

EXPLORING EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR) AS A TECHNIQUE FOR THERAPEUTIC INTERVENTION OF ADOLESCENTS EXPERIENCING TRAUMA

by
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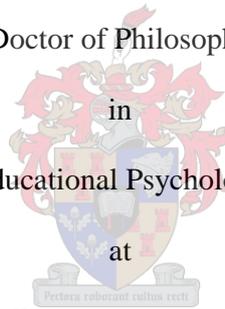
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DECLARATION

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ABSTRACT

The research explores Eye Movement Desensitisation and Reprocessing (EMDR) as a possible therapeutic technique in interventions dealing with trauma. The study focuses specifically on the adolescent phase. A distinction is made between developmental trauma and single-incident trauma and its impact on development.

An attempt is made to acquire a deeper insight into adolescents' experience of trauma. The purpose of the adolescent phase is the development of a sound identity. The challenges and the impact of traumatic experiences on the development of the adolescent on the road to adulthood are examined more closely. The symptoms of trauma and specifically the effect of trauma on the adolescent are highlighted.

The study adopted an interpretivist paradigm. A qualitative design with multiple case studies was selected for the research. The research included five cases. The study was limited to adolescents who ranged in age from 13-19 years in an Afrikaans school in Johannesburg. Intake discussions were held with the parents. Intake discussions in accordance with the EMDR approach were held with the participants. Each participant attended 4 sessions.

Various themes were identified in each interview, but two main themes emerged: the emotions of the adolescents regarding the trauma they experienced; the influence of trauma on the self-concept of the participants; that led to a deeper grasp of the participants' experiences. An insight was gained into the influence that traumatic experiences had on the lives of the participants as well as the influence of these experiences on their families, school and social contexts.

The main findings indicate that EMDR as a therapeutic technique does have the potential to provide support to adolescents who have been exposed to single-incident or developmental trauma.

SAMEVATTING

Die navorsing handel daaroor om Oogbeweging Desensitisasie en Herprosessering (*Eye Movement Desensitization and Reprocessing*) (EMDR) as terapeutiese tegniek te eksplorieer as moontlike intervensie vir trauma. Die studie fokus spesifiek op die adolessente fase. Daar sal onderskei word tussen ontwikkelingstrauma en 'n enkele traumatiese ervaring en die impak daarvan op ontwikkeling.

Daar is gepoog om 'n verdieping van insig met betrekking to die adolessent in sy ervaring van trauma ter verkry. Die adolessente fase het ten doel tot die ontwikkeling van 'n gesonde identiteit. Die uitdagings en die impak van traumatiese ervarings op die ontwikkeling van die adolessent op sy pad na volwassenheid word van naderby bekyk. Die simptome van trauma en spesifiek die effek van trauma op die adolessent word uitgelig.

Die studie was vanuit die interpretivistiese paradigma onderneem. 'n Kwalitatiewe navorsingsontwerp met meervoudige gevallestudies was geselekteer. Vyf gevallestudies is in die navorsing ingesluit. Die studie was beperk tot adolessente wat wissel tussen die ouderdom van 13-19 jaar wat verbonde is aan 'n Afrikaanse skool in Johannesburg. Invoergesprekke is met die ouers gehou. Invoergesprekke volgens die EMDR benadering is met die deelnemers afgelê. Daar is 4 EMDR sessies aan elke deelnemer gebied.

Verskeie temas is in elke onderhoud geïdentifiseer. Daar het twee hooftemas na vore gekom: die emosies van die adolessente ten opsigte van die trauma wat hulle beleef het, die invloed wat trauma op die self-konsep van die deelnemers uitgeoefen het wat ondersteun het tot 'n diepe begryping van die deelnemers se ervarings. Insig is verkry in watter invloed traumatiese ervarings op die lewe van die deelnemers gehad het asook die invloed daarvan op hul gesinne, skool en sosiale konteks.

Die hoof-bevindinge dui daarop dat EMDR as terapeutiese tegniek wel oor die potensiaal beskik in die ondersteuning aan adolessente wat aan 'n enkel-insident of ontwikkelingstrauma blootgestel is.

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TO GOD ALL THE GLORY

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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The rationale for this research will be clarified in this introduction by elaborating on the nature of traumatic experience and Eye Movement Desensitisation and Reprocessing (EMDR) as a therapeutic model. Cohen, Mannarino and Deblinger (2006) describe examples of traumatic events as: child physical and sexual abuse, domestic violence and witnessing violence at school. The impact of such events differs from child to child and is influenced by the intensity of the event, developmental level and age (Cohen et al. 2006; van der Kolk, van der Hart & Weisaeth, 2007). EMDR is a therapeutic method addressing trauma experienced by individuals. In this study the focus will be on the adolescent phase and adolescents' experiences of trauma.

The literature emphasises that the adolescent phase is regarded as one of the most complex phase of development (Dinkmeyer & McKay 1998; Levine & Kline 2007; Solomon & Siegel 2003). Trauma symptoms in adolescents can manifest in different ways such as becoming defiant, aggressive or withdrawing from social activities and communication (Kaminer & Eagle 2010). Therefore the purpose of the research is to explore whether Eye Movement Desensitisation as treatment modality is suitable for adolescents who have experienced trauma and present with trauma symptoms such as, anger, shame, guilt, irrational beliefs and a negative self-image.

Central to this chapter is the description of the research design, the paradigm and the methodology chosen for this study. After the outline of the research methodology, the scope of the inquiry and ethical considerations will be discussed. This chapter will conclude with a summary of the structure of the study.

1.2 DESCRIPTION OF CONCEPTS

1.2.1 Adolescence

Geldard and Geldard (2010:4) describe adolescence as:

the period of human development during which a young person must move from dependency to independence, autonomy and maturity.

According to the American Psychological Association (APA) (2002), there is no single definition for adolescence. Adolescents' physical, social and cognitive development and age need to be taken into consideration. For defining adolescence according to age, the World Health Organisation (WHO) (2009) suggests the age between 10-19 years. Ackerman (2001) also divides adolescents according to their chronological age, with the young adolescent phase (12-15 years), middle adolescence (15-18 years) and late adolescence (18-22 years).

Ackermann (2001) adds that the adolescent phase can be defined according to different approaches. The psychological approach suggests that adolescence starts at puberty and involves the developing of attitudes, beliefs and behaviour patterns to participate in society. An indication of the onset is sexual maturity, body growth and maturation of the reproductive system. The cognitive approach defines adolescents by their abstract-logical reasoning, problem-solving strategies and meta-cognition. The sociological approach suggests that the socio-cultural context of the individual must be understood to define adolescence as each society and culture differs. Culture plays an important role in this approach, as some cultures define adolescence as starting after an initiation process. The psychological approach is concerned with the adolescent's participation in society. Their attitudes, beliefs and behaviour are taken as markers for definition. Different theoretical perspectives when defining the adolescent phase will be presented.

Proponents of different theoretical perspectives provide their understanding of adolescence in the ways described below.

Sigmund Freud advances a psychoanalytic theory that discusses adolescent development in terms of psychosexual development. Freud states that the stages of

psychosexual development are genetically determined and are relatively independent of environmental factors and include behavioural, social and emotional changes and the influences on the self-image. The physiological changes are related to emotional changes with an increase in negative emotions, which include moodiness, anxiety, loathing and tension (Meyer, Moore & Viljoen 2003).

Erik Erikson's theory of identity development has a core concept of an ego identity, with identity crisis being the most essential characteristic of adolescence (Wenar & Kerig 2006). Erikson argues that although a person's identity is established in ways that differ from culture to culture, the developmental task has a common element in all cultures – to acquire a strong and healthy ego identity the child must receive consistent and meaningful recognition of his achievements and accomplishments. Erikson describes adolescence as the period during which the individual must establish a sense of personal identity and avoid the dangers of role diffusion and identity confusion. He states that adolescents must answer questions for themselves about where they came from, who they are and what they will become. He elaborates by stating that identity is a sense of sameness and continuity which must be searched for. It is not given to the individual by society, but it must be acquired through sustained individual efforts (Meyer et al. 2003).

Jean Piaget defines the developmental stages in cognitive development. He focuses on the concept of egocentrism in development with the adolescent falling into the category of the formal stage (Wenar & Kerig 2006). While the child at the concrete operational stage becomes able to reason on the basis of objects, the adolescent begins to reason on the basis of verbal propositions. Piaget states that the adolescent can not only think beyond the present, but can analytically reflect on their own thinking. They are able to control events in their minds through logical deductions of possibilities and consequences. He states that the adolescent who has mastered the formal operation stage begins by thinking of all logical possibilities and then considers them in a systematic fashion, with reality being secondary to possibility (Ackerman 2001; Geldard & Geldard 2010).

1.2.2 Trauma

The *Oxford Dictionary of Psychology* (Coleman 2009:780) defines trauma as:

a physical injury or wound, or a powerful psychological shock that has damaging effects.

According to Lewis (1996:6), trauma is “an experience that is sudden, horrifying and unexpected. The person feels fear and is helpless and out of control. It could be a single incident or repetitive.”

Flannery (1995) describes trauma as a frightening situation that we are confronted with and over which we do not have control, and no matter how hard we try we cannot respond effectively. Shapiro (2010:xiii) defines trauma as an overwhelming experience which influences the relationships in the brain and hinders one from functioning well. This has an effect on coping strategies.

When one hears the word “trauma” one usually thinks of events such as fires, explosions, automobile accidents, hurricanes and floods, but Shapiro (2001) distinguishes between small (small t) and big Traumas (big T). Small t traumas may be more subtle. They do not match the DSM-5 definition of PTSD as they are not seen as life threatening. Clusters of small-t traumas may also be highly damaging to the person and can contribute to major problems for individuals. These trauma clusters impact on beliefs about the self, others and the world and affect self-esteem, self-definition, self-confidence and optimal behaviour. Small traumas maintain the ability to elicit negative thought and behaviour and have the potential for other long-term effects (Forgash & Copely 2008). Big T traumas precipitate post-traumatic stress disorder (PTSD) (Shapiro 2001). Post-traumatic stress is an acute or ongoing trauma which has an impact on the adolescent’s functioning; the term PTSD will be elaborated on in more detail in the discussion of concepts. According to van der Kolk (2005), adolescents who were victims of trauma may experience depression, increased aggression against oneself or others, dissociation, addictions, decline in family functioning, distrust, shame, amnesia, somatisation, self-hatred, feeling over-responsible for their problems without meeting the full criteria for PTSD. When the child is given a co-morbid diagnosis, treatment approaches may not be successful. Chronic exposure to childhood trauma can alter personalities and can therefore be diagnosed with developmental trauma disorder (DTD). Although not included in the DSM 5 as a specific diagnostic criteria, this contributed to the consideration of developmental phases in PTSD diagnostic criteria. Trauma may also cause lasting

neuronal and hormonal changes, which in turn shape brain structures and functioning (van der Kolk 2007).

These changes can have profound effects on all dimensions of social, cognitive, biological and emotional development. Levine and Kline (2007) therefore state that “trauma is not in the event itself; rather trauma resides in the nervous system.” The individual displays these changes through different trauma symptoms that can lead to PTSD. Cohen et al. (2006) divide these symptoms into categories: affective trauma symptoms, behavioural trauma symptoms, cognitive trauma symptoms.

Fear, depression, anger and affective dysregulation are symptoms of affective trauma.¹ When the adolescent experiences fear, large amounts of adrenergic neurotransmitters are released, which can further reinforce anxiety. When the fear creates general anxiety, the adolescent may feel generally unsafe and is always on guard to prevent exposure again. Depression can occur with PTSD symptoms and may elicit after loss of trust in other people and the world, and may include shame, low self-esteem, guilt, feeling worthless and suicidal tendencies. Furthermore, the individual may make the wrong choices in peers and romantic partners, and develop self-destructive behaviour such as alcohol abuse and cutting (Cohen et al. 2006). Anger usually results from the perception that an experience was unfair. Anger after a traumatic experience becomes visible as unpredictable mood changes, tantrums or physical aggression towards property or other people. Affective dysregulation involves sudden changes in emotional wellbeing and/or difficulty in coping with negative affective states. It seems to occur more in children experiencing abuse or domestic violence. The parent responsible for the abuse and the victimised parent (who fears that it might intensify the abuse) might tell the child to keep quiet (Cohen et al. 2006).

Behavioural symptoms are an attempt to avoid negative emotions that create pain, sadness, and fears. Children avoid thoughts, people, places or situations that serve as a reminder of traumatic experiences, e.g. a child who is bullied on the playground will avoid going to school. Behavioural symptoms may be due to modelling an abusive parent. A child who grows up in such negative environments may also observe and learn maladaptive behaviours and coping strategies (Levine & Kline 2007).

¹ Affect dysregulation is an emotional response that is poorly modulated.

Cognitive trauma symptoms could result in irrational beliefs about themselves and other people. The individual generally tries to look for a rational explanation in traumatic experiences. In situations where no rational explanation is found, irrational beliefs may develop in an effort to gain control. Blaming oneself is the most common irrational belief and believing one is bad or shameful helps to justify the traumatic experiences. Parents are responsible for protecting their children and not harming them. Children exposed to trauma by their parents are therefore not safe at home and may develop and generalise irrational beliefs towards other people such as 'no one is trustworthy'.

Wilkinson (2010) states that the mind, brain and body are linked and that the self and the mind reflect the brain and body. It can be argued then that 'the mind can alter the brain and the brain can alter the mind'. The aim of therapy is to stimulate neural integration and bring homeostasis in the body after traumatic experiences (Solomon & Siegel 2003). After a traumatic experience a person may develop traumatic stress disorder (or PTSD) and traumatic memories are not processed normally and therefore cannot be resolved by the traumatised individual (Shapiro 2001). It can therefore be argued that traumatic stress and PTSD (single or multiple exposure) can be treated in therapy (Hensel 2009; Taylor & Chemtob 2004; Vickers 2005). EMDR is one of the possible modalities to treat traumatic stress and PTSD (Shapiro 2009).

