

Responsive Integrative Treatment of Clients with PTSD and Trauma-Related Disorders: An Expanded Evidence-Based Model

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In this article a practitioner oriented review of the literature on the treatment of post-traumatic stress disorder is used to construct a phase-based model that can serve as a basis for case formulation and treatment planning. Treatments shown to be efficacious in randomized controlled trials are listed and two discourses about them are contrasted. One calls for therapists to implement treatments scrupulously according to the manual, the other calls for flexibility and responsiveness to contextual understanding of the situation and personality of individual clients. Evidence for the centrality of the principles of this latter discourse for professional practice is summarized from work on case formulation, standards for therapist competence, and the concept of evidence-based practice. This provides the foundation for a model for treatment of PTSD, both simple and complex, that has five levels which represent increasing degrees of depth of clinical work. In accordance with the phased approach, conditions at one level need to be satisfied before proceeding to work on a deeper level. At each level specific areas of clinical focus are highlighted including risk management (at level 1), building the therapeutic alliance (at level 2) and trauma-focused work (at level 3). The model serves as a broad structured summary of accumulated clinical knowledge about PTSD and its treatment that provides an evidence-based foundation for assessment and treatment planning.

Keywords: case formulation, cognitive behaviour therapy, evidence based practice, posttraumatic stress disorder, psychotherapy integration, trauma-focused therapy

Despite the wealth of published research evaluating a wide range of psychological interventions for clients with PTSD and other disorders consequent on experiencing traumatic events, conflicting messages from competing discourses often leave practitioners and health care administrators confused about how to provide appropriate treatment. In this article, a practitioner oriented literature review provides a basis for constructing a model that offers a broad framework within which to formulate cases of PTSD. It expands an earlier model (Edwards, 2009) whose aim was to cut through polarizing debates about treatment brands and provide therapists and supervisors with a pragmatic evidence-based guide with respect to decisions on timing and sequencing interventions. Based on a long tradition of phased approaches, the model addresses both simple PTSD, as defined in the ICD-10 (WHO, 1992) and DSM-IV-TR (American Psychiatric Association, 2000) and complex PTSD which is not formally recognized in these diagnostic systems though authoritatively discussed in the literature (Chu, 2011; Courtois & Ford, 2009; Grey, 2009; Herman, 1995; Lee, 2006).

Complex PTSD, also referred to as “treatment resistant PTSD” (Jackson, Nissenon & Cloitre, 2010, p. 86), does not respond to brief trauma-focused treatments. There is typically a history of repeated trauma, for example, sexual abuse during childhood, or a prolonged abusive situation such as being taken hostage and incarcerated (Herman, 1995), or trauma in the context of a disturbed pattern of attachment which often presents as borderline personality disorder (BPD). Brown, 2009; Chu, 2011). The term Type II trauma is also used to refer to cases where treatment of single trauma is complicated by personality factors (Lee, 2006).

Empirical Support for Psychological Treatments for Clients with PTSD

Research using randomized controlled trials (RCTs) has provided evidence for the effectiveness of a large number of treatments for clients with PTSD. These include various forms of trauma-focused cognitive-behaviour therapy (TF-CBT): Foa’s Prolonged Imaginal Exposure (PIE) (Foa et al., 2005); several CBT packages evaluated by Bryant, Sackville, Dang, Moulds, and Guthrie (1999) and Bryant et al., (2008) including one with a hypnotic induction (Bryant et al., 2006); Cognitive processing therapy (CPT) (Monson et al., 2006, Resick, Nishith, Astin, Weaver, & Feuer, 2002; Resick, Williams, Suvak, Monson, & Gradus, 2012); Ehlers and Clark’s Cognitive Therapy (ECCT) (Ehlers, Clark, Hackmann, McManus, & Fennell, 2005); Kubany et al.’s (2004) Cognitive trauma therapy for battered women (CTT-BW); Levitt and Cloitre’s (2005) STAIR/MPE (Skills Training in Affective and Interpersonal Regulation plus Modified Prolonged Exposure) for survivors of child abuse; and Narrative exposure therapy (NET) applied to work with refugees (Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004; Ruf et al., 2010), which, despite its name, is a form of TF-CBT based on similar principles to ECCT (Mueller, 2009).

Other efficacious treatments that do not brand themselves as forms of TF-CBT have in common a focus on experiential engagement with the trauma memory. In part because of the way it has been promoted, Shapiro’s Eye Movement Desensitisation and Reprocessing (EMDR) has attracted scepticism from leading researchers (Herbert et al., 2000). Though often contrasted with CBT, the treatment protocol overlaps considerably with TF-CBT and Seidler and Wagner (2006) found no difference between the two in efficacy and no conclusive evidence that the

eye-movements, that are EMDR's distinctive feature, made a detectable contribution to outcome. Gersons, Carlier, Lambert, and van der Kolk's (2000) Brief Eclectic Psychotherapy (BEP) combines CBT and psychodynamic principles, but the "psychodynamic" aspect mainly refers to engaging with the client's personal meaning system, a central feature of cognitively oriented treatments. Barabasz, Barabasz, and Watkins' (2011) Ego-state therapy evokes intense re-experiencing of the trauma, and emotionally engaged re-experiencing is also central to Paivio, Jarry, Chagigiorgis, Hall, and Ralston's (2010) Emotion Focused Therapy for Trauma (EFTT) which is specifically directed at survivors of child sexual abuse. Finally, Bradshaw, Cook, and McDonald's (2011) Observed and Experiential Integration (OEI) uses a range of experiential techniques as well as EMDR to heighten engagement with the trauma memory.

From Empirically Supported Treatments to Evidence-Based Practice

The concept of empirically supported treatments (ESTs) was intended to provide a scientific foundation for treatment selection on the basis of the results of RCTs (Chambless & Hollon, 1998). In line with this, several professional organizations offer guidelines about treatments for clients with PTSD that are best supported by RCT evidence. Forbes et al. (2010) noted that all guidelines recognized TF-CBT as the first line of treatment and cautioned against the use of single session psychological debriefing. Most recommended medication as the second line where TF-CBT had failed or was not available or acceptable. However the American Psychiatric Association recommended medication as the first line, less based on evidence than on practical convenience and protection of professional turf, because "most physicians (to whom these guidelines are directed) do not practice cognitive-behavioral therapy" (p. 550). Forbes et al. (2010, p. 551), after reviewing the guidelines, switch from an EST to a practitioner-oriented discourse. Clinicians have to make "decisions around the intricacies of implementation," they observe. Intervention "is embedded in broader clinical care that includes ... building a therapeutic alliance, comprehensive assessment, case formulation, and treatment planning" which means that "it is unrealistic to assume that every aspect of care will be guided by Level I empirical data [i.e. results of RCTs]."

Scientific Evaluation of Treatments and the Centrality of Clinician Responsiveness

This discourse shift reflects the conflict between the EST approach and the realities of clinical practice. The emphasis on RCTs has contributed to a chronic divide between researchers and practitioners, with the former feeling entitled to prescribe to practitioners on the basis of the results of RCTs, in a manner that suggests that treatments can be applied inflexibly (rather like a course of medication), while practitioners point to the need for responsiveness to features of the client's personality and context. Several authors have suggested that many practitioners, feeling restricted by institutional demands to follow manualized treatments, resent the implication that they are not expected to think for themselves but must follow the dictates of an approach to evidence that has been widely criticized (Maxwell, 2008; Miller & Miller, 2005; Nel, 2012). The result is that they take little interest in the results of RCTs (Dattilio, Edwards, & Fishman, 2010) or treat manuals as generic templates that need to be contextually adapted.

Such an attitude cannot be dismissed as "unscientific." Rather the problem is the research methods used to determine what are to be considered ESTs. Krause and Lutz (2009, p. 76) argue that research methods need to be practitioner oriented as it is "the therapist's professional responsibility to ably and intelligently manage the process of psychotherapy." They point out that even in an RCT where researchers attempt to control the way treatment is delivered, no two clients receive the same treatment in the way that two individuals can receive an identical course of medication. This has implications for interpreting statistical analyses which are predicated on the assumption that all participants in an experimental group are treated in the same way. There is also a need for patient-centred research that provides results that contribute to "respect for and responsiveness to individual patient preferences, needs, and values ... [and] help ensure that patient values and circumstances guide clinical decisions" (Helfand, Berg, Flum, Gabriel, & Normand, 2012, p. 14).

"Barriers to the dissemination of ESTs are not the result of sophistry, but a rational reaction to an interpretation of the evidence," argue Wampold, Imel, and Miller (2009, p. 144). Wolfe (2012) uses an imagined chair dialogue to capture the values and perspectives of the two competing views and the manner in which a rapprochement is emerging. This highlights the impracticality of a strict EST approach and the impact of several discourses within clinical psychology that emphasize the centrality of clinician responsiveness. These will be reviewed below.

