

EXPLORATION OF EYE MOVEMENT DESENSITIZATION AS PART
OF TREATMENT OF TRAUMATIC MEMORIES/ POST TRAUMATIC
STRESS DISORDER IN RAPE SURVIVORS IN SOUTH AFRICA

KEALOGETSWE MAUREEN MONGALE

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ABSTRACT

This study documents eye movement desensitization (EMD) therapy sessions of 2 female in-patients suffering from Post Traumatic Stress Disorder as a result of rape.

The literature review considers the three main approaches to understanding and treating PTSD (psychodynamic, crisis, and behavioural), before consideration of EMD. A brief comparison of EMD and Hypnosis is also presented in this section.

The case material provides an account of the application of EMD and its therapeutic outcome. The patients' verbal reports and nurses' observations were used as measurement strategies to estimate the therapeutic success.

The discussion explores various factors which influenced the therapeutic outcome. In conclusion it is hypothesized that EMD has a cathartic effect which needs to be further explored and considered in its theorization.

Finally, implications of the findings for clinical work with PTSD in South Africa are discussed.

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CHAPTER ONE

1.1 INTRODUCTION

The majority of South Africans have undergone diverse psychological traumas. This is due to continuous exposure to violence and other effects of apartheid such as socio-economic deprivation (Straker, 1987).

Across different racial and social groups, sexual violence in the form of rape has been another type of oppression which has exposed women to a variety of emotional and psychological turmoils. The latest official rape statistics by the Annual Report of the Commissioner of the South African Police reveal a total number of 27 056 reported rape cases during 1993 in comparison to 24 360 cases in 1992. This shows an increase of 11,07% of reported cases. Although these numbers are alarmingly high they are not a true reflection of the prevalence of rape in South Africa. Some criminologists feel that the ratio of reported assaults to actual assaults is likely to be only 1 in 20, especially for certain populations (Levett, 1981).

According to Levett (1981), there has been a tendency in the police system to blame women for what has happened to them or to regard their reports as unfounded. Being blamed is perceived by victims as further traumatization and can be seen as one of the factors influencing women's decisions not to report (Murphy, 1980).

Klapholz (1980) states that the experience of different professionals working with rape survivors indicates that the most common reasons for non-reporting are the survivors' fear of embarrassment, humiliation and uncertainty about treatment in the legal system.

It is against the above background of political and sexual violence that the risks of suffering from delayed post-traumatic stress in South Africa become enormous.

1.2 AIMS AND RATIONALE

According to Smith and Holford (1993) many South African children in particular are presenting with Post Traumatic Stress Disorder (PTSD). This is seen as a direct consequence of increasing political violence or of indirect political violence which manifests in social upheaval, criminal violence, unemployment, domestic violence and acute personal insecurity. Following these traumas these children are subject to subsequent traumas in the form of loss of home, family, school environment and all that was once familiar to them. To address these issues emphasis by many politicians and different professionals is on developing strategies on how to break this culture of violence and to improve the victims' standard of living.

With regard to sexual assaults in particular there has been an attempt by support services such as LIFE LINE and PEOPLE OPPOSING WOMAN ABUSE (POWA) to create public awareness to report rape (South African Police Annual Report, 1993).

Concerned mental health workers are, however, still confronted by the challenge of offering cost effective psychological therapeutic intervention to the victims. According to Straker (1987) groups like the National Medical and Dental Association (NAMDA), Detainee Counselling Service (D.C.S.), the organization for Appropriate Social Services in South Africa (OASSSA) and the Sanctuary Counselling Team (S.C.T.), were formed to meet this need. The fact that individuals are subjected to continuous trauma in South Africa has had numerous implications for their treatment. One of the most important developments has been the emphasis on the single therapeutic interview. The return of a

counsellor has never been guaranteed. Therefore, it was essential that each session be complete within itself but still offer the potential for follow up (Straker, 1987).

The aim of this study is therefore to begin to explore in the South African context, the therapeutic potential of the Eye Movement Desensitization technique which was developed by a clinical psychologist Francine Shapiro in 1987. This might be a useful and effective therapeutic intervention. Ideally it is applied in 3-4 sessions. However, a single session is effective and it provides an opportunity for follow-up.

According to Butler (1993) since 1987 over 4,000 therapists in America, Israel, and Australia have been trained to use the technique which to date has proven to be the most successful, time and cost effective therapy for traumatic memories. The revised version of EMD is referred to as Eye Movement Desensitization and Reprocessing (EMDR). Its details have however not yet been published (Forbes et.al, 1994). The two terms have been used interchangeably by some authors.

1.3 OUTLINE OF THE STUDY

The review of the literature (Chapter 2) first covers the definition of PTSD within its historical context. This is followed by the psychoanalytic perspective on the nature of the psychological damage experienced by PTSD victims and psychodynamic oriented therapeutic approaches in the field. Crisis theory and crisis intervention with rape survivors will also be discussed. From the behavioural perspective, the learning theory model on rape induced symptomatology followed by behavioural approaches to treating PTSD will also be presented. EMD itself, and its relationship to hypnosis, is then discussed.

In an attempt to adequately theorize the basis of the efficacy of EMD, it was imperative that EMD be explored in the context of other therapeutic treatment models as well. Psychoanalytic

theory, crisis theory, and learning theory, are particularly explored as they are the dominant theories in the work with rape survivors.

In Chapter 3 the case-study method used in this study is outlined, and the two cases are reported in Chapter 4.

Chapter 5 discusses the results and their implications for clinical work with PTSD in South Africa.

CHAPTER TWO

LITERATURE REVIEW

2.1 POST TRAUMATIC STRESS DISORDER

2.1.1 BRIEF HISTORICAL BACKGROUND

According to Goodwin (1986) the conception that traumatic experiences produce a specific cluster of psychological symptoms has been debated for more than a century. The most recent calamity reviving the debate was the recognition in Vietnam veterans that combat was not the only source of PTSD. Any psychologically traumatic events outside the range of usual human experience including rape and assault have the potential to produce PTSD.

In the American Civil War what we now term PTSD was called "nostalgia", a "mild type of insanity caused by disappointment and a continuous longing for home" (Goodwin, 1986:179). At first the victims were first hospitalized. Then the military changed its policy, which resulted in them being imprisoned rather than hospitalized. The incidence of nostalgia then disappeared.

PTSD (as we now call it) was first formally studied by John Erichsen in the nineteenth century following a rash of railway disasters. Erichsen realized that victims of railway accidents presented with anxiety, recollection of the event and recurrent dreams, sleep disturbance, and reduced involvement with the external world. He maintained that the cause was physical: a "spinal concussion" which was later termed Erichsen's disease (Goodwin, 1986).

Throughout the First World War PTSD was termed "shell shock" with the cause ascribed to neurological damage from bursting artillery shells. After realizing that the same symptoms occurred in soldiers not exposed to cannon fire as well, two "types of shell shock came into existence: the legitimate type from neurological damage, and the 'cowardly' type handled as a disciplinary matter" (Goodwin, 1986:179). For the Germans shell shock was outlawed and anyone presenting with it would be shot.

During the Second World War there was a shift towards treating PTSD more humanely at times. Soldiers who developed PTSD were told they were victims of an unhappy childhood. However, this awareness of predispositional factors led to the rejection of individuals believed to be vulnerable to PTSD. Despite this, rejection of potential soldiers on psychiatric grounds and the belief that PTSD should be punishable by death, it continued to exist (Goodwin: 1986).

PTSD emerged as a formal diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders, 1980 (DSM-111). Several additional symptoms were noted in the (DSM-111-R) in 1987 (Carson et al., 1988). The following list is the latest diagnostic criteria as it appears in 1994 (DSM-1V) with very few changes made as compared to the DSM-111:

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person 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.

B. The traumatic event is persistently reexperienced in one

(or more) of the following ways:

- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
- (2) recurrent distressing dreams of the event.
- (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).
- (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 symbolize 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 trauma), as indicated by 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 or 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 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 two (or more) of the

following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hypervigilance
- (5) exaggerated startle response

E. Duration of the disturbance (symptoms in B, C, and D) is more than 1 month.

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

Specify if: Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Delayed Onset: if onset of symptoms is at least 6 months after the stressor

2.2 PTSD AND VICTIMS' SHATTERED ASSUMPTIONS

According to Janoff-Bulman (1985) post traumatic stress following victimization is largely due to the impact of victimization on three particular assumptions: (a) the belief in personal invulnerability, (b) the perception of oneself as positive, and (c) the perception of the world as positive. These assumptions are implicit rather than explicit, and they are in general relatively inaccessible to introspection (Janoff-Bulman, 1985).