The term 'trauma' in this study refers to psychological trauma (emotional trauma). A traumatic memory generally includes intense emotion (Wastell 2005). Experiencing intense trauma is overwhelming and is usually unexpected; this view is in agreement with Lewis's (1996), Flannery's (1995) and Shapiro's (2010) definitions.

1.2.3 Diagnostic Criteria

The definition of reactive attachment disorder is presented in this study merely to provide the reader with the needed information for understanding trauma in the early years. The diagnostic criteria according to the DSM-5 (2013:304) are described below.

Reactive attachment disorder of infancy or early childhood is characterized by a pattern of markedly disturbed and developmentally inappropriate attachment behaviors, in which a child rarely or minimally turns preferentially to an attachment figure for comfort, support, protection and nurturance. The essential feature is absent

or grossly underdeveloped attachment between the child and putative caregiving adults. Children with reactive attachment disorder are believed to have the capacity to form selective attachments. However, because of limited opportunities during early development, they fail to show the behavioral manifestations of selective attachments. That is, when distressed, they show no consistent effort to obtain comfort, support, nurturance, or protection from caregivers. Furthermore, when distressed, children with this disorder do not respond more than minimally to comforting efforts of caregivers. Thus, the disorder is associated with the absence of expected comfort seeking and response to comforting behaviors. As such, children with reactive attachment disorder show diminished or absent expression of positive emotions during routine interactions with caregivers. In addition, their emotion regulation capacity is compromised, and they display episodes of negative emotions of fear, sadness, or irritability that are not readily explained. A diagnosis of reactive attachment disorder should not be made in children who are developmentally unable to form selective attachments. For this reason, the child must have a developmental age of at least 9 months. It is unclear whether reactive attachment disorder occurs in older children and, if so, how it differs from its presentation in young children. Because of this, the diagnosis should be made with caution in children older than 5 years.

Post-traumatic stress disorder is described by FOA, Keane and Friedman (2000:1) as:

A serious psychological condition that occurs as a result of experiencing a traumatic event. The symptoms that characterize PTSD are reliving the traumatic event or frightening elements of it; avoidance of thoughts, memories, people, and places associated with the event; emotional numbing; and symptoms of elevated arousal.

Wastell (2005) is of the opinion that PTSD is a disorder that can develop after experiencing a traumatic event that is life-threatening for oneself, one's family or friends. Symptoms of PTSD in adolescents may include feelings of shame, guilt, irritability and anger. Changes in behaviour such as becoming detached and withdrawn or acting out, sexual promiscuity, alcohol, drug abuse, a lack of interest in hobbies and sport. Changes in mood such as depression and suicidal thoughts may surface (Levine & Kline 2007).

According to the recent DSM-5, PTSD can occur at any stage. Symptoms can therefore begin within the first 3 months after the trauma is experienced; however, there may be a delay of months or years before actual criteria for the diagnosis could be met. The DSM-IV used the term “delayed onset” but the DSM-5 use the term “delayed expression” recognizing that some symptoms could appear immediately and that the delay is in meeting full criteria (DSM-5 2013:276). Table 2.5 below presents the diagnostic criteria for PTSD according to the newly published DSM-5 for adults and children older than six years (2013:271-272):

Posttraumatic Stress Disorder

Note: The following criteria apply to adults, adolescents and children older than 6 years.

- A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
1. Directly experiencing the traumatic event(s).
 2. Witnessing, in person, the event(s) as it occurred to others.
 3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

- B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
 2. Recurrent distressing dreams in which the content and/or affect of the

dream are related to the traumatic event(s).

Note: In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

Note: In children, trauma-specific re-enactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g. "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
3. Persistent, distorted cognitions about the cause or consequences of the

- traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
 5. Markedly diminished interest or participation in significant activities.
 6. Feelings of detachment or estrangement from others.
 7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
- E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
1. Irritable behavior and angry outbursts (with little or no provocation typically expressed as verbal or physical aggressions toward people or objects).
 2. Reckless or self-destructive behavior.
 3. Hypervigilance.
 4. Exaggerated startle response.
 5. Problems with concentration.
 6. Sleep disturbance (e.g. difficulty falling or staying asleep or restless sleep).
- F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
- G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: the individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of

surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Adolescents not meeting the full PTSD criteria may experience the same functional impairment as those meeting the full criteria of PTSD (De Bellis, Hooper, Woolley & Shenk 2010). They do re-experience events through flashbacks, but will attempt to avoid those thoughts and feelings that trigger the distressing memory. They might dissociate or numb them out which is evident of a delayed expression according to the DSM-5. Therefore teens turn to alcohol, sex, drugs and thrill-seeking behaviour to avoid those feelings. Irritability, sleeplessness, depression, anxiety tend to develop, which influences their grades, leads to truancy and defiant behaviour, or hyperactivity (Dass-Brailsford & Myrick 2010).

1.3 PROBLEM STATEMENT

1.3.1 Adolescence as Developmental phase

Adolescence is regarded as one of the most complex developmental phases in the human life cycle (Campbell 2005). This complexity is related not only to the nature of adolescence, but also to the basic task of defining it. It is the transitional stage from childhood to adulthood, with physical, cognitive and psychological changes. Physically adolescents change in appearance and develop sexually. They tend to explore new relationships and engage in new social challenges. The changes associated with adolescence occur at different ages in this phase and for the late developer this can

cause embarrassment or feelings self-consciousness among their peers. Cognitively they move from concrete thinking to more abstract thinking. They start to develop a skill to process information differently and become able to solve problems in a wider variety of situations. Apart from abstract thinking, egocentric thinking is typical of this phase. They want attention focused on themselves and might even exhibit certain behaviours to invite attention. Their focus on themselves could easily entail the belief that no one else is capable of understanding them or how they are feeling. Physical and cognitive changes have an impact on the adolescents' psychological changes.

Normal adolescent development can therefore be seen as chaotic and confusing for the child inhabiting his or her new body. In addition to the academic pressures faced by school-aged children, they have the additional task of individuation² planning their future and sexual development. They are also subjected to intense peer-group pressure that is bound to collide with family ideals (Levine & Kline 2007). Developing a personal identity is the main aim of this phase. Any negative attachments during their development might lead to failure to achieve a satisfying personal identity, which has negative psychological implications (Geldard & Geldard 2010).

1.3.2 Influence of Trauma on the Adolescent

Child and adolescent exposure to a broad range of traumatic experiences and its influence has been examined in a vast amount of research. The National Centre of PTSD provides view of such research on adolescents exposed to trauma (Fairbank 2008:1-8);

- A longitudinal general population study by Costello, Erkanli, Fairbank and Angold of children and adolescents (9-16 years old) in western North Carolina found that one quarter had experienced at least one potentially traumatic event in their lifetime, 6 percent within the past three months.
- High estimates of psychiatric symptom prevalence have been reported in studies of children and adolescents exposed to various types of disasters that affected entire communities. Hoven and colleagues (2005) reported findings from the New York City, NY Department of Education Study, which assessed needs among public school students in New York City in Grades 4 – 12 after

² Individuate – to distinguish oneself from other adolescents.

the terrorist attacks on the World Trade Center. Six months after the attacks, the estimated prevalence of PTSD was 10.6%; with agoraphobia at 14.8%; conduct disorder at 12.8%; separation anxiety at 12.3%, and for teens, alcohol problems at 4.5%. Over 60% experienced at least one major traumatic event prior to the attacks.

- *The National Incidence Studies* (NIS; Sedlak & Broadhurst, 1996) were mandated by the US Congress to establish the incidence of child maltreatment. To date, there have been three NIS studies conducted and analyzed (results reported in 1981 (NIS-1), 1988 (NIS2), and 1996 (NIS-3)). The NIS studies use a “sentinel” methodology in which official field observers report all cases of suspected child abuse encountered during a fixed sampling frame. The NIS estimates include children investigated at CPS agencies, but also include maltreated children who are identified by professionals in a wide range of agencies in representative communities. The most recent National Incidence Study (NIS-3) findings indicated that the total number of abused and neglected children was two-thirds higher in the NIS-3 published report than in the NIS-2 published report. A second source of child maltreatment data is the National Child Abuse and Neglect Data System (NCANDS; US Department of Health and Human Services), a federally sponsored effort that collects and analyzes annual data on child abuse and neglect submitted by the states. The most recent statistics were published in *Child Maltreatment 2005* (US Department of Health and Human Services, 2007). From 1994 to 2005 there was an overall drop in the total number of officially reported cases. It is important in child maltreatment research to note whether or not the case was “substantiated,” defined as a type of investigation disposition that concludes that the allegation of maltreatment or risk of maltreatment was supported or founded by state law or state policy. The peak year was 1994, with 1,031,000 substantiated cases for all forms of child maltreatment. In 2005, the last year for which data were available, there were 899,000 substantiated cases.
- Several studies have focused specifically on at-risk populations rather than general populations. Abram, Teplin, Charles, Longworth, McClelland and Duncan (2004) and Abram, Washburn, Teplin, Emanuel, Romero, McClelland (2007) had a Northwestern Juvenile Project of youth 10-18 years of age held in

a detention center found that 84% reported multiple exposures to trauma, with a majority exposed to six or more. PTSD was prevalent and highly comorbid with other disorders. Stein, Zima, Elliot, Burnam, Shahinfar and Fox (2001) documented a high prevalence of exposure to violence among children in foster care. Widom, DuMont and Czaja (2007) longitudinal study of a cohort of abused and neglected children has shown that the accumulation of multiple adverse childhood experiences predispose children towards negative trajectories that contribute significantly to adult outcomes such as major depression. Few children in need of trauma-informed mental health services receive them, however. Findings from the National Survey of Child and Adolescent Well-Being (Burns, Phillips, Wagner, Barth, Kolko, Campbell & Landsverk 2004) estimated that nearly half of the children in the child welfare system are in need of mental health services, yet only a quarter of these received any such services.

- South Africa presents serious challenges for adolescents in their journey to becoming healthy balanced adults. A study by Lewis and Ngqela (2012) indicated that a school reflects what happens in its community. Difficulties related to the culture of poverty and the provision of education for disadvantaged South African learners is a concern as they represent the majority of the school communities. In addition, family disruptions in South African society such as family conflict, family violence and divorce contribute to the fact that many adolescents have to deal with developmental tasks regarding interpersonal relationships with very limited positive modelling available. The identity development of the adolescent may therefore be influenced negatively (Ackerman 2001; Kaminer & Eagle 2010; Lewis & Ngqela 2012; Prinsloo 2005).

Prinsloo (2005) also argues that societal life in South Africa is characterised by a general trend towards distrust and having no interest in the welfare of the broader community. Children as young as 2 years and also babies of a few months are raped and abused. Cluver, Fincham and Seedat (2009) report that it is likely that between 400,000 and 500,000 children are raped in South Africa every year. The authors also found that 1.6% of woman have been reported as being forced into sexual acts before the age of 15. Teenage pregnancies are on the increase. South Africa has one of the highest rates of HIV/AIDS infection in the world (Kaminer & Eagle 2010). These

statistics seems to be an under-representation of the true numbers and the sexual violence experienced is surely far higher than what the data suggest. A study of men in the Eastern Cape and KwaZulu-Natal 27.6 per cent of participants admitted to have raped at least one person. These findings do not include intimate partner abuse, which confirms that the true prevalence of rape might be higher than suggested by studies on rape (Kaminer & Eagle 2010) As for rape, violence on children is becoming a concern in South Africa. Schonteich and Louw (2001) report in their study that of all the individuals who experienced at least one violent crime in South Africa, almost a third were aged between 16 and 25. Rising crime seems to influence people's sense of safety and Prinsloo (2005) states that South African citizens are of the opinion that crime in South Africa is out of control.

The above studies suggest that as social structures change, more South African youths are exposed to higher levels of trauma. It is evident that adolescent trauma requires more attention than it currently receives. Kriel (2009:1) states that, according to the report of Solidarity Helping Hand, 'the average social worker handles nearly 200 cases each year, while the accepted norm is 60.' It therefore seems essential to explore more options for treatment for trauma in adolescents that has an immediate effect on relieving symptoms. EMDR seems a promising treatment option and a beneficial effect may be achieved in fewer sessions (Ironson, Freund, Strauss & Williams 2002; Tufnell 2005). In South Africa there is limited research to verify this outcome and therefore this study could contribute to research field in South Africa on the impact of trauma on adolescents. In fact during the literature search for this study no publications on studies in South Africa could be found in this regard.

1.3.3 Treatment Choice

Research confirms EMDR as a therapeutic technique has been successful in treating adults with developmental traumas that could lead to PTSD (Adler-Nevo & Manassis 2005; Shapiro 2001).

As discussed, psychological trauma involves intense emotion which can affect the individuals' coping strategies. Eye movement desensitisation and reprocessing (EMDR) is an information-processing-based treatment technique for resolving traumatic memories. It involves an eight-phase approach to address the past, present

and future aspects of maladaptive traumatic memories and integrates these memories into functional explicit memory networks. It develops new learning, eliminates emotional stress and develops cognitive insights. During the EMDR process bilateral stimulation is used, which consists of moving the eyes from side to side, vibrations or tapping movements on different sides of the body. EMDR was found to be an efficacious treatment for PTSD.

The basic components of the EMDR procedure include image, negative cognition, positive cognition, emotions and their level of disturbance, bilateral stimulation and physical sensations.

The goal of the *image* is to make a connection between the conscious mind and where the disturbed information is stored in the brain; therefore having a blurred image or fragments of an image is quite common. The therapist can ask the client to share an image that represents the entire incident or the most disturbing part of it.

Negative cognitions (NCs) in EMDR are used to signify a negative belief the client has of him/herself associated with the image of the traumatic experience. Identifying the NC not only assists the adolescent to realise its irrationality, but also helps to stimulate dysfunctional information that needs reprocessing. Identifying the NC is usually the most difficult part and the therapist may assist the client in this process by asking “What does that image make you believe about yourself?” or “What does this image say about yourself as a person?” or “What words go best with the picture that expresses your negative belief about yourself now?” If a client makes a statement that does not meet format requirements, the therapist may reinterpret to make that statement more suitable. Cognitions that merely verbalise sad or unfortunate childhood experiences are not accepted, e.g. “It was unfair” or “I didn’t stand a chance” should be adapted into appropriate NCs. A list of common negative cognitions may be shown to adolescents to orient them towards possibly useful responses (Shapiro 2001).

