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Bean, Miles

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A MULTIPLE CASE STUDY EXPLORATION OF THE IMPLEMENTATION OF THE WITS INTEGRATIVE TRAUMA COUNSELLING MODEL

A dissertation submitted in partial fulfilment of the requirements for the degree of
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By

Miles Bean
(0707091M)

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Supervisor: Gill Eagle

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ABSTRACT

The purpose of this research is to document and describe an exploration and appraisal of the implementation of a brief-term integrative intervention model, known as the Wits Trauma Model, used widely in the Gauteng region of South Africa by both volunteer and professional counsellors for the treatment of acute and post-traumatic stress in counselling victims of violence. Literature is reviewed pertaining to psychotherapeutic treatment techniques for acute and post-traumatic stress, efficacy research and the premise that an integrative psychotherapy approach is ideally suited to the treatment of psychological trauma. The study adopted a qualitative approach, making use of a multiple, case-based design in which archival case-based data served as the basis for extracting thematically selective case narratives that demonstrated the application of the model and illustrated the operationalisation of its principles. In interaction with the literature reviewed, six sets of case notes provided the basis for highlighting and discussing both the strengths and perceived lacunae within the model as well as how it appeared to work in practice. In all six cases, significant relief from traumatic stress symptoms was found to be achieved in a relatively limited time frame and sufficient qualitative evidence suggested a causal relationship between the different clients' initial symptom presentation, reported improvements and the activities and changes in their lives that they undertook in response to the treatment model. The model was also found to hold a degree of clinical flexibility in terms of timing, emphasis and technique regarding its implementation by the different therapists. In addition, by investigating how the different therapists appeared to have implemented and understood the Wits Trauma Model, as well as the dilemmas and challenges they faced in working with traumatised individuals, the study aimed to provide valuable insights into the clinical utility and implementation of the model, thereby informing best practice for practitioners who might be utilising the model in the future.

CHAPTER 1

1.1. Introduction

The recognition of post-traumatic stress disorder (PTSD) and the development of psychotherapy integration are both areas of clinical interest that have truly come of age in the last few decades. This study serves to highlight psychotherapy integration as presenting an ideal approach to addressing the impact of traumatic stressors on human functioning and illustrates this by providing evidence for the applicability of an integrative model for the treatment of post-traumatic stress derived within the South African context.

South Africa has a violent past and continues to suffer from many serious social problems. The high rate of violence and trauma in South Africa today has left many "victims" powerless, hopeless, and incapable of coping with the effects that exposure to trauma produces. Violence in the country has reached pandemic proportions, the expression of which, according to McDermot (2004) includes a range of features: structural (abject poverty and inadequate housing); criminal (assault, robbery and murder); sexual (rape, molestation and forced prostitution); and physical well-being (HIV/AIDS, malnutrition and substance abuse). The climate of violence is such that even though a single event may cause the traumatic reaction, this is often against a background of traumatic events that increases vulnerability. Although we have moved away from the State sanctioned atrocities of the 1980's and early 90's, we are still facing human suffering on a day-to-day basis.

Edwards (2005b) demonstrates through a review of specific clinical and epidemiological literature that PTSD and its related conditions are a significant public health dilemma in South Africa and Africa at large. For example, at a primary health care clinic in

Khayelitsha, it was found that 94% of adult respondents, ranging in age from 15 to 81 years, had experienced at least one severely traumatic event in their lifetime (Carey, Stein, Zungu-Dirwayi, & Seedat, 2003). Furthermore, in a sample of Pretoria Technikon students, it was found that a significant number of students had been exposed to traumatising events such as unwanted sexual activity (10% of the female students), witnessing serious injury or death (19%), being victim to violent robbery (13,5%), and physical assault (8%). Of those who were exposed to trauma, a high proportion reported PTSD symptoms (Hoffman, 2002). Edwards' (2005b) concluded that PTSD is a significant public health concern, based not only on the prolific occurrence of PTSD in South Africa, but also on its debilitating effects which have a marked impact on different areas of human functioning.

According to the South African Department of Safety and Security (2008), over the period of 1 April 2007 to 31 March 2008, vehicle hi-jacking rose from 13599 to 14201, an increase of 602 cases; while a total of 18487 cases of murder were reported, 6763 cases of indecent assault, and 118312 cases of robbery with aggravating circumstances, further indicating the severity and significance of exposure to traumatic events in South Africa. The most recent available statistics may also be seen as an underestimation of these particular crimes, as there are many factors that limit both reporting of the crime and the recording of the data (Kanyegirire, 2008). As these types of crimes are significantly associated with the production and maintenance of both acute and post-traumatic stress, the fact that the statistics are so high in this country warrants considerable attention. Recognising the negative effects that trauma has on victims of violence in particular and the large numbers of people affected by forms of traumatic stress in South Africa, there is clearly a need and demand for workable, brief-term forms of intervention.

Over recent decades, substantial progress has been made in understandings of the impact of trauma on survivors and research has shown that although much has been written and proposed regarding treatment strategies and techniques for the treatment of traumatic stress symptoms, relatively little research has been devoted to developing empirically-

supported interventions for the prevention of both acute and chronic post-traumatic stress. The question as to what treatment methods are effective in preventing the development of full blown post-traumatic stress disorder has been a source of considerable debate among practitioners and researchers alike. In light of the increasing levels of violent crime and trauma in South Africa and increasing numbers of individuals seeking psychological assistance, the lack of suitable services and the need for suitable interventions is a pressing concern for trauma professionals (CSVR Annual report 2001/2). It is therefore necessary to appraise existing trauma intervention models so as to establish whether they appear to be effective tools for reducing the risk of developing traumatic stress responses and related problems.

1. 2. Aims and Rationale

The Wits Trauma Model (WTM) is a brief term integrative intervention used widely in the Gauteng region of South Africa by both volunteer and professional counsellors for the treatment of post-traumatic stress in counselling victims following various types of traumatic incidents (Renes, 1999). The model was developed for intervention with adult trauma survivors and integrates psychodynamic and cognitive approaches to treatment in theoretical base and application. In reflecting on the model in the light of recent developments in the fields of trauma and psychotherapy, the researcher felt it was important to examine exactly what it is about this particular intervention model that accounts for its usefulness in clinical practice and where there might be room for improvement.

The purpose of this research is to document an exploration and appraisal of the implementation of the WTM. The study adopted a qualitative approach making use of archival case-based data that served as the basis for constructing thematically selective case narratives that demonstrated the application of the model and illustrated the operationalisation of its principles. The narratives provided a source for highlighting and discussing both the strengths and perceived lacunae or areas within the model which may need to be supplemented or refined as well as how it appears to work in practice. In

addition, by investigating how therapists appear to have implemented and understood the model, as well as the dilemmas and challenges faced by therapists working with traumatised individuals using the WTM, the study aimed to provide valuable insights into the clinical utility and implementation of the WTM thereby informing best practice for practitioners who might be utilising the model in the future.

The format of this report is loosely based on a conceptual framework for trauma intervention research suggested by Edwards (1998) in that the evaluation and appraisal of the application of psychotherapeutic interventions is a central feature of professional practice and such evaluation is often undertaken by means of case studies. Arguments about therapeutic merits and demerits can also be strengthened when there are data from a series of cases, i.e., in multiple case study research. Case study based research is also warranted where economic and situational constraints preclude the use of large control based studies.

What follows is a brief review of the theoretical definitions of the terms relevant to this study.

1.3. Definitions

1.3.1. Trauma

According to Edwards (2005a), in psychiatric and clinical settings, the term trauma refers to extreme and often catastrophic events that pose a sudden threat to a person's life or physical integrity and produce a specific pattern of distress. Although there is a consensus about the criterion for considering an event to be traumatic in psychiatric terms (Mc Cann & Pearlman, 1990), it is recognised that there is diversity in an individual's subjective experience of that trauma. A person's reaction is often the benchmark of whether an event is viewed as traumatically stressful or not and thus, it is sometimes difficult to separate out the event criteria from the experience.

1.3.2. Post-traumatic Stress and Acute stress disorder

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

Frequently, a person's reaction to a trauma initially meets criteria for Acute Stress Disorder (ASD) in the immediate aftermath of the trauma. In keeping with the DSM-IV-TR definition (APA, 2000), ASD is distinguished from PTSD because the symptom pattern in ASD must occur within 4 weeks of the traumatic event. The disturbance lasts for a minimum of 2 days and is resolved within that four week period. In addition, at least one symptom from each of the symptom clusters required for PTSD is present. If the symptoms persist for more than one month and meet criteria for PTSD, the diagnosis is changed accordingly (American Psychiatric Association, 2000).

Brewin and Holmes (2003) state that PTSD is associated with disturbances in a myriad of psychological processes including memory, attention, cognitive-affective reactions, beliefs, coping mechanisms, and social support. In the aftermath of trauma, trauma-related emotions are typically powerful and beliefs distorted. Due to the avoidance of the unbearable material, these beliefs and feelings are often not subject to reality testing.

They therefore tend to remain unmediated and are frequently the main cause for the chronic nature of the symptomatology of PTSD (Resick & Schnicke, 1992).

It has been highlighted by Regehr, Marziali and Jansen (1999) that trauma survivors often report a range of emotional reactions including grief, generalised fears, self blame, emotional lability and emotional numbing, as well as cognitive reactions such as flashbacks, intrusive thoughts, denial and difficulties with concentration. They further highlight that social withdrawal and avoidance of social interaction may also occur post-trauma and are often exacerbated by the fact that many survivors change aspects of their lives such as jobs or locations. Recognition of the negative effects that trauma has on victims of violence in particular and the implications of traumatic stress, for general lack of functionality, underpins the need and demand for workable, brief-term forms of intervention, particularly in a country such as South Africa where large numbers of people are affected and professional services are limited.

What follows is a review of the literature outlining the basis for the Wits Integrative Trauma Counselling Model, its theoretical underpinnings and the central features of intervention.

CHAPTER 2

2.1 Literature Review

A review of the literature on post-traumatic stress can at times lead one to believe that one is dealing with completely disparate phenomena. Although different authors conceptualise trauma in various ways, essentially, what these different understandings point to is the complexity of the phenomenon of traumatic stress and the range of potentially complementary perspectives from which it can be understood. It is further argued that this complexity arises out of "the unique epistemology pertaining to traumatic stress, i.e., as a form of disturbance representing an interface of externally and internally based psychopathology" (Eagle, 2000). Freud's deceptively simple description of traumatic stress as arising as a consequence of 'an extensive breach being made in the protective shield against stimuli' (1920/55, p. 31), serves to highlight this attack on the interface between the internal and external world of the trauma survivor. Garland (1998) suggests that in the event of trauma, both internal and external anxieties coincide, where the external event is perceived as confirming the worst of the internal fears and phantasies. "Working with trauma therefore requires a dual focus on both external behaviour and internal processes" (Eagle, 2000, p. 303) and it is this characteristic that lends itself so ideally to an integrative intervention. As such, the Wits Trauma Model was developed out of an amalgam of theoretically informed approaches and clinical experience in treating traumatic stress conditions (as will be elaborated on later).

Although many of the promoted interventions for traumatic stress encompass integrative components, their rationale is not necessarily understood as such. Unlike the Wits Trauma Model, available treatment strategies (although encompassing a range of dimensions) tend to direct their interventions at specific dimensions of traumatic stress i.e., a strong focus on either cognitive features or exposure elements and anxiety management (Foa et al., 1991) or psychodynamic elements which tend to locate the impact of the trauma more within the person's historical context (Horowitz, 1992).

Sherman (1998) found significant effects for all psychological therapies, yet found no support for one single rationale for therapy. He did however; find that individual psychotherapy is the most common approach taken to the treatment of post-traumatic stress disorder. Prout and Schwarz (1991) argue the benefits of using a short-term integrated therapeutic approach. They identify five strategies common to a range of different treatment modalities: supporting adaptive coping skills; normalising the abnormal; decreasing avoidance; altering attributions of meaning and facilitating integration of self. The various benefits of different treatment interventions including debriefing, supportive counselling and psychotherapy are commented on by Raphael & Wilson, (1993, p. 112) as commonly encompassing the following: helping the individual to confront what has happened; expression of feelings associated with the event; construction of meaning; and gaining practical and cognitive mastery. However, according to Eagle (2000), the theoretical basis for these comprehensive interventions within an integrative psychodynamic/cognitive-behavioural perspective is not addressed by either pair of the aforementioned authors.

Two of the foremost authors associated with brief term psychodynamic interventions for traumatic stress are Horowitz (1976) and Lindy (1996). Their interventions tend to place greater weight on locating the impact of the trauma within the person's historical context, the therapeutic relationship and an explicit focus on the value of interpretive work leading to the integration of an altered sense of self. Horowitz (1976) developed a brief psychodynamic intervention which he based on cognitive stress theories and psychoanalytic theory. The focus is on solving the intrapsychic conflicts that result from a traumatic experience using information processing ideas and the relationship with the therapist is viewed as central to change. The change produced in the victim does not aim to include personality changes, as it is directed at the discontinuation of the current disorder, i.e., traumatic stress conditions (Brom et al., 1989).

According to Horowitz (1974), in this type of psychodynamic therapy, the traumatised individual must reconcile the traumatic event and its meaning with his or her concept of the self and the world. The primary goal of this psychodynamic intervention is to

facilitate the integration of the traumatic experience by means of therapeutic re-experiencing in a supportive environment, and this is called working through (Horowitz, 1974). In order to aid the victim in mastering the trauma and to restore functioning, insight into both the conscious and unconscious meanings of the symptoms must be developed (Sherman, 1998). In this regard, Horowitz (2001) draws on psychodynamically informed theories of bereavement, as well as contemporary cognitive behavioural theories of PTSD to explain the complex trajectory of recovery from trauma. Horowitz (1974) further states that psychodynamic therapy recognises the influence of dispositional variables on the response to both trauma and therapy.

According to Friedman (2003), Brief Psychodynamic Psychotherapy (BPP), conducted within 12-15 sessions, focuses on the traumatic event itself. Through the retelling of the trauma story to a calm, empathic, compassionate, and non-judgemental clinician, the client achieves a greater sense of self-cohesion, develops more adaptive defences and coping strategies, and successfully modulates intense emotions that emerge during therapy. While working through the traumatic memories, the clinician also addresses the link between post-traumatic distress and current life stress. Clients learn to identify current life situations and environmental triggers that set off traumatic memories and exacerbate PTSD symptoms. Although BPP has similar goals to exposure/cognitive therapy, the conceptual underpinnings and therapeutic techniques are extremely different (Friedman, 2003).

Cognitive theory has inspired and informed a number of distinct forms of psychological interventions generically referred to as cognitive therapy. Cognitive models for trauma intervention are concerned with the conscious personal significance of traumatic events for each survivor. Different models offer specific accounts of how information processing takes place, but a common theme is that each survivor is confronted with a challenge to integrate trauma-related impressions into existing cognitive structures (Orner & Schnyder, 2003). Cognitive behavioural interventions recognise that the underlying problem associated with traumatic stress reactions cannot be solely attributed to the maintenance of the fear response or anxiety but that additional difficulties exist which are

related to the individual's overactive cognitive patterns or schemata. These difficulties lead trauma victims to irrationally interpret external and internal experiences as dangerous (Foa et al., 1991). Cognitive treatment as applied to the treatment of traumatic stress focuses on two primary processes: 1) "changing a person's cognitive appraisal of the traumatic event or changing the process by which an individual attaches meaning to the event and, 2) changing a person's attribution of the event" (Sherman, 1998, p. 415). Cognitive interventions help the individual to identify and correct distorted schemata and attributions by training the individual to monitor negative thoughts, identify distorted schemata, and substitute reality-orientated interpretations (Meichenbaum, 1985).

For example, Ehlers and Clark's (2000) basic premise – which is based on and incorporation of different cognitive theory, literature and research spanning many years – is that the traumatic event is cognitively processed in a specific way that produces a sense of serious current threat by means of two key processes: (1) The appraisal of the trauma and its sequelae and (2) the nature of the memory for the event and its link to other autobiographical memories. These two processes have a reciprocal relationship, which further detracts from the individual's ability to see the trauma as a time limited event that does not have global negative implications for their future. The cognitive processing of the traumatic event is therefore dependent on a variety of factors such as prior beliefs, cognitive state factors (such as intoxication at the time of the trauma), the actual characteristics of the trauma, intellectual functioning and past experience (specifically prior traumatisation) to name a few. The way the trauma is then processed has a direct effect on both the trauma memory and the appraisals of the trauma and its sequelae. The treatment includes a variety of components such as psychoeducation, trauma reliving, cognitive restructuring and behavioural experiments (Ehlers & Clark, 2000).

Exposure therapy is also an established cognitive-behavioural PTSD treatment which emphasises the reduction of avoidance through repeated exposure exercises and usually takes the form of systematic desensitisation, in which the patient is gradually encouraged to reduce avoidance of the feared image or memory. Exposure therapies can also be combined with cognitive processing interventions (e.g. Resick & Schnicke, 1992). Stress

inoculation training (SIT) is also widely used in combination with relaxation techniques and anxiety management training (Foa et al., 1991). Another form of exposure therapy employs cognitive reprocessing combined with saccadic eye-movements (eye-movement desensitisation and reprocessing, EMDR). Proponents of EMDR believe that saccadic eye movements reprogram brain function so that the emotional impact of a trauma can be finally and completely resolved (Friedman, 2003). However, although research evidence seems to suggest that short-term approaches with trauma survivors, such as direct exposure therapies within a cognitive behavioural framework, appear to offer the promise of great benefit, they also appear to have produced mixed results (Yule, 1999). Foa et al. (1991) conducted a comparison of two cognitive behavioural techniques and discovered that anxiety management techniques were more beneficial to victims immediately after the treatment, but exposure techniques appeared more beneficial in the long-term. This led to the conclusion that in order to achieve optimum results, treatment of trauma survivors should include both techniques. In addition to this, in a study comparing psychodynamic theory, hypnotherapy and trauma desensitisation, Brom et al. (1989) found that psychodynamic techniques were better at alleviating avoidance symptoms whereas hypnotherapy and trauma desensitisation seemed superior in diminishing more intrusive type symptoms.

In a study involving Sudanese refugees who suffered from PTSD, Neuner, Schauer, Klaschik, Karunakara and Elbert (2004), found narrative exposure therapy (NET), a short-term integrative approach based on cognitive-behavioural therapy and testimony therapy to be more effective in reducing traumatic stress symptoms than supportive counselling and psychoeducation. The focus of NET is two-fold, that is, the habituation of emotional responding to reminders of the traumatic event and the construction of a detailed narrative of the event and its consequences (Neuner et al., 2004). Narrative therapy holds that our identities are shaped by the accounts of our lives found in our stories or narratives. Since many of the people who have been subjected to severe trauma struggle with a loss of voice, of entitlement and of a sense of themselves (Durrant & Kowalski, 1992), therapists need to leave enough space for clients to fully articulate their own personal experience. Through this process, the external traumatic event becomes

dispossessed of its identity-shaping powers with the focus shifting to clients' internal choices and agency in handling the crisis. Clients are then in a better position to separate from interpretations of traumatic memories that have eroded their preferred experiences of self and live a more satisfying life (Durrant & Kowalski, 1992).

In keeping with the benefits of using a short-term integrated therapeutic approach, it was hoped that early interventions such as Critical Incident Stress Debriefing (CISD) and one-session psychological debriefing, might prevent the development of PTSD in individuals exposed to trauma. However, the appropriateness of such practices has been questioned (Gray & Litz, 2005). Some criticism stems from a growing concern that aspects of psychological debriefing as it is commonly practiced are out of step with what we are learning about how people respond to and recover from trauma. Even if we could accurately identify individuals certain to develop post-traumatic stress disorder, it does not seem plausible that a single session of psychological debriefing would be sufficient to prevent the disorder from occurring (Gray & Litz, 2005). In fact, there is some reason to think that some vulnerable individuals may experience more symptoms as a result of a debriefing intervention and that single session debriefing interventions should not be routinely implemented following a traumatic event (Bisson, 2003). This suggestion that debriefing may make some people worse, may in part be due to the use of procedures that are too short, resulting in exacerbation of symptoms rather than habituation. Equally, if interventions are offered too soon after the traumatic event, those involved may not be "ready" psychologically to make use of such interventions (Yule, 1999).

Similarly, Orner and Schnyder (2003) argue that crisis intervention is not a sufficiently elaborate strategy for addressing the early sequelae of traumatic related disorders. However, they do recommend that priority should be given to early interventions that re-establish a steady state in the trauma survivor, which is promoted by regaining control over one's life and especially over the initial emotions engendered by the traumatic event. It is only when psychological and social homeostasis is re-established that consideration should be given to introducing further therapeutic methods. According to these authors, there is strong reason to believe that to the extent that early intervention strategies

incorporate the principles that underpin crisis intervention; it may be possible to affect some secondary preventative interventions in respect of the development of PTSD.

Although their rationale is not necessarily understood as such, it is evident that the aforementioned psychotherapeutic treatment techniques for post-traumatic stress encompass integrative components, target similar symptoms and identify common goals for treatment recovery. However, despite the considerable degree of overlap within these methods, clinicians still tend to view their interventions as relatively purist, conceived within specific schools of psychotherapy and according to Eagle (2000), specific reference to integrative psychotherapy in the trauma treatment literature is lacking. Stickle (2006), concurs in this regard yet also states that such approaches appear to be common in practice. He suggests that although an eclectic approach to treatment augmentation has appeal based on its perceived relevance to immediate clinical phenomena and its potential to involve clinicians in refining treatments, it remains unclear how best to piece together components of therapies, processes, and strategies.

In South Africa, workers in the field of trauma have ranged freely across psychodynamic, cognitive-behavioural, and indigenous treatment modalities and have, in several instances, integrated these to provide innovative interventions for trauma (Eagle and Watts, 2002a). Eagle (2000) advocates an integrative approach synthesising psychodynamic principles with cognitive-behavioural (CBT) interventions in the treatment of psychological trauma. According to Eagle (2000), this combination has validity not only in terms of the assertion that trauma impacts dynamically on both internal and external psychological functioning, but also in terms of comprehension of the mechanisms of damage and repair.

The cognitive approach aims at facilitating the development of coping skills and in assisting the individual to identify and correct cognitive distortions and attributions of meaning (Sherman, 1998). Furthermore, the therapist wishes to prevent the development of phobic avoidance initiated by what could be considered a powerful classical conditioning experience, stimulating associations between intense anxiety and various

features of the traumatic situation (Kilpatrick et al., 1979). The goal of psychodynamic interventions is to facilitate the integration of the trauma and to prevent the use of repression as a defence. The therapist is also invested in protecting the person against further regression given the overwhelming assault of traumatic exposure on ego-functioning (Freud, 1920/55). The influence of dispositional variables on the individual's response to the trauma and therapy is acknowledged and insight into the conscious and unconscious meaning of the symptoms is encouraged (Eagle, 2000; Sherman, 1998). Thus, the process of trauma intervention can be understood as reparative and preventative within both frameworks.

Most of the treatment literature on trauma is in agreement that the intervention required is generally of a short-term nature (Prout & Schwarz, 1991), often lasting from as little as 2 up to a maximum of 15 sessions. Such brief-term interventions are widely advocated as the treatment of choice for adult trauma survivors (Eagle, 2000) and are particularly relevant to a South African context where the need exists to develop alternative and effective brief-term interventions that are both cost effective and efficient in order to meet the needs of a considerably impoverished population with access to limited services. Similar to crisis interventions, in most cases brief- term interventions for traumatic exposure or Acute Stress Disorder (ASD) assume relatively healthy premorbid functioning and aim to restore equilibrium as quickly as is feasible (APA, 2000).

Although the WTM can be implemented at differing levels of depth depending on the skill of the practitioner, its relatively straightforward set of intervention guidelines means that it is suitable for training of and implementation by trainee psychotherapists and volunteer counsellors. Renes (1999) found that it was the most widely used intervention model amongst NGO's in the Gauteng region. This again points to some need to systematically investigate the employment of the model in practice.

