Chapter 1

Introduction, statement of the problem, aim of study and clarification of concepts

1.1 Introduction

Violent crime and trauma are currently very common within the South African society (Hamber & Lewis, 1997:1). Presenting a conference paper, Penaar (2000:133) stated that the number of trauma victims, particularly children, grows hourly, and the need for appropriate therapeutic intervention becomes even more urgent. Given the escalating crime rate in the country that is reported daily in the media, it very likely that many people in various sectors of the society are affected both as victims and witnesses. Students at the technikon, as part of the broader South African community are not unaffected by the scourge of violent crimes and the resultant trauma that are threatening our country.

1.2 Analysis of the problem

1.2.1 Awareness of the problem

Students at tertiary institutions like the technikon are exposed to the many traumatic situations that are characteristic of the broader South African context. A study conducted by Hoffman (2002:2) on the incidence of traumatic events and trauma-associated symptoms amongst tertiary students revealed that more than 70.6% of the sample (N = 245) reported one or more traumatic events during the preceding year, with the most frequent traumatic event categories being the death of a loved one, negative change in life circumstances and witnesses to injury.

Students experience trauma resulting from previous incidences that happened in their homes in their early years. Firstly, these are traumas resulting from childhood abuses, parental conflicts and family violence. Secondly, the students also experience current trauma resulting from rape, violent relationships, and abusive relationships with peers and families, crime in the city and on the campus. There have been reports in the media, on television, radio and newspapers on the escalating crime, violent sexual attacks on children, abuses, killings as a result of robberies and suicides. Recently, the technikon lost one of its professors due to the
violent murder at his home in Pretoria. These and more are part of the histories that the
students at the technikon bring with as they study and it is some of these issues that lead to
post-traumatic stress. Apart from the encounters that the students might have had from their
past, safety has been identified as one of the major obligations of the technikon since there
have been reported cases of incidences such as rape, robbery and burglary involving students.

It is clear that the increased crime and violence in the society in general reflects strongly
within the microcosm of the institution’s population, given the number of trauma related
cases that are reported. The researcher is working as a student counsellor at student
counselling services of the Bureau for Academic Support at Pretoria Technikon. A significant
percentage of cases that are reported for therapy are related to stress, depression and anxiety
resulting from traumatic experiences. A report compiled by the bureau showed an increase in
the number of rape cases from N=7 in 2001 to N=13 in 2002, which is almost double. Overall
increase in the number of cases reached 48% from 2001 to 2002 (Bureau for Academic
Support Annual Report 2002)

1.2.2 Exploration of the problem

According to Hamber and Lewis (1997:4) many South Africans remain exposed to high
levels of different forms of violent crimes, including public violence, rape, hijacking of cars,
aggravated assault, aggravated robbery and murder. These different types of violence affect
both individuals and society as a whole.

Individuals who have undergone terrifying experiences exhibit a post-traumatic stress
reaction pattern that may endure for weeks, months and even for years, though sometimes the
post-traumatic stress can be delayed (Carson, Butcher and Coleman 1988:159). There are
different ways of defining trauma. Norris in Hoffman (2002:4) describes traumatising events
as those life events involving violent encounters with nature, technology or the social
environment. These events are characterized by extreme and/or sudden force, involve an
external agent, and arouse intense fear. Hoffman (2002:4) states that another approach has
been to look at traumatic events in terms of the effect or symptoms of the particular event and
the emotional results.
Trauma is an intensely stressful event during which a person suffers serious harm or the threat of serious harm or death or witnesses an event during which another person is killed, seriously injured or threatened. These traumatic events are commonly classified as follows:

- Abuse: mental, physical, sexual or verbal
- Catastrophe: harmful and fatal accidents, natural disaster and terrorism
- Violent attack: animal attack, assault, rape, battering or domestic violence
- War: death, explosion or gunfire (http://www.mentalhealthchannel.net/ptsd/2002/12/10)

Post-traumatic stress is an anxiety that a person may experience after experiencing and witnessing an extreme overwhelming traumatic event during which he or she felt intense fear, helplessness or horror. The dominant features of post-traumatic stress disorder are emotional non-responsiveness (emotional numbing), irritability or constant alertness for danger and re-experiencing of the trauma through flashbacks and intrusive emotions (http://www.mentalhealthchannel.net/ptsd/2002/12/10). A traumatising event results in the person experiencing intense fear, helplessness and horror. Such an event usually involves actual or threatened death or serious injury or threats of harm to oneself or to others.

The following are examples of events that are experienced by the individual as traumatizing. A traumatized person may be:

- Physically attacked as in the case of domestic violence or rape
- Injured in a serious car, plane or train accident
- Hurt or traumatized by a natural disaster, such as hurricanes and floods
- Told about the sudden, unexpected death of a loved one (file://A:\ZOLOFT2002:1)

According to the American Psychiatric Association (http://www.psych.org.htm 2002:1) post-traumatic stress disorder usually appears within three months of the trauma. The symptoms fall into the following three categories:

- Intrusion
- Avoidance
- Hyperarousal
a. Intrusion

Memories of the trauma reoccur unexpectedly, and episodes called flashbacks intrude into their current lives. This happens in sudden, vivid memories that are accompanied by painful emotions that take over the victim’s attention. This flashback or recollection may be so strong that individuals almost feel like they are actually experiencing the trauma again or seeing it unfold before their eyes as and in nightmares.

b. Avoidance

Avoidance symptoms occur when the person often avoids close emotional ties with family, colleagues and friends. At first the person feels numb, has diminished emotions, and can complete only routine and mechanical activities. Later when re-experiencing the event, the individual may alternate between the flood of emotions caused by re-experiencing and the inability to feel or express emotions at all. The person with post-traumatic stress will always avoid situations or activities that are reminders of the original traumatic event. Because the victims are not able to work out grief and anger over injury or loss during the traumatic event it means that the trauma continues to affect their behaviour without them being aware of it.

c. Hyperarousal

People who suffer from post-traumatic stress may act as if they are constantly threatened by the trauma that they have experienced before. They can become suddenly irritable, and explosive even when they are not provoked (http://www.psych.org.htm 2002:2).

1.3 Delimitation of the study

This study will look at the incidence of post-traumatic stress amongst students at the Technikon Pretoria and explore psycho-educational intervention techniques. Due to the limited extent of this study, a limited number of cases will be explored looking at the nature of the problem and the traumatizing event, the state of the client and the psycho-educational intervention techniques that are used and the effects thereof.
It is not the focus of this study to look at the clinical aspect of post-traumatic stress disorder. This study will focus only on psycho-educational intervention techniques of dealing with the problem of post-traumatic stress. The researcher is well aware of the fact that post-traumatic stress disorder belongs to clinical psychology.

1.4 Statement of the problem

According to Bouma (2000:26) a statement of the problem must explicitly identify the issues on which the researcher has to focus. In this study the research problem could be stated as follows:

a) Which psycho-educational intervention techniques can be used for students suffering from post-traumatic stress?

b) What is the effect of psycho-educational intervention on students suffering from post-traumatic stress?

1.5 Aims

1.5.1 Primary aim

The primary aim of this study is to explore how psycho-educational interventions are used to assist students who experience post-traumatic stress.

1.5.2 Specific aims

In order to realise the primary aim of this study, the researcher aims to:

a) Undertake a literature study regarding post-traumatic stress.
b) Undertake a literature study regarding intervention techniques for post-traumatic stress.
c) Identify suitable psycho-educational intervention techniques to use for students at Technikon Pretoria who suffer from post-traumatic stress.
d) Empirically research the psycho-educational intervention techniques on students at Technikon Pretoria who suffer from post-traumatic stress.
1.6 Clarification of concepts

1.6.1 Psycho-educational

According to Van den Aardweg and Van den Aardweg (1993:77) psycho-education is concerned with the understanding of the nature of the learner and the learning process with social interaction and behaviour. Psychological principles and techniques are applied to develop interventions and techniques. According to Anderson and Kleckham (2002:4), the basic assumption of psycho-education is that life-skills can be taught and that people can learn new ways of dealing with problems. Through psycho-education people will learn new skills to apply to their personal lives and with practice, the skills can be used consistently to cause change in their lives.

1.6.2 Technikon students

In the context of this study, technikon students are those young people who are registered for study at the technikon in the age-group of mainly between 18 and 25 and above. These students may be day students who commute daily to the technikon campus to attend their classes or they may be residential students who lodge at the technikon’s residences.

1.6.3 Stress

The term stress has typically been used to refer both to the adjustive demands placed on an organism and to the organism’s internal biological responses to such demands. The adjustive demands are referred to as the stressors and the effects that they have on the individual, is called stress (Carson et al., 1988:138). Stress results from intense pressure that is exerted on the individual by the issues of life which his or her biological and mental systems cannot cope with at that time. Sears, Peplau, Freedman and Taylor (1988:512) state that events that we experience are stressful only to the degree that we perceive them as such and that the experience of stress is as a result of the balance between primary and secondary appraisal of the event.
1.6.4 Trauma

Trauma can be defined as an experience that involves an actual experience of injury or death, or threat of injury or death. Trauma is an intensely stressful event during which a person suffers serious harm or the threat of serious harm or death or witnesses an event during which another person is killed, seriously injured or threatened (http://www.mentalhealthchannel.net/ptsd/ 2002:1). During the experience of a traumatic event the individual’s coping resources are overwhelmed and he or she cannot cope. When harm or threat is high and the resources are minimal, a lot of stress may result but when the resources are plentiful and threat is low, trauma is minimized (Sears et al. 1988:512).

1.6.5 Post-traumatic stress

Post-traumatic stress is a debilitating condition that follows a terrifying event. Often people with post-traumatic stress have persistent frightening thoughts and memories of their ordeal and feel emotionally numb, especially with people with whom they were once close (http://www.psychnet_uk.co 2002). When a person suffers from post-traumatic stress, scenes from the past traumatic event would return and run repeatedly through the mind and disrupt his or her focus. In essence this means that even though the actual event has passed, the person keeps on re-experiencing the effects as if it has re-occurred. Kaplan and Sadock (1998:617) describe post-traumatic stress as a set of symptoms that develop after a person sees, is involved in, or hears an extreme traumatic stressor where he or she reacts with fear and helplessness persistently reliving the event.

1.7 Research design

A qualitative research approach will be used in this study to describe how psycho-educational intervention techniques are used in helping students with post-traumatic stress.

A sample will be drawn from cases that have been referred to and dealt with by the Students’ Counseling Service team at the Bureau for Academic Support at Technikon Pretoria. One case will be studied in-depth in order to obtain maximum results that will be applicable to the study.
1.8 Programme of study

Chapter 1

This chapter comprises the background, the statement of the problem, aim of study, research design, delimitation of the study and clarification of the concepts.

Chapter 2

This chapter comprises the literature study of post-traumatic stress. It will look at the DSM IV classification, the physiology of stress, traumatic events and symptoms. Some theoretical frameworks of post-traumatic stress will also be looked into.

Chapter 3

This chapter comprises the literature study of intervention techniques for post-traumatic stress. The focus will be on different intervention techniques and how they are implemented in therapy.

Chapter 4

This chapter comprises the research design and methodology. The research method, selection of the subject and the instruments used will be outlined in this chapter.

Chapter 5

This chapter outlines the empirical study and findings.

Chapter 6

In this chapter a summary of findings and conclusions from the previous chapters will be given. The limitations and recommendations of this study will be outlined.

1.9 Summary
The incidence of crime and violence in our society permeates itself into all the sectors of the society and a lot of people have fallen victims to this scourge. A number of cases are reported daily in the media and there have been an increased number of incidences in areas which would otherwise be regarded as safe such as the technikon. An increased number of cases have been reported amongst students who have been robbed, raped, mugged, abused and physically and emotionally molested at home or at the institution by other people. The need for all sorts of intervention strategies has never been as high as in times such as these when so many students experience difficulties due to post-traumatic stress. The following chapter provides a deeper understanding of the problem of post-traumatic stress and current trends and research in the field.
Chapter 2

Post-traumatic stress disorder

2.1 Introduction

Post-traumatic stress disorder is regarded as a serious mental health problem although it was given official recognition by the American Psychiatric association as general diagnostic criteria in 1980 (Scott, 1994:1). According to Scott (1994:10) the delay in defining post-traumatic stress disorder was due to the fact that symptoms are usually presented in conjunction with some other problems such as depression or substance abuse.

Stromnes (1999:10) mentions that over a period of several years there has been many changes in the concept and description of post-traumatic stress disorder, where concepts such as compensation neurosis, shell shock, traumatic neurosis, soldier’s heart, combat neurosis and fight fatigue were used. Post-traumatic stress disorder was officially recognised in the DSM III in the eighties (Scott 1994:1; Stromnes 1999: 10; Meichenbaum 1994:41).