There are however particularly impactful events in people's lives which force them to recognise, objectify, and examine their basic assumptions (Janoff-Bulman, 1985). These events, which include disasters, serious diseases, accidents, sexual assaults, and criminal acts, "produce tremendous stress and anxiety, for the

victim's experience cannot be readily assimilated, the assumptive world, developed and confirmed over many years cannot account for these extreme events" (Janoff-Bulman, 1985: 18).

Victims feel that things are no longer the same, the stability with which they are ordinarily able to function is destroyed, their perceptions are now marked by threat, insecurity, danger, and self questioning which then produce a psychological upheaval (Janoff-Bulman, 1985).

As Rose (1991) states it, one way to understand this psychological upheaval in rape survivors is that the internal self and object representations and adaptive techniques for understanding and dealing effectively with the feelings, fantasies, thoughts, and impulses arising from the stressor which is rape, are not developed or adequate. This results in feelings of intense anxiety, helplessness and the new perception of vulnerability manifests themselves, in part, in the victim's preoccupation with an extreme fear of recurrence.

The coping process for all victims would therefore entail reworking their assumptions about themselves and the world so that they fit with their new personal information (Janoff-Bulman, 1985).

This review will continue with a consideration of the three main approaches to understanding and treating PTSD (psychodynamic, crisis, and behavioural), before consideration of EMD, the treatment examined in this study.

2.3 PSYCHOANALYTIC PSYCHOTHERAPY OF POST-TRAUMATIC STRESS DISORDER

2.3.1 LINDY'S MODEL

According to Lindy (1986) intrapsychic processing of trauma is the core of treatment in PTSD. "The therapist strives to occupy

place during the course of therapy poised intrapsychically between the reminder of trauma and the potential for psychic overload". (Lindy, 1986:197) It is hoped that in the process of therapy, the therapist and the patient will form a unit capable of tolerating and working through more affect-laden memory than the patient alone can tolerate. From the patient's point of view therapy may be conceptualized as a transition from psychiatric casualty to survivor whereas from the therapist's point of view it is an effort to remove the obstacles to an essentially spontaneous healing process. In order for this to happen the therapist must be invited and allowed entry to the boundary of the trauma membrane (Lindy, 1986).

2.3.1.1 LINDY'S OUTLINE FOR PSYCHOTHERAPY

2.3.1.1 (i) OPENING PHASE

This is an extremely tentative and gradual process during which the patient risks allowing the therapist to enter beneath his/her trauma membrane. Through interpretation, the therapist re-establishes the link between derivative reminders and the traumatic memories themselves, including specific associated affect states.

2.3.1.1 (ii) WORKING THROUGH PHASE

The patient is assisted by the therapist to organise currently experienced pathological reflections of segments of specific traumatic experiences. The therapist also clarifies defenses and underlying affect states such as rage, helplessness and guilt. In this stage rapid management and interpretation of negative transferences are important in that uninterpreted negative transference threatens to disrupt the therapeutic alliance.

2.3.1.1 (iii) TERMINATION PHASE

In this phase the patient begins to experience mastery from working with the new reminders of the trauma. S/he gains confidence in her/his ability to maintain ongoing cohesion in the presence of such threats. Grief now surfaces spontaneously, and working through delayed bereavement connected with the trauma becomes central.

Upon termination it is hoped that the patient would have gained a larger repertoire of coping behaviours although certain symptoms of PTSD might persist. Furthermore as the symptoms become less consuming and less the entire focus of the patient, there will be more energy available for other activities. "There is an increased sense of continuity with the past, the reexperiencing of joy, and the integration of meaning of the experience into the subject's world view". (Lindy, 1986:203)

2.3.2 ROSE'S MODEL OF PSYCHODYNAMIC PSYCHOTHERAPY WITH THE RAPE SURVIVOR

This model was developed in addition to several models for treatment of PTSD in adults. Rose (1991) derived it from her own experience in providing individual psychodynamic psychotherapy to rape survivors, and consultation to psychotherapists and staff of rape crisis centres, and teaching. The model includes general principles of treatment of PTSD and also addresses the particular techniques required in treatment of the rape survivor.

Rose outlines the following as some of the technical problems which occur in the psychodynamic psychotherapy of rape survivors: "formation of a therapeutic alliance, identification and interpretation of defenses, the victim's conflict over aggression, pre-existing psychodynamics, countertransference reactions, and contact with societal institutions" (Rose, 1991:85). Failure to address any of these areas effectively

results in rupture of the therapeutic alliance and traumatization of the survivor.

2.3.2 (i) FORMATION OF THE THERAPEUTIC ALLIANCE

This phase encompasses the initial presentation of the rape survivor who commonly at this stage may be mistrustful, suspicious, regressed or even impaired in her capacity to verbalize. Attempts by the therapist to explore and interpret are likely to be experienced by the survivors as judgements, violations, and rejections. Furthermore the survivor experiences her internalized objects as having been shattered and no longer available to her. She becomes enraged at the maternal introject and holding environment for what she perceives as abandoning, failing and betraying her during the rape. This commonly results in survivors interpreting the actions of those who are attempting to help as betrayals and intentional failures of caring. Dealing with these dynamics in the first contact increases the likelihood that the patient will enter into therapy. At this point in therapy silence in the therapist is rarely appropriate as it might be disruptive to the therapeutic alliance.

2.3.2 (ii) IDENTIFICATION AND INTERPRETATION OF DEFENSES

Major defenses, such as dissociative defenses, reenactment and avoidance, need to be explored, confronted and linked to the rape from the beginning of psychotherapy as they may defend against crucial issues.

2.3.2 (iii) THE CONFLICT OVER AGGRESSION

Key manifestations of the conflict over aggression include: the absence of any conscious anger at the rapist, massive guilt, identification with the rapist, inability to report or prosecute, and reenactments of aspects of the rape. The guilt results in depression and destructive actions directed toward the self and others, ending of relationships, loss of job, abuse of alcohol,

and suicide. Resolution of this conflict is therefore central in therapy and brings about rapid and dramatic shifts in the survivor.

2.3.2 (iv) PRE-EXISTING PSYCHODYNAMICS

It is imperative to explore the survivor's pre-existing psychodynamics as they contribute a pre-existing character style and defenses. "Certain conflicts from the rape will have added meanings, and some victims will have impaired ability to recognize dangerous situations that increase the likelihood of an assault". (Rose, 1986:91) Failure to explore the meaning of these pre-existing conflicts hampers the resolution of related conflicts from the rape.

2.3.2 (v) COUNTERTRANSFERENCE

Countertransference is divided into two sets of identifications: the therapist as the rapist and the therapist as the survivor. When the therapist experiences being the rapist the common reaction would be to defend against this countertransference which may result in the rape not being discussed or not being considered to be important in the patient's therapy. In the latter the therapist may identify with many of the aspects of the survivor's experience, such as helplessness, degradation and feeling dirty and having aggressive fantasies and impulses. In defending against these feelings the therapist might blame the survivor or minimize the impact of the rape. In defending against an experience of helplessness and damage in particular, the therapist, may feel helpless and think that the survivor can never recover or even pressurize the survivor to act on her aggressive impulses.

2.3.2 (vi) CONTACT WITH SOCIETAL INSTITUTIONS

Lastly, the author notes that the therapist's knowledge of the criminal justice system and the services of the rape crisis centre is essential as most survivors are unfamiliar with these services until the assault. Working in tandem with the rape crisis centre is helpful in that they can provide additional support and information to the survivor and significant others. This aspect of the approach has much in common with crisis intervention, as will be seen below.

2.3.3 PSYCHODYNAMIC PSYCHOTHERAPY IN THE SOUTH AFRICAN CONTEXT

Psychodynamic psychotherapy has relevance to the treatment of trauma including rape in South Africa. It subscribes to the belief that the resolution of trauma involves working through intrapsychic conflicts related to the trauma. The process of therapy deals with a number of psychodynamic issues on a broader level to enable healing to take place. However, therapeutic outcome is largely dependent on the therapeutic relationship and the therapist's ability to effectively address some problems which are characteristic of psychodynamic therapy in this field.

Furthermore although psychodynamic psychotherapy with rape survivors in particular can be challenging and difficult, it "offers the opportunity to resolve pre-existing conflicts unmasked by the trauma" (Rose, 1991:94).

In most cases, however, treatment goals cannot be achieved on a short term basis. This necessitates long term therapy which is in most cases only available from private practice. The majority of South Africans cannot afford fees charged in private practice.