2.1.1. Research on the effectiveness of PTSD and ASD treatments

We live in an age of accountability and clinicians are increasingly being asked (particularly in public- funded services) to justify the interventions they use. In many

countries there is a move towards evidence-based practice (EBT), the underpinning of which is that when we intervene in the lives of others, we should do so on the basis of the best evidence available regarding the likely consequences of that intervention (Orner & Schnyder, 2003). Treatment procedures and programs for traumatic stress conditions and PTSD are becoming more prevalent and more standardised procedurally and most of them seem to share basic treatment components and goals. However, despite the increase in such programs and although extensive literature exists concerning adjustment to traumatic events and traumatic stress symptoms, there remains a need for further research to be conducted around the effectiveness of specific psychotherapeutic methods for treatment of traumatic stress and PTSD (Brom et al., 1989).

Treating both PTSD and ASD is obviously a complex process that poses a great challenge to all practitioners as they try to contain severe distress and suffering. What makes this treatment process even more difficult is the uncertainty that has arisen about which treatment interventions are the most appropriate and effective (Sherman, 1998). According to Perconte (1989), much of the existing treatment literature consists of case studies, case reports, and uncontrolled investigations. However, despite the lack of controlled outcome studies confirming the efficacy of the various psychological treatments of PTSD sufferers, researchers express optimism regarding this field of research. Fairbank and Nicholson (1987) report such optimism because they believe that the initial positive findings and replications in reported case studies are sufficient evidence for good groundwork. This sentiment is echoed by Yule (1999), who reports that many single case descriptions of treatment outcome have been undertaken within rigorous single case experimental methodologies that permit drawing the conclusion that the treatment was responsible for the change observed. He further refers to the usefulness of such studies in establishing the efficacy of different treatment packages. Edwards (2005b), suggests that considerable attention has been paid to the treatment of PTSD in the past decade and that there is a growing body of efficacy research that has evaluated a large number of interventions in randomised controlled trials.

2.1.2. Description and outline of the Wits Trauma Model

The Wits Trauma Model was developed by Eagle, Friedman, and Shumkler (members of staff at the Psychology Department of the University of the Witwatersrand). The model was formulated and developed over several years out of an amalgam of theoretically informed approaches and clinical experience, for example, in working with rape survivors in Rape Crisis organisations. The model thus incorporates many elements of previously documented and undocumented intervention practices and was amended on the basis of clinical feedback. For example, the focus on issues of self-blame was a later addition in developing the model. Methodologically, therefore, the model was in part developed out of an empirical multiple case study approach located within a South African context.

The model was employed by Wits Clinical Psychology Masters trainees and others from the early nineties but it was only in 2000 that Eagle wrote an article outlining the theoretical premises on which the model is based. The model utilises an integrative approach i.e. drawing upon psychodynamic and cognitive behavioural understandings and approaches, as conceptualised within the integrative psychotherapy paradigm. The intervention lasts from as little as 2 up to 12 sessions, though experience with the model has generally indicated that as little as 4 to 6 sessions may be sufficient in dealing with a range of traumatic experiences. It is therefore ideally suited to the South African context where the enormous demand for such services necessitates a time limited, efficient and cost effective approach. The model continues to inform the training placement work for clinical trainees and staff at the Centre for the Study of Violence and Reconciliation (CSVR Trauma and Transition Program), offering one of the few specifically trauma oriented service centres in the Gauteng region.

Due to its brief-term nature, the model is best suited to post-traumatic stress cases that are not complex in nature in that they do not involve prolonged and repeated trauma. It is thus perhaps best suited to traumatic stress response and ASD presentation treatment rather than for treatment of fully developed PTSD, although it has been used with some success with clients presenting with PTSD and delayed onset PTSD (usually in more extended form).The model is also not applicable to ongoing traumatic events and

phenomena, such as war, for example, as this would ususally require more traditional long-term psychotherapeutic intervention. It is also perhaps limited in its application to cases of chronic PTSD which also tend to require longer term treatment.

From an integrative perspective, writing on the model provides an explanation of how psychodynamic and cognitive-behavioural processes interact to influence the development, maintenance and/or prevention of post-traumatic stress symptoms (Eagle, 2000). The epistemological foundation underpinning the model is perhaps its greatest strength and the key to its success, that is, an explicit recognition that trauma impacts on both internal and external psychological functioning, and therefore requires a treatment approach which addresses both the more internal, psychodynamic phenomena, as well as a focus on external stimuli and patterns of response which is structured and problem-oriented (Hajiyiannis & Robertson, 1999).

In outlining each component of the model, Eagle (2000) highlights how the psychodynamic and cognitive-behavioural perspectives compliment each other. The researcher acknowledges the use of Eagle's (2000) format and description of the counselling process in the next section. As this study aims to explore and highlight the strengths and possible limitations of the Wits Trauma model, it will be presented in detail.

The model involves five related components of intervention that may be given different emphasis depending on the client and what preoccupations they bring to the session. The five components are as follows:

1) Telling/retelling the story
2) Normalising the symptoms
3) Addressing self-blame or survivor guilt
4) Encouraging mastery
5) Facilitating creation of meaning

Telling/retelling the story:

This involves the client giving a detailed description of the traumatic event (in sequence of events), including facts, feelings, thoughts, sensations, as well as imagined or fantasised aspects. This allows expression of the client's previously repressed feelings and fantasies connected with the traumatic event. In this component of the model, it is often useful to address the most difficult aspects of the event - the main cognitive themes or 'hot spots' (Ehlers & Clark, 2000) - through asking the client what the worst or most painful moment of the experience is. This provides both the client and counsellor with more information about what the most difficult part of the experience was and often points to areas that need further exploration.

The advantages of retelling the story are many: the sharing of feelings and fantasies prevents their repression and displacement into other symptoms; in telling the story the client is able to impose a time sequence onto the event, aiding the transformation of what are often sensory and episodic memories into the realm of reflective thought and symbolisation; by providing a sense of containment, the counsellor is able to act as a positive role-model to the client in that they are able to demonstrate the ability to tolerate horrific or overwhelming aspects of the traumatic event, serving as a positive model to clients when traumatic memories are evoked in the future; detailed telling of the story encourages confronting rather than avoiding aversive stimuli, thereby serving to reduce anticipated anxiety associated with the stimulus. From a psychodynamic/ Winnicottian perspective, the therapeutic space can be understood as a transitional space in which the trauma is relived in the realm of the symbolic rather than the actual and thus becomes accessible to processing. The presence of a 'holding' or 'containing' other is also seen as significant informing the therapeutic attitude and stance of the therapist. Narration of the story and the therapist's empathic attitude in response to this are essential features of the intervention.

Normalising the symptoms:

The first step in any therapeutic undertaking is to make sure that clients understand the nature of traumatic stress and its effects on them. This component involves obtaining

client information about symptoms experienced, as well as educating the client about what symptoms to anticipate. The client's symptoms are discussed and empathised with, while simultaneously providing education with regards to post-traumatic stress symptoms. Counsellors make links between the traumatic event and symptoms experienced, all the while reassuring the clients that their responses are normal reactions to an abnormal event and that they will diminish in time. This component is important as it serves to engender a profound sense of relief by reducing the client's common fears that they are going 'crazy' or 'losing their mind'. This also serves to reduce the chances of a client suffering secondary traumatisation due to the anxiety associated with their own uncharacteristic reactions/symptoms.

Addressing survivor guilt or self-blame:

In this phase of the model, feelings of self-blame or survivor guilt are explored.
In many cases, survivor guilt may not be present, but in virtually all cases there are feelings of self-blame. Self-blame may represent a wish to retrospectively 'undo' the trauma and thereby restore a sense of control. It may also relate to the belief that the person could have done more to prevent the trauma. Survivor guilt may emerge when the client has survived a trauma 'better off' than others who were similarly exposed (e.g. others who were injured or even died in the incident). During this phase it is important to take the client through the events very carefully, simultaneously exploring other ways of handling the situation and using a reality oriented approach to identify how useful these would have been in the real situation. During this process, the client often realises that their guilt or self-blame is irrational and that they did the best they could under the circumstances. Socratic questioning may be used to explore the validity of self doubt and self recrimination. In cases where the client's actions caused the traumatic event, for example a drunken driver who knocks over and kills a child, the counsellor needs to help the client distinguish between outcome and intent or motive.

Addressing survivor guilt or self-blame serves various functions: it reassures the client that they did the best they could under the circumstances; helps restore self- esteem by affirming any thoughts, behaviours or strategies that were effective in the situation; helps

to separate motive from outcome by reinforcing the fact that the client's actions facilitated their survival; and helps to overcome irrational beliefs that the client may have, for example feeing unable to take care of others in the future.

Encouraging mastery:

In this phase of the model the counsellor assists the client to continue with the tasks of daily living, with the aim of restoring the client to previous levels of coping and functioning. One of the most important aspects of coping is adequate support. The client is encouraged to seek out and utilise existing support structures and where necessary, the counsellor provides various techniques to assist with coping. These techniques include relaxation exercises, anxiety and stress management skills, cognitive techniques such as thought stopping, distraction and time structuring, as well as systematic desensitisation. All the techniques aim to restore the client's coping capacity and consequently, to reduce anxiety and increase a sense of control.

Facilitating creation of meaning:

The final stage of the model is optional, and is only used if meaning related issues are raised by the client. By engaging with the client's existing belief system - this may be on a cultural, political, spiritual, or existential level - the client can be assisted with establishing meaning around the traumatic event. Work in this area must, however, remain respectful of the client's beliefs and experience, while simultaneously assisting the client in deriving some meaning from the event in a way which engenders hope and some future perspective. Essentially, this component of the model can be viewed as enhancing the client's ability to understand him/herself as a survivor rather than a victim of the trauma and resonates with both psychodynamic and narrative understandings of trauma work.

It should be noted that the therapeutic relationship is not included as a specific component of the model, although it is assumed to be imperative and its effects are viewed as important throughout the counselling process (Eagle, 2000; Naggan, 1998).

The reader is referred to Eagle (2000) for a more detailed theoretical exposition of the integrative nature of the model and its components.

2.1.3. Previous appraisals of the Wits Trauma Model

Although the Wits Trauma Model has not been subject to rigorous evaluative experimental research, qualitative investigations of both client and counsellor perspectives, client feedback, and clinical evaluations have demonstrated the usefulness of the model in alleviating traumatic stress symptomatology.

In a paper presenting counsellor's appraisals of the model, Hajiyiannis & Robertson (1999) identify a number of strengths of the WTM as well as potential limitations. They highlight the success of the model as lying in its flexibility and its ability to meet the unique individual needs of clients. Limitations relating to the assumption that clients have sufficient ego strength were encountered when working with clients who are still in the process of reliving events, are highly anxious and who display regressive features. Other shortcomings of the model included the preclusion of the possibility of adequately addressing the transference and countertransference aspects of the therapeutic process due to its brief-term nature. However, Eagle (2000) does address this issue stating that, "within the Wits model the transferential elements of the relationship tend to be recognized, but remain uninterpreted and unelicited" (p 309). Regarding the model's effectiveness in cases of traumatic bereavement, the failure to integrate principles of bereavement counselling into the model, is also viewed as problematic (Hajiyiannis & Robertson, 1999). Furthermore, the paper makes recommendations for the improvement of the model, with particular reference to working with the elderly, anger management, and the inclusion of a socio-political analysis component in order to facilitate meaning.

Naggan's (1999) exploratory telephonically administered questionnaire based study into the Wits Trauma Model's efficacy as perceived by clients who had been treated using the model found that there was generally substantial support of the model in terms of participant's subjective ratings of the counselling process. The questionnaire was

designed to operationalise various elements of the model (as accessible to understanding by the clients) and to ask clients to indicate how helpful they had found various aspects on a Likert scale. The results of the study indicated that the therapeutic relationship was viewed as particularly important, followed by the components of the WTM in the following order: normalising, retelling, addressing self-blame and encouraging mastery, in fairly close succession. Her findings also indicated that components involving facilitating the creation of meaning were only found to be important in a minority of cases. However, given the brief length of interventions involved as well as the small sample size (N=20), this lack of differentiation in the results was to be expected. Of further interest was the fact that all the participants in the study reported symptom alleviation and overall improvement in functioning (Naggin, 1999).

CHAPTER 3

3.1 Research Methodology

3.1.1. Research Design:

The research utilised a qualitative approach in the form of a multiple-case study design, a design which entails investigating two or more of the same types of units. This allowed the opportunity for comparison of different cases studied in the same context (Yin, 1989). An embedded design study was necessary in order to systematically examine three aspects of the selected cases: 1) sub-units of the case, 2) the case as a whole, and 3) how the sub-units related to each other and to the larger case. For example, in studying the different therapy cases, one can study both the whole case and individual sessions as separate sub-units within themselves and in terms of how they relate to the total case. A separate analysis of each example of the implementation of the model in brief-term psychotherapy was therefore conducted on a session-by-session basis in order to explore its perceived impact and usefulness to the client (as reported by the therapists) and how the individual sessions related to each other and to each case as a whole.

3.1.2. Data Collection:

According to Creswell (1998), the choice of data collection method depends on the type of data the researcher needs. The aim of the study was to explore and appraise the implementation of the Wits Trauma Model by making use of archival case based data that demonstrated the application of the model and illustrated the operationalisation of its principles. As the situation in which qualitative research is done is indeterminate, that is, it cannot be controlled as in conventional research methods, the qualitative researcher has to rely on techniques such as interviews, observations, document analysis and non-verbal cues (Hammersley, 1998). In this case the data took the form of documents, case file notes recording brief term interventions with traumatised clients using the WTM.

The data were manually obtained from past Wits University case files, consisting of student's case notes – selected cases in which the model had been used as the primary method of treatment intervention, detailing implementation of various aspects of the model with clients presenting with traumatic stress symptoms following various types of traumatic incidents**.** A total of six case files from both Alexandra Clinic and the Centre for the Study of Violence and Reconciliation (CSVR Trauma and Transition Program), were found to meet the criteria for inclusion and 'mined' for appropriate case data.

Case files from between the period of 2001 to 2006 were selected on the basis of several predefined criteria: the nature of the trauma; minimum number of sessions and thoroughness of case notes, all of which are elaborated further. The intention was to obtain sufficiently rich data so as to be able to meaningfully analyse material with regard to the implementation of the WTM. All of the cases had been seen by clinical Psychology Masters students in their first year of training who had received training in the WTM at the outset of their year and were supervised on their work with trauma related cases within the framework of the model. As will be further apparent in the findings and analysis section, the case notes recorded the work of 6 different trainees, all of whose files fitted the profile for the research. It was intended that looking at the implementation of the model by different therapists would control to some extent for the particularity of each therapists style, allowing for a more considered evaluation of the model across different cases and therapists.

The six sets of case notes were selected from a total of forty available trauma case files on the basis of the availability of thorough case notes documenting client exposure to a traumatic event that involved an act of criminal violence (e.g., armed robbery, mugging, and hijacking). As the Wits model was designed primarily for the treatment of more straightforward presentations of acute stress and post-traumatic stress disorders, the target sample excluded victims of many or multiple traumas, victims of long-term sexual and/or physical abuse, and victims of domestic violence, due to the complexities involved in these kinds of trauma. Victims of rape were also excluded, as sexual violence may have additional gender-based dynamics that may not present in the other types of traumatic

experiences. Only cases in which there were reports of at least 4 sessions of intervention were included as it was understood that it was important to have sufficient data to analyse. The search for 'suitable' cases was not exhaustive, but as is clear from the numbers a large proportion of the files that were scrutinised did not fit the criteria for a range of reasons, predominantly, however, because clients had been seen for less than 4 sessions, which is interesting in and of itself.

Case notes had been written during and directly after each session and each case data set comprised a minimum of 5 to 6 sessions depending on the type and severity of the trauma. The quality and extent of the case notes were found to vary in length from a minimum of 1½ to a maximum of 7 pages per session and all were structured so as to include all or some of the following sections: 1) biographical and referral information; 2) mental status; 3) historical background; 4) relevant history of the presenting problem; 4) clinical interview; 5) evaluation of the session; 6) provisional DSM-IV-TR diagnosis; 7) treatment plan and notes for supervision. Case notes from earlier sessions tended to include more diagnostic information whereas recording of subsequent sessions focused more strongly on intervention dimensions and ongoing assessment of clients' responsiveness and difficulties. Finally, the data were checked and validated for applicability for this research by the research supervisor.

3.1.3. Ethical considerations regarding data use:

Ethical considerations were given careful consideration. Only the files of clients and counsellors who had previously given signed informed consent to use the data for research purposes were scrutinized (see appendix G). Only the researcher and the research supervisor discussed the case material and it was never discussed in any other context. In writing the case narratives participants were given pseudonyms and specific personal information (e.g., where they lived, their exact ages) was omitted. On occasion information which was found to have no clinical relevance was altered (e.g., where a situation in a particular locale was discussed, the name of the locale would be changed). In addition and in keeping with the principle of beneficence, it was decided that any very

recent case data should be excluded. Thus the most recent case file included was a record of work conducted in 2006.

3.1.4. Data Analysis:

A thematic content analysis was used to both inductively and deductively explore the case note material. According to Ezzy (2002), a thematic analysis should make use of open coding, the process of constant comparison, axial coding and selective coding in order to inductively explore and reflect on the data. The task entails the development of an 'emergent fit' between categories that emerge through data analysis and knowledge of categorical schemas utilised in pre-existing theory, potentially allowing a new understanding to emerge, one that explores similarities, and differences, across a number of different cases.

Following this methodology, the data analysis included the following phases:

Phase 1: This phase commenced with data collection. By the time the data were collected the researcher had a preliminary understanding of the meaning of the data. This understanding was gained by the fact that the researcher collected the data personally reading through all the available case files and thus developed an intuitive understanding of the data at the outset.

Phase 2: After reading and re-reading the case notes, the researcher inductively explored the data, extracting units of information deemed relevant to the research focus.

Phase 3: The different sections or units of data were explored in terms of what the WTM holistically aims to achieve in a limited time frame, the contribution of each component of the model to the course of therapy and obstacles to progress as they played out in each particular case. In this regard, a set of broad questions and related thematic criteria were developed in line with Kanfer and Schefft's (1988) "phases of therapeutic change" model, in which a client's responsiveness to particular therapeutic procedures varies in

terms of what phase of the therapeutic process the client is in (Fishman, 2005). The questions and related thematic criteria utilised in this research are detailed as follows:

1. How did the model as a whole appear to work in practice?
   More specifically, was there:
   - Evidence of symptom reduction
   - Evidence of appropriate coping or readjustment
   - Evidence of greater client agency or autonomy over time
   - Evidence of greater understanding or insight on the part of the client

2. Which component/s of the model is/are in evidence in each session and how does/do this /these aspect/s appear to work?
3. What were the perceived lacunae or areas within the model which may need to be supplemented or refined?

Many uncontrolled variables, including extra-therapy events and elements in the therapy process itself could account for a favourable outcome and were also considered where case notes provided sufficient access to such information. Addis et al., (1999) in Fishman (2005) highlight dialectical dilemmas pertaining to adherence to a model versus individual-client-focused flexibility from the individual therapist's perspective. In this light, the research analysis also aimed to reflect on issues and sub-questions such as:

1. Does the model encourage creativity in applying the treatment principles and strategies?
2. Was the model flexible in terms of the therapist's adherence to its different phases or to the needs of specific contexts and the personalities and circumstances of individual clients?
3. Were there related non-specific therapy factors such as the relationship between client and therapist that appear to influence therapeutic outcome?
4. Has the model been used in the service of broader treatment goals?

Phase 4: Based on the preceding phases, a selective thematic case narrative was synthesised for each of the six selected cases. The different narratives incorporated all central phenomenological themes and therapeutic elements so as to accurately capture the flow and form of therapy as the clients moved through the treatment process in each case.

Phase 5: A synthesising commentary or overview, drawing together the thematic analysis observations is offered, allowing for a meta-analytic perspective on the implementation of the WTM as observed through the lens of the six sets of case note data.

CHAPTER 4

4.1. Findings and Interpretation of the Data

In order to provide a context for the reader, the researcher has included the thematically selective narrative for client 1, the case of 'Sylvia', in full. Following this, narratives for clients 2 to 6 are outlined in the form of a synopsis and analysis of each session, while the full elaboration of material pertaining to each of these cases can be found in the appendix section. In view of the ethical considerations mentioned in the previous chapter, a process of thick or 'verbal disguise was used in all the narratives and each client was given a pseudonym. Care was taken to maintain veracity as far as possibly despite the disguising of material. The researcher refers interchangeably to 'the client' and the client by name, given that he is not the therapist and is therefore taking a more distanced stance. It should also be noted at the outset that although the case work narratives or synopses are clearly mediated through the therapists' accounts of and reflections upon what took place in each session (with possible omissions and enhancements), for the sake of simplicity or clarity, the case notes are treated as truthful accounts of what occurred. However, it is recognised that this represents an important limitation in the analysis as will be discussed later. Therapist case notes have been viewed as legitimate data for many other studies nonetheless (Breakwell et al., 1998).

Units of information deemed relevant to the research focus were extracted and the thematic analysis observations structured, interpreted and described according to the following criteria: 1) indications of client improvement or progress (or lack thereof) with reference to the criteria outlined in the methodology chapter; 2) any reference to use of elements of the WTM and illustration of this; 3) any reference to other intervention aspects, including relational elements; and 4) inferences or observations which seem important in terms of evaluation of the implementation of the WTM.

4.1.1. CLIENT 1: THE CASE OF 'SYLVIA'

Sylvia was an English speaking white female in her middle twenties who reported for trauma counselling following an incident in which she was accosted by two men outside a block of flats. The men then proceeded to hijack her car. This was Sylvia's second hijacking and she was seen for a total of five sessions (including termination) by a 'coloured' female trainee clinical psychologist at the CSVR (trauma clinic). Sylvia reported recovering quickly from the first hijacking experience but described feeling more vulnerable on this second occasion. She was struggling with issues of self-blame, intrusive thoughts and feelings of insecurity. She further reported having 'flashbacks', feeling anxious, concentration difficulties, absent mindedness and agitation.

Session 1:

During the course of the first session Sylvia narrated her story in considerable detail which included facts, affect, and fantasised aspects of her traumatic ordeal. It became apparent during the course of her narrative that she had not been completely honest in her initial interview and that she had not given all the details relating to the traumatic incident. On re-telling the story in more detail Sylvia explained that she had actually been to the specific area on several occasions in the past, for the illicit purpose of purchasing drugs and that the night watchman at the flat block was her usual contact in this regard. On this particular occasion, she had only seen the two hijackers, whom she assumed were her new contacts. It emerged that she was taken by the two men into the night watchman's room after which she was tied up and blindfolded at gun point.

The most disturbing aspects of the traumatic experience for her were as follows: 1) standing in the room and realising that she had no way of escaping; 2) feeling terrified that the two men would rape her, and 3) claiming that she should have known better. She described being pulled onto a table and kissed forcefully and repeatedly on the face and mouth. Sylvia said that she had felt extremely repulsed by the act and that although she was forced to respond, she had begged the men not to rape her. She further described that the kissing made her feel as though her integrity had been taken by force. Sylvia recalled

thinking that if she was to survive the incident, she needed to make the men feel as if they were in control; she was also careful not to irritate or provoke them and did everything they requested of her. She reported having been able to reflect on her circumstances while in the corner of the room and that in doing so she had managed to achieve a sense of calm in the face of her situation. Towards the end of the session Sylvia spontaneously ventured that the retelling of the traumatic event was helpful in terms of putting things into perspective and reported the normalising of her symptoms to be reassuring.