The purpose of the *positive cognition* (PC) is to set a direction for treatment (Shapiro 2001). Greenwald (2001) describes the positive cognition as a statement that represents a formulation of the goal of the treatment: how the client hopes to view himself afterward. Once the negative cognition is stated, the client is asked to choose

a more positive, adaptive self-statement, even if it does not feel completely true prior to reprocessing. Just like the negative cognition, the positive cognition needs to be descriptive – e.g. “I am a good person” or “I am safe now.” The therapist may elicit the positive cognition by saying, “What do you wish you could believe about yourself, instead of that (negative cognition)?”

The *validity of cognition (VOC)* and *Subject Unit of Disturbance Scale (SUDS)* provide a concrete means to track the progress that has occurred during and after the session. The VOC is a 7-point Likert scale which provides a measure for the strength of a client’s PC. Hensley states that the VOC needs to be at least a “2” for it to be considered a workable cognition. She argues that it is very difficult for a client to go from “total disbelief” to “total belief”. Also one’s experience on a SUDS or VOC can constitute training in self-awareness and monitoring, often a goal in therapy. This phase provides a baseline measurement of the adolescent’s response to the memory, while focusing the client on the memory to be reprocessed.

Eye movement desensitisation and reprocessing (EMDR) is described by Oras, De Ezpeleta and Ahmad (2004) as a treatment method using bilateral stimulation when processing traumatic memories in clients. EMDR is a three-pronged treatment approach that focuses on past events, current stimuli and future situations (Hensley 2009). The memories of the past lay the foundation for a client’s current presenting issue or problem. The present target is recent situations, such as aggressive behaviour at school. Each subsequent target is addressed as the previous one is resolved (Silver, Rogers & Russell 2009). The future desired state would, for example, focus on sensations the adolescent would like to experience, what he/she would like to believe and how the adolescent would like to act in the present and in the future (Hensley 2009). The future desired state could assist in giving adolescents a chance to rise above their circumstances, develop a positive identity and give them hope for their future.

According to Shapiro (2001), this approach is guided by the adaptive information-processing model. Shapiro reasons that humans gather information from different experiences and it is then processed to adapted states where learning takes place. She states that traumatic memories are differently stored like other memories. The AIP model describes how disturbed memories are identified and adapted by applying

the EMDR technique so that learning can take place. Therefore the goal of EMDR is to develop new connections between unprocessed memory and more adaptive information that is contained in other memory networks.

Evidence-based research on EMDR in the USA indicate that it is acknowledged as an effective therapy technique for trauma. In treatment of war veterans with EMDR clients resolved issues like death of a friend, depression, anxiety, combat-related medically unexplained symptoms like his body shaking in as few as 4 sessions. A study on using EMDR with traumatized young women with symptoms of depression and anxiety reached a degree comparable to what “normal” people experience. Research where EMDR and PE (Prolonged Exposure) as technique for PTSD were done, results suggested that both EMDR and PE are equally effective at reducing symptoms of PTSD and depression. However, important EMDR was more likely than PE to result in a 70% reduction of PTSD symptoms following three active treatment sessions. Seven of the ten EMDR clients who participated in the study achieved satisfactory improvement compared to two of the nine PE participants in the study. These results are consistent with the findings of Rogers, Silver, Gross, Obenchain, Willis and Whitney (1999), but stand in contrast to those reported by De Villy and Spence (1990), the only comparison reported that favoured PE. EMDR was better tolerated as indicated by lower dropout. Already after the first session, distress levels as measured by SUDS¹ were lower with EMDR than PE.

The history of EMDR dates back to 1987. Dr Francine Shapiro developed the EMDR process. She was walking in a park and noticed that the disturbing thoughts which she had tended to disappear. When she was recalling the distressing material, it was not upsetting or as potent any longer. She then started to pay attention to what happens when disturbing thoughts enter her mind. She realised that her eyes started moving spontaneously rapidly from side to side again, resulting in her thoughts being less valid with no effort. Dr Shapiro explored this new discovery by making deliberate eye movements while focusing on distressing material, resulting in positive results. She decided to explore this discovery. She then worked with 70 people over 6 months. Her focus was on reducing anxiety and her primary modality was behavioural; this led to the term ‘Eye Movement Desensitisation’ (EMD) (Shapiro 2001).

Shapiro (2001) then expanded the idea of Eye Movement Desensitisation (EMD) to Eye Movement and Desensitisation and Reprocessing (EMDR), when she realised that EMDR not only resulted in a relaxation response, but also reprocessed trauma (Parnell 1997; Shapiro 2001; Shapiro 1999). Not only were there changes in experiences of anxiety and fears, but negative emotions were replaced with positive ones, body sensations changed, new behaviours emerged and insights surfaced. Although EMDR initially involved eye movements, other stimuli (alternating bilateral hand taps and auditory tones) can be applied and are also effective (Shapiro 2001).

Shapiro (2001) stated that a person with PTSD is not able to make use of the inherited ability for spontaneous healing after trauma because traumatic memories are not processed normally. Contrary to normal memories, which are under the person's control to recall or conceal, the traumatic memories have control over the person through recurrent and intrusive distressing recollections of the traumatic event. EMDR is suggested to neutralise these traumatic memories by re-processing the information to a normal resolution that facilitates the healing process and enables the person to gain control over the traumatic memories. Consequently a decrease in post-traumatic stress symptoms is evident. Research done by Broad and Wheeler (2006) supports the view that trauma is a right-brain phenomenon and most psychotherapy is largely a left-brain endeavour; thus there may be significant areas that are not accessible with talking therapy only – and Cohen, Mannarino and Deblinger (2006) concur. EMDR may assist in reconnecting these neural pathways that have been dissociated or disconnected from each other because of a traumatic experience (Gunter & Bodner 2009; Shapiro 2001).

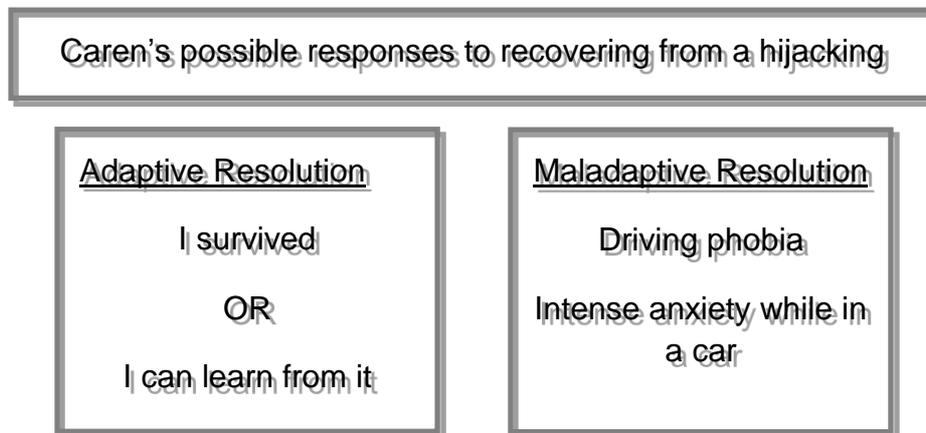
EMDR treatment of war veterans resolved issues such as the death of a friend, depression, anxiety and combat-related medically unexplained symptoms, such as shaking, in as few as four sessions (Silver et al. 2009). A study on using EMDR with traumatised young women with symptoms of depression and anxiety reached a degree comparable to what “normal” people experience. Van der Kolk (2003) notes in his research that EMDR done with an adult suffering from depression and attention deficit disorder resulted in positive outcomes. The adult discontinued the use of medication for depression and ADHD, and experienced a significant improvement in overall functioning.

In research utilising EMDR and PE (prolonged exposure) as techniques to treat PTSD, results suggested that both EMDR and PE are equally effective in reducing symptoms of PTSD and depression (González-Prendes & Resko 2012). However, EMDR was more likely to result in a 70% reduction of PTSD symptoms following three active treatment sessions. Seven of the ten EMDR clients who participated in the study showed improvement. Research by Lee, Garriel, Drummond, Richard and Greenwald (2002) supports these results. Ironson et al. (2002) reported that already after the first session distress levels measured by SUDS³ were lower with EMDR than PE. However, a study by De Villy and Spence (1999) favoured PE. The adaptive information-processing (AIP) model explains how trauma symptoms are relieved. The AIP model was developed by Shapiro (2001) and serves as a theoretical framework to explain the mechanisms by which EMDR assists clients in moving disturbances to adaptive resolution.

According to the AIP model, our memory network forms the basis of our perceptions, attitudes and behaviours. These memories consist of stored information from sensory input, thoughts, emotions and beliefs. Shapiro explains that when trauma happens, it causes a disruption in our information-processing system, leaving any associated sensations and perceptions unprocessed and then stored dysfunctionally.⁴ The dysfunctional material can manifest in current symptomology that could correlate with symptoms of PTSD. An individual could go through life with this dysfunctionally stored material, preventing that person from functioning at full potential (Shapiro 2001). According to Adler-Tapia and Settle (2008), in the case of children this can also impact on neurological development and all future experiences in the child's life. It appears as if the person becomes fixated on the traumatic event with no adaptive resolution. Figure 1.1 shows an example of adaptive versus maladaptive resolution as cited by Hensley (2009).

³ The Subjective Units of Disturbance Scale (SUD 0-10) is used to measure the level of distress associated with a memory, where 0 is no disturbance/neutral and 10 is the highest disturbance/distress.

⁴ Dysfunctionally stored material – information which is not integrated.



Does "Caren" not need a bit context?

Figure 1.1: Adaptive vs. maladaptive resolutions

Being "stuck" results in a negative belief and emotional and physical sensations of the event being stored in the nervous system. Because of a person being "stuck" repeatedly, negative patterns of cognition, emotion and behaviour arise, limiting the person from developing fully (Hensley 2009). When a response is triggered by stimuli from the past, the person will react in a similar way as when the traumatic event occurred in the past. Therefore Shapiro (2001) is of the opinion that "*past is present*," meaning that the affect of past events overflows into the present and EMDR targets the experiences that caused the person to become "stuck" or "blocked." Doing EMDR results in the "block" being shifted and the disturbance is brought to an adaptive resolution when the healing process is activated. Changes can occur immediately. The figure below explains the adaptive information processing and how EMDR works (Shapiro 2001):

EMDR – The process

ACCESSED	PROCESSED	RESOLVED
Client focuses on aspect of traumatic event	Client's inherent self-healing processes are stimulated	Client assimilates adaptive information

Adaptive information processing before and after EMD

Before	After
Client experiences negative event, resulting in:	Client experiences adaptive learning, resulting in:
Intrusive images Negative thoughts or beliefs Negative emotions and associated physical sensations	No intrusive images No negative thoughts or beliefs No negative emotional and/ or physical sensations Client possesses empowering new positive self-belief Positive self-belief
What happens?	What happens?
Information is dysfunctionally stored Developmental window may be closed	Information is adaptively processed Adequate learning has taken place
Resulting in:	Resulting in:
Depression Anxiety Low-self esteem Self-deprecation Powerlessness Inadequacy Lack of choice Lack of control Dissociation	Sense of well-being Self-efficacy Understanding Catalysed learning Appropriate changes in behaviour Emergence of adult perspective Self-acceptance Ability to be present
Client experiences negative event resulting in:	Client experiences adaptive learning, resulting in:
Intrusive images Negative thoughts or beliefs Negative emotions and associated	No intrusive images No negative thoughts or beliefs No negative emotional and/ or physical sensations Client possesses empowering new positive self-belief

Figure 1.2: EMDR in terms of the AIP model

The brain's information-processing system includes memory networks. Memory networks can be pictured metaphorically as a series of channels (cluster memories) where related memories, thoughts, images, emotions and sensations are stored and linked to one another. In an EMDR session a person will be asked to recall a memory of the trauma or target. The goal of the therapeutic process is for the person to react calmly to the target. It is important to clear each channel by reprocessing all of the dysfunctional stored material connected to that target. The reprocessing is done during each set of eye movements (or other stimuli). The figure below is a graphic representation of the associative channels connected to the target that need to be cleared (Shapiro 2001):

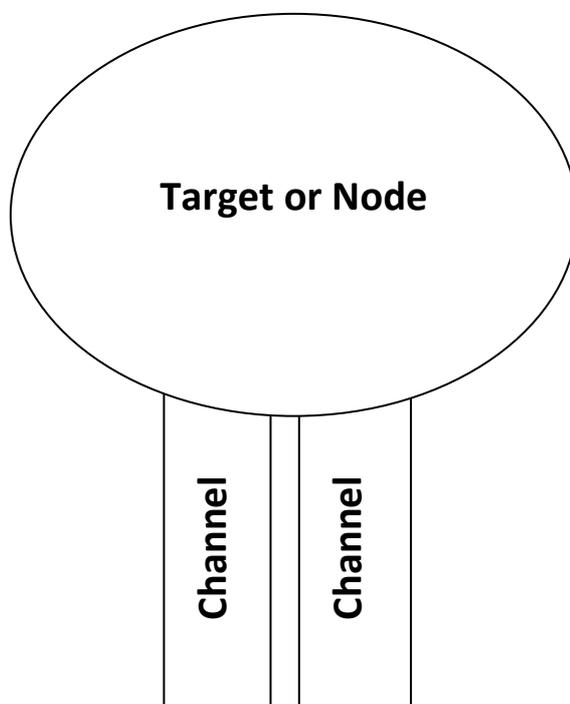


Figure 1.3: A graphic representation of the progression of EMDR treatment through the memory network

Different types of targets

Targets from the past are called the *touchstone memory or event*. This memory forms the basis of the current problem and creates the core of the dysfunction. The event often occurs in childhood or adolescence.