2.4 CRISIS THEORY

"A crisis is a turning point characterized by a state of intrapsychic disequilibrium in which the individual's usual problem-solving mechanisms are ineffective". (Bassuk, 1980:121) It is usually initiated by an unexpected, uncontrollable, life threatening event which disturbs the individual's homeostatic balance and puts her or him in a vulnerable state (Golan, 1978, Levett, 1992). To regain equilibrium the person goes through a series of predictable phases. First, there is an attempt to use the person's customary repertoire of problem-solving mechanisms which is accompanied by a rise in tension. If this fails, tension increases and the person mobilizes new, emergency strategies to cope with the situation. If the problem cannot be resolved, avoided or redefined, tension rises to a peak. A precipitating factor during this phase of extreme vulnerability leads to a state of active crisis (Golan, 1978).

As in other crisis states, the rape crisis produces a complex set of emotions and symptoms which must be resolved and integrated, in order to restore the survivor's previous level of functioning (Bassuk, 1980). These symptoms unfold in the second stage of crisis, the Impact phase. They involve experiencing flashbacks, intrusive thoughts, or unexpected outbursts of anger or tears. Impaired concentration, insomnia, development of phobias and gastrointestinal distress are also common. "This phase corresponds to the immediate aftermath of the rape, when recognition of the actual danger is experienced". (Bassuk, 1980: 123)

Is it important to note that response reaction to crisis can be within hours, days, or a couple of weeks after the crisis event (Levett, 1992). In Posttraumatic Stress Disorder duration of the disturbance is more than one month. With delayed onset symptoms manifest at least six months after the stressor (DSM-IV, 1994).

2.4.1 CRISIS INTERVENTION

According to Nadelson and Sauzier (1986) the goal of treatment is to restore equilibrium and to help the survivor develop more adaptive coping mechanisms. "These goals are best met by intervening as soon as possible after the crisis situation develops". (Nadelson & Sauzier, 1986: 162) At this stage "customary defense mechanisms have become weakened, usual coping patterns have proved inadequate, and the ego has become more open to outside influence and change" (Golan, 1978:9). Appropriately focused intervention can prove more effective than more extensive therapy at a period of less emotional accessibility (Golan, 1978).

In crisis intervention treatment is short-term (3-20 sessions) and focused specifically on resolving the crisis at hand (Levett, 1992). There is no attempt to alter basic personality structure. Unlike in traditional psychodynamic therapies, therapists take much more active roles. They may intervene on the patient's behalf to help her or him resolve a practical problem such as obtaining emergency social services (Nadelson & Sauzier, 1986).

Calhoun and Atkeson (1991) outline the following methods of crisis intervention with rape survivors:

1. Establish a therapeutic relationship
2. Encourage expression of emotions
3. Provide factual information
4. Anticipate future problems
5. Adjust immediate role responsibilities
6. Identify and mobilize social support
7. Interface with medical and law enforcement agencies
8. Explore perception of personal safety
9. Arrange for follow-up

For them the above goals can be accomplished in one session. They

however acknowledge that it is unreasonable to expect complete resolution of the assault and its aftermath in one session. "Instead, the therapist works to reduce the victim's emotional distress, enhance her coping strategies, and prevent the development of more serious psychopathology". (Calhoun and Atkeson, 1991:39)

2.4.2 CRISIS INTERVENTION IN THE SOUTH AFRICAN CONTEXT

Crisis intervention has been shown to have practical application in South Africa. Due to the shortage of counsellors and problems with follow-up as already been mentioned by Straker (1987), it has been necessary to complete counselling in one session. Despite its inability to accomplish all intervention goals in such a short time, it has been relied upon and widely used in the treatment of trauma and sexual assaults. Controlled studies of single-session crisis intervention have however not been reported in the South African literature.

2.5 LEARNING THEORY

According to Golan (1978) learning theory is based on a cognitive perspective with emphasis on information processing, to look at coping and decision making. For learning theorists the person experiencing a crisis has previously been able to perceive, think, evaluate, respond, and make decisions. These processes are now interrupted as a result of some psychological or physical overload.

The crisis situation demands that s/he acquire new information, build new cognitive maps, and develop the capacity to design and choose from among possible coping strategies. Therefore, treatment by behavioral modification techniques focus on "the unlearning of old, unsuccessful, or damaging patterns of interaction and the learning of new, constructive ones" (Golan, 1978: 23).

2.5.1 THE LEARNING THEORY MODEL OF THE ETIOLOGY OF RAPE-INDUCED PROBLEMS

Kilpatrick et al.'s (1985) work with rape survivors predated the current interest in PTSD, as a result of which they did not use PTSD as a theoretical construct to explain the etiology of rape-induced problems. Instead, they attempted to predict and explain rape-induced anxiety and fear, depression, sexual dysfunction on the basis of simple principles derived from learning theory.

In summary they "believe that victims' fear and anxiety problems are largely acquired through classical conditioning, stimulus generalization, and second order conditioning. Victims perceive rape as a situation in which their physical well-being and even their lives are in jeopardy. Natural, unconditioned responses to this type of painful, and potentially life threatening, unconditioned stimuli are feelings of terror and autonomic symptoms of extreme anxiety" (Kilpatrick et.al, 1985:118). Therefore, any stimuli associated with the rape become conditioned stimuli that acquire the capacity to elicit anxiety and fear as well. Thus conditioned stimuli such as people, situations, or events present at the time of the rape acquire the capacity to evoke conditioned responses of anxiety and fear through their association with rape-induced terror. Some stimuli that are present in all rape incidents, such as a man and cues associated with sexual intercourse, could be conditioned stimuli for anxiety and fear for practically all rape survivors (Kilpatrick et al., 1985).

According to classical conditioning literature, fear and anxiety responses can generalize to other stimuli similar to conditioned stimuli present during the rape. The anxiety response induced by the stimulus of the assailant might generalize to other men with similar physical characteristics (Kilpatrick et al., 1985).

It has also been argued by Kilpatrick et.al (1985) that cognitive events can become conditioned stimuli by their association with

the rape incident. Thus, thoughts that are associated with the rape experience become conditioned stimuli for fear and anxiety. An example of this phenomenon is when the survivor becomes anxious when asked to describe the rape incident. In such a case, there are few, if any, physical stimuli to remind the survivor of the rape incident. Rather, it is the cognitive stimuli that elicit anxiety through their association with the rape.

"Second-order conditioning is defined as the process in which a previously neutral stimulus, if associated with a conditioned stimulus capable of eliciting a particular response, acquires the capacity to elicit that response". (Kilpatrick et.al, 1985:120) Therefore, any stimulus present at the same time as rape-related conditioned stimuli or cues can become a second-order conditioned stimulus that also elicits the conditioned response of anxiety and fear.

Second-order conditioning is important in that it promotes generalization of rape-induced anxiety to new situations and stimuli. "Every time a victim becomes anxious in response to a rape-related stimulus, a whole new set of stimuli and situations become conditioned stimuli. Additionally, there is every reason to believe that it occurs any time a victim experiences anxiety in the presence of those with whom she discusses or think about the rape". (Kilpatrick et.al, 1985:120)

2.5.2 BEHAVIOURAL APPROACHES TO TREATING PTSD

According to Jensen (1994) most of the behavioral approaches that have been used in the treatment of PTSD are essentially exposure-based approaches that can be categorised as systematic desensitization, flooding, or implosive therapy.

Systematic desensitization "basically involves identifying a series of increasingly anxiety-arousing stimuli or situations, training the patient in muscle relaxation techniques, and then systematically presenting the stimuli to the patient in vivo or

by imagination while concurrently having the patient actively maintain relaxation" (Bowen & Lambert 1986:282). Although this technique has been applied to many phobic stimuli and has received some support in treating PTSD, controlled studies in this area are lacking (Jensen, 1994). As a result "its application to the treatment of PTSD has not been extensively reported in the research literature" (Bowen & Lambert 1986: 282). In addition Shapiro (1989a) has also criticised systematic desensitization due to the length of treatment required, and for high rates of patient non-compliance (Jensen, 1994).

Flooding may be defined as the continuous presentation of conditioned traumatic cues in the absence of actual threat, so that the anxiety associated with the cues is eventually diminished (Jensen, 1994). In cases which traumatic conditioning took place under truly life threatening circumstances like with the combat veteran population, in vivo flooding has generally been considered impractical. As a result of this shortcoming, imaginal flooding which involves the presentation of critical cues via imagery has been considered the treatment of choice. There has been some success reported in group studies investigating imaginal flooding as treatment for combat related PTSD (Jensen, 1994).

Although the literature lends general support to exposure-based therapies as effective treatment of combat-related PTSD, "reviewers have identified shortcomings and potential hazards in these approaches" (Jensen, 1994:312). First, they may expose subjects to levels of anxiety that may be too long in duration and too intense (Wolpe & Abrahams, 1991). Wolpe (1990) maintains that prolonged in vivo exposure does exacerbate occasional cases. Finally, Shapiro (1989a) maintains that these techniques may fail to address irrational cognitions, and may also fail to offer generalizable coping skills.