Case Formulation Implies Responsiveness

Responsiveness is central to an idiographic approach to treatment planning where each case is individually formulated and treatment decisions are based on a "hypothesis about the causes, precipitants and maintaining influences of a person's psychological, interpersonal and behavioural problems" (Eells, 2007, p. 4). This approach was well established in medicine when, during the nineteenth century, the burgeoning field of psychological intervention gave birth to the terms "psychotherapeia" by the English surgeon Dendy (1853), and (as cited by Shamdassani, 2005) "psychotherapeutics" by Daniel Hack Tuke in 1872, and "psychotherapy" by Bernheim, in 1891.

Formulations need to have "treatment utility" (Tarrier, 2006, p. 1) in that they guide the choice of interventions and are testable and subject to revision where treatment based on the formulation is not working (Edwards & Young, 2013). Kuyken, Padesky and Dudley (2009) recommend that formulation be carried out in collaboration with clients so that treatment proceeds from a rationale that both therapist and client share. Case formulation has always been central to CBT (e.g., Kuyken et al., 2009; Tarrier, 2006). The British Association of Cognitive and Behavioural Psychotherapies makes a distinction between manualized CBT and cognitive behavioural psychotherapy. The term "psychotherapy" is not used for self-help, assisted self-help, and the application of circumscribed manualized interventions for specific problems for example by nurses or other health workers (usually supervised by a psychologist). "Psychotherapy" is reserved for treatments guided by case formulation where clients

... require expert interventions The relationship between the therapist and the client is paramount and expert skills are required to engage the client in a therapeutic alliance. Once this is established therapy can proceed collaboratively through assessment, formulation and intervention. . . . [Therapists] would evaluate the efficacy of any

intervention and change tack if necessary (Grazebrook & Garland, 2005).

These broad principles also apply to case formulation in a range of psychodynamic and integrative therapies (Eells, 2007). They address the complexity involved in the “translation of theory into therapy” (Tarrier, 2006, p. 4) and the fact that, as Norcross and Lambert (2011, p. 10) put it “psychotherapists endeavour to create a new therapy for each patient.” They are incompatible with the “ballistic” (Stiles, Honos-Webb, & Surko, 1998, p. 440) approach of the EST model.

Competencies and Metacompetencies are Intrinsic to Practice

Responsiveness is also central to another growing discourse aimed at defining psychologists’ areas of competency. This addresses two problems: diversity of theory and practice undermines psychologists’ status with respect to other professionals who cannot count on knowing exactly what expertise individual psychologists have; also, because licensing bodies differ in the range of competencies they require, psychologists moving from one jurisdiction to another usually have to undertake re-examination or retraining (in North America, each US state and Canadian province has a separate licensing body). Initiatives to address this by establishing nationally and internationally recognized core competencies for psychologists have been ongoing in North America and the United Kingdom. Competencies being discussed include broad characteristics of personal maturity and flexibility (Fouad, et al., 2009). For example, among the baseline competencies for trainees, before they work directly with clients are “Personality characteristics, intellectual and personal skills” in the interpersonal, cognitive, affective, expressive and reflective domains that include:

the ability to be open to feedback ... an attitude of intellectual curiosity and flexibility, and abilities in problem-solving, critical thinking, and organized reasoning ... the ability to tolerate affect, to tolerate and understand interpersonal conflict, and to tolerate ambiguity and uncertainty ... openness to new ideas, honesty and integrity and the valuing of ethical behavior, and personal courage... [and] the ability to examine and consider one’s own motives, attitudes and behaviors and one’s effect on others (Hatcher & Lassiter, 2007, p. 60).

In the UK, Roth and Pilling (2008) distinguish between competencies¹ and metacompetencies. “Competencies” refer to specific skills like the ability to identify “patterns of avoidance and/or safety behaviours associated with the phobia ... [and] adaptive and maladaptive coping skills employed by the client to manage their phobia” (University College London, n.d.-b). Metacompetencies underlie the appropriate and flexible application of competencies. Examples are: the “ability to detect and respond to implicit feedback which indicates that the client has concerns about important aspects of the therapy;” the ability to develop “a comprehensive formulation that takes into account all relevant aspects of the client’s presentation” and work from it “in a manner which is flexible and appropriately adapted . . . which ensures that the intervention is not reductionist or simplistic” (University College London, n.d.-a). Using an information processing model, Bennett-Levy, McManus, Westling and Fennell (2009, p. 573) show how this reflects the realities of the cognitive systems that are the basis for professional learning. Metacompetencies depend on learning in the reflective cognitive system which allows therapists to learn from experience and “acquire a progressively refined set of ‘when-then’ rules,

procedures and skills.” This allows for responsive application of information and theoretical frameworks in the declarative system (acquired through lectures and reading) as well as of applied skills in the procedural system (learned through practical experience).

Evidence-Based Practice is Flexible and Responsive

The centrality of clinician integrity and responsiveness is also recognized in the concept of evidence-based practice (EBP). Initially defined within medicine (Sackett, Rosenburg, Gray, Haynes, & Richardson, 1996), EBP was adopted by the American Psychological Association in a policy document that defined it as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (Levant, 2005). EBP recognizes that clinical expertise and adapting treatment to contextual factors calls for skilfulness and flexibility:

manifested in tact, timing, pacing, and framing of interventions; maintaining an effective balance between consistency of interventions and responsiveness to patient feedback; and attention to acknowledged and unacknowledged meanings, beliefs, and emotions (APA Presidential task force on EBP, 2006, p. 276).

Based on this, the National Institute for Clinical Excellence (2005, p. 9) in the UK argues that “Guidelines are not a substitute for professional knowledge and clinical judgment... and [do] not override the responsibility of healthcare professionals to make appropriate decisions in the circumstances of the individual patient.” Evidence that this contributes to the effectiveness of psychotherapy (Horvath, Del Re, Fluckiger, & Symonds, 2011; Norcross & Lambert, 2011) means that it is central to EBP.

EBP also recognizes multiple sources of research evidence. Where the EST approach relies on multivariate research models and RCTs in particular, EBP also embraces qualitative and case-based research. Resistance to qualitative research has been particularly slow to dissipate in the USA, despite the longstanding work of prominent qualitative researchers there. However, an increasing appreciation of methodological complementarity and the emergence of a mixed methods approach as an alternative research paradigm (Dattilio et al., 2010) is reflected in the American Psychological Association’s three volume *Handbook of Research Methods in Psychology* (Cooper, 2012) which includes several chapters on qualitative methods, the first of which introduces a pragmatic approach to fitting the method to the problem (Pistrang & Barker, 2012). Kazdin (2012) comments that this makes:

a strong statement that qualitative research provides novel information that complements what is learned from the more commonly published studies in the quantitative tradition ... and that the standards of science apply equally well to these different traditions (e.g., use of theory, replicability).

An Expanded Model for Case Formulation and Treatment Planning for Clients with PTSD

This emphasis on responsiveness means that the challenge for therapists treating clients with PTSD is not in choosing between treatment brands, that often offer clinicians limited insight into “what specifically promotes therapeutic change” and may even encourage “faulty assumptions about why patients got better” (Ablon, Levy, & Katzenstein, 2006, p. 229). It is rather in selecting and sequencing interventions in a way that is responsive to the changing needs of clients as they cope in the aftermath of trauma, often in complex and challenging life contexts.

The earlier model (Edwards, 2009, 2010) drew on a case series examining the application of ECCT in South Africa. The revised model, presented in Figure 1, draws on additional South African cases (Fox, 2010; Laas, 2009; Padmanabhanunni, 2010; Sokutu, 2010). These cases were all adults and adolescents – the youngest was 15 (Payne & Edwards, 2009). However the principles apply equally to work with children since an adaptation for children of ECCT has proved effective (Smith et al., 2007; Smith, Perrin, Yule, & Clark, 2010). Goodyear-Brown (2010) describes a similar integrative approach using play therapy for trauma processing, and the model fits the treatment of a 12-year-old boy in England (Raby & Edwards, 2011).

The expanded model can guide therapists in answering the question “How can I draw on the comprehensive framework of accumulated knowledge about treating clients with PTSD and adapt it to the needs of this client in this session?” It organizes interventions on 5 levels, representing a hierarchy of priorities in accordance with a phased approach to treatment (Chu, 2011; Courtois, Ford & Cloitre, 2009; Herman, 1992; Jackson et al., 2010; Steele & van der Hart, 2009). Initial focus needs to be on the earlier levels and only when these have been taken care of is it appropriate to move to a later level.