Targets usually emerge during a thorough assessment of the person's presenting problem. A target could be an image, picture, complete or partial memory, sight, sound, taste, touch, or even recurring thoughts or fear that something is going to happen. A target needs to be concrete, not abstract. It is common for the person to have only a blurred image or fragmented view of the target as the goal is to establish a link between consciousness and where the information is stored in the brain. The person needs to generate the image, and to visualise it with self-generated details, thus filling it with the necessary personal validity and meaning and emotion. The image is only one manifestation of the disturbing information regarding the event stored. If the person does not remember events in terms of an image, he might only recall physical sensations or emotions, which then focus as the access point to the targeted information and it stimulates the person's own subjective connections (Shapiro 2001).

Targets from the present could be *circumstances*, meaning situations that activate a disturbance, or *internal/external triggers* which stimulate maladaptively stored information and bringing emotional or behavioural disturbances to surface. Targets from the future are the *future desired state*. The future desired state targets how the person would like to feel, sense, perceive or behave now and in the future.

Targeting a present problem may cause the person to shift automatically to an earlier memory with full intensity of the abreaction. Shapiro (2001) states that an abreaction is a normal cognitive processing of traumatic memories, which will be discussed below.

Abreaction, Blocked Processing, and Cognitive Interweaves

Abreaction is a flow of intense emotions with high levels of affect. Greek dramatists used the term *catharsis* to describe the purging effect that the release of emotion provides. Thus abreaction is a verbal, and/or an emotional and physical expression of unconscious material (Hensley 2009). Blocked processing occurs when the spontaneous link between dysfunctional and functional becomes blocked during processing. Processing seems to be blocked when there is no change in two or more successive sets of reprocessing. There is no change in thoughts, bodily sensation or emotions after successive sets of bilateral stimulation, or when the SUD scale stays

the same (Hensley 2009). Hensley suggests that a cognitive interweave⁵ would be appropriate to release the affect that is concerned with the blockage. Strategies to implement the cognitive interweave should be, for example, changing the speed direction and/or modality of bilateral stimulation, offering words of encouragement “Good”, “It’s in the past,” or “Just go with it” (Hensley 2009).

A target discussed thoroughly will help the individual and therapist to understand the trauma context and configuration (all the details that make up the trauma and response) and will result in more rapid processing. The most useful parameters for treatment are the picture, the negative and positive cognition, the emotions and their level of disturbance, and the physical sensations. These aspects of the target must be clearly defined for initiating, processing and concluding EMDR treatment.

In summary, the research discussed focuses on adults only and the research has been done internationally. To my knowledge, searches on the use of EMDR were done by other researchers and, as noted, there do not seem to be publications in this field in the South African context. Ogden, Minton and Pain (2006) also explain that when trauma is experienced, defensive actions may persist in distorted forms, such as muscles held in a chronically tightened pattern, an exaggerated tendency to be triggered suddenly into aggression, or a chronic lack of tone or sensation in a particular muscle group. When the components of the defensive response to trauma persist in these altered forms, individuals react inappropriately to perceived threats or reminders of past threat in the present. They may become too aggressive or too passive. The possible use of this technique in the prevention of future negative behaviours by reducing the impact of the triggers of past in the present will also be explored.

As South Africa moved from the era of apartheid, extensive trauma research was generated in response to this historical transition. In 1994 an inquiry was done on public violence and intimidation of children (Duncan & Rock 1997). These youths were exposed to tear-gassing, detention without trial, torture and some were killed. In 2008 a study was conducted on adult males who were recruited into the armed forces. The study focused on the long-term consequences of child and adolescent paramilitary

⁵ A strategy for offering statements that therapeutically weave together the appropriate neuro-networks and associations (Shapiro 2001:249).

engagements in the early 1990s in townships. Consequences appeared to be social alienation, substance abuse and rigidity of identity (Langa & Eagle 2008). Other studies on trauma in the South African context explored the symptoms related to PTSD after exposure to a traumatic incident; Barbarin, Richter and de Wet (2001) researched coping resources and adjustments in South African children; Carey, Walker, Rossouw, Seedat and Stein (2008) explored the risk indicators and psychopathology in traumatised children and adolescents with a history of sexual abuse; Dawes, Tredoux and Feinstein (1989) researched the effects of political violence on South African children; Seedat, Nyamai, Njenga, Vythilingum and Stein (2004) researched trauma exposure and post-traumatic stress symptoms in urban African Schools; Seedat, van Noord, Vythilingum, Stein and Kaminer (2000) did a school survey on exposure to violence and PTSD in adolescents; and Straker (1992) explored the impact of violence on township youths and its psychological effects. Other trauma-related problems in South Africa that have been explored in research are the loss of a parent because of AIDS (Cluver, Fincham & Seedat 2009; Cluver & Gardner 2006) and sexual abuse (Labe 2005).

Current studies on adolescents in South Africa focus on alcohol abuse (Cuzen 2012), mixed-race stepfamily in post-apartheid (Marks 2012), juvenile delinquency in secondary schools (Ntshangase 2012) and the influence of resilient behaviour on the academic performance of poverty-stricken adolescents (Hamilton-Green 2012). There seem to be a gap on research on treatment of trauma in adolescents. No research could be found specifically on EMDR as treatment for trauma and its application to adolescents in South Africa. The research discussed seems to indicate that trauma is escalating in South Africa.

Donson (2011) provided an overview of the statistics from The South African Medical Research Council on youth violence in South Africa and stating that there were over 1 000 homicides to boys and nearly 900 to girls under the age of 1 in 2007. In addition, 27 417 sexual offences were reported against children under 18 years of age, which represents an increase of 36%. The research council is of the opinion that violence was profoundly gendered, with young men between 15 and 29 years of age engaged in violence as victims and perpetrators. Donson (2011) stated that social factors (poverty, unemployment, vulnerabilities of families, exposure to violence in

childhood, access to firearms, alcohol and drug abuse) are driving the problems. This is confirmed by “Crime Stats SA” (2013), who provide comparative statistics on various crimes between 2004 and 2013,

	2004	2013
Murder	19 824	177 593
Sexual crimes	66 048	667 803
Burglary at residential premises	299 290	2 583 185
Common robbery	95 550	675 329
Theft from a motor vehicle	171 982	1 318 800
Car hijacking	13 793	125 824
Culpable homicide	11 096	121 599
Public violence	979	11 962
Neglect and ill-treatment of children	6 504	42 541
Kidnapping	3 004	29 900

Therefore this study can make a contribution towards introducing EMDR as a treatment modality for addressing trauma in our country.

This study aims to answer the following research question:

- How does the adolescent experience EMDR as a treatment modality for trauma?

1.4 RESEARCH DESIGN

A qualitative inquiry is the approach selected for this study. Patton (2002) states that qualitative designs are naturalistic, which means that the research takes place in real-world settings and that the researcher does not attempt to manipulate the phenomenon of interest. Merriam (2002) defines qualitative research as a means for exploring and understanding the meaning individuals make of their experiences. It

implies addressing how an experience is 'lived' or 'felt' or 'undergone', and how this influences the individual, which is the focus of this study.

Multiple case studies will be conducted which will involve collecting and analysing data of five cases. The findings are first presented as individual case studies and then cross-case analysis will be done (Merriam 2002). A case study is described by Creswell (2008) as the process where the case (person under study) is explored and information is collected using various methods over a period of time. According to Lindegger (2006), in case study research it is important not to lose focus on the individuals under study, but to study 'individuals as individuals' and not just as members who are part of a society. The literature shows that there are doubts about case studies as far as their generalisability is concerned (Reinharz 1992). Punch (2005), however, takes a different view, which ties in with the current research focus. The author states that a case study can make a valuable contribution in situations where there is shallow or non-existent knowledge, and can in this way contribute to development of the research field. The first point is that what can be learned from a particular case as a case study is unique. The second contribution, which Punch (2005) highlights, is that only a case study can provide an understanding of the important aspects of a new research area. As discussed earlier in the chapter, EMDR as therapy technique has not been studied in the South African context which can, according to Punch's argument make a contribution. By doing this research, much can be learned about each participants' experience of their trauma by applying the method and ascertaining whether it would be useful in our context. As the participants' experiences have led to complex social behaviour, it is important to develop an understanding of them and to discover important features. This in turn provides a platform for further study, which Punch argues is best achieved through the case study strategy. He states that quantitative research on its own does not provide the full understanding of the phenomenon being studied.

The multiple case studies approach was chosen for this study as it allows the researcher to use the replication strategy, therefore increasing confidence in the robustness of the theory (Yin 1994). Yin states that the generalisation of results is made to theory and not to populations, therefore "the multiple case study approach does not rely on the type of representative sampling logic used in survey research, the

typical criteria regarding sample size are irrelevant” (Yin 1994:50). The goal of the study establishes the parameters (Hamel, Dufour & Fortin 1993). The sample size is therefore determined by the number of cases that is required to reach saturation. Data in this study will therefore be collected until the saturation point is reached.

1.5 PARADIGM

A paradigm is a fundamental model or scheme that organises our view of something. Babbie (2007:32) refer to paradigms as ‘models or frameworks for observation and understanding which shape both what we see and how we understand it.’

Lincoln and Guba (1994:105) define paradigms as:

The basic belief system or worldview that guides the investigation, not only in choices of method but in ontology and epistemologically fundamental ways.

Ontology indicates the reality of the research. Epistemology is concerned with ‘how we know what we know’, and the methodology specifies the process of the research (Terre Blanche, Durrheim & Painter 2006). Chapter 3 will offer a discussion of how the fundamental view of reality shapes the present study.

Terre Blanche, Durrheim and Painter (2006) comment that one paradigm is not better than another, and that the researcher chooses a paradigm which he can connect with. Positivism suits those who are interested in facts, while social constructionism suits those researchers who wonder how the social world gets constructed. The interpretative paradigm was chosen for this study as the basis of understanding is concerned about the meanings that people attach to facts with the emphasis on experience and interpretation (Bernard 2000; Henning 2004).

As mentioned, interpretive research is fundamentally concerned with meaning and understanding of situations. Knowledge is constructed not only by observation, but also by descriptions of the adolescents’ beliefs, intentions, values and reasons, meaning making and self-understanding (Henning 2004). Thus participants’ perceptions are what they consider “real” to them and what directs their actions, thoughts and feelings (McMillan & Schumacher 2001). This ties in with the proposed

research, as its purpose is to gain a deep level of understanding of the trauma that adolescents experienced, the meanings they assign to them that influence their day-to-day functioning and whether symptoms reduced after applying the EMDR technique.

1.6 RESEARCH METHODOLOGY

1.6.1 Sampling

Sampling is equally important in quantitative and qualitative designs. The type of sampling is important as we cannot study everything about everyone. The two major differences in sampling between quantitative and qualitative approaches are that in quantitative research the focus is on people which are representative of the larger population – probability sampling. The findings in quantitative research can then be inferred back to the population (Punch 2005). In qualitative research the focus is on non-probability sampling. Non-probability sampling is used in situations that do not permit large-scale social surveys. The type of non-probability sampling chosen for this study is purposeful sampling (Babbie 2010).

In purposive sampling or selection the primary concern is to acquire in-depth information from those who are selected (Cohen, Manion & Morrison 2007; Creswell 2009). Merriam (2002) states that purposeful sampling is based on the assumption that the investigator wants to discover, understand and gain insight, and therefore must select a sample from which the most can be learned. Patton (2002) argues that the logic and power of purposeful sampling lie in selecting information-rich cases for study in depth and those from which one can learn a great deal about the purpose of the inquiry. With these authors' views in mind, the following selection criteria were applied to gain understanding and insight:

- Five adolescents who experienced trauma. The trauma experienced could be developmental or a single-incident event;
- Participants do not need to meet the criteria of post-traumatic stress disorder;
- The respondents need to be from the one specific high school in Johannesburg where the study would be done;

- The first five adolescents who respond and who experienced trauma will be selected.

1.6.2 Data collection

The qualitative researcher studies the spoken and written presentations of participants' experiences using multiple methods. This makes it possible for the researcher to give a full picture (thick description) of the case, which adds to the quality and validity of the research (Punch 2005). Punch further explains that there are two aspects to the idea of a thick description. The first aspect is the importance of the description of the case. This means providing everything the reader needs to know to understand the findings. The second aspect is that the researcher has to provide sufficient information about the context so that the reader can judge the generalisability of the findings. To provide the readers of this study with a thick description, the following data-collection procedures were chosen: interviews, observations, field notes and video recordings.

1.6.2.1 Interview

The purpose of interviewing is to allow us to enter into the other person's perspective. We want to see what is in and on someone else's mind, such as thoughts, feelings and intentions, as we cannot observe this directly (Creswell 2009; Patton 2002). In this study the aim is to gain an in-depth understanding of the context, how the parents perceive their children, and the trauma experienced by the children. This will also give an insight into how the participants themselves define situations and construct their reality (Punch 2005; Taylor & Bogdan 1998). The semi-structured interview was chosen for this study.

In a semi-structured interview the researcher sets the agenda in terms of the topics covered, but the interviewee's responses determine the kind of information produced about those topics, and the relative importance of each of them (Crabtree & Miller 1999; Green & Thorogood 2009). Semi-structured interviews were done with all participants' parents taking part in the study. Interviews with participants will be conducted according to the EMDR protocol.

1.6.2.2 Observations, field notes and video recordings

Clinical observations are a major means of collecting data. They offer a first-hand account of the situation under study and, when combined with interviewing, a holistic interpretation of the phenomenon being investigated can be obtained (Merriam 2002). The EMDR protocol and recordkeeping will assist in gaining a rich description of the adolescents.

EMDR treatment consists of eight essential phases (Shapiro 2010). The number of sessions devoted to each phase and the number of phases included in each session vary greatly from client to client. Each participant will have four to eight EMDR sessions.

The first phase involves taking a history of each participant and planning the treatment. This is followed by the preparation phase, in which I will introduce each participant to the EMDR procedure and theory. I will establish expectations about treatment effects and prepare participants for possible between-session disturbance.

