

Treating complex post-traumatic stress disorder following childhood neglect, sexual abuse and revictimisation: Interpretative reflections on the case of Khuselwa

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This paper describes the psychological assessment and treatment process with Khuselwa, a South African adolescent survivor of multiple sexual traumas presenting with complex post-traumatic stress disorder (PTSD). The paper identifies some of the common barriers encountered by practitioners in delivering treatments in local contexts and highlights the role of external safety and stability and social support in providing a vehicle for change and a basis for overcoming the psychological handicaps reinforced by repeated and multiple traumas and chronic neglect.

INTRODUCTION: CHILD SEXUAL ABUSE, COMPLEX PTSD AND SCHEMA THERAPY

Childhood sexual abuse (CSA) is highly prevalent in South Africa with 40% of reported cases of rape involving child victims below age 16 (Carey, Walker, Rossouw, Seedat & Stein 2007; Payne & Edwards 2009). For many of these children, CSA is not limited to a single episode but occurs over an extended period of time (Carey *et al.* 2007), often in the context of neglectful circumstances with parental alcohol abuse identified as a significant risk factor (Sartor, Agrawal, McCutcheon, Duncan & Lynskey 2008). CSA is associated with drug and alcohol abuse problems, sexual risk taking behaviour and revictimisation in adulthood (Messman-Moore & Long 2003). A central and pervasive feature of the phenomenology of exposure to rape is post-traumatic stress disorder (PTSD) (Padmanabhanunni 2010) with its characteristic symptoms of intrusive re-experiencing, avoidance of reminders of the trauma and symptoms of physiological hyper-arousal (American Psychiatric Association 2000). Repeated exposure to CSA is associated with more severe psychological sequelae in the form of complex PTSD characterised by deficits in five domains of functioning (Briere & Lanktree 2008): alterations in affect regulation (for example, alexythymia) and attention and consciousness (such as amnesia or dissociative episodes); chronic characterological problems (such as a sense of being ineffective or

permanently damaged); alterations in systems of meaning (including a sense of hopelessness and despair) and; somatisation (Ford & Courtois 2009; Pelcovitz *et al.* 1997; Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola 2005).

Cognitive behavioural treatment (CBT) models are the most extensively researched and widely used approaches for targeting PTSD. Ehlers and Clark's (2000) cognitive therapy (CT) (Clark & Ehlers 2005; Ehlers, Clark, Hackmann, McManus & Fennell 2005; Grey, Young & Holmes 2002) is one of the most efficacious and comprehensive. It provides a psychologically coherent explanation for each of the symptoms of PTSD, a comprehensive understanding of the persistence of the disorder without treatment and a rationale for treatment which follows from established treatment protocols for other anxiety disorders, yet is specific to the disorder. The treatment approach has consistently yielded greater effect sizes than all other treatments for PTSD. Few to no dropouts have been reported in efficacy studies. The model is also formulation driven, allowing practitioners to customise the treatment and session content to suit the needs of the client (Brewin & Holmes 2003; Dunmore, Clark & Ehlers 2001; Gillespie, Duffy, Hackman & Clark 2002).

The assessment phase involves investigating the nature of the trauma memory, identifying the main cognitive themes (that is, problematic appraisals of the traumatic event and/or its sequelae) and problematic cognitive/behavioural

strategies that need to be targeted. It also includes provision of psychoeducation about PTSD and mechanisms underlying the disorder and a rationale for treatment. The treatment phase involves modifying excessively negative appraisals of the trauma, reducing re-experiencing through further elaboration of the trauma narrative and discrimination of triggers for intrusive memories (that is, identifying similarities and differences between the trigger in the current context and in the context of the trauma thereby helping the client to appreciate that the trigger is now benign and does not carry the same meaning as it did in the context of the trauma) and helping the client drop dysfunctional behaviours/cognitive strategies (Ehlers & Clark 2000).

In the treatment of complex PTSD, it is particularly important to use a phased approach, beginning with a focus on safety and stabilisation, moving on to building a working alliance with the therapist and motivating the client to face memories of the traumatic events, and, finally, working with the active components of treatment (that is, addressing triggers, targeting intrusions, correcting appraisals and repairing and enlarging social connections) (Edwards 2009). Schema therapy (ST) (Young, Klosko & Weishaar 2003; Rafaeli, Bernstein & Young 2011) is one of many approaches to complex trauma that integrates interventions from a range of psychotherapy traditions (Edwards 2009). Central concepts in ST are Early Maladaptive Schemas (EMSs) and schema modes. EMSs are “reality-based representations of the child’s environment” (Young *et al.* 2003:9) elaborated throughout life and consist of memories, emotions, cognitions and bodily sensations regarding oneself and one’s relationship with others that form in childhood or adolescence. Young *et al.* (2003) identify 18 EMSs that arise from “unmet core emotional needs in childhood” (Young *et al.* 2003:9), grouped into five broad schema domains: disconnection and rejection; impaired autonomy and performance; impaired limits; other-directedness and; over-vigilance and inhibition.

A schema mode is “an organised pattern of thinking, feeling and behaving based on a set of schemas, relatively independent from other schema modes” (Arntz, Klokman & Sieswerda 2005:199). These include dysfunctional child modes resulting from unmet core childhood needs, dysfunctional coping modes that correspond to an overuse of fright, flight or freeze coping styles and dysfunctional parent

modes that reflect the internalised behaviour of the parent towards the child (Young *et al.* 2003). There are two adaptive modes, the Healthy adult mode which reflects adaptive thoughts, feelings and behaviours and the Happy Child, a source of spontaneity, creativity and playfulness (Arntz & van Genderen 2009; Young *et al.* 2003).

