

Using Systematic Case Studies to Investigate Therapist Responsiveness: Examples from a Case Series of PTSD Treatments

DAVID J.A. EDWARDS^{a,b}

^a Department of Psychology, Rhodes University

^b Correspondence concerning this article should be addressed to David J.A. Edwards, Department of Psychology , Rhodes University, Grahamstown, 6140, South Africa.

Email: d.edwards@ru.ac.za

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ABSTRACT

This article highlights the emerging literature on therapist responsiveness in psychotherapy and examines several concepts used to identify dimensions of responsiveness. Some methodological obstacles are identified to studying responsiveness in a systematic manner, and several examples of existing responsiveness research are reviewed. It is argued that meaningful theory on responsiveness has emerged from research methods that are qualitative and interpretive and that the writing of systematic case studies can be of particular importance since only the presentation of a case unfolding over time can disclose some of the more complex aspects of therapist responsiveness. Examination of a series of systematic case studies of the treatment of posttraumatic case disorder in South Africa was used to derive a model for guiding therapist responsiveness with respect with what to focus on at a particular phase of the therapy within a particular session. Material from the cases is used to illustrate aspects of the model related to building social support for the client and promoting emotional processing of trauma memories.

Keywords: cognitive therapy; evidence-based practice; posttraumatic stress disorder; therapist responsiveness; case studies

A central feature of the practice of psychotherapy is the responsiveness of the therapist to the client. This ranges on a continuum from the moment-to-moment responsiveness where, for example, the therapist notes and responds to a client's non-verbal expression of discomfort or shift of mood, to responsiveness across sessions, as when the therapist judges that a particular approach is not working well and decides to try a different one (Stiles, Honos-Webb & Surko, 1998). Sometimes the language of empirically supported treatments and manualized therapies can be taken to imply "the sterile, mechanical application of procedures" (Friedberg & Gorman, 2007a, p. 121) in which therapist responsiveness is limited. However this is a serious misunderstanding. Psychotherapy cannot be delivered in what Stiles et al (1998, p. 440) call a "ballistic" manner, that is in a way that is rigidly standardized for each client. Psychotherapy without therapist responsiveness is simply not psychotherapy. This article examines research on therapist responsiveness and provides examples of how material from systematic case studies can contribute to this important field.

THERAPIST RESPONSIVENESS: A FUNDAMENTAL ASPECT OF THE PRACTICE OF PSYCHOTHERAPY

A policy document of the British Association of Cognitive and Behavioural Psychotherapies (Grazebrook, Garland & the Board of the BABCP, 2005) categorizes interventions in cognitive-behaviour therapy (CBT) into four levels. Level 4 is client use of self-help books (bibliotherapy). Level 3 is “assisted self-help” as in computerized CBT or the use of self-help exercises presented by a support worker with limited training. Level 2 is the delivery of “specific CBT interventions for specific problem areas” by health workers who work under close supervision and “are not required to adapt the treatment.” At none of these levels is delivery of CBT classified as a form of “psychotherapy.” This term is reserved for level 1, called “Formulation driven CBT.” At this level, it is recognized that clients “have sought help from a trained professional and require expert interventions,” that therapists need to give considerable attention to establishing a therapeutic alliance, and that therapy is preceded by a systematic process of assessment and formulation. Therapists use specific interventions as appropriate” and “evaluate the efficacy of any intervention and change tack if necessary” (Grazebrook et al, 2005, pp. 2-3)

The factor that separates the four levels of practice is the increasing responsiveness to the needs and behavior of the client on the part of the individual delivering CBT. At level 4, there is no responsiveness at all as the client is merely reading a book. There is some limited responsiveness at level 3 and even more at level 2. However, the range and depth of responsiveness that characterizes psychotherapy is only found at level 1. Here, the document points to a high level of responsiveness with respect to attention to the therapeutic alliance, and collaborative engagement with the client in the processes of assessment, treatment contracting, delivery of interventions, selection of appropriate techniques, and changing the direction of the therapy if needed.

Similarly, Friedberg and Gorman (2007b, p. 189) point out that “patients respond in many different ways to identical procedures and methods and point to three domains of responsiveness in the delivery of CBT. They recommend that therapists learn to engage in “simultaneous consideration of psychotherapeutic structure, content and process.” This means working within the structure of the session (client feedback, agenda setting, selection of focus) and of the therapy approach (specific technical interventions appropriate to the client’s problems and the stage they are at in the therapy). It also means responding to the content, that is the specific thoughts, feelings and behaviors of the client both within and outside of the session. It also means responding to the process which is “the way that patients work their way through the routine and standard procedures.”

Therapist responsiveness therefore involves more than adapting techniques to make them meaningful and acceptable to clients. Roth and Pilling (2008) conceptualize responsiveness within two broad domains: competences and metacompetences. The successful delivery of psychological treatments requires clinicians to have expertise in both these. A competence refers

to therapists' capacity to deliver a specific technique, and here responsiveness refers to the way in which they monitor a client's understanding or engagement with the intervention and adjust their response accordingly. Some interventions may be easy to specify in detail (for example, a protocol for systematic desensitization). However, many of the competences used in contemporary CBT call for considerable responsive adaptation to the needs of the client. Even once a therapist selects a specific intervention, responsiveness is needed in its implementation and attention needs to be given to the contextual aspects of clients' lives, including their cultural background, level of education, intelligence, work and family context, interests, and current mood.