The third phase, assessment, includes determining the trauma and baseline response using the SUD (Subjective Units of Disturbance Scale) and VOC (Validity of Cognition Scale). The fourth phase, desensitisation, addresses the participant's disturbing emotions, and elicits insights and appropriate associations. The fifth, or installation, phase focuses on an enhanced integration of the cognitive reorganisation. The sixth phase, which evaluates and addresses residual body tension, is the body scan. The participant will hold in mind both the traumatic event and the positive cognition, and scan his/her body mentally from top to bottom and identify any residual tension in the form of body sensation. These body sensations are then targeted for successive sets. Closure follows a phase that includes debriefing and is essential for maintaining equilibrium between sessions. The eighth and final phase is termed re-evaluation and is implemented at the beginning of each new session. The participant's previously reprocessed targets will be re-assessed to review the participant's responses in determining if treatment effects have been maintained. See attached addendum of an example of EMDR Protocol and Recordkeeping.

1.6.2.3 Data management and analysis

The data will be analysed qualitatively. Case analysis involves organising the data by specific cases for in-depth study and comparison. The purpose is to gather comprehensive, systematic and in-depth information about each case of interest. It is a process that results in a product (Henning 2004). Content analysis was chosen for this study as it refers to searching text for recurring words related to the study, which in turn gives rise to themes (Patton 2002). According to Merriam (2002), all qualitative data analysis is content analysis in that it is the content of interviews, field notes and documents that is analysed for themes and recurring patterns of meaning. The EMDR procedure for analysis, as set out by Shapiro (2001), will also be included in the search for information rich data.

- Negative cognition (NC) refers to the negative belief of self-associated with unprocessed dysfunctional stored negative memories. The Subjective Units of Disturbance Scale (SUD 1-10) is used to measure the levels of distress of each participant associated with this memory, where 0 is no disturbance/neutral and 10 is the highest disturbance/distress.
- Positive Cognition (PC) refers to the positive belief that is more adaptive and is the desired perception of self identified in relation to the unprocessed, dysfunctional stored negative memory. The Validity of Cognition Scale (VoC 1-7) is a measurement of how valid or true this positive cognition feels as the participant focuses upon the target, where 1 is completely false and 7 is completely true.

Interviews will be transcribed. Transcription is the process of converting audiotape recordings or field notes into text data. Content analysis aims to present the key elements of respondents' accounts (Crabtree & Miller 1999; Creswell 2008). Each interview will be coded. Coding in this study is the process of putting individual words against pieces of the data with the goal of attaching meaning to the data. This enables the possibility to identify themes (Punch 2005). This is essentially a comparative process by which the various accounts gathered are compared with each other to classify those "themes" that recur or are common in the data set (Green & Thorogood 2009; Henning 2004).

1.6.2.4 Data verification and triangulation

Data from different sources will be used to build a coherent justification for themes to answer the research question. Triangulation produces knowledge of different levels and thus contributes to promoting quality in research. Data will be collected from different adolescents using different types of methods (interviews, observational field notes, video recordings, EMDR protocol and record keeping). The different types of data collected and analysed will enhance the accuracy and validity of the study (Creswell 2009; Flick 2009).

Furthermore, in qualitative research a new language was created by Guba (1981) to describe concepts that are related to reliability and validity. Guba proposed 'trustworthiness' as a synonym for 'reliability' and 'validity'. Trustworthiness in the qualitative context describes the belief system with which the researcher approaches the study (Guba & Lincoln 1982). By manifesting trustworthiness, I hope to achieve the following outcomes:

- Credibility
- Transferability
- Dependability
- Confirmability

These outcomes will be discussed in more detail in Chapter Three.

1.7 SCOPE OF INQUIRY

The study will be limited to adolescents who have experienced trauma. These adolescents will be of both genders in the same school.

This study aims to explore the participants' view of their traumatic experience and if there were any changes in the symptoms and behaviour of participants experiencing trauma after applying the EMDR therapy technique.

1.8 ETHICAL CONSIDERATIONS

Participants' information and data produced will remain confidential. The participants will be assured that participation in the research study is voluntary. Informed consent will be obtained whereby the content and intentions will be clarified in writing.

EMDR is a therapeutic technique and therefore changes might take place that activate certain emotional needs. An educational psychologist was appointed to determine if the participants' needs were taken care of. Should the need arise, debriefing and support would be provided for all participants.

1.9 STRUCTURE OF THE STUDY

Chapter One is an introduction to this study. Diagnostic criteria for traumatic events will be presented. The motivation and the statement of the problem will be discussed. The choice of treatment will be presented. The research design, research paradigm and research methodology are broadly outlined.

Chapter Two surveys the literature on trauma and trauma symptoms, and the difference between stress and trauma will be clarified. A clarification and detailed discussion on EMDR will be presented. The adolescent developmental stage and challenges will be described. The effects that trauma has on the brain will be discussed as well as possible therapy for trauma.

Chapter Three deals with the theoretical framework and the research methodology for the study. The process of EMDR therapy technique as a mean to collect data will be explained. The ethical principles adhered to and the credibility measures applied will be addressed.

Chapter Four presents the implementation of the study. Detailed biographies of the participants will be given and discussed. The data analysis and findings will be reported.

Chapter Five summarises the research. The conclusions, the limitations of the study and recommendations for future researched will be presented.

CHAPTER TWO

LITERATURE REVIEW ON TRAUMA

2.1 INTRODUCTION

Adolescence is discussed in Chapter One as a critical developmental phase, but it is also a critical period for healthy development. Many children are affected by trauma because of the high levels of violence, both within the home and the wider community in South Africa. Common types of violence in the home include sexual abuse, physical abuse and corporal punishment.

When elaborating on the word “trauma”, there is a need to understand its origin and how it is viewed and diagnosed by professionals. The different views in the research on this concept will be surveyed in this chapter. A clarification of EMDR and the process of implementing the therapeutic technique will be offered. It is also extremely important to discuss the internal experiences of the adolescent experiencing trauma and effects of this on the environment, relationships, school functioning and development of his or her identity, focusing on what actually happens in the brain when experiencing trauma as well as the consequences for memory, emotions and behaviour. The chapter will conclude by discussing possible therapeutic models to facilitate a balanced life and positive adulthood.

Statistics on the incidence of trauma on children are under-reported, because the events often occur in private settings and are therefore not visible. Children do not report as they have less of a “voice” than adults and feel fearful about reporting when they fear they might be blamed. The research on the prevalence of trauma reveals a negative picture that seems to worsen by the day. Statistics seem to be rising; for example, the South African Police (SAPS) estimated in 2003 that a woman is raped every 36 seconds and a child every 15 minutes (Itano 2003). The 2010/11 statistics from the SAPS record a total of over 50 000 crimes against children, 52% of which were sexual in nature (Dawes & Ward 2008). What is concerning is that the most reported crimes are committed against children between the ages of 15 to 17 years

old, 61% of the children were under the age of 15 years, and 29% were between 0-10 years (SAPS 2011). A survey by Jewkes, Levin, Mbananga and Bradshaw (2002) showed that of 11 735 South African woman, 2% reported being raped before the age of 15 and 85% had been raped between 10-14 years. Most of the abuse took place in their homes. Physical abuse seems to follow the same trend as sexual abuse, but it is difficult to determine the exact statistic. Childline received 3 428 calls on their crisis line from children reporting physical abuse (Van Niekerk 2009). Not only do children experience abuse themselves, but being exposed to physical violence against their mothers may traumatise children. A study by Singh (2005) suggests that children exposed to violence directed at their mothers often display the same psychological distress as children exposed to abuse themselves. Experiencing abuse and being exposed to abuse both elicit traumatic stress and may lead to post-traumatic stress disorder (Margolin & Vickerman 2007). It is thus clear that trauma among individuals during the child and adolescent phase is a common problem in South Africa and that more children are diagnosed with PTSD. The Child and Adolescent Psychiatry Unit at Tygerberg Hospital reports that PTSD has become one of the most common disorders, which is a matter of concern for their health as future adults (Traut, Kaminer, Boshoff, Seedat, Stein & Hawkrige 2002).

2.2 OVERVIEW OF TRAUMA

2.2.1 What is trauma?

According to the definitions of trauma presented in Chapter One, trauma can be experienced from various situations such as: natural disasters which include earthquakes, large fires, floods, avalanches, hurricanes, tornados and volcanic eruptions extreme temperatures where the extent of physical injury, fear of death and loss are the traumatizing aspects of these events (Briere & Elliot 2000; Goenjian, Molina, Steinberg, Fairbanks, Alvarez & Pynoos 2001).

Acts of violence that involve high numbers of injuries that do not occur in the context of war – including terrorist attacks such as that of September 11 in America and the attacks on the London mass transit system – are obvious causes of trauma (Alexander & Brenner 2001). Other forms of violence that are causes of trauma include domestic violence (Socolar 2000), rape and sexual assault. Child abuse can

range from fondling to rape and severe spankings to life-threatening beatings. Children may be psychologically abused and or neglected (Orbach, Lamb, Sternberg, Williams & Dawud-Noursi 2001).

Muggings, beatings, stabbings, shootings attempted strangulations are usually motives for expression of aggression by a stranger or gangs to assert dominance (Currier & Briere 2000). Domestic violence is usually defined as physically or sexually assaultive behaviour and emotional abuse by one adult against another. Threats may also include violence against children, pets or property (Straus & Gelles 1990).

Emergency workers exposure to trauma could be traumatized in their effort to help others and then become traumatized themselves, e.g. firefighters, rescue workers, paramedics. These rescue workers encounter potentially traumatic situations, which could result in fatal injuries, traumatic amputations and severe burns to themselves (Fullerton, Ursano & Wang 2004).

Medical trauma could refer to reactions a person has to pain, injury (Powers 1999) and life-threatening illnesses such as cancer (Brown, Madan-Swain & Lambert 2003; Stuber, Shemesh & Saxe 2003) or to invasive medical procedures like surgery or treatments such as burn care that could affect the mind and the body (Van Niekerk, du Toit, Nowell, Moore & Van As 2004), road traffic injuries (Sudhai, Noah & Prinsloo 2004; Zatzick & Roy-Byrne 2003).

Traumatic grief may occur following the loss of a loved one due to AIDS (Cluver, Fincham & Seedat 2009), divorce or separation, with the loss experienced becoming traumatic (Prinsloo 2005).

2.2.2 History of trauma

Although the etymology of the word 'trauma' goes back to the Greek word for 'wound' (Kirmayer, Lemelson & Barad 2008), van der Kolk and McFarlane (2007:3) state that trauma is an essential part of being human. They say: "*History is written in blood.*" Throughout history people have been through dreadful experiences.

In the 1800s scientific discussions reflected conflicting views on the etiology of trauma. The question was whether trauma is physical or psychological. The history of trauma reflects the efforts to providing medical services to soldiers and civilians in time of war.

As technology developed, new weapons brought new types of injuries and fears (Kirmayer et al. 2008).

The conflict about the physical or psychological origins of traumatic neuroses was relevant for combat soldiers in the 1900s. If trauma was physical, it is an illness and to define such an illness in the medical literature was difficult. To ascribe issues of cowardice and shirking to physical problems offered an honourable solution to the problems faced by soldiers. Cardiovascular symptoms such as rapid or irregular heartbeat, palpitation or shortness of breath were diagnosed as “irritable heart” and “soldier’s heart”. Myers (1915) was the first to use the term “shell shock”. However, it became difficult to explain shell shock in soldiers who had never been exposed to gunfire. It then became clear that the causes of trauma might have an emotional origin (van der Kolk 2007). Churchill’s doctor, Lord Moran, confessed in his memoirs of his service in World War I that it was difficult to distinguish between *shell shock* and *cowardice*. Interestingly, in World War II 2 200 British soldiers were condemned to death for *cowardice* and *desertion*, but only 200 were executed as a lesson to others.

A pioneer in the field of studying neurosis was Jean-Martin Charcot. He was a French neurologist and a professor of anatomical pathology and is known as “the founder of modern neurology”, and was specifically interested in hypnosis and hysteria. He initially believed that hysteria was a neurological disorder but near the end of his life concluded that hysteria was a psychological disease (Lamberty 2007:5). His work led to great advances into researching the relationship of the mind and body. In the 1900s Pierre Janet used the term “subconscious” to mean “The collection of memories forming the mental schemes that guide a person’s interaction with the environment” (van der Kolk & McFarlane 2007). In the case of a traumatic event, these memories are “split off” from the conscious awareness and the memory is stored in the subconscious, which reproduces the trauma over and over again. Janet proposed that when trauma is experienced, the individual gets stuck and become attached to the trauma; therefore no new learning can take place (van der Kolk 2007; Wastell 2005).

Freud (as cited by van der Kolk et al. 2007:54) agreed with the possibility of ‘splitting off’ from consciousness, but disagreed that childhood memories were the reason. Freud’s view was not that the actual memories of childhood caused the split off from consciousness, but that “*It is rather unacceptable sexual and aggressive wishes of the*

child that threatened the ego and motivated defences against the conscious awareness of these wishes.” Abram Kardiner worked with Freud and reassessed the meaning of symptoms of trauma. He proposed that individuals diagnosed with “traumatic neuroses” act as if the original traumatic situation was still in existence, thus being fixated on the trauma and showing chronic irritability, startled reactions and aggressive responses. He expanded on this view by stating that this is the result of the ego that dedicates itself to ensuring that the individual is safe and tries to protect itself against recollection of the trauma. Being fixated on the trauma alters the conception of the self in relation to the world. Kardiner’s view on trauma and its effect was “the beginning of integration” and influenced the definition of PTSD (van der Kolk 2007; Wastell 2005). Below is a summary, adapted from Hyman, Wignall and Roswell (1996) by Sadock and Sadock (2007:613), of the way the term PTSD as we know it today came to be classified.