2.2 DSM IV Classification

According to Kaplan & Sadock (1998: 619-621) the DSM IV classification system classifies post-traumatic stress disorder according to the following criteria:

A. The person has been exposed to a traumatic event in which both of the following were present:
   1. The person has experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others;
   2. The person’s response involved intense fear, helplessness or horror (in children, disorganised or agitated behaviour)

B. The traumatic event is persistently re-experienced in at least one or more of the following ways:
1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions (in young children, repetitive play may occur in which themes or aspects of the trauma are expressed).
2. Recurrent distressing dreams of the event (in children, there may be frightening dreams without recognisable context).
3. Acting or feeling as if the traumatic event were recurring, including a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated (in young children, trauma-specific re-enactment may occur).
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three or more of the following:
   1. Efforts to avoid thoughts, feelings or conversations associated with the trauma.
   2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
   3. Inability to recall an important aspect of the trauma.
   4. Markedly diminished interest in participation in significant activities.
   5. Feeling of detachment or estrangement from others.
   6. Restricted range of affect (e.g., Unable to have loving feelings).
   7. Sense of a foreshortened future (e.g., Does not expect to have a career, marriage, children or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two or more of the following:
   1. Difficulty falling or staying asleep.
   2. Irritability or outbursts of anger.
   3. Difficulty concentrating.
   4. Hyper vigilance.
   5. Exaggerated startle response.
E. Duration of the disturbance (symptoms in criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or marked impairment in social, occupational, or other important areas of functioning.

Specify if:
Acute: if the duration of the symptoms is less than 3 months
Chronic: if the duration of the symptoms is 3 months or longer

Specify if:
With delayed onset: onset of symptoms is at least six months after the stressor.

The Harvard Mental Health Letter (2002:3-4) states that post-traumatic stress is like a lingering wound from an overwhelming assault on the emotions and the symptoms are stated as other primary features of post-traumatic stress disorder in the DSM IV as:

a. Re-experiencing the trauma through intrusive recollection, flashback or dreams.

b. Victims may relive the traumatic event in the form of intrusive memories, nightmares and feeling or acting as though the experience is recurring. They may be upset when they are exposed to anything, an emotion, sensation, place or person that recalls or resembles some aspect.

c. Avoidance of the stimuli associated with the event or emotional numbing to other life experiences and relationships. Victims often try to avoid thoughts and feelings they had at the time of the trauma and all people, places, and activities that bring the experience to mind. In the process their lives become restricted and their emotions numbed. They lose interest in everyday activities and feel estranged from others. They may suffer from a sense of futility and expect to die before their time.

d. The persistent experience of increased automatic arousal, depression and cognitive difficulties. Victims may be irritable or subject to angry outbursts. Their sleep is troubled and their concentration is poor. They are jumpy, showing exaggerated startle response and constantly on guard as though they are still being threatened.
e. Symptoms must persist for at least one month, and the disturbance must cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

2.3 The physiology of stress

Reactions to stress involve the body as well as the mind. An automatic stress response is normal whenever an emergency disrupts or severely tests adaptive capacity. As the body mobilises to confront the crisis, the adrenalin hormones cortisol and adrenaline begin to circulate, responding to signals passed through the pituitary glands from the hypothalamus, deep in the brain. The chemical messengers dopamine and norepinephrine are released in the sympathetic nervous system. Muscle tense and heart rate, blood pressure and respiratory rate rise (Harvard Mental Health Letter 2002:4)

Christianson in Williams and Banyard (1999: 35) hypothesised that increased stress results in a narrowing of attention, which in turn leads to an increased concentration of central information. In times of increased stress and perceived threat, peripheral details are not as strongly encoded or retained, whereas the central details of stressful events are retained especially well in memory. Increased stress may enhance memory through either physiological or psychological means (Williams & Banyard 1999:35).

People who develop post-traumatic stress disorder show higher arousal levels than other survivors of the same catastrophe, more activity in the sympathetic nervous system, higher levels of adrenaline, and greater rise in the heart rate and blood pressure. These people have lower than average levels of cortisol, which supplies a feedback mechanism that turns off the alarm when the emergency is over. As soon as it reaches a certain level in the blood, the brain receives a signal and delivers a reply, turn down the sympathetic system and suppress the secretion of adrenaline (Harvard Mental Health Letter 2002: 4-5).

2.4 Traumatic events

Stromnes (1999:12) states that the most crucial aspect of post-traumatic stress disorder is establishing the nature of the traumatic event. Traumatic events that are so extreme or severe, so powerful, harmful and/or threatening demand extraordinary coping efforts. These traumatic events may take the form of an unusual event or a series of continuous events that
subject people to extreme, intensive and overwhelming bombardment of perceived threat to themselves or significant others. Such events may overwhelm a person’s sense of safety and security. Examples of these traumatic events, which may be brief and powerful are rape, assault, witnessing a crime, being in disaster, or some other form of personal threat (Meichenbaum 1994:17; Meck 1990:11)

Meichenbaum (1994:17) states that the traumatic event may take the form of a single traumatic event with the following examples:

- a. Natural disaster: the most common natural hazards are floods, hurricanes, tropical storms, tornadoes, severe windstorms, earthquakes, volcanoes and avalanches.
- b. Accidental disasters: car, train, boat, airplane accidents, and fires and explosions.
- c. Deliberately caused disasters or those that are intentionally caused by human design such as bombing, shooting, rape, terrorist attack, hostage taking, assault, battery, robbery and industrial accident (Petersen, Prout & Schwarz 1991:15)

Baum et al. as cited in Meichenbaum (1994) have noted that the disturbing, rapidly unfolding events create terror, extreme fright, threat to life, feelings of helplessness, vulnerability, loss of control and uncertainty. These traumatic events can cause very long-term changes as asserted by Williams and Banyard (1999:35) by stating that traumatic events interfere with the processing of information through the creation of abnormalities in the function of brain regions and systems involved in memory.

The likelihood of developing post-traumatic stress disorder may increase as the intensity of the physical proximity to the stressor increases. The severity, duration and proximity of the individual’s exposure to traumatic events are most important factors affecting the likelihood of developing post-traumatic stress disorder. On the other hand, Kleber, Figley and Gersons (1995:40) state that the individual’s mental state may have important effects on their behaviour and consequent danger. People who panic or who respond in other maladaptive ways may effectively increase their apparent exposure. According to Maercker, Schutzwohl and Solomon (1999:53), prior experiences have been reported to operate as a risk factor in coping with later events and they explain this by stating that the accumulation of various critical events within a given period of time represents a serious threat to the individual’s resource-deficit balance in coping with the current traumatic event.
2.5 Reactions to traumatic events

As outlined in the DSM IV and DSM IV-TR, the following may result from experience of a traumatic event:

2.5.1 Re-experiencing the trauma

Petersen et al. (1991:16) state that re-experiencing of the trauma takes a variety of forms but for a positive diagnosis of post-traumatic stress disorder only one form of re-experiencing the original stressor need to be present:

a. Recurrent / distressing disturbing recollection of event

The most common form of intrusion is involuntary recollection of the stressor. Thoughts, feelings, images and memories of the traumatic event emerge into conscious awareness and are experienced as disturbing to the patient. Attempts to suppress this material are frequently difficult, if not impossible. Intrusions, when present in this form, are a recurring feature of the clinical picture. Krupnick and Horowitz (1981) cited in Petersen et al. (1991:16) have isolated ten common themes manifested in intrusive thoughts:

i. Rage at source
ii. Sadness over loss
iii. Discomfort over vulnerability
iv. Discomfort over aggressive impulses
v. Fear of loss of control over aggressive impulses
vi. Guilt over responsibility
vii. Fear of similarity to victim
viii. Rage at those exempted from loss or injury
ix. Fear of repetition of the event
x. Survivor guilt

b. Recurrent distressing dreams or nightmares
Another way in which intrusive thoughts, feelings, images, and memories are re-experienced is through dreams and nightmares. Usually dreams repeat the event or aspects of the event exactly as they occurred. Wilmer (1982) as cited in Petersen et al. (1991:17) noted four categories of nightmares found in people manifesting post-traumatic stress disorder symptoms:

i. A recurring nightmare that resembles a real experience.
ii. A nightmare of events that were untrue in the dream’s experience, but that could have happened.
iii. A nightmare of events that were untrue of the original experience, and also improbable, but not impossible.
iv. A nightmare completely divorced from reality.

c. Reliving the event, illusions, hallucinations and flashbacks

Dissociative reactions to extreme traumatization are a less frequently occurring form of intrusion. They have been noted primarily in survivors of concentration camps and combat veterans or populations that have usually experienced multiple traumatic stressors. Blank (1985) in Petersen et al. (1991:17) noted the following as characteristics commonly found with flashbacks:

i. Powerful emotions are expressed
ii. Sudden onset
iii. Discontinuity with normal behaviour
iv. Post-flashback amnesia or confusion
v. The “primal nature” of the psychological issues (for example annihilation versus non-annihilation).

In reliving experiences, the individual is awake but appears to be in a state of altered consciousness and often has subsequent amnesia for what takes place.
d. Distress at exposure to events symbolizing or resembling trauma

Symptoms characteristic of post-traumatic stress disorder are often intensified when the individual is exposed to situations or activities that resemble or symbolise the original trauma. External cues may prompt various forms of intrusive recall ranging from distressing recollections and increased nightmares to flashbacks and dissociative phenomena.

2.5.2 Persistent avoidance and numbing of responsiveness to the external world

Trauma victims may avoid certain cues in order to minimize experiencing overwhelming memories and fears (Freedy & Hobfoll 1995:15). There is a fear of evoking intense emotions through re-experiencing of the trauma and therefore they would go to great lengths to avoid the stimuli associated with the traumatic event (Stromnes 1999:14).

Avoidance and numbing of responsiveness to the external world has, according to Petersen et al. (1991:22-24) the following characteristics:

a. Diminished interest in significant activities. A person is no longer interested in activities that he was previously engaged in.

b. Restricted range of affect. Following a traumatic event, a person’s range of affect often becomes restricted. The person may report loss of feeling associated with intimacy, tenderness or sexuality.

c. Feelings of detachment or estrangement which could be manifested in disrupted family life and is found to be highly correlated with restricted range of affect.

d. Psychogenic amnesia. This is the inability to recall certain aspect of the traumatic event. Going along with psychogenic amnesia is a sense of foreshortened future characterised by a sense of bad luck, fear, loss of trust, experience of vulnerability, anticipation of future catastrophes and dreams of personal death (Petersen et al. 1991:26; Meck 1990: 28;68).

2.5.3 Increased arousal

Observations of increased physiological and automatic arousal have been reported in people who have experienced extreme traumatisation. Stromnes (1999:15) mentions that following a
traumatic experience, various physiological changes occur which prepare the individual for a “flight or fight” response. Since mostly neither of these responses is possible, the adaptive mechanism is disturbed causing the individual to remain in a state of hyperarousal. Increased arousal is associated with the following:

a. Sleep difficulties, both dependent or independent of nightmares, are commonly found in patients with post-traumatic stress disorder.

b. Memory impairment or difficulties concentrating. The American Psychiatric Association (1980) and Wilmer (1982) as cited in Petersen et al. (1991) state that there are three cognitive changes that are found in people with post-traumatic stress disorder. These are 1) impaired memory, 2) concentration difficulties, and 3) difficulties associated with finishing a task.

c. Irritability and outbursts of anger, rage, hostility and feelings of violence are common features in people who have endured extreme traumatization.

d. Physiological reactivity to events resembling the traumatising event and the startle response. Physiological arousal and the existence of startle responses have been frequently noted with respect to those who have experienced a traumatic event. An example could be of a person who was a victim of a bank robbery may start to show a reaction similar to that one every time he goes into the bank. Kolb and Mutilipassi (1982) cited in Petersen et al. (1991:30) did a study with the following findings:

i. The existence of an abnormal potential for arousal of the emotions of fright with all its concomitants when exposed to appropriate stimulation.

ii. The existence of an on-going perceptual motor abnormality with regressive impairment of perceptual discrimination and fixation through emotional conditioning to a startle-arousal pattern.

iii. The physiological over-reactivity is probably mediated through central adrenergic pathways.

iv. Hyperalertness and hypervigilance are common features of post-traumatic stress disorder associated with increased physiological arousal. Hypertension and hypersensitivity are some of the common symptoms found. The
hyperactivity of the central dopamine systems, located at the prefrontal cortex and the nucleus, is believed to be related to hyperactivity and the hyperarousal (Hovens 1994:28).

Kinchin (1994:62) states that having once received the chemical messages during traumatic event, it appears that the brain is extremely alert and waiting for similar messages. The state of hyperalertness or hypervigilance means that the sufferer’s body is constantly expecting to be faced with a serious situation.