However, the task of selecting a specific intervention, whether within the flow of an individual session, or when planning the next session at a supervision meeting, calls for another kind of skill. For example, therapists may have to choose whether to focus on a possible rupture in the therapeutic relationship, or on a specific intervention aimed at a specific problem area. Or they may have to choose which of several problems presented by the client is likely to be most useful to focus on right now. Metacompetences are ingredients of the kind of "procedural knowledge" involved in making these strategic decisions (Roth & Pilling, 2008, p. 135). They are skills in applying general principles of case formulation and treatment planning in ongoing strategic decision-making about where to focus as the case unfolds. These skills include the initial case formulation, the ongoing review and revision of the case formulation and the use of formulation to inform the timing of interventions. Such metacompetences are the basis for the delivery of the therapy "in a coherent and informed manner ... that is responsive to the needs of an individual client" (p. 140).

THE CHALLENGE OF RESEARCH ON RESPONSIVENESS

Although many commentators have seen a conflict between therapist responsiveness and manualization of treatments, the authors of many manualized therapies emphasize its importance. Freidberg and Gorman (2007b, p. 192) emphasize the need for therapists to work on "responsive customizing of protocols to clinical practice" in delivering CBT to children. Kendall, Aschenbrand, and Hudson (2003, p. 84) emphasize the importance of flexibility in the application of their manual for the treatment of childhood anxiety, and describe how:

... the therapist being mindful of the goals of each session and features of the child, adapts the protocol to the individual needs of the child, tailoring the program to an optimal fit.

Similarly, in discussing the clinical use of a manual for panic control, Huppert and Baker-Morissette (2003) observe that "There are a number of techniques and ideas that are not fully articulated in the ... therapist guide, but may be important in facilitating outcome." They organized these into a set of guidelines which they present as a kind of supplement to the manual.

Unfortunately, from the perspective of a positivist research model, the scientific basis of these kinds of clinical guidelines has been considered problematic since they are largely derived from the clinical observation of cases by practitioners, and communicated through supervision,

workshop training and written summaries. As a result, formalizing the task of deriving principles from a sound empirical base and finding ways to test and refine them has proved a challenge for researchers. Yet the difficulty lies not in the inherent impossibility of the task but in blind adherence to positivist principles which exclude from science any findings not derived from quantification and statistical hypothesis testing. This reflects the longstanding divide between researchers and clinicians which has been commented on for over a quarter of a century (Edwards, 2007). Today the two parties still act as if they speak “different languages” with the result that, as Friedberg and Gorman (2007a, p. 119) wittily observe, practitioners trying to implement research based treatment protocols can easily become “lost in translation”.

The academic research perspective often does not sufficiently acknowledge the central role of qualitative interpretative research in generating clinical knowledge (Edwards, Dattilio, & Bromley, 2004; Dattilio, Edwards, & Fishman, in press). For example, despite systematic and sustained attempts to change its meaning, the word “empirical” does not mean “demonstrated by studies using quantitative measures and group comparison designs.” It means “based on factual observations” (Edwards, 2007). The kind of clinical guidelines about therapist responsiveness offered by Huppert and Baker-Morissette (2003) are undoubtedly empirical in this sense. They are an example of what Bromley (1986, p.2) called “case law” which “provides rules, generalisations and categories which gradually systematize the knowledge (facts and theories) gained from the intensive study of individual cases.” The clinical literature contains a wealth of similar material on the subtler points of adapting treatment to the needs of the client and the context derived by clinicians working with cases and building theory from the bottom up (Edwards et al, 2004). These processes of clinical practice constitute an important kind of research which cannot be replaced by elaborate research using group comparison designs.

However, because critics argue that there is insufficient rigor in principles drawn from the activities of clinical practice, where much of the data on which conclusions are drawn are not well documented, clinical research of this kind is often presented apologetically. Thus Huppert and Baker-Morissette (2003) apologize for not having “hard data to back up our suggestions” (p. 3), displaying this all too common confusion about appropriate methodology. But just how hard does data have to be? By now there is a comprehensive methodology literature going back at least 20 years on how to answer this question. Researchers using an interpretative approach to qualitative data have pointed out that it takes just a few small steps to make a process of qualitative enquiry sufficiently systematic to ensure that it yields valid knowledge.

From the methodological perspective of interpretive research, the approach used by Huppert and Baker-Morisette (2003) looks very sound. They derived principles from a review of their own cases and those of colleagues. They then showed them to other experts who confirmed that they were in accordance with how they worked when delivering the treatment themselves. This looks like what in qualitative, interpretative research is called triangulation. The term refers to a geometrical technique used for distance estimation in navigation and surveying. The distance of an object O can be calculated provided that it can be observed from two different points A and B. The distance between A and B must be known as well as the angle made between the line AB and the two lines OA and OB. A single observation from A or B yields information of limited value. Two observations from A and B enable the dimensions of the

triangle OAB to be determined and this yields information of great accuracy.