Case formulation in terms of schema modes is particularly valuable for clients with personality disorders (PD’s) such as borderline personality disorder (BPD) who switch rapidly from one mode to the other (Eurelings-Bontekoe, Luyten, Ijsenngger, Van Vreeswijk & Koelen 2010; Johnston, Dorahy, Courtney, Bayles & O’Keane 2009). For example, in BPD, the Healthy Adult (HA) mode may be attenuated, meaning that clients have limited capacity for rationality and practical problem-solving. Instead, their experience is dominated by the following modes (Lobbestael, van Vreeswijk & Arntz 2008; Lobbestael, Arntz, Löbbses & Cimma 2009; Young *et al.* 2003):

- 1 The Abandoned and Abused Child (AAC) is based on memories of being abused, abandoned, emotionally deprived or subjugated as a child within the family of origin. Typical associated beliefs are that other people are dangerous and cannot be trusted and will abandon or punish the patient if they become close to them (for example, “My hurt will never stop”, “nobody will help me”, “I will be punished if I share my feelings”). When in this mode, individuals behave like a desperate child, longing for affection, nurturance and contact but also fearing it.
- 2 The Angry and Impulsive Child (AIC): here the child’s anger in response to neglect and abuse gives rise to childish rage and impulsiveness. Beliefs underlying this mode include, “other people are bad” and “I must take what I need to survive”.
- 3 The Punitive Parent (PP) is an internalised parent figure who originally responded to the child’s needs and feelings with rage, abuse or subjugation. In this mode, clients are self-critical, condemning themselves for being bad or evil and deserving of punishment, using words like “your needs are not important” and “you are only pretending to be hurt”.
- 4 In Detached Protector (DP) mode, clients detach from EMS related needs, emotions and thoughts by numbing emotional

responses. This may protect from involvement in attachment relationships which can trigger emotions related to neglect, abuse, betrayal or abandonment.

- 5 In Detached Self-Soother (DSS) mode, clients shut down emotions by using drugs, alcohol, comfort eating, or distracting activities such as internet surfing.

The aims of ST are to heal the AAC, disempower the PP, redirect the energies of the AIC, and strengthen the HA (Arntz & van Genderen 2009; Johnston *et al.* 2009; Young *et al.* 2003). Three studies have provided evidence for the efficacy of the approach for BPD (Farrell, Shaw & Webber 2009; Giesen-Bloo *et al.* 2006; Nordahl & Nysæter 2005).

This paper describes the psychological assessment and treatment process with Khuselwa, a South African adolescent survivor of multiple sexual traumas presenting with complex PTSD. It highlights some of the common barriers practitioners face in delivering treatments in local contexts and illustrates the significance of social support and external safety and stability in offering a vehicle for change and a basis for overcoming the psychological handicaps reinforced by repeated and multiple traumas and chronic neglect. The case is, retrospectively, conceptualised using the ST model and illustrates the utility of this approach in understanding client behaviour within and outside of session.

CASE CONTEXT AND METHOD

Khuselwa (17), from a disadvantaged township setting with limited access to social services, was referred to the research team by Grace who worked for a non-government organisation (NGO) after she disclosed that she had been raped by her mother's boyfriend at age 12 and was having difficulty coping. She had complex PTSD and was assessed and treated by the first author (AP) under the supervision of the second author (DE). The treatment process was not straightforward and treatment seemed to have limited impact. Despite this, follow-up interviews two years later provided evidence that, despite the difficulties experienced by the therapist, treatment had been of benefit.

This case was part of a research project regarding the adaptation of treatments for PTSD to South African conditions (Edwards 2010). This generated a series of systematic case studies, several of which have been published or are available as online dissertations (Boulind & Edwards 2008; Davidow & Edwards 2005;

Karpelowsky & Edwards 2005; Laas 2009; Padmanabhanunni, 2010; Payne & Edwards 2009; Smith 2006; Swartz 2007; Van der Linde 2007). Systematic case studies are a form of research that is complementary to randomized controlled trials as a means of developing evidence-based practice (EBP) (Dattilio, Edwards & Fishman 2010; Edwards, Dattilio & Bromley 2004). They can provide important information on such aspects as: specific obstacles encountered in working with a client; how therapists adapt interventions to individual clients and; the rationale behind the choice and timing of a particular intervention. This kind of information is of practical utility to clinicians and offers a bridge between group comparison research and the details of clinical reality. This case study which examines work with a client with whom it was not easy to establish a therapeutic alliance provides a basis for theoretical reflection on some of the barriers encountered by practitioners in delivering treatments in local contexts.

Khuselwa signed written consent to participate in the research in terms of ethical procedures approved by Rhodes University. She had completed Grade 10 and was articulate in English and she was able to understand and complete self-report scales used in the assessment process. She was seen for 20 sessions of 60 minutes each. The first 8 were classified as the assessment phase (A1-A8) as they mainly focused on gathering information. The remaining 12 were classified as treatment sessions (T1-T12). Two years later Khuselwa was seen for two follow-up interviews (FU1-2). The data sources on which this study is based are as follows:

- Voice recordings of sessions.
- Session Records: Shortly after each session, AP made detailed summaries of events in the session including her experience of the session and observations of the client.
- Verbatim transcripts of sessions. All voice recordings were transcribed and, for quality control, the transcript of one session was randomly selected and assessed by an independent assessor using an evaluation form. No distortions were found in the transcript.
- *Brief symptom-focused inventories*: Three self-report scales were administered regularly during assessment and treatment: *Post-traumatic Diagnostic Scale (PDS) - Part 3* (Foa, Cashman, Jaycox & Perry 1997)

contains 17 items assessing the nature and severity of PTSD symptoms; *Beck Depression Inventory (BDI-II)* (Beck, Steer & Brown 1996), a 21 item measure of clinical depression; *Beck Anxiety Inventory (BAI)* (Beck & Steer 1993), a 21 item measure of clinical symptoms of anxiety. BAI results are not reported here.