2.6 Secondary symptoms of post-traumatic stress disorder

Petersen et al. (1991:35) state that the clinical picture presented by people with post-traumatic stress is usually not restricted to the symptoms and clusters outlined in the diagnostic criteria. There are other secondary features that are associated with the disorder (Kinchin 1994:78):.

2.6.1 Panic

Panic attacks can be extremely frightening and totally exhausting. According to Kinchin (1994:78-79) following a traumatic event, certain sights, smells or sounds may spark off an instant warning that the event is about to be repeated.

2.6.2 Depression

Post-traumatic stress disorder is often exacerbated by an underlying depression and frequently the symptoms of these two disorders overlap to an extent that it becomes difficult to distinguish between them (Stromnes 1999:16). An awareness of and attendance to depression is a crucial aspect of the assessment and understanding of the broader clinical picture of post-traumatic stress disorder (Petersen et al. 1991:37).

Kinchin (1994:83-84) mentions the following as common symptoms of depression that are linked to post-traumatic stress disorder:

a. Depressed mood most of the day, and nearly every day
b. Little interest or pleasure in any activity
c. Insomnia  

d. Loss of energy nearly every day  

e. Diminished ability to think clearly  

f. Bouts of sadness, tearfulness or anger  

g. Loss of interest in food  

h. Pre-occupation with guilt feelings  

i. Reduced concentration  

j. Feelings of hopelessness  

k. Recurrent thoughts of death or suicide  

2.6.3 Anxiety  

Anxiety has been noted over the years as a manifestation of post-traumatic symptomology. Anxiety equivalents that were found in sufferers of post-traumatic stress disorder included heart palpitations, excessive sweating, hyperventilation and other forms of the central nervous system overactivity (Petersen et al. 1991:37).  

2.6.4 Death imprint  

People suffering from post-traumatic stress disorder experience death imprint due to what is called by Lifon in Petersen et al. (1991:38) as the radical intrusion of an image, feeling of threat or end to life.  

2.6.5 Substance abuse  

When people are desperate for help they will turn to anything or anyone who they think might be a source of comfort. Self-medication with alcohol is used by people in inducing sleep, reducing anxiety and easing muscle tension (Petersen et al. 1991:38). Koefoed et al. (1993) as cited in Yehuda (2002:15) concluded that post-traumatic stress disorder and substance abuse should be treated simultaneously.
2.6.6 Somatization

Individuals suffering from post-traumatic stress disorder usually complain of numerous psychosomatic symptoms. According to Petersen et al. (1991:39) the common forms of somatization and tension include excessive tenseness, exhaustion, pain in muscle joints, arthritic like attack, headaches, ulcers, colitis, respiratory syndromes, cardiac syndromes, hypochondriasis, gastric overactivity and allergic symptoms.

2.6.7 Other secondary symptoms

Other secondary symptoms of post-traumatic stress disorder include adjustment problems, disrupted interpersonal functioning, pronounced sexual difficulties, secondary mental illness, alterations in lifestyle, intense feelings of mistrust, feelings of being betrayed, feelings of being scapegoat, regression, explosive anger, aggression and disrupted self-image (Petersen et al. 1991:41; Yehuda 2002:13).

2.7 Theoretical frameworks of post-traumatic stress disorder

There are different conceptual models that have been developed to explain the formation and the resultant symptomatic picture of post-traumatic stress disorder. These conceptual models stem from a variety of frameworks such as the learning theories, cognitive theories, information processing, personality and social learning theories.

2.7.1 Learning theory

The learning theory explains that fear acquisition occurs through classical conditioning, in which a neutral stimulus (the conditioned stimulus) is paired with an aversive stimulus (the unconditioned stimulus) so that the conditioned stimulus comes to elicit a conditioned response of fear. In explaining some of the symptoms of post-traumatic stress disorder, the previously neutral stimuli that were present during the trauma come to elicit anxiety themselves. Additionally, through generalisation and second order conditioning, stimuli associated with both the feared and neutral stimuli that were present during the trauma also come to evoke fear.
Through the process of operant conditioning, avoidance behaviour is established where an individual learns to reduce trauma-related anxiety through avoidance of, or escape from the conditioned stimulus through the process of negative reinforcement (Foa & Rothbaum 1998:69).

2.7.2 Cognitive theories

Cognitive therapy is not founded on the assumption that the events themselves cause emotional distress, but rather one’s interpretation of the events that is responsible for the evocation of emotional reactions. Cognitive therapy maintains that an event can be interpreted in different ways and consequently can evoke different emotions.

2.7.3 Personality and social psychology theories

The personality and social psychology theories explain the psychological effects of traumatic experiences by invoking the concept of “schemas”, being the core assumptions or beliefs that guide the perception and interpretation of incoming information. According to Foa and Rothbaum (1998:71) these theories suppose that the processing of a traumatic experience requires modification in existing beliefs.

Epstein (1991) cited in Foa and Rothbaum (1998:71) suggests that the four core beliefs that change after a traumatic experience are:

a. The belief that the world is benign
b. That the world is meaningful
c. That the self is worthy
d. That the people are trustworthy

Modification of beliefs is accomplished through the processes of assimilation and accommodation. The victim therefore must assimilate the traumatic experience into the old set of assumptions, or to change the assumptions so that they can accommodate the traumatic experience.
2.7.4 Emotional processing theory

Foa and her colleagues (Foa and Riggs 1993; Foa et al. 1989, 1992) cited in Foa and Rothbaum (1998:72) have integrated learning, cognitive and personality theories into a theoretical approach called an emotional processing theory. This theory explains why some individuals recover satisfactorily from a traumatic experience while others develop chronic disturbances. This theory states that emotional experiences can often be relived well after the original emotional events have occurred and that this reliving involves re-experiencing of the emotion itself, as well as details of the original event and the thoughts associated with that event. An example of this can be seen in the case of a rape victim who, when remembering the rape, is likely to experience feelings of dread and helplessness she originally felt during the rape long after the rape’s occurrence. Foa and Rothbaum (1998:73) refer to this as emotional re-experiencing.

2.8 Summary

This chapter looked into the concept of post-traumatic stress and its definition which has changed over a period of time. The criteria for diagnosis on the DSM IV classification system and the important characteristics and features of the disorder were highlighted. Other aspects of post-traumatic stress that were looked into are the physiology of the stress, that is how the stress develops in the mind and the body, the events that create trauma, primary symptoms and secondary symptoms and also various theoretical approaches that influence our views about post-traumatic stress and consequently how we deal with it in therapy.

In the next chapter various intervention techniques for dealing with post-traumatic stress in therapy will be highlighted.
Chapter 3

Intervention techniques for post-traumatic stress

3.1 Introduction

Post-traumatic stress is a complex condition that can be associated with significant morbidity, disability and impairment of life-functions. Foa et al. (2000:1) state that in the development of guidelines for the treatment of post-traumatic stress it must be acknowledged that traumatic experiences can lead to the development of several different disorders, including major depression, specific phobias, disorders of extreme stress not otherwise specified, personality disorders and panic disorders.

Various techniques for the treatment of post-traumatic stress and their relative efficacy will be explored in this chapter.

3.2 Techniques used

3.3 Interventions shortly after the trauma

Koss and Harvey (1987) as cited in Foa and Rothbaum (1998:36) state that crisis intervention and group psychotherapy for trauma victims are some of the most common procedures used especially in rape crisis centres. The interventions shortly after the trauma incorporate dissemination of information, active listening and emotional support. Foa and Rothbaum (1998:37) maintain that the interventions shortly after the trauma ensue from the debriefing model by Mitchell and Bray (1990) cited in Foa and Rothbaum (1998:37). The psychological debriefing model can be described as a semi-structured crisis intervention designed to reduce and prevent unwanted psychological sequelae following traumatic events by promoting emotional processing through the ventilation and normalization of reactions and preparations for possible future experiences. The debriefing model includes seven phases that are conducted in small groups as follows:

First phase: Explaining the purpose of the debriefing and the purpose of participation.
Second Phase: “Recreating” the traumatic event by asking all participants to discuss their perspective on what occurred.

Third Phase: Discussion of the participants’ thoughts at the time of the event.

Fourth Phase: Description of the worst part of the event for them.

Fifth Phase: The educational component in which the facilitator describes common reactions to trauma in order to normalize participants’ responses.

Sixth Phase: Participants provide comments and closing statements.

Seventh Phase: Informal session where participants meet with the team leaders and discuss with one another informally.

The debriefing approach, such as the one described above is mostly applied to survivors of a variety of traumatic situations such as bank robberies, emergency workers and military personnel (Foa & Rothbaum 1998:37).

3.3 Cognitive Behavioural Counselling

Cognitive Behavioural Counselling is a problem-oriented, active and directive process. The emphasis during therapy is on the counsellor encouraging the client to view negative beliefs as hypotheses to be tested, rather than as facts to be adhered to (Scott & Stradling 1993:32). The client comes to therapy with negative beliefs and thoughts that have resulted in behaviour problems. The therapist helps the client to have a different view that will allow him or her to deal with those situations in a positive way.

The cognitive behavioural therapy theory supposes that emotions are produced by the interpretation of events rather than by the events themselves. This means that the same event can be interpreted in different ways and consequently can evoke different emotions (Foa & Rothbaum 1998: 176; Scott & Stradling 1993:30). According to Kruger (1994:88) cognitive behavioural therapy focuses on the modification of negative thinking leading to realistic thinking. The therapist listens carefully to the client’s problem, and tries to understand its
nature. The client is asked questions that are so direct and so that he or she can identify faulty thinking (Kruger 1994:88).

### 3.3.1 Cognitive restructuring

According to Scott and Stradling (1993:39) cognitive restructuring leads to accurate perception of the trauma. In replaying the trauma with the client, the counsellor will probably find that the client emphasizes some details and minimizes others. In this way, the cognitive behaviour therapist highlights that the trauma does not simply exist in objective reality but that the client responds to their construction of it. Cognitive restructuring involves the client representing the whole picture and not uses a mental filter on the positive aspects. The client must describe the trauma as it was without seeking to minimize the negative aspects or negating the positive aspects but balancing the negative and the positive aspects.

Meichenbaum (1985) as cited in Scott and Stradling (1993:39) applied the Self-Instruction Training technique, which involves identifying the specific thoughts or self-verbalisations related to the trauma, which cause distress. The therapist then assists the client in modifying the negative self-verbalisations and replacing them with positive self-statements. Through Self-Instruction Training, the client is taught how to replace negative thoughts with positive thoughts (Foa, Davidson & Frances 1999:14). According to Resick and Schnicke (1993:17) the goal of cognitive behavioural training is to assist the client in refraining from distorting the event to fit prior beliefs and in accommodating schemata to the new information without over-accommodating. Scott and Stradling (1993:43) mention some of the cognitive biases that have to be dealt with in therapy as follows:

a) All or nothing thinking: Everything is seen in black and white terms where the client tells himself or herself “I am either in control of what is happening to me or I am not”.

b) Over-generalisation: Expecting a uniform response from a category of people because of the misdeeds of a member, for example, “all men are potential rapists”.

c) Mental filter: Seizing on a negative fragment of a situation and dwelling on it. For example, “I could have been killed in that encounter”.

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d) Automatic discounting: Brushing aside the positive aspects of what was achieved in trauma, for example, “I was only doing my duty in saving the child”.

e) Jumping to conclusions: Assuming that it is known what others think, for example, “They all think I should be over it by now, it was six weeks ago after all”.

f) Magnification and minimization: Magnification of shortcomings and minimization of strengths, for example, “Since the trauma I am so irritable with the family and just about manage to keep going to work”.

g) Emotional reasoning: Focusing on emotional state to draw conclusions about oneself, for example, “Since it happened, I am afraid of my own shadow, I guess I am just a wimp”.

h) “Should” statements: Inappropriate use of moral imperatives such as should, must, have and ought, for example, “It’s ridiculous that since the attack I now have to take my daughter with me shopping. I should be able to go by myself”.

i) Labelling and mislabelling: For example, “I used to think of myself as a strong person. I could handle anything, but since it happened I am just weak”.

j) Personalization: Assuming that because something went wrong it must be your fault. For example, “I keep going over my handling of the situation. I must have made a mistake somewhere for the child to have died”.

3.3.2 Desensitisation to the trauma

Scott and Stradling (1993:37) state that when traumatic intrusions persist despite all efforts at containing it, a technique of desensitisation to the trauma is useful in a situation where there is a sound therapeutic alliance.

The desensitisation procedure involves encouraging the client to make a 10-15 minute audio tape recording of the original trauma, describing the events that occurred and the associated
thoughts, feelings and behaviours. The client then should play the tape at least once a day but not switch the tape off until they have become more relaxed. Unless there is habituation to the trauma during a listening session there will be no decrease in distress from session to session, that is why it is very important that the tape is not switched off until the client is more relaxed (Scott & Stradling 1993:38).

