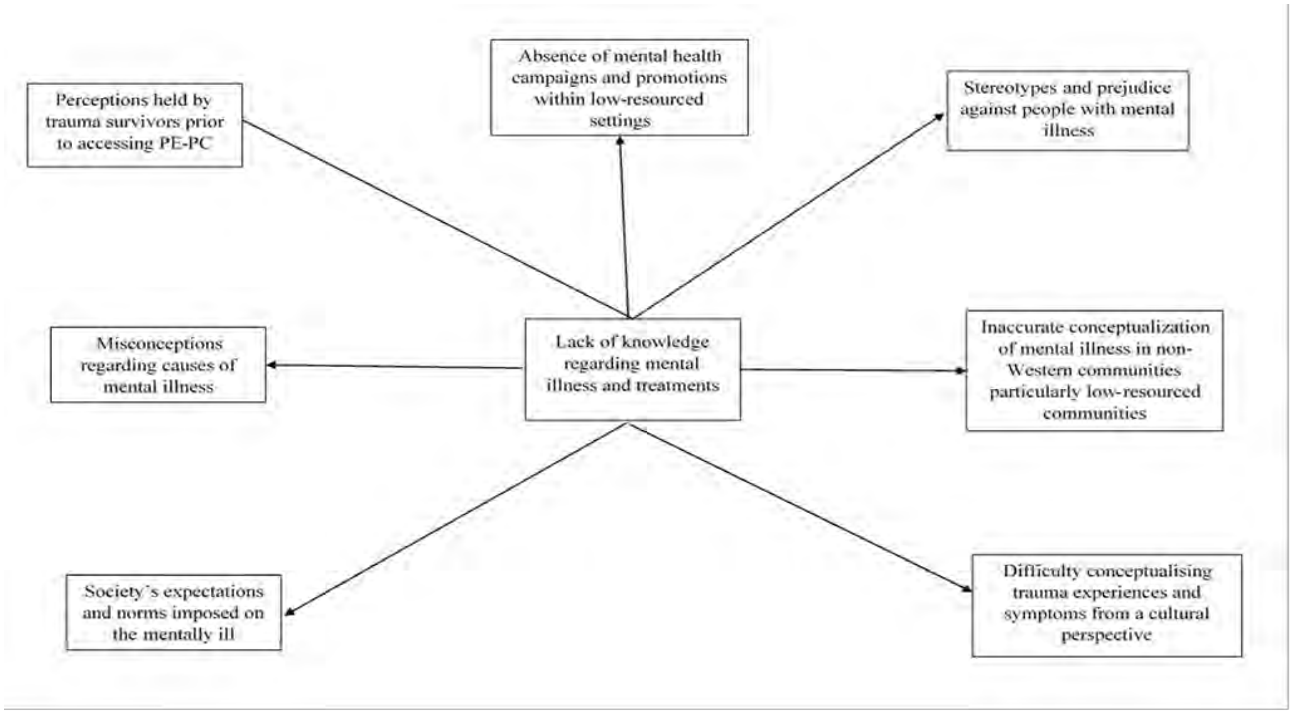
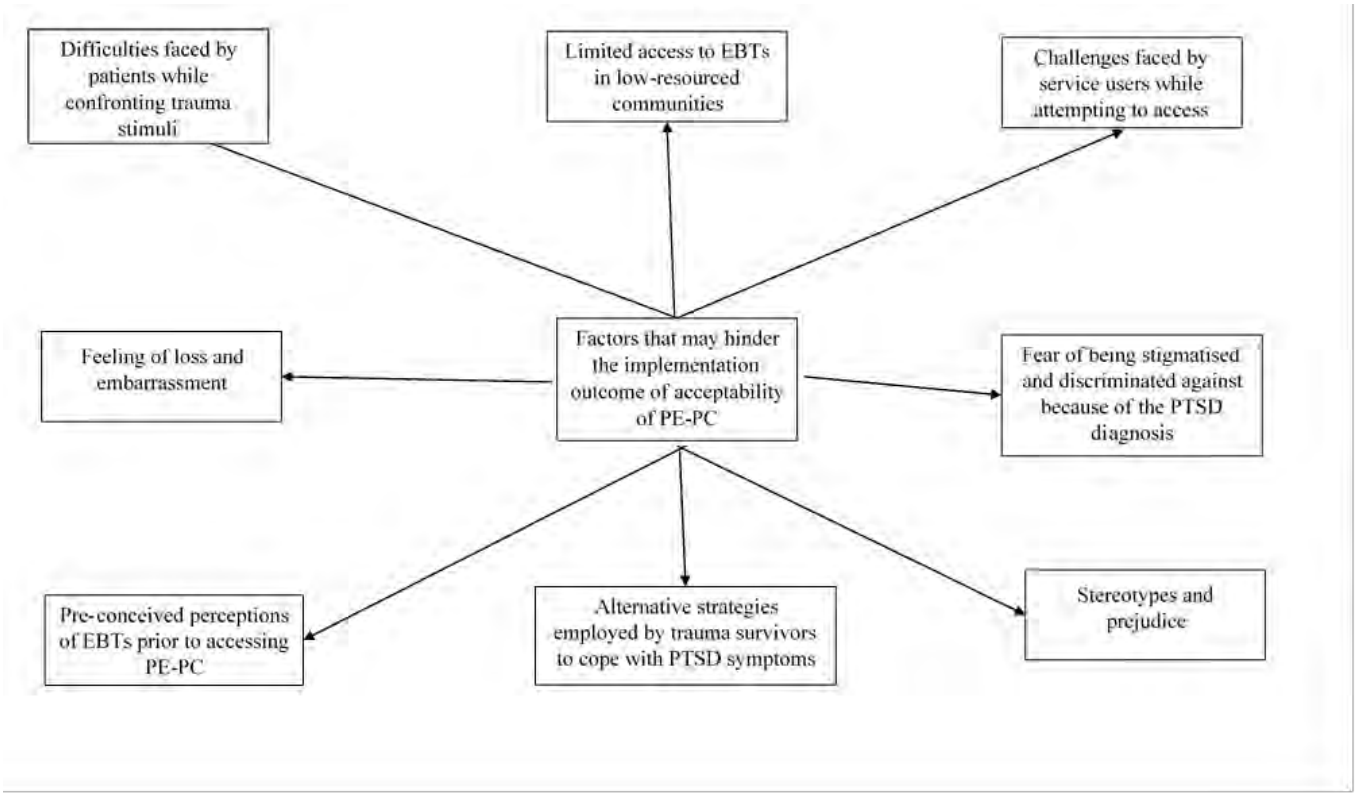