- *Khuselwa's journal and letters* that she brought with to therapy were photocopied.
- *Interview records* from the initial and follow-up interviews with Grace, the referral agent.
- *Supervisory notes*.

The following data reductions were written, based on these sources, and drawing on Fishman's (2005) guidelines for the online journal *Pragmatic Case Studies in Psychotherapy*: a case history; an assessment summary and; a narrative of Khuselwa's assessment and treatment process as well as of information gathered at follow-up. In these summaries, pseudonyms were used for all individuals except the therapist. These have been abbreviated for this presentation and written as first person accounts by the therapist (AP).

KHUSELWA: ASSESSMENT NARRATIVE

A narrative of the 6 assessment sessions is presented to document the challenges posed in working with Khuselwa.

Sessions A1-A3: Fostering trust

In A1, Khuselwa stared fixedly at the floor and would not make eye contact or interact. I explained the reason for the referral and offered psycho-education about ways a psychotherapist could help her. Invited to share her experiences, Khuselwa spoke tentatively of being raped at age 12 and then withdrew into silence. When the clinician reflected on her ambivalence in sharing her experiences, Khuselwa disclosed that she did not want to be in therapy but felt compelled by Grace and would not be returning. I expressed concern for Khuselwa's wellbeing, expressed my wish to help her recover from the trauma and indicated I would not compel her to do anything against her will. Khuselwa abruptly left. However, she arrived 20 minutes early for A2 and, after being asked after her experience of A1, reported that it had been "fun". She then alternated between staring at the floor and burying her head in her lap while providing only monosyllabic or cursory responses as can be seen in the segment below taken from the transcript of A2:

AP: How have you been doing since we last spoke?

K: Fine

AP: Just fine. You haven't been upset or sad or maybe feeling down?

K: No

Silence for 20sec

AP: How was your day at school today?

K: It was fine

Silence for 1min

AP: What did you do during the weekend?

K: Nothing

Silence for 3min

AP: Is there anything you would like to talk about today?

K: *[does not respond]*

AP: Maybe there's something you want to talk about but you don't know where to start?

K: *[does not respond]*

I focused on promoting trust and enhancing her sense of safety by responding with warmth and empathy and encouraging her to take the lead in session. This helped her provide a brief factual description of each of the five incidents of sexual assault she had experienced. She kept her head lowered and giggled throughout her narrative, attempting to minimise her distress. In A3, she disclosed that the perpetrator in her abduction and rape had tried to visit her home when her mother (Nokhanyo) was away but she had refused him entry. I explained that it was important that the perpetrator be removed from her community and that she needed to report the incident to the police but she adamantly refused. When I offered to accompany her to the police station, she was silent for 10 minutes before announcing that she had "given up" on the matter because "bad things just happen" and she blamed herself for the rape. I stated firmly that she was in no way to blame and, concerned about her lack of safety, I asked her permission to contact Nokhanyo and Grace. Khuselwa then threatened to terminate if I did so and turned her chair to face away from me. I suggested she was afraid of being removed from her mother's care and she vigorously nodded. I explained I would not contact anyone without her consent but she remained withdrawn for the remainder of the session. When I announced the end of the session, Khuselwa stated petulantly that the office belonged to her and that I should leave. Gently, I explained that I could only see her for specific time periods and we had come to the end of the current session. Khuselwa immediately rose and giggled as she left the office.

A4-A5: Setting limits

After arriving 30 minutes early for A4, Khuselwa sat unresponsively in her chair. As

she appeared extremely forlorn, I judged it would be unhelpful to discuss session times and, instead, attempted to help her share her experience by repeatedly reassuring her that she was cared for. At the end of session, Khuselwa scribbled on a note that she had visited a clinic earlier in the day for HIV testing and learnt she was HIV positive. I extended the session by forty minutes and expressed my sadness at this news and reassured her of my support. I also offered some psychoeducation about HIV but she remained unresponsive. When I explained that it was the end of the session, Khuselwa remained seated. I repeated that the session was over and opened the door. Khuselwa then reached into her bag and drew out a comb, lip gloss and mirror and started fixing her hair and makeup. I was surprised and perplexed as she intermittently looked at me and then said petulantly, "What are you looking at?!" I responded gently that I was waiting for her to leave as the session was over. She then rose and, as she walked out, I remarked that I would see her soon. Khuselwa laughed and quickened her pace.

For A5, Khuselwa again arrived 30 minutes early, walked into the office and seated herself. I explained that the session was of one hour duration and that she needed to arrive at the specified time. Khuselwa stared fixedly at the floor. I reflected on her disclosure of her HIV status and reiterated that she could still lead a full life provided that she looked after herself. Khuselwa stated that she did not believe this was possible as she found it difficult to care about herself. I commented on how so many people had shown complete disregard for her welfare and Khuselwa indicated she believed she had been raped because there was something inherently "bad" about her. I stated firmly that Khuselwa was not a bad person but she reverted to staring silently at the floor. At the end of the session, she handed me her homework book, stating that she had had to write an essay on sexual abuse. I skimmed the contents which included a brief account of the first rape and reflected on her courage in writing about her experiences. I returned the book and suggested we speak more about this during our next session. Khuselwa angrily reached for her bag and took out her comb, lip gloss and mirror and proceeded to adjust her hair and makeup while intermittently turning to look at me and giggling. I advised Khuselwa that this was not the appropriate place for her to be tending to her hair and makeup and invited

her to use the ladies room for this purpose. I then opened the door and remarked that I would see her at our next meeting. Khuselwa immediately put her makeup back in her bag and laughed as she walked out of the office. After this, she arrived on time for appointments, respected the one hour time limit and stopped bringing out her makeup kit.