The particular aspects of the tape that create maximum distress will often vary from day to day, as the client is looking at the trauma from new angles to try to make sense of it. Foa and Kozak (1986) as cited in Scott and Stradling (1993:38) state that the intention of desensitisation is to expose the clients to an immediate level of fear that is not so great that they are prevented from processing the trauma material, nor so slight that they are not engaging with the trauma material.

3.3.3 Rational Emotive Therapeutic Technique (RET)

Rational Emotive Therapy as a cognitive restructuring procedure is an important component of cognitive behavioural therapy. One of RET’s points of departure is that emotions and behaviour mutually influence each other. RET is directive, strongly didactically oriented and views thoughts to be just as important as feelings.

According to RET, the individual has the potential towards self-development, thinking, luck, verbalizing, love, communication with others, growth and self-actualisation. The individual also has the tendency for self-destruction, procrastination, and repetition of mistakes, perfectionism, self-blame and under-actualisation of the growth potential. RET is based on the assumption that the person has the potential to think both rationally and irrationally and that his or her irrational thoughts give rise to emotional problems (Kruger 1994:92).

Möller (1993:175) as cited in Kruger (1994:72) indicates that RET comprises of the ABC theory of emotions as follows:

A = Activating agent
B = Belief System
   rB = Rational Belief which entails correct judgements and perceptions
   iB = Irrational Belief which entails incorrect judgements and perceptions
C = Consequences  
rC = Rational consequences which entail suitable and rational emotions and/or behaviour  
iC = Irrational consequences which entail irrational emotions and/or behaviour

In the context of post-traumatic stress, “A” leads to trauma, “B” leads to the traumatized person’s thinking, values, life philosophy and C leads to the feelings and behaviour (Kruger 1994:184).

### 3.3.4 Task orientation problem-solving technique

Although it is appropriate to disengage from various activities when faced with a major trauma due to its overwhelming nature, continued disengagement from routine activities however, is unlikely to be an appropriate response to changed circumstances when the trauma is over. According to Scott and Stradling (1993:44) it would not be appropriate to continue simply to facilitate an emotion-focused coping. Through this technique, the client is engaged in a process that deals with tangible concerns of his or her environment and not just the emotions. Scott and Stradling (1993:45) list the following procedures for the problem-solving approach:

1. Problem definition: What is exactly the problem? The problem is to be defined in specific terms.
2. Brainstorm: Generate as many solutions as possible. The more the better.
3. Weigh up the advantages and the disadvantages of each of the solutions. Try to look at the advantages and disadvantages both in the long-term and short-term.
4. Choose a solution: Plan its implementation in specific terms, one step at a time.
5. Review coping efforts: If the chosen solution is not successful or incomplete go back to stage 2 and brainstorm, and continue to cycle through the problem-solving procedure until reasonably content.

### 3.3.5 Stress Inoculation Training (SIT)

Meichenbaum (1977) cited in Meichenbaum (1996:4) mentions that Stress Inoculation Training (SIT) emerged out of an attempt to integrate the research on the role of cognitive
and affective factors in coping processes with the emerging technology of behaviour modification. Stress Inoculation typically consists of education and training of coping skills which include deep muscle relaxation, breathing control, role playing, covert modelling, thought stopping and guided self-dialogue (Foa & Rothbaum 1998: 53).

The idea of Stress Inoculation Training is that people suffering from post-traumatic stress experience a great deal of anxiety in their lives because they are frequently reminded of the trauma.

According to Meichenbaum (1996:4) the Stress Inoculation Training is implemented in the following three phases:

a. First phase

This is the conceptualisation phase in which a collaborative relationship is established between clients and the therapist. During this phase the client is educated about the nature and impact of stress and the role of both appraisal processes and the transactional nature of stress. Clients are encouraged to view perceived threats and provocations as problems to be solved and to identify those aspects of their situations and reactions that are not changeable. The client is taught how to break down global stressors into specific short-term, intermediate and long-term goals.

b. Second phase

The second phase of Stress Inoculation Training focuses on the skills acquisition and rehearsal that follows naturally from the initial conceptualisation phase. The coping skills that are taught and practiced primarily in the training setting and then gradually rehearsed in vivo, are tailored to the specific stressors that clients may have to deal with, such as chronic illness, traumatic stressor, job stress, surgery, sports, competition and military combat. The specific coping skills may include emotional self-regulation, self-soothing and acceptance, relaxation training, self-instructional training, cognitive restructuring, problem-solving, interpersonal communication skills training and attention diversion procedures.
c. The final phase

The final phase of Stress Inoculation Training is that of application and follow-up which provides opportunities for the client to apply the variety of coping skills across increasing levels of stressors. Techniques that are employed are imagery, behavioural rehearsal, modelling, and role playing and graded in vivo exposure in the form of “personal experiments”. In order to further consolidate these skills individuals may even be asked to help others with similar problems.

3.3.5 Reality Therapy Technique

Corey (1986:242) cited in Kruger (1994:94) sees reality therapy as a technique, which is based on the central idea that the individuals are responsible for their own behaviour. This means that the person is not viewed as the victim of life’s circumstances but as someone who is involved with life. The client is helped to effectively take control of his or her own life and to lead a quality life.

It is important for the therapist not only to concentrate on feelings, but also on thoughts and actions. During reality therapy the client is led towards responsible decisions and choices regarding his or her future. It does not help the client to concentrate and be stagnated on the misfortunes of the past (Kruger 1994:95).

When a traumatized client comes into contact with the therapist, the therapist will help the client to realize that negative feelings are unnecessary. The therapist who is working with the traumatized client will help him or her to change his or her behaviour to achieve his or her objectives. A contract with the therapist is made so that the client should be assured that he or she is not alone. A new identity must be realized in the place of a misfortune identity related to the past traumatizing event (Kruger 1994:96).

Kitchen (1991:34-38) cited in Kruger (1994:96) explains the application of reality therapy in the context of post-traumatic stress as follows:

- First phase: Establishment of empathy with the client.
- Second phase: Focus on the present or what is currently applicable, for example the therapist can ask questions such as; “What do you hear or see in your head?” “What goes on in your mind?” Through the details of the trauma, the therapist helps the client to gain control of the current situation. An example of a relevant question would be, “What troubles you at the present moment?”

- Third phase: The therapist helps the traumatized client to gain control over himself or herself and his or her environment. Emotional energy can be channelled into healthy creative activities. The reality therapist must show the client that there is nothing that he or she can do or change about the past, but that he or she can control his or her own response and the way he or she reacts to the situation (Kruger 1994:96-97).

3.3.7 Other useful therapeutic techniques for the facilitation of post-traumatic stress.

Kruger (1994:67-87) mentions some of the following techniques that can be used in the facilitation of post-traumatic stress therapy:

a) The use of drawings as a technique in post-traumatic stress

Glaister and McGuiness as cited in Kruger (1994:69) are of the opinion that victims of prolonged chronic traumas like molestation need to work intensively on their emotional well being. A drawing is seen as a particular useful technique that can be applied in post-traumatic stress. During the application of this technique, a client is given a piece of paper and something to write with. The instruction that is given is that the client must draw how he or she felt during the experience of the trauma. The artistic quality of the drawing is not important as the client is looked at in terms of the thoughts and feelings that are represented in the drawing.

Kruger (1994:70) cites the following as handy guidelines for the interpretation of the drawing:

- The size of the figure is meaningful and gives an indication of the person’s self-image. A big figure may point toward aggression while a small figure may mean a low self-image.
The amount of detail included in the drawing may represent the person’s preferences and interest in his or her world. It may also indicate problem areas. Scanty or lack of detail may be an indication of depression or introversion.

When the figure is placed at the right hand side of the page, it may point to intellectualising and the need to be in control, while if the figure is on the left hand side of the page may be an indication of impulsivity and fixation on the past.

The use of one colour and dark shadows on the drawing usually show a correlation with the client’s verbal expression of low self-image and feelings of powerlessness. The use of many colours may point to a positive self-image.

Kruger (1994:71) indicates that the goal of using drawing is to help the client to come into contact with his or her feelings which have for a long time been suppressed.

b) Letter writing as post-traumatic stress therapy technique.

Through the writing of a letter to an imagined recipient, the traumatized person is able to express emotions, desires, and guilt feelings.

c) Keeping of diary as post-traumatic therapeutic technique

Rosser and Dewar (1991:3) cited in Kruger (1994:74) state that keeping of a diary could be a useful technique in post-traumatic stress. The traumatized person can write into the diary anything that he or she goes through in life, his or her feelings and handling thereof.

d) Role-playing as post-traumatic therapeutic technique

The therapist can use role-play in order to bring out certain reality. The aim is to help the client come to a position where he or she can develop his or her own autonomy (Kruger 1994:75).
e) Psychodrama as post-traumatic stress therapeutic technique

Psychodrama as technique can be used in therapy in order to “replay” the client’s past. The rationale behind psychodrama is that the client can objectively re-visit his or her past and exchange negative feelings and experiences with constructive positive ones.

f) Dream analysis as post-traumatic therapeutic technique

Dreams that occur whilst the person is undergoing post-traumatic therapy are looked at as post-traumatic phenomena. The anxiety that is experienced by traumatized person manifest in dreams. Nightmares and/or repetitive dreams are the subconscious mind’s way of dealing with the trauma.

g) Empty chair as post-traumatic therapeutic technique

According to Corey (1986:163-164) as cited in Kruger (1994:78) another way of bringing to surface negative feelings, is to let the client sit in front of an empty chair. The client can freely express himself or herself against the “person” in the empty chair without any discomfort or feelings of guilt.

h) Pet facilitated post-traumatic therapeutic technique


According to Kruger (1994:105) the interaction between a person and a pet is not a new invention as this has been used in the past centuries. Odendaal (1992:10) cited in Kruger (1994:106) said that the motivation to use pets is two-fold. Firstly, pets are used to reach the person’s emotions and secondly, animals are used on account of their helpfulness and usefulness to the person, for example guide dogs, sniffer dogs and police dogs.

An important starting point for the use of pets in the facilitation of post-traumatic therapy is the acknowledgement of the fact that some people who are emotionally and socially isolated, as well as lacking in communication skills, would find it easier to relate to animals in therapy.
Kruger (1994:122) provides the following synopsis for the implementation of pet facilitated therapy:

i. Pet facilitated therapy is not a standardized therapeutic technique. This means that there are no prescribed rigid directions.

ii. Pet facilitated therapy is implemented in consistence with the specific client’s needs.

iii. The choice of a pet must take into account various factors, namely the compatibility of the pet with the client and therapist, the external environment, the acceptance of the pet by the people who come into contact with the client on a daily basis as well as financial implications.

iv. Pet facilitated therapy is used only as an addition to the therapeutic process. It cannot be implemented exclusively or replace the therapist’s inputs.

v. The value of pet facilitated therapy lies in the animal’s ability to bring to surface the person’s emotional and behavioural responses, to deroute attention to dysfunctional cognitive defence mechanisms, and psychological stress, and to restore the individual’s inner strength (Kruger 1994:122).

3.4 Eye Movement Desensitization and Reprocessing (EMDR)

Eye Movement Desensitization and Reprocessing (EMDR) is a method that combines elements of behavioural and client-centred approaches. The procedure involves having the client to concentrate intensely on the most distressing segment of a traumatic memory while moving the eyes rapidly from side to side by following the therapist’s fingers moving across the visual field in front of his or her face. Following the initial focus on the memory segment, after each set of eye movements of about 30 seconds, the client is asked to report anything that came up whether an image, thought, emotion or physical sensation. The focus of the next set is determined by the client’s changing status. The procedure is repeated multiple times until the client reports reduction of distress (Hembree & Foa 2000:33; Fletcher 2003:9).
According to Foa et al. (2000:141) EMDR treatment requires the patient to identify multiple aspects of the traumatic memory, including the images associated with the event, the affective and physiological response elements, the negative representation induced by the traumatic experience, and an alternate desired positive self-representation. EMDR is used for what is called resource installation by amplifying memories and sensations of safe or pleasant experiences in the client’s mind (Yehuda 2002:149).

Shapiro (1995) as cited in Foa et al. (2000:142) maintains that EMDR is a structured, multi-component treatment package incorporating the following eight stages:

1) Client history and treatment planning stage where the therapist evaluates patient readiness, barriers to treatment, dysfunctional behaviours, symptoms and illness characteristics.

2) Preparation stage is used to establish an appropriate treatment relationship and explain the rationale behind EMDR to the client.

3) Assessment stage includes a) identifying the distressing image in memory, b) identifying an associated negative cognition, c) identifying an alternative positive cognition, d) rating the validity of the positive cognition, e) identifying emotions associated with traumatic memory, f) rating the subjective level of disturbance and g) identifying trauma-related physical sensations and their bodily locations.