2.5.3 BEHAVIOUR MODIFICATION IN THE SOUTH AFRICAN CONTEXT

As in psychodynamic psychotherapy behaviour modification techniques are also largely unavailable for the majority of South Africans. In addition to these shortcomings interventions also have the potential to exclude patients on the basis of language.

Most behavior modification therapists are either English or Afrikaans speaking. For a patient to benefit from therapy s/he has to understand the language in order to grasp the instructions involved in the training of relaxation techniques and the hierarchical building of anxiety-arousing stimuli.

2.6 EYE MOVEMENT DESENSITIZATION

According to Wolpe and Abrahams (1991) a good deal of success has in recent years been achieved by the use of behavioural techniques in the treatment of PTSD. However, the techniques have been time-consuming and laborious, and there have been many failures. As a result theoretical structures continued to evolve to foster more understanding of PTSD and to advance rational treatment approaches. Despite these efforts PTSD remains one of the more recalcitrant of the anxiety disorders (Kleinknecht & Morgan, 1992).

In 1987, an apparently much more rapidly effective method consisting of desensitization and using, in place of muscle relaxation, saccadic (rapid, rhythmic) eye movements was accidentally discovered by Francine Shapiro upon noticing in herself that recurring disturbing thoughts were mysteriously disappearing and not coming back (Wolpe & Abrahams, 1991). On careful self-examination she got to know that her eyes were moving involuntarily in a multisaccadic manner when the disturbing thoughts arose. If a deliberate attempt to retrieve the thoughts which had completely disappeared was made, they were found to be no longer distressing. Shapiro then made deliberate use of her observation with a variety of patients (Wolpe, 1990).

Marquis (1991) reports Shapiro's (1989a) controlled study where she demonstrated the technique's efficacy in eliminating the conditioned emotional responses to traumatic memories and associated reactions in subjects with PTSD. The study comprised 22 rape/molestation and Vietnam veterans (Shapiro, 1989a). In this study, the subjects (ages 11-53 years, mean = 37 years) reported traumatic memories that had been persistent for 1-47 years (mean = 23 years). They had been in previous therapeutic treatment for 2 months-25 years (mean = 6 years). Their presenting complaints included flashbacks, intrusive thoughts, sleep disturbances, relationships problems and low self-esteem. "A pivotal aspect was the memory of one or more traumatic incidents" (Shapiro, 1989a: 212). The dependent variables, measured at the initial session and one and three months later were (1) anxiety level, (2) presenting complaints, and (3) validity of a positive self-statement/assessment of the traumatic incident. "Each subject received a single session, with marked improvement, in contrast to the controls, which did not improve" (Marquis, 1991). Three months follow-ups revealed in treated subjects almost no return of the anxieties or associated complaints. The control subjects were then given the treatment, with beneficial results (Marquis, 1991).

2.6.1 APPLICATION OF THE TECHNIQUE

According to Shapiro (1989b) the traumatic memory is treated by requiring that the client maintain in awareness one or more of the following: (1) an image of the memory (2) the physical anxiety response, and (3) the negative self-statement or assessment of the trauma. Thereafter the client is asked to rate the subjective level of disturbance (sud) on a scale of 11 points (0 = no anxiety, 10 = highest anxiety possible) as in systematic desensitization. Although the optimal condition occurs when all three representations are held in the client's awareness, the presence of any one of them is sufficient to achieve full desensitization (Shapiro, 1989b).

With head immobile and the image held the client then visually tracks the therapist's index finger. The finger is moved rhythmically and rapidly back and forth laterally across the client's field of vision approximately 18 inches in front of the client's face, two back and forth movements per second (Puk, 1991). The back and forth movement of the therapist is repeated 12-24 times, each such grouping being referred to as one set (Shapiro, 1989b). After each set of saccades, clients are asked to blank the picture out and take a deep breath. Clients are then told to bring up the picture again and to give a sud rating. Marquis (1991) reports that if the sud level does not decrease after two sets of saccades, the client is questioned, to determine why. Often it is because of the intrusion of a difficult feeling, image or thought related to the original one. The intrusion must then be desensitized before returning to the old picture. Upon returning to the latter, it will often be discovered that the sud level has dropped considerably.

McCann (1992) maintains that EMD has also been reported by Shapiro (1989a), Puk (1991), Wolpe and Abrahams (1991) and Marquis (1991) to be very effective, often in one session even in cases that have been symptomatic for a prolonged period of time. According to their reports, "there are essentially no negative 'side effects' and there is practically no tendency to relapse" (McCann, 1992:319). His personal experience on the effective use of a single session of EMD was of an exceptionally severe case of a patient who endured 8 years of intense suffering from symptoms of PTSD. "The patient was the survivor of burns that left him with massive scarring, total deafness, bilateral amputations of the upper extremities above the elbow, severe contractures, and severely damaged feet and ankles" (McCann, 1992:319).

Although EMD has been used primarily to treat PTSD encountered in rape survivors and Vietnam veterans it has also been effective with other types of traumatic memories. Two such cases have been reported by Puk (1991). One was based on memories of a

terminally ill sister, and the other was based on traumatic memories of childhood sexual abuse. Follow-ups of 12 and 6 months after desensitization, showed maintenance of treatment effects. As a client states it:

"I have been treated using EMD in relation to early child sexual and physical abuse. I have been diagnosed as MPD and the treatment has seemed to help, although it helps more with some alters (sic) than with others, I'm not sure why, some refuse to try it. As to why it works, or doesn't work, I really don't know, although supposedly it "simulates" REM in dream states (?) So while we are remembering a particularly bad bit from the abuse our therapist directs us in EMD and we sometimes get relief of the very powerful feelings that were associated with the memory, emotions that often had us screaming or hitting ourself before the EMD. After the EMD we can sometimes manage to actually verbalize what the memory was about, and not totally collapse from it". (Internet message posted to the author, 1994)

Despite the effectiveness of the EMD procedure, Shapiro (1989b), however, states that it must be emphasized that in her cases the technique served to desensitize the anxiety related to traumatic memories, not to eliminate all PTSD-related symptomatology and complications, nor to provide coping mechanisms for the victims. It has been necessary for her to work with some clients for a number of sessions before all problems for a given client were resolved. In such cases an average treatment time of five sessions have provided profoundly successful results. These sessions also included modified EMD instructions to the client for personal use.

2.6.2 THEORIES OF FUNCTIONING OF EMD

Since EMD holds much promise in the treatment of PTSD many clinicians who have used it feel that a lot of research is needed to theorize the basis for its effectiveness which is still a mystery. For Shapiro (1989b) the crucial component of EMD procedure is the repeated eye-movements while the memory is maintained in consciousness. Therefore it is of interest to speculate how saccadic eye movements might produce these results. She believes that one of the most potentially fruitful areas of study involves Pavlov's theory of psychotherapeutic effect and the basis of neurosis which involves a balance between excitatory and inhibitory processes. According to this theory "if a given locus of the cortex excitation and inhibition come into conflict with each other at high intensity, the neural elements concerned may be unable to bear the strain and so undergo a pathological change by which the balance is overthrown, and then the animal presents neurotic symptoms. In accordance with this hypothesis, the essence of therapy would be to restore the balance" (Shapiro, 1989a: 220).

From this view-point Shapiro (1989a) states that the concept of information processing of the trauma "frozen state" needs examination. It may be suggested that pathological neural changes caused by a traumatic overload "freeze"/maintain the incident in its original anxiety-producing form. "This pathological change of neural elements blocks the neural progression of continued information processing to a resolution". (Shapiro, 1989a: 220) The incident is thus maintained in active memory and triggered as intrusive thoughts, nightmares, and flashbacks. Rhythmic, bilateral saccadic movements along with an alignment of cognition with pictorial image which connects to the physiologically stored traumatic memory may reverse the neural pathology, restore the balance, and allow the information processing to proceed to resolution with a consequent cessation of intrusive symptomatology.

The theory assumes that the effect of the traumatic incident is excitatory in nature and causes the imbalance of neural elements which is then inhibited by the repetitive multi-saccadic movement of the EMD process. This hypothesis has however been indicated by both experimental and clinical observations to be deserving further investigation (Shapiro, 1989a).

Montgomery and Ayllon's (1994) study supports the efficacy of saccadic eye movements in the EMD procedure. This study included six subjects who met the diagnostic criteria for PTSD. The study compared two EMD-based procedures: a non-saccade phase which functioned as a control and a second phase that included saccadic eye movements. Dependent variables included self report information and physiological data. Results showed no significant decreases in sud levels in the non-saccade phase. All self report measures for five of the six subjects revealed clinically and statistically significant treatment gains. However, all psychophysiological measures of treatment efficacy for all six subjects failed to demonstrate statistical significance.