Synopsis and analysis of the session:

It was clear from Sylvia's own retrospective appraisal of her thoughts and behaviour during the incident that she was already demonstrating *aspects of mastery* and *meaning making* at this early stage in her narrative. However, it was not clear as to whether these were addressed in this particular session by the counsellor. At the end of the session Sylvia described the *retelling of the traumatic event* as helpful in terms of putting things into perspective, suggesting that the exposure function of the retelling aspect of the model had been experienced as beneficial, as well as assisting in the creation of a more reflective, coherent, narrative account. She also reported that she had found the *normalising* of her symptoms reassuring. The most difficult aspects of her traumatic memories appear to have been explored, although Sylvia's self-blame was not explored or addressed in this session. Furthermore, the opportunity to enhance her self-esteem by, for example, reframing her cooperative behaviour during the incident as adaptive or pointing to her ability to reason during the event,was not evidenced from the case note record of the session.

Session 2:

Sylvia's symptom picture seemed to have improved somewhat as she reported feeling much better and she reported that increasing her exercise sessions had also helped to calm her down. Although she was still reportedly jittery and wary of her surroundings, she was not re-playing the incident in her head as much as before and the 'flashbacks' had reportedly stopped. Sylvia was however concerned that she was still clumsy and absent-minded.

Sylvia experienced the retelling of the incident as less emotional in that she could recount the facts of the event without experiencing the accompanying fear that she had felt with the first telling. She still reported standing in the night watchman's room as her most powerful memory and she repeated that the event had triggered a realisation as to how gullible she was and how stupid she felt for not heeding her internal alarm signal. Sylvia further described that she remembered being terrified that the men were going to kill her because one of them had shouted three times that he was going to shoot her and then leave her. She reported a fantasy in which the man that had kissed her and told her that he would not rape her, had saved her from being killed. She felt that he had a certain regard for her life and that he had been sincere about not harming her. She also felt that because the hijackers were pressed for time and risked getting caught, they did not rape her.

The counsellor reflected that it seemed as though Sylvia had experienced the hijackers as split - a good guy and a bad guy, almost in the sense of playing two different roles. Sylvia responded that she had found this reflection useful in terms of putting a name to her confusion, as well as in assisting to describe how she had experienced the trauma at times. She further reported being specifically angered by what the hijackers had done because the insurance company had been delaying paying her out for her car until the investigation was complete. Sylvia reported that she had not been completely honest in detailing the circumstances of her hijacking - telling the police and the insurance investigators that she had been in that particular area to visit a friend.

Synopsis and analysis of the session:

Although the client still reported symptoms of hypervigilance, clumsiness and absentmindedness, it was clear from the session extract that there was evidence of partial symptom reduction in terms of the intensity of Sylvia's symptom picture. These former mentioned aspects of her behaviour could be understood as representing some degree of regression and cognitive disorganisation, including difficulty in concentrating. Sylvia's report that her exercise classes had made a substantial contribution to reducing her

anxiety could be seen as referencing an aspect of 'intervention' beyond the scope of the WTM and yet, also suggestive of the benefit of the *mastery aspect* of the model in terms of highlighting greater agency on the part of client through the active use of her own resources in the restoration of previous levels of functioning. Her experience of the *retelling of the incident* in this second session as less emotional than the first telling provided some evidence of an increased tolerance of the anxiety provoking material and the effectiveness of the controlled exposure element attached to this component of the model. The difficult memories or hot spots of the trauma were still evident as was the element of self-blame, however, in recounting the trauma as a sequential story; new details or aspects of her memory appeared to emerge, indicating that the regressive impact of the event in the form of cognitive disorganisation had at least been partly ameliorated. It was also evident that Sylvia had attempted to *make meaning* through her retrospective appraisal of why her assailants did not rape her, and in the sharing of her fantasies with the counsellor in this regard, the repression of key aspects and displacement onto other symptoms was possibly prevented. For example, she was able to openly talk about her fantasy of being raped and her dream of being 'protected' by one of her hijackers – a complex representation of her mixed feelings in attempting to engage with both hostility and apparent leniency on the part of her attackers. She seemed to respond positively to some reflective, meaning-making around this. However, the client's issues around anger and self-blame could have been addressed as well as the secondary stress regarding her insurance claim difficulties. This secondary stressor seemed to be complicating her recovery at this point in the therapy.

Session 3:

Sylvia reported that she was no longer feeling as 'paranoid' on the roads as before and that she had returned to the scene of the crime twice in the past week. She went once with the insurance assessors and reported feeling 'somewhat on edge' after being at the scene again. She returned a second time, at night, with her brother in order to speak to the night watchman. She told him to tell both the insurance assessors and the police the truth should they question him about the incident as she 'wanted to come clean' regarding why she was really there. Sylvia described a feeling of relief in finally being able to tell

everyone what had really happened and reported that the insurance company would now pay her out for her loss.

When Sylvia retold the story this time she reported that the retelling felt less traumatic. She described experiencing very little discomfort attached to the incident and she also described feeling less of a need to tell other people about what had happened because it was no longer as pressing for her. According to the client, the last time she had told the story to anyone was in the previous session.

Sylvia reported feeling that her support systems had also been important in putting the incident behind her; close friends had constantly checked up on her and her sister had monitored her distress and need for support very carefully. She also reported feeling far less clumsy and not as absent-minded as before. Sylvia felt that the incident had helped her to take ownership of areas in her life that she had previously not been very assertive in. She ended the session by explaining that she had been having fantasies of 'bumping into her assailants and taking revenge' upon them.

Synopsis and analysis of the session:

There was further evidence of reported symptom reduction in terms of the client's diminished feelings of insecurity as well as improved reasoning capacity. The fact that the client had returned twice to the scene of the crime showed a marked increase in self-efficacy, reduction of avoidance symptoms and enhanced coping ability. It was not clear whether this action had been prompted directly by the therapy, however. Although guilt and self-blame were still not addressed by the counsellor, the client seemed to be developing her own insights and dealt with this aspect in her own way, thereby evidencing spontaneous mastery, meaning making and reduction of self-blame. Again, there was a suggestion that the exposure element underlying her retelling of the story was working in that she reported experiencing very little discomfort related to the incident and less of a need to have to retell the story to others. The counsellor's intervention regarding the *mastery aspect* of the model involved supporting her mobilization of existing support structures.

Sylvia's capacity to derive meaning from the experience also seemed to spontaneously emerge during the counselling as evidenced in her feeling that the incident had helped her to develop new convictions and directions for her life. However, it was unclear as to whether this was specifically facilitated by the therapy at this time. Her underlying hostility and aggression were also still evident in her reported 'retaliatory' fantasies of bumping into the hijackers and taking revenge. These fantasies could also have been normalised in terms of being common in trauma survivors, particularly where there is a perception of abusiveness on the part of the perpetrators, and concerns about lack of retribution through the criminal justice system (Eagle, 2000).

Session 4:

Sylvia reported that the insurance company had paid her out for her claim and that she had been car hunting in the past week. She seemed optimistic about her future and was looking for new employment. In this regard, she explained that she was bored in her job and felt that she needed a change. When the counsellor intervened to assess whether her need to change jobs might be related to the hijacking incident Sylvia reported that she had not been happy in her job for a long time and that she enjoyed being on the 'cutting edge' and could not bear to be in a setting where her work no longer challenged her. The counsellor urged her not to be impulsive and to resign before she had secured alternative employment and she had agreed. It appeared that the search for new employment was related to her sense of having developed new insights as a consequence of having undergone the trauma (*meaning making*). Sylvia had reportedly not thought about the incident at all in the past week.

When Sylvia 'freely associated' about the incident in the session, she reported fantasies of the assailants shooting her and wondered what it would have felt like if she had been shot. She continued to explain that she no longer had retaliatory fantasies but that she felt consoled on a 'karmic level' that 'the wheel of justice would turn and that, somehow, the hijackers would pay for what they had done'. She reported that these thoughts gave her a sense of peace. The counsellor then discussed her understanding of the process of therapy and how she had adjusted to the traumatic experience. Sylvia reported that she was

coping much better and that none of the initial presenting symptoms remained. The counsellor further affirmed her resilience and ego-strength (her ability to draw on her internal resources) and commended her for her cooperation and willingness to use the therapeutic space. She, in-turn, reportedly experienced this feedback as affirming and termination after a two-week break was then raised. Sylvia reported that she felt ready to terminate.

Synopsis and analysis of the session:

There was evidence of further symptom reduction as reported by the client who appeared to no longer be experiencing any of the presenting symptoms. The client had again introduced the issue of *meaning making* in terms of her optimism about her future and looking for a new job. Growth oriented thought on the part of the client would therefore suggest that the trauma was relatively resolved and this was further confirmed by the counsellor through some exploration of the motivation for such change and judicious use of *psychoeducation,* (suggesting that major life change decisions following a trauma are sometimes impulsive and require careful consideration). Her reported fantasies of being shot and wondering what it would have felt like were also perhaps indicative of some advance in terms of *mastery* and some reduction in avoidance at the level of thought or fantasy in that where it was probable that she could not previously allow herself to entertain these types of thoughts she was now able to tolerate the anxiety associated with this fantasy. She was, however, quick to cognitively re-appraise this scenario which provided further evidence of improved self management. In addition, the client's thoughts around 'karma' could also be suggestive of the engagement of a more complex cognitive explanatory system in which ambivalence and ambiguity could now be entertained and her need for personal retribution put to rest. She seemed to have adopted a more existential perspective on the trauma, her attackers and the outcome.

Session five: (Termination)

Sylvia reported one single incident that had reminded her of her hijacking. She was a passenger in her cousin's car when it seemed to her that her cousin began to panic about something- she struggled to change gears and accelerated suddenly. Sylvia was

‘convinced’ that her cousin feared they would be hijacked. She reported feeling very ‘shaken-up’ by this, however, her cousin apologised and said that she was simply struggling to change gears and eat at the same time.

Sylvia reported feeling that she had benefited from therapy and that she had felt able to process more of the incident every time she retold the event. She reported no further symptoms and said that she now saw the event as an ‘unfortunate incident of being in the wrong place at the wrong time’. She described being excited about the prospect of a new job and reflected that she had decided to take greater responsibility for her actions. This was an important realisation for her, especially since she and her brother had recently purchased a new home together.

Synopsis and analysis of the session:

It would seem that Sylvia’s initial traumatic symptoms were largely resolved for the most part, although she still showed partial signs of vulnerability in terms of her reported intrusive symptomatic response to the reported trauma related stimulus. However, it was clear from the bulk of the case notes for this session that she had perceived the therapy intervention as beneficial and that her cognitive re-appraisal of the traumatic event and its sequelae reflected a more realistic and manageable perspective and even a positive outcome in terms of the development of new convictions, meaning and direction for her life.

Commentary

In reading through the case notes there is a strong suggestion that Sylvia’s sense of culpability in being traumatised in a context in which socially she was involved in some ‘wrongdoing’ appears to have complicated her response to an event that had many traumatic elements in addition to this. It appears that there was a significant shift in terms of her recovery at the point at which she decided to be honest about her reason for being at the location of the attack and experienced a lack of censure from her support system and the authorities. It is not clear that the counsellor really took up this issue, although the case notes suggest that preoccupation around this aspect was brought to several sessions.

It is possible to speculate that the 'confession' to the therapist and lack of judgement on her part, as well as the support in coming to terms with and making sense of the event and her very real victimisation, provided some basis for the client to disclose this aspect of the trauma to others. The disclosure appears not only to have reassured her with regard to practical gains (the insurance payout) but also at a psychological level in perhaps removing some sense that she had invited or even deserved the trauma. She seems to have used her experience of the incident and the therapy to revisit aspects of her judgement and self care taking capacities.

4.1.2. CLIENT 2: THE CASE OF 'LEBO'

Lebo was a middle aged black woman who was seen at the CSVR (trauma clinic) by a white male trainee clinical psychologist, following the traumatic death of her husband under somewhat bizarre and grotesque conditions. She was seen for a total of six sessions (including termination). Lebo's main complaint was a marked inability to concentrate to a degree that impaired her social and occupational functioning. She further reported increased appetite, arousal symptoms, indicated by a difficulty in falling asleep, and avoidance symptoms, indicated by social withdrawal, and an inability to mourn for her deceased husband. She complained of being constantly tearful and sometimes experienced intrusive thoughts concerning the manner in which her husband may have been killed. (See appendix A for a more detailed description of the traumatic event and the course of therapy)

Synopsis and analysis of session 1:

Four of the model's five components were evidenced as being utilised interchangeably in this session. The session began with a *retelling* of the traumatic event, during which the counsellor reflected feelings and content and encouraged sensory associations as a means of enhancing a more detailed recall. During this telling, issues concerning *self-blame and possible guilt* were explored and reframed. Lebo's current symptoms were explored and *normalised* in the context of the trauma and her loss. Means of *coping and accessing sources of support* were explored and reinforced and some *meaning was made* around

Lebo's difficulty in accepting her husband's death in relation to conflict with her in-laws. Furthermore, the counsellor explained how the model was to be used in the service of a broader therapeutic goal, that being, the additional facilitation of the client's bereavement process. It was interesting to note, however, that in the words of the therapist the session seemed to 'jump around a lot', with the focus alternating between the trauma and the client's inability to grieve for her husband. Although this speaks to some degree to the flexibility of the model, this deviation from the purely trauma focus on the part of the client left the counsellor feeling unsure as to which theme to follow and resulted in his feeling somewhat stuck. It appeared that the counsellor was perhaps a bit too trauma focused in his adherence to, and application of, the different phases of the model in this first session, which resulted in his attempting to lead the client as opposed to following what she brought as her focus.

Synopsis and analysis of session 2:

In *retelling* the story, the client was encouraged not to avoid the aversive stimuli regarding her intrusive thoughts and her feelings of guilt and self-blame seemed to emerge as traumatic foci in the narrative. These feelings were re-examined and reframed. According to the literature outlined under this component of the model, self-blame is related to a wish to retrospectively "undo" the trauma and the therapeutic work in this regard is designed to provide the client with a greater sense of agency (Eagle, 2000, p.313). By exploring and cognitively reframing her guilt, the client's fantasies surrounding the unknown circumstances and the lack of clarity concerning her husband's death were at least partially addressed and the most acceptable and comprehensible explanation in her terms was discussed. By encouraging Lebo to develop her own guided insights in this way, her release from self-criticism was enhanced and the counsellor reported this intervention as having provided her with some sense of relief.

The second half of the session seemed to take on a more dynamic and interpretive orientation, with the counsellor's interpretation regarding the loss of the 'ideal' husband, aimed at further relieving Lebo of the necessity to employ the defence of idealisation of her murdered husband. This seemed to result in a further enhancement of the client's ego

functioning as was evidenced by her increased engagement and affective expression in the session. The counsellor's intuitive and creative application of the working through of the self-blame dimension of the model was clearly evidenced in the case notes as was his use of the model in the service of a broader goal, that being, the facilitation of the client's grieving process. In this instance there was some apparent link between idealisation and guilt that needed to be explored in order both to reduce the trauma impact and allow expression of affect associated with her traumatic loss.

Synopsis and analysis of session 3:

There was evidence of at least partial symptom reduction in terms of the client's reported improvement in both mood and concentration, possibly due to the enhancement of ego functioning and improved reality contact, as evidenced in the previous session. The client was again encouraged to *retell* the story with a focus on the most difficult aspects of the trauma narrative. Lebo described feeling less anxious with this retelling and it emerged that the most disturbing aspect of the trauma continued to relate to self-blame. This time, however, it emerged that Lebo's self-blame pertained to a fantasy of not having been a 'perfect wife' and as such, was linked to a strong feeling of responsibility and subsequent guilt for not having prevented her husband's death. It also emerged that she had actually felt somewhat relieved at her husband's death and it would seem that this served to exacerbate her guilt. Interestingly, it was only after several retellings of the story that Lebo was able to access her feelings and fantasies associated with this part of the experience and it would seem that the therapist was at pains to provide a sense of respect and legitimization of the client's thoughts and behaviour while at the same time empathising with the painfulness of the experience.

The *therapeutic relationship* and the counsellor's ability to contain and translate the client's unmanageable feelings of guilt into words and symbols seemed to have a highly cathartic effect for the client and were clearly visible in the description of this therapy session. The therapist reported that the client was visibly relieved at having someone who was able to understand her feelings of guilt and that she indicated that the non-judgemental space was distinctly helpful to her. This suggests that in addition to the

telling and retelling of the story the *relational aspect* of the intervention was important. The counsellor's exploration and reframing of Lebo's feelings of *guilt and self-blame* appear to have further aided in the restoration of self-esteem, the realistic appraisal of her own role in the marriage, her response to her husband's death, and the *promotion of a sense of mastery.* The session ended with the counsellor's examination of Lebo's presenting symptoms and some *psychoeducation* around allowing herself sufficient time to expect to return to her previous level of functioning without putting too much pressure on herself.

Synopsis and analysis of session 4:

Lebo reported a marked improvement in both mood and concentration. She further stated that during the previous week she had performed a cleansing ritual with the guidance of a traditional practitioner. This was an interesting addition to therapy and might well have played a role in her reported symptom reduction. However, this also served to highlight greater agency, self management and *meaning making* on the part of the client. The *mastery aspect* of the model was evidenced by Lebo's reported resolution of her conflictual relationship with her husband's family, as well as by the more adaptive use of her religion as a support structure. In this instance, Lebo's sense of mastery was encouraged by the counsellor's reframing and contrasting of her participation in these activities with her earlier feelings of powerlessness and helplessness and this was reported to have been very encouraging and relieving for the client. The counsellor's use of *psychoeducation* served to further normalise the client's symptoms as well as to facilitate the broader therapeutic goal of advancing her grieving process.

Synopsis and analysis of session 5:

The counsellor reported that Lebo had reported a continued improvement in her functioning. She rarely had sleep difficulties and had returned to a normal level of functioning at work. According to Lebo, she was now able to enjoy her work again and had shifted to more future oriented thinking. The session focused on an exploration of Lebo's current functioning as well as her improvement, steady progress and the gains she had made. This reflective discussion was reinforced by the counsellor through the use of

additional *psychoeducation*. Consolidation and validation of previous insights regarding her relationship with her husband and the impact of his death was evident and the session ended with a discussion regarding termination and how a gradual disengagement from therapy was necessary so as not to be perceived as 'another loss' for her. The importance that Lebo had placed on engaging in the therapeutic process and the possibility of entering long-term therapy was also explored.

The client's shift to future oriented thinking reflected an aspect of *meaning making* and was growth oriented. The session further suggested that the trauma was relatively resolved in that the client has begun to resume her existence at previous levels of functioning. Reference to Lebo's engagement in the therapeutic process could also be seen as further evidence of the *mastery aspect* of the model as well as being indicative of a strong therapeutic alliance, evidencing the importance of the *relational aspect* in addition to the specific interventions.

Synopsis and analysis of session 6 (termination):

The counsellor reported that the session involved a comprehensive overview of the course of therapy in which the *meaning making* aspect of the client's traumatic experience as well as the *mastery aspects* in terms of her progress toward resolution and grieving were highlighted. In particular, the counsellor re-examined her ambivalent relationship with her husband and the way in which her traumatic experience had led her to become aware of this ambivalence. The need to acknowledge her ambivalence in order to begin the process of grieving was also examined. This intervention could be understood from a cognitive-behavioural perspective as facilitating the development of a more complex cognitive system in which Lebo's ambivalence could now be entertained, but could also be understood as a process of having brought a more unconscious aspect of her response to the surface, allowing her to acknowledge the manner in which this had complicated her traumatic stress and bereavement responses. The counsellor appears to have sensitively assisted her to come to terms with this aspect of her response without carrying the guilt that initially appears to have somewhat paralysed her.

Commentary

In this therapy the Wits Trauma Model appears to have been helpful at a number of levels including the capacity for Lebo to entertain the horror of what had happened to her husband, identification and encouragement in engaging with her symptomatic response and attempts to make meaning of the event. Her emotional attachment to the therapist and the relational element of the therapy seems to have been important and to have assisted in the potency of the reframing and the receipt of psychoeducational aspects. However, from the full set of case notes it appears that the most significant work concerned dealing with aspects of self-recrimination and guilt, not only in relation to non-protection of her husband from his horrible death, but by association, and in addition to this, her acknowledgement of feelings of anger and disappointment in relation to him and the quality of their marital relationship. It seemed that the more complex cognitive or interpretive work around this aspect was central in her traumatic stress recovery and movement into a healthier bereavement process. External interventions, such as traditional burial or death rituals and church member support appear to have complimented the psychotherapeutic process. There is some suggestion that the therapy allowed her to access this support more readily.

4.1.3. CLIENT 3: THE CASE OF 'MARGARET'

Margaret was a black, Zulu speaking female in her early fifties who was referred for trauma counselling following an incident in which she was assaulted by her neighbour. She was seen for a total of six sessions (including termination) by a white Afrikaans speaking trainee clinical psychologist at Alexandra Clinic. Margaret presented with a host of symptoms ranging from anger and frustration, to difficulty sleeping, depressed mood, blunted affect, avoidance of stimuli, a headache and sore muscles as well as short-term memory loss (possibly due to a head injury sustained during the assault). (See appendix B for a more detailed description of the traumatic event and the course of therapy)

Synopsis and analysis of session 1:

It seemed that although the client's initial expectations of the therapy process were different to those of the therapist, her need to narrate the incident in the presence of a supportive other was evident, highlighting the importance of the *relational aspect* of the model. During the *retelling*, the counsellor reported that Margaret was able to touch on her feelings of anger and frustration, as well as to link past history to present material, This served to reinforce a movement away from regression as well as to create some cognitive structure around the event and to assist her with some initial exposure to the traumatizing memories and associations. However, it seemed that the client presented with strong avoidance symptoms, evidenced primarily in emotional numbing and suggestive of possible intense feelings of fear, helplessness and horror associated with the assault. Interestingly, it is usually only during several retellings of the story that the client may access strongly felt, but distressing, emotions and it might have been beneficial had the counsellor educated the client about the common employment of numbing or emotional repression in response to a trauma and normalised the client's symptoms with regard to this aspect.

Synopsis and analysis of session 2:

Although the client initially reported no change in her symptoms in this session it is clear from the case notes that there was evidence of partial symptom reduction in terms of the intensity of her symptom picture. Margaret was encouraged by the therapist to *retell* her story and to remember more visual and feeling related details as, according to the therapist, these were the modalities that she had used most predominantly in describing her experiences in the therapy up to this point. Margaret spoke a lot more freely about the assault, giving a lot more detail, and was reportedly also tearful in the retelling, suggesting her willingness to use the therapeutic space in order to allow the expression of affect. Margaret explained that the retelling was 'like watching a movie in slow motion and that she could not get the movie out of her head'. As intrusive memories are often the most emotionally laden and distressing parts of the traumatic event, they can be used to guide the therapist in uncovering the most disturbing parts of the trauma. Margaret's comment on her experience of retelling the story in this instance was indicative of the

intensity and recurrent nature of her intrusive symptoms and appears to explain some of her need to avoid thinking about, or feeling very much, pertaining to the incident. It appeared that the therapist was attempting to gradually increase her tolerance of the anxiety provoking material. Her affect was no longer as restricted as in the previous session indicating that the exposure and narrative aspects underlying the *retelling* component of the model appeared to be working effectively.

The therapist's ability to link the client's symptoms and emotions to the traumatic event appeared to allow the client to make further links between how the event had caused her to think about other areas in her life that were of importance to her, such as the wellbeing of her grand-daughter. The creation of a more reflective, coherent, narrative account of the event appeared to enhance the client's spontaneous arrival at some sense of *meaning making* regarding the event.

According to the session notes, Margaret had attempted to contact the therapist on several occasions and it would seem that her unavailability had angered her. The counsellor appeared to recognise some transferential aspect in this instance and her interpretive reflection, which linked Margaret's anger with her experience regarding the police and their poor response in attending to her trauma, seemed to enhance Margaret's understanding of her displaced anger and at the same time provide a sense of respect, affirmation and compassion for the client. The fact that Margaret allowed herself the space to cry was suggestive of an increase in trust between counsellor and client and the importance of the *relational aspect* of the counselling, as well as an increase in the client's ability to tolerate and manage the expression of emotion, indicative of the *mastery enhancement* aspect of the model. Also evidenced in the session was the counsellor's use of *normalising* of symptoms. Margaret reported having 'very stiff shoulders and a terrible headache' and she made some links between the traumatic experience and the symptoms experienced by the client. Stress management in the form of progressive relaxation techniques was taught to the client, indicative of the employment of a further element of the *mastery component* of the model.