4) Desensitisation and reprocessing stage is where the client is asked to hold in mind the disturbing image, the negative cognition and the bodily sensation associated with the traumatic memory. The therapist moves his or her fingers back and forth in front of the client’s face, while the client tracks the moving fingers with his or her eyes.

5) Installation of positive cognition is the stage where the client is instructed to think of the target image while covertly rehearsing the positive cognition. Another set of eye movements is performed.
6) Body scan stage is the stage where the client is asked to check for any signs of residual physical tension or discomfort.

7) The closure stage is where the therapist prepares the client for leaving each session.

8) Re-evaluation stage is where there is an assessment of whether treatment goals have been reached or not.

### 3.5 The story telling technique

Phillips (1999) in Roberts and Holmes (1999:27) said that we live in and through the stories we tell and imagine about ourselves. Brooks (1984:3) in Roberts and Holmes (1999:27) further states that our lives are ceaselessly intertwined with the stories that we tell and hear told, those that we dream or imagine or would like to tell, all of which are reworked in that story or our own lives. Our lives are multi-storied and there are many stories occurring at the same time and different stories can be told about the same events (http://www.dulwichcentre.com.au/alicearticle.html).

The stories that we have about our lives are created through linking together events in a particular sequence across a period of time and finding a way of explaining them. The meanings to our stories are given as we live our lives. Among the many stories of our lives’ experiences, the dominant story will have dominant effects and implications for future actions (Morgan 2000:5-9).

According to Morgan (2000:12) the client is, during therapy helped towards alternative stories and creation of conversations or stories that will assist the client to break from the influence of the problems they are facing.

### 3.6 Psychopharmacology in post-traumatic stress therapy

Mejo (1990:43) cited in Kruger (1994:98) states that there is a physiological response when individuals are exposed to stress. Psychotherapy is considered to be a major part of treatment, however there are times that the distress and discomfort from the hyperarousal of the
sympathetic nervous system may inhibit or impede the psychotherapeutic approach. When this happens, medication can be helpful in controlling the trauma-related symptoms.

Pharmacotherapy in post-traumatic stress disorder is based on the neurobiological evidence that uncontrolled life-threatening trauma leaves an imprint on the opiate and other neuropeptidergic systems, the hypothalmic-pituitary-adrenal axis, and the autonomic nervous system (Foa & Rothbaum 1998:45). Friedman in Wilson and Raphael (1993:785) states that there are physiological and neuroendocrinal alterations in post-traumatic stress, which have significant implications for treatment. It appears that any drug that can dampen physiological hyperactivity, ameliorate the disturbed sleep, attenuate sympathetic hyperarousal or reduce anxiety should be helpful in post-traumatic stress disorder.

According to Davidson and Nemerhoff (1989:424) as cited in Kruger (1994:98) the treatment of post-traumatic stress with medication has the following goals:

- The reduction of recurring mental incidents around the trauma.
- The decrease of avoidance behaviour.
- The reduction of the permanent alertness where the body expects the trauma to occur again.
- An improvement of sleep pattern
- Better control over destructive behaviour
- Management of depression, panic and anxiety

Prescription of medication is a specialized field of medical doctors and psychiatrists. The educational psychologist can make a referral to any of the specialists if he or she sees that the client in attendance may not benefit from psychotherapy alone.

3.7 Summary

This chapter explored the various techniques that are used for the treatment of post-traumatic stress both psychotherapeutically and pharmacologically. It is the therapist’s discretion based on the diagnosis of the client, taking into consideration the unique circumstances of each and every client, to decide the most appropriate technique to employ.
Yehuda (2002:71) is of the opinion that treatment techniques and their effectiveness should time and again be evaluated and those that do not work in particular cases be discontinued. Another way of enhancing treatment is to integrate the use of medication with psychotherapy.
Chapter 4

Research design and methodology

4.1 Introduction

The previous two chapters mainly focused on the theoretical aspects of post-traumatic stress and the theoretical exposition of various techniques that can be implemented in therapeutic intervention by an educational psychologist. This chapter describes the research design and methodology used in this study. The aim of the study, the methods, the procedures, the selection of a subject and the instruments used in the study are described.

4.2 The statement of the problem

In this study the research problem has been formulated and stated as follows:

a) Which psycho-educational intervention techniques can be used for students suffering from post-traumatic stress?

b) What is the effect of psycho-educational intervention with students suffering from post-traumatic stress?

4.3 The aim of study

4.3.1 Primary aim

The primary aim of this study is to explore how psycho-educational interventions are used to assist students who experience post-traumatic stress.

4.3.2 Specific aims

In order to realise the primary aim of this study, the researcher aims to:

a) Undertake a literature study regarding post-traumatic stress.
b) Undertake a literature study regarding intervention techniques for post-traumatic stress.

c) Identify suitable psycho-educational intervention techniques to use for students at Technikon Pretoria who suffer from post-traumatic stress.

d) Empirically research the psycho-educational intervention techniques on a student at Technikon Pretoria who suffers from post-traumatic stress.

4.4 Empirical Investigation

The purpose of the empirical investigation is to explore therapeutic techniques that are implemented among students suffering from post-traumatic stress by the educational psychologist.

4.4.1 Selection of the subject

This study is of a limited scope and therefore only one student will be used. The subject that will be used in this study will be drawn from students that report for counselling services at the Bureau for Academic Support presenting post-traumatic stress problems. A client will be selected at random to participate in this study.

4.4.2 Research method

Shaughnessy and Zechmeister (1997:80) state that an important task of the researcher is to describe behaviour in the natural context and to identify relationships among variables that are present. The descriptive, qualitative research method will be used in this study.

4.4.3 Instruments used

4.4.3.1 The Trauma-100-Questionnaire

Kruger (1994) developed the Trauma-100-Questionnaire which will be used in this study. The questionnaire may be completed in the presence of the therapist or the traumatised person may complete it at home. Apart from measuring the depth of the trauma, the Trauma-
100-Questionnaire also serves as a means of communication and information to the traumatised person or as a guide for an interview.

It consists of a hundred questions and serves as an operational measuring instrument to determine the impact of trauma on the traumatised person. The questionnaire measures the following:

a) Typical reactions of the traumatised person:

Insomnia, loss of appetite, gastro-intestinal problems, poor concentration, memory problems, motor (movement) problems, confusion, shock, fear, disorientation, disbelief, a feeling of “this is too much”, distortion of time and sound, distortion of physical pain, chest pains, dizziness, weariness, lower back pains, flashbacks, avoidance behaviour, permanent hyper alertness, no hope for the future, suicidal thoughts, euphoria, relief, tearfulness, irritability, anxiety, feelings of guilt, shame, depression, nightmares, decreased libido, impulsive behaviour, alcohol abuse, realisation of the fragile nature of human beings, expectation of more disasters or traumas, encouragement by other people to normalise life is despised, violent thoughts, mood swings, affected religion, feelings of hopelessness, lack of strength, aggression, and repetition of thoughts (e.g. “why me?”).

b) Negative consequences of the trauma:

Feelings of unhappiness and aggression linger, occupational life is negatively affected, family members suffer, quality of life lowers, marriage problems and/or problems with family members may develop, stigmatisation and subjection to judgemental remarks, indifference of the community, people feel uneasy when the topic of the trauma is raised, and blame from the community.

c) Implications of the negative consequences:

Development of personality is affected, social interaction is affected, secondary traumatisation by the community, traumatised person is isolated, and blame by the community adds to the feelings of guilt as already experienced by the traumatised person.
d) Positive consequences:

Group cohesion emerges where people experience the same or similar trauma/s, new relationships are established, new solutions are found, valuable life experience is acquired, a new perspective on life emerges, losses are calculated in terms of relativity where groups are involved, and positive characteristics are reinforced or developed.

e) Implications of the positive consequences:

Positive feelings may counteract negative feelings, the person feels stronger and richer after he or she has worked through the trauma, and traumatised persons who reckon that their losses are less than their fellow members of the traumatised group, deal more easily with the post-traumatic situation.

f) Ego defence mechanisms:

i. Apathy – a state of emotional anaesthesia which is marked by indifference, listlessness, uninvolvelement and disinterest.

ii. Dissociation – it may be defined as a disruption of the normal integration of cognition, affect, behaviour, sensation, and identity.

iii. Aggression – it is an emotion which is expressed in hostility, destruction or physical attacks on a person or object.

iv. Suppression – it is the unconscious forcing of feelings or impulses into the subconscious so as not to allow them to come into conscious.

v. Compensation – it entails a huge effort on the side of the traumatised person to overcome the trauma. The person may compensate in a direct manner when attempting to confront the trauma (e.g. the traumatised person starts to work at a funeral parlour after the death of a loved one) or indirectly when all energy is canalised into a certain direction in order to forget the trauma (e.g. the person plunges into work to “work” the trauma away).
vi. **Rationalisation** – the person tries to escape an emotion by dealing with it on a cognitive level. Reasons and apologies are common.

vii. **Projection** – it is a process in which subconscious contents are attached to external people or objects. The process of projection relieves stress and anxiety.

viii. **Denial** – denial refers to an intrapsychic process, in which the implications of the event are denied.

ix. **Substitution** – it is the diversion of energy (action) from its original source to a more noble or higher purpose. Freud considered it to be the most mature of all defence mechanisms. It is not uncommon for a traumatised person to become very creative when pursuing a new life goal after a trauma (e.g. a raped woman may devote her life to the hardening of sentences for rapists).

**Interpretation of the Trauma-100-Questionnaire**

The numbers (1 or 2) indicate the presence of post trauma reactions, consequences, implications and ego defence mechanisms. All the blocks with the lines through them must be ignored.

If the blocks are predominantly marked with 1’s, the following may be applicable:

- The person experiences the post-traumatic situation severely
- The person has experienced the trauma recently
- The person’s general functioning is markedly affected

If the blocks are predominantly marked with 2’s, the following may be applicable:

- The person does not experience the post-traumatic situation as problematic
- The person denies the effects of the trauma.

The findings from the questionnaire can be verified by asking the person questions.
4.5 Therapeutic design

After the initial investigation with the Trauma-100-Questionnaire, the researcher will facilitate post-traumatic therapy, which is embedded in his theoretical framework of relations theory.

4.5.1 Relations theory

This is the model on the basis of which diagnoses are made. The client comes for therapy with a specific story but that is not the focus of therapy. Through the relations theory, the therapist focuses on how the events have affected the client and these are the things that have to be dealt with and not the story, for example, the effects that events had on the client’s intrapsychic structure result in the client’s ego-strength affected and this leads to vulnerability, as well as interpsychic structure (relations). Intrapsychic and interpsychic processes are analysed through the following categories of the relation’s theory:

- **I/Ego** – consists of the rational conscious self and operates on the reality principle and finds real objects in the environment that will satisfy drives and reduce tensions. The ego needs attention and respect as an individual.
- **Self** – it is that part of us of which we are consciously aware. It is what we know about ourselves, what we think (self-concept) and what we feel about ourselves (self-esteem).
- **Feelings and Experience** – these determine the quality of the relationships that we have. It stresses the uniqueness of each person’s relationship.
- **Thinking** – Thinking or cognition is influenced by the emotions. Meaning based on illogical reasoning and deduction can be regarded as irrational.
- **Involvement** – involvement refers to the psychic vitality of the person as a whole and it is related to one’s experience and significance attribution. If one sees the world as threatening, he or she is less likely to be involved.
- **Identity** – Identity has to do with the roles that we play in terms of our functioning.
- **Self-concept** – the self-concept consists of three mutually dependent components, namely self-identity, action and the worth that we place on ourselves.
- **Self-actualisation** – this refers to making the most of all the potential you have, being the best that you can be.
• **Relations** – the person has relations with himself or herself, other people, objects and ideas. These relations may be positive, negative and neutral.

• **Significance attribution** – as soon as meaning is attributed, it directs the person’s behaviour. Meaning is attributed according to the individual’s view of the world.

• **Self-talk** – this refers to the way the person talks to himself or herself about himself or herself.

### 4.5.2 Therapeutic intervention techniques

The following therapeutic techniques will be used to facilitate therapy:

- Cognitive restructuring
- Rational Emotive Therapy
- Reality Therapy
- Drawings
- Letter Writing
- Empty chair technique

### 4.6 Summary

In the following chapter the implementation of the empirical investigation mentioned in this study will be described as well as the discussion of the findings.
Chapter 5

Empirical study and findings

5.1 Introduction of case study

In this empirical study the researcher will implement some of the therapeutic techniques that are mentioned in the previous chapter with a student who was referred for therapy suffering from post-traumatic stress. Although the case in study was done in a real situation, the name used is not the real name to ensure that the identity of the client is protected.