The appropriation of triangulation as a metaphor for qualitative research points to the way that observations gathered from different perspectives or by different methods provide a basis for much stronger degrees of certainty about findings than if they were derived from only a single perspective or method. In Huppert and Baker-Morisette's study, the principles had already been tested in several cases. Indeed, many of the principles will be recognizable to therapists not familiar with the particular panic control manual which is the focus of their study. This alone suggests that they were not just derived from this one clinical context but are principles that form part of a wider existing case law. By having the principles evaluated by independent judges who were experts in the field, a further step was taken to ensure the strength of the conclusions. Huppert and Baker-Morisette could argue that their findings accord with Guba and Lincoln's classic criteria for trustworthiness in qualitative research (Lincoln, 2002). Principles derived and cross-checked in this way are likely to be *credible* (in that they are likely to work), *transferable* (in that other clinicians are likely to be able to learn and use them), *dependable* (in that they are likely to work repeatedly given the right conditions) and *confirmable* (in that it is likely that other clinicians will be able to evaluate them when working with new cases).

OTHER APPROACHES TO THE STUDY OF THERAPIST RESPONSIVENESS

Safran, Muran, Samstag and Stevens (2001) conducted a research program that led to the writing of detailed guidelines for the management of one important aspect of therapist responsiveness: dealing with clients' negative attitudes towards the therapist or the therapy. If not properly addressed, such attitudes can result in ruptures in the alliance which have been shown to predict poor outcome. Safran et al observed that therapists may respond counter-therapeutically by "increas[ing] their adherence to their preferred treatment model in a rigid fashion," or "by expressing their own negative feelings in a defensive fashion." By contrast, they can promote therapeutic progress by "responding flexibly to a perceived rupture in the alliance" (p. 406). In order to make detailed recommendations of how therapists can best handle ruptures in the alliance, Safran et al (2001) conducted "a series of intensive analyses of single cases" (p. 409). Using session recordings, they examined the flow of client-therapist interaction from moment to moment and from session to session to identify potential alliance ruptures and how they were handled by the therapist. This was used as the basis for as a basis for developing a categorization of the different kinds of alliance ruptures that might threaten therapy progress and a model for identifying and repairing them. This led to the writing of a treatment manual that was evaluated in further cases.

Levitt, Butler and Hill (2006) also argue that research on therapist responsiveness must examine the "moment-to-moment process within the psychotherapy session" (p. 314) and the personal meanings for clients of changes that occur as a result of psychotherapy. They reviewed the literature on significant moments in therapy, which does address personal meanings, but found that little could be learned about therapist responsiveness because these moments

tend not to be contextualized within the therapist-client interaction and not to convey *when* an element might best be used or privileged over another element (p. 315).

They examined responsiveness retrospectively by interviewing 26 clients who had recently completed psychotherapy about what was significant for them about their experience of psychotherapy, their relationship with the therapist, and moments that seemed particularly important. From this data, they derived a set of principles of therapist responsiveness that were based on the evidence of clients' experiences. These are largely in the domain of metacompetence in that they do not address therapists' implementation of specific techniques, but rather the way in which they monitor broader aspects of the relationship with the client and the ongoing therapy process.

For example, one principle addressed obstacles to the client's commitment to therapy: Initially, clients may enter therapy with expectations or fears that work against their engagement. If a commitment to therapy does not develop, it may be helpful if clients are guided to frankly discuss their shame or fear of examining threatening topics, or if the relationship is mutually examined (p. 317).

Another was relevant to the process of engendering the client's trust:

Clients tended to develop trust after scrutinizing therapists for displays of caring, especially when vulnerable issues arose. Therapists can convey caring by appearing genuine, showing respect for the client's process, and demonstrating faith and expertise in the therapeutic process (p. 318).

Another illustrates the interplay between competence and metacompetence:

Allowing the client to set goals is experienced as empowering, but, when mired in unimportant topics, clients want therapists to provide direction after checking for clients' consent (p. 319).

Goal setting is a standard CBT intervention (competence). But therapists need to draw on their experience to judge how proactive to be in order to make it work by ensuring that the goals selected are such that a focus on them is likely to benefit the client. These examples show how Levitt et al (2006) were able to identify several areas where clients were aware of therapist's responsiveness or lack of it and perceived it as a significant factor in the progress of the therapy.

USING A CASE SERIES TO DERIVE A MODEL TO GUIDE THERAPIST RESPONSIVENESS IN THE TREATMENT OF PTSD

Another approach to the study of therapist responsiveness grew out of my own research project on the treatment of PTSD in South Africa. My students are clinician/researchers who treat cases of PTSD under my supervision and write them up as systematic case studies (Fishman, 2005). Treatment of this disorder calls not only for specific technical interventions which have been widely described in the literature, but also for therapist responsiveness with

respect a range of factors that include client motivation and engagement with treatment, the therapeutic relationship and the extent to which the client can tolerate the more emotionally intense aspects of the treatment. Inevitably, a great deal of attention is given to case formulation, to ongoing monitoring of clients' responses to interventions and to their readiness to engage with interventions that are likely to challenging and evoke strong emotions.