Hedstrom (1991) recommends that an exploration of variation in the eye movements suggested by yoga procedures may be fruitful to explain and optimize clinical success. This suggestion is based on his personal experience with EMD which he employed for some time to self-manage his early awakening insomnia. At first he experienced some relief by using a progressive relaxation series involving 16 muscle groups which was not always adequate. He then experimented with the addition of a series of eye movements he learned in a yoga workshop which proved to be beneficial. Barm (1965) as cited by Hedstrom (1991) believes that eye movements distract one's attention from other problems and relieve muscular tension and enhances relaxation.

Following their study in which they concluded that eye movements are not essential to treatment outcome Renfrey and Spates (1994) suggested the following possibilities:

Firstly, it is possible that any object attended to in the visual task of EMD or other features of the EMD procedure function as safety signals. According to their safety signal hypothesis the omission of anticipated punishment is a reinforcing event. Brief exposure period and the therapist's controlled thought-stopping technique in EMD may keep anxiety within tolerable limits. "As a function of this 'dosing' of exposure to trauma recall, the level of distress experienced may be reduced below that anticipated thereby endowing salient features of EMD with safety. Accordingly, subject avoidance of trauma-related stimuli during treatment may be significantly reduced". (Renfrey & Spates, 1994: 231)

Secondly, the possible role of the visual task in EMD as a distractor needs consideration. Tracking a moving object likely requires greater attention than focusing on a fixed point. It is proposed that EMD may owe part of its efficacy to the distraction provided by the saccadic eye-movement task (Renfrey & Spates, 1994).

Lastly, in addition to a number of hypotheses most giving central credence to the role played by eye movements, Renfrey and Spates (1994) hypothesize that the eye movements of EMD may mimic those of REM sleep. This may account for anxiety reduction in EMD.

2.6.3 CRITICISMS

The latest literature maintains that a revised version of the technique, eye movement desensitization and reprocessing (EMDR) has been developed by Shapiro in 1991. It is presently widely taught in workshops throughout the world. As mentioned earlier, details of this revised procedure have not yet been published (Forbes et.al, 1994). This literature also criticises previous studies for not using objective or standardized measures of pathology to assess changes as a function of treatment. "In all cases, estimates of treatment efficacy were based on verbal reports from patient to therapist". (Forbes et. al, 1994: 114)

To counteract this flaw Forbes et. al (1994) conducted a study in which their purpose was to evaluate the efficacy of EMDR in the treatment of PTSD by using a range of objective and standardized measurement strategies at pre and posttreatment and three month follow-up. The study was originally designed to include a waiting list control group. There was, however a high drop-out rate from that group and time constraints precluded the possibility of recruiting further subjects. Therefore reported data was exclusively on active treatment group.

They used several strategies including structured interviews for PTSD to determine its presence and severity. Those subjects meeting the criteria for PTSD were further assessed using the Structured Clinical Interview for DSM-III-R in order to determine the presence of any comorbid diagnoses. This was included in order to investigate whether treatment effects would generalise to existing comorbid symptomatology.

Three self-report scales and the suggestibility scale were also used. "Suggestibility was selected as a pertinent area of investigation as the EMDR protocol includes a number of features reminiscent of hypnotic procedures". (Forbes et.al, 1994:114) The Stanford Hypnotic Clinical Scale was used to investigate the

effects of suggestibility on treatment outcome. Muscle tension was also assessed to provide a physiological correlate of clinical improvement.

Subjects comprised five males and three females recruited from a variety of sources, including public sector, psychiatric services, private practitioners, and a Veteran's Counselling Service. Treatment involved four, once weekly, 90 minute sessions.

Although findings suggested that EMDR may be at least moderately effective in reducing symptomatology in all three PTSD symptom categories, self-report measures suggested that significant pathology remained following treatment. This was "highlighted by the finding that 50% of the subjects still met the criteria for a full diagnosis of PTSD at both posttreatment and 3-month follow-up" (Forbes et.al, 1994:18).

Another interesting feature of this study was the incongruence between subjects' reports of having "gained a great deal" and "feeling better" at posttreatment despite high levels of residual symptomatology remaining on objective assessment. Considerable variation was evident between subjects' responses to treatment, ranging from little or no change in some to dramatic in others. Of all the factors that may be associated with EMDR, suggestibility correlated significantly with pre to posttreatment improvement. "One explanation for this finding may be that suggestibility is a measure of a subject's ability to generate images". (Forbes et.al, 1994: 19)

Lastly, "a significant negative correlation was evident between chronicity and longer term response to treatment. As with other interventions it is possible that EMDR is optimally effective with more acute forms of the disorder" (Forbes et.al, 1994:119).

Although the extent of improvement in this study was limited, which can be said of other contemporary treatments for PTSD, this

research nevertheless provided some support for the technique. Researchers have also stated that these findings must be interpreted cautiously due to the small sample size and the absence of placebo treatment condition to control for nonspecific therapist effects (Forbes et.al, 1994).

In another recent study Jensen (1994) investigated EMDR with 25 Vietnam combat veterans with PTSD, randomly assigned to EMDR or a control group. Data from this study failed to support the effectiveness of EMDR with Vietnam combat veterans. Although effective in reducing in-session subjective anxiety upon exposure to traumatic cues, EMDR "was not effective in improving other PTSD symptoms, in contributing to goal attainment, or in increasing subjects' beliefs in their desired positive cognition. The results imply that EMD/R may not be successful in treating Vietnam combat veterans with PTSD" (Jensen, 1994:311).

According to Jensen (1994) results of this study should, however, also be interpreted with caution due to a number of limitations. For example, in addition to the need for increased standardization, it is also possible that more experienced therapists may have been more effective in providing treatment. Therefore, "increased standardization in training, and in the EMD/R procedure itself, appears necessary for therapists in the field approach the efficacy in using EMD/R" (Jensen, 1994:323).

According to Jensen (1994) lack of supportive results in future studies and continuing unimpressive results in controlled studies, would limit the significance of any current and future theoretical EMDR developments, and would indicate insufficient justification for continued clinical use of the technique. They could also cast doubt "on the validity of Shapiro's (1989a, 1989b) suggestion that simultaneously induced eye movements, combined with appropriate cognitions and images, genuinely contribute to a restoration of neural balance, ultimately ceasing intrusive symptomatology" (Jensen, 1994:323).

According to Marano (1994) EMDR is used by 7,000 therapists in America and other countries. All of them have paid large sums of money to learn the technique which is in Marano's opinion simple-looking. Some of the questions further raised by Marano are as follows: Is EMDR:

- (1) A blatantly commercial enterprise?
- (2) The cure for victims of traumatic memories of questionable authenticity?
- (3) A quick psychiatric fix tailor-made for a generation unwilling to do the hard work necessary for mental health in a complex world, the behavioral equivalent of Prozac?
- (4) A substantially untested treatment?

For Marano, EMDR turns out to be all of the above. S/he further reports that in an attempt to understand the technique s/he realised that "nothing is quite what it seems, even the hand waving" (Marano, 1994: 22).

2.6.4 COMPARISON BETWEEN EMD AND HYPNOSIS

Hypnosis is a "special state of conscious awareness in which certain chosen behavior of everyday life is manifested in a direct manner, usually with the aid of another person" (Erickson, 1980:54). It is well known that in the state of ordinary, conscious awareness different ideas and understanding can impinge easily upon a performance and distort those goals which may have been singly desired (Erickson, 1980). In a state of hypnosis however, the field of conscious awareness is limited and tends to be restricted to exactly relevant matters, other considerations being irrelevant. This then results in the client being open to suggestions which would either bring full relief or the reduction of the symptomatology (Erickson, 1980).

Although in principle hypnosis and EMD procedure are different, based on the above definition and usage of hypnosis the similarity is that in its nature EMD also limits the client's

conscious awareness, and enhances attention because he/she is asked to exactly visualize the traumatic memory only. If there is any intrusion, of a difficult thought or feeling in the process, the intrusion is desensitized first. This desensitization of intrusions as they come along can also be seen as enhancement of performance which could disrupt the desired goal as in hypnosis.

The therapist's fingers which move across the client's field of vision can be seen as suggestion by gesture especially if its relaxation effects have been explained to the client. These fingers can also resemble a hypnotic pendulum although they are not accompanied by strong suggestions as in hypnosis. The outcome in both techniques i.e. in hypnosis with its usage of the pendulum and EMD with the elicitation of eye movements, is relaxation, which is the aim of both techniques. This relaxation in receptive hypnotic subjects enhances drowsiness, or concentration (Satow, 1923). Concentration and attention are also enhanced in EMD. Much of the relaxation induced by multi-saccadic eye movements in EMD is said to be anxiety counter-active. Orne et. al (1988) also maintains that hypnotic induction and its deepening procedures induce calmness, pleasantness and security.