Level 1: Crisis Intervention and Stabilization

This level reflects the consensus about the need for an initial focus on safety, prioritizing the client’s needs for stabilization and restoring a basic level of everyday functioning (Chu, 2011; Hobfoll et al., 2007). It is not appropriate to move to the next level if clients do not have food and shelter, or are living in unsafe circumstances and priority needs to be given to addressing these conditions (*CF 1*). *Risk assessment and management (CF 2)*, a standard part of psychological assessment (Edwards & Young, 2013), also need to be prioritized. Where clients are suicidal (or even homicidal) or at risk for harmful abuse of substances, prompt action may need to be taken to prevent serious consequences (Steil, Dyer, Priebe, Kleindienst, & Bohus, 2011). *Resource building* refers to directive interventions that raise awareness, reduce the intensity of distress, enhance impulse control, target avoidances, develop self-protection, increase social support and the quality of social relationships, and promote rational problem solving. Resource building features at Levels 1, 2 and 4. At Level 1 (*CF3*) the aim is to support the establishment of safety and de-escalate emotions (such as panic attacks) and behaviours (such as extreme withdrawal) that are likely to intensify hopelessness and interfere with engagement with treatment. Thus behavioural activation (Jakupcak, Wagner, Paulson, Varra, & McFall, 2010; Wagner, Zatzick, Ghesquiere, & Jurkovich, 2007) and anxiety management (Falsetti, Resnick, Davis, & Gallagher, 2001; Teng et al., 2008) may be indicated.

Level 2: Establish Necessary Conditions

Level 2 defines conditions that need to be established before trauma-focused work (level 3) can proceed. *CF 4 Building the therapeutic alliance* is an essential foundation for working together on processing memories of traumatic events. Horvath et al. (2011, p. 28) summarize Bordin’s influential account of this in terms of “agreements on the therapeutic goals, consensus on the tasks that make up therapy, and a bond between the client and therapist,” observing that the “emergent quality of partnership and mutual collaboration between therapist and client” can develop more or less slowly. However, there is an extensive literature on the challenges posed by clients with personality dis-

orders (Millon & Grossman, 2007a, 2007b) and work with, for example, avoidant clients (Muller, 2010) calls for a very different approach than work with clients who are exceptionally anxious, mistrustful, dependent, or anticipating abandonment, and especially where there is a history of disorganized attachment. Where high levels of shame and self-criticism make it hard for clients to accept care (Lee, 2010), therapists will need to spend time building a relationship within which clients feel respected and safe. Greenberg and Goldman (2007, p. 387) suggest that “sometimes for very fragile clients ... the establishment of a validating relationship itself ... is the goal.” Therapists must be prepared to accept clients’ volatility and inconsistency and help them clarify what is happening in the relationship with the therapist (Chu, 2011; Davies & Frawley, 1999). In such cases, there may need to be an emphasis on “treatment designed to remap attachment representations ... foster self-development ... and facilitate affective development (Brown, 2009, p. 138). Attention to the relationship is an ongoing process. Even when work has progressed to Level 3 or 4, therapists need to be alert for fluctuations and ruptures and attend to them to prevent a breakdown in the therapy (Safran, Muran, Samstag, & Winston, 2005). This is as true for CBT approaches as it is to relational/psychodynamic ones. For example, specific CBT metacompetences include the ability “to discuss and resolve any disruptions to collaboration,” and “to balance the need to structure sessions against the need to allow the client to make choices and take responsibility” (University College London, n.d.-a).

CF 5 Establishing motivation. Collaboration depends on clients being motivated to engage in treatment. But this cannot be taken for granted (Barrett et al., 2008). Clients need to understand the nature of their problem in psychological terms and a rationale for how treatment can be expected to address it. This can emerge naturally as the therapist conducts an effective assessment, shares a meaningful case formulation and responds with empathy and care to the client’s concerns. However, clients who believe that facing the trauma memory is not in their interests, and that “it is better to put the past behind you” (Slater, 2003) may need a great deal of careful psychoeducation. Education about what can be expected in the therapy process can be valuable, including reading about others’ experiences (Barrett et al., 2008). Client motivation can be assessed on a dimension that has lack of awareness of any need for change at one end, and readiness to work actively for change at the other (Prochaska & Norcross, 2001). Where motivation is insufficient, motivational enhancement interventions are indicated (Barrett et al., 2008; Hayes, Villatte, Levin & Hildebrandt, 2011).

CF 6 Resource building (2) has the goal of establishing conditions supportive of the trauma-focused work at Level 3. Attention should be given to enhancing social support (Markowitz, Milrod, Bleiberg, & Marshall, 2009; Tarrier & Humphries, 2003). Clients living in situations of ongoing abuse will need guidance in taking steps to end this before trauma-focused work can begin (Kubany et al., 2004). Trauma-focused work may leave clients exhausted and emotionally vulnerable. Therapists will need to be concerned about the kind of environment to which they will return after sessions. Some avoidant clients may be able to tolerate going back home alone (e.g., Karpelowsky & Edwards, 2005) although this increases risk of depressive withdrawal. Sessions with one or more family members or significant others in which the treatment and its rationale are explained can provide them with guidance in supporting clients during treatment (e. g., Raby & Edwards, 2011). Greenman and Johnson (2012) even describe treating PTSD within the frame-

Level 1	Crisis intervention		
	CF 1 - Ensure basic needs are met Shelter, food, transport, safety	CF 2 - Risk assessment and intervention Suicidal or homicidal ideation/attempts/ threats; drug abuse	CF 3 - Resource building (1): to address withdrawal, isolation, panic attacks and other immediate obstacles to domestic/occupational functioning
Level 2	Establish necessary conditions		
	CF 4 - Build therapeutic alliance Build trust; establish credibility; develop shared understanding of tasks and goals	CF 5 - Build motivation Provide psychoeducation, share case formulation and implications for treatment; motivational enhancement	CF 6 - Resource building (2): social support, emotional awareness/tolerance/regulation, impulse control, problem-solving, assertiveness/self protection
Level 3	Promote processing of trauma memory and integration into autobiographical memory		
	CF 7 - Work with triggers Bring to awareness and monitor, identify memory being triggered, "here and now vs there and then" discrimination	CF 8 - Promote experiential engagement with trauma memory Reliving, narrative, expressive methods (drawing etc.), site visit	CF 9 - Modify problematic appraisals (peritraumatic and posttraumatic) associated with full range of distressing emotions (fear, anger, shame, guilt, disgust, helplessness, despair etc.)
Level 4	Address vulnerabilities, consolidate resources		
	CF 10 - Address pre-existing vulnerabilities that impact on treatment Rescript memories that are part of maladaptive schemas related to of earlier distressing events/ traumas, disturbed attachment history, etc		CF 11 - Resource building (3) Enhance and extend coping and competence in areas listed under CF 6
Level 5	Reclaiming one's life / rebuilding a new life post trauma		
	CF 12 - Blueprint for a new life Encourage clients to think explicitly about plans, activities (occupational, recreational), relationships post trauma.	→	Work at level 2 to 4 ↓ Identity change → Promote posttraumatic growth

Figure 1. Responsive treatment for PTSD: An expanded evidence-based model

work of emotion-focused therapy (EFT) for couples. Third, therapists should evaluate whether additional work on mindfulness, emotional awareness, tolerance of distress, assertiveness, challenging negative assumptions and beliefs and building a basis for self-esteem is needed to provide the foundation for trauma-focused work. Structured programs incorporating such interventions for sexual abuse survivors are described by Levitt and Cloitre (2005) and by Steil et al. (2011, drawing on a dialectical behaviour therapy approach).

Level 3: Promote Processing of Trauma Memory and Integration into Autobiographical Memory

All guidelines recognize that treatment effectiveness calls for trauma-focused work involving engagement with memories of the traumatic event(s) (Forbes et al., 2010). The rationale for this, based on a contemporary cognitive model of autobiographical memory, is the basis of ECCT (Clark & Ehlers, 2005; Ehlers & Clark, 2000; Ehlers, Hackmann, & Michael, 2004). When ev-

eryday events become incorporated into this ever evolving structure that underlies an individual's sense of identity and continuity, they can be recalled voluntarily, but do not typically get triggered involuntarily. Traumatic events fail to get assimilated into autobiographical memory because the normal processes by which memories are usually assimilated are disrupted. Intense emotions evoked during the trauma interfere with normal information processing, and attempts to reflect on what happened are aborted because they evoke distressing emotions that may cover the range of human distress, including fear, anger, guilt, shame, betrayal, disappointment and disgust (for a fuller treatment see Edwards, 2005). Unassimilated memories give rise to the distinctive features of PTSD, remaining vulnerable to involuntarily triggering by a range of sensory and semantic cues, resulting in re-experiencing symptoms in the form of flashbacks and nightmares. This maintains a sense of unreality: clients may continue to say, "I can't believe this really happened." Yet there is a paradox, because it is as if the trauma is

ever present, ever happening in the now. This in turn generates a sense of current danger, associated chronic hypervigilance and distortion of appraisals of risk.

Level 3 consists of the strategies, central to ECCT, for promoting the integration of the trauma memory. *CF7 Identifying and working with triggers*, may even be begun as part of *Resource building (1)* as a strategy for managing panic attacks. For many clients, the apparent arbitrariness and mysteriousness of the triggering process makes it all the more disorienting. Therapists can help them identify the cues that trigger flashbacks and to see the flashbacks for what they are, vivid replays of aspects of the trauma memory. As clients develop distance and mindfulness, the process of triggering becomes less disorienting. Triggering also confronts them with the fact that the memory has not yet been integrated and this can be used to build motivation for the next task.