Table 2.1: Eponyms and symptoms of Post-traumatic Stress Disorder in various US wars

War	Disorder
US Civil War	“Irritable heart”: fatigue, shortness of breath, palpitations, headache, excessive sweating, dizziness, disturbed sleep, fainting
World War I	“Effort syndrome”: fatigue, shortness of breath, palpitations, headache, excessive sweating, dizziness, disturbed sleep, fainting, difficulty concentrating
World War II	“Combat stress reaction”: fatigue, shortness of breath, palpitations, headache, excessive sweating, dizziness, disturbed sleep, fainting, difficulty concentrating, forgetfulness
Vietnam War	“Post-traumatic stress disorder”: fatigue, shortness of breath, palpitations, headache, muscle and joint pain, dizziness, disturbed sleep, difficulty concentrating, forgetfulness
Gulf War	“Gulf War syndrome”: fatigue, shortness of breath, headache, muscle and joint pain, disturbed sleep, difficulty concentrating, forgetfulness

During these wars there were no classification criteria for symptoms such as reactions to combat stress, minor personality disturbances, psychosomatic reactions and neurotic symptoms. There was thus a need for developing diagnostic criteria for PTSD. The World Health Organisation (WHO) then included mental disorders in the sixth revision of the International Statistical Classification of Diseases, Injuries, and Causes of Death (ICD-6) in 1948. In the ICD-6 PTSD was called “acute situational maladjustments.” The *Diagnostic and Statistical Manual of Mental Disorder* (DSM-I), developed by the American Psychiatric Association, called this “transient personality disturbance” in 1952. When revising the criteria, no changes were reported in the ICD-7 and in the DSM-I.

The DSM-II (APA 1968) was based on the ICD-8 (WHO 1969) in the mental disorders section. Following the ICD-8 was the ICD-9 (WHO, 1977), which was revised and the term “acute reaction to stress” was used. The ICD-10 (WHO 1992) and the DSM-III (APA 1980) applied changed in the terminology. The stress disorders are no longer restricted to acute responses in healthy individuals. This means that traumatic stress can cause chronic reactions and that responses to traumatic stress are evident in those with previous and simultaneous conditions. It is interesting to note that the ICD-10 (WHO 1992) also includes enduring personality changes after catastrophic experience as a diagnosis for traumatic reactions (Brett 2007). Upon revising the diagnostic criteria, the decision needed to be made about where to place PTSD in the new edition of the diagnostic manual. Discussions turned into heated debates between Advisory Subcommittee members of the DSM-IV and the DSM-IV Task Force. They had to take a decision on whether PTSD needs to be classified under the anxiety or dissociative disorders. The Task Force did not support the view that PTSD be placed in a new stress response category and therefore PTSD remains classified as an anxiety disorder (Brett 2007; van der Kolk 2003; Wastell 2005). In the newly published DSM V (2013:265) PTSD is now included in a new section: “Trauma- and Stressor-Related Disorders” and a separate criterion was added for children 6 years old or younger. The diagnosis for PTSD and acute stress disorder (Criterion A1) was modified and the requirement for specific subjective emotional reactions (Criterion A2) was removed. The recent diagnostic criteria for PTSD in the DSM-V is presented in Chapter One.

2.2.3 The difference between stress and trauma

Stress is defined as “A mental state or emotional strain or tension resulting from adverse or very demanding circumstances” (New Oxford Dictionary of English 2001:1839). Sadock and Sadock (2007) describe stress as a circumstance that disturbs the normal physiological or psychological function of a person. Chrousos (1998:311) is of the opinion that life itself entails “stress and coping” and that these have positive and negative features disrupting the homeostasis in our bodies. Fortunately humans are adaptive and by adapting to stress they can improve their chances of survival.

Perry and Pollard (1998) are of the opinion that when we are confronted with a stressful situation, our bodies activate their stress-response mechanisms (central and peripheral nervous system, neuroendocrine and immune responses) to support the body in adapting in the situation, but later return to equilibrium. If the stress is too intense, unpredictable or chronic, the body’s coping mechanisms becomes over-active or fatigued with no restoration of homeostasis. This disruption can create a persisting set of compensatory responses, creating a new state of equilibrium which is not flexible. Hans Selye (1993:7) defines stress as “the nonspecific response of the body to any demand” and makes a distinction between *eustress* and *distress*. *Eustress* is seen as positive stress, which produces effective coping for individuals, while *distress* is defined as negative stress and can impair future functioning. Smith and Carlson (1997) found a consistent relationship between stress and psychological and behavioural problems in children and adults. According to their research, there is a link between life events, stress, and adverse child and adolescent outcomes, which include depression, anxiety, suicide attempts, anti-social behaviour and health problems. Thus stressful life events do influence the child and adolescent development process and are seen as stressors.

Stressors can vary in intensity and can originate from within the child or from his/her context, including factors such as temperament, conduct problems, deprivation, abuse or neglect, violence at home or in the neighbourhood. Stressors activate anxiety. Garland (2002) differentiates between ‘signal’ and ‘automatic’ anxiety. Signal anxiety is a reaction warning a person of a possible threat to his or her safety. Automatic

anxiety arises in a real threatening situation and the person involved switches to fight, flight or freeze mode.

In the case of stress, people experience signal anxiety to be warned of a possible threat, after which the body returns to homeostasis, e.g. when a person hears a noise outside and investigates. Automatic anxiety will arise in a case of a traumatic experience. Automatic anxiety is activated and the brain makes involuntary decisions, e.g. in the case of a traumatic event, a similar noise in the future will make the person panic. When the person is exposed to repeated trauma, automatic anxiety becomes the body's norm for functioning and healing becomes more difficult as the world is considered an unsafe place.

According to the literature, there is a clear distinction between stress and trauma. The Israel Centre for the Treatment of Psychological Trauma (2012) describes the three factors that influence stress and trauma in the table below.

Table 2.2: The difference between stress and trauma

The situation itself	
Trauma	<ul style="list-style-type: none"> • A traumatic event is often life threatening. It is an event that dramatically explodes into our daily life and changes our perception of the world.
Stress	<ul style="list-style-type: none"> • A reaction to less dramatic events that are perceived as threatening, e.g. job interview, deadlines, etc.
Feeling in control	
Trauma	<ul style="list-style-type: none"> • Feel loss of control and experience repeated memories and they cannot control their thoughts. Reliving the traumatic event in their imagination and dreams impedes their ability to live their lives.
Stress	<ul style="list-style-type: none"> • Although people experiencing stress may appear short-tempered or worried, they still have a feeling of control over their lives and do not feel completely out of control.
Respite	
Trauma	<ul style="list-style-type: none"> • They have no respite from unpleasant emotions or negative thoughts, they are constantly triggered by them.
Stress	<ul style="list-style-type: none"> • They are capable of disconnecting from their negative thoughts and can relax and still enjoy life.

Freud (as cited in Fargher & Dooley 2011) states that people have a protective shield (mental shield) to allow or prevent thoughts and feelings into the mind by this mental shield. Our mental shield therefore sifts through thoughts, dreams and experiences, and allows them to enter the conscious mind when the individual seems ready to think about it or to process stimuli. In this way people protect themselves from thoughts that may be too unbearable. This is part of normal development and is a daily process for healthy functioning. In the case of a traumatic event, the shield is broken and the process of “sifting information” is not functioning effectively, resulting in anxiety entering the conscious mind, leaving the person traumatised. The person’s internal defences and strengths determine if the mental shield will allow the traumatic event to be recalled and brought to consciousness, and enable them to deal with the traumatic situation. When a person’s internal defences and strengths are not strongly developed and the mental shield is breached, traumatic experiences triggers primitive anxieties and normal daily thinking, functioning and development are adversely affected.

Lewis (1999) argues that crises need to be added to the classification when distinguishing between stress and trauma. The author states that stress, crises and trauma are inextricably linked, but do differ conceptually. According to the author, stress is a feeling of pressure experienced during a difficult time, whereas crisis is described as a reaction felt during a difficult time. Feelings of confusion and an inability to cope may be experienced. Stress and crisis can have positive outcomes, but may lead to trauma which is negative in nature. As discussed in the previous heading on history of trauma, the new DSM 5 categorizes stress and trauma differently. It is felt that exposure to a stressful or traumatic event symptoms may have an anxiety-or fear-based context with externalizing angry and aggressive symptoms or dissociative symptoms. Therefore a combination of these symptoms (with or without anxiety- or fear based symptoms) may be evident. It is therefore decided to group these disorders under a separate category “*Trauma- and stressor-related disorders*” (DSM 5 2013:265).

2.2.4 Symptoms of trauma

The experience of trauma is complex. Trauma varies in type, source and impact within different contexts and at different developmental stages (Blaustein & Kinniburgh 2010). As noted in the previous section, trauma symptoms refer to behavioural, cognitive, physical and emotional difficulties related to a negative experience.

Simeonsson (1994) is of the opinion that 15-18 percent of adolescents who experienced trauma present with behavioural disorders that are psychological in origin. He divides the behavioural disorders into internalising or externalising disorders. Internalised disorders show symptoms of feelings of loneliness, depression, anxiety, social withdrawal. Externalising disorders are characterised by aggression, hyperactivity or acting out. Internal and external behaviours correlate with symptoms of PTSD (Cohen et al. 2006). Levine and Kline (2007) developed a checklist of behavioural signs of trauma in adolescents:

- Abrupt changes in relationships like sudden lack of interest in favourite people;
- Becoming detached and withdrawn;
- Radical changes in grades, life attitudes and/or appearance;
- Sudden changes in behaviour like life-threatening re-enactment or other acting out;
- Sudden changes in mood, especially anxiety, depression and thoughts of suicide;
- Dependency on alcohol and drugs;
- Sudden lack of interest in favourite hobbies or sports;
- Irritability, anger and the desire to take revenge;
- Sexual promiscuity.

Wastell (2005) provides a model, developed by Horowitz, for individuals not meeting the full criteria for PTSD. His model of trauma suggests that a person is flooded with

information when they experience trauma. Information taken in integrates with other previous schemas, but information that is overwhelming remains in active memory. Recurring flashbacks, nightmares and avoidances indicate that the information of the traumatic memory has not been integrated. In Horowitz's model he sets out a series of five phases that follow a traumatic event. The phases 'denial' and 'intrusion' do not occur in any prescribed pattern and their symptoms are crucial to understand his model. The denial phase involves symptoms such as emotional numbness, selective inattention, complete or partial amnesia, and constriction of associational thinking. Behaviour expected could frantic activity often followed by withdrawal and inactivity. The intrusion phase is characterised by sleep disturbance, hyper-vigilance, intrusive thoughts, repetitive thoughts and confusion. Horowitz's model is presented in the figure below:

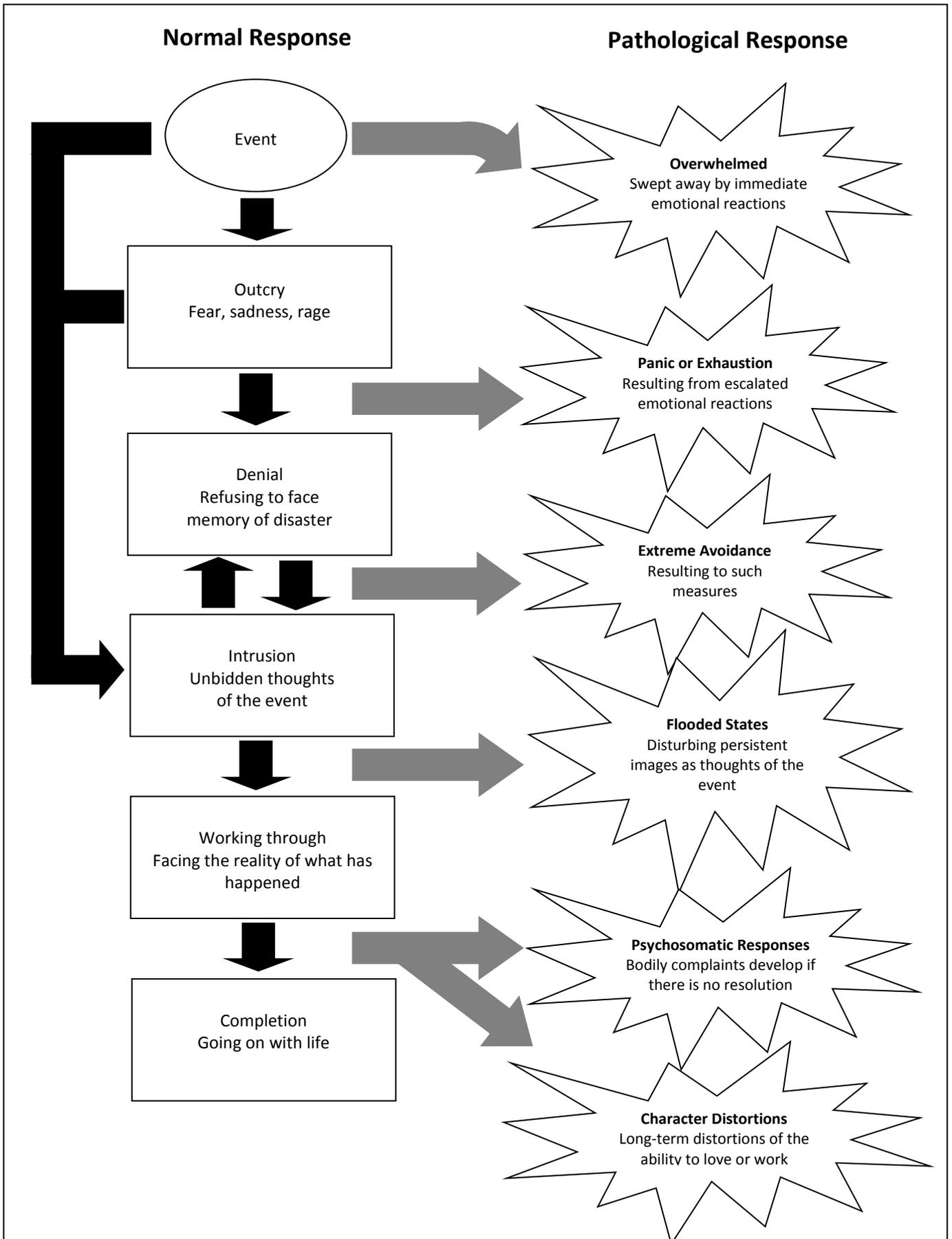


Figure 2.1: Horowitz's Model

2.3 TRAUMA IN ADOLESCENTS

Chapter One touched briefly on the adolescent phase. To understand the impact of trauma on the adolescent a brief discussion of this critical development phase will follow.