This is the case of Nontombi, a 21 year-old female student in her third year, studying for a degree in cost and management accounting at the Technikon Pretoria. She is the eldest child in a family of three children. Her siblings are still at high school. Her parents got divorced and she and her siblings stay with their mother. Whilst at the technikon she rents a flat that she shares with other students, including her cousins. Nontombi’s problem was that she has found that she is no longer the “same person as she used to be” and has feelings of sadness, loneliness and pain as well as sleeping problems. She has lost interest in many activities and spends a lot of time by herself. She indicated that she does not have friends any more “except for this girl” who studies with her. A lot of time she says she finds herself getting deep in thoughts, absent-minded, meditative and loses sense of the people around her. This is disturbing her because she even becomes absent-minded during lectures. Although she still manages to pass, her performance has been going down.

She does not feel she need anyone around and has severed relations with a lot of people. Nontombi does not have an adequate support system since her home town is in another province where her family is living. She has broken up a relationship with her boyfriend whom she said she did not understand, and she regrets that she has ever been involved with him. She is worried about her lifestyle and the thoughts that come to her when she is alone.

During the process of therapy, it emerged that Nontombi’s problem is related to the abuse that she suffered when she was still young. She is a victim of psychological torture and physical abuse by her father that took place at their home for a long period in time. Nontombi’s mother and father had a difficult and troubled marriage. They were always
fighting in front of their children and Nontombi, being the eldest of the children was always
drawn into these battles. She remembers very well at some stage when her father had pushed
her against a table corner that left her scarred on the stomach, as well as when her father was
beating her mother with the butt of the gun, threatening everyone in the house. She has some
scars on her body that are testimony of her father’s physical attacks on her.

Due to the prolonged differences and conflict that her parents have had, Nontombi has not
had a father figure to look up to. She does not remember any good moments with her father.
All she knows is that her father used to beat her mother and the fighting would spill over to
the children.

Nontombi’s maternal grandmother had to take Nontombi away from her parents because
amongst the other children, she had started to show signs of being affected by her father’s
attacks on the family. Her stay at her grandmother’s place provided her with a protective
environment in which she felt secure. She also on the other hand became attached to her
grandmother and that is the person she said she would talk to about many things. She would
share her joys and her sorrows with her grandmother.

Although her departure from her parents to stay with her grandmother was to provide her
with an alternative environment where she could feel safe, she begun to doubt if she was her
father’s real child. Up to now she doubts if her father is her biological parent although she has
not asked anyone. Her grandmother is deceased and that was the person she would ask if her
father was her stepfather or her true biological father. This question, she says makes her feel
insecure and that she is not like other people because she believes there is someone who must
be her real father though nobody had informed her that that is the case.

She feels guilty in that that she must have been a contributing factor to her of the parents’
conflict and the resultant divorce because her father did not like her, as she “was not his
child”. Although she said her father treated her the way he did because she was not his
biological child, she was not sure of that fact because no one has ever told her that. She said
that she does not have any concrete facts about this issue, but she is convinced that this might
be the case because she overheard one day when her mother was talking to a friend, she
seemed to agree that it is not a big issue if a man marries a woman who has already has a
child from another man as long as they love each other. When she heard this from her
mother’s discussion with a friend she concluded that they might be referring to her. When she looked at her relationship with her father and his attitude towards her and her mother, she started to harbour such thoughts, even though she has never discussed this with anyone or tried to find out from her parents or grandparents.

During the interview Nontombi was asked to tell about her life and to highlight the milestones and experiences in her development as far as she could remember. She wrote the following down as her milestones:

0–5 years: “Can’t remember much except for Sunday school. Didn’t go to crèche, stayed home with granny – I learned from her. Family was close.”

5–6 years: “Suffered from abuse. I can’t remember much of it, a lot of strange things happening. (Dreams). Family was close but most of the time I was not clearly understood. My father was not there – He was never home.”

10 till now: “I live in the world of my own (world of my own). Created thought of where I would be happy. Lived in fantasy, not the real world. Schooling far away from home. Needed support – there was none to find. Come home – parents fight – the effect – me alone.” (See Fig. 1)

Fig. 1: Nontombi’s milestones
The above is what Nontombi said is the story of her life which she said she felt comfortable to tell by way of writing. She said most of the time when she feels bad or attacked by negative thoughts she would express herself in writing.

Nontombi also indicated how, due to her experience with her she sees every man as a potential abuser. She has lost all trust of men.

5.2 Investigation of the trauma

5.2.1 Results of the Trauma-100-Questionnaire

The Trauma-100-Questionnaire was implemented and Nontombi’s responses were as follows:

<table>
<thead>
<tr>
<th>THE TRAUMA-100-QUESTIONNAIRE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME Nontombi</td>
</tr>
<tr>
<td>AGE 21</td>
</tr>
</tbody>
</table>

INSTRUCTIONS:

Indicate which of the following statements apply to your personal situation or your emotional life AFTER you have experienced the trauma. If the statement has no relevance, ignore it by drawing a line through the block. Say for instance you have a lifelong problem with insomnia, the first statement (nr 1) will be ignored.

Positive answers to the statements must be indicated according to intensity, using the following scale:

1 = Severe / Definitely
2 = Not that severe / To a lesser degree

1  □  I have sleeping problems. (I have problems falling asleep / I wake up in the middle of the night and cannot go back to sleep again / I wake up early in the morning.) 1

2  □  I have nightmares. 2

3  □  I have lost my appetite. 1
I have problems with stomach ache / stomach cramps / bloatedness / diarrhea/ constipation. -

I find it hard to concentrate. 1

I have difficulty in remembering things. 2

I do things slower than usual. (Previously I was able to function effectively, now things take longer to be completed with the result that less is completed.) -

I walk slower than I used to. -

I am not concerned about my posture. (I could not care less whether I walk up straight or whether my tummy is tucked in.) -

I get chest pains. -

I am dizzy from time to time. 2

I am tired. 1

I get lower back pains. -

I get flash backs of the terrible events. 1

I try to organise my life in such a way that I will never find myself in a similar position or situation. 1

I do not have any hope for the future. (It feels as if there is no future.)-

I think about suicide. -

I am depressed. 1

I am relieved that everything is over and done with.-

I am tearful. 1

I am irritated. 1

I am scared. (It is difficult to say what I am actually scared of, but I have this fearful feeling.) 1

I feel guilty. 2

I am unhappy. -

It feels as if I have been cheated.-
I feel incomplete as if I have lost something. -
I am angry. -
I feel ashamed. -
I act on impulse. (E.g. I will buy something without thinking twice.) -
I take too much alcohol. (It helps me to forget and to feel better.) -
My sexual needs have decreased. -
I am without a will of my own. (It feels as if I am not in charge of my life. Things are just happening to me.) 1
I am without a personality. (My “usual self” is gone.) -
I cannot continue on my own. -
My work/occupational life is negatively affected. -
My family suffers as a result of this. -
The quality of my life has lowered. -
My personality has changed. 1
My social life is in ruins. -
I have engaged in new relationships. -
I love to associate with people who had similar experiences. 1
I have learned to find new solutions. 1
I have gained valuable life experience. 1
I use positive feelings to counteract negative feelings. -
I feel a stronger and richer person. -
I am aware of the fragile nature of human beings and that they can easily get hurt. 1
I am expecting the next disaster. It is just a matter of when and where. (I am wondering what the next thing will be that will go wrong) -
I have changed my outlook on life. (Things that used to be important, are not important any more.) -
I have problems with my marriage after this trauma. -
I have problems with my family members after this trauma. -

I get violent thoughts. (E.g. I fantasise how I am going to repay this person who put me through this hell.) -

My religious life has reached an all time low. -

I loose track of time. (E.g. at one stage it is still morning and the next thing that I am aware of is that it is already late in the afternoon. I cannot recall the time in between.) -

People tell me about things that I have done or said which is very unlike me and which I cannot remember. 2

I get confused about things which I think I have already done, but in the meantime I have dreamt about it or I was still busy planning it. -

I find myself sometimes in places without knowing how I got there. -

Sometimes my body feels as if it is not my body. -

Sometimes it feels as if I am only watching my body from a distance and that I am not part of my body. (I am not inside my own body.) -

I get the feeling that the world does not really exist. -

It feels sometimes as if I am in a thick mist. 2

I sit and think for hours. 1

I think about nothing. -

I shut myself off from the outside world. 2

I am able to shut myself off from painful experiences. -

I am in a trance sometimes. -

I feel nothing. (I feel feathers. I do not feel good or bad.) -

I withdraw myself from the outside world. (I do not go out and visit my friends anymore.) -

I feel hostile towards the world around me. -

I act aggressively. -

I try to suppress my feelings. 1

I throw objects around. -
I do not care about my belongings anymore. -

I try to compensate for what has happened. (E.g. I try to be mother and father for my children.) -

I try to conceal the truth from other people. -

When I enter a room where people are busy talking, it feels as if they are talking about me. -

The community has labelled me. (They are not concerned about the facts - they judge me.) 1

I have mood swings. (At times I feel good, other times I feel aggressive, or tearful, or depressed, or irritable.) 1

I feel hopeless. (I cannot help myself.) -

I do not have any strength. 1

I do not experience any particular emotions. (I get the impression that I am supposed to be cross or sad, or whatever, but I do not feel that way.) -

I take too many tablets. -

I watch television for hours on end. -

I read excessively. -

I entertain people with exaggerated joking. -

The community are unaware of what I am going through. -

Nobody wants to discuss the events with me. (They feel uneasy about the topic and prefer to avoid it.) -

I become irritated when people encourage me to continue my life as usual. -

The community blames me for what has happened. -

I cannot believe that this has happened to me. (It always feels as if it happens to somebody else.) -

I ask myself constantly if I could not have done more to prevent it. 1

It feels as if I am being punished for something that I have done wrong. 1
5.2.1.1 Interpretation of the results of the questionnaire

The blocks are predominantly marked with 1’s and indicate thus that Nontombi experiences the post-traumatic stress severely. This is already verified by the abovementioned story of her life.

The following summary indicates her various responses to her childhood trauma of abuse:

- Types of reactions:
  - Sleeping problems (1)
  - Loss of appetite (3)
  - Concentration problems (5)
  - Exhaustion (12)
  - Flashbacks (14)
  - Reorganisation of life (15)
  - Depression (18)
-Tearful (18)
- Irritability (21)
- Fear (22)
- Awareness of fragile human nature (46)
- Mood swings (77)
- Loss of strength (79)
- Recurring thoughts (90)
- Feeling of being punished (91)
- Wondering why her (92)

• Negative consequences: - Labelling by community (76)

• Implications of negative consequences:
  - Change of personality (38)

• Positive consequences: - Love to associate with people with similar experiences (41)
  - Have learned to find new solutions (42)
  - Have gained valuable life experience (43)

• Implications of positive consequences:
  - Support from associating with people of similar experience

• Ego-defence mechanisms: - Apathy (32)
  - Dissociation (61)
  - Suppression (70)

The results of the questionnaire show that Nontombi’s personality has changed and she has feelings of guilt about herself and those have negative effects on her life. She associates with people who have had similar experiences as she has and believes that what she has gone through is valuable experience in her life and through that she has learned to find new solutions. When asked further on this question she said that the fact that she did not have a happy family to bring her up made her fend for herself most of the time and she has learnt how to survive.
By associating with others who have had similar traumatic experiences makes her feel better because they share their stories and she feels that others have had worse situations than hers. That she feels better with people with whom they share the same experience has however negative effects in that she tends to withdraw from other relationships or avoid other people.

Although Nontombi’s traumatic experiences are not recent she still shows strong emotional reactions to that. (See types of reactions)

During the interview it came to light that Nontombi employs the following defence mechanism apart from those identified in the Trauma-100-Questionnaire:

- **Rationalisation:** She sometimes tries to conceal the truth from other people. Nontombi seems to try to escape her traumatic emotions by dealing with them on a cognitive level. She said of herself that she “likes rationalising about things”.

- **Dissociation:** With regard to dissociation which is a dominant defence mechanism in Nontombi’s life, she said that people tell her about things that she has done or said which are very unlike her and which she cannot remember. She feels that sometimes she is in a thick mist and likes to sit and think for hours. Nontombi says that she has the tendency to shut herself from painful experiences.

### 5.2.2 The Neethling Brain Preference Profile

Because of the drop in Nontombi’s marks and her primary occupation as a student, the researcher deemed it necessary to investigate her functioning as a student. The Neethling Brain Preference Profile looks at the thinking preferences of the individual, and then recommends certain areas of study or employment in which the person would be most comfortable. It is a measure of the individual’s thinking preferences presenting results which are non-judgmental.