CF 8 Experiential engagement with the trauma memory can be achieved by a variety of methods including imaginal reliving, systematically telling the story as a narrative, and returning to the site of the trauma and attempting to reconstruct what happened. This is where trauma treatments appear to differ, some emphasizing reliving, others the construction of a narrative, others specific techniques believed to aid the process such as the eye-movements in EMDR or Eye Movement Integration Therapy (Beaulieu, 2003), and others specific expressive methods such as drawing or psychodrama (Bannister, 1997; Kellerman & Hudgins, 2000). However, all these have in common that they promote reprocessing of the trauma memory and expressive methods are regularly integrated into many treatment models with adults as well as children (Butler & Holmes, 2009; Goodyear-Brown, 2010; Raby & Edwards, 2011). It is important to be aware of individual differences between clients in their capacity to access the traumatic material. Some respond rapidly to intense reliving, a gentler construction of the narrative may suit others, and others may respond better to expressive drawing. Whatever the medium, therapists need to assess the degree of experiential engagement with the memory. Too intense evocation of the memory can result in clients becoming overwhelmed and swept away in re-experiencing (called revivification by Phillips and Frederick, 1995, or, misleadingly, dissociation). This is not therapeutic since incorporating material into autobiographical memory requires the activation of working memory and the capacity for distance and reflection. In such cases, therapists need to help clients slow down, perhaps by having them write the story, tell it with eyes open or using imagery in which the client sees the events on a movie screen, which can be made larger or smaller as a way of managing emotional intensity.

By contrast, clients who recall events in some detail but remain emotionally disconnected need to be guided by experiential techniques to make an affective connection. This is critical because any part of the memory that remains dissociated can give rise to re-experiencing symptoms in the future. Although many parts of the memory may be easily retrieved, those associated with the most intense affect may be difficult to access and clinicians may need to be persistent in encouraging clients to focus on gaps in the memory or emotions and body sensations that are disconnected from episodic memory. OEI (Bradshaw et al., 2011) includes a particularly wide range of experiential techniques for addressing this. In difficult cases, a clinician's ability to draw on methods that heighten emotional experiencing may determine whether dissociated aspects of the memory are adequately recovered and processed. So it is valuable to have a

range of techniques to draw on and responsiveness means finding the most helpful method(s) for each client.

CF 8 interventions are not included in several effective treatments designed for particularly vulnerable client groups. These include group schema therapy for BPD (Farrell, Shaw & Reiss, 2012), CBT for clients with severe mental illness (Mueser et al., 2008), "Seeking safety" treatment for those with PTSD and substance dependence (Najavits, Gallop & Weiss, 2006) and interpersonal therapy (Markowitz et al., 2009). However, if the dissociated memory is not addressed, clients will remain vulnerable to flashbacks, nightmares and other PTSD symptoms. For this reason, phased treatment programs place emphasis on Level 2 work to provide a foundation for trauma processing (Levitt & Cloitre, 2005; Jackson et al., 2010; Steil et al., 2011). Similarly, in individual schema therapy, one of the most efficacious treatments for BPD (Giesen-Bloo et al., 2006; Nadort et al., 2009), work with traumatic memories, usually of childhood abuse, plays a central role (van Vreeswijk, Broersen, & Nadort, 2012; Young, Klosko, & Weishaar, 2003). However this is preceded by extended work with psychoeducation, motivation, shared case formulation, emotional awareness training and relationship building with therapists explicitly adopting a limited reparenting stance towards the client. Initial engagement with trauma memories is carefully managed and there is an emphasis on rescripting them including the incorporation of protective imagery (Arntz, 2012).

It is important to *Target problematic appraisals (CF 9)* associated with the various episodes of the trauma memory (peri-traumatic) and its aftermath (post-traumatic). These will be associated with a wide range of problematic emotions and although some may self-correct through the process of re-experiencing the trauma and feeling safe with the therapist, many appraisals and their associated emotions do not automatically remit (Grunert, Weis, Smucker & Christianson, 2007). These need to be identified and addressed with focused work using appropriate techniques. This is particularly the case with guilt and shame (Lee, 2010; Lee, Scragg & Turner, 2001; Smith, 2006). Peritraumatic appraisals may need to be addressed by cognitive restructuring within reliving to ensure that corrective information reaches the part of the cognitive system where the trauma related appraisal is encoded (Grey, McManus, Hackmann, Clark, & Ehlers, 2009; Grey, Young & Holmes, 2002). Some appraisals seem incompatible with one's former identity. This is particularly salient when working with combat related PTSD where the sufferer has seen and/or perpetrated terrible acts of killing and maiming and destruction. As Tick (2005, p. 106), puts it, the survivor "has not returned as the same person who left, and asks, 'Why can't I be who I was before?'" Thus working with appraisals involves more than developing a more rational attitude. It can involve deep exploration of one's sense of existential meaning and spiritual questions about one's integrity and place in the greater scheme of things (Kaminer & Eagle, 2010).

Level 4: Address Vulnerabilities and Consolidate Resources

As trauma-focused work proceeds, two categories of additional intervention may be needed. First, it may be necessary to *Address pre-existing vulnerabilities that impact on treatment (CF 11)*. Where re-experiencing symptoms are not limited to the current trauma or problematic personal meanings are embedded in early maladaptive schemas, work will need to address memories of earlier events that were traumatic or important at-

tachment experiences that were disturbed (Lee, 2010; van Vreeswijk et al., 2012; Wild, Hackmann & Clark, 2007; Young et al., 2003). Jackson et al. (2010) help clients identify schema level beliefs at Level 2, and then look for and restructure them when they emerge in the trauma focused work. In some cases these may already have been identified and partially addressed in work on the therapeutic alliance (CF 4). For example, in treating a woman with rape related PTSD, Padmanabhanuni (2010) incorporated rescripting work with early memories of being bullied by her brother and emotionally neglected by her parents. Similarly, Lee describes two cases of PTSD following rape where addressing negative appraisals called for extended work on building new positive self-schemas (Lee, 2006) and addressing attachment based self-loathing and shame (Lee, 2010). Nevertheless, some clients with complex PTSD can process a recent trauma without engaging with earlier traumatic events or attachment disturbances. For example, Padmanabhanuni (2010; Padmanabhanuni & Edwards, 2013) was able to address PTSD following rape in 12 sessions, in a client with a history of family abuse and evident borderline traits, and Grey et al. (2009) describe two cases where symptoms remitted from focus on the current trauma with limited attention to earlier developmental issues including a history of sexual abuse.

CF 11 *Resource building* at this level extends and elaborates interventions at Levels 1 and 2. As work with the trauma memory proceeds, it may be helpful to enhance the client's social support and assertiveness. As clients recover, new problems may come into focus. For example, social anxiety associated with self-consciousness that preceded the trauma may be exacerbated as a result of the trauma related anxiety, and it may be appropriate to address this using standard approaches to social phobia (Wild et al., 2007).

Level 5: Reclaiming One's Life / Rebuilding a New Life Post Trauma

While the process of reclaiming one's life or rebuilding a new life post-trauma may emerge automatically from the trauma-focused work of Level 3, in many cases it is important for the therapist to promote it by encouraging clients to focus on their strengths and develop a *Blueprint for a new life* (CF 12) (Ehlers et al., 2010; Grey et al., 2009). This may go beyond restoring a previous level of functioning by building on challenges to schema level negative beliefs brought into focus by the trauma. Where the traumatic event has occasioned loss or disability, clients need to be supported in coming to terms with these and envisioning a meaningful future in the new life circumstances in which they find themselves (Wild, 2009). Therapy may also result in a second kind of shift: a significant *change in identity*. This has not been numbered as a separate CF because it emerges naturally from reappraisals of deeper beliefs about the self and one's place in the world, that occur within CF 9 (coming to terms with the trauma itself), and from Level 4 interventions that may result in an enhanced sense of agency, improved self-esteem, and greater attachment security than can enhance flexibility in important relationships.

Aspects of this can be conceptualized as posttraumatic growth (PTG) (Calhoun & Tedeschi, 2006). This has five dimensions: a new way of experiencing the world in which priorities are different and there is a greater appreciation of simple things, a greater capacity for human connection, an increased sense of one's own strength through discovering the capacity to cope with extreme adversity, a greater appreciation of life as a source of new opportunities, and a sense of spiritual awakening or

deepening. As clients face the traumatic event and its meanings, incorporating it into autobiographical memory calls for considerable accommodation on the part of the existing structure. The "individual's struggle with the new reality in the aftermath of trauma" (Tedeschi & Calhoun, 2004, p. 5) gives rise to a re-examination of core beliefs about the world that may have been previously unrealistic, idealized and childlike. The kinds of activities that Ehlers et al. (2004) identify as promoting the elaboration of the trauma memory and its incorporation into autobiographical memory are the same as those identified by Calhoun and Tedeschi (2006) as promoting PTG. These include willingness to experience emotions, exploring their meaning, seeking social support with others who can share the experience in a supportive and authentic way, and reflecting on the implications of the experience for assumptions about how the world is (Kaminer & Eagle, 2010, chapter 4).