As discussed, adolescence is seen as a time of change. It is a stage in a person's life between childhood and adulthood and is defined as "the period of human development during which a young person moves from dependency to independence, autonomy and maturity" (Geldard & Geldard 2010:4). Gulotta, Adams and Montemayor (1995:17) view adolescence as "a period of experimentation, of practice in making decisions, of making mistakes and discovering one's errors, and of gradually assuming new freedoms while building towards adult responsibilities.' It is understood as a cycle of moving from being part of a family group, moving forward to being part of a peer group and eventually standing alone as an adult; hence the development of identity and understanding of the *self*. Thus it is a period of transitions that differs in length for each individual (Ackermann 2001). The adolescent phase involves a process where the adolescent is confronted with biological, cognitive, psychological, social and moral challenges. The adolescent needs to confront and deal with these challenges and integrate them meaningfully to provide a positive identity and foster resilience (Blaustein & Kinniburgh 2010). These challenges refer to different developmental tasks which include abilities, skills, attitudes and behavior patterns the adolescent should achieve during this phase.

2.3.1 Normal development of the adolescent

2.3.1.1 *Developmental tasks*

Ackerman (2001:105) describes some of the most important developmental tasks during the adolescent phase:

- The acceptance of body changes;
- The development of an integrated gender role identity;
- The development of a personal identity;
- The development of relative independence;

- Preparation, including exploration and decision-making, regarding a future career;
- The development of emotional control and sensitivity to the emotions of others;
- The development of more permanent relationships.

Psychological challenges involve the formation of a personal identity. Personal identity involves the skill to differentiate ourselves from others developing into a unique individual.

Erikson describes this development task as one asking the question “Who am I and what can I be?” Erikson uses the term “identity crisis” when explaining this phase. Although the adolescent phase is the phase which focuses on the development of the identity of the adolescent, Erikson points out that each stage that came before and that follows this phase has its own ‘crisis’ and that the need for the individual to go through each phase influences the way the adolescent perceives himself. The stage of Identity seems to be the synthesis of earlier stages and the anticipation of later ones. The previous stages the development depended upon what is done to the individual and from the adolescent phase development depends primarily upon what the adolescent does from now on. Life for the adolescent therefore can become more complex, struggling with social interactions to become part of the wider society. The adolescent may find himself in a state of ‘identity confusion’ since commitments in the wider society are asked for before particular identity roles were formed. The problem with role confusion is that teens may sink into a period of withdrawing from responsibilities. Society normally makes allowances for youth to ‘find themselves’ which Erikson terms a ‘moratorium’. Erikson believes that it is essential to have enough space and time to experiment and explore to develop a sense of identity, an emotional and deep awareness of who he or she is. A reluctance to commit can haunt a person into his mature years.

In the search for the *self* adolescence is often a time of extremes, experimenting, discarding different roles, developing strong views and judgments. It can be seen as a high-risk time, if the individual has been exposed to a single-incident trauma or trauma developing over a period of time (Casey, Jones & Hare 2008; Fargher & Dooley 2011; Geldard & Geldard 2010; Levine & Kline 2007), resulting in unresolved issues that can

interfere with the way the adolescent adapts to the challenges of adolescence, which in turn influences adult functioning (Fargher & Dooley 2011; Prachett & Yehuda 2011; van der Kolk 2007).

Biological changes are defined by (Arnett 2007) as the physical transition marked by the onset of puberty and the termination of physical growth. Biological changes include changes to the sex organs, height, weight and strength. These changes happen at different ages over a period of time. Early and late maturation have advantages and disadvantages for the adolescent. Early maturation for boys seems beneficial whereas for the early maturing girls can cause disruptions in existing relationships and these girls tend to develop relationships with older boys. Late maturation can result in the adolescent feeling embarrassed, self-conscious and anxious about their appearance and feeling out of step with their peers (Ackerman 2001; Geldard & Geldard 2010).

Piaget explains the cognitive development of the adolescent as the stage when the adolescents' thoughts start taking more of an abstract form and the egocentric thoughts decrease, allowing the individual to think and reason in a wider perspective (Arnett 2007). They can therefore more easily comprehend proverbs, metaphors and analogies, which permits them to appreciate different ways in which language can be used to convey messages such as using metaphors and sarcasm. They develop the ability to imagine possible and impossible events, solve problems and are less likely to accept facts as absolute truths (Albert & Steinberg 2011; Smetana & Villalobos 2009).

They also have a desire to feel important in their peer groups and enjoy social acceptance. Balance between the development of the adolescents' own identity and integration with society is needed. When adolescents cannot achieve balance, their sense of being valued by others may be reduced (Geldard & Geldard 2010). The development of a social identity is affected by the environment the adolescent grows up in. A child who grows up in a more privileged environment is more likely to be exposed to more opportunities and more positive situations. Whereas an adolescent from an inner city or environment which is crime-ridden is more likely to be exposed to situations that could be negative to their development and have a major affect on future decisions, exposure to positive environments could contribute to a more successful identity development (Steinberg 2008).

Moral development, according to Kohlberg, is concerned with ‘how children come to internalize their parents’ values and teachings’ (Wenar & Kerig 2006:58). Geldard and Geldard (2010:15) adopted Kohlberg’s model, which outlines the stages of moral development:

Stage one: pre-conventional morality (age 4-10 years). In this stage a child will do good or avoid wrong with a motive of either avoiding punishment or receiving a reward.

Stage two: conventional morality (age 4-10 years). The child learns to conform to the society in which they live. Doing good or avoiding wrong depends on the approval of older people. Thinking is absolutist and inflexible – right is right and wrong is wrong.

Stage three: post-conventional morality (age 14 years onwards). The adolescent becomes aware of human rights and judges behavior accordingly. They develop clear ideas about their beliefs and are prepared to stand up for them. They therefore do not act out of fear or need for approval anymore.

It cannot be guaranteed that all young people reach stage three. It seems that for some young people morality is linked with rewards or not getting caught which is typical of stage one. Gender difference, intellectual ability and the context in which the adolescent lives also influence their moral development (Wenar & Kerig 2006).

2.3.1.2 *The importance of early attachment*

Levy and Orlans (1998:1) defines attachment as “the deep enduring connection established between a child and caregiver in the first several years of life”. John Bowlby developed the Attachment theory and views the infant and the mother as participants in a consistent, self-regulating and mutually interacting system (Bowlby 1969). Bowlby is of opinion that, in order for an infant to grow up mentally healthy, the infant should experience an intimate, warm and continuous relationship with its mother or primary caregiver (Bowlby 1969). Attachment therefore indicates an ongoing, reciprocal relationship in which individuals are attuned to each other, give and receive love, and seek comfort (Gray 2012). The attachment theory thus explains how much the caregiver’s relationship with the child influences development. Norcross (2002) highlights four definitional features: proximity seeking, comfort seeking, separation

anxiety and relying on the attachment figure as a secure base from which to explore and a safe haven to return to. Under optimal conditions a stable sense of attachment security are most likely to develop when:

- the attachment figures were available in times of need having basic physical and emotional needs met;
- attuned parental responses were applied;
- have a regulated environment;
- co-regulating interactions with caregivers;
- modulation of arousal;
- nurturing touch, and activities that stimulate the body and brain to develop and operate at full capacity.
- the child could experience others as trustworthy and the self as worthy (Bath 2008; Becker-Weidman & Hughes 2008; Norcross 2002).

Children who begin their lives with a secure attachment fare better during their development in the following areas (Levy & Orlans 1998:3):

- Self-esteem;
- Independence and autonomy;
- Resilience in the face of adversity;
- Ability to manage impulses and feelings;
- Long-term friendships;
- Relationships with parents, caregivers, and other authority figures;
- Pro-social coping skills;
- Trust, intimacy, and affection;
- Positive and hopeful belief system about self, family, and society;
- Empathy, compassion, and conscience;
- Behavioral performance and academic success in school; and
- Promote secure attachment with their own children when they become adults.

Levy and Orlans (1998:3) also identify risk factors which can unfold during a child's development if they began their lives with disrupted attachments:

- Low self-esteem;
- Needy, clingy, or pseudo-independent;
- Decompensate when faced with stress and adversity;
- Lack self-control;
- Unable to develop and maintain friendships;
- Alienated from and oppositional with parents, caregivers, and other authority figures;
- Antisocial attitudes and behaviors;
- Aggression and violence;
- Incapable of genuine trust, intimacy, and affection;
- Negative, hopeless, and pessimistic view of self, family, and society;
- Lack empathy, compassion, and remorse;
- Behavioral and academic problems at school; and
- Perpetuate the cycle of maltreatment and attachment disorder in their own children when they reach adulthood.

Ainsworth expanded on Bowlby's work in her famous "Strange Situation" study. This study involved observing children between the ages of 12-18 months responding to a situation in which they were briefly left alone and then reunited with their mother. Based on these observations, Ainsworth concluded that there were three major styles of attachment with their characteristics (Ainsworth, Blehar, Waters & Wall 1978):

Secure attachment

As children:

- Are able to separate from parent
- Seek comfort from parents when frightened

- Greet the return of parents with positive behaviour
- Prefers parents to strangers

As adults:

- Have trusting, lasting relationships
- Tend to have high self-esteem
- Are comfortable sharing feelings with friends and partners
- Seek out social support

Ambivalent-insecure attachment

As children:

- May be extremely suspicious of strangers
- Display distress when separated from a parent or caregiver
- Do not appear to be comforted when their parents return. Child might even passively reject the parent by refusing comfort or display direct aggressions towards the parent or caregiver.

As adults:

- Could feel reluctant about becoming close to others
- Worry that their partner does not love them, which could lead to frequent breakups
- Can become very distraught after the end of a relationship

Avoidant-insecure attachment:

As children:

- Tend to avoid parents and caregivers usually after a period of absence
- Might not reject attention from their parent but neither do they seek contact or comfort

- They do not show preference between a parent and a complete stranger

As adults:

- May have difficulty with intimacy and close relationships
- Do not invest much emotion in social and romantic relationships. Show little distress when a relationship ends
- Fail to support partners during stressful times and show an inability to share feelings, thoughts and emotions with partners.

Attachment and trauma in the adolescent

According to Geldard and Geldard (2010:19), attachment problems are one of the unresolved issues that need to be looked into in understanding adolescent behaviour. He defines attachment challenges as *“the tendency of a child to repeatedly seek closeness with a specific person, usually the mother, in order to reduce internal tension.”* The kind of attachments a child develops with his caregiver has an effect on the child’s development throughout his life and how he deals with stressful and traumatic situations. Providing a nurturing environment is, according to Wilkinson (2010), the key to emotional wellbeing and thus positive attachments. He elaborates on this topic by stating that secure and loving care giving is important for an individual to develop to his or her full potential. Furthermore, “parent’s model containment of anxiety and difficult emotions for their children and their children learn from them” (Fargher & Dooley 2011:3). The authors explain that parents then act as ‘gatekeepers’ protecting their baby from any situation that the baby cannot cope with or endure. When experiencing this security, the baby internalises this function; therefore the parents help their children to think emotionally and process anxiety and deal with it in ordinary life. It can then be argued that the care given by the parents thus reflects the parents’ own early experience of being cared for and therefore the parents’ own attachment style (Wilkinson 2010). Attachment problems have been linked in adolescents to eating disorders, substance abuse, violence, poor self-image and anxiety (Wenar & Kerig 2006). Adverse childhood experiences are therefore a strong predictor of emotional and physical problems in adulthood (Broad & Wheeler 2006).

2.3.1.3 Maltreatment and Neglect

Wenar and Kerig (2006) documented a definition of maltreatment by The World Health Organization Consultation on Child Abuse Prevention (1999) stating that child abuse consists of any treatment that results in actual or potential harm to children that has a negative impact on the child's health, survival, relationships, development, dignity, trust or power.

2.3.1.3.1 Maltreatment and neglect within the family

Camilleri (2007) agrees with the definition set out by Wenar and Kerig (2006) and elaborates on the nature of maltreatment by parents. He is of the opinion that a negative family environment and disadvantaged families, could produce negative outcomes for children. Stressful situations such as job loss, moving or death create frustration and sadness, which parents often do not have the resources to cope with and children become their victims McLloyd (1990). Thus most traumatic experiences such as child abuse begin at home and also have a profound impact on many different areas of the adolescent's functioning.

The author is of the opinion that parenting not only entails providing basics such as food, supervision and clothing, but that children are also in need of structure, education, physical and mental health, safe living conditions, someone to listen to them, and engage in conversations with them. If these are not provided, this could be seen as neglect, resulting in the adolescent showing a lower interest in work and school, and higher involvement with delinquency and substance abuse (Wenar & Kerig 2006).

Furthermore, a study by Gorman-Smith, Tolan and Henry (2000) found that children show delinquency in households where there were high levels of discipline, structure and parental monitoring, but low levels of family cohesion, emotional closeness and dependability. Sagrestano, Paikoff, Holmbeck and Fendrich (2003) found that an increase in conflict and a decrease in parental monitoring in the home were associated with increases in depressive symptoms in children and adults. The authors found that when there is a peer-like relationship between adults and children, a lack of boundaries and role definitions occurred.

In single-parent families where the mother had to work long hours and had several jobs, there is a lack of parental supervision and adolescents are left to take care of themselves after school. These parents depend on the adolescent to take over family responsibilities and take care of their siblings as well as do the cooking and cleaning. A study by Deardorff, Gonzales and Sandler (2003) confirms their view that single-parent homes also have a direct impact on depressive symptoms in adolescents. The adolescents showed symptoms of anxiety, suicidal tendencies, academic deficits and substance abuse. Wenar and Kerig (2006) add that unavailable mothering (psychological unavailability) can also result in self-abusive behaviour.

Deardorf et al. (2003) thus argue that it seems that family stress is something the adolescent has no control over. Feelings of hopelessness about being able to change their circumstances develop, which can lead to depression. In addition, psychological abuse predicts the development of eating disorders and these youths demonstrate poor social competence and are likely to be more aggressive and engage in assaultive behaviour (Wenar & Kerig 2006). Swick and William (2006) and Wenar and Kerig (2006) elaborate on violence in the family and describe it as emotional trauma for children and adults, and note that violence can become the norm in later relationships, focusing on power and control.