We work, largely, but not exclusively, with black African clients. This article is based on the first six systematic case studies written from this project. A seventh study of a series of three cases that did not engage with treatment (Swartz, 2007) was also drawn on, although these cases are not discussed in the present article. The six cases are:

1. Langu (21) had PTSD after identifying the body of his brother who had died in a car accident in which the car caught fire. After the funeral, his father instructed him to put his brother's death behind him and get on with his studies. He returned to university, 1500 km away, where he lived in a student residence, but had no close friends. He was so depressed that he could not do any productive academic work (Karpelowsky & Edwards, 2005).
2. Oratilwe (23) was a young working woman who had been raped by her boyfriend and felt unable to tell her family because her parents were religious fundamentalists who had forbidden her to engage in sexual activity (Davidow, 2006; Davidow & Edwards, 2007).
3. Zanele (15) had been raped twice in the township when visiting her disabled father. He had separated from her mother because of alcohol dependence. Her mother worked in an unskilled job and was a breadwinner and her uncle offered practical support. On several occasions, Zanele had run out of the classroom in a panicky state (Payne & Edwards, 2009).
4. Mark (35), the only white person in the series, had been with his girlfriend when they were hijacked two years previously. He had left the city where he lived and moved to a seaside town where his parents had a holiday house. This meant leaving his job and his girlfriend. He was seen by us when he was hospitalized when he became suicidally depressed (Smith, 2006).
5. Bongi (23) presented with depression, panic attacks and a general feeling of being ill. She was from Swaziland and had been raped three times, at the ages of 9, 19 and 20. Her father was authoritarian and emotionally abusive and her mother, though caring, was unassertive and downtrodden. Bongi had been a model and made friends easily but she had never had anyone to confide in. Now she was a student completing her degree (van der Linde, 2007).
6. Grace (22) came for help because of headaches and increasing difficulty in concentrating and making decisions. She was clinically depressed, had withdrawn socially, was self-critical and had been losing weight. These symptoms turned out to be secondary to PTSD precipitated by her decision to abort an unwanted pregnancy. She and her boyfriend were from Zimbabwe so she was far from home and her boyfriend, though caring, had little input into the decision (Boulind & Edwards, 2008).

Roth and Pilling (2008, p. 142) point to the centrality of supervision in delivering

evidence-based treatment, particularly where there are strategic choices to be made:

... supervisory input proved critical to keeping casework on track and on model. Fairly consistently (and despite the screening of referrals) significant and relevant clinical and social issues emerged and needed to be responded to, but without losing focus.

As supervisor it is my responsibility to help students find the balance between being flexible and keeping the therapy focused on the clients' goals. Since I am working with beginning therapists, my supervision must provide the metacompetences that the students are in the process of developing. In working with PTSD, strategic decisions may need to be made at every weekly supervision session. Thus therapist responsiveness has become a natural focus of the research program.

Our treatment approach is founded on Ehlers and Clark's (Ehlers & Clark, 2000; Clark & Ehlers, 2005) cognitive therapy for PTSD which incorporates a great deal of what has been learned in the past decades both theoretically and with respect to treatment planning. Their theory is integrated with current research in cognitive science and explains why clients become symptomatic, how symptoms are maintained, and how specific interventions lead to the amelioration of symptoms. The treatment has been evaluated in randomized controlled trials and effect sizes are the largest reported for any approach to intervention for PTSD (Ehlers et al., 2003; Ehlers, Clark, Hackmann, McManus, & Fennell, 2005). My research is on the transportability (Schoenwald & Hoagwood, 2001) of this model to local clinical settings in South Africa (Edwards, 2005). It is a case-based project which has so far generated six systematic case studies.

Roth and Pilling recognize that some treatment manuals are quite prescriptive and focus largely on specific, technical competencies. Others, including the Ehlers and Clark approach, are

set out at a much more conceptual level, drawing attention to the elements of the intervention and to the management of common clinical issues and impasses, but clearly assuming that the manual is being read by an individual with prior clinical experience (Roth & Pilling, 2008, p. 137).

This means that delivery of the treatment involves a range of competences and metacompetences and that therapist responsiveness is a central aspect of ongoing treatment planning.

On the basis of a review of these cases, Edwards (2009; available in the second section of this issue) developed a model that could be used as a guide to making decisions about the appropriate focus of treatment for a particular client at a particular time. Seven areas of potential Clinical Focus (CF) were identified, each covering a specific kind of work or task that the therapist might give attention to. These were organized into a three-level model, which is reproduced in Figure 1 (see end of article).

The model is based on a stage approach that is widely described in working with trauma (Herman, 2001; Philips & Frederick, 1995; Steele, van der Hart & Nijenhuis, 2005). The key principle is that problems at a lower level must be attended to before meaningful work can

proceed at a higher level. Thus priority must be given to establishing safety and dealing with psychological crises at Level 1. Where these do not present a problem, therapists can work on Level 2, where the focus is on ensuring that clients have a psychological understanding of their problems and of what treatment will involve and can work collaboratively with the therapist.

Once these building blocks are in place, it is appropriate to begin Level 3, i.e., to initiate active interventions designed to activate the trauma memory and restructure problematic meanings, as well as to help clients build a life beyond the trauma. There is not necessarily a simple linear progression. Depending on the needs of the client, arising out of the therapy process or from extra-therapy events, it is common for therapists to return to a lower level so that the process is often described as a spiral (Herman, 2001; Philips & Frederick, 1995; Steele et al, 2005).

In the following sections, some material from the cases used to derive the model will be examined with respect to two themes that are pervasive in treatment planning for PTSD: social support and the telling or reliving of the trauma story.