Synopsis and analysis of session 3:

There was further evidence of symptom reduction as reported by the client. Margaret explained that she was feeling more relaxed and that she was determined to hold on to that 'good feeling' throughout the session. Although not evidenced as being interpreted by the therapist in the actual session, after reflecting on the session, the therapist reported that she was concerned that the client's reported feeling of happiness was not necessarily reality based in that it still seemed very important for Margaret to see herself as 'better and happy' as a way of avoiding her underlying anxiety. The client reported finding the *retelling* of the incident beneficial in that it had made her feel less worried and upset, which again suggested that the narrative and exposure elements underlying this aspect were working. Some *meaning making* aspects were also evidenced in the session and briefly reflected upon in terms of how the traumatic event had enabled Margaret to think somewhat differently about the importance of her relationship with her grand-daughter. Furthermore, the progressive relaxation exercises *(mastery aspect)* were reported to have worked well in that they provided Margaret with some tension relief.

Synopsis and analysis of session 4:

It would appear that further symptom reduction had taken place and that Margaret was not as defensive as in previous sessions. The therapist reported that the client spoke a lot more freely about her feelings and her memories and that she seemed to use the therapeutic space in a more meaningful way, again perhaps indicative of the effectiveness of the exposure function underlying the *retelling component* of the model and an enhanced ability to process her feelings related to the traumatic event.

Enhanced *meaning making* was evidenced regarding the meaning of the trauma in relation to her grand-daughter as well as to her deceased brother. The client's reflections and fantasies around her deceased brother as a protector were suggestive of new information coming to light and a more elaborate narrative. Margaret told the counsellor that she had been thinking about her brother who had recently passed away and how she saw him as the fighter and protector of the family. She described her fantasy in this regard and how she had felt that this event would never have taken place had he still been

alive. The counsellor reflected that sometimes a trauma could make one remember other important moments in life, yet it might also have been beneficial to interpret her fantasy and her idealisation of her brother as way of attempting to undo the traumatic event. A degree of *meaning making* was, however, achieved through a more interpretive /dynamic framework to that outlined in the model. The counsellor also reported a deepening of the therapeutic relationship yet it was unclear as to whether this *relational aspect* was due to the extra therapeutic event of organising a doctor's appointment for the client or the therapist's engagement in the room or both.

Synopsis and analysis of session 5:

It would seem as though the trauma was relatively resolved and that Margaret appeared to be regaining a measure of her previous autonomous functioning. The therapist reported her demeanour as happy and engaging and in the words of the therapist, 'she had a whole new sense around her, that of a healthy and capable agent in the world'. Although the session extracts highlighted elements of *coping and mastery*, there was also some evidence of continuing underlying avoidance symptoms on the part of the client which the counsellor seemed hesitant to address; preferring to remain strongly focussed on the relational aspect of therapy.

Synopsis and analysis of session 6 (termination):

The therapist reported no further signs of traumatic stress symptoms related to the incident, although there was still evidence of some anger towards both the justice system and the perpetrator. This could however be seen as understandable and completely normal in the context of the trauma. It was not clear whether these angry feelings were either explored or linked to the trauma impact in the session. The session also provided evidence of the counsellor's commitment to the client and her respect for the client's wishes to terminate therapy. This was further suggestive of the importance of the *relational aspect* of the counselling. The counsellor reported in her concluding evaluation that she had enjoyed working with the client and had been surprised at how their relationship had strengthened after the somewhat difficult initial session. She further

described her perception of the client as having valued the safe, holding environment that the therapy space offered.

Commentary

In this case the client appears to have entered the therapy with an expectation of instrumental support and with strong avoidance symptoms both in terms of thinking or talking about the traumatic incident and with regard to emotional numbing. The employment of the WTM appears to have assisted in approaching and engaging with the traumatic memories and the fantasies associated with this. The clients' linking of the experience to a prior loss was also significant. In remaining engaged with the client, despite some initial antagonism on her part, the therapist appears to have gained the client's trust and to have restored her sense of the availability of a responsive, containing other. The client also appears to have used the sessions to explore the meaning of the trauma for herself and to have developed some future orientation in focusing on the upbringing of her grand-daughter.

4.1.4. CLIENT 4: THE CASE OF 'SEBOLELO'

Sebolelo was a black, Xhosa speaking female in her early twenties who was referred to the CSVR (trauma clinic) following an incident in which her boyfriend was robbed and murdered. She was seen for a total of five sessions (including termination) by a black, female, trainee clinical psychologist. The client presented with the following traumatic stress symptoms: tearfulness and depressed mood, anger and irritability (both at home and at work), suicidal ideation, hyperarousal and avoidance of stimuli associated with the event. (See appendix C for a more detailed description of the traumatic event and the course of therapy)

Synopsis and analysis of session 1:

Four of the model's five components were utilised interchangeably in this session. The session began with the counsellor's assessing of the client's current functioning and a *retelling* of the traumatic event with the inclusion of as much detail as possible along

with the associated feelings. During this telling, issues' concerning *self-blame and possible guilt* were explored and reframed. Sebolelo's current symptoms were also explored and *normalised* in the context of the trauma and her loss. Means of *coping and accessing sources of support* were explored and reinforced as it appeared that the client had no accessible support structure in place. It was of interest to note, however, that in her attempt to reframe the client's self-blame through the use of guided imagery, the counsellor seemed to be expressing her own fantasy of what might have occurred and the client responded somewhat doubtfully to the intervention. In response to Sebolelo's assertion that she should have been with her boyfriend at the time of his attack the counsellor attempted to reassure Sebolelo that her presence might have aggravated the situation and that she might even have been raped or killed had she been there.The practice of or revisiting options in order to address self-blame has to be carried out judiciously with the emphasis on the client's fantasies (almost in the sense of a guided fantasy exploration) and cannot be equated with telling the client that it could have been worse in an attempt to reassure them. The introduction of the latter kind of response might have had the effect of disqualifying or minimizing the client's suffering. The client needed to be encouraged and guided towards developing her own insights in this regard, thereby making her release from self criticism more authentic and powerful. However, this session did evidence the ease in which the model could be comprehensively implemented by a trainee therapist.

Synopsis and analysis of session 2:

Although no symptom reduction was reported, there was evidence of growth in that Sebolelo was willing to entertain the idea of a new relationship. Validation and respect of the client's perspective was also evident in that the focus of therapy was directed both by the client's preoccupations and the counsellor's subscription to the WTM principles of intervention. The unexpected deviation from the trauma focus on the part of the client in discussing her anger at having recently found out that her new boyfriend was still involved with another woman, evidenced flexibility on the part of the counsellor in that she managed to link the new content with the client's traumatic experience. Although the session was not directly trauma focussed, the client's expression of displaced anger as

well as aggressive fantasies, were in keeping with the psychological symptoms evoked in response to her trauma. It might have been even more helpful if this concern, as well as her apparent avoidance of the process of mourning associated with her boyfriend's death and her irrational thoughts involving blaming him for her recent relationship difficulties, had been explored and understood as possibly occurring as part of a complicated trauma response. This would have allowed for some degree of psychoeducation, insight and potential normalisation.

Synopsis and analysis of session 3:

Self-blame and feelings of guilt were still prominent. Her negative appraisals and overgeneralisations in respect of viewing the world as a bad place and God as punishing her could possibly have been explored, reframed and normalised in this session with a view to helping the client to come to terms with the reality of what had taken place and the role she had played in this. Generalising her story telling to a supportive other and the journaling of her thoughts were reported by the client to be helpful. Both steps to engage with the trauma were indicative of the client's improvement in terms of the *mastery component* of the model and increased willingness to approach the material (exposure element). Use of the exposure element was further evidenced when Sebolelo was encouraged to retell other aspects of her story and to include the sensory associations around her experiences of going to the mortuary and the funeral. Through the reintroduction of the *retelling component* of the model, the counsellor facilitated a more detailed or enriched narrative which in turn allowed for a deeper exploration of the client's relationship with her deceased boyfriend. This seemed to be helpful in that the client engaged more deeply with her feelings of guilt and self-blame, linking these to her anger towards her boyfriend for the fact that he had cheated on her. In making this link she was able to become more rational about her inability to protect her boyfriend and that she was displacing some of her anger into current relationships.

Synopsis and analysis of session 4:

Evidence of symptom reduction was reported with regards to the client's improved mood, although she still found Thursdays extremely depressing and remained unsure as to why.

Further psychoeducation and normalisation regarding the nature of traumatic stress symptoms and triggering events (e.g. anniversaries) would perhaps have been beneficial in this regard, but it appears that this aspect was not explored or interpreted by the counsellor at this time. Moreover, it was unclear as to whether the client's irrational thoughts involving a wish to form a group and to kill all men was explored and reframed, as suggested in the model. Such revenge fantasies should be actively engaged with as part of the negative psychological response to trauma, in this case involving overgeneralisation and possibly 'identification with the aggressor' to avoid feelings of powerlessness.

Sebolelo was encouraged to *retell* her story as well as to include the facts surrounding the argument she and her boyfriend had had on the day of his death. The client's *self-blame and guilt* were re-examined and her actions were reframed in a more adaptive and realistic light. The *meaning making aspect* of the model was evidenced in that Sebolelo's previously unexpressed and displaced anger was interpreted and given a more symbolic focus. The counsellor further assisted in facilitating the *creation of meaning* by engaging with the client around her wish to enact a symbolic ritual. The ritual involved knitting a jersey for the deceased and presenting it to him at his grave site as an expression of her forgiveness and care for his spirit.

Synopsis and analysis of session 5 (termination):

The counsellor reported both symptom reduction and an all-round improvement in the client's demeanour. Her feelings of self-blame and guilt no longer seemed apparent and there was no further mention of Thursdays as being specifically problematic. The counsellor described Sebolelo's appearance as more relaxed and indicated that she had reported feeling much better. Sebolelo also reported that her relationship with her child had greatly improved. There was further evidence of enhanced *coping and mastery* in her work life and with regard to the ritual performed at her boyfriend's grave site. The client reported feeling as though a 'huge burden' had been lifted from her shoulders since performing the ritual, and this extra-therapeutic intervention was an interesting addition to the therapy process. The counsellor also highlighted the *relational aspect*

underpinning the employment of the model in recognising the positive transferential element of the relationship and the client's somewhat idealised view of her. Sebolelo was comfortable with terminating the therapy at this point.

Commentary

The case notes for this therapy intervention suggest a degree of clinical flexibility in that the client's response to the trauma was somewhat complicated. The focus of therapy was directed both by the client's preoccupations and the counsellor's subscription to the WTM principles of intervention and it was only after several sessions and through the use of slightly more interpretive cognitive work, that a deeper exploration and a more rational engagement with the client's feelings of guilt and self-blame about her not being either present with or able to protect her boyfriend from the attack could be facilitated. Although the survivor guilt and/or self-blame does not appear to have been fully addressed during the counselling process the client's insight and acknowledgement of her feelings of displaced anger and disappointment in relation to her boyfriend and the quality of their relationship seemed to enhance meaning making and the therapist seems to evidence an interest in uncovering a more unconscious element or set of interpretive links within the trauma. In this way, she was able to facilitate her traumatic stress recovery and movement into a healthier grieving process. As in the case of Lebo, external interventions, such as symbolic death rituals and external support appear to have complimented the therapy process and it would seem that the therapy allowed her to access these sources of support more readily.

4.1.5. CLIENT 5: THE CASE OF 'GREG'

Greg was an English speaking, white, male foreigner in his late thirties who was referred to the CSVR (trauma clinic) following an incident in which he was held up at knife point by three black men. He was seen for a total of five sessions (including termination) by a white female trainee clinical psychologist.

Greg reported the following symptoms: feeling frightened, agitated, mistrusting (of black people in particular), avoidance of stimuli associated with the event, extreme negativity

and a sense of helplessness. (See appendix E for a more detailed description of the traumatic event and the course of therapy)

Synopsis and analysis of session 1:

The focus of the intervention centred on establishing rapport, *retelling* and exploring the details of the traumatic event as well as associated emotions. In the retelling the client's attempt to conceal certain facts about his behaviour from the therapist suggested some underlying feelings of shame and guilt and although the therapist attempted to reframe his behaviour as adaptive, evidencing use of the component of the model designed to address self-blame, this intervention seems to have had little effect, highlighting an area that needed to be further addressed in the therapy. The client's feelings regarding self-blame and anger were further reflected in his reported fantasy of wanting to shoot his assailants. These fantasies could have been elaborated and reframed and perhaps Greg's sense of helplessness, following the incident could also have been normalised in terms of being common to trauma survivors. The counsellor did, however, make reference to wanting to explore these potential traumatic foci in the next session.

Greg's memories of the traumatic event were associated with intense fear which seemed to have become generalised, distorting his experience so that nowhere felt safe and more threatening events were anticipated. The counsellor therefore reported placing an emphasis on *psychoeducation and normalising* these emotional reactions, which included the client's fears that the traumatic experience would change his personality and that he would never recover from it. Moreover, in attempting to contextualise the trauma intervention as a whole for the client, the counsellor made reference to the *meaning making* component of the model as well as to the *mastery* element regarding the future exploration of Greg's coping skills. The counsellor also referred to wanting to explore the impact of the trauma on the client's felt masculinity since his feelings of shame, self-blame and guilt seemed possibly to be related to this aspect of his identity.

Synopsis and analysis of session 2:

According to the therapist, the client reported a slight reduction in his avoidance symptoms in that he described himself as being somewhat less fearful yet still avoidant of the 'more dangerous areas'. He was, however, still hyper-vigilant and markedly overestimated the probability of negative events happening to him. He continued to generalise his experience so that nowhere in South Africa, apart from his home, felt safe. The exposure element involved in the retelling aspect of the model was evidenced in work in the session drawing out further difficult elements of the trauma. *Meaning making was evident* in the client's reflection that the trauma had instantiated a shift in his life focus from being oriented solely to making money to the importance of his family and being alive. The counsellor's introduction of a more dynamic and interpretive focus to attempt to understand the client's displacement and distancing as defensive processes, as well as the counsellor's shift to a more supportive focus in order to track the client's avoidance of the trauma, further evidenced the flexibility of the model.

Synopsis and analysis of session 3:

The therapist reported that the client had indicated that he was 'feeling much better', evidencing partial symptom reduction. However, symptoms of hypervigilance and avoidance were still present as was his marked overestimation of the probability of negative events happening to him. He also introduced the theme of racism in keeping with the kinds of overgeneralization common in many trauma survivors. In this instance these negative generalisations served to underpin Greg's negative emotions and appeared to support a chronic mode of experiencing in which there was selective attention to threat cues and increased vigilance for signs that a further trauma might occur. This in turn served to increase Greg's anxiety and the frequency of the intrusive images. However, there was evidence of improved *mastery* on the part of the client in terms of his description of conducting his business in a more cautious manner in order to reduce his vulnerability to victimization. The use of the *normalisation* component of the model by the counsellor in an attempt to cognitively link Greg's racism to the impact of the trauma on his life was also evident. This could further be seen as an attempt by the counsellor to

facilitate the process of assimilation and accommodation of the traumatic experience into the client's existing cognitive frameworks.

The counsellor did not challenge Greg's racist assumptions, preferring to interpret this response as a defence against his underlying feelings of helplessness and loss of control. This suggested the counsellor's employment of a more psychodynamically oriented approach in addressing Greg's avoidance symptoms. The session record also included a focus on non-specific therapy factors such as enhancing the quality of the *therapeutic alliance*.

Synopsis and analysis of session 4:

Although there were signs of partial symptom reduction, the therapist reported this as being based on an external therapy factor related to the client's work environment. Greg's avoidance symptoms were still prominent in the form of his strong mistrust of black people in general and his continued feelings of being unsafe in a range of contexts. He continued to feel helpless with little sense of control and expressed a strong wish to escape South Africa and return to his country of origin. The counsellor *normalised* these symptoms through the use of *psychoeducation* and also included a slightly more interpretive focus, in that she linked Greg's wanting to return home to the motherland as being symbolic of his need to return to the safety and predictability of his mother's arms. She reported this intervention as successfully providing the client with some sense of anxiety reduction.

After evaluating the session, the counsellor reflected that an important part of Greg's experience was the extent to which the traumatic event had changed his sense of the world as predictable in keeping with Janoff-Bulman's (1992) argument that core assumptions tend to be 'shattered' by exposure to traumatic experiences. It would appear from the session notes that Greg was having particular difficulty in terms of incorporating the traumatic experience into his existing belief system.

There was also evidence of the client's spontaneous referral to *making some meaning* of the event, including a fantasy of what might have happened if he had been killed. This was facilitated by the counsellor's reframing of his actions and behaviour as adaptive in an attempt to reduce his *self-blame* and sense of helplessness as well as to facilitate *enhanced mastery*. However, the client's ruminations in this regard could perhaps have been explored in greater detail, and confirmed as being evidence of some degree of integration of the experience in that he could not previously allow himself to entertain these types of thoughts. Such mastery would have hopefully served to counteract regression and have allowed for the internalisation of some sense of self-efficacy.

Furthermore, the session clearly showed that despite evidence of a strongly negative countertransference on the part of the counsellor, she was at pains to provide a sense of respect for and validation of the client's behaviour, while at the same time empathising with the painfulness of his experience. In this way, and in accordance with the literature pertaining the model, the transferential elements of the relationship were observed but not worked with explicitly which seemed to enhance cooperation in other aspects of treatment. The difference between crime and race and how the two had become equated for the client was explored and reframed and the counsellor reported that some *meaning making* was evidenced by the client in exploring this link more carefully.

Synopsis and analysis of session 5 (termination):

The counsellor made reference to overall symptom reduction and to what appeared to be a partial resolution of the trauma. She reported that the client had begun to make some necessary links to the traumatic event and through talking about it, process and make some meaning out of his experience. He reported being better able to function in both occupational and social settings and a restored feeling of competence, stating that through his experience of counselling and talking about his traumatic experience he had been able to help a friend to better manage his trauma related responses. This report speaks to the *mastery* component of the model as well as to the implication that his experience of the treatment intervention as a whole, was found to be beneficial. The employment of the *mastery* component of the model was also evidenced in Greg's generalising of his story

telling to supportive others and the *meaning making* component was highlighted in terms of his ability to understand himself and to view the world in a more realistic and manageable way. He reported feeling in some ways that he had gained an enriched appreciation of life, both in the present and in relation to the future.

Commentary

The session notes suggest that this was a difficult case to deal with in that the client's response was one of both angry alienation and intense fearfulness, possibly because of his non-national identity. While various elements of the model seem to have been useful it appears that it was the combination of normalizing and meaning making that assisted the client to reduce some of his over-generalization and consequently to be able to operate in the context with less anxiety. As in some of the other cases it seems that it was the cognitive work that was particularly important, in addition to the exposure and narrative elements. As in other cases it also appeared that the relational element, in the form of a sound working alliance, was of significance in that this allowed the client to cooperate in the therapy despite his anxiety and antagonism. The counsellor's management of her own discomfort with aspects of the client's material and his somewhat sceptical attitude to the therapy was also crucial in ensuring a reasonably successful outcome.

4.1.6. CLIENT 6: THE CASE OF 'BRIGHTNESS'

Brightness was a black, Sotho speaking woman in her mid thirties who was referred to the CSVR (trauma clinic) following an incident in which she was attacked by two strange black men on her way home from work. She was seen for a total of five sessions (including termination) by an Indian female trainee clinical psychologist. Brightness presented with traumatic stress symptoms ranging from a headache and sore muscles (due to a neck and back injury), hyperarousal, avoidance of trauma related stimuli, an exaggerated startle response, sleep disturbance, intrusive recollections of the event, loss

of appetite and poor concentration. (See appendix F for a more detailed description of the traumatic event and the course of therapy)

Synopsis and analysis of session 1:

The counsellor began the session by establishing some rapport with Brightness, evidencing the importance of the *relational aspect* of the therapy. It was also evident as the session progressed that the narrative function of the *retelling* component was experienced by the client as beneficial and that the exposure element implicit in this helped the client in to develop increased tolerance for anticipated anxiety. The client narrated her story in quite a lot of detail including some aspects which suggested some *mastery* related behaviours for the counsellor to pick up on at a later stage. By moving her chair closer to that of the counsellor, the client was seen to have evidenced enhanced cooperation, which indicated a deepening of the *relational aspect* of the therapy. Following this, the counsellor clearly evidenced compassion, empathy, and affirmation of the client's perspective. The counsellor *normalised* the client's symptoms with regards to her fears of returning to her work place and reaffirmed her thoughts and behaviour as adaptive in that they had resulted in her survival. Interestingly, at this stage the client deviated from the normal course of therapy, requesting the counsellor to take a more instrumental role in the process by contacting her manager at work. This request required a problem solving intervention beyond the frame of the WTM and after speaking to her supervisors the therapist decided that the focus of the session should remain on the trauma counselling process, *normalising* the situation and positive reinforcement. The counsellor also made use of the *coping or mastery aspect* of the model in her exploration of the client's existing support systems. This was, however, done with a more relational focus in mind and it appeared that the client was not encouraged to utilise her existing support systems or to generalise her story telling to supportive others as outlined in the literature on the model. However, this aspect of intervention did appear in the counsellor's treatment plan for the next session.

Furthermore, the counsellor attempted to locate the impact of the client's traumatic experience within her prior personality, history and current life circumstances thereby

evidencing some employment of the *meaning making* aspect of the model albeit from a more interpretive/dynamic focus than the WTM generally proposes. Brightness's anxiety regarding the potential loss of her job and the possible consequence of this in then failing those who were dependent on her, was also considered as part of the *meaning making* process. The counsellor's treatment plan indicated the intended use of a more trauma focused approach as a means to return the client to her previous level of functioning. The treatment plan also pointed to the counsellor's use of the model in the service of a broader, more long-term goal, involving integrating the trauma with respect to the client's related historical experiences regarding her relationship with her father and ex-boyfriend. In this regard, the therapist also made reference to other deeper issues surrounding the client's overwhelming need to be the strong one in her family and not to openly display her weaknesses. It was recognised, however, that this more interpretive exploration would require a more psychodynamic focus and might be beyond the scope of brief term intervention.

Synopsis and analysis of session 2:

The client's avoidance in talking about the emotional effects of the trauma was still prominent, as were her intrusive symptoms in the form of nightmares. Brightness's hyperarousal symptoms were also reported as still being quite severe, with the client stating that she was constantly aware of any and all sounds around her. Moreover, she complained of headaches and of experiencing immediate memory problems which in turn resulted in her becoming frustrated and moody. The focus of therapy was directed both by the client's preoccupations with work related problems as well as by the therapist's more trauma related focus in that she continually attempted to centre the client's preoccupations on the traumatic incident and its sequelae. This speaks to some degree of flexibility within the model. It was also evident that the therapist was relatively directive in the session using a more focused style of intervention. Brightness seemed to feel exploited as an employee and although her symptoms had a basis in reality, she evidenced a large amount of displaced anger towards her boss, anger which had come to a head in response to the trauma. Three of the components of the model were evidenced in the session. Firstly, the client was encouraged to *retell* her story, and according to the

therapist, she still experienced difficulty with regards to expressing herself around the attack and how it had affected her emotionally. Brightness reported that fantasises concerning whether her attackers were going to rape her or kill her were present during the attack and she further described having had fantasies about what would happen to her son and her mother if she had been killed. It is therefore evident that Brightness was attempting to *make some meaning* through her retrospective appraisal of why her assailants attacked but did not rape her. The counsellor's facilitation of the elaboration of a greater and more enriched narrative, including associations to the event and her frightening fantasies, appeared to offer Brightness some sense of relief. She expressed that she felt able to communicate with the counsellor better than anyone else, because 'they don't understand her trauma'. This was suggestive of a positive transference in which the client had begun to develop a somewhat idealised view of the therapist which probably enhanced her cooperation in other aspects of the treatment. This further highlighted that it was in the telling of the story that the relational support was experienced as important to this client. Brightness believed that if she continued with therapy she would be 'okay', further evidencing the importance of the *relational aspect* in engendering 'hope' and an expectation of assistance. However, she gave the counsellor strong indication of continuing avoidance symptoms which the counsellor did not appear to address in this particular session. Finally, Brightness had started to generalise her retelling, by sharing the story of her attack with people she was close to. She reported the accessing of their support as being helpful to her evidencing that the *mastery aspect* of the model was working as well. The counsellor's treatment plan further suggested the *promotion of mastery* through the possible use of graded exposure in order to address the client's avoidance symptoms and to facilitate the gradual tolerance of the anxiety provoking material. The counsellor once again suggested a more interpretive and dynamic focus regarding Brightness's relationship history, further evidencing the use of the model in the service of a broader and more long-term therapeutic goal as well as an additional focus, outside of that proposed in the model.