Clinicians should be aware of the growth trajectories that can lead to PTG, but, as it is not an invariable outcome of working with trauma memories, it is inappropriate to pressure clients to achieve it and it should not be considered a *goal* of treatment (Tedeschi & Calhoun, 2004, p. 15). Furthermore, PTG often only emerges "after many months or even years of internal processing and reflection" (Kaminer & Eagle, 2010, p. 73). However, where appropriate, clinicians can promote the kinds of experiential engagement with the trauma memory and broader reflections on existential issues that are likely to lead to PTG. Finally, PTG is not the same as resilience. People who learn to cope with ongoing continuous trauma by becoming rigid, dictatorial and invested in retaliation may make claims about being strengthened by trauma but what they are describing is defensive coping, not genuine PTG (Hobfoll et al., 2007; Tedeschi, Calhoun, & Cann, 2007).

Discussion: The Model in Practice

The model which integrates insights from cognitive-behavioural, psychodynamic and process/experiential psychotherapy with trauma, can serve as an orienting, permission-giving and guiding framework for clinicians and supervisors who, under pressure to provide rapid structured treatment, may doubt their own metacompetency. Two clinicians who contributed to the South African case series commented on the enabling quality of the original (Edwards, 2009) model. Fox (2010, p. 57) observed that it helped her understand "the cyclic nature of working with trauma ... which meant I needed to shift the clinical focus back to assessing and building material and social support" and then returning to addressing the PTSD "when appropriate." Sokutu (2010, p. 82) commented that it helped her "take cognisance of the fact that the therapeutic process might be slower and take longer due to the complexity of the nature of [the client's] presentation."

The model caters for brief treatment in straightforward cases of PTSD (Boulind & Edwards, 2008; Drake & Edwards, 2012) where the work of Levels 1 and 2 is accomplished during one or two hours of assessment and the Level 3 work takes only a few sessions. It also allows for longer treatments in complex cases, where the work at Levels 1 and 2 may take months with a focus on building emotional awareness self-regulation and addressing damaged attachment schemas. Progress through the model is not necessarily linear. Edwards (2009) cited authors who use the metaphor of a spiral, although that is rather too smooth an image. Clients who have begun trauma-focused work may need to return to Level 1 in the event of a crisis (Fox, 2010; Sokutu, 2010; van der Linde & Edwards, 2013), or to

Level 2 in the event of a rupture in the therapeutic relationship. Where clients fail to progress to trauma-focused work, unresolved obstacles at Levels 1 and 2 can usually be identified (Padmanabhanunni & Edwards, 2012; Swartz, 2007). The model also makes sense of why psychological debriefing has been repeatedly discredited (Forbes et al., 2010). This refers to a single trauma-focused session with an unknown counselor in the immediate aftermath of the trauma. In many cases, the Level 1 condition of establishing stability and the Level 2 conditions of building social support, motivation and a therapeutic alliance will not be established in a single session.

Responsiveness not only refers to being willing to change the formulation from session to session, but includes openness to the client's unfolding experience moment to moment within sessions (Stiles, Honos-Webb & Surko, 1998). Focus on an existing formulation can result in the therapist missing the client's here and now experience and in EFT it is recommended that formulations be "constantly checked with the client [whose] moment to moment processing in the session remain[s] the ultimate guide" (Greenberg & Goldman, 2007, p. 387). This kind of affective focusing is most clearly articulated in EFT but is quite compatible with the style of cognitive therapy described by Hackmann (1997). It provides the means for "identifying and articulating the problematic cognitive-affective processes underlying and generating symptomatic experience" (Greenberg & Goldman, 2007, p. 387). EFT principles, originally developed for the treatment of depression (Watson et al., 2003), have been effectively applied to couples therapy (Johnson, Hunsley, Greenberg, & Schindler, 1999) and complex trauma (Paivio et al., 2010). Experiential methods of deepening access to experience are of particular importance for trauma focused work at CF 8 (Bradshaw et al., 2011), relationship building at CF 4, and schema level work at CF 10. The resulting focus on themes relevant to therapeutic progress provides a basis for collaboration between therapist and client and enhances the effectiveness of treatment (Greenberg, 2004; Greenberg & Goldman, 2007). This kind of clinician responsiveness is increasingly being incorporated into treatment manuals used in efficacy trials, which specify the principles on which decisions about the use of particular interventions are to be based rather than dictating the details session by session (e.g., EFT: Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003; ECCT: Ehlers et al., 2005; schema therapy for BPD: Giesen-Bloo et al., 2006).

The map of the territory offered by the expanded model is more differentiated than that provided by the 2009 model. While it cannot summarize in its entirety the rich research and clinical experience contained in the literature reviewed here, it is grounded in a range of diverse research evidence and incorporates central theoretical understandings of the challenges of treating PTSD. The literature reviewed here shows that the model is an expression of what it means to engage in EBP when working with clients affected by traumatic events.

References

- Ablon, J. S., Levy, R. A., & Katzenstein, T. (2006). Beyond brand names of psychotherapy: Identifying empirically supported change processes. *Psychotherapy: Theory, Research, Practice, Training*, 43(2), 216–231.
- American Psychiatric Association. (2000). *DSM-IV-TR: Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: American Psychiatric Association.
- Arntz, A. (2012). Imagery rescripting as a therapeutic technique: Review of clinical trials, basic studies, and research agenda for personality disorders. *Journal of Experimental Psychopathology*, 3, 189–208.
- Bannister, A. (1997). *The healing drama: Psychodrama and dramatherapy with abused children*. London, England: Free Association Books.
- Barabasz, A. F., Barabasz, M., & Watkins, J. G. (2011). Single-session manualized Ego State Therapy (EST) for combat stress injury, PTSD, and ASD, Part 1: The theory. *International Journal of Clinical and Experimental Hypnosis*, 59, 379–391.
- Barrett, M. S., Chua, W., Crits-Christoph, P., Gibbons, M. B., Casiano, D., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy: Theory, Research, Practice, Training*, 45(2), 247–267.
- Beaulieu, D. (2003). *Eye Movement Integration Therapy: The comprehensive clinical guide*. Bancyfelin, United Kingdom: Crown House.
- Bennett-Levy, J., McManus, F., Westling, B. E., & Fennell, M. (2009). Acquiring and refining CBT skills and competencies: Which training methods are perceived to be most effective? *Behavioural and Cognitive Psychotherapy*, 37, 571–583.
- Boulind, M., & Edwards, D. J. A. (2008). The assessment and treatment of post-abortion syndrome: A systematic case study from Southern Africa. *Journal of Psychology in Africa*, 18(4), 539–548.
- Bradshaw, R. A., Cook, A., & McDonald, M. J. (2011). Observed & Experiential Integration (OEI): Discovery and development of a new set of trauma therapy techniques. *Journal of Psychotherapy Integration*, 21(2), 104–171.
- Brown, D. (2009). Assessment of attachment and abuse history, and adult attachment style. In C. A. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 124–144). New York, NY: Guilford.
- Bryant, R. A., Moulds, M., Nixon, R. D. V., Mastrodomenico, J., Felmingham, K., & Hopwood, S. (2006). Hypnotherapy and cognitive behaviour therapy of acute stress disorder: A 3 year follow up. *Behaviour Research and Therapy*, 44, 1331–1335.
- Bryant, R. A., Moulds, M. L., Guthrie, R. M., Dang, S. T., Mastrodomenico, J., Nixon, R. D. V., . . . Hopwood, S. (2008). A randomized controlled trial of exposure therapy and cognitive restructuring for posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 76, 695–703.
- Bryant, R. A., Sackville, T., Dang, S. T., Moulds, M., & Guthrie, R. (1999). Treating acute stress disorder: An evaluation of cognitive behavior therapy and supportive counseling techniques. *American Journal of Psychiatry*, 156(11), 1780–1786.
- Butler, G., & Holmes, E. A. (2009). Imagery and the self following childhood trauma: Observations concerning the use of drawings and external images. In L. Stopa (Ed.), *Imagery and the threatened self: Perspectives on mental imagery and the self in cognitive therapy* (pp. 166–180). Hove, United Kingdom: Routledge.