A6-A8: Offering guidance and direction

During A6 Khuselwa gave me a letter, elaborately decorated with hearts and flowers in which she disclosed that she had an anniversary reaction of the first rape and had locked herself in her room so her mother would not notice she was upset. "I do not trust anyone even my mother," she wrote. I reflected on how sad she seemed and gave her some psycho-education about anniversary reactions. I emphasised that the trauma was in the past, that she had been extremely brave in prosecuting the perpetrator (discussed under case history) and that he would not hurt her again. Khuselwa remained silent, her head downcast. At the end, she asked me to accompany her out of the building. Near the main door of the building, Khuselwa stated that she would not make the next session as she was relocating to a different province to live with her aunt. When I stated firmly that I would see her the following week, she appeared surprised and, as she dashed down the stairs, shouted back that she was fibbing and would see me soon.

In A7, Khuselwa appeared less distressed but remained withdrawn and unresponsive. I offered psychoeducation about PTSD and emphasised that people often experienced such reactions after a severe trauma. Using the analogy of a cupboard (Ehlers & Clark 2000) to describe the storage of memories, I explained that people are often not able to make sense of an overwhelming experience and information simply floods into the cupboard and is not properly organised. Consequently, it is difficult to close the cupboard and things often fall out. This gives rise to flashbacks. It was our job in therapy to organise this cupboard by taking everything out and placing it back in order. This would mean discussing the traumatic events in detail including what she thought and how she felt about each trauma.

This explanation made sense to her and, in A8, she brought her journal, also decorated with flowers and hearts. After much reassurance, she shared the content in the form of brief narrative accounts of the rapes, excluding the most recent

episode where she was abducted and raped (discussed under case history). These were written shortly after A7, each was entitled “My story” and numerically labelled (“My story 1” to “My story 4”). Without pausing, she read each one to me. Thereafter, she was emotionally overwhelmed and I encouraged her to speak about aspects unrelated to the trauma to allow her to achieve emotional distance from the material. She spoke of the subjects she liked to study at school and of her fondness for *Harry Potter* films and became calmer.

CASE HISTORY, ASSESSMENT SUMMARY AND CASE FORMULATION

Despite the practical difficulties, sufficient information was obtained to write a brief case history and make a diagnosis.

A brief history

Khuselwa was abandoned by her father at age 4, and raised by her mother who abused alcohol, behaved erratically and frequently left her at home, alone and unsupervised. As a child, she often felt afraid to approach her. Aged 12, Khuselwa was raped by her mother’s boyfriend, whom she regarded as her “step-father”. She felt betrayed and, equating virginity with “goodness”, believed the rape had made her “bad”. She disclosed the rape to Nokhanyo who had her boyfriend arrested and prosecuted. He was given a ten year sentence. Aged 14, Khuselwa was raped by her first boyfriend, became pregnant and aborted it by drinking household detergents. She told no-one, fearing that she would be blamed. When she was 15, a man gained entry into the house one evening, claiming to be a friend of her mother’s. He raped Khuselwa who was alone at the time. Aged 16, she was raped by a neighbour and, after learning he was HIV positive, she attempted suicide by drinking bleach but was rescued by her only friend (Nomsa) and taken to hospital. Age 17 (6 months prior to treatment), while walking home from school with Nomsa, Khuselwa, was accosted by a friend of Nokhanyo’s who insisted they accompany him to a shed behind his house as he wanted to “show [them] something.” He kept them captive in the shed for one month and repeatedly raped them. Nokhanyo did not report Khuselwa missing or attempt to locate her during that time. Afterwards, Nomsa reported the abduction and rape to the police and testified in court and the rapist was sentenced to nine months in prison.

Khuselwa was currently in Grade 11 and attended a local government school.

Diagnostic considerations

Khuselwa met criteria for PTSD. Her PDS score (Figure 1) was in the ‘moderate to severe’ range. Intrusive memories of the first rape were present for five years after the trauma and intrusions related to her abduction and rape were present for six months after the trauma. Khuselwa found it too threatening to speak about the content of her intrusions which were triggered when she thought about the rapes or heard stories of sexual abuse. She experienced hyperarousal and hypervigilance when in her home and her community due to the presence of the perpetrators and frequently monitored her surroundings to ensure she was safe. She avoided thoughts of the rape, suppressed her trauma memories and avoided situations that triggered memories (such as the shed she was held captive).

Khuselwa met criteria for chronic Major Depressive Disorder (MDD). Her BDI-II score (Figure 2) was at the upper end of the moderate range. She had experienced sadness and dejection for five years and believed she had been made “bad” by the first rape. Revictimisation shattered her belief in personal control, exacerbating helplessness/powerlessness and depression. Khuselwa believed she was to blame for her most recent rape, reporting that she had felt “something was wrong” as she approached the shed but had not given much heed to this feeling.