Synopsis and analysis of session 3:

Apart from her intrusive recollections of the traumatic event, Brightness's symptom profile appeared to be improving with a reported reduction in her avoidance symptoms. It is of interest to note that at the beginning of the session Brightness referred to coping a lot better and to accessing other 'healing systems' by doing a ritual to help keep her fears away, implying an interesting addition to the therapy process and one that might well have played a role in her reported symptom reduction. This, however, also served to highlight greater agency, self management and *meaning making* on the part of the client. Brightness seemed to have displaced her fears regarding the attack onto her son and reported having become a lot more protective over him since the incident. Although not evident in the session, this disclosure might usefully have required some further exploration by the counsellor. A direct link to the trauma in this regard, might have inhibited her need to become overprotective or over attached to her son as a means of avoiding her own related fears. According to the counsellor, Brightness's narrative also evidenced a large amount of displaced anger towards her boss and anxiety associated with his unsympathetic response to her. Her more enriched narrative suggested that the exposure function of the model was working. The counsellor addressed ways in which Brightness could re-establish control in her life. One of the methods suggested was the utilisation of a graded approach involving the client's going out at night in a taxi with a friend as a means to gradually exposing her to a situation which she found particularly anxiety provoking. This intervention was suggestive of the counsellor's promotion of the *mastery aspect* of the model. Other secondary stressors were also explored in relation to Brightness's mother and their relationship difficulties, with the counsellor's employing a somewhat more dynamic and interpretive focus in this regard. The *mastery aspect* was further evidenced in the client's generalising of her story telling to supportive others, as well as in the counsellor's exploration of the client's reference to having smoked marijuana in the past and her possible use of the substance at present, as a means of coping with her sleeping problems. After some psychoeducation, however, the client seemed to conclude that continued use of the substance was not a viable option in that it would ultimately serve to mask her intrusive symptoms and to complicate and delay her recovery process.

Synopsis and analysis of session 4:

There was reported evidence of further symptom reduction, especially with regard to the client's avoidance symptoms. However, she still reported sleep disturbances involving nightmares of being attacked as well as some avoidance symptoms, although the latter did not appear to be directly related to the trauma but rather to the secondary stress caused by her relationship with her mother. It would also seem that her anger towards her boss and associated anxiety had diminished somewhat, further suggestive of improved management and coping ability and evidencing the usefulness of the *mastery aspect* of the model. Furthermore, the exposure aspect of the model seemed to be working as evidenced by the client's increased anxiety tolerance with respect to going out at night. The session further highlighted the counsellor's use of a more interpretive and dynamic focus on Brightness's anxieties around her problematic relationship with her mother. The counsellor facilitated the *creation of meaning* by interpreting to the client how feelings outside of conscious awareness may be surfaced in response to traumatic events and explored the possibility that although Brightness had come to therapy as a result of her attack, it was the attack that allowed her to become more aware of her problematic and anxiety provoking relationship with her mother. After evaluating the session, the therapist proposed that perhaps the client's continuing nightmares might also be linked to her feeling of constantly being attacked by her mother and that it would be important to further explore these feelings in relation to her childhood history. This would, however, require a more long term focus and as previously mentioned lay beyond the scope of brief term intervention.

Synopsis and analysis of session 5 (termination):

It would seem that the client's experience of the trauma was relatively resolved as she appeared happy and confident and no longer reported experiencing any of her initial traumatic stress symptoms. She expressed feeling relieved and confident that she had healed. She reported a reduction in her anxiety and said that she had encouraged friends who were having similar problems to come for therapy as she had realised how beneficial it had been for her. The session evidenced the usefulness of the *mastery aspect* of the model in that the therapeutic input appeared to have translated into behavioural change at

a number of levels. Brightness reported that she had become able to actively seek the support of others and she reported feeling an increased confidence in her ability to cope outside of the therapy setting. Although there was evidence of greater autonomy on the part of the client, greater understanding in terms of insight or meaning making was not evident in this particular session. The client indicated that she would like to terminate the therapy process in order to see if she could cope on her own and this was respected by the therapist despite some misgivings reported in her case notes concerning a possible need for longer term intervention to address current relational difficulties with her mother in particular. The case as a whole, however, could be seen as indicative of the counsellor's use of the model in the service of a broader, more long-term therapy goal, and the counsellor's application of the model utilising a slightly more interpretive and dynamic focus.

Commentary

The WTM seems to have been helpful at a number of levels in treating Brightness. The more instrumental aspects such as narrative repetition, normalization and behaviourally oriented homework seem to have been helpful in giving her a greater sense of control and agency and in reducing her avoidance symptoms. In addition, the more interpretive cognitive work appears to have been helpful in linking aspects of her trauma response and her feelings towards and relationship with both her boss and her mother. While this latter work could probably have been extended into a slightly longer insight oriented process, the therapist respected both the client's wishes and the premise that trauma counselling should generally remain circumscribed and focused.

Chapter 4 has aimed to provide a fairly extended outline and appraisal of the therapy process in each of the six cases with an emphasis on the reported use of aspects of the WTM. The apparent benefits of the approach as well as the application of other therapeutic principles and the possible role played by extra therapeutic factors were addressed. Some possible limitations in the application of the WTM in practice were also highlighted. Thus chapter 4 represents some of the 'findings' of the research study that require further extrapolation and discussion as undertaken in the following chapter.

CHAPTER 5

5.1. Discussion of the Therapy Process and Outcome

Out of the data analysis, and in conjunction with the literature reviewed in chapter two, a synthesising commentary or overview, drawing together the thematic analysis observations, is offered, allowing for a meta-analytic perspective on the implementation of the WTM as observed through the lens of the six sets of case note data. In addition, and in order to inform best practice for practitioners who might be utilising the model in the future, the discussion also focuses on how the different therapists appeared to have implemented and understood the model, as well as the dilemmas and challenges they faced in working with traumatised individuals. It should be noted that all the findings are interrelated and examples chosen to illustrate one theme are therefore also, in some instances, illustrative of other themes.

The thematic analysis observations for this higher order discussion were structured with reference to the criteria as outlined in phase 3 of the methodology chapter. Firstly, the overarching question regarding how the WTM as a whole appeared to work in practice is broken down and discussed according to the following criteria: (1) evidence of symptom reduction and improved quality of life (2) evidence of appropriate coping or readjustment (3) evidence of greater client agency or autonomy over time (4) evidence of greater understanding or insight on the part of the client. Secondly, the question as to which phases of the model were in evidence in each session and how these aspects appeared to

work in practice is explored. Thirdly, broad issues pertaining to the treatment process, such as flexibility in terms of the therapist's adherence to the different phases of the model, therapist's creativity in applying the treatment principles and related non-specific therapy factors such as the therapeutic relationship that appeared to influence therapeutic outcome are outlined and commented upon. Lastly, any perceived lacunae or areas within the model which may need to be supplemented or refined are examined and integrated into the discussion as and when this is deemed appropriate.

5.2. How the WTM as a whole appeared to work in practice:

Practically, what one witnesses during the aftermath of traumatic events is a combination of responses to both primary and secondary stressors, overlapping stages of response with regards to trauma impact, and varied patterns of coping in response to the range of stressors associated with a particular trauma. Given the idiosyncratic demand characteristics of trauma, intervention models need to be implemented in a manner that allows for responsiveness to a variety of evolving situations (Orner & Schnyder, 2003). The Wits Trauma Model, in keeping with this proviso, aims to address the distress of the client in as comprehensive a manner as possible, using a range of intervention components.

Although no self-report scales were used to quantitatively monitor the ongoing impact of the therapy, evidence of symptom reduction and improved quality of life as reported by the clients to the therapists and recorded in the case notes was tracked on a session-by-session basis and in all six case narratives, sufficient qualitative evidence suggested a causal relationship between the different clients' initial symptom presentation, reported improvements, intra-therapeutic work and the activities and changes in their lives that they undertook in response to the treatment. One factor that would need to be considered is normal spontaneous recovery since we know that there is a considerable degree of improvement in these kinds of presentations in the majority of people over time. However, it was noted in all 6 cases that the time between the trauma and the initiation of therapy was less than 96 hours, further providing evidence as to the effectiveness of treatment proper. For example, Lebo's main complaint in the first session was a marked

inability to concentrate to a degree that impaired her social and occupational functioning. She further reported increased appetite, increased arousal symptoms, indicated by a difficulty in falling asleep, and avoidance symptoms, indicated by social withdrawal and an inability to mourn for her deceased husband. In session 3, the therapist reported partial symptom reduction in terms of Lebo's improved mood and concentration as well as a reduction in her avoidance symptoms in that she had begun to entertain feelings and thoughts about her husband's loss. In session 4, the therapist reported a further improvement in both mood and concentration. Furthermore, the client reported that she had slept soundly for the past four nights, also indicating a reduction in her arousal symptoms. In session 5, the therapist indicated further improvement in sleep as well as a marked improvement in her work related participation and satisfaction. At termination, the therapist reported that the trauma was relatively resolved in that the client had begun to resume her previous levels of functioning and no new symptoms were reported by the client.

In general, and apparently to some extent as a result of the successful application of the model, all of the therapists reported a positive outcome at therapy termination. Four of the six clients were seen for a total of five sessions and two for six sessions, including termination. In all six cases, appropriate coping or readjustment as well as evidence of greater agency or autonomy over time were visible. Evidence of greater understanding or insight on the part of the client was also visible in four of the cases.

On termination, Sylvia reported feeling that she had benefited from therapy and that she felt able to process more of the incident every time she retold the event. Her cognitive re-appraisal of the traumatic event and its sequelae reflected a more realistic perspective and the case notes go so far as to suggest a positive outcome in terms of the development of new convictions, meaning and direction for her life.

In Lebo's termination session, the counsellor reported greater agency, self management and meaning making on the part of the client. This was further evidenced by Lebo's

reported resolution of a conflictual relationship with her husband's family as well as by the more adaptive use of her religion as a support structure.

Margaret explained how she had enjoyed having someone outside of her home to speak with and volunteered that she appreciated the space to voice her worries and to feel supported by a concerned other. In the fifth session, the therapist reported her demeanour as happy and engaging and observed that she appeared changed in the sense of becoming a healthy and capable agent in the world. Moreover, greater understanding and insight was evidenced regarding the meaning of the trauma to Margaret in that it had caused her to think about other areas in her life that were of importance to her, such as the wellbeing of her grand-daughter.

Sebolelo appeared to have somewhat idealised her counsellor during the course of the therapy (telling her how 'amazing' she was and how she had told other girls about how much she had been helped by the process). Such idealization usually arises when the intervention is experienced as effective (Eagle, 2000) and could therefore be seen as indirect evidence of the efficacy of the trauma intervention in this case. In the final session, the therapist described Sebolelo's appearance as much more relaxed and reported that she had indicated that she was feeling a lot better. Sebolelo also reported that her relationship with her child had greatly improved and there was evidence of enhanced coping and mastery over angry feelings in response to her work situation.

Greg reported a restored feeling of competence and stated that through his experience of counselling and talking about his experience, he would be better able to help his friend/manager. He further expressed strong appreciation for the work he and the counsellor had done together at the clinic. Greater understanding or insight was reported by the therapist in terms of Greg's ability to understand himself and to approach the world in a more realistic and manageable way. The client also reported an enriched appreciation of life, both in the present and in relation to the future.

Brightness expressed a feeling of relief, that she had 'healed' and stated that she had also encouraged friends who were having problems to come for therapy as she had realised how much it had helped her. Although there was evidence of greater autonomy in her case, greater understanding regarding insight or meaning making in response to the trauma was not evident upon termination.

The above examples provide at least partial evidence that the treatment was centrally implicated in the clients' improvements and is suggestive of the likelihood that their gains were not simply attributable to spontaneous recovery factors. The case examples are further indicative of the fact that significant relief from traumatic stress symptoms can be achieved in a relatively limited time frame providing adequate support is in place.

5.3. How each of the five components appeared to work in practice:

i. Telling / retelling the story:

In the retelling of the story it appeared that both the cognitive- behavioural and psychodynamic elements underpinning this aspect of intervention appeared helpful. In all six cases, the exposure element linked to the narration of the trauma seems to have assisted in the client's increased tolerance of the anticipated anxiety associated with recollecting and 'approaching' the trauma incident and the diminution of this anxiety. In addition, the detailed revisiting of the traumatic event appeared to lead to the recovery of lost memory fragments and the building of a continuous, more detailed and enriched trauma narrative. Furthermore, all counsellors seemed to engage with the difficult emotional foci or what Ehlers and Clark (2000) would refer to as the 'hotspots' in the trauma narrative and appraisals connected with them, and as such, the most disturbing and intractable aspects of the trauma were highlighted and assessed for further exploration.

From a cognitive perspective, the story telling in all six cases was seen to allow the client to create a cognitively consistent structure around the event which placed the trauma in

sequence, in context, and in the past, and thus, according to Eagle (2000), facilitated the clients' process of accommodating the traumatic experience into existing cognitive frameworks. From a psychodynamic perspective, the narration was seen to mobilise the engagement of both an observing and an experiencing ego (Eagle, 2000), and the capacity to use both these aspects simultaneously appeared to enable the clients to think about their experiences of the trauma in a different light. This is evident in some of the clients' accounts of their ability to reflect upon aspects of the trauma from a more distanced stance. It was reported that several of the clients spontaneously volunteered that they had found the detailed re-telling beneficial, even if this was sometimes experienced as difficult to do.

The case of Lebo provides a good example of the application and perceived effectiveness of this component. In the first session, the client was encouraged to tell her story and to make sensory associations to the traumatic event as a means of enhancing a more detailed recall. The therapist empathically reflected feelings and content and explored and reframed the client's self-blame and feelings of guilt related to her thoughts about possibly having been able to prevent her husband's death. In the re-telling in the second session, the client was encouraged not to avoid the aversive stimuli and her intrusive thoughts, which appeared to result in an expanded and enriched narrative as well as improved cognitive structure, leading to greater awareness of further associations to the traumatic event and related fantasies. As her husband's death took place under somewhat bizarre and grotesque circumstances, Lebo's difficulties around not knowing what had actually caused his death seemed to significantly impair her attempts to explore her feelings and to mourn for him. During the second session re-telling, the most plausible and acceptable explanation for Lebo herself was explored and the therapist reported that this seemed to offer her some sense of relief. In addition, according to the therapist, it was the exploration and interpretation of the Lebo's fantasies associated with his manner of dying and the history of their relationship which resulted in an increased affective display and an enhanced engagement in the session.

Lebo's fantasies surrounding the hypothetical circumstances of her husband's death were an integral 'experienced' aspect of the trauma which might have been missed without a detailed retelling and invitation to engage with all associations to the event. The volunteering and sharing of her anxieties then allowed for some processing and resolution of the material. In a sense her anticipatory anxiety about what could have unfolded regarding the circumstances surrounding her husband's death could be 'bound' or diminished retrospectively. In this instance, a further link between Lebo's idealisation of her husband and self-blame surrounding his death was explored in order to reduce the trauma impact and to allow for the expression of affect associated with her traumatic loss.

In session three, the client was again encouraged to retell the story with a continued focus on the most difficult aspects of the trauma narrative. It emerged that the most disturbing aspect of the trauma was still related to self-blame pertaining to Lebo's fantasy of being the 'perfect wife' and a personalised sense of failure in not having prevented her husband's death. It also emerged that in some ways Lebo actually felt relieved at her husband's death and that this served to further exacerbate her guilt. It was only after several retellings of the story that Lebo was able to access her feelings and fantasies associated with this part of the experience and it seemed as though the therapist went to great lengths to provide a sense of respect and legitimation of the client's thoughts and behaviour while at the same time empathising with the painfulness of her experience. The therapist reported visible relief on the part of the client. It seemed that the 'cathartic' impact of openly confessing some of her ambivalence towards her husband and her related guilt stemmed from having access to someone who was able to understand and in a sense 'contain' her guilt. Lebo indicated that the non-judgemental space that therapy offered was distinctly helpful to her, further indicating the importance of trust in the therapist in relation to cooperating in ongoing exposure-related interventions and the importance of a sense of 'psychological accompaniment' in the telling and retelling of the story. According to the therapist, Lebo described feeling less anxious with each re-telling evidencing the benefit of the exposure element linked to the narration of the trauma.

ii. Normalising the symptoms:

In all six cases, information about symptoms experienced was obtained and the client's symptoms were discussed and empathised with. Counsellors made links between the traumatic event and symptoms experienced, all the while reassuring the clients that their responses were normal reactions to an abnormal event and suggesting that in the usual course of events they would diminish over time. However, it seemed that psychoeducation was the most underutilised aspect of this component in that minimal evidence was found in the case notes of interventions designed to educate the client about what symptoms to anticipate, individual differences in pathways to recovery, or the role of behavioural, cognitive and emotional avoidance mechanisms in maintaining the traumatic stress symptoms. Furthermore, in four of the cases, while the clients reported fantasies associated with the aftermath of the trauma, such as fearful or revenge fantasies, there was no evidence in the case notes that such fantasies were normalised in terms of being common to trauma survivors or interpreted in terms of their possible relationship to the traumatic experience.

For example, in the case of Sebolelo, the client was reported as making continual reference to her symptoms as being worse on 'Thursdays' (which was the day on which her boyfriend was murdered), but it appeared that this associative link was not addressed during the course of therapy. Psychoeducation and normalisation regarding the nature of her traumatic stress symptoms and triggering events that resembled or symbolised an aspect of the trauma (e.g. anniversaries) would probably have been therapeutically beneficial in this instance. The client also referred to several fantasies in her sessions which were also not evidenced as being either normalised or interpreted. For example, it seemed that the client's irrational thoughts and fantasies involving a wish to form a group and to kill all men was not explored or reframed as a probable overgeneralisation resulting from the trauma of her experience. Eagle (2000, p.314)) suggests that these types of aggressive fantasies may be a hypothetical form of defence, relating to self-blame or survivor guilt. Fantasies of violent retribution or revenge may involve "becoming like" the aggressor in order to symbolically assume power rather than remain with unbearable feelings of powerlessness.

One possible explanation for this apparent lack of implementation of an element of normalization of symptoms or psychoeducation could be that the trainee clinical psychologists were not adequately trained in the application of this particular aspect of the model. A second explanation could be that the somewhat skewed leaning on the part of the counsellor(s)/ supervisor(s)/ institution towards a more dynamically oriented perspective precluded the use of more active or directive interventions in favour of a less structured, and more interpretive approach. This point is further highlighted in Sebolelo's therapist's evaluation of their third session, in which the therapist admitted to being preoccupied with two aspects of the case in particular: (1) the dynamics of the client's relationship with her boyfriend and the other girl he had been previously involved with, and (2) an exploration of what had really happened on that particular Thursday so as to result in the client feeling so miserable every Thursday thereafter. In noting her interest in these two issues in her case notes the counsellor seems to evidence an interest in uncovering a more unconscious element or set of interpretive links within the trauma.

It must be stated that the proposed ideal of offering both reassurance and psychoeducation is not limited by the model itself, but rather by the implementation of the WTM on the part of the practitioners in response the clients' informational needs. An advantage of psychoeducation is that it serves to enhance clinician credibility in that it quickly lets clients know that the counsellor understands their problem at its most fundamental level. It is a rapid and effective communication that the clinician deserves trust and is qualified to treat them, helping them make sense of their disturbing and disruptive symptoms (Friedman, 2003). While the counsellors appear to have conveyed this to some extent in their acknowledgement of and empathy towards symptomatic presentations it seems that they could usefully have placed more emphasis on taking on this 'expert' role in dealing with this aspect of clients' traumatisation.

iii. Addressing survivor guilt or self-blame:

In this phase of the model, feelings of self-blame or survivor guilt are explored. In many cases, survivor guilt may not be present, but in virtually all cases there is some evidence of self-blame, the impact of which is almost always detrimental to self-esteem (Eagle,

2000). Eagle also states that self-blame is often related to a wish to retrospectively "undo" the trauma, thereby providing the client with a greater sense of agency (Eagle, 2000, p.313). Although different aspects of this element of the 'typical' trauma response were present in all six cases, interventions to address such concerns were only evidenced as being utilised with three of the six clients.

In the case of Lebo, the counsellor began session two with an exploration of the her intrusive thoughts regarding the unknown circumstances surrounding her husband's possible murder as well as her self-blame and associated guilt feelings, which centred on her not having prevented her husband from going out and attending a party on the night that he was killed. These feelings emerged as traumatic foci in the narrative and as such, were re-examined and reframed. Lee, Scragg, & Turner (2001) caution that exposure work with an individual whose underlying emotions related to a trauma are those of shame and guilt often activates these emotions, potentially inhibiting further processing. They further argue that the therapist needs to deal directly with these emotions in order to resolve traumatic stress symptomatology. It emerged that Lebo's difficulties around 'not knowing' and the lack of clarity concerning the circumstances surrounding her husband's death seemed to significantly impair her attempts at both exploring her feelings of self-blame and grieving for her husband. Lebo was therefore encouraged to develop her own guided insights about how her husband might have died and the most acceptable and comprehensible explanations in her terms were explored. During the exploration, Lebo was encouraged not to avoid aversive stimuli and her fantasies about how her husband might have died were addressed. The therapist reported that this intervention appeared to offer the client some sense of relief.

In session three, Lebo's fantasy of being the 'perfect wife' was explored and interpreted as underlying a strong sense of responsibility and subsequent self-blame at not having prevented her husband's death. It also emerged that in some ways, she had actually felt relieved at her husband's death and that this feeling had also served to exacerbate her guilt. The counsellor's non-judgemental exploration, empathic reflection, and reframing of Lebo's thoughts and feelings enabled her to better articulate her guilt and facilitated a

realistic appraisal of her own role in the marriage and response to her husband's death. According to the session notes, this afforded Lebo considerable relief suggesting that the reframing of her role in the traumatic experience had helped to restore some sense of self-esteem. One further point regarding this intervention is that from a psychodynamic perspective, it is possible that the regressive nature of the trauma harnessed Lebo's more primitive, judgemental and critical super-ego and that the intervention allowed for the tempering of this punitive super-ego influence, enhancing her ego functioning and in particular, the aspect of reality contact.

A similar, yet perhaps less interpretive intervention on the part of the counsellor was evidenced in session one, in the case of Sebolelo. The counsellor reported that Sebolelo blamed herself for her boyfriend's death and fantasised about how things might have been different had she accompanied him home that night. The counsellor suggested to her that her presence might have aggravated the situation and that she might even have been raped or killed had she been there. This she agreed to, but very doubtfully. Interestingly, in her attempt to reframe the client's self–blame through the use of guided imagery, the counsellor in this instance appeared to be expressing her own fantasy of what might have occurred and hence, the client responded somewhat sceptically to the intervention. In this regard, Eagle (2000) suggests that the client needs to be encouraged and guided towards developing his/her own insights, thereby making his/her release from self criticism more authentic and powerful.

In session four, however, the re-examination and reframing of aspects of Sebolelo's self-blame in a more realistic light was reported as having a more successful outcome. In this instance, the client was again encouraged to use a guided imagery enactment of preferred scenarios with the therapist interceding through the use of appropriate reality constraints. Her behaviour was reframed and reinforced as being adaptive and the therapist reminded the client that her presence might have made the situation worse and that she might also have been killed, leaving her baby orphaned. It would appear that this intervention facilitated Sebolelo's appreciation of the impossibility of her fantasised actions regarding

the prevention of her boyfriend's death and her awareness or acknowledgement that her potential actions may even have led to greater damage.