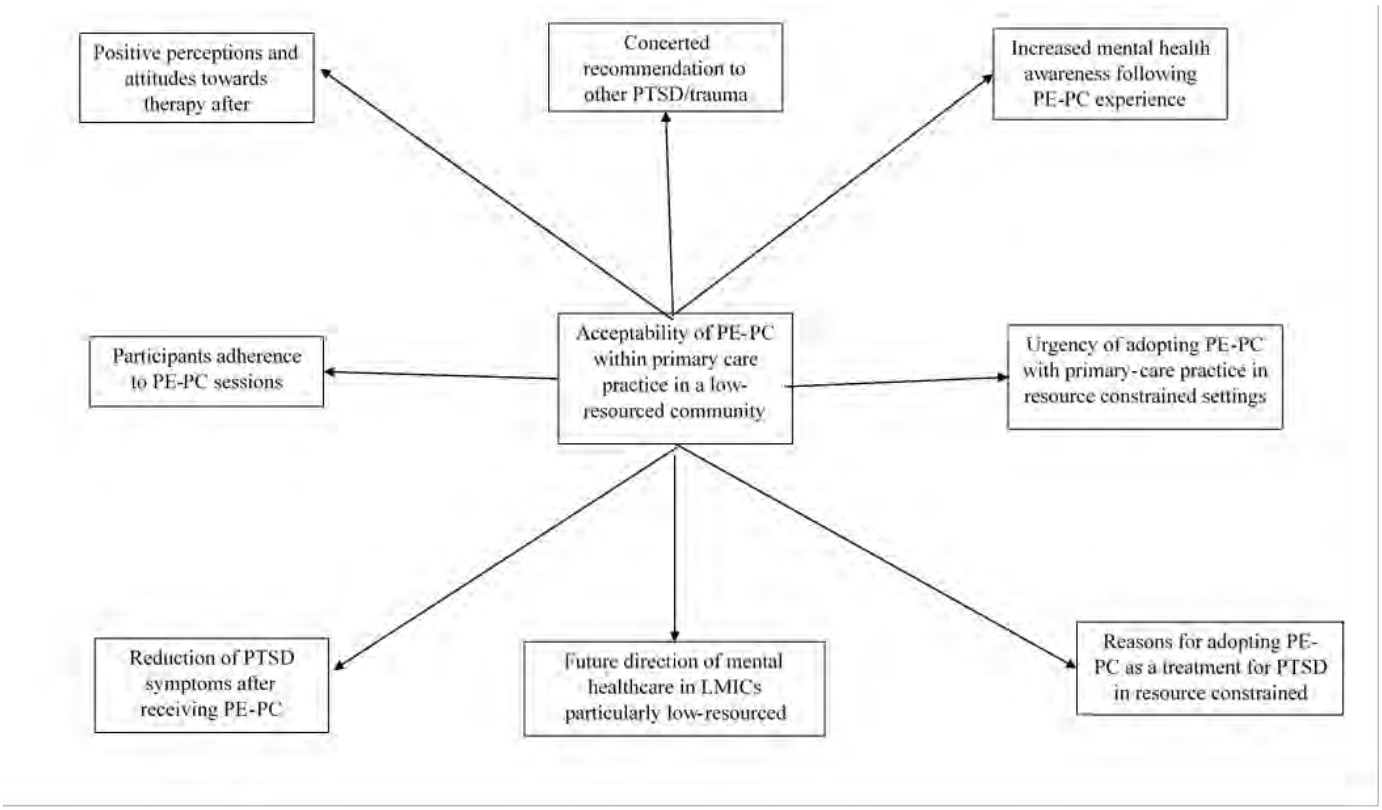
Appendix D