- Calhoun, L. G., & Tedeschi, R. G. (Eds.). (2006). *Handbook of posttraumatic growth: Research and practice*. Mahwah, NJ: Lawrence Erlbaum.
- Chambless, D., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*(1), 7–18.
- Chu, J. A. (2011). *Rebuilding shattered lives: Treating complex PTSD and dissociative disorders*. Hoboken, NJ: Wiley.
- Clark, D. M., & Ehlers, A. (2005). Posttraumatic stress disorder: From cognitive theory to therapy. In R. L. Leahy (Ed.), *Contemporary cognitive therapy* (pp. 141–160). New York, NY: Guilford.
- Cooper, H. (Ed.). (2012). *APA handbook of research methods in psychology, Volume 1-3*. Washington, DC: American Psychological Association.
- Courtois, C. A., & Ford, J. D. (2009). *Treating complex traumatic stress disorders: An evidence-based guide*. New York, NY: Guilford.
- Courtois, C. A., Ford, J. D., & Cloitre, M. (2009). Best practices in psychotherapy for adults. In C. A. Courtois, & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 82–103). New York, NY: Guilford.
- Dattilio, F. M., Edwards, D. J. A., & Fishman, D. B. (2010). Case studies within a mixed methods paradigm: Towards a resolution of the alienation between researcher and practitioner in psychotherapy research. *Psychotherapy: Theory, Research, Practice & Training, 47*, 427–441.
- Davies, J. M., & Frawley, M. G. (1999). Dissociative processes and transference-countertransference paradigms in the psychoanalytically oriented treatment of adult survivors of sexual abuse. In L. Aron (Ed.), *Relational psychoanalysis: The emergence of a tradition* (pp. 269–304). Hillsdale, NJ: Analytic Press.
- Dendy, W. C. (1853). *Psyche: A discourse on the birth and pilgrimage of thought*. London, England: Longman, Brown, Green and Longmans. Retrieved from <http://books.google.co.za/books?id=UeYtAAAAAYAAJ>
- Drake, B., & Edwards, D. J. A. (2012). Treatment of posttraumatic stress disorder following an armed robbery: A case study testing of the transportability of trauma-focused cognitive-behavioural therapy to Urban Africans. *Journal of Psychology in Africa, 22*(3), 361–370.
- Edwards, D. J. A. (2005). Treating PTSD in South African contexts: A theoretical framework and model for the development of evidence-based practice. *Journal of Psychology in Africa, 15*(2), 209–220.
- Edwards, D. J. A. (2009). Responsive treatment of posttraumatic stress disorder in South Africa: An integrative model grounded in case-based research. *Journal of Psychology in Africa, 19*, 189–198.
- Edwards, D. J. A. (2010). Using systematic case studies to study therapist responsiveness: An examination of a case series of PTSD treatments. *Pragmatic Case Studies in Psychotherapy [Online], 6*(4), Article 3, 255–275. Downloaded 1st June 2012 from <http://pcsp.libraries.rutgers.edu/index.php/pcsp/article/view/1047/2459>.
- Edwards, D. J. A., & Young, C. (2013). Assessment in routine clinical and counselling settings. In S. Laher & K. Cockroft (Eds.), *Psychological assessment in South Africa: Research and applications* (pp. 320–335). Johannesburg, South Africa: Wits University Press.
- Eells, T. D. (Ed.). (2007). *Handbook of psychotherapy case formulation* (2nd ed.). New York, NY: Guilford.
- Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38*, 319–345.
- Ehlers, A., Clark, D. M., Hackmann, A., Grey, N., Liness, S., Wild, J., . . . McManus, F. (2010). Intensive cognitive therapy for PTSD: A feasibility study. *Behavioural and Cognitive Psychotherapy, 38*, 383–398.
- Ehlers, A., Clark, D. M., Hackmann, A., McManus, F., & Fennell, M. (2005). Cognitive therapy for post-traumatic stress disorder: development and evaluation. *Behaviour Research and Therapy, 43*, 413–431.
- Ehlers, A., Hackmann, A., & Michael, T. (2004). Intrusive re-experiencing in post-traumatic stress disorder: Phenomenology, theory and therapy. *Memory, 12*(4), 403–415.
- Falsetti, S. A., Resnick, H. S., Davis, J., & Gallagher, N. G. (2001). Treatment of posttraumatic stress disorder with chronic panic attacks: Combining cognitive processing therapy with panic control treatment techniques. *Group Dynamics: Theory, Research and Practice, 5*(4), 252–260.
- Farrell, J. M., Shaw, I. A., & Reiss, N. (2012). Group Schema Therapy: Catalyzing schema and mode change. In M. van Vreeswijk, J. Broerson, & M. Nadort (Eds.), *The Wiley-Blackwell handbook of schema therapy: Theory, research and practice* (pp. 341–358). Chichester, United Kingdom: Wiley-Blackwell.
- Foa, E. B., Hembree, E. A., Cahill, S. P., Rauch, S. A., Riggs, D. S., Feeny, N. C., & Yadin, E. (2005). Randomized trial of prolonged exposure for posttraumatic stress disorder with and without cognitive restructuring: Outcome at academic and community clinics. *Journal of Consulting and Clinical Psychology, 73*, 953–964.
- Forbes, D., Creamer, M., Bisson, J. I., Cohen, J. A., Crow, B. E., Foa, E. B., . . . Ursano, R. J. (2010). A guide to guidelines for the treatment of PTSD and related conditions. *Journal of Traumatic Stress, 23*, 537–552.
- Fouad, N. A., Grus, C. L., Hatcher, R. L., Kaslow, N. J., Hutchings, P. S., Madson, M. B., . . . Crossman, R. E. (2009). Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. *Training and Education in Professional Psychology, 3*, S5–S26.
- Fox, S. (2010). *Re-packing the cupboard: A systematic case study of the treatment of PTSD following rape* (Unpublished master's thesis). Rhodes University, Grahamstown, South Africa.
- Gersons, B. P. R., Carlier, I. V. E., Lamberts, R. D., & van der Kolk, B. A. (2000). Randomized clinical trial of Brief Eclectic Psychotherapy for police officers with posttraumatic stress disorder. *Journal of Traumatic Stress, 13*, 333–346.
- Giesen-Bloo, J., Van Dyck, R., Spinhoven, P., Van Tilburg, W., Dirksen, C., Van Asselt, T., . . . Arntz, A. (2006). Outpatient psychotherapy for borderline personality disorder: Randomized controlled trial of schema-focused therapy vs transference-focused psychotherapy. *Archives of General Psychiatry, 63*, 649–658.
- Goodyear-Brown, P. (2010). *Play therapy with traumatized children: A prescriptive approach*. Hoboken, NJ: Wiley.
- Grazebrook, K., & Garland, A. (2005). *What is CBT?* Retrieved from <http://www.babcp.com/Public/What-is-CBT.aspx>