Of further interest is the fact that Sebolelo's irrational thoughts and fantasies involving a wish to form a group to 'kill all men' was not explored and reframed as a possible overgeneralisation resulting from the trauma of her experience and as possibly serving a compensatory function in relation to her guilt about not being either present with her boyfriend during or able to protect her boyfriend from the attack. This dynamic seems to be one that might fit in this case. However, while these observations can be made with hindsight in retrospectively reviewing the case notes, this link either escaped the counsellor or there were other reasons why the survivor guilt and/or self-blame does not appear to have been fully addressed during the counselling process.

iv. Encouraging mastery:

In all cases, the six counsellors appeared to assist their clients to continue with the tasks of daily living, with the aim of restoring them to previous levels of coping and functioning. This was evidenced as being the most utilised phase of the model and one of the most important aspects of coping was seen to be the accessing of adequate support. The clients were encouraged to seek out and utilise existing support structures and where necessary, the counsellors provided various techniques to assist with coping. These techniques included training in relaxation exercises, anxiety and stress management skills, cognitive techniques such as distraction and time structuring, as well as elements of systematic desensitisation and/or graded approach. All the techniques used, aimed to restore the clients' coping capacity and consequently, to reduce anxiety and increase a sense of control.

Specific examples of the use and benefit of certain aspects of the component were evidenced as follows:

After the initial assessment of the client's support systems, it emerged that Brightness had been isolating herself from both friends and family and that she had been struggling to manage her anxiety on her own. Over the course of therapy, the client was encouraged to utilise her existing support systems and Brightness reported having found the generalising of her story telling to supportive others as helpful. The counsellor also suggested the use of graded exposure in order to address the client's avoidance symptoms and to facilitate the gradual tolerance of the anxiety provoking material. Brightness had reported finding it particularly difficult to go out at night as she was still experiencing nightmares involving people attacking her. In order to restore some sense of control, the therapist's intervention involved a graded approach with support in which the client was encouraged to go out at night but only in the company of a friend who could both protect and support her. This intervention appeared to have produced some positive results as evidenced in session five, where Brightness reported that she had become able to actively seek the support of others and she reported feeling an increased confidence in her ability to cope outside the therapy setting. In her second session, Margaret complained of 'very stiff shoulders and a terrible headache'. After normalising these symptoms as a common post-traumatic stress reaction, the therapist advocated stress management in the form of progressive relaxation techniques which she taught to the client in session. This intervention was reported by the client as useful and as having worked well in providing her with some tension relief.

In Lebo's first session, her means of coping and sources of support were explored and reinforced where apparently adaptive. It was reported that she had strong support from her friends and community, although she complained of conflict with her in-laws. This conflict had come to a head at her husband's ritual ceremony and Lebo was forced to confront her in-laws and arrive at some form of resolution. Lebo's sense of mastery in relation to the confrontation was explored and enhanced by the therapist's contrasting of her earlier feelings of helplessness and powerlessness to her more recent ability to tolerate the strong affect that their presence at the ritual had elicited. Lebo's therapist reported that this intervention had offered the client a sense of relief. According to the case notes, mastery was further enhanced through a discussion around time expectations, the nature of trauma and its resolution. In order to restore the client's previous levels of

functioning Lebo was encouraged by the therapist not to place too much pressure on herself in her attempts to overcome the trauma.

v. Facilitating Creation of Meaning:

The final stage of the model is optional, and should only be used if the client raises meaning issues. By engaging with the client's existing belief systems – this may be on a cultural, political, spiritual, or existential level – the client can be assisted with establishing meaning around the traumatic event (Eagle, 2000). The creation of meaning was evidenced to varying degrees in all six case narratives and work carried out in this area by all the therapists appeared to remain respectful of each client's particular beliefs and experiences, while simultaneously assisting the clients to derive some meaning from the event in a way which engendered hope and offered some future perspective.

In the cases of both Lebo and Sebolelo, the therapists assisted their clients in the creation of meaning by engaging with their belief systems around the use of a symbolic ritual intrinsic to a traditional healing and ancestral power related belief system. After performing the ritual, Sebolelo reported feeling as though a 'huge burden' had been lifted from her shoulders and Lebo's therapist reported that the ritual appeared to have aided her in the grieving process. Although these types of extra-therapeutic events fall outside the scope of the model, they constitute an interesting culturally framed compliment to the therapy process and the therapists acknowledgement of the importance of these actions for the clients speaks to a multicultural sensitivity and respect on the part of the counsellors and an appreciation that meaning making is influenced by the client's particular belief systems and life circumstances.

It was of interest to note that in all but one of the cases, aspects of meaning making were arrived at through the therapist's utilisation of a slightly more interpretive/ psychodynamic framework than that which appears to inform the meaning making aspect of the WTM (Eagle, 2000). The therapists' interventions tended to place weight on addressing the links between post-traumatic distress and current life stress, and in locating the impact of the trauma within the historical, interpersonal and pre-trauma

personality contexts of the different clients. Through the use of these types of interventions the therapists appeared to successfully enable their clients to identify current life situations and environmental triggers that set off traumatic memories and associations and exacerbated their traumatic stress symptoms. Supplementing the model in this area might enhance its applicability in the treatment of more complex trauma cases, cases in which the trauma resonates with other core conflicts or issues within the individual's life. It is interesting that many of the aspects worked with in this way (i.e. through interpretive linking to prior historical and intrapsychic dynamics) also represented some of the more intractable aspects of the client's responses in the earlier stages of the counselling.

One could perhaps infer that what Ehlers and Clark (2000) refer to as the 'hot spots' in the trauma story may be related not only to the most traumatically experienced elements in the sense of terror or horror or life threat, but might also be linked to prior unresolved conflicts, as would be suggested by psychodynamically oriented trauma therapists (Garland, 1998). Again, the focus on these issues by this particular group of therapists might have been an artefact of their training as mentioned previously, but there was enough evidence to suggest that for most of the clients the trauma threw up core areas of distress or conflict that required some resolution as part of the working through of the trauma. A more specific example could be seen in the case of Lebo. Added to the impact of the traumatic event was the task of mourning – difficult under any circumstances, but made more so by the guilt and self-blame her husband's death had evoked. The fact that Lebo's relationship with her husband was both troubled and somewhat ambivalent, seemed to underlie her feelings of self-blame and guilt which emerged as traumatic foci in the narrative and were reported by the therapist as having significantly impaired her attempts to both explore her feelings and to grieve for her deceased husband.

As a result, the therapist made use of a more interpretive/dynamic focus as part of working through the trauma, which centred on the dual representations that Lebo held of her husband and explored her feelings around the loss of hope relating to a fantasy that their relationship might still have changed for the better had he not died. Lebo ultimately

arrived at the reality that her husband had often made life very difficult for her and hence gained a better understanding of her feeling of some relief at his passing and the related guilt feelings that this feeling had triggered. It also emerged that her ideal of being the 'perfect wife' was directly related to her belief that she could have somehow prevented her husband's death. This intervention concerning her insight into relational dynamics and how these were implicated in responses to and fantasies surrounding her husband's death, although not focal in the sense of concentrating purely on the actual traumatic event, touched on more unconscious associations, linked past history to present material and appeared to offer Lebo a great sense of relief. According to Freud (1923/1961) interventions addressed to the ego of the client can bolster the ego in dealing with the impact of the trauma and also serve to reinforce the reality principle and a movement away from regression. Lebo appears to have developed a better reality oriented perspective as a consequence of bringing these associations to light and the interpretive links the therapists offered, such that her sense of guilt was reduced and she was better able to engage with her rejecting in-laws and to function better at work.

5.4. Interchangeability of the components of the model:

In all of the selected narratives, each component of the model in its own right was evidenced as being beneficial. However, each mechanism of intervention also appeared to be enhanced by others and is therefore best understood as representing an integration of both different elements of the WTM and psychodynamic and cognitive-behavioural principles of intervention. In general, and depending on the needs of the clients and the natural flow of the session(s), each component of the model was found to be introduced both flexibly and interchangeably by all six counsellors. This is illustrated by the following specific case example: At the end of her first session Sylvia described the retelling of the traumatic event as helpful in terms of putting things into perspective. She also reported that she found the normalising of her symptoms to be reassuring. On recounting the trauma as a sequential story; new details or aspects of her memory appeared to emerge in session 2, indicating that the regressive impact of the event was being partly ameliorated through the use the retelling component. It was also evident that

Sylvia was attempting to make some meaning through her retrospective appraisal of why her assailants did not rape or attack her.

In session 3, there was further evidence that the exposure element underlying Sylvia's retelling of the story was working in that she reported experiencing very little discomfort related to the incident and reported that she felt less of a need to have to retell the story to others. The counsellor's intervention at this stage regarding the mastery aspect of the model involved the encouragement of mobilisation of existing support structures. Sylvia's capacity to derive meaning from the experience had also spontaneously emerged and was facilitated by the counsellor in the subsequent sessions.

In session 4, signs of growth oriented thought suggested that Sylvia was moving towards resolution of the trauma and this was further confirmed by the counsellor through the use of psychoeducation. Sylvia's fantasies of being shot and wondering what it would have felt like were seen as perhaps indicative of mastery over the event in that previously she would not have allowed herself to entertain these types of thoughts. She was, however, quick to cognitively re-appraise this scenario which further evidenced improved self management. In addition, Sylvia's thoughts around 'karma' were explored and seemed suggestive of the development of a more complex cognitive system in which ambivalence and ambiguity could be entertained. In session 5 (termination), the counsellor continued to facilitate meaning making by exploring with the client, how her cognitive re-appraisal of the traumatic event had produced a more realistic perspective regarding her risk taking behaviour and even a positive outcome in terms of the development of new convictions, meaning and direction for her life.

Interestingly, throughout the course of therapy, there is little indication that Sylvia's self-blame and her associated guilt feelings were explored or addressed. Despite the fact that her guilt and self-blame were not addressed and her thoughts and behaviour possibly re-framed as adaptive, Sylvia continued to develop her own insights and to deal with this aspect in her own unique way. Once again each mechanism of the intervention was enhanced by the other as was evidenced in Sylvia's enlistment of the help and support of

her brother in order to return to the scene of the crime. This seemed to suggest that the counsellor's earlier engagement around the mastery component of the model was effective (although indirectly) in the reduction of the client's difficulties in the area of self-blame. An integrative understanding therefore transcends the contribution of each component in isolation and speaks to a degree of clinical flexibility in terms of the timing, emphasis and employment of strategies and technique in the implementation of the WTM. It must be stressed, however, that the WTM is only a framework for working, the successful implementation of which is dependent on a solid foundation in counselling skills and underpinned by a good therapeutic relationship.

5.5. Flexibility in the implementation of the model:

There was some evidence that on occasion the therapists felt pulled in different directions in terms of whether to give priority to adherence to the model as opposed to diverging from this framework to respond more particularly and flexibly to needs of particular cases that did not seem to be met by working within the WTM. This was clearly evidenced in the first two sessions with 'Lebo'. The therapist noted that the sessions seemed to 'jump around a lot'; with the session focus alternating between the trauma related content and the client's felt inability to grieve for her husband. The therapist further noted that this dual focus on the part of the client left him unsure as to which theme to follow and resulted in his feeling of 'being stuck'.

Should the therapist deviate from the parameters of the model in order to recognize and deal with such dilemmas? In this case, the therapist had initially discussed the goals of the trauma focused treatment with the client. He explained that the therapy would initially deal with the trauma of the experience with a later focus on the complicated nature of the client's bereavement since it is generally understood that the trauma response features, such as elevated arousal, shock and intrusions, are a barrier to processing loss of this nature and generally, as far as possible, need to be addressed at the outset without denying the importance of the bereavement dimension. If both counselor and client had adhered to this, having the experience of working successfully on the trauma while

putting the bereavement work on hold (albeit temporarily), this might possibly have enhanced Lebo's belief in her ability to make changes in her life, as opposed to being overwhelmed by a multitude of concurrent problems. However, most counselling places considerable importance on 'tracking' of clients and working with their preoccupations so it is also possible that attempting to move the trauma treatment in a particular direction might have alienated the client.

According to Stickler (2006), another solution sometimes employed when clients present with multiple concerns or difficulties is to target the most distressing problem and proceed with other problems as the initial one diminishes. Although such an approach can be effective, it is often unclear how to determine which problem is primary and how changes in one set of concerns and symptoms may be impeded (or possibly enhanced) by work on other problems. One also has to accept that such decisions can only be made in the presence of the client who is giving feedback by their responses. It is apparent, however, that in some instances the sense that adherence to a particular model, such as the WTM, may create difficulties, particularly for trainee therapists who may feel less able to rely on their own discretion.

Addis et al., (1999) suggest that these kinds of dilemmas might be better served in attempting to find a 'middle ground' regarding the client's preoccupations (Fishman, 2005), and allowing for attention to both sets of issues. This approach was evidenced in Lebo's second session which was divided into two halves by the therapist. The first half of the session retained a focus on the trauma work using the WTM and the second, comprised a more interpretive and dynamically focussed exploration of the client's relationship with her husband. The counsellor reported a positive outcome as a consequence of this decision and stated that the client seemed to 'come alive' during the second half of the session, resulting in a more animated affective display and an engagement in the process in a manner that had not been seen previously.

A similar dilemma was seen in session two, in the case of Brightness. In this instance, the focus of therapy was directed by both the client's preoccupations with work as well as by

the therapist's more focused assessment of trauma impact. Although meaning making was ultimately achieved, in this case meaning was derived only as a consequence of the counsellor's exploration of the client's relationship with her mother and by the linking of this to the traumatic event. Both examples can, however, be seen as speaking to a degree of flexibility within the model in terms of the counsellors' dynamic employment of different elements as well as to the counsellors' creativity in applying the treatment principles and strategies. The potential of the WTM to generally, comprehensively meet the unique needs of each client as well as some flexibility in implementation can thus be considered a strength.

5.6. The role of the therapeutic relationship:

The success of the model is predicated upon the counsellor accompanying the client through each step of the trauma experience and its impact and although not included as a specific component of the model, the success of the intervention in practice is underpinned by the centrality of the therapeutic relationship. In all six cases the presence and containing attitude of the counsellor was found to be an essential feature of the intervention and all counsellors appeared to evidence a demonstrable level of respect for their clients and interest in their experiences, as well as to have actively legitimated their behaviour and responses. Reading the case notes it is apparent that there was a strong degree of therapist investment in the work and empathy for their clients.

Based on a psychodynamic understanding of psychotherapy Eagle (2000) suggests that the role of the therapist should be that of a containing witness who symbolically accompanies the client through the traumatic experience, restoring some sense of a good internal object. As evidenced in session three, the counsellor reported that Lebo found great relief in having someone who was able to understand her feelings of guilt around being relieved at her husband's death and volunteered that a non-judgemental space was distinctly helpful to her. In this case, the counsellor's ability to contain and translate the client's unmanageable feelings of guilt into words and symbols seemed to have played a

highly ‘cathartic’ function for the client and the success of this particular intervention could be seen as predicated on a strong therapeutic alliance.

In session four, Margaret’s therapist reported a deepening of the therapeutic relationship although it was unclear as to whether this was due to an extra therapeutic event (organising a doctor’s appointment) or the therapist’s empathic interventions, or both manifestations of care and concern. Similarly, in her first session, Brightness requested that the counsellor take a more instrumental role in the process by contacting her manager at work and asking him to change her work assignment. Both cases therefore required instrumental and problem solving interventions on the part of the therapists beyond the general scope of the model and although they seemed to produce some alleviation of the clients’ anxiety, they also implied that the client could not cope without assistance and this might have been disempowering for the client. However, according to Friedman (2003), counsellors should sometimes act as advocates for clients in obtaining those services required to enhance treatment, as seemed to be the case in the first instance. Finding a balance between supporting people whose coping capacities and ego resources have been severely strained and who may be somewhat regressed and at the same time encouraging mastery, resilience and autonomy as a component of recovery is a delicate element of trauma work in general.

As further evidence of the importance of the relational dimension, in her second session Brightness expressed that she could communicate with the counsellor better than with anyone else, because ‘they don’t understand her trauma’. According to Orner & Schnyder (2003), transference demands particularly careful management in clinical practice with trauma cases as therapists are often idealised as ‘saviours’ and the only persons ‘who understand what has happened’. Eagle (2000) concurs and suggests that the therapist needs to avoid fostering a dependent transference, although this aspect of the therapeutic relationship can be used to enhance cooperation in other aspects of the treatment. Brightness believed that if she continued with therapy she would be ‘okay’, confirming the suggestion that the therapeutic alliance may be important in engendering ‘hope’ and

motivating participation in treatment, such as undertaking mutually agreed to 'homework' activities.

Since the short-term nature of the model precludes the possibility of adequately addressing transference and countertransference aspects of the therapeutic process, it was generally evident that the different therapists managed to bracket any interpretation of this aspect in the therapy even when it appeared in certain cases to be prominent. This was clearly evidenced at the end of the fourth session in the case of Greg. Despite evidence of a strongly negative countertransference on the part of Greg's therapist (who reported feeling quite angry towards him), she was at pains to provide a sense of respect for his attitudes and behaviour, at the same time empathising with the painfulness of his experience. In this way, and in keeping with the aims of the model, any introduction of transferential dynamics into the actual counselling sessions was avoided, rather than interpreted or confronted, which in turn seemed to enhance Greg's cooperation in other aspects of treatment. According to the therapist, over time Greg became more receptive to her interpretive links which in turn enabled her to better facilitate his understanding of the traumatic event and its impact upon his world.

5.7. Conclusion:

The selected thematic case narratives provided the basis for highlighting and discussing both the strengths and possible weaknesses of the WTM as well as how it appeared to work in practice. In all six cases the model as a whole appeared to work well in practice evidencing, in the short term at least, a reduction in post-traumatic stress symptoms as well as improved coping in the clients treated.

In general, and depending on the needs of the clients and the natural flow of the session(s), each component of the model was found to be introduced both flexibly and interchangeably, although unexpected deviations from the model in response to client preoccupations left some therapists unsure as to which theme to follow or whether to maintain a strictly trauma focussed approach to treatment. Different options were discussed and illustrated regarding the therapist's adherence to the different phases of the

model in conjunction with taking account of contextual issues and the personalities and circumstances of the specific clients. Examples of this included looking at the different choices made by the counsellors in dealing with these dialectical forces throughout the course of therapy, together with process and outcome information about the consequences of such choices in individual cases. However, any limitations in this respect were found to pertain more clearly to the counsellor's choice of intervention and manner of employment of the WTM than to the model per se.

On the whole, and in keeping with its integrative perspective, the model was found to hold a degree of flexibility in implementation in terms of timing, emphasis, and technique, and each component, when introduced, was found to have a beneficial outcome. Each individual mechanism of intervention also appeared to be enhanced by the other, with the integration of elements informing the therapist's interventions transcending the contribution of each component in isolation. It was apparent that the therapist's seemed to draw upon both psychodynamic and cognitive-behavioural principles depending on the clients' issues and how they were raised, as well as perhaps their own therapeutic values and style.

There was evidence that the "Encouraging mastery" aspect of the WTM was the most commonly utilised dimension. One of the most important aspects of this component appeared to be the encouragement of clients to access adequate support and to actively begin to use the resources that they usually would draw upon to cope with stress. In all cases, the clients were encouraged to seek out and utilise existing support structures and where necessary, the counsellors provided various techniques to assist with coping. The emphasis on utilising extra therapeutic support systems makes sense in the context of a short term intervention where therapist input is time limited and is also in keeping with research evidence that demonstrates that social support is beneficial in trauma recovery (Brewin & Holmes, 2003).

Psychoeducation was found to be the most underutilised aspect of the model and minimal evidence was found regarding the educating of clients about what symptoms to

anticipate, individual differences in pathways to recovery, or the role of behavioural, cognitive and emotional avoidance mechanisms in maintaining the traumatic stress symptoms. This finding was not, however, viewed as evidence of a limitation inherent to the model per se, but rather, a possible short-coming in terms of the individual therapists' implementation and emphasis of this particular aspect of the WTM. According to Friedman (2003), it may be helpful to consider addressing the client's informational needs in the initial interview, including potentially offering some basic literature on traumatic stress symptoms as well as on post-trauma recovery and management strategies. This information could also be extended to the client's immediate family or support system as a means of helping them understand any potentially disturbing behaviour on the part of the traumatised client that might previously have been erroneously interpreted (see appendix F for more details).

The creation of meaning was evidenced to varying degrees in all six case narratives and work in this area on behalf of all the therapists appeared to remain respectful of the different clients' beliefs and experiences, while simultaneously assisting the clients in deriving some meaning from the event in a way which engendered hope and some future perspective. A possible obstacle which needs to be taken into account when working in a multicultural/multilingual society is the possibility of the therapist speaking a different language to his/her client. Due to its narrative and meaning making emphasis, the successful application of the model requires a degree of verbal fluency on the part of the client and therefore the need to work in a second language could pose a problem for clients and therapists. This was not, however, reported as a difficulty in the research case material and it appeared that the different clients' levels of proficiency in English were sufficient to allow for a more than adequate processing and understanding to emerge.

It was of interest to note that in all but one of the cases, aspects of meaning making were arrived at through the therapists utilisation of a slightly more interpretive/ psychodynamic framework to that outlined by the WTM. The therapists' formulations and interventions tended to place greater weight on the interpretive and symbolic linking of the traumatic event to clients' pre-existing conflicts and intrapsychic dynamics. By using a somewhat

more creative application of the treatment principles and strategies than that which appears to inform the meaning making aspect of the model as outlined in Eagle (2000) the therapists seemed able to address some of the more intractable aspects of the clients' traumatic responses, and in this way, aid in the process of meaning making, integration and resolution. It was suggested that supplementing the model in this area might enhance its applicability in the treatment of cases in which the trauma resonates with other core conflicts or issues within the individual's life.

Two of the cases were found to be of particular interest in that the therapists' assisted their clients in the creation of meaning by engaging with their client's belief systems around the use of a symbolic ritual intrinsic to a traditional healing and ancestral power related belief system. In attempting to assist their clients to derive some salutary meaning from their traumatic experiences, these interventions constituted an interesting culturally framed compliment to the therapy process and the therapists' acknowledgement of the importance of these actions for the clients was indicative of a multicultural sensitivity and respect on the part of the therapists and an appreciation that meaning making is often influenced by the client's particular belief systems and life circumstances.

Related non-specific therapy factors that might influence therapeutic outcome, such as the relationship between client and therapist, were considered and discussed and in all of the cases reviewed, the therapeutic relationship was found to be central and to play an important role throughout the counselling process. Based on a psychodynamic understanding of psychotherapy Eagle (2000) suggests that the role of the therapist should be that of an involved and containing witness who symbolically accompanies the client through the traumatic experience. Similarly, Garland, (1998), states that without the client's renewed experience of containment there can be no real treatment. In all of the case analyses, the presence and containing attitude of the therapist appeared to be an essential feature of the intervention and all of the trainee therapists, through the apparent use of active listening, congruence and empathic reflection, appeared to establish a strong therapeutic alliance based on an atmosphere of trust and safety, thereby "earning the right

to gain access" (Friedman, 2003, p. 36) to the clients' carefully guarded, traumatic material.

It was of interest to note that in two of the six cases, problem solving interventions on the part of the therapists beyond the general scope of the model were employed. In both cases, however, the clients' requests were given careful consideration (particularly in supervision) and as a result, each intervention appeared to have had a beneficial outcome.

Finally, issues around transference and countertransference were explored and discussed. In general, and in keeping with the aims of the model, the different therapists managed to bracket any interpretation of this aspect of the therapeutic relationship even when it appeared in certain cases to be a fairly prominent element. The acceptance of generally positive and sometimes idealized transferences appeared to enhance cooperation in treatment interventions related to other components of the WTM. There was also evidence of tolerance of possible displaced anger and mistrust from clients on the part of the therapists, a tolerance which appeared to lead fairly quickly to a more positive working relationship without any need for interpretive interventions.