Social Support at Each of the Three Levels of the Model (CF 1, CF 5, and CF 7)

PTSD symptoms are maintained by avoidance and relieved by reviewing the memory of the trauma in a way that enables it to be fully integrated into autobiographical memory (Clark & Ehlers, 2004; Ehlers & Clark, 2005). For many people this occurs naturally as, in their everyday relationships, they share what happened and discuss it in a way that helps them make sense of it. In all the cases in our series social isolation was a significant factor maintaining their problems. None of them had had anyone to confide in about what had happened to them.

1. Langu was far from home and believed that none of his family could understand what it meant to him to have lost his brother. At the university, he had little social support, and was the kind of person who was not used to confiding his feelings to anyone.
2. Oratilwe had kept the story of her rape completely to herself until, two years later, she responded to a notice posted in the street and saw the clinician/researcher.
3. Zanele's mother and an uncle were caring and concerned. They knew about the rapes, but did not have the psychological insight to communicate with her about her feelings following the rapes.
4. Mark had left the city where he had been hijacked and broken off contact with his girlfriend who had been with him. He had hardly any contact with their daughter, now two years old, who had been born a few months after the hijacking had taken place.
5. Bongi was outgoing and popular but having been raised in an emotionally abusive family she was not used to disclosing intimate personal information to friends.
6. Grace's family knew nothing about the abortion and although her boyfriend had discussed it with her and supported her in making the decision, she felt that she had carried the burden of

the decision herself and that he had not been involved in any meaningful way.

Level 1

While in the first version of the model (Edwards, 2008) social support was a single CF spread across all three levels, as indicated in Figure 1, experience with the model subsequently led us to separate the three aspects. First, at Level 1, we tried to ensure that when clients went home after a distressing therapy session, they would not be in a threatening environment that might destabilize them or undermine the therapy (CF 1). There was the concern that as the client started to talk about the trauma in therapy, this would be distressing and their lack of social support would create problems with respect to coping. This was less of a concern for Mark who was assessed and treated in hospital. It was a particular concern for Langu who was so severely depressed that he was socially withdrawn, unable to study, and felt hopeless and suicidal.

Level 2

Fortunately, however, none of the clients in this series was living in a chaotic or abusive family or social context so we were able to focus on the second aspect of social support. This is the Level 2 activity of building a trusting relationship with the therapist within which frightening and shameful material can be disclosed (CF 5). For Langu, there seemed no options for building meaningful support outside the therapy, and once he had established a meaningful connection with the therapist and understood the rationale for treatment (Level 2, CF 5), the decision was taken to go ahead with work on reliving his trauma (a Level 3 activity). The absence of support outside the therapy puts a greater burden on the relationship with the therapist, but this proved to be sufficient to enable him to tolerate revisiting the memory of identifying his brother's burned body in the police morgue. In every case in the series, building a relationship with the therapist in which the client came to experience the therapist as empathic, trustworthy and professionally competent served as a basis for work on processing the trauma memory.

This observation is, or course, not news to the trauma literature (Courtois & Ford, 2009; Herman, 2001; Pearlman & Courtois, 2006) and serves to confirm that monitoring and managing the client's relationship with the therapist is an essential aspect of therapist responsiveness. Nevertheless there were marked individual differences with respect to the attention that had to be given by the therapist to this clinical focus. It was particularly important in working with Bongi and this was probably because there was chronic emotional abuse in her family while she was growing up and the first of the three rapes occurred when she was only 9. It was also important for Langu because his symptoms were particularly intense and disabling and the therapist was inviting him to stir up further intensely painful emotions. The problem manifested in a different way for Oratilwe, who regularly failed to attend sessions. Although it was clear this was an avoidance response, it was difficult for the therapist to engage with her about this. By contrast a trusting relationship was established with Grace particularly quickly and she proved to be intelligent and resourceful in engaging with the therapy process.

Level 3

We worked to help clients build strong supportive relationships with significant others to whom they could disclose their experiences and feelings and expect to receive empathy and understanding. While this could be seen as part of CF 1, and ensuring support outside therapy may protect against suicide risk (CF 2), it is conceptualized here as part of CF 7 where the emphasis is on clients reclaiming their lives and building a strong base for independent functioning once therapy is over. This is because even with limited meaningful support from friends and family, all the cases in our series were able to work at level 3 on reprocessing the trauma memory.

At the same time, although putting work on rebuilding and reclaiming one's life at CF 7 suggests that it is a late focus of therapy, this is not the intended implication of the model. Ehlers and Clark (2000) emphasize this aspect right from the beginning of treatment, although it is difficult to consolidate it fully until significant progress has been made with work on the trauma memory. Thus in session 3, Oratilwe's therapist suggested to her that she would feel better if family members knew about how she had been raped and shared her sense of injustice and anger towards the perpetrator. Oratilwe agreed to disclose the rape to her older sister in the therapist's presence and in session 4 planned with the therapist how she would do this. The first part of session 5 was used for this purpose, and Oratilwe experienced this as positive.

In Grace's therapy a major focus was on letting her fiancé know how alone she had felt making the decision to have the abortion and going through the procedure by herself. He had been supportive but had not recognized the painful process that it had involved for Grace. In addition, he lived in a neighboring country and much of their contact was by telephone. However, once Grace had realized what she needed to say to him, she was able to express everything to him when she next returned home for the vacation which had the effect of strengthening the relationship considerably.