Khuselwa displayed features of BPD and complex PTSD. BPD features included a self-image characterised by the assumption that she was a bad person, signs of impulsivity evident in suicidal gestures and, as illustrated above, oscillation between needing interpersonal closeness/proximity and fearing it. Symptoms of complex PTSD, described under associated features of PTSD in the DSM-IV-TR, included interpersonal deficits and problems with affect regulation that manifested as alexythymia and dissociative tendencies. As documented above, she often responded with monosyllables or single sentences, found it challenging to engage with the clinician and had a limited emotional vocabulary, often using the words “not good” to describe negative emotional reactions. Often, when emotionally threatened she would shut down, usually by curling into a ball, placing her thumb in her mouth and staring fixedly into space.

Case formulation

Khuselwa was raised in a neglectful and abusive home environment and she concluded that her mother's inability to provide her with care and affection was indicative of her being defective and unworthy of love, care and protection. Inconsistent and neglectful care-giving contributed to Khuselwa expecting that she could not rely on other people to be available and adequately responsive to her needs. She assumed that if she expressed her needs and feelings to others they would behave in a rejecting and hurtful manner. She therefore developed the following EMSs: defectiveness/shame; mistrust/abuse; abandonment/instability and; emotional deprivation.

At school, Khuselwa learned to equate virginity with "goodness" and believed the first rape had compromised any goodness that was in her. Being raped by the man with whom she had her first romantic relationship, two years later, affirmed her belief that she had been made "bad" by the first assault, deserved such abuse, had no personal control and could not protect herself from danger. Three further episodes of rape, the most recent involving her being kidnapped and held captive for one month while her mother made no concerted efforts to search for her or report her disappearance to the police, served to reinforce and consolidate her negative assumptions. The resulting escalation of Khuselwa's symptoms of PTSD and depression prompted her to seek help. However, it was difficult for her to form a trusting relationship as she viewed others as sources of threat, did not trust that they would be available or responsive to her needs, and believed that she was deserving of the abuse and that she was not worthy of protection, care and empathy.

Treatment approach

Khuselwa needed to be part of a long term therapy programme and, in presenting the treatment plan in A8, the clinician emphasised that she wanted to work towards helping Khuselwa cope with the effects of the rapes on her life and try to help her heal. Khuselwa assumed a crouched position in her chair and kept her head facing the ground and would not engage at all. The therapist judged that it would not be helpful to specify each of her problem areas (for example, PTSD, depression, relational difficulties) and that it would be more beneficial to follow Khuselwa's lead in sessions as much as possible and

thereby foster trust and safety.

THE COURSE OF THERAPY

T1-T2: Tentative disclosures

At T1, Khuselwa reported less severe PTSD symptoms (see Figure 1), perhaps because she had shared some of the trauma narratives, but her depression had moved into the severe range (see Figure 2). When, after much encouragement, she hesitantly disclosed that she was experiencing self-blame related to her assumption that the rapes were "punishment" for her being "bad," I offered psychoeducation about the factors underlying rape and firmly stated that she was blameless. This affirmation of her innocence appeared to have touched her for she hid her face behind her palms, turned to face the wall behind and sobbed. Then, at the end of session, Khuselwa reported she would not return to therapy because she was going to jail for stabbing a boy at her school who had teased her. Once I expressed concern and enquired further, she giggled and stated she was fibbing and would make the next session.

She arrived 30 minutes late for T2, stared at the floor throughout and would not respond to my enquiries. At the end, she reported that she would not be able to come in future because she had made firm plans to relocate and reside with her aunt. When I expressed concern, she retracted her statement and reported that she had been feeling sick.

T3-T4: Self-assertion

During T3 Khuselwa responded to all my enquiries by grunting that she wanted the question repeated and then not offering a reply. I gently pointed out what she was doing and, giggling, she stated that she simply wanted to hear me repeat the question. I empathically confronted Khuselwa by pointing out that I wanted to gain a better understanding of her but her responding with one word answers inhibited this process. I asked how we could make it easier for her to feel able to self-disclose. Khuselwa then turned her chair away to face the wall, placed her thumb in her mouth and stared fixedly at a picture on the wall in a trance like state. I repeatedly called to her but she would not respond and after 10 minutes turned further away so that her back was completely facing me.

Realising that my behaviour had been threatening to Khuselwa, I apologised for any hurt I had caused, indicating that I had not

intended to hurt her. Khuselwa sobbed, grabbed a piece of paper and wrote that she would not return to session because my remarks had hurt her and her school teachers often scolded her for not participating in class and for giving “one word answers” and she did “not know how else to talk”. I thanked her and apologised again, saying that in future I would respect her abilities and did not want her to stop coming for session. Khuselwa nodded and abruptly dashed out of the office. I felt deeply saddened that she had experienced me as punitive and was very relieved when she arrived promptly for the next session.

Khuselwa brought a letter to T4, apologising and stating that she would “try to talk more” and “try to be happy” and a poem that expressed her fondness for me. I explained that she did not need to apologise because she had done nothing wrong and emphasised that it was I who was in the wrong for pushing her further than she was comfortable with. I again apologised. Khuselwa lowered her head and stared at the floor and would not engage further. Before the close of session, Khuselwa drew a colourful picture of me and offered it to me. She then drew from her pocket a small brown teddy bear, named Lucky, holding a heart between its paws on which was inscribed ‘I love you.’ She placed it near me, saying she had bought it for me. I thanked her and indicated that I would look after Lucky and keep him in a safe place. I placed Lucky on a table beside me before each of Khuselwa’s subsequent sessions.