It is hoped that this extended discussion of the selective case material highlights that the treatment of traumatic stress and the exploration of its impact is no simple matter. Much as it is important to recognise, accurately diagnose and effectively treat trauma syndromes, it is equally important to remember that human beings are complex creatures, who have individual histories, idiosyncratic vulnerabilities and areas of resilience. As Herman (1997, p. 156) suggests, "there is no single, efficacious 'magic bullet' for trauma syndromes and in this regard, the Wits Integrative Trauma Counselling Model aims to address the distress of the client in as comprehensive a manner as possible but does not claim to be universally helpful or successful in treating psychological trauma. It does, however, appear to be a reasonably effective model that can be easily learned and implemented by trainee therapists as a brief term intervention for a range of traumatic stress cases. It encompasses many of the principles and techniques common to brief term

trauma treatment and appears to have been beneficial in counselling clients from a variety of demographic back grounds in South African clinic contexts.

CHAPTER 6

6.1. Research critique and Recommendations for Future Research

Archival data can be considered to be representational or available data – that is, data that are present in the environment rather than generated intentionally by the researcher (Breakwell, Hammond & Fife-Shaw, 1998). In this research study the researcher made use of available archival case-based data in part because access to a personal case study subject proved unfeasible. However, for both practical and ethical reasons, specifically relating to the context of this study, available data had the advantage over generated data in that data collection methods were then neither intrusive, nor directly susceptible to researcher-derived effects (such as demand characteristics, leading questions, etc.). Available data, however, had the disadvantage of being produced for reasons other than for the purposes of the researcher and was therefore subject to particular characteristics which constrained the information that was gathered (Breakwell, Hammond & Fife-Shaw (1998). In this instance the researcher had access to an indirect source of information in the sense that he did not have direct contact with the therapists but rather had access to their case notes. This meant that a fair degree of inference was required. Nevertheless, the fact that the case notes had been written to provide a record of the course of therapy (guided by the WTM) meant that there was no attempt to either represent the model or the therapy in such a manner as might have biased the research findings.

The quality and scientific rigour of the research is, however, compromised in terms of its reliance on the evidentiary value of secondary data in the form of archival case notes. There was no verbatim account of the sessions by the client and therefore no possibility of checking the accuracy of the counsellor's memory or representation of the material. In terms of outcomes, the study typically had only the counsellor's word that the client improved, or not, and in what ways, to rely upon in terms of inferring the benefits of the

model directed treatments. There may have been misrepresentation of events or their sequencing. For example, it is fairly obvious that trainee therapists who are having their case notes scrutinized under supervision are unlikely to wish to represent themselves too negatively. However, extensive process notes were made after each session and discussed with both supervisors and peers in a weekly supervision group, a process that "supports an ongoing critical approach and accountability" (Edwards 1996, p. 14). Furthermore, having different 'trainee' therapists from different backgrounds using the same model was beneficial in terms of taking account of therapeutic style and in avoiding the influence of a particular interpretive bias on the part of the therapists in their observations of their own implementation of the WTM and their clients' responsiveness to their intervention process.

Some protection against a very narrow selection of data was the selection of six cases for analysis although it proved somewhat difficult to find sets of case notes that met the criteria defined at the outset of the study, for example the minimum number of sessions required, and thus the overall sample was still relatively circumscribed. Providing a cross-section of case material allowed for a more reliable and nuanced understanding of the application of the WTM. In addition, there was some emphasis placed on examining case material for new possibilities for advancing theory and technique. The idea was not only to present case data in order to illustrate the veracity of the pre-existing theory underpinning the trauma model or to provide uncritical support for its use, but also to study the case data in such a way as to allow for a range of understandings to emerge as well as to identify possible points of critique. Furthermore, the research was supervised which provided some check on the researcher's conceptualisation and also offered the possibility of new insights.

It can therefore be said that although the research data were characterised by case illustrations and anecdotal evidence, and the study did not make use of carefully designed treatment outcome measures, the research can still be viewed as a tentative response to a growing imperative to further evaluate and substantiate an evidentiary base for the use of the Wits Integrative Trauma Counselling Model with trauma survivors. As this is a stand-

alone study, the findings cannot be generalised to all situations. What can be said, however, is that the conclusions based on applying the research to actual particular trauma intervention cases adds to the existing database of knowledge on the model and that this can in turn make the findings more functionally focussed and inductively generalisable. Furthermore, by documenting an exploration and appraisal of the implementation of the model the study provides valuable insights into its clinical utility and application thereby informing best practice procedures for practitioners who might use the WTM in the future.

Although the present study offers a promising addition to the existing body of research on the model, it cannot be viewed as an end in itself but rather as a precursor to continued and more formal research and evaluation. The following recommendations are offered as to the possible direction of future research.

First, it would be valuable to examine a case series in which the methodology was improved in the following ways: (1) the regular monitoring of symptoms by means of appropriate and perhaps standardised symptom check lists; (2) the use of follow-up assessments several months after the end of treatment in order to evaluate the long-term effects of the treatment. Other more rigorous parameters could also be introduced such as comparative treatment across the WTM and other modalities or the use of wait list patients as controls. In efficacy oriented research it is always important to attempt to control as far as possible for the influence of extraneous variables, such as extra-therapeutic factors that may aid or impede recovery.

Second, since the model was designed primarily for the treatment of more straightforward presentations of acute stress and posttraumatic stress symptomatology, it would be valuable to evaluate its applicability in the treatment of a slightly more complex trauma case. A case of this nature would require an extended intervention and could be evaluated using a more formal and extended single case-based methodology, as outlined by Fishman (2006). This would also provide a basis for establishing those factors that might be associated with a need for more traditional long-term therapeutic methods.

Third, in many South African contexts the therapist and client do not speak the same language, or if they do, there may be marked cultural differences. To date, the intervention has appeared useful with clients who speak the same language and come from similar cultural groupings. Research in the field of transcultural and multicultural training has pointed to the complexities of cross-race therapeutic relationships in the treatment of traumatic stress conditions (Eagle, 2005). It would therefore be valuable to investigate the feasibility of using the intervention where there are marked differences between client and therapist in terms of multicultural dynamics.

Fourth, more research is needed into the complexities involved in establishing a therapeutic relationship that accounts for the intensity of working through the traumatic experience in a brief term framework. This might include the common transference and countertransference aspects of the therapeutic relationship in relation to brief term trauma work as well as insight into difficulties around termination and the clients' possible feelings around abandonment.

Finally, given the fact that traumatic bereavement is one of the most common reasons for referral in many South African contexts (Hajiyiannis & Robertson, 1999), further research would be valuable in terms of the possible integration of principles of bereavement counselling into the trauma model.

6.1.1. Final Conclusion:

Despite several limitations, most particularly the use of constrained secondary data, the study has contributed to a more rigorous examination of a commonly employed brief term trauma intervention model, the WTM, in the South African context. The research found that reflections of six trainee therapists on their interventions informed by the WTM with six rather different clients point to observations of considerable improvement at a symptomatic and broader psychological level. The case notes suggest a relationship between the implementation of various dimensions of the WTM and change processes in the clients. Without revisiting some of the more specific observations, the study points to

the likelihood that the WTM is beneficial if well implemented and makes a minor contribution to case study based research on brief term therapeutic interventions in the trauma field.

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APPENDIX A

CLIENT 2: THE CASE OF 'LEBO'

Description of traumatic incident:

Lebo is a middle aged black woman who was seen at the CSVR (trauma clinic) by a white male trainee clinical psychologist following the traumatic death of her husband. She was seen for a total of six sessions (including termination).

Initial symptom presentation:

Lebo's main complaint was a marked inability to concentrate, to a degree that impaired her social and occupational functioning. She further reported increased appetite, difficulty falling asleep and avoidance symptoms as indicated by social withdrawal as well as an inability to mourn. She complained of being constantly tearful and sometimes experienced intrusive thoughts concerning the manner in which her husband may have been murdered.

Session 1:

In the retelling of the traumatic event, Lebo described that her husband was found dead after having left the house the previous evening to attend a party. His body had been quite badly mutilated and there was no conclusive explanation as to how he had died. Although Lebo had not initially identified the body, she had however, viewed it at the morgue. During this telling, the counsellor reflected feelings and content as well as the exploration and reframing of issues concerning self-blame and possible guilt regarding Lebo's not having prevented her husband from attending the party. Lebo's current symptoms were explored and normalised in the context of the trauma and her loss. Means of coping and

sources of support were explored and reinforced. Lebo had strong support from her friends and community; however, there was conflict with her in-laws surrounding her husband's death. This conflict and her feelings surrounding it were also explored and some meaning made around her difficulty in accepting her husband's death in relation to this conflict.

Due to the unknown circumstances of his death, as well as the suddenness of the experience, Lebo was in a great deal of denial about the experience and the session often centred on her difficulty in both accepting and coming to terms with her husband's death. The counsellor explained that the therapy would initially deal with the trauma of the experience, with a later focus on the complicated nature of her bereavement. Despite Lebo's depressed mood, she engaged well with the counsellor, and good rapport was established. The Wits Integrative Trauma Model was followed during the session, however, the session seemed to 'jump around a lot', with the focus alternating between the trauma and Lebo's inability to grieve for her husband. It became difficult to separate these two themes and to only focus on the trauma. In this regard, the therapist often felt stuck during the session, not quite knowing where to go next.

Session 2:

The session began with an exploration of Lebo's intrusive thoughts regarding her husband's possible murder and her previous feelings of guilt and self-blame were re-examined and reframed. The difficulties around 'not knowing' the circumstances surrounding his death seemed to be significantly impairing Lebo's attempts to both explore her feelings and to grieve for her husband. The most acceptable explanation was explored in her terms which seemed to offer her some relief. The session then moved on to an examination of her relationship with her husband in order to aid her in the grieving process.

After evaluating the session, Lebo seemed to 'come alive' during the second half of the hour and this coincided with the discussion around her husband and the nature of their relationship together. The acknowledgement by the counsellor that perhaps she had lost

her ‘real’ husband a long time ago, and that his death now represented a loss of the ‘ideal’ which she still fantasised might come to fruition. This interpretation seemed to ‘animate’ Lebo, resulting in a more affective display and an engagement in the session in a manner in which she had never done before. However, I once again left the session with a feeling of being stuck at times, similar to that of the first session.

Session 3:

Lebo reported a partial improvement in both mood and concentration; she also explained that she had begun to feel as though she could mourn her husband. The session focused on a retelling of the trauma in order to determine and explore which points in her narrative still produced anxiety for her. The session also examined the dual representations that Lebo holds of her husband and we explored feelings around the loss of hope relating to her fantasy that the relationship might still have changed for the better. Lebo reported feeling less anxious during this retelling, although she still reported feeling guilty about having allowed her husband to go to the party that night as well as feelings of guilt surrounding the fact that in some ways, she actually felt relieved at the death of her husband. The reality that he had often made things difficult for her was explored as well as her ideal of being the ‘perfect wife’ and how this might relate to her belief that she could have stopped him from going to the party. This seemed to resonate with her and Lebo came to the realisation that things were in fact better for her now, because she now had more freedom than she had had before. The relief of someone being able to understand her feelings of guilt around being relieved at her husband’s death was clearly evident in Lebo, and she was able to admit that a non-judgemental space was distinctly helpful to her. The session ended with an examination of Lebo’s presenting symptoms and a discussion around taking things slowly, in order to allow herself the necessary time needed to restore her previous level of functioning without putting too much pressure on herself.

Session 4:

The client reported a marked improvement in her mood as well as her ability to concentrate and that she had slept soundly for the last four nights. The session focused on a ritual undertaken by her family, which included her husband’s family with whom she

has had a conflictual relationship since her husband's death. His parents had been accusing Lebo of having her husband murdered and this was particularly difficult for her to accept. The conflict had complicated Lebo's grieving process, as she was unable to understand why her husband's family would not be supportive. The fact that they were present at the ritual was distressing for Lebo and the counsellor reflected on her feelings of intense fear around what could possibly have resulted from this conflict and she spoke about her decision to simply ignore her husband's family and continue with the ritual. She also explained that this prevented them from engaging in an argument with her. Her sense of control and power in this conflictual situation was explored and contrasted with her earlier feelings of helplessness and powerlessness. The realisation that they could no longer harm her was relieving for Lebo and although the ritual appeared to have aided her grieving process, it would seem as though it was the resolution of her conflict with her husband's family that relieved her the most.

A brief exploration around the ritual and Lebo's religion was then undertaken as she had spoken, in her previous sessions, of her inability to understand why God had allowed this to happen to her. Her religion and church have played a crucial part in her life and her feelings of resentment and betrayal were explored in this regard. It seemed, however, that with her continuing improvement, she had found meaning in her religion once more, which had now become a source of support for her. The session ended with some psychoeducation regarding both Lebo's diminishing symptoms and the grieving process.

Session 5:

Lebo's symptoms continued to improve. She rarely had difficulty sleeping and had returned to a normal level of functioning at work. She was now able to enjoy her work again and had shifted to future oriented thinking. The session focused on an exploration of Lebo's current functioning. Her improvement and the fact that she was taking things slowly were reinforced with additional psychoeducation. Consolidation and validation of previous insights regarding her husband and their relationship was undertaken. The session ended with a discussion regarding termination and how a gradual disengagement from therapy was necessary so as not to be perceived as 'another loss' for her. The

importance that Lebo had placed on engaging in the therapeutic process and the possibility of entering long-term therapy was also explored.

Session 6: (termination)

The counsellor began the session by asking Lebo about the symptoms that had originally brought her to therapy. An exploration of her current situation was also undertaken in order to determine whether there were any new symptoms which might have developed since her last session. The session then focused on a revisiting of some of the main themes that had been covered in therapy, and a highlighting of the progress that Lebo had made with regards to trauma resolution and the grieving process. In particular, the counsellor re-examined her ambivalent relationship with her husband and the way in which her traumatic experience had led her to become aware of the ambivalence. The need to acknowledge her ambivalence in order to begin the process of grieving was also examined.

APPENDIX B

CLIENT 3: THE CASE OF 'MARGARET'

Description of traumatic incident:

Margaret is a black, Zulu speaking female in her early fifties who was referred for trauma counselling following an incident in which she was assaulted by her neighbour. She was seen for a total of six sessions (including termination) by a white Afrikaans (first language) trainee clinical psychologist at Alexandra Clinic.

Initial symptom presentation:

Margaret presented with a host of symptoms ranging from anger and frustration, to difficulty sleeping, depressed mood, blunted affect, avoidance of stimuli, a headache and sore muscles as well as short-term memory loss (possibly due to her head injury).

Session 1:

Margaret's initial expectation of therapy was to acquire a psychological assessment report to use as evidence in her upcoming court case against her neighbour. However, as I was not able to provide court evidence, she subsequently found it difficult to understand that I could not help her directly but that I would help her by referring her to an appropriate doctor. She was however eager to speak and before I could explain to her what therapy is about, she had immediately started telling her story.

Margaret explained that she was assaulted by her neighbour while she and her son were busy organising an event for her son's daughter. Her neighbour jumped over the fence and asked why he had not been invited to the event. He then proceeded to assault her with

a brick. She managed to escape in order to phone the police and the ambulance, neither of which came. Her son was also badly beaten with a bottle. She continued to explain that she refused to sleep at home and that she had been staying with a friend in order to avoid her home because although the perpetrator was arrested, he had somehow managed to get out on bail. She reported feeling sad, angry, frustrated and scared in this regard although her affect seemed somewhat blunted. Margaret continued to explain that she had a long and complicated history with her neighbour in that he was also involved in an assault incident at her house some ten years prior. Furthermore, she described this man as being well known in the community as a 'fighter'. During the retelling, Margaret was able to touch on her emotions of anger and frustration as well as to link her symptoms of memory loss and difficulty sleeping with the traumatic event.

Session 2:

There was no reported change in symptoms and Margaret began the session by immediately making a joke about how angry she felt. She expressed how her son had tried to contact me several times over the past week and it was therefore my unavailability which had angered her. I reflected that this must have felt similar to the treatment she had received from the police (as described in the first session) in that they had not immediately responded to her request for help and had promised her support which she never received. This reflection seemed to resonate with her, although she found it really difficult to express this verbally and simply smiled.

In retelling her story, I encouraged her to remember more visual and feeling details as these were the senses that Margaret used most predominantly. Margaret spoke a lot more freely about the assault, giving a lot more detail, and also allowed herself the space to cry, possibly suggestive of her willingness to use the therapeutic space. Margaret explained that it was 'like watching a movie in slow motion and that she could not get the movie out of her head'. She also spoke further about how the event made her worry about her granddaughter.

Margaret reported having ‘very stiff shoulders and a terrible headache’. I suggested some relaxation exercises to stretch the muscles and attempted to normalise her symptoms, telling her that it was common for people who had been in a terrible situation to feel a lot of stress. She continued to reiterate seeing the event as happening like a ‘movie before her eyes’ and further complained that she was having difficulty sleeping. In this regard, I was further able to link her symptoms and emotions to the event and she seemed to make further links between how the event had caused her to think about other areas in her life that were of importance to her, such as the wellbeing of her granddaughter.

Session 3:

Margaret reported feeling happier and seemed more vibrant at the start of the session. She explained that she was feeling more relaxed and that she was determined to hold on to that ‘good feeling’ throughout the session. She further reported that having spoken about the trauma with me had made her feel less worried and upset and that the relaxation exercises I had recommended, had worked well in providing her with some tension relief. We then spoke briefly about her granddaughter and explored how an event like this can make one think about things that are important to us in life.

Upon reflecting on the session, it seemed very important for Margaret to be ‘better and happy’. It also seemed as if my suggesting other possible outcomes for the court case made her angry and anxious again. However, despite my feeling that her happiness was superficial, I felt that it was important to give strength and acknowledgement to her feeling better in the session. I would like to continue with trauma counselling, allowing her to remember new aspects of the story as and when they come up, giving her the space to reflect on how daily events remind her of the assault and to continue to connect these with her feelings.

Session 4:

Margaret presented for the session looking happy and energetic. She displayed a good level of comfort and found it easier to speak about her feelings than in previous sessions. She mentioned that a good friend of hers was also receiving counselling and they spoke

about the process together and how although she was getting used to it, she still found it slightly strange. We discussed Margaret's symptoms both past and present and continued making meaning around how the traumatic event seemed to have made her think about the things in her life that she found important, for example, her granddaughter. Margaret told me that she had also been thinking about her brother who had recently passed away and how she saw him as the fighter and protector of the family. She described her fantasy in this regard and how she felt that this event would never have happened had he still been alive. I further reflected that sometimes a trauma could make one remember other important moments in life.

My sense throughout the session was that of a deeper connection or bond between us. I wondered whether this was because I had managed to organize her doctor's appointment for her as opposed to letting her down again, which was perhaps what she had expected. In speaking freely about her feelings and her memories she seemed to use the space in a more meaningful way. I felt slightly sad to hear that Margaret would prefer to only come back to me after her doctor's appointment yet it seemed important for her to make this decision as if the sense of control it gave her was significant.

Session 5:

Margaret was nicely dressed and looked beautiful. She was full of energy, engaging and seemed happy to see me. We spoke about her doctor's appointment as well as how she might feel if her assailant were to get off free. Margaret was able to engage with the concept which felt like progress as in the previous session she would angrily insist that there was no other alternative. She spoke more about her assailant, how he had no people around him, 'no community' and at one point, I detected a hint of sadness in her voice over who he was and how 'pathetic' he had become for her. Margaret seemed very much in control of the session and spoke about the things that she wanted to and any uncomfortable exploration was pushed aside. Margaret had a whole new 'sense' around her, that of a healthy and capable agent in the world. I felt that we had found a new aspect to our relationship, one that started to speak about other things and this was an interesting development.

Session 6: (termination)

Margaret presented as happy and cheerful in the session and showed no signs or symptoms regarding her initial traumatic experience. She began the session by apologising for missing our previous session and then told me that the court case had been postponed to later in the month. She described feeling angry about the court process and explained how she felt that the justice system 'simply wanted to forget what had happened so that they would not have to charge the man'. She then restated that 'she would not forget that she would never forget what he had done'.

Margaret continued to explain how she had enjoyed having someone outside of her home to speak with and that she appreciated the space to voice her worries and to feel supported by a concerned other. She further reported that she saw the therapy as being beneficial. I have enjoyed working with her and at times been amazed at how our relationship developed. Although Margaret did not always use the space to 'work' as such, she seemed to enjoy the safe, holding environment that it brought. I think both her and I are sad that the process has reached termination.

APPENDIX C

CLIENT 4: THE CASE OF 'SEBOLELO'

Description of traumatic incident:

Sebolelo is a black, Xhosa speaking female in her early twenties who was referred to the CSVR (trauma clinic) following an incident in which her boyfriend was robbed and murdered. She was seen for a total of five sessions (including termination) by a black female trainee- clinical psychologist. (This was the counsellor's first session with a trauma survivor)

Initial symptom presentation:

S presented with traumatic stress symptoms ranging from tearfulness and depressed mood, anger and irritability, suicidal ideation, to hyperarousal and avoidance of stimuli.

Session 1:

On presenting at the Trauma Clinic, Sebolelo was in a tearful state and experienced some difficulty with expressing herself verbally. Upon asking the client why she had only now decided to come for counselling, she explained that she had been coping (or at least trying) and that her symptoms seemed to have become a lot worse, specifically on Thursdays, the day on which her boyfriend was killed. Sebolelo briefly narrated the course of events leading up to the trauma and described hearing seven gun shots shortly after her boyfriend had left her flat. She did not however think at the time that her boyfriend was involved. She explained that she only found out about the killing the following day, when her mother had come to fetch her from work.

The Wits Trauma Model was used to assist Sebolelo in coping with the traumatic event. Sebolelo was encouraged to retell the story in as much detail as possible along with the associated feelings. I also explained that her symptoms were normal in terms of how people respond to a traumatic event and that she would get better with time. We looked at how she had been coping with regards to her child and when asked about her support systems, Sebolelo described that she did not have anyone as her mother was in a different township and she did not intend to go there. Sebolelo further indicated that she had no friends and that when she was depressed, her way of coping was to 'close herself in her room and play the music very loud' and that this helped her. The counsellor encouraged her to establish support structures in this regard. When looking at self-blame, the client indicated that she blamed herself because if she had agreed to go with her boyfriend, maybe she could have screamed for help, or maybe the robbers wouldn't have come or she might have recognised on of them. The counsellor reassured her that her presence might have aggravated the situation and that she might even have been raped or killed had she been there. This she agreed to, but very doubtfully.

Session 2:

Although still tearful, Sebolelo presented with extreme anger and began the session by explaining that she had a new man in her life and that she was angry because she had recently found out that he is still involved with another woman. However, the aim of the session (as discussed in supervision) was to focus on the other aspects of the trauma, and in particular, her feelings related to when she heard about her boyfriend's death. At this point, Sebolelo indicated that she was still very confused about the matter in that she still did not believe that her boyfriend was actually gone and that he would be coming back to her and her baby. She also described that he had left her feeling helpless and that she felt that she could not cope without him. Sebolelo continued to explain that her boyfriend was directly to blame for her recent relationship difficulties saying that, 'I wouldn't be in this mess if he was still around, because he was a very honest partner, unlike my current boyfriend'. This continued for most of the session and involved Sebolelo expressing her

fantasies of how she would really like to beat her current boyfriend's other girlfriends up, or maybe even to shoot them.

Although I found this line of thought somewhat unsettling and unfocused, I allowed the client to continue to talk about her current relationships in an attempt to understand her motives for bringing this up as well as to make links to her traumatic experience. My concern, however, was that the client was avoiding talking about the event and it was decided after supervision that I should try to refocus the next session by talking to her about her experience of going to the morgue as well as her feelings regarding the funeral process.