In this session the Neethling Brain Preference Profile was implemented to evaluate the extent to which the Nontombi is functional or dysfunctional in the context of being a student at the technikon. The following is a summary of the results of Nontombi’s profile:
High Preference – L1: 92

Nontombi’s profile shows that she is very comfortable with factual, logical, rational and critical thinking. She prefers to work with facts, technical, mathematical or scientific information. She would prefer to be clear on what has to be done, would complete a task in a precise and accurate way. She would be able to focus on a task for a period of time. Feelings will not play an important role when coping with problems.

Average Preference – R1: 78

Nontombi is comfortable in situations that require processes such as the search for alternatives, taking risks and looking at the bigger picture. She will tend to use her preferences for dealing with facts in an analytical and precise way to plan the future and as stimulus for new ideas.

Average Preference – L2: 76

Nontombi is comfortable with processes that require detail, organisation and discipline. She can be dedicated and would be comfortable with routine. She will be comfortable in a more structured, controlled and organized environment. When necessary she will handle routine matters and follow instructions.

Very Low Preference – R2: 54

It is unlikely that Nontombi will enjoy constant interaction with others, as she prefers to work on her own or as part of a small team. She will probably not be comfortable in an environment that requires her to be emotionally sensitive, show empathy and to support others on an on-going basis.

Brain Profile Preference shows that Nontombi’s preference is in line with her current course, cost and management accounting. A drop in her marks is unlikely to be due to lack of interest in the course but that the post-traumatic stress that she experiences may be responsible.
5.2.3 Analysis using the relations’ theory

- **I/Ego** – Nontombi has a weakened ego. She has a need for attention and respect that she could not find in her father.

- **Self** – What Nontombi knows about herself is that her father “had destroyed her” in her childhood. She has a poor self-concept. She thinks she is not like other students at the technikon and that she did not grow up like other children. For example “school away from home…needed support but there was none”. “Didn’t go to crèche…stayed home with granny”. “My father was not there…he was never home”.

- **Feelings and experience** – Nontombi does not seem to have had quality relationships in her life. She wrote, “…suffered from abuse, I can’t remember much of it and a lot of strange things happening”.

- **Thinking** – There is a lot of irrational thinking. She says, “I live in the world of my own. Lived in a fantasy world”. She also thinks that because of her father being the abuser, every man she comes into contact with is the abuser. This is irrational thought.

- **Involvement** – Nontombi sees the world around her as threatening. She keeps herself away from others and does not have friends “except for one girl” she studies with. She broke up with her boyfriend because she feels threatened in a relationship.

- **Identity** – Nontombi’s functioning shows the identities as student or learner, where she has registered to study for a course, as a friend who has problems because she cannot sustain friendships, as a child from broken and dysfunctional family.

- **Self-talk** – There is a lot of negative self-talk from Nontombi. She says she was in the family “but most of the time not clearly understood.” She continues to say most people do not understand her. Due to negative self-talk she resorts to withdrawing from relationships. She said she “lived in a fantasy world” and this is where she fed herself with negative self-talk.

- **Self-actualisation** – With all the negative self-talk, lack of involvement and poor relations, it is less likely that Nontombi will self-actualise. She feels that it is safe for her to “live in a fantasy world of her own” and that does not give her opportunity to move towards self-actualisation.
5.3 Planning and progress of therapy

5.3.1 Letter writing as post-traumatic therapy technique

Nontombi was asked to write a letter to someone like her mother or her father. She refused to write to either of them saying that she does not have anything to tell them in a letter. She was then asked if she were to write a letter, who would she write to, and she wrote a letter to God as follows:

Dear God

Another day has come. I guess some days mark new beginnings and some don’t. But for me I just want to view each day as unique because I know that once tomorrow comes today will be gone. First things first, thank you once again for the protection, blessings, the beautiful skies, and for my own life. I guess sometimes I don’t realise how beautiful life and how great is the things you do for us. Any way enough about that.

Sometimes I wonder how you make things operate in human beings. It’s kind of odd but I guess that is how you made it to be the way of life or that is how life goes, I would like to view it. I am surprised to see how patient you are, full of mercy, and love that surpasses us all. At times I don’t think I deserve all the good things you give, not able to understand the bad or the cloud of darkness that sometimes crawls into each and everyone of us. I think that as a human being you could only just take a limited amount of bad or good, not too much because too much of everything is sin. I would like though just to have a little wisdom to understand how you operate because I think with that understanding I would definitely know your ways better and become a better person than I already am.

It’s all for now till we chat again.

Yours faithfully
Daughter Nontombi

_____________________

The letter that Nontombi wrote does not show any emotion compared to what she is going through in reality. She seems to be trying hard not to put herself in the picture. This may be the reason why
she does not want to write to her father saying that she does not have anything to tell them. She is being defensive because she knows that would evoke certain real emotions and feelings that are more related to her situation. On the other hand it shows that because of her experiences with people such as his father and the vulnerability and helplessness of her mother she tends to be a religious person who finds solace in her faith in God.

Nontombi believes that there is nobody for her in this world and uses her faith in God to cope and generate hope for herself. The rejection that she felt at her home and among her family has led her to find someone that is to her more than the mother, more than the father and that person knows it all and that is God in her life. Her experience of God is that of someone who has “all the good things” to give and in knowing God’s ways and coming into contact with the reality of God she “would definitely know your ways better and become a better person than I already am...”. It seems that Nontombi after losing her father through the divorce and having poor relationships with her family, she found God as the “person” she can trust and relate to about her deepest feelings.

The reader will realise that Nontombi has experienced disappointments in her relationships with people. In order to keep herself going forward with her life she has chosen a relationship with God in whom she invests her time and trust and she believes that God will be the only “person” that will not treat her like her father did and she does not have any fear that God would let her down. What this relationship does for her is that she knows that even though all other people and relationships fail her, in God she has someone she can put her trust and therefore she has a “person” to talk to and to commit to in a relationship.

5.3.2 Drawings as post-traumatic stress therapeutic technique

Nontombi was asked to draw a person (DAP). In her drawing of a person she drew herself only the head on the middle right side of the page. Above the drawing she wrote the words that read as “the girl who is trying to make it against all odds” (see fig. 2).

This drawing confirms her rationalisation (section 5.2.1.1) when she depicted herself as merely a head of which the brain is the centre. The position of the figure (right hand side of the page) might also point to her intellectualising (also see chapter 3, section 3.1.2.7). All else that is included with the drawing is the inscription of her struggle to survive in spite of her barriers.
She took another page and drew another person who was also just the head without the body and wrote the words, “a woman who worked hard to were she is a fighter and not a quitter.” (See fig. 3).
Fig. 3: Nontombi’s DAP – second figure

She said this woman (fig. 3) is her mother. The drawing looks very sad with wrinkles and some marks on the face, which could be indication of a bruised face. She has an angry look and she described her as “a fighter…” Nontombi seems to have a good relationship with her mother and admires of her fighting spirit, her endurance, and perseverance amidst adversity. She seems to have in her mother someone who is able to protect her because she sees her as “a fighter and not a quitter”. This may mean that she can look up to her mother when she is in danger or unable to fend for herself. This is perhaps what she learnt when her father would attack her, her mother was there to fight and not to quit “against all odds.”
The themes in the two drawings, that of herself and of her mother points to the conflict and physical abuse that they experienced. She is “trying to make it against all odds” and her mother “worked hard...is a fighter, not a quiter.”

The next drawing was a kinetic family drawing (KFD). She drew a house that was separate on the left-hand top corner of the page and there were four figures in the picture (See fig. 4).

Fig. 4: Nontombi’s KFD

There are two persons in the bathtub that was full of water and they were bathing. Those she said were her two little sisters. They seemed engaged by themselves in the bath.
On the right hand side was a bigger picture of a woman with folded arms and that she said was her mother. At the bottom was another drawing of herself not far from the mother. The two, although close to each other were not talking or doing any physical activity. She said they were thinking about their experiences in the family and how they will make it. The big figure of her mother may depict her as the dominant person. Her mother’s face had wrinkles and bruises which she said is due to the fact that her mother is always working hard to keep the family going. When asked if the family was complete as it is, she said she does no longer count her father as a member of their family any more because he divorced the mother and has gone to live elsewhere with another woman and other children. It seems her thought of her father evokes those bad memories, negative feelings and emotions that are associated with her father’s abuse. She feels that taking him totally out of the picture would take away the pain and negative experiences that she suffered at the hands of her father.

Nontombi indicated that she sometimes presents her thoughts and feelings by means of drawings and as homework she did a drawing which she brought in during the session (See fig. 5).

![Fig. 5: Nontombi’s free drawing](image-url)
In that drawing she pictured herself in a bathtub full of water and only her head is rising above that water which seemed like stirred water. There is a big hand which she described as the “hand of God” that is reaching out to her and overlooking her at the top of the picture is the eye which she says is the “eye of God” which is looking after her.

Although Nontombi could draw fairly well, her drawing of herself did not have distinct arms and there were no hands or fingers (fig. 4). This could be an indication of low self-esteem and a lack of confidence. She and her mother are sitting down and this may mean they are in a situation where they feel helpless. In the DAP, she drew only the head and the question may arise, where is her body, what happens to her body? Is it because of the scars of abuse that she does not draw her body?

5.3.3 Modified speech, countering overgeneralisation

Nontombi’s relationship with other people, especially with the opposite sex was severely affected. She was suspicious of most people who would want to initiate some relationship with her. Nontombi’s self-talk with regard to the males needed attention. She has had a relationship with a boyfriend which she broke off and in her own words puts it “I had to cut off the relationship because I do not want any one to take advantage of me any more in my life...I had suffered a lot at the hands of my father and he was the only man that was ever close to me.”

She has this negative judgement of men most of the time. When she comes into a context where there are men, she becomes overly critical of their motives and actions to the extent that she reacts negatively towards them. According to her “all guys are just the same” and when she remembers what her father did to her and her mother she feels negative towards men. She gave an example of the discussion group that she has with fellow students and says that among the people in the group, she always develops negative feelings to the male members. These feelings are so strong that she feels insecure and “cannot handle anything”. Because of her negative experiences with her own father, she attaches those negative qualities of her father to the male population in general.

Nontombi makes use of this negative self-talk to protect her ego so that she will no longer find herself involved with any man. She is projecting negative feelings attributed to her father to men in general. She generalises her experience with her father as applicable in all situations involving men.
In dealing with this negative self-talk and projection, Nontombi had to realise that she could channel her energy and her psychic vitality into things that contribute to her well being. It takes a lot of energy to feed her negative self-talk and that causes her not to move forward with her life.

The negative self-talk and overgeneralisation have a limiting effect because every man that she comes across evokes similar negative feelings and emotions that her father used to. Most men would come into her life being different from her father and she should look at every person and relationships realistically, judging each matter and every person for what he or she is.

In order to further discount the overgeneralization, Nontombi had to realise that people have experiences that are different from others, but whether it was good or bad they still continue with life and they maintain normal and healthy lifestyles with new relationships.

She had to realise that it is because of her negative self-talk resulting from overgeneralisation that she reacts negatively and treats every situation on the basis of her experience and relationship with her father who was abusive.

5.3.4 Cognitive restructuring through ABC

Nontombi’s relationship with male persons was faulty and needed to be attended in therapy. She presented with a tendency of perfectionism and irrational thinking that contributed to her emotional problems. She has indicated that when she has to relate with any male person, she thinks that such a man is the same as her own father and therefore develops anxiety in that relationship. She feels anxious and does not have trust in that relationship and especially if there is any difference of opinion, she sees the male person in her life as a potential abuser like her father. The following are examples of working with Nontombi to deal with her negative and irrational self-talk:

\[
\begin{align*}
A &= \text{Being in a relationship with a man} \\
iB &= \text{He is going to abuse me, he is not sincere} \\
iC &= \text{I must get out of this relationship}
\end{align*}
\]

\[
\begin{align*}
A &= \text{Being in a relationship with a man}
\end{align*}
\]
The man that I have a relationship with is there to provide me with different experience of a man, he is not like my father. He and my father do not even know each other.

I can get into a relationship, to love and to be loved.

My mother in a marriage relationship
My mother is going to suffer because this man is going to abuse her
She is wasting her time staying with a man she should leave and be on her own

My mother in a marriage relationship
Marriage or relationship does not necessarily mean abuse, and my mother can be happy
I can look forward to a happy family

Me in a relationship with a guy
He is taking advantage of me and he is going to abuse me later
I cannot trust him and all that he does is telling me lies

Me in a relationship with a guy
Everybody is unique with strengths and weaknesses and I need to give the person in my life his chance to prove himself and not measure him against my father
I can make something out of the relationship I enter into.