T5-T8: Feeling safe

In T5, Khuselwa was encouraged to use drawing to share her experiences but only participated when I suggested we draw a picture of a house, tree and person together. Her picture consisted of a transparent house with a large, bare tree next to it and a girl, resembling that drawn in T4, holding a heart shaped balloon. In T6, Khuselwa tentatively asked if we could sit in silence for the session and, after a few minutes, she closed her eyes and fell asleep but intermittently roused herself to check that I was still present and watching her. It was clear she was feeling safer and cared for. Before leaving, Khuselwa mentioned, uncharacteristically, that she would see me soon.

For T7, Khuselwa brought her journal and read out three poems. The first was about cherishing one’s dreams, the second was about friendship and the third was about the importance of trust, unconditional love and

patience. At T8, she requested to read two new poems. The first, entitled “My Life Story”, spoke about how the rapes “had destroyed my life.” The second, entitled “Don’t,” reflected her increasing awareness that it was the perpetrator that was to blame for the rape and expressed assertiveness about having her body respected:

Don’t. Don’t say it. I want to know how you betray my trust... simply because of lust. Don’t touch me. I don’t want to feel how you are ripping my heart out of my chest without any regrets. Don’t stare at me. I don’t want to see the pieces of my life after you have destroyed everything...

I encouraged her to continue expressing herself through poetry.

T9-10: Engaging with active treatment components

At T9, Khuselwa’s symptoms were elevated (Figures 1 and 2) as a result of experiencing two flashbacks of the first rape triggered by hearing a story about CSA while attending a workshop organised by Grace. She asked for help in coping with this and I offered psycho-education about triggering to normalise her experience. I explained that if she could speak about her experiences in detail this would help to process the memory and reassured her that this would proceed at a pace she was comfortable with and Khuselwa agreed to this.

To help with retelling of the first rape, I drew blank squares on a piece of paper and equated the trauma memory with a cartoon strip, explaining that each square represented an aspect of the trauma (that is, the first represented the moment he entered her bed-room, the last represented her mother comforting her). Khuselwa engaged with this format, reporting that the second represented him shaking her and forcing her to wake up. One intrusion represented the contents of the next square but she could not elaborate on this. The final square was blank because she could not remember him leaving her room. Afterwards, I emphasised that the trauma was in the past and that I cared about her and wanted to support her recovery.

In T10, she disclosed that two days after T9, she moved into a girls’ shelter due to her mother’s frightening behaviour when inebriated and I actively encouraged her to remain there. Since she had coped well with the retelling in T9, she wanted to continue this process. I suggested she draw the layout of the room in which the first rape occurred. She engaged well, reporting that she had been asleep when he entered her room and had been awoken by him

violently removing her clothing. At that moment, she thought she was going to die. Remembering this distressed her and I helped her calm down. I likened the memory to a scary film and explained that initial reviewing would elicit strong feelings but these would subside as she became familiar with the memory. I gave her a letter reflecting on her bravery in speaking about the trauma and motivating her to remain in treatment.

T11-T12: Offering reassurance and care

At T11, there were marked reductions in her PTSD (see Figure 1) but her depression had increased and was in the severe range (see figure 2) and she was experiencing enhanced feelings of sadness related to the loss of her identity as a virgin. Interventions focused on normalising her reactions and stabilising her. She remained withdrawn but asked me to “draw a heart” for her and “write something on it”. I drew a series of red hearts and wrote that I knew she was feeling heart sore and that I cared

for and believed in her. Khuselwa read each message and then held it to her chest. She then asked me to read to her and was attentive to the story (Mphahlele 1985) but reported that she preferred *Harry Potter*. I offered to read from *Harry Potter* for the next session and she said she would like this. However, she did not return. I repeatedly contacted her at the shelter and encouraged her but to no avail. Grace offered to monitor Khuselwa while she stayed at the shelter. Then, a month later, Khuselwa arrived unexpectedly (T12). I focused on re-establishing contact but she remained largely withdrawn. She did not make the next scheduled meeting and further attempts to contact her proved unsuccessful.

Khuselwa’s scores on the PDS and BDI are provided below and document the changes in her symptoms of PTSD and depression as treatment progressed and at follow-up (FU) two years later.

Figure 1: Khuselwa’s PDS Scores

At termination (T12), there was significant reduction in her PTSD reactions but, because her trauma memories had not been fully processed, these symptoms persisted as is evident in her follow-up scores.

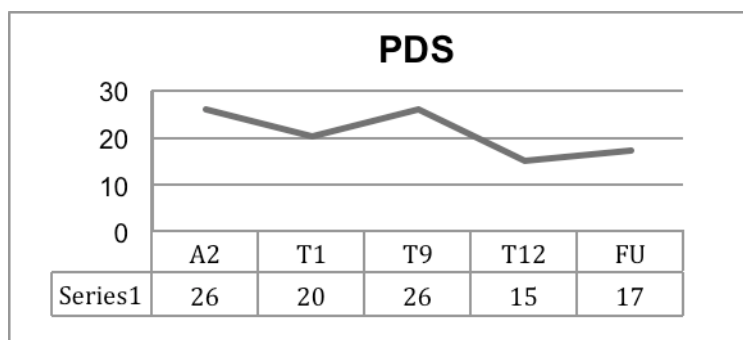
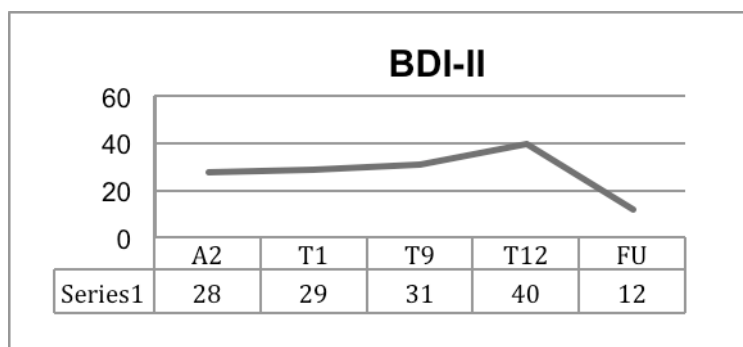