Furthermore both techniques force clients to hold to consciousness the memories that they have been resisting or repressing and actively participate in the reorganization of these memories. The subject's participation and activity in medical hypnosis is highly valued since it is his/her needs that must be met (Erickson, 1980). Orne et. al (1988), however state that the reorganization of psychic life and the success of hypnosis owes much to the fact that often when patients hold to consciousness the memories that have been repressed, they experience intense emotions of which the patient was previously unaware and such abreaction is generally followed by clinical improvement.

In an attempt to speculate the reasons for the effectiveness of

EMD, Wolpe (1990) cites Jacobson (1939) who also mentioned that in his observation relaxation of the extrinsic eye muscles has extraordinary emotional potency. "This covariation of memory and emotion leads naturally to debate over which process is responsible for the patient's improvement - insight from the memory, or experience of the intense emotion, or both". (Orne et. al, 1988:38)

Both Erickson (1980) and Orne et. al (1988) also stress the importance of the therapeutic relationship in the success of hypnosis. Orne et. al (1988) maintain that the therapist's willing, non-critical acceptance of the patient's evoked affect and behavior is crucial. This non-critical acceptance and support of the therapist also alleviates the patient's internally and externally feared criticism of the emotional response. The same applies for the guilt or shame, that may be aroused in the patient when later thinking of the traumatic event. Although the importance of a healthy therapeutic relationship has not been mentioned in the literature on EMD it is assumed that its success would also be influenced by the nature of the therapeutic relationship. Its somewhat mysterious nature can lead to rejection if the patient has not developed trust in the therapist.

Lastly, the Pavlovian theorization seems to apply in both techniques. According to the Pavlovian system inhibition is a protective mechanism necessary for the survival of the organism. According to Das (1965) inhibition and excitation are at opposite poles. When a nerve cell is stimulated beyond its physiological capacity, inhibition takes place. When an extinguished conditioned stimulus is also continuously applied, inhibition sets in, to protect the cortical cells from unnecessary excitation.

This theory assumes that the effect of the traumatic incident is excitatory in nature and causes the imbalance of neural elements which predispose the organism to pathological stimulation

irrelevant for its survival (Shapiro, 1989a). The EMD procedure, therefore, returns balance to the neural elements with rhythmic multi-saccadic movements which may be the body's automatic inhibitory or excitation releasing mechanism (Shapiro, 1989a). In hypnosis although sleep and internal inhibition are not identical they are similar in that sleep works on the same principle as in EMD to bring about neural balance.

2.7 CONCLUSION

All the different therapeutic interventions covered in the literature have received some support in the treatment of traumatic memories. Except for crisis intervention which can range from 1-20 sessions the others are however much more lengthy and not fully accessible to the majority of South Africans.

Therefore, this study has explored clinical experience with EMD, which is a short term therapeutic intervention and can be easily offered over brief periods of admissions in hospitals and trauma centres. The therapeutic procedure and instructions involved in EMD are also simple enough to accommodate victims of different educational backgrounds.

CHAPTER THREE

METHOD

This exploratory study is based on a case study method as described by Bromley (1986). "The term 'case study' means different things to different people. To the psychologist it means the study of an individual person, usually in an a problematic situation, over a relatively short period of time". (Bromley, 1986: IX) A case study gets as close to the subject of interest as it possibly can, by means of direct observation and its access to subjective factors (Bromley, 1986).

A case study also allows the subjects to give views of themselves, their circumstances, and enables them to deal with episodes of deep emotional significance. This is beneficial to both the subject and the investigator in terms of improving the understanding and management of the problem. However, subjects who do not have the insight needed to give a personal account of themselves and their circumstances may not benefit much from counselling directed towards increased self-understanding and self-management (Bromley, 1986).

Confidentiality is in most cases a major concern, as subjects disclose their private personal information. A case study allays this anxiety by disguising the subject's origins and identity without significantly affecting the validity of the analysis (Bromley, 1986).

Bromley (1986) further states that, although the case study is sometimes said to provide insight into, rather than refutation or confirmation of, a law or a principle, a rigorous and systematically detailed case study will often refute any obvious, simple-minded theory and will itself stimulate original, creative thinking that leads to solutions to difficult problems. It enables the investigator to formulate a convincing theory that

accounts for the facts of the case, or to realize that a particular interpretation is correct. Furthermore, an expert investigator will occasionally deal effectively with a particular case which if made known to others, sets a precedent and contributes to the development of 'case-law' in that area (Bromley, 1986).

Despite its ability to offer a more global form of understanding, its potential to reveal social structures and processes, and its usefulness as an exploratory method, the case study approach has been neglected. "The neglect has been aggravated by the identification of the case-method with psychodynamic psychology and with social work, where there appears to have been no success in developing a scientifically acceptable framework for understanding and dealing with individual cases". (Bromley, 1986: X) Case studies are also not prominent in scientific work because they deal with private matters and can usually be reported only with the permission of the subject concerned or if suitably modified to avoid identification (Bromley, 1986).

In this study a case study method allows a detailed exploration and analysis of each individual case from which hypothetical and theoretical explanations on the efficacy and process of EMD can be based.

PROCEDURE

The procedure adopted in this study was to provide a brief account of what occurred throughout the eye movement desensitization process in two cases. My main emphasis was, however, on the application of the technique and its therapeutic outcome. Both my patients, whose names I will not use for purposes of confidentiality, were admitted to a large psychiatric hospital in Cape Town. They were both rape survivors and they both qualified for the diagnosis of post-traumatic stress disorder. Some of the content of their traumatic experiences have, however, been disguised and trivial details have been also

censored.

I saw each of them twice a week for approximately 30-50 minutes sessions over a period of one month. Throughout my intervention I relied very much on the nursing staff's observations of my patients to verify the effects of the technique. Of significance is that in the first case I was a team member of the ward whereas in the second case I was an outside therapist and only came in for therapy sessions. In both cases therapy sessions also included history taking.

CHAPTER FOUR

CASE MATERIAL

4.1 CASE ONE4.1.1 BACKGROUND INFORMATION

The patient was a 33 year old, divorced, female. She was employed and lived with her three children under extremely poor living conditions. She was raped in a train toilet six months prior to admission. Shortly after this incident she experienced feelings of shame and humiliation, and became withdrawn at work. She also suffered nightmares, flashbacks of being choked by the rapist, and an extreme persisting fear of all toilets. The latter was so severe that she demanded to be accompanied to the toilet. A month later she began to drink alcohol excessively but stopped on realizing that the symptoms were still persistent. This was then followed by insomnia, decreased appetite, loss of energy and weight and poor concentration. Three months later she started seeing a male psychologist once a month but found it difficult to trust and work with him because of his gender. She terminated therapy and withdrew from all interactions with males. At this point she was already on an anti-depressant. She then began to have serious interpersonal conflict with some of her co-workers which reinforced her isolation. She went on leave during which time she deteriorated, became suicidal, and needed hospitalization. In the ward round she expressed her emotional distress and her wish to die if she continued to have the toilet phobia. She also reported physical complaints like constipation which she linked to her inability to go regularly to the toilet.

She was diagnosed to have both Major Depression and Post-traumatic stress disorder.

4.1.2 IN PATIENT MANAGEMENT

The team decided that an attempt to desensitise the patient from the toilet phobia should be the first priority in individual therapy as the problem was not only distressing for her but also predisposed her to secondary medical complications. She was also to join group therapy, anxiety management group, and participate in ward programmes in general once her depression had slightly lifted. Social work services regarding placement of the children during the patient's admission, and assistance in finding a house, were also offered. The patient was also to continue with medication.

4.1.3 INTERVENTION

4.1.4 APPLICATION AND PROCESS OF EYE MOVEMENT DESENSITIZATION

4.1.4 (1) FIRST SESSION: (Day 12 of her admission)

The patient was still distressed by her toilet phobia and expressed her motivation and willingness to participate in therapy so that she could be cured. I asked her what comes to her mind when she has to go to the toilet and she said it was an image of the rapist. In simple language I explained to her that she acquired this maladaptive fear through learning to associate the toilet train with the rape incident. It is this association which evokes severe anxiety in her each time she has to go to toilet. I also explained the EMD technique and its procedure including the subjective level of disturbance scale (sud scale).

We used a 1-10 sud scale with 0 = no anxiety and 10 = highest anxiety. The patient immediately rated herself 7 out of ten. She was then asked to hold the image of the rapist while visually tracking my finger which moved rapidly and rhythmically across her field of vision. In the middle of this process the patient burst out crying and verbalised feelings of self-blame, self-

hatred, guilt, and anger towards the rapist. At this point I stopped the EMD procedure and facilitated the ventilation of feelings. At the end of the session the patient rated her anxiety 3 out of 10 on a sud scale.