- Greenberg, L. S. (2004). Emotion-focused therapy. *Clinical Psychology and Psychotherapy*, 11, 3–16.
- Greenberg, L. S., & Goldman, R. (2007). Case formulation in emotion-focused therapy. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulation* (pp. 379–411). London, England: Guilford.
- Greenman, P. S., & Johnson, S. M. (2012). United we stand: Emotionally focused therapy for couples in the treatment of posttraumatic stress disorder. *Journal of Clinical Psychology*, 68(5), 561–569. doi:10.1002/jclp.21853
- Grey, N. (2009). Cognitive therapy for post-traumatic stress reactions: An introduction. In N. Grey (Ed.), *A casebook of cognitive therapy for traumatic stress reactions* (pp. 1–13). London, England: Routledge.
- Grey, N., McManus, F., Hackmann, A., Clark, D. M., & Ehlers, A. (2009). Intensive cognitive therapy for post-traumatic stress disorder: Case studies. In N. Grey (Ed.), *A casebook of cognitive therapy for traumatic stress reactions* (pp. 111–130). London, England: Routledge.
- Grey, N., Young, K., & Holmes, E. (2002). Cognitive restructuring within reliving a treatment for peritraumatic emotional “hotspots” in posttraumatic stress disorder. *Behavioural and Cognitive Psychotherapy*, 30(1), 37–56.
- Grunert, B. K., Weis, J. M., Smucker, M. R., & Christianson, H. F. (2007). Imagery rescripting and reprocessing therapy after failed exposure for post-traumatic stress disorder following industrial injury. *Journal of Behavior Therapy and Experimental Psychiatry*, 38, 317–328.
- Hackmann, A. (1997). The transformation of meaning in cognitive therapy. In C. Brewin (Ed.), *The transformation of meaning in psychological therapies: Integrating theory and practice* (pp. 125–140). Chichester, United Kingdom: John Wiley.
- Hatcher, R. L., & Lassiter, K. D. (2007). Initial training in professional psychology: The practicum competencies outline. *Training and Education in Professional Psychology*, 1, 49–63.
- Hayes, S. C., Villatte, M., Levin, M., & Hildebrandt, M. (2011). Open, aware, and active: Contextual approaches as an emerging trend in the behavioral and cognitive therapies. *Annual Review of Clinical Psychology*, 7, 141–168.
- Helfand, M., Berg, A., Flum, D., Gabriel, S., & Normand, S. (2012). *Our questions, our decisions: Standards for patient-centered outcomes research*. (Draft Methodology Report). Washington, DC: Patient-Centred Outcomes Research Institute. doi: <http://www.pcori.org/2012/methodology-report/>
- Herbert, J. D., Lilienfeld, S. O., Lohr, J. M., Montgomery, R. W., O'Donohue, W. T., Rosen, G. M., & Tolin, D. F. (2000). Science and pseudoscience in the development of eye movement desensitization and reprocessing: Implications for clinical psychology. *Clinical Psychology Review*, 20(8), 945–971.
- Herman, J. L. (1992). *Trauma and recovery: From domestic abuse to political terror*. New York, NY: Basic Books
- Herman, J. L. (1995). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. In J. M. Lating (Ed.), *Psychotraumatology: Key papers and core concepts in post-traumatic stress* (pp. 87–100). New York, NY: Plenum.
- Hobfoll, S., Hall, B. J., Canetti-Nisim, G., Galea, S., Johnson, R. J., & Palmieri, P. A. (2007). Refining our understanding of traumatic growth in the face of terrorism: Moving from meaning cognitions to doing what is meaningful. *Applied Psychology: An International Review*, 56, 345–366.
- Horvath, A. O., Del Re, A. C., Fluckiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 25–69). New York, NY: Oxford University Press.
- Jackson, C., Nissenon, K., & Cloitre, M. (2010). Treatment of complex PTSD. In D. Sookman & R. L. Leahy (Eds.), *Treatment resistant anxiety disorders: Resolving impasses to symptom remission* (pp. 75–104). New York, NY: Routledge.
- Jakupcak, M., Wagner, A., Paulson, A., Varra, A., & McFall, M. (2010). Behavioral activation as a primary care-based treatment for PTSD and depression among returning veterans. *Journal of Traumatic Stress*, 23, 491–495.
- Johnson, S. M., Hunsley, J., Greenberg, L. S., & Schindler, D. (1999). Emotionally focused couples therapy: Status and challenges. *Clinical Psychology Science and Practice*, 6, 67–79.
- Kaminer, D., & Eagle, G. (2010). *Traumatic stress in South Africa*. Johannesburg, South Africa: Wits University Press.
- Karpelowsky, B. J., & Edwards, D. J. A. (2005). Trauma, imagery and the therapeutic relationship: Langu's story. *Journal of Psychology in Africa*, 15(2), 185–195.
- Kazdin, A. E. (2012). A comprehensive guide to the rich and rigorous research methods of psychological science. Review of *APA Handbook of Research Methods in Psychology. PsyCRITIQUES*, 57(21). doi: 10.1037/a0028394
- Kellerman, P. F., & Hudgins, M. K. (2000). *Psychodrama with trauma survivors: Acting out your pain*. London, England: Jessica Kingsley.
- Krause, M. S., & Lutz, W. (2009). Process transforms inputs to determine outcomes: Therapists are responsible for managing process. *Clinical Psychology: Science and Practice*, 16, 73–81.
- Kubany, E. S., Hill, E. E., Owens, J. A., Iannce-Spencer, C., McCaig, M. A., Tremayne, K. J., & Williams, P. I. (2004). Cognitive trauma therapy for battered women with PTSD (CTT-BW). *Journal of Consulting and Clinical Psychology*, 72(1), 3–18.
- Kuyken, W., Padesky, C. A., & Dudley, R. (2009). *Collaborative case conceptualization*. New York, NY: Guilford.
- Laas, S. J. (2009). *An evaluation of the Ehlers and Clark cognitive therapy model within the South African context: The assessment and treatment of a survivor of violent criminal victimization* (Unpublished master's thesis). Rhodes University, Grahamstown, South Africa.
- Lee, D. (2006). Case conceptualization in complex PTSD: Integrating theory with practice. In N. Tarrier (Ed.), *Case formulation in cognitive-behaviour therapy: The treatment of challenging and complex cases* (pp. 142–166). London, England: Routledge.
- Lee, D. A. (2010). Using a compassionate mind to enhance the effectiveness of cognitive therapy for individuals who suffer from shame and self-criticism. In D. Sookman, & R. L. Leahy (Eds.), *Treatment resistant anxiety disorders: Resolving impasses to symptom remission* (pp. 233–254). New York, NY: Routledge.
- Lee, D. A., Scragg, P., & Turner, S. (2001). The role of shame and guilt in traumatic events: A clinical model of

- shame-based and guilt-based PTSD. *British Journal of Medical Psychology*, 74, 451–466.
- Levant, R. F. (2005). *Report of the 2005 Presidential Task Force on Evidence Based Practice*. Retrieved from <http://www.apa.org/practice/resources/evidence/evidence-based-report.pdf>
- Levitt, J. T., & Cloitre, M. (2005). A clinician's guide to STAIR/MPE: Treatment for PTSD related to childhood abuse. *Cognitive and Behavioral Practice*, 12, 40–52.
- Markowitz, J. C., Milrod, B., Bleiberg, K. L., & Marshall, R. D. (2009). Interpersonal factors in understanding and treating posttraumatic stress disorder. *Journal of Psychiatric Practice*, 15, 133–140.
- Maxwell, J. A. (2008). The value of a realist understanding of causality for qualitative research. In N. K. Denzin & M. D. Giardina (Eds.), *Qualitative inquiry and the politics of evidence* (pp. 163–181). Walnut Creek, CA: Left Coast Press.
- Miller, D. W., & Miller, C. G. (2005). On evidence, medical and legal. *Journal of American Physicians and Surgeons*, 10(3), 70–75.
- Millon, T., & Grossman, S. (2007a). *Moderating severe personality disorders: A personalized psychotherapy approach*. Hoboken, NJ: Wiley.
- Millon, T., & Grossman, S. (2007b). *Overcoming resistant personality disorders: A personalized psychotherapy approach*. Hoboken, NJ: Wiley.
- Monson, C. M., Schnurr, P. P., Resick, P. A., Friedman, M. J., Young-Xu, Y., & Stevens, S. P. (2006). Cognitive processing therapy for veterans with military-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 74, 898–907.
- Mueller, M. (2009). The role of narrative exposure therapy in cognitive therapy for traumatized refugees and asylum seekers. In N. Grey (Ed.), *A casebook of cognitive therapy for traumatic stress reactions* (pp. 265–282). London, England: Routledge.
- Mueser, K. T., Rosenberg, S. D., Xie, H., Jankowski, M. K., Bolton, E. E., Lu, W., . . . Wolfe, R. (2008). A randomized controlled trial of cognitive-behavioral treatment for posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology*, 76(2), 259–271. doi:10.1037/0022-006X.76.2.259
- Muller, R. T. (2010). *Trauma and the avoidant client: Attachment-based strategies for healing*. New York, NY: W. W. Norton.
- Nadort, M., Arntz, A., Smit, J. H., Giesen-Bloo, J., Eikelenboom, M., Spinhoven, P., . . . van Dyck, R. (2009). Implementation of outpatient schema therapy for borderline personality disorder with versus without crisis support by the therapist outside office hours: A randomized trial. *Behaviour Research and Therapy*, 47, 961–973.
- Najavits, L. M., Gallop, R. J., & Weiss, R. D. (2006). Seeking safety therapy for adolescent girls with PTSD and substance use disorder: A randomized controlled trial. *Journal of Behavioral Health Services and Research*, 33, 453–463.
- National Institute for Clinical Excellence. (2005). *Clinical guidelines CG26: Post-traumatic stress disorder: The management of PTSD in adults and children in primary and secondary care*. doi:www.nice.org.uk/cg26
- Nel, P. W. (2012). The trouble with clinical psychology. *Clinical Psychology Forum*, 235, 18–22.
- Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T. (2004). A comparison of Narrative Exposure Therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. *Journal of Consulting and Clinical Psychology*, 72, 579–587.
- Norcross, J. C., & Lambert, M. J. (2011). Evidence-based therapy relationships. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 3–21). New York, NY: Oxford University Press.
- Padmanabhanunni, A. (2010). *A series of systematic case studies on the treatment of rape-related PTSD in the South African context: Implications for practice and policy* (Doctoral dissertation). Rhodes University, Grahamstown, South Africa. Available at <http://eprints.ru.ac.za/1991/>
- Padmanabhanunni, A., & Edwards, D. J. A. (2012). Treating complex post-traumatic stress disorder following childhood neglect, sexual abuse and revictimisation: Interpretative reflections on the case of Khuselwa. *Child Abuse Research in South Africa*, 13(1), 40–54.
- Padmanabhanunni, A., & Edwards, D. J. A. (2013). Treating the psychological sequelae of proactive drug-facilitated sexual assault: Knowledge building through systematic case based research. *Behavioural and Cognitive Psychotherapy*. doi:10.1017/S1352465812000896
- Paivio, S. C., Jarry, J. L., Chagigiorgis, H., Hall, I., & Ralston, M. (2010). Efficacy of two versions of emotion-focused therapy for resolving child abuse trauma. *Psychotherapy Research*, 20(3), 353.
- Payne, C., & Edwards, D. J. A. (2009). What services and supports are needed to enable trauma survivors to rebuild their lives? Implications of a systematic case study of cognitive therapy with a township adolescent girl with PTSD following rape. *Child Abuse Research in South Africa*, 10(1), 27–40.
- Phillips, M., & Frederick, C. (1995). *Healing the divided self: Clinical and Ericksonian hypnotherapy for posttraumatic and dissociative conditions*. New York, NY: Norton.
- Pistrang, N., & Barker, C. (2012). Varieties of qualitative research: A pragmatic approach to selecting methods. In H. Cooper (Ed.), *APA handbook of research methods in psychology, Volume 2. Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 5–18). Washington, DC: American Psychological Association.
- Prochaska, J. O., & Norcross, J. C. (2001). Stages of change. *Psychotherapy*, 38(4), 443–448.
- Raby, C., & Edwards, D. (2011). Unrecognized hospital trauma as a source of complex psychiatric symptoms: A systematic case study with implications for children's rights and evidence-based practice. *Psychotherapy Research*, 21, 541–553.
- Resick, P. A., Nishith, P., Astin, A. C., Weaver, W. L., & Feuer, C. A. (2002). A comparison of cognitive-processing therapy with prolonged exposure and waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology*, 70(4), 867–879.
- Resick, P. A., Williams, L. F., Suvak, M. K., Monson, C. M., & Gradus, J. L. (2012). Long-term outcomes of cognitive-behavioral treatments for posttraumatic stress disorder among female rape survivors. *Journal of Consulting and Clinical Psychology*, 80(2), 201–210. doi:10.1037/a0026602