A major focus of Mark's therapy was the re-establishment of contact with his girlfriend and daughter. In order to engage with this he had to overcome his shame about being too weak to protect her and his fear of facing the possibility that she had been raped by the hijackers (it turned out that she had not). Once they started having contact, there was a rapid re-engagement with the relationship which was a large factor in helping him overcome his depression.

In the case of Zanele, some work was done to strengthen the relationship with her mother. Sessions with her mother were not easy to arrange due her work commitments and the fact that she lived in another town an hour away. The therapist used a board from the "Snakes and Ladders" game [in the United States, the "Chutes and Ladders" game] to teach Zanele how the process of recovery could be expected to have its ups and downs. She subsequently gave Zanele the game to take home and she played it with her mother. Later, after medical tests showed that Zanele had been infected with HIV and several other sexually transmitted diseases, Zanele asked for the therapist to tell her mother who was brought to one of the sessions for this purpose. This was a valuable intervention. Nevertheless the therapist wished she could have done more to promote meaningful emotional support for Zanele.

Telling the Story and Reliving the Trauma (CF6): More Decisions for the Therapist

In the model in Figure 1, CF 6 addresses the task of reprocessing the memory of the trauma in such a way that it can be integrated into autobiographical memory. When this is successfully achieved, parts of the memory are no longer triggered involuntarily to produce distressing re-experiencing symptoms and overgeneralized appraisals derived from the trauma memory (“I am not safe anywhere,” “all men are rapists”) are re-evaluated in light of other life experiences. A great deal of the literature on the treatment of PTSD, including the work of Ehlers and Clark (2000), describes work within this CF 6 area. However, while there is broad agreement about the need to help clients reprocess the memory, there are many techniques which can facilitate this and the selection and timing of specific interventions is an important part of treatment planning.

Ehlers and Clark describe three methods of eliciting the trauma memory: telling the story, reliving the event in imagery, and visiting the site. Sometimes all three of these may be of value, usually in the order set out above. However, not all clients welcome these interventions as they can elicit intense emotional distress. Huppert and Abramowitz (2003, p. 1) observe that, “many cognitive-behavioral manuals are written as if the patient will willingly comply with each treatment procedure,” but that this cannot be taken for granted.

In introducing these interventions for PTSD, the therapist usually has to do considerable motivational and psychoeducational work at level 2 (CF 4). There are also decisions to be made about whether to go directly to reliving (which can resolve symptoms rapidly, but which can also be frighteningly intense for some clients) or to work with a gentler narrative approach (which is more tolerable to clients, but which may fail to elicit parts of the trauma memory which are the cause of re-experiencing symptoms). As with other aspects of the treatment there was great variability within our six cases, and in this section, the way treatment decisions were made in three of them will be briefly presented as a way of illustrating the range of different experiences clients have and their implications for therapist responsiveness.

Grace

Grace presented with depression and it was only in the third session when the clinician was trying to identify what was happening at the time of onset that she disclosed the abortion (Boulind & Edwards, 2008). She had not mentioned it initially out of shame and fear of criticism, but she also had not recognized its contribution to her symptoms. Once she disclosed it and gave a brief narrative of the context, even though as yet there had been limited emotional engagement with the events, her symptoms largely remitted. For this reason there was no urgency to relive the memory and the next 5 sessions focused on related aspects which concerned her. These included her ability to trust others (there had been a painful rejecting experience at her church not related to the abortion itself); feelings about her planned marriage and the quality of her relationship to her fiancé; and whether she had properly thought through the decision to have the abortion.

At this stage the therapist initiated a session that focused on reliving the day of the abortion. This brought into focus her need to mourn for the child that was never born and for her to share her experience in depth with her fiancé. These were essential stepping stones to reclaiming her life and putting her plans for the future on a sound footing. A review of the narrative of the 12 sessions of assessment and treatment, written as part of the systematic case study, provided evidence that a good balance was struck between attending responsively to the concerns and needs expressed by the client (both directly and indirectly) session by session and using the principles of the Ehlers and Clark (2000) model to guide the selection of interventions.

Langu

In the case of Langu, by contrast, there was more urgency to work directly with the trauma memory (Karpelowsky & Edwards, 2005). In the first five sessions, he had told the therapist about a series of motor vehicle accidents that had affected him and his family members, culminating in the one in which his brother died, and after which he had the painful task of identifying his brother's burned body. He had described the content of several distressing dreams and the therapist had helped him name and acknowledge the intense and painful feelings these disclosed. He had done some drawing which had also helped him express some of what this all meant to him. However none of this impacted on his symptoms.

Therefore, in session 6 the rationale for reliving was explained to him and this was carried out in session 7. It was a harrowing experience not only for him but for the therapist who questioned in supervision whether conducting the reliving been the right decision. However, the session proved to be a breakthrough. Langu reported that the following morning he awoke with feeling of lightness and a sense that he had "made peace with God" (p. 190).

This was not of course the end of the therapy. However, Ehlers and Clark (2000) argue that the time devoted to these intense reliving sessions can be relatively short provided that the material that emerges is used to identify emotional "hotspots" and that the meanings associated with them are systematically addressed. Langu's therapy provided evidence for this. There were three more intense imagery sessions, and after each one Langu reported a noticeable reduction in re-experiencing symptoms. In session 9 the therapist initiated an imagery dialogue with his dead brother, there was a further reliving in session 15, and another imagery dialogue in session 19. The total therapy was 22 sessions. His PTSD had resolved and although he still experienced depressed mood at times it was no longer disabling.