4.1.4 (ii) SECOND SESSION: (Day 15 of her admission)

The patient reported feeling better. Flashbacks and nightmares had significantly decreased. Since the previous session she had been able to go to toilet by herself. She, however, still found it difficult to interact with male patients in the ward.

She rated her anxiety three out of ten as she visualised an image of herself sitting around the table with male patients during meal times. Sets of 30 saccades were again generated during which she appeared calm and her anxiety had decreased to 1 at the end of the session. She was then encouraged to start using other hospital toilets during the day time apart for the ones in the ward.

4.1.4 (iii) THIRD SESSION: (Day 17 of her admission)

The patient was found to have been completely desensitized from the toilet phobia and her thoughts about the rape were no longer distressing. Flashbacks and nightmares had disappeared. She also felt less anxious in the presence of male patients. EMD therapy was terminated.

On discharge 3 follow-up sessions at two months intervals were arranged in which the patient continued to be asymptomatic. Her relationships at work had improved and she had begun to be very active in church. In the last session she reported witnessing a rape incident in the train while she was travelling from work to home. This incident however did not precipitate a relapse.

4.2 CASE TWO

4.2.1 BACKGROUND INFORMATION

The patient was a 32 year old, unemployed, single, female from Port Elizabeth. She had left her two children with their paternal grandparents in Port Elizabeth. She had been violently raped three years prior to admission by a man who was known to her friends. The incident took place in the rapist's house where he had a fish tank which he constantly spoke to during the rape. For fear of being humiliated she kept the incident secret. Shortly after the incident she felt depressed, lost appetite and weight, and could not concentrate as she was always preoccupied with the rape and especially with the memory of the fish tank. Four months later she began to suffer insomnia, nightmares, and flashbacks of being beaten by the rapist. Her nightmares were so severe that she woke up every morning around 3 am and walked outside. She also began to avoid contact with males which led to termination of her relationship with her children's father.

At the beginning of 1994 the patient decided to move to Cape Town in a desperate attempt to forget about the rape. She moved in with a friend and also found a job. She continued to have debilitating flashbacks at work and decided to resign. She then began to have physical complaints which needed medical attention. Physical examination by a male doctor then precipitated a relapse which led to admission.

4.2.2 IN PATIENT MANAGEMENT

As in the first case, part of treatment involved participation in ward programmes. Psychotropic medication was also prescribed for the patient. The patient also had a permanent male therapist in the ward whom I was to liaise with in terms of giving feedback on the therapeutic progress. The role of this therapist was mainly to offer support and containment if needed by the patient

in between EMD sessions. Due to gender issues the patient however preferred to use his therapeutic services minimally. Reasons underlying the gender issue in the work with rape survivors are discussed in the following chapter.

Most of the liaison however took place via the nursing staff whom I consulted with before each EMD session for feedback on the patient's daily functioning. The decision on the patient's discharge from the ward relied mainly on progress made in the EMD therapy.

4.2.3 INTERVENTION

4.2.4 APPLICATION AND PROCESS OF EYE MOVEMENT

DESENSITIZATION

4.2.4 (1) FIRST SESSION: (Day 14 of her admission)

The patient reported inability to sleep the previous night due to nightmares and flashbacks. She also spoke about her feeling of helplessness which persisted since the rape incident. She felt guilty about having not defended herself although she perceived the rapist as a dangerous psychopath who could have killed her if she had attempted to fight back. It was clarified to the patient that her feeling of helplessness during the rape was however accompanied by fear and extreme anxiety. Therefore any thought associated with this incident acquired the potential to evoke fear and anxiety in her. She therefore constantly attempted to avoid these thoughts which only served to perpetuate her symptoms.

The EMD technique and its procedure including the sud scale was then explained. Thereafter the patient was asked to hold an image of the rapist and to rate her anxiety which she rated 5 on a scale of 1-10. She then visually tracked my finger until a set of 30 saccades was completed. She was again asked to rate her anxiety which had increased to 8. We repeated the same procedure with the same image. In the middle the patient began to sweat

profusely and burst out crying. She said the picture was becoming more vivid and brought on memories that she had forgotten about the rape especially the memory of the fish tank to which the rapist constantly spoke during the rape. We agreed on desensitising her from this memory in the next session. Although the therapeutic environment was very containing and the patient's anxiety had decreased to 3, she appeared very vulnerable and exhausted at the end of the session. Nursing staff were specifically asked to offer the patient further containment in the ward.

4.2.4 (ii) SECOND SESSION: (Day 17 of her admission)

Patient was still willing to deal with the fish tank memory. She was then asked to maintain in her awareness the image of the rapist talking to the fish tank and how she felt at that time. With this image in awareness she rated her anxiety 7 out of 10. We repeated the procedure until the patient's anxiety decreased to 2.

4.2.4 (iii) THIRD SESSION: (Day 20 of her admission)

In this session the patient reported that she had been practising the technique on her own and that flashbacks and nightmares were disappearing. Her thoughts about the rape were also no longer distressing because she had learned to accept that it had happened. She also began to develop friendships with males in the ward. She then asked me to desensitise her from another memory which involved a sexually transmitted disease which she contracted following the rape. Her anxiety rated 4 and had decreased to 0 at the end of the procedure. The patient cried at the end of the session and said they were tears of relief because she had eventually confronted the problem.

4.2.4 (iv) FOURTH SESSION: (Day 24 of her admission)

The patient reported that her nightmares had completely

disappeared and that she no longer anticipated flashbacks. She felt that her self confidence and self esteem have also improved. Therapy was terminated. The patient was referred for psychotherapy to deal with long-term psychodynamic issues which had been evoked by the rape.

On follow-up after four weeks the patient was still asymptomatic. She had managed to go back home in Port Elizabeth to see her children. In Port Elizabeth she coincidentally saw the rapist but this had no impact on her although it reminded her of the rape.

CHAPTER FIVE

DISCUSSION

In this study two inpatient rape survivors were given 3-4 sessions of EMD. The patients' verbal reports and nurses' observations were used to evaluate the therapeutic process and outcome. They showed significant improvement in the patient's functioning. Various factors need to be considered in evaluating the effectiveness of EMD.

5.1 CATHARTIC EFFECT

According to Biaggio (1986) there has been a growing body of literature which seriously questions the value of therapeutic catharsis. However, many psychotherapists still subscribe to this Freudian perspective on expression of repressed or unexpressed emotions. For them ventilation in therapy is desirable and beneficial for clients. The literature also states that patients who show the most catharsis do not necessarily show the most change whereas those who do not express feelings at all do not improve (Engle et.al, 1991).

Despite all these debates there is some consensus that constructive catharsis with a caring and empathic psychotherapist may produce significant psychotherapy outcome (Engle et. al, 1991).

Focused Expressive Psychotherapy (FEP) which is based on the principles of Gestalt therapy specifically focuses on inhibited and constricted emotions to enhance the patient's well being (Engle et.al, 1991). In crisis intervention with rape survivors, individual counselling, and group psychotherapy with PTSD patients, permitting of the venting of feelings of anger, guilt, pain, and feelings of inferiority has proved to be one of the curative factors (Makler et.al, 1990).

It is against the above theoretical background and the

therapeutic outcome in both case studies that I hypothesise that EMD facilitated catharsis which was necessary and beneficial for both patients. Due to its focused nature and clearly defined therapeutic goal it forced them to bring to conscious awareness traumatic memories about the rape which they previously avoided or repressed. This restriction and visualization of the rape incidents elicited an affective experience which in turn facilitated ventilation. This happened during the first session of the desensitization procedure.

Although one of the patients appeared vulnerable and exhausted towards the end of the session, her anxiety on the subjective level of disturbance (sud) scale had decreased. This indicates that therapy had brought some relief. It cannot be entirely argued that the vulnerability somehow resulted from prolonged exposure to heightened anxiety as in flooding because the administration of eye movements stopped during the second set of saccades to allow ventilation. The exhaustion could be linked to a period of exhaustion which normally follow strong abreaction (Carek, 1990).

Catharsis in both cases was however not therapeutic in itself. I had to be flexible in my therapeutic approach, shift from waving my fingers in the patients' field of vision to establishing a therapeutic ambience conducive for effective and healthy catharsis. This environment required full empathic support and availability and sharing of the patients' anger and pain. In the first case active physical support and comfort had to be offered as well.

The gender issue could be seen to have had a positive effect on the therapeutic relationship as my patients clearly verbalised lack of trust for male therapists. According to McCombie and Arons (1980) lack of trust for men is common in almost all female rape survivors. They prefer relating to female therapists because they assume that women are capable of offering empathy and understanding in such a situation.