My father abused me and my mother
Like my father, my boyfriend will abuse me
I won’t allow anyone to have a relationship with me

My father abused me and my mother
My boyfriend is not like my father in the same way that I am not like my mother. Whatever was a problem between them is not a problem between us.
I will be happy in my relationship and be free with my boyfriend.
A= I am in the class
iB= I think everybody is looking at me and sees that I am not like them because of my experiences
iC= I will withdraw myself and keep everyone away

A= I am in the class
rB= No one in the class knows my background and where I come from. Apart from that, they are all involved with the lecture and classroom activities
rC= I will be open and take part in the classroom activities

5.3.5 Empty chair technique

According to Corey (1986:163-164) cited in Kruger (1994:78) the empty chair technique can be used to bring to surface negative feelings. The client sits in front of the empty chair and freely expresses himself or herself against the “person” in the empty chair without any feelings of discomfort.

Nontombi had negative feelings against her father and she said she does not even believe that she is “that man’s own child” because of the way that he had treated her, her mother and her other siblings. She said that her father had destroyed her and caused her not to enjoy her childhood. She feels that her father had “robbed her of what she deserved like other children” of her age when she was growing up and up to now her negative feelings of her father are still with her.

During therapy in this session Nontombi had to address her father as the “person” who sat in front of her in the empty chair. Initially it was very difficult for her to speak to her father during the empty chair process. She had said that she does not want to speak to her father because she does not know what to tell him. The therapist led Nontombi and said, “Welcome Mr Ngomemnandi (Nontombi’s father). I would like you to sit in this chair and face your daughter, Nontombi who would like to speak to you today. And now Nontombi your father is here, please take your time and speak to him. You and I have talked about a lot of things that you were going through and now it is time to tell your father whatever you would like him to know.”
Nontombi’s heart was beating heavily as she lifted her head facing the empty chair in front of her in which her father was sitting waiting to hear her speak to him and she said:

“Dad, today is the most important day in my life that I am able to speak to you face to face for the first time after so many years. I have had these issues in me for so long and never knew how I would talk to you because you were nowhere I could find you. Daddy, tell me where you have been and why all these things happened to me. I want you to know why I did not grow like other children, you did not give me the love and the support that the other children had. I remember how much you hurt me physically and emotionally. My life became shattered because of you as you know how you used to fight with my mother and also involved us. Daddy I remember how you used to shout at us, I remember how you used to be angry and cruel at me and my mom. I still have the mark of the bruise when you pushed me and hit me against the table corner that night….it was very painful. I remember when I had to flee home and live with my grandmother when you said I am just like my grandmother and you refused to speak to me, you refused to do anything for me and my grandmother had to take me to school. I remember when you threatened to kill my mother and all of us….or may be it is because you were drunk all the time. Because you were not to be there in my life I had to try out life and fend for myself with no one to care for me like a father. Daddy, I am disappointed because up to today I do not know where we were wrong…but why did you do that to us if we were your own children? I have been bottled with these feelings against you. I felt frustrated and at times angry at you. Daddy, now that I am talking to you and you are listening I feel better. I want to forget the past and go on with life. I forgive you and want you to forgive me if there is any wrong you have against me. You are my father and I want us to make up. I also want to be like other children and speak to you and you speak to me. I wish you could care a bit and understand what my sisters, my mother and I go through, because of the way you handled us. Thank you for listening to me. Thank you!”

During the process of the empty chair technique, Nontombi was very emotional. She initially struggled to speak and literally had to force her mouth to open and pronounce words that she addressed to her father in the empty chair. As she started talking, the more she spoke the more she was opening up and fluent in her speech to her father. Towards the end she was more at ease and relaxed and even her facial expression changed and appeared more relaxed. Her tone did not show the anger with which was explicit in the beginning.
5.3.6 Psychodrama technique

Psychodrama technique is used in therapy in order to in order to replay the client’s past. This technique allows the client to revisit his or her past objectively and exchange negative, destructive feelings and experiences with constructive, positive ones. Through this technique underlying issues that are traumatising to the client are brought to surface, the past incident is played out and the client will, in a safe environment gain insight and emotional relief (http://www.meta.co.uk/therap/psyc/psychodrama.asp).

Because Nontombi was not in a group but attended therapy as an individual, she was given the following instruction by the therapist:

“You know the story of your life and how things have been bad for you over time, you recall exactly the incidences and experiences that have affected you and your being negatively. Suppose that this was a drama that you have to rewrite where things were to go contrary to the way they have happened, with a happy ending, what are things that you would change in your writing?”

During this process, Nontombi made a comment “What can I change? Do I change the ending or what?” Some of the things that she would change included her mother’s behaviour, that her mother would be more stronger and not have “allowed her father to do as he wished about her”. It was interesting that she would also change her behaviour and response to her father’s treatment of her. She said in this drama “Nontombi will be strong and stay away from harm, she will be an independent thinker, successful and achieve so much without depending on her father or anyone. She would go on with her life, with pride and prove to everyone that she can do it.”

This activity helped her to realise that it is more of how she views her experiences that she feels the way she does and that she can change her mind about it all and that will change her negative feelings. When asked about how she feels about the whole exercise she acknowledged that it is difficult to change what has happened or what was done by others but she can change whatever is in her mind because she has control over that. She said she can feel that one can be able to rewrite whatever has gone wrong from the past and look forward to a better situation than the one already experienced.
5.3.7 The story telling technique

Phillips (1999) in Roberts and Holmes (1999:27) said that we live in and through the stories we tell and imagine about ourselves. Brooks (1984:3) in Roberts and Holmes (1999:27) further states that our lives are ceaselessly intertwined with the stories that we tell and hear told, those that we dream or imagine or would like to tell, all of which are reworked in that story or our own lives. Our lives are multi-storied and there are many stories occurring at the same time and different stories can be told about the same events (http://www.dulwichcentre.com.au/alicearticle.html).

As Nontombi came for therapy there is a dominant story in her life. She has certain events that happened in her life dominating and overshadowing her other experiences that may give her alternative experience to that which she is experiencing now. Her father’s abuse of her is the dominant story and it forms the big part of what she remembers and tells about her life story. With this type of story being dominant Nontombi was bound to have problems and negative emotions. For her this was the only story and it is the way she would describe herself. Through this technique Nontombi had to revisit the story of her life and realise that apart from the dominant story of her life whereby her abusive father was the main figure, there are other stories which she can tell about her life and other figures involved. It is in her realisation of the other stories that the dominant negative story will diminish and be overshadowed by the other stories often referred to as the alternative story and this would emerge with an alternative emotion with positive feelings.

Looking back, Nontombi would see her grandmother as a “player” in the events of her life, how she loved her and took her home to safety and protection when her father was threatening her. Her grandmother literally played a mother’s role to her and she became someone she could trust, talk to, run to, play with and share with. Deconstructing her story and bringing in the positive elements and events that are positive means making her positive experiences feature dominantly in her life so that she can feel positive about herself. Her other relationships, for example with her grandmother where there were positive relations, are significant and form part of the stories that are to be told about her. These stories have positive memories and help her in developing a positive outlook of life.
5.4 Outcome of therapy

When Nontombi reported for therapy the first time she pointed out that among other things, she was feeling angry at her father who had abused her and never cared for her when she needed him most, sad because of her losses in life, lonely because she did not have any friend and was afraid of entering into relationships, difficulty to sleep since she would think about her experience and “worry” about herself and pain because her father had hurt her. She presented herself as someone that does not have interest in life and her motivation and orientation towards her studies were waning as a result of post-traumatic stress.

The process of therapy that the client, Nontombi underwent helped her to gain insight in areas of her life and being. The techniques that were implemented, provided her with a means to venture towards self-actualisation. She gained insight into her intra-psychic and inter-psychic relations and how these influence her life view. Nontombi, through this process was able to confront her negative life experience and re-oriented herself from the traumatic experience of the past to the future.

She wrote the following letter (unedited) that she brought with to one of the last sessions:

“I have come to realise that life is unpredictable that no matter the age, race or place you come from. One way or another as a human being you have to pass through trials and tribulation its only normal though not acceptable and though it takes time to understand. The bottom line is life its not a problem fire zone. Just because of problems your life should be on hold for when one door closes another opens.

I’ve also come to realise that some pains and heartaches we suffer are brought upon us by our own actions taken and some by circumstances and some suffer because of other people’s mistakes. In all this I’ve realised that there are 2 ways 1) to sit and mourn and waste away and 2) to get up and deal with it.

I believe that when one door of life shuts another one opens. Use those problems as an opportunity to try something new. Once a wise man said “the darkest hour is nearer dawn.” For me it says when things are tough it is then that I should not give up for tough times never last but tough people do.
I also believe that nothing is by any chance an accident, things happen for a reason. There is a Bible verse which say a person and his tribulation is like a gold which need to be refined by fire so that the genuine and precious gold is left. So when the person stood the test of time he become stronger, wiser and considerate. He or she teaches others by his or her own life experiences.

So I am thankful for what I went through it made me stronger, wiser and channelled me to look at life in a different way. It made me want to work harder to make all my dreams come true, to fear God, to love unconditionally for a person lives one. For no one has a clue of what to morrow will be like or what life will through or have in store for us.

I have learned to live like it’s my last to strengthen feeble hands, to encourage the broken for beyond the grave there is no more a chance to say I forgive, I love you, let me do this, let me do that.

I like each day as it come. I accept everything either it be joy, either it be heartache. Life is too short to hold on to anger and hate for the things they end up destroying you as a person. My hand is too tired to write but a lot I’ll tell some other time.

I live like there is no tomorrow. My yesterdays does not stop me to wanna try again, to wanna achieve, to wanna dream for tomorrow.”

5.5 Summary

In this chapter various therapeutic techniques that can be used by educational psychologist, taken from the literature were implemented with a client suffering from post-traumatic stress. The techniques may be adapted to be in line with the client’s needs and the process of therapy itself. The techniques in this study were varied for purposes of the study.
Chapter 6

Findings, limitations and recommendations

6.1 Introduction

Post-traumatic stress impacts negatively on the functioning of students both academically and socially. A look at some of the reports and the literature study showed that students at the technikon experience post-traumatic stress resulting from, *inter alia*, the following:

- Rape
- Physical abuse
- Trauma resulting from accidents, violent crime and disasters

In the previous chapter various intervention techniques were implemented with the subject. The psycho-educational techniques that were used in this process were described and the outcome of therapy discussed.

The aim of this study was to explore the use of psycho-educational intervention techniques in assisting a student who suffers from post-traumatic stress. In order to realise the goal of this study, the researcher 1) undertook a literature study regarding post-traumatic stress, 2) undertook a literature regarding intervention techniques for post-traumatic stress, 3) identified suitable psycho-educational intervention techniques to use for students at Technikon Pretoria who suffer from post-traumatic stress and 4) empirically studied psycho-educational intervention techniques with a student at the technikon presenting with post-traumatic stress.

The findings of this study showed that there are a variety of techniques that can be implemented psycho-educationally for intervention with students suffering from post-traumatic stress. Some of these techniques can be adapted in therapy according to client’s needs and disposition.

The use of a variety of techniques provides deeper exploration of the client’s problem and helps the client gain more insight into his or her situation. What is not achieved using one technique, may be achieved using another. The techniques complement one another.
6.2 Limitations of the study

The following are limitations found in this study:

- The study was of a limited scope and so there was limited exploration of the problem of study. It was not possible to study a wide range of events that lead to students’ trauma at the technikon. The findings were limited to one subject participating in the study. A larger sample would have allowed for further investigation into the nature of students’ stressors and their traumatic experiences.

- The use of one subject in the research implies that the findings cannot be generalised to all technikon students. The subject was selected on the basis of convenience as an available client for the purposes of the study and was not selected from a representative students’ population.

- It was not possible to evaluate the effectiveness of the psycho-educational therapeutic techniques that were implemented in therapy by the researcher since there was no means of specific feedback or evaluation, except Nontombi’s feedback.

6.3 Recommendations for further study

- An evaluation or feedback by the client on the process of therapy would help shed more light on the outcome of therapy and effectiveness of the psycho-educational techniques that were implemented in therapy. Research can be done to develop a more structured evaluation of the effectiveness of the psycho-educational techniques that were implemented during therapy. At this stage the researcher can only rely on feedback by the client.

- A follow up study with a larger sample drawn from a representative population at the technikon would provide extensive exploration of the problem and yield more results. From the literature review it shows clearly that the incidence of post-traumatic stress as a result of traumatic events and situations experienced by students is growing at an alarming rate.
• An investigation into the types of traumatic events, what they are, when and where they are experienced would help shed light on the preventive measures that can be implemented and other intervention strategies that can be put in place.

6.4 Conclusion

There are various techniques that can be used psycho-educationally in intervention with students suffering from post-traumatic stress. Some of the techniques were implemented in this study. Although there was no structured evaluation of the process, the client’s feedback indicates that the intervention was effective.
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