Thematic Maps






Difficulties faced by patients while confronting trauma stimuli
Limited access to EBTs in low-resourced communities
Challenges faced by service users while attempting to access
Feeling of loss and embarrassment
Factors that may hinder the implementation outcome of acceptability of PE-PC
Fear of being stigmatised and discriminated against because of the PTSD diagnosis
Pre-conceived perceptions of EBTs prior to accessing PE-PC
Alternative strategies employed by trauma survivors to cope with PTSD symptoms
Stereotypes and prejudice


Positive perceptions and attitudes towards therapy after
Concerted recommendation to other PTSD/trauma
Increased mental health awareness following PE-PC experience
Participants adherence to PE-PC sessions
Acceptability of PE-PC within primary care practice in a low-resourced community
Urgency of adopting PE-PC with primary-care practice in resource constrained settings
Reduction of PTSD symptoms after receiving PE-PC
Future direction of mental healthcare in LMICs particularly low-resourced
Reasons for adopting PE-PC as a treatment for PTSD in resource constrained

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Appendix E

Trauma Support for Survivors of Trauma

RESEARCH SITES: Rhodes University Psychology and Assumption Development Centre.

PURPOSE OF THE STUDY: Considering the levels of violence and trauma, the project aims to explore the effectiveness, feasibility, and acceptability of brief trauma therapy in Makhanda.

PARTICIPANTS MUST BE:

- Adults (18 – 65 years).
- Ability to speak English and/ or Afrikaans, isi-Xhosa and or English.
- Must report to have experienced or witnessed a traumatic event (i.e., physical assault or sexual trauma) and have subsequent difficulty due to the traumatic experience.

PARTICIPANTS WILL:

- Will be assessed before and after the intervention
- Receive brief trauma support from a trained and supervised Trauma Support Worker
- Post-counselling interview about your experience of the counselling (audio recorded).

POTENTIAL BENEFITS:

You will receive trauma therapy which is based on an evidence-based psychological treatment for traumatic stress. Your treatment will only be for 2 weeks. You can give feedback about your experience of the therapy. The research will contribute to the literature on evidence-based trauma therapies in South Africa.

PAYMENT FOR PARTICIPATION

You will not receive any remuneration for your participation in the study

Interested: CLICK HERE

https://docs.google.com/forms/d/e/1FAIpQLSfQniDH_2GooT6ybIBQ0N6UvqXFJ-NDZ48ffM6W1sltZ91tsg/viewform?usp=sf_link

Contact: Dr Duane Booysen – d.Booysen@ru.ac.za

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Appendix E

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Human Ethics subcommittee
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www.ru.ac.za/research/research/ethics
NHREC Registration no. REC-241114-045

19/11/2020

MR Duane Booysen

Email: D.Booysen@ru.ac.za

Review Reference: 2020-1558-4720

Dear Mr. Duane Booysen

Title: Implementation of Prolonged Exposure Therapy for PTSD at a Community Trauma Centre in a Low Resource Context: A Hybrid Type-1 Effectiveness- Implementation Clinical Trial

Principal Investigator: Mr. Duane Booysen

This letter confirms that the above research proposal has been reviewed and **APPROVED** by the Rhodes University Human Ethics Committee (RU-HEC). Your Approval number is: 2020-1558-4720

Approval has been granted for 1 year. An annual progress report will be required in order to renew approval for an additional period. You will receive an email notifying you when the annual report is due.

Please ensure that the ethical standards committee is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators. Please also ensure that a brief report is submitted to the ethics committee on the completion of the research. The purpose of this report is toindicate whether the research was conducted successfully, if any aspects could not be completed, or if any problems arose that the ethical standards committee should be aware of. If a thesis or dissertation arising from this research is submitted to the library's electronic theses and dissertations (ETD) repository, please notify the committee of the date of submission and/or any reference or cataloging number allocated.

Sincerely,

Prof Arthur Webb

Chair: Rhodes University Human Ethics Committee, RU-HEC

cc: Mr. Siyanda Manqele - Ethics Coordinator