Figure 2: Khuselwa’s BDI-II Scores

Her BDI scores indicated an increase in symptoms of depression during treatment due to increased awareness of the care and support missing in her external environment and the losses incurred as a result of the rapes. At follow-up, Khuselwa’s scores had decreased significantly due to increased social support in her external environment, discussed in the subsequent sections.



FOLLOW-UP INFORMATION FROM NGO

Previously I had respected Khuselwa's request not to speak to Grace or other parties. Now, however, I asked Grace, during two interviews, about her situation and learned that Khuselwa was frequently reprimanded at school because her school uniform skirt was inappropriately short and she tended to wear no underwear. She was also often absent from school. At the shelter, she was also frequently in trouble, was involved in physical fights and did not make any friends. She often had nightmares and would wet her bed and blame the other girls for this which contributed to fights. She also did not follow curfew, often arriving at the shelter late at night in an inebriated state.

A year later, in an interview with Grace, I learnt that Khuselwa had been evicted from the shelter, four months after terminating treatment, for stabbing another girl. She was returned to her mother's care but repeatedly ran away from home and stayed in different places, usually with men who were strangers. She visited the NGO over a six month period and requested birth control pills and it was suspected that she was having sexual intercourse with these men. She also requested an HIV test on three separate occasions and each test revealed that she was HIV negative.

FOLLOW-UP MEETING WITH KHUSELWA

Two years after stopping treatment, Khuselwa asked Grace if she could meet me again. At the first of two meetings, Khuselwa was more forthcoming and eager to share her experiences. She had been living with her aunt (Pumla), a school teacher who had returned to the area from a different city, about ten months ago. I learnt that Pumla had often cared for Khuselwa when she was a young child but, after her marriage, she had relocated. After hearing of the rapes and Nokhanyo's alcohol abuse, Pumla insisted that her niece live with her. She provided a stable, predictable and safe home, actively encouraged Khuselwa to share her experiences and took an active interest in her life. Khuselwa described her as "strict" but fair. She reported that she had decided that she "would never allow anyone to hurt her again" because she was a "good" person "with a future". She described being accosted by three teenage boys who behaved aggressively towards her as she returned from a shop. She had physically attacked one of them with a

stick, prompting the others to flee. She told Pumla who then located the boys and informed them that she would have them arrested if they ever approached Khuselwa again.

Khuselwa still experienced PTSD (Figure 1): intrusions of the first rape occurred at least once a week. Pumla tried to distract Khuselwa during these times, believing this would help her cope. She also experienced hypervigilance and hyperarousal related to the presence of the perpetrators. After his release, the man who abducted and raped Khuselwa approached her, apologised for hurting her and requested her forgiveness. She had been frightened and, to get rid of him, she told him she had forgiven him. Although she still frequently cried because she felt "sad for [herself]," her depression was markedly reduced and was now in the minimal range (See Figure 2). She now believed the perpetrators motive in raping her had been to ensure she "would not succeed in life" but she had decided that she was going to reclaim her life and future. She had returned to high school, repeated Grade 11 and was in her final year of school. She was invited to return to treatment and reported that she did not believe that she needed therapy because she was coping well but that she would consider this. At the conclusion, Khuselwa laughingly told me she would not make the next meeting - playfully attempting to rekindle the bond with me. I responded in kind, saying I looked forward to the next meeting and Khuselwa giggled, stated she was joking and would see me soon. She did come and, although she decided not to resume therapy, she invited me to remain in touch with her.

DISCUSSION AND CONCLUSION

This narrative of Khuselwa's therapy offers material for reflection on the challenges of offering therapy to vulnerable individuals with a history of neglect and repeated trauma and for an examination of two broad questions: how can we understand Khuselwa's varied and unpredictable behaviour within the sessions, and, despite the obstacles, did the therapy help her?

The first lesson from this case is that individual outpatient treatment was not the ideal treatment. By age 17, Khuselwa had suffered abandonment, neglect, emotional abuse, and several rapes starting at age 12. Although a full assessment was not possible, she had chronic depression and PTSD, appeared to have all the

features of conduct disorder and, although details are lacking, was involved in inappropriate relationships with older men. There was no reliable caretaker and she lived in close proximity to the men who raped her, a situation that increased risk of further harm (Payne & Edwards 2009). Khuselwa would have more likely benefited from an inpatient treatment programme (Busuttil 2005) where a stable environment could have been provided, as well as peer support enabled by group therapy (Briere & Lanktree 2008; Farrell *et al.* 2009). The clinician was faced with the dilemma in that, to understand the case, she needed to do a more thorough assessment by getting collateral from her teachers and Grace but this could have broken trust and been counterproductive.