Bongi

Bongi presented an even more complex challenge (van der Linde, 2007). She had been raised in an abusive environment, had been raped for the first time at the age of 9, she had been raped on two further occasions and had been involved in three abusive romantic relationships. Three months after enrolling at the University, she approached the University's medical services with severe symptoms of depression, anxiety and somatic complaints. She was referred for psychological evaluation and the assessment process itself took eight sessions (two per week) of 90-120 minutes each. During this time she shared a great deal of information including details of

the rapes. However, she was very vulnerable and would typically be evasive or vague when talking about the rape incidents. In effect, the assessment process and the early sessions of therapy involved work at level 2, building a relationship of trust with the therapist and educating her about the nature of her problems and about how the treatment approach could help her. Although the therapist explained the importance of knowing about the trauma memory and associated emotions in some detail and described the process of reliving, she indicated she was not prepared to do it. The therapist recognized that it was important to proceed slowly.

So when the therapy phase formally began, there was still a great deal of information to be gathered about the rapes and her experiences of them. Furthermore, in session 1, she was in a crisis with respect to her accommodation and the session focused on problem-solving about this (Level 1, CF 1). In the next session she was very angry, triggered by ongoing conflicts about her accommodation. She also became angry with the therapist when he tried to direct attention back to the tasks of therapy. After the next session the therapist would be away for two weeks. He directed attention to strengthening his relationship with Bongi (CF 5) and motivating her to work on the PTSD when he returned (Level 2, CF 4). There was also crisis intervention and the possibility of a voluntary hospital admission was explored because of some suicidal ideation (Level 1: CF 2).

She seemed much more cheerful in session 5, and not clinically depressed. However she reported that she had had sex with two men during the vacation, one older than her father. She had not enjoyed it on either occasion and felt guilty and disgusted. The therapist gave her a chapter by a sexual abuse survivor and presented a formulation of the links between her current difficulties and the sexual abuse she had experienced. She understood the formulation and appeared to find it helpful.

However, at the next session, she was withdrawn and found it hard to speak. Unexpectedly, the man who had raped her most recently was attending a conference at the University and she had met him and even given him her phone number. Again the session was focused mainly at level 2, providing empathic understanding and motivating her to use therapy to break through the shame and empower herself.

In the next session there was more work on formulating how her difficulties in addressing her current problems were linked to longstanding problems in her development and discussing how she could experiment with change. This led to role play work on responding assertively to men who approached her to initiate romantic/sexual contact, which she found valuable and this was followed up in a subsequent session. This is a CF 7 activity, important to enable her to learn that she could change entrenched patterns. Even though as yet there was no progress on CF 6 the important work of processing and reevaluating the trauma memories, this focus was directly relevant to challenging appraisals of herself as a helpless “victim of circumstances” (a phrase she had used about herself in session 3).

In session 7 she reported that she had told a friend that she had been raped and that this had been an affirming experience. This had been suggested by the therapist in session 5 and is an example of building social support outside the therapy (a CF 7 activity, as discussed above).

The therapist continued to motivate her to go into the trauma memories by means of reliving and in session 8 he gave her a narrative of a reliving session with another young woman (Zanele).

In the next session (9) Bongi agreed to relive the third rape. This yielded a wealth of important new information about her appraisals associated with the rape. However, Bongi felt angry with therapist afterwards and in the next session he expressed his concern that in pushing her to relive the rape he was recapitulating the rape incidents themselves where, in each case, despite her unwillingness, she was forced to do something against her will. This helped her clarify the difference between the rape situations and the situation with the therapist.

There were ten more sessions before the end of the academic year when the therapy would have to end as Bongi was moving to another city. There was more focus on the PTSD in these sessions (CF 6) and she learned to identify when distressing emotions and somatic discomforts were actually flashbacks to the rapes triggered by current cues. The reliving had brought into focus several features of her experience, including a sense of loss ("I've lost my soul"), shame, guilt, and mental defeat, all of which were at least partially addressed in these sessions.

In addition feelings of disgust and contamination emerged in some vivid nightmares, in the last of which she saw what looked like worms eating her from the inside and reached down her own throat to pull something out. This seemed to be a positive commentary on the therapy process. Although she did not engage in further reliving, the material from the reliving session was used as a therapy focus in later sessions and she became increasingly able to engage with the material and feel less intense distress. There was a corresponding drop in her PTSD symptoms as measured by a self-report scale. In session 15, the therapist used guided imagery to invite her to find resources within herself and she pictured

a confident and proud Black woman, wearing a comfortable long red dress with flowers on it...She is smiling, has loving eyes, and the way she smells has a calming effect on me...as if I want to breathe in deeply. She is concerned about my life. (van der Linde, 2007, p. 82).

This contact with a strong part of herself can be conceptualized as an aspect of CF 7.