Session 3:

Sebolelo began the session talking about how she had removed her child from crèche as she believed that they had tried to poison her (at this point, she started to cry). She continued to explain that she thought God was punishing her. When asked the reason behind this train of thought, she avoided the topic and started to describe how she had been feeling much better, although she still felt depressed, irritable and short-tempered on Thursdays. She excitedly reported having found someone to talk to, an Indian girl who was living in the same flat. She explained that talking to her had really helped and that she had also found my suggestion regarding writing her thoughts down when there is nobody to talk to as helpful.

Furthermore, on encouraging Sebolelo to tell me more about going to the mortuary as well as the funeral process, (as previously discussed in supervision) she pointed out that she had remembered seeing her boyfriend at the mortuary, but that she had proceeded to faint and woke up at home feeling very confused. She described the funeral as 'very sad and because he was such a good person, everybody was crying'. Sebolelo went on to describe her relationship with her boyfriend in more detail, highlighting an event in which he had cheated on her. In this regard, she explained that it used to make her extremely angry but that she had forgiven him and they had moved passed it. She concluded by telling me that they had also been fighting on the day he was killed

although they had talked about it and managed to resolve their differences before he left that evening. However, after evaluating the session, I was preoccupied about two things in particular (1) the dynamics of the client's relationship with her boyfriend and the other girl he had been previously involved with, and (2) I would like to explore what really happened on that particular Thursday so as to result in the client feeling so miserable every Thursday thereafter.

Session 4:

Sebolelo indicated that she had been feeling a lot better although she was still finding Thursdays extremely depressing and that she was unsure as to why.

I asked her to retell her story as well as to include the facts surrounding the argument they had had on the day of his death. Sebolelo described that she still blamed herself in this regard because, if they had not argued, he would not have been angry and perhaps he would have been observant enough to see his assailants coming and therefore, could have defended himself. I reminded her that her presence would have made the situation worse and that she might have also died, leaving her baby orphaned.

Sebolelo continued to describe how she had been unable to express the full extent of her anger towards him due to his apologising to her and that she did not want to spoil their reconciliation. It was at this point that I realised how important it was for Sebolelo to acknowledge her feelings of anger in order to allow her to mourn for the deceased. I reflected to her that as a result of her unexpressed anger she still felt guilty and blamed herself for his death because a part of her actually wanted to kill him for cheating on her. Sebolelo indicated exactly how angry she still was over her boyfriend's death and how at times she had fantasised about killing the girl who he was involved with or one of his friends who she believed might have been involved in his murder. She also indicated that at times she wished to form a group and to kill all men. We further discussed her idea around performing a ritual at his grave site, involving her presenting him with a jersey she had knitted for him the day after his death, and how the symbolism of the act might be beneficial in terms of closure.

Session 5: (termination)

Sebolelo's whole manner appeared much more relaxed in this session. She mentioned that she was feeling much better and that her relationship with her child had greatly improved. Sebolelo also described how her relationships at work had improved and that she was no longer getting angry with her boss when he shouted at her. She reported an incident which had occurred in the morning at work in which her boss had thrown files on the floor and how she had learned to differentiate between what was actually her fault and what was simply 'his stuff', which he was taking out on her. Moreover, she described making a concerted effort not to get angry with him and instead of 'storming out the office', as she would normally have done, she had just picked up the files and continued to work.

I reminded her that it was our last session and that I wanted to look at any issues that she felt were still hanging over her. Sebolelo explained that she had performed her ritual at her boyfriend's grave site and that she felt as though she had begun to make peace with him. She described expressing her anger towards him for cheating on her and that she was now ready to move on with her life. Moreover, she reported feeling as though a 'huge burden' had been lifted from her shoulders since performing the ritual and that she no longer felt frightened of him. We talked further about the possibility of her entering into long-term therapy, which she agreed to, but that she was going to speak to her boss first and that she would call me to set up an appointment. On discussing the session in supervision, it was agreed that I should refer her to a fellow counsellor as she had begun to idealise me (telling me how amazing I was and how she had told other girl's about how much I have helped her) and that this would not be beneficial to a long-term therapeutic relationship.

APPENDIX D

CLIENT 5: THE CASE OF 'GREG'

Description of traumatic incident:

Greg is a white male foreigner in his late thirties who was referred for trauma counselling following an incident in which he was held up at knife point by three black men. He was seen for a total of five sessions (including termination) by a white female trainee clinical psychologist at the CSVR (Trauma Clinic).

Initial symptom presentation:

Greg reported the following symptoms: feeling frightened, agitated, mistrusting (of black people in particular), avoidance of stimuli associated with the event, extreme negativity and a sense of helplessness.

Session 1:

The client was late and agitated on arriving at the clinic and complained about having difficulty finding the place. He described feeling particularly fearful about having to come to the city centre. After introducing myself, setting the frame and revealing the nature of trauma counselling, I proceeded to ask him to describe the traumatic event in as much detail as possible, including the pre – and - post traumatic situation.

The client described feeling extremely frightened after the event and that he could no longer trust people, particularly black people. This was affecting his work as he no longer

felt safe, thus causing him to avoid going to certain places where he used to do business. He described having a very negative attitude and that he often thought about returning to his home country. His negative attitude centred on the senselessness or meaninglessness of the crime and how he felt that he could be the target of attack at any time. He also seemed to feel helpless and alone which seemed to be a feature of the traumatic event, in that he felt that he was attacked for no reason.

The focus of the intervention centred on establishing rapport and exploring the details of the traumatic event as well as the associated emotions. A particular emphasis on 'normalising' the client's emotional reactions so soon after his experience seemed appropriate as Greg appeared particularly concerned that this experience would change his personality and that he would never recover from it. In this regard, it also appeared necessary to advise the client that in addition to addressing his emotional responses to the event, our aims would also include an exploration of ways in which he could integrate his experience in a way that would be most beneficial to him and that this would take some time.

As the client appeared to demonstrate a somewhat typical traumatic response to the incident, the Wits Trauma Model will be followed quite closely.
The counsellor would also like to explore the client's ways of coping in order to reduce his anxiety and fear as well as what types of adjustments he will have to make and what these might mean to him. To proceed slowly and carefully is a priority in this regard in order to insure the careful assessment and monitoring of his adjustment. After reflecting on the session in supervision, the counsellor would also like to explore the impact of the trauma on his masculinity, his sense of helplessness and limited control, as well as possible fantasies of what he feels could have happened. Greg seemed to be extremely perplexed by the ingenuity with which the three men carried out the attack and it is not certain what the implications of this might be at this stage.

Session 2:

Greg described feeling somewhat less fearful although he still avoided going into what he described as ‘the more dangerous areas’. He further described feeling a lot more cautious and that he only felt safe, when at home. Greg talked about feeling extremely negative living in South Africa and we discussed the meaning of the trauma for him at present. Greg explained that whereas before he was very concerned about making money, spending time with his family and being alive are now central in his mind. For the better part of the session however, Greg related stories about violent incidents that had happened to other people that he knew, seemingly in an attempt to convince himself of just how bad the situation was here and to support his desire to return to his home country.

Following my unsuccessful attempts to focus the client on his own experience of the traumatic event, I decided that perhaps it would be important to allow Greg to rid himself of the volumes of stories he seemed to be carrying and his seeming need to tell them to me. My thoughts at this point were centred on finding a common theme with which to make links to his traumatic experience and to listen for any latent messages which might tell me more about him in order to address these in the following session. Following supervision, the counsellor would like to try to better understand what the client’s narrations might mean in relation to his own experience and whether or not they serve as a defence by which he attempts to create distance from his own experience.

Session 3:

The client phoned to say that he had been delayed in the bank and as a result, we only had fifteen minutes together. Greg reported feeling much better; that his business was doing well and that he was making more money than before the attack. However, he was still extremely weary of blacks whom he felt were not to be trusted and reported that he still felt extremely negative about living in South Africa, especially because he no longer felt in control here and that his family are unsafe.

We further discussed how he had become more cautious about the way in which he conducted his business than before, specifically regarding carrying cash in his pockets,

which made him less of a target. The counsellor encouraged Greg in this regard by indicating that his improvements were a good sign but that perhaps his experience made him feel distrustful of black people in general, while this had not been the case for him before the incident. The counsellor would like to further explore how this impacted on his work and life.

Greg continued to speak about general experiences of crime in the country and averted any attempts to reflect his feelings or relate them to his own experience. His racist comments were particularly difficult to listen to and it seemed as if he wanted me to agree with him or indicate that I too share his sentiments, something I was not prepared to do in the session. I realised however that it was perhaps more important to explore his sentiments in the next session than to challenge his assumptions. My suspicion was that his racist attitude might be more of a defence against his own underlying feelings of helplessness and loss of control. I am also feeling unsure as to whether Greg's wanting to leave the country is a symptom of the trauma or if it was on the cards for him and his family before the incident occurred.

Session 4:

Greg reported that his week has been markedly better, the evaluation of which, he based on increased sales and the fact that he had employed a helper who, despite his racist comments thus far, happened to be a black man. He still however presented as mistrusting of black people in general and that he felt as though there was no safety in this country. Although Greg described still feeling angry at his attackers he mentioned the ingenuity of the attack and said that it was carried out with 'elegance'. He explained further, that 'it was a mistake to think that blacks were stupid'. On exploring this further, it seemed to me that an important aspect of Greg's experience was the extent to which the traumatic event has changed his sense of a world once considered predictable in which all blacks were considered stupid to a world now considered dangerous and unpredictable in which all blacks are to be distrusted. There was little doubt in my mind that Greg had conflated crime and race, where his racist attitudes once serving his sense of control, now following his traumatic experience, served to justify his lack of it.

I reflected to Greg that the world in which he once believed all blacks to be stupid was no longer the world he now knew and that it was difficult to feel both victimised by his attackers, and admiration for their ingenuity. He responded by telling me that he felt safer with his helper due to the fact that he had control over him and could watch his every move and that while they worked together, he still did not trust him. Greg continued to explain that he would still like to leave the country but that it would be extremely difficult on his in-laws in that they would no longer be able to see their daughter or grandchildren. I expressed to Greg that it was a common experience following a traumatic event to want to return to that which feels safe and more predictable whether it be home, mother, or mother land. He then nodded and put his head down and it seemed to me that this comment afforded him with at least some relief. Greg explained that while it is much easier to make 'a lot of money' in this country, it is not worth his life or the life of his family. Furthermore, on reflecting on his experience and how terrified he felt after the threat of losing his life, Greg explained that he often thougt about what would have happened if he had been killed. The only response that I could think of was to reiterate that he did not die and that by virtue of his sensible actions at the time, he had prevented serious harm and possibly even his own death.

Upon evaluating the session, I started off by feeling quite angry toward Greg, firstly due to his being late and secondly because he forgot my name. My general feeling, however, is that rapport is still good and that our work has taken on some depth since the first session. He has become more receptive to my links and it seems as though I am now better able to facilitate the client's understanding of the event and how it has impacted on his world, not only in his wanting to return to the mother land, but also in terms of his racist beliefs and that there is a difference between crime and race and how the two had become acquainted for him personally.

Session 5: (termination)

The session proceeded as usual with Greg telling me about another's experience of crime. This time, however, it involved his employer/ friend who had been held up at gun point

by three black men. Greg explained that he spoke to the man about his experience and acknowledged the help he had needed in order to facilitate his recovery process. He reiterated that through his experience at the Trauma Clinic and talking about his experience, he would be able to help his friend. Greg also explained that while he felt that his employer was still in denial about what happened, his employer's wife had told him about his dreaming of his deceased mother the other night. Greg then linked this to what we had discussed in the previous session about how it is common for trauma survivors to want to return home, to family, to mother, and to how his own wish to return home now made sense.

We further explored his being able to talk about his experience as opposed to his employer who could not, and what this difference meant to him. Greg seemed proud of the fact that, unlike his employer, he had the courage to talk about his experience with both his family and myself. Furthermore, it seemed particularly important for Greg to make the links that he did and that through talking about his experience, he was able to begin processing it. This seemed to give him a sense of empowerment and he reported that the event had put him more in touch with his feelings, whereas before the event, his sole focus was on making money. He now feels that spending time with his family and doing the things he really enjoys are more important and that his feelings of fear and anxiety are more appropriately directed towards taking measures to ensure both his and their safety. Greg further expressed feeling grateful for the support of his wife and family and mentioned again, the work we did together here at the clinic.

APPENDIX E

CLIENT 6: THE CASE OF 'BRIGHTNESS'

Description of traumatic incident:

Brightness is a black, Xhosa speaking female who in her mid thirties who was referred for trauma counselling following an incident in which she was assaulted by a strange man on her way home from work. She was seen for a total of five sessions by an Indian female trainee clinical psychologist at Alexandra Clinic.

Initial symptom presentation:

Brightness presented with traumatic stress symptoms ranging from a headache and sore muscles (due to a neck and back injury), hyperarousal and avoidance of stimuli, an exaggerated startle response, sleep disturbance and intrusive recollections of the event, loss of appetite and poor concentration.

Session 1:

I introduced myself, explained my role and how the process would work and Brightness began her retelling of the incident. This included a detailed description of the event as well as a description of how she had managed to fight of her attackers and how she had attempted to get the licence plate number of their vehicle. Brightness also described having had troublesome sleep patterns saying that she had been experiencing constant nightmares. She further explained that she had not reported the incident as she could not describe her assailants and did not have the licence plate number. She described feeling

afraid to leave her house and that she was still feeling very nervous - any sound out of the ordinary frightened her. She also explained that she was feeling very tired, unable to eat, and unable to concentrate. Brightness was very afraid of returning to work as she fantasised about her assailants waiting for her after work in order to attack her again.

She further explained that she would like to change her job, or at least work the day shift and in a different office block and asked if I could get in contact with her manager in order to explain the situation to him and recommend that he take her request for a different work assignment into consideration. I responded by saying that I would check with my supervisors and that perhaps I could write a letter for her. On taking this information to my supervisors, we agreed that the focus should stay on trauma debriefing, normalising the situation and positive reinforcement. When I returned from supervision I noticed that Brightness had moved her chair closer to mine and as she continued to narrate her story, I could see that she was struggling to hold back her tears. I reassured her that this was a safe space and that it was okay to cry. Brightness described how afraid she was of returning to work and I told her that it was normal to feel afraid of returning to the place that she had experienced something so traumatic, especially considering how recent the incident was. I then took the opportunity to reinforce the fact that her actions had resulted in her survival and I reflected to her how much courage it had taken for her to get out of that dangerous situation.

Although Brightness was responsive and willing to share her experience, she seemed resistant towards showing any emotions at first and just told her story. However, as the session progressed, it became clear that this experience was stressful for her and she allowed herself to cry as well as to experience the anxiety and trauma of her situation. On further evaluation of the session it would seem that Brightness focused on her immediate concerns regarding her return to work, based on the need to take care of her son. However, this was done at the expense of having to deal with her own emotions at present. I feel that Brightness sees her role as the strong one and she has the overwhelming need to stay within that role or maybe even a fear of not letting go because she is afraid to be seen as weak. This results in her holding back the true intensity of her

fears and anxieties. I encouraged her to talk about her experience to supportive others if possible.

Session 2:

Although Brightness seemed a lot more comfortable speaking to me, she found the retelling of her story difficult with regards to expressing herself around the attack and how it has affected her emotionally. Brightness explained that she had begun to share the story of her attack with people that are close to her and reported their support as being helpful to her. She also said that she felt a lot of relief during and after talking in the sessions and that she could communicate with me better than anyone else, because 'they don't understand her trauma'. She explained that she gets depressed sitting at home all day because she is used to keeping herself busy. She also said that she feels her life has changed because she cannot even read or watch anything violent as it upsets her much more than usual. Brightness did however report that if she continues with therapy she will be okay.

Brightness complained of headaches and of still experiencing problems with memory and concentration and that this was making her extremely moody and frustrated. She shared how scary it was for her to return home after our session last week as she was constantly aware of any and all sounds around her, especially when alone. She stated that whenever it was time to leave our sessions she would worry about going to get a taxi and that she was still experiencing problems with sleeping particularly at night. She was still having nightmares as well as constant headaches and back pain. She described feeling anger towards her attackers and that she fantasised around whether they were going to rape her or kill her. She further described fantasies about what would happen to her son and her mother if she had been killed and that God would punish them for their criminal actions.

Brightness explained that she felt very lucky and how she prays and thanks both God and her ancestors that she was not killed. Brightness voiced her main concerns as being related to her returning to work, as she was already struggling financially and did not want to be a burden on her mother in this regard. She does not however recognise the

effect that the attack has had on her and the need to work through those feelings before she can return to work. She felt that the work situation had to change, and did not recognise that her attitude towards returning to work needs to become a positive one. She was avoiding talking about the emotional affects of the trauma preferring to focus on her financial needs. She also mentioned that she was already considering other job options. I felt, however, that in this regard Brightness wanted to avoid any possibility of returning to the scene of the attack and was even considering changing jobs to do so. It was also likely that she was using her managers 'negative attitude' as an excuse to leave and that she was avoiding the deeper issues of how this attack had affected her emotionally.

I think it is important that we begin focusing on what she can do in order to start preparing herself to return to work as it is likely that she will have to return to the same work assignment, or run the risk of losing her job. I would also like to discuss the options of graded exposure and what the possibilities of her doing some of these exercises might be. I want to attempt to bring her focus to the fact that these men took away something important and precious from her and to feed on her anger in a positive way, using it to enhance her strength in order to work towards getting her level of functioning back to normal. I would also like to explore her history of experiences with men, keeping the focus on her attacker and her manager for now and when the appropriate time arises, bring in her experiences with her father and her ex-boyfriend. I think that these negative relationships have deeply affected the way in which she relates to men and how she interprets their attitudes towards her.

Session 3:

Brightness expressed that she was 'coping' and that she was finding it a lot easier to be alone than before. She explained that she was also no longer afraid to be on the streets by herself during the day, although he still found it difficult at night, as she was still having nightmares involving people attacking her. Brightness began telling me that she had been performing a ritual to help keep her fears away and then told me about her family history of having a 'healers' blood line. She further reported that she had become a lot more protective over her son after the attack and that she did not let him play in the street and

kept him within her view at all times. She described reporting her boss to the CCMA and the resultant difficulties involving her unemployment insurance fund and how she was taking her boss to court. She said her boss 'pissed her off' and caused her to get angry and yet she had to work in order to remain financially independent.

She then spoke about how scared she still was to go out at night alone and that she only goes out at night by car and with a friend. She spoke about an incident involving 'a group of guys who were drunk and fighting' and how one of the men had a gun, and that although she was scared, she managed to keep on walking past them. She said that it was extremely important for her to regain control of her life and I asked her how she would feel about going somewhere by taxi at night, with a friend, in order to see what her anxiety levels would be like. She answered that although the thought scared her, she would try if it meant that she would regain a sense of control over her life. The counsellor explored the client's reference to having smoked marijuana in the past and her possible use of the substance at present, as a means of coping with her sleeping problems. After some psychoeducation regarding the use of drugs however, Brightness concluded that continued use of the substance was not a viable option in that it would only serve to mask her intrusive symptoms.

Session 4:

Brightness began the session by giving me copies of the letters her boss had been sending her with regard to disciplinary hearings for her 'absenteeism'. Last week when she spoke about her boss she seemed very angry at his behaviour. However, although she seemed irritated today, it was not apparent in her voice. She called him a 'hypocrite' once and made no further harsh comments towards him.

She went on to say that she was feeling more confident at night because she had been to a party, only returning home at 1 am and that it did not worry her at all. She also described having had a fight with her mother and that her mother caused her a lot of stress. She explained that she was still having nightmares of being attacked and that they felt as though they have gotten worse due to the stress regarding her mother. She said that she was very angry and would like to fight with her mother, and that she cannot talk to her

because she does not listen. She ‘dreads going home’ because she knows that she is going to be stressed. I interpreted how sometimes it is possible that only after experiencing something traumatic that other hidden feelings come to the surface. We explored the possibility that although she came in for counselling due to her attack, that it is her anxieties around her relationship with her mother that are really the feelings that are problematic and that the attack allowed her to become more aware of these feelings.

Session 5 (termination):

Brightness was well groomed and she appeared happy and confident. She spoke openly and excitedly about all that occurred in the last week. However, she expressed being sad about ending therapy but appeared excited about being herself again. She seemed unable to associate themes of behaviours or recognise unhealthy relationships. She therefore does not see the need to continue therapy, as she felt that she had achieved her aims, which were to regain her confidence and to lower her anxiety. She immediately began by saying that she felt good and that she thought her problem was gone now. She said she was no longer afraid and had ‘no more shock’. She told me that her sleeping pattern has gone back to normal and that she was no longer having nightmares. Furthermore, she expressed that her mother had gone away for a week and that she was left alone at home an that she had experienced no anxiety or stress.

Brightness then moved on to her work situation and how the lack of money was still causing her stress, her concerns centring on whether or not she would be able to support her son. She explained that she had been looking for a new job and that she was becoming more social and going out more, enjoying spending time with people again. She then said that she would like to end therapy so that she could see if she could cope on her own. She spoke further about her boyfriend and their relationship, something about which she had never spoken before, and described him as being extremely supportive and caring. She then began speaking about how confident she felt and that she has gained so much from her sessions. She said that she felt ‘relieved’ and that she had ‘healed’ and that she no longer felt ‘pressured’. Brightness began saying that she had encouraged friends who were having problems to also come for therapy because she realised how

much it had helped her. I was glad that she felt she had the ability to stop therapy, that she was confident and had no more anxiety. However, I felt that her problems were much more deeply rooted around issues with her mother, but, until she is ready to talk about that, it cannot be forced. Hopefully she will return to therapy if she begins to feel she needs to talk.

APPENDIX F

Common Signs and symptoms of a stress reaction in a traumatised person

Physical	*Thinking (cognitive)*	*Emotional*
Nausea	Slowed thinking	Anxiety
Upset stomach	Difficulty making decisions	Fear
Tremors (lips, hands)	Difficulty in problem solving	Guilt
Feeling uncoordinated	Confused	Grief
Profuse sweating	Disorientated (especially regarding time and place)	Depression
Chills	Difficulty calculating	Sadness
Diarrhoea	Difficulty concentrating	Feeling Lost
Dizziness	Memory problems	Feeling abandoned
Chest pain (should be checked at hospital)	Difficulty naming common objects	Feeling isolated
Rapid heart beat	Seeing the event over and over again	Worrying about others
Rapid breathing	Distressing dreams	Wanting to hide
Increased blood pressure	Poor attention span	Wanting to limit contact with others
Headaches		Anger
		Irritability

Muscle aches Sleep disturbance		Feeling numb Startled Shocked

POST TRAUMA RECOVERY STRATEGIES

- Eat well balanced meals, regularly even if you don't feel like it.
- Get plenty of rest.
- Exercise regularly. It can help to work off some physical stress symptoms and it may leave you feeling calmer and better able to relax. It may also energise and clear your mind.
- Avoid caffeine, especially if you have trouble sleeping.
- Avoid the use of drugs and alcohol, including prescription and over-the counter drugs to numb the pain. It complicates and delays the recovery.
- Structure your time and set priorities. Maintaining normal basic routines is important, but you can also allow yourself to skip the extras for a while.
- Don't make any major life changes or decisions.
- Making a number of small daily decisions may reassert your sense of control.
- Don't try to avoid or deny reoccurring thoughts and feelings about the incident. They are normal and will decrease over time.
- Allow yourself to feel down and share your feelings with others.
- Doing enjoyable things like going out to dinner, taking time alone and going to the movies is important.
- Talking to people you trust provides an opportunity to relive the experience in safe environment.
- Don't be afraid to set limits with others when you don't feel like talking. You don't have to discuss the incident or your feelings if you don't want to

- Don’t label yourself as crazy. Remind yourself you having normal reactions

- Write down your thoughts and feelings. This can be especially helpful if you are having trouble sleeping or when you wake from a nightmare.

- Ask for help if you need it. If you are having trouble coping on your own, help is available from many places.

Adapted from the University of South Africa’s Victim Empowerment and Support Study Guide: 2001