Khuselwa - a schema mode analysis

Khuselwa's treatment, though fairly brief, was conceptualized within the ST model (Lobbestael *et al.* 2005; Giesen-Bloo *et al.* 2006; Rafaeli *et al.* 2011). The concept of *limited reparenting* (Arntz & van Genderen 2009; Rafaeli *et al.* 2011) was particularly important, together with the recognition from the trauma literature on the importance of creating a safe place, and provided a guide with respect to offering care, and tolerating the situation when it was difficult to establish a collaborative alliance (Keller, Zoellner & Feeny 2010; Nadort *et al.* 2009). It includes responding with warmth, care and empathy, respecting her needs, wishes and capabilities, owning mistakes made and modelling appropriate behaviours and reactions that the client will ultimately internalise. It also includes challenging problematic behaviours using *empathic confrontation* (Young *et al.* 2003).

The theory of modes in ST (Rafaeli *et al.* 2011) is designed to map the kinds of unpredictable and erratic behaviour displayed here. An understanding of Khuselwa in terms of schema modes was developed largely retrospectively from close reflection on the case narrative (see Figure 3). As a result of her history of chronic neglect, unpredictability of caretakers, emotional and sexual abuse, and betrayal, Khuselwa had a strong AAC mode. Despite her mother's unpredictability, Khuselwa still clung to her as her only source of comfort and nurturance. This betrayal blindness (Gobin & Freyd 2009) served to maintain a needed attachment relationship, while placing her at risk for further harm. Her need for connection, her longing for it, and her confusion and

mistrust of it lay behind her desire to be with the clinician. This was reflected in her coming early, her difficulty in leaving at the end of sessions, and the theme of love and images of hearts in her letters and drawings. Khuselwa's lying to the therapist about her HIV status could represent a desperate attempt to be cared for and to be treated compassionately. Her request to spend a session in silence suggests that she found the therapy room a safe place and that, although she did not know what to do with all that it evoked, she wanted to experience it as it was something different to other relationships she had known. She was opening to another mode, the happy or contented child (CC). Yet activating her child side also opened her to the AAC and this was enormously painful. She coped by switching into DP mode, presenting as emotionally cut off with her attention away from the therapist and interaction with her. Turning her chair against the wall might be considered a step further into Avoidant Protector Mode.

At other times, she would switch into the AIC who would behave provocatively, lying and teasing and testing the therapist's care. At this stage the therapist was unaware of just how much this mode was active outside the session in her conduct disordered behaviour with peers and at school nor did she know of the provocative and inappropriate sexualized behaviour (short skirts, lack of underwear) which is often a feature of those who have been sexually abused (Laylor & McElvaney 2010; Messman-Moore & Long 2003). Her use of alcohol and her relationships with older men represent another mode: detached self-soother (DS), a means of distracting from and soothing away the distressing feelings of the AAC (Raefeli *et al.* 2011).

Khuselwa's PP mode presented another difficulty. She believed she deserved to be punished. In T3, the therapist's requests that she speak more fully and articulately evoked memories of being scolded by teachers. She feared that if she did not comply with the therapist's demand that she share her experiences, she would be abandoned. It is hypothesized that her statement that she was going to jail for stabbing someone was also from this mode as she was feeling guilty for her conduct disordered behaviour outside sessions. The therapist's repeated apology was a way of breaking the power of the PP mode and led to Khuselwa bringing a letter to T4, indicating that she would attempt to talk more and be happy.

Figure 3: Khuselwa's schema modes

The figure below represents a graphical schema mode analysis, illustrating Khuselwa's dominant modes.



Was this a healthy recognition of a need for collaboration, or a switch into complaint surrenderer mode in which the individual behaves in a complaint and submissive manner? Her bringing of the teddy bear Lucky at this session, suggests a healthy reaching out to the therapist and accepting her care.

Throughout, the therapist was faced with the dilemma: How could she break through the DP to reach out to the damaged child? The narrative shows that at times she did. There was thus an emerging Healthy Adult mode seen in Khuselwa's asking for help in coping with PTSD reactions, actively engaging with treatment and deciding to move into the shelter away from her mother. Despite the long silences, Khuselwa progressively disclosed more and more and began to do things that might be expected to help her come to terms with what had happened to her, writing narratives of the abuse and poems expressing what she felt. The therapist was able to actively and firmly correct a range of Khuselwa's negative beliefs about herself and there is evidence that Khuselwa's beliefs did change. The content of her poems and her attitudes at follow-up show that she did internalize some of the therapist's care and belief in her, and was able to build on it once her Aunt had taken her under her wing. Although this led to a decrease in her PTSD symptoms, it seems probable that the associated engagement with the child side of her evoked a longing for care and support that was too painful to bear, as the therapist's

care was circumscribed and was inevitably followed by the neglect she experienced outside of session. We hypothesize that this lay behind her terminating treatment.

Was Khuselwa helped?

Despite her early termination, the follow-up provides evidence for at least a partially happy ending. Khuselwa appeared to be genuinely rebuilding her life and there was evidence of growth in three areas namely, perception of self, relationship to others and philosophy of life (Tedeschi & Calhoun 2004). She seemed to believe in herself and her future and to be better able to protect herself. It seems probable that much of the remarkable turnaround in her life was due to her Aunt's provision of care, firmness and stability. This in itself is testament to the role of safety and stability in providing a vehicle for change (Woodward & Joseph 2010) and a basis for overcoming the psychological handicaps confirmed by trauma and neglect (Cohen, Deblinger & Mannarino 2010; Coulter 2011). It reflects the consensus of trauma therapists that the first phase should involve promoting such safety and stability (Cloitre *et al.* 2010; Edwards 2009). Perhaps Khuselwa's mention that she was relocating to stay with an aunt reflected her search for such stability. There is no doubt that its absence placed severe limitations on the benefits that therapy could offer in a context where the therapist herself was unaware of just how disturbed Khuselwa's behaviour was outside of sessions.

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