CONCLUSIONS

Of all the cases in our series, Bongi's therapy most clearly illustrates the complexity of treatment, and the value of the metaphor of a spiral as forward progress in treatment occurs against the background of flexible shifting from one CF to another and one level to another. It also demonstrates the challenge to the therapist to be responsive to the changing needs and situation of the client as well as the trajectory of the unfolding process of healing. However, in all the cases the progress of the therapy was unpredictable, and although it was possible to make a general treatment plan after the assessment phase, the focus of each session could often only be planned on a session-by-session basis. These examples (and the full systematic case studies from which they are drawn) illustrate the true nature of cognitive-behavioral psychotherapy, which, as the BABCP definition (Grazebrook et al, 2005) shows, is inevitably a complex process molded

by therapist responsiveness to the needs and context of the client and the unfolding process of therapy.

The model for treatment planning outlined in Figure 1, which was derived from the experience of supervising the cases (both in treatment and in the writing of the systematic case studies) points to a level of therapist responsiveness that is not covered by Friedberg and Gorman's (2007b) distinction between structure, content, and process, referred to above. Rather, it embraces aspects of metacompetence that are particularly emphasized in the literature on trauma, where a recurring theme concerns the challenges involved in the selection of the appropriate focus for therapy at any given time (Herman, 2001; Philips & Frederick, 1995; Steele, van der Hart & Nijenhuis, 2005). Given the complexity of the session-by-session decisions about treatment focus that need to be made, it is hard to see that models for guiding treatment could be derived in any other way than from the data of systematic case studies.

In the work of Herman (2001), Philips and Frederick (1995), and Steele, van der Hart and Nijenhuis (2005), as with a great deal of clinical theory of this sort, the actual case studies (or the majority of them) are not written up and published and remain as a hidden resource available only to the theorist. The present study offers a more systematic approach. All six treated cases were originally written up as systematic case studies in research theses. Of these, three have been published and are freely available in the second section of this issue of the *PCSP* journal (Boulind & Edwards, 2008; Karpelowsky & Edwards, 2005; Payne & Edwards, 2009); and electronic copies of the three unpublished ones (Davidow, 2006; Smith, 2006; van der Linde, 2007) are freely available online. The analysis of three cases that failed to engage with treatment by Swartz (2007) is also freely available online. Since then, three students have added new case studies (Fox, 2010; Laas, 2009; Sokutu, 2010) and a fourth has submitted a PhD thesis based on a further seven (Padmanabhanunni, 2010). Thus the total material available contains 19 systematic case studies performed by 11 different students.

These 19 case studies include successful treatments, partially successful treatments, the three cases that never started treatment (Swartz, 2007), and another two which appeared to be too complex for outpatient treatment that are part of Padmanabhanunni's (2010) series. These case studies will all in due course be freely available online directly (a) through this *PCSP* journal (see section four of this issue), or (b) through Rhodes University's "eResearch Repository" (<http://eprints.ru.ac.za/>). The full list is presented in Table 1. Thus, the project is in line with the mission of this journal, which is to make case series available that address a common problem. This body of material not only allows for the examination of therapist responsiveness (the focus of this article), but also for the investigation of other themes that were the focus of the case studies themselves: the effectiveness of Ehlers and Clark's cognitive therapy for PTSD; its transportability to other clinical contexts, particularly in Africa; and the kind of modifications and elaborations that seem to be called for to meet the needs of particular cases.

The current model is intended as an aid to responsive treatment planning. It can be used in supervision especially when problems arise in the delivery of the therapy by serving to remind therapist and supervisor that they may need to check other aspects of the case before proceeding. It presupposes that therapists and supervisors are engaged with ongoing case formulation as a

basis for making the strategic decision to focus on one CF area rather than another, and determining how to proceed within a specific CF area. It is a model that can be tested against new and existing cases (where a clinical focus not adequately covered by the present model might be shown to be important). Fox (2010) and Sokutu (2010), in the most recent cases in the author's South African series, reported that the model was a valuable resource in treatment planning without requiring modification. However, the model does need elaboration since the present model does not offer detailed guidelines about how to decide which CF should be the current focus, or for decision making within a specific CF. Despite its obvious abstraction, however, the model should be of value in its present form, and other therapists working with PTSD are invited to test it and comment on it on the basis of new systematic case studies.

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**Table 1. The South African PTSD Case Series
Supervised by David J.A. Edwards at Rhodes University**

1. Boulind, M. & Edwards, D. J. A. (2008). The assessment and treatment of post-abortion syndrome: A systematic case study from Southern Africa. *Journal of Psychology in Africa*, 18, 539-548. (Included in the fourth section of this PCSP issue.)
2. Davidow, A. (2006). *From 'here and now' to there and then: The evaluation of the effectiveness of Ehlers and Clark's model for treating PTSD in a rape survivor* Unpublished research report for Master's in Clinical Psychology. Grahamstown: Rhodes University. Available at <http://eprints.ru.ac.za/1834/>
See also: Davidow, A. & Edwards, D. J. A. (2007). *Treatment of PTSD and depression in a black South African rape survivor: A case based evaluation of Ehlers and Clark's clinical model*. Paper presented at the World Congress of Behavioral and Cognitive Therapies: Barcelona, Spain (July).
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Figure 1.
**A Model for Evidence-Based, Responsive Treatment Planning for PTSD,
with Seven Distinct Clinical Foci (CF 1 to CF 7)**
(Note: This Figure originally appeared in Edwards (2009)
in the *Journal of Psychology in Africa* and is used with permission.)