- Roth, A. D., & Pilling, S. (2008). Using an evidence-based methodology to identify the competences required to deliver effective cognitive and behavioural therapy for depression and anxiety disorders. *Cognitive and Behavioural Psychotherapy, 36*, 129–147.
- Ruf, M., Schauer, M., Neuner, F., Catani, C., Schauer, E., & Elbert, T. (2010). Narrative Exposure Therapy for 7- to 16-year-olds: A randomized controlled trial with traumatized refugee children. *Journal of Traumatic Stress, 23*, 437–445.
- Sackett, D., Rosenburg, W., Gray, J., Haynes, R., & Richardson, W. (1996). Evidence-based medicine: What it is and what it isn't. *British Medical Journal, 312*, 71–72.
- Safran, J. D., Muran, J. C., Samstag, L. W., & Winston, A. (2005). Evaluating alliance-focused intervention for potential treatment failures: A feasibility study and descriptive analysis. *Psychotherapy: Theory, Research, Practice, Training, 42*(4), 512–531.
- Seidler, G. H., & Wagner, F. E. (2006). Comparing the efficacy of EMDR and trauma-focused cognitive-behavioral therapy in the treatment of PTSD: A meta-analytic study. *Psychological Medicine, 36*, 1515–1522.
- Shamdasani, S. (2005). Psychotherapy: The invention of a word. *History of the Human Sciences, 18*, 1–22.
- Slater, L. (2003, 02/23). Repress yourself. *New York Times*. doi: <http://www.nytimes.com/2003/02/23/magazine/repress-yourself.html?pagewanted=all&src=pm>
- Smith, P., Perrin, S., Yule, W., & Clark, D. M. (2010). *Post traumatic stress disorder: Cognitive therapy with children and young people*. Hove, United Kingdom: Routledge.
- Smith, P., Yule, W., Perrin, S., Tranah, T., Dalgleish, T., & Clark, D. M. (2007). Cognitive-behavioral therapy for PTSD in children and adolescents: A preliminary randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(8), 1051–1061.
- Smith, T. (2006). *Frozen in time to reclaiming one's life: The evaluation of the Ehlers and Clark cognitive therapy model in the assessment and treatment of a hijacking survivor*. Master's thesis, Rhodes University, Grahamstown, South Africa. Available at <http://eprints.ru.ac.za/1834/>
- Sokutu, N. (2010). *Longstanding trauma, disrupted interpersonal relations: an evaluation of the Ehlers And Clark model for PTSD in a complex case* (Master's thesis). Rhodes University, Grahamstown, South Africa.
- Steele, K., & van der Hart, O. (2009). Treating dissociation. In C. A. Courtois, & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 145–165). New York, NY: Guilford.
- Steil, R., Dyer, A., Priebe, K., Kleindienst, N., & Bohus, M. (2011). Dialectical Behavior Therapy for posttraumatic stress disorder related to childhood sexual abuse: A pilot study of an intensive residential treatment program. *Journal of Traumatic Stress, 24*(1), 102–106.
- Stiles, W. B., Honos-Webb, L., & Surko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology: Science and Practice, 5*(4), 439–458.
- Swartz, K. (2007). *Contextual obstacles to the delivery of effective psychological treatment of PTSD in a South African community setting* (Unpublished master's thesis). Rhodes University, Grahamstown, South Africa. Retrieved from <http://eprints.ru.ac.za/1830>
- Tarrier, N. (2006). An introduction to case formulation and its challenges. In N. Tarrier (Ed.), *Case formulation in cognitive-behaviour therapy: The treatment of challenging and complex cases* (pp. 1–11). London, England: Routledge.
- Tarrier, N., & Humphreys, A. (2003). PTSD and the social support of the interpersonal environment: The development of social cognitive behavior therapy. *Journal of Cognitive Psychotherapy, 17*(2), 187–198.
- Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*, 1–18.
- Tedeschi, R. G., Calhoun, L. G., & Cann, A. (2007). Evaluating resource gain: Understanding and misunderstanding posttraumatic growth. *Applied Psychology: An International Review, 56*, 396–406.
- Teng, E. J., Bailey, S. D., Chaison, N. D., Petersen, N. J., Hamilton, J. D., & Dunn, N. J. (2008). Treating comorbid panic disorder in veterans with posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 76*, 704–710. doi:10.1037/0022-006X.76.2.259
- Tick, E. (2005). *War and the soul: Healing our country's veterans from post-traumatic stress disorder*. Wheaton, IL: Quest.
- University College London. (n.d.-a). *Generic metacompetences*. Retrieved from http://www.ucl.ac.uk/clinical-psychology/CORE/CBT_Compeences/Metacompetences/Metacompetences.pdf
- University College London. (n.d.-b). *Problem specific competences*. Retrieved from http://www.ucl.ac.uk/clinical-psychology/CORE/CBT_Competences/Problem_Specific_Competences/Problem_Specific_Competences.pdf
- van der Linde, F., & Edwards, D. J. A. (2013). "It's like uprooting trees:" Responsive treatment for a case of complex post-traumatic stress disorder following multiple rapes. *Journal of Psychology in Africa, 23*(1), 31–30.
- van Vreeswijk, M., Broerson, J., & Nadort, M. (Eds.). (2012). *The Wiley-Blackwell handbook of schema therapy: Theory, research and practice*. Chichester, United Kingdom: Wiley-Blackwell.
- Wagner, A. W., Zatzick, D. F., Ghesquiere, A., & Jurkovich, G. J. (2007). Behavioral activation as an early intervention for posttraumatic stress disorder and depression among physically injured trauma survivors. *Cognitive and Behavioral Practice, 14*(4), 341–349. doi:10.1016/j.cbpra.2006.05.002
- Wampold, B. E., Imel, E., & Miller, S. D. (2009). Barriers to the dissemination of empirically supported treatments: Matching messages to evidence. *The Behavior Therapist, 32*(7), 144–155.
- Watson, J. C., Gordon, L. B., Stermac, L., Kalegerakos, F., & Steckley, P. (2003). Comparing the effectiveness of process-experiential with cognitive-behavioral psychotherapy in the treatment of depression. *Journal of Consulting and Clinical Psychology, 71*, 773–781.
- WHO. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva, Switzerland: World Health Organization.
- Wild, J. (2009). Cognitive therapy for post-traumatic stress disorder and permanent physical injury. In N. Grey (Ed.), *A casebook of cognitive therapy for traumatic stress reactions* (pp. 131–146). London, England: Routledge.
- Wild, J., Hackmann, A., & Clark, D. A. (2007). When the present visits the past: Updating traumatic memories in social pho-

bia. *Journal of Behavior Therapy and Experimental Psychiatry*, 38, 386–401.

Wolfe, B. E. (2012). Healing the practice-research split: Let's start with me. *Psychotherapy*, 49, 101–108.

Young, J. E., Klosko, J., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York, NY: Guilford.

Endnotes

¹ Roth and Pilling in their 2008 article and web based documentation refer to “competences” and “metacompetences” whereas Hatcher and Lassiter and others refer to “competencies.” The latter spelling which appears to be more widely used is adopted here.

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