Sessions which followed the first session revealed a significant decrease in PTSD symptomatology. The first patient was completely desensitized from the toilet phobia. The second patient reported that since she has learned to accept the rape the thoughts about it were no longer distressing. She had also learned to administer eye movements on herself when the memories come instead of avoiding them like she previously did. It shows that the patient had regained some control and a sense of competence. Her acceptance of the rape also indicates a sense of mastery over the rape. This may be further explained as an increased sense of continuity with the past, and the integration of meaning of the experience into the patient's world view which takes place during Lindy's (1986) termination phase in psychotherapy of PTSD.

The sense of mastery and control had a positive effect on their restoration of a sense of self-worth and esteem which showed in their improved relationships with males in the ward. On follow-up the first patient reported that she had joined church and this required a lot of interaction with men which she was happy about. Shapiro's (1989a) controlled study with rape and Vietnam veterans also revealed a marked improvement in relationships and self-esteem after treatment.

Furthermore in my case studies the criticism by Marano (1994) that the application of EMD engenders dependence and powerlessness in clients was not supported. Once the therapeutic goal had been achieved both patients were happy with termination and felt ready for a discharge so that they could go and commence their normal day to day functions.

5.2 HOSPITAL CARE

Although EMD therapy was the primary treatment modality it was interwoven with other milieu programmes such as group therapy and anxiety management groups. The input from these groups could be said to have contributed towards the therapeutic success. The first patient however joined them after termination of the EMD

procedure. Prior to this she would not have been able to participate and benefit from these groups due to her incapacitating depression which was linked to her distress about her toilet phobia. The role of psychotropic medication in the upliftment of her depression also cannot be ignored. The second patient joined the groups while half way through the EMD process.

According to Robbins (1980) therapeutic milieus with their different programs are designed to elicit patient participation in their treatment and increase their sense of being in charge of themselves. This reduces inappropriate regression and a sense of isolation and dependence. Support provided by a multidisciplinary professional team also makes it possible for anxiety laden material to be dealt with more rapidly and effectively than could ever be possible if patients were not hospitalized (Schwartz & Swartzburg, 1976).

In the first case in particular, team support included social work services geared towards arranging appropriate placement for the patient's children while she was still admitted. On elaborating on the need to adjust immediate role responsibilities in the treatment of rape survivors Calhoun and Atkeson (1991:42) state "the responsibility for caring for a home and children may create additional stress for the victim so that her recovery is delayed". There was also an attempt to reduce the patient's long term psycho-social stressors by extending services so as to include assistance with finding a better house for the patient. All these were beneficial and enhanced treatment.

5.3 THEORETICAL IMPLICATIONS OF THE STUDY

Both case studies revealed positive therapeutic outcome achieved in less than four sessions. However, it is difficult to attribute the improvement to EMD alone as much of the healing seems to have been achieved in the first session which was predominantly cathartic for the patients.

Although the focus was not on the clarification of underlying defenses as in psychodynamic psychotherapy, reflection on patients' feelings of self-blame and anger towards the assailant was necessary to facilitate constructive catharsis. In psychodynamic terms this conscious awareness and ventilation of anger towards the perpetrator is highly valuable. It is assumed that in most cases survivors internalize the anger which then manifests in a variety of destructive actions (Bassuk, 1980).

It is surprising that in her theorization Shapiro has not considered the probable cathartic effect or the affective experience elicited by the technique. PTSD is characterized by extremely traumatic memories hence the memories are constantly avoided or repressed. Visualization of these memories elicit not only anxiety but a variety of emotions. Once these memories have been accessed they will need an outlet. It cannot be simply assumed that repetitive application of eye movements will induce relaxation or serve as a competing stimulus which would then be followed by inhibition of anxiety and the restoration of neural imbalance.

Shapiro's explanation is based on the Pavlovian theory and has already been strongly criticized by authors such as Marano (1994) for being very mechanistic. To give further evidence on why she sees the theory as mechanistic, Marano (1994) reports that in her conversation with Shapiro, Shapiro maintained that traumatic memories are locked in a neurochemical envelope in the nervous system. Marano rejects this physicalistic metaphor. Such strong

criticisms however fail to acknowledge that Shapiro has not yet taken a definite theoretical stand point but is rather still speculating how the technique works.

Furthermore, although EMD served to direct and focus the patients' attention on the therapeutic goal, which was desensitization from anxiety related to the rape, it is also hypothesized that the patients' strong motivation and willingness to participate in therapy had a positive influence on the outcome. They were both genuinely desperate to regain their normal functioning. This desperation resembles a crisis situation in that their previous coping mechanisms and defenses were failing as a result their ego had become more open to treatment and change (Golan, 1978). There is a strong likelihood that patients who are not fully motivated and committed would reject EMD as it seems too simple and mysterious.

In general EMD seems to be a promising treatment for traumatic memories. If therapeutically adapted to each individual patient's needs and guided by a broad theoretical understanding of the dynamics involved in the treatment of traumatic memories such as rape and PTSD it can prove to be time and cost effective.

Shapiro (1989a,b) emphasizes that specialized and intensive training for clinicians in the EMD procedure will be necessary for the highest success rates. However, the fact that other untrained therapists have successfully used it strengthens the contention that it is a standardized treatment procedure, independent of Shapiro's special and perhaps unspecifiable personal characteristics (Shapiro, 1989a). In this study my lack of training did not seem to affect therapeutic outcome. The technique was easy to learn and administer. However, clinical and therapeutic experience were necessary to complement treatment.

This study supports the opinion that EMD still needs to be further researched and adequately theorized to justify its usage. One clinical psychologist specializing in trauma and PTSD

maintains that there is currently a great interest and a lot of work is being done to figure out the mechanism of how it works. "There are likely to be a number of factors involved and the salient eye movements may be only one of several 'ingredients'-- so less important than they first appear". (Internet message posted to the author, 1994)

Adequate research and theorization will protect it from continuous criticisms in the field of psychology. Marano (1994) has already stated that it is embarrassing and exposes psychology to the potential of ridicule and also causes a rift between the science of psychology and practice of psychotherapy. While such criticisms might be valid they might also stem from clinicians' loss of hope stemming from failure in the treatment of PTSD.

Despite criticisms people benefitting from treatment continue to report:

"I can tell you my perspective as someone going through this therapy.. The results have been tremendous. But my understanding (also..maybe wrongly) was that this particular therapy targeted trauma. I have been severely traumatized and I have experienced a great deal of relief since I started this treatment". (Internet message posted to the author, 1994)

"I know we have a lot to work through but I am feeling much better about the process even though it is very difficult and tiring with the sessions. At times I think..this is all in my head..but then who cares if the relief from the trauma is forthcoming" (Internet message posted to the author, 1994)

5.4 CONCLUSION AND IMPLICATIONS FOR SOUTH AFRICA

Through personal communication the author was made aware of the existence of the only two qualified EMD therapists currently in South Africa. These therapists have however not yet conducted research in this field. As a result there is a strong likelihood that the present exploratory study is the first of its nature in South Africa. Therefore the positive therapeutic outcome achieved in the two cases needs to be used or interpreted with caution. More studies and research need to be done so as to validate the usage of EMD in the South African context.

Due to its novelty especially in South Africa therapists will have to be careful in administering it on an outpatient basis. It has a strong provocative nature which might be harmful if not met by a supportive and containing environment. As mentioned in the introduction, many South Africans live in exceptionally stressful and violent circumstances. This difficult context needs to be born in mind when decisions about in-patient or out-patient EMD are made. One advantage of in-patient treatment is that it can offer support for the therapist. Treating PTSD with a new therapeutic technique is not only challenging but also induces emotional fatigue.

It may be worthwhile therefore to explore EMD on an in-patient basis first before moving to out-patient settings. Out-patient settings in the long run are desirable for reasons of cost and accessibility.

In addition to its time- and cost-effective nature, EMD seems to have the potential to meet the needs of our multilingual society. The procedure and instructions involved in its administration are less verbally loaded even than those in systematic desensitization and therefore can be easily translated into different languages. For example in this study the therapist's original language is Tswana. Both patients were Afrikaans

speaking but understood and could converse in English. Despite their ability to speak English, however, the first patient preferred speaking Afrikaans during therapy sessions. To maximise the therapeutic outcome it was deemed necessary to conduct therapy and administer EMD in the patient's language. This was done with ease.

Furthermore the hypothesis that the technique is cathartic needs to be further investigated. Catharsis is non-verbal. Therefore it is assumed that if EMD is cathartic most South African patients would benefit irrespective of their different spoken languages. An in depth analysis and comparison between EMD and hypnosis would be worthwhile to unravel the cathartic theorization. Regardless of how (or even whether) EMD works, it seems to assist both clinician and patient to focus on traumatic memories. This alone implies that its potential for further use in South Africa should be explored.

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