2.3.1.3.2 Maltreatment and neglect due to exposure of violence

Lewis (2009:14) states that “Many South African children are affected by trauma because of the high levels of violence, both within the home and the wider community”. Lewis (1992) reports that over approximately 30 years the level of violence in schools has increased rapidly. Learners in 1976 protested at Afrikaans being the medium of instruction in schools. According to Khoza and Zwane (as cited by Lewis & Ngqela 2012:89), the apartheid government used the education system to oppress black people, which contributed to the violence experienced among youths in schools. Oppression was evident in the overcrowded township schools, inadequate teaching and learning resources, and poor infrastructure. Teachers in the black community were poorly trained, all leading to the development of resistance among black township learners against the apartheid education system.

Exposure to violence causes school-aged children to develop depression and anxiety. The anxiety can manifest in behaviours such as extreme worrying that they might get shot or die, or wishing they were dead. Symptoms of PTSD, including intrusive thoughts, dissociation and nightmares, are experienced. These children may show low self-esteem, poor academic performance, distractibility and inattention (Wenar & Kerig 2006), and have high levels of absence from school (Camilleri 2007). Their sense of self and identity may be fragmented and negative frames develop over time. Feelings of shame, self-blame, guilt and powerlessness develop (Blaustein & Kinniburg 2010). Violence seems to have its roots in past experience.

2.3.1.3.3 Maltreatment and neglect due to sexual abuse

In the case of sexual abuse, Deblinger, Steer and Lippman (1999) identified symptoms such as powerlessness, external locus of control, self-blame and post-traumatic stress disorder. Prachett and Yehuda (2011) comment that not only is there a strong association between child abuse and adult post-traumatic stress disorder, but they also state that child abuse sets the stage for PTSD as an adult. The authors refer to Saigh and Bremner (1999), who point out that 72%-100% of adults who experienced child abuse are diagnosed with PTSD. A SASH survey by McGregor, Schoeman and Stuart (2002) confirms their view and documented in their survey that twelve per cent of South African adults reported physical abuse by a caregiver in childhood. Prachett and Yehuda (2011) conclude that it seems that the full impact of child abuse sometimes becomes evident only in later years. The authors argue that a possible explanation for this “delay” in symptoms manifesting could be that more developed cognition and maturity are required to understand and deal with such trauma.

2.3.1.3.4 Impact of maltreatment and neglect on development and education

Fargher and Dooley (2011) state that in normal development, thinking moves from concrete, rigid thinking to abstract sophisticated thinking. During normal development children develop their ability to link their bodily sensations, thoughts, feelings and experiences, thus thinking symbolically. Thinking symbolically allows the child to view experiences more objectively and with a more sophisticated understanding of an experience. Traumatic experiences influence the adolescent’s ability to think clearly,

symbolically and to connect and integrate incoming information, resulting in a reversion to old ways of thinking to protect themselves, which in turn influences normal development. The more concretely the adolescent relates to the world, the more difficult it becomes to recover after trauma or maltreatment.

Maltreatment can cause cognitive and language, emotional, behavioural and social impairment. The adolescent's cognitive and language development can show a setback in academic performance of even more than 2 years; their emotional and behavioural problems intensify and their problem behaviour could result in peer rejection, refuelling further aggression. Impairments at early ages therefore seem to become a high risk for psychiatric disorders in adolescence such as substance abuse, borderline disorder, and eating, dissociative, affective, somatoform and sexual disorders (Schore 2009).

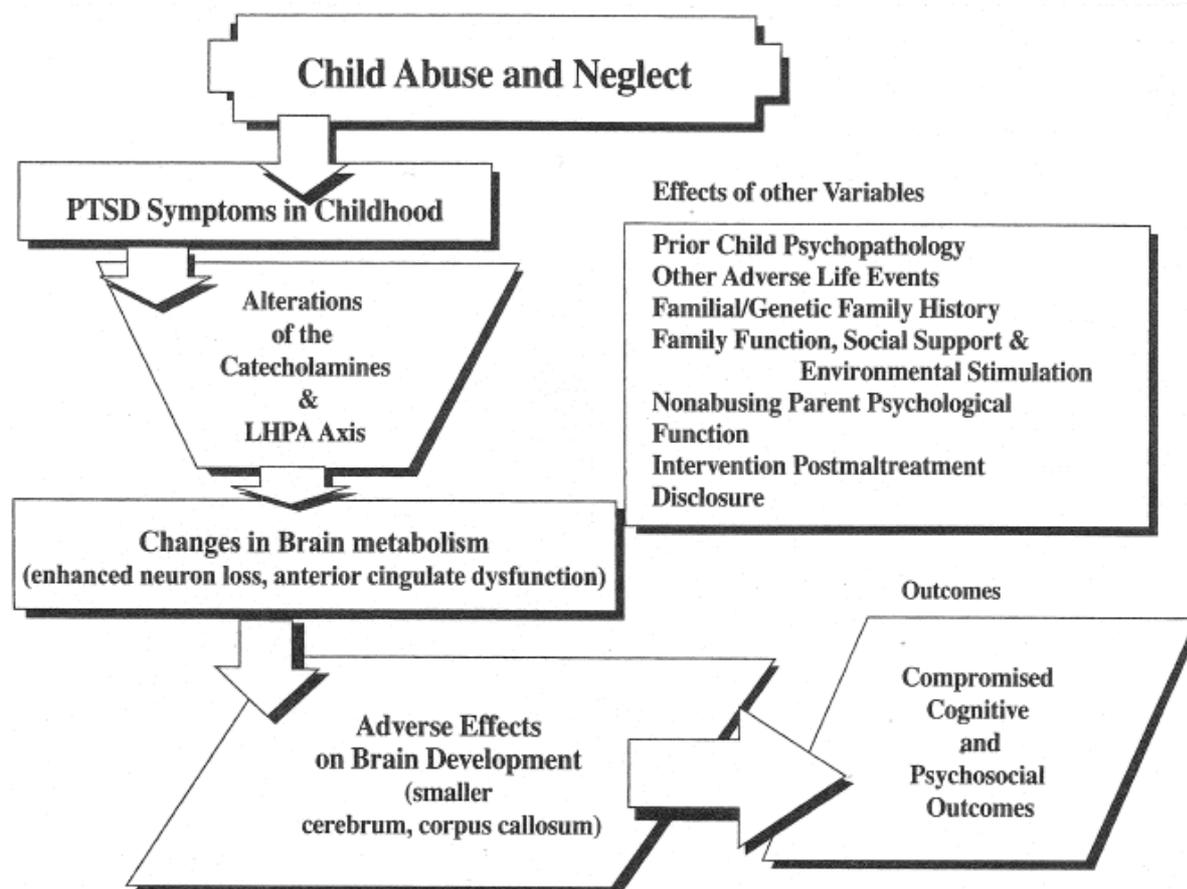


Figure 2.2: Effects of trauma on the developing brain

2.4 IMPACT OF TRAUMA ON THE BODY

2.4.1 Fight, flight and freeze response

The fight-or-flight response is also referred to as a stress reaction. It describes how a person reacts to a perceived or actual threat in the environment and is experienced through a combination of physical, mental and emotional reactions such as (Bourne 2011). When a situation is perceived to be life-threatening the sympathetic nervous system releases stress hormones, adrenaline and cortisol. These reactions assist the body in activating strength and power in preparation to fight or escape (Levine 2010). A person may then experience symptoms such as increased heart rate, rapid breathing, trembling, excessive sweating and shaking (Bourne 2011). Once the threat is gone, the symptoms will lose their intensity and a message will be sent to the brain to reduce the levels of stress hormones. However, if the message is not given to the brain, it will continue to release high levels of adrenaline and cortisol and the body will stay in this highly charged state. The frozen response or immobility response arises mostly when a person is injured or feels overwhelmed. When a person does not feel the emotions and therefore release this frozen energy, they numb it out. Levine (2010:31) also states that when residual energy is discharged, a person feels less threatened and overwhelmed and is therefore no longer frozen in fear. When a person remains in a frozen state, any movement can be experienced as frightening and chaotic, and it then becomes difficult to return to a normal state.

2.4.2 Dissociation

Dissociation is a coping mechanism as result of overwhelming trauma (Weiten & Lloyd 2008). Levine and Kline (2007) define dissociation as the mind and body separating to disconnect unpleasant experiences. By dissociating, it helps instant avoidance of painful reminders entering consciousness. He explains that this process happens involuntarily and helps to prevent a possible nervous breakdown. By dissociating, it is as if the memory doesn't exist. It implies "*a splitting of awareness*" (Rothschild 2000:65). Cohen et al. (2006:9) agree, but they add that when a child is unsuccessful in avoiding negative emotions, he or she could first develop numbing and in severe cases dissociation. Loewenstein (1993:581) defines dissociation as "*the mind's attempt to flee when flight is not possible.*" It can be expressed as "It was like I left my

body” or “I could not feel any pain.” Putnam (1997) mentions that there is a connection between development of dissociation and early childhood abuse. The author is of the opinion that there are three primary defensive functions of dissociation: automatic behaviour, separating information and affect, and change of identity. Somatic symptoms are also involved in flashbacks (Levine & Kline 2007; Rothschild 2000).

2.4.3 Emotions related to trauma

Emotions are a sense felt in the body and can be reflected on the outside in different ways. Rothschild (2000) defines different emotions related to trauma in Table 2.3 below.

Table 2.3: Emotions and trauma

Anger/Rage	<ul style="list-style-type: none"> • An emotion for self-protection.
Fear	<ul style="list-style-type: none"> • Alerts one to danger or potential harm. • Is stimulated by something in the environment. It is the core of psychological disorders such as phobias, anxiety and panic disorder and obsessive-compulsive disorders.
Terror	<ul style="list-style-type: none"> • Is the most extreme form of fear and is the core of an experience of trauma
Anxiety	<ul style="list-style-type: none"> • Is stimulated by something within the self.
Shame	<ul style="list-style-type: none"> • Is a disappointment in the self.
Grief	<ul style="list-style-type: none"> • Is a response to loss or change.

The sensory system and memory are interrelated. Thus all memory begins with sensory input. Somatic sensations could be smells, sights, sounds, touches, tastes and movement, and it is important to understand the effect of traumatic memories such as self-abuse (pulling out your hair, cutting) (Cozolino 2010). Van der Kolk (2007:214) describes this as “*The Body Keeps the Score.*” Traumatic memories can be coded implicitly and explicitly just like other memories; however, people suffering from PTSD are missing the explicit information to be able to make sense of their somatic symptoms or body sensations of the implicit traumatic memories (Ogden, Minton & Pain 2006; Rothschild 2000). Traumatic experiences activate our survival instincts and our bodies react physically to the situation. The individual might

experience the stress in terms of pain or discomfort in their organs (e.g. stomach ache because of fear) rather than as psychological states (Saxe, van der Kolk, Hall, Hall, Schwartz, Lieber & Berkowitz 1993). As with different emotions and behaviour there are different treatments for trauma which will be discussed below.

2.4.4 Impact of trauma on the brain

The brain, being an integral part of the body, contributes to the creation of the sense of “self.” In psychiatry the mind “governs the total organism and its interaction with the environment.” Therefore throughout life the mind develops when we interact with others and the environment. The mind regulates the flow of energy and information, meaning that the mind is “created in the interaction between neurophysiological processes and interpersonal relationships”. Alterations in the mind can create lasting changes in the neuronal structure and function, and transform the mind and therefore the “self”. As discussed in Chapter One, it seems that ‘the mind can alter the brain and the brain can alter the mind’. The body is part of the brain, thus the consequences after experiencing a traumatic event could be that the integration of brain and body is fragmented, affecting the “self” (Solomon & Siegel 2003:8-13). Different areas in the brain and body perform specific functions, which creates the experience of the mind and influences the way people process information. Traumatic experiences can result in information not being integrated with the consequence that thoughts, emotions and physical sensations would remain separate entities and would not be recalled as a whole, which is what underlies PTSD. The traumatic experience may then decrease the ability to concentrate, effects planning skill, problem solving, feeling and expressing emotions perseverance which has a negative effect on the adolescents academic functioning, relationships and resulting in emotional problems or psychiatric illness (Amen 1998).

2.4.5 Traumatic Memories

Memory is the ability to remember and recall information. Our brain receives information from our senses which is stored as emotions, images, sensations and thoughts as short-term memory. If it is necessary to recall the image, sensation, emotion or action, it is retrieved from long-term memory (Bernstein 2011; Rothschild 2000).

In the case of a traumatic experience the amygdale continues to respond regardless of the intensity of the arousal and suppressing the hippocampus's functioning. This results in traumatic memories being stored in the implicit memory (unconscious), recalling upsetting emotions, disturbing sensations without the explicit memory to access information about the context to prepare the body to use dissociation as a coping mechanism and/or the fight-flight or freeze response, to be able to create homeostasis after a traumatic experience (Rothschild 2000).

The hippocampus plays an essential role in memory forming, organising and storing information. Prolonged stress on the hippocampus can result in deficits of new learning as well as in short- and long-term memory. Prolonged stress leads to high levels of arousal in the amygdale. Extreme arousal and early trauma disrupts hippocampal functioning. Memories are then stored as affective states or somatic sensations and visual images, and not as integrated information cognitively (new learning), affecting retrieval of information (short and long term) that makes sense to the individual in the situation. Thus stimuli associated with trauma are not integrated with previous information or schemas, resulting in responses, attention and stimulus input being inhibited (Cozolino 2010; van der Kolk 2007).

2.4.5.1 Flashbacks

A flashback occurs when a traumatic event is re-experienced. Cozolino (2010:274) agrees but adds that "*it includes physical arousal, sensory stimulation and emotion impact of the traumatic experience.*" The author warns that flashbacks can be very intense and overwhelming, disconnecting one from the present into a familiar nightmare. The person suffering can struggle to distinguish current reality from the past: "*it feels like it is happening now*" (Rothschild 2000:45). During a flashback the traumatic memory is stored in more primitive circuits with less cortical and left hemisphere involvement and thus are strongly somatic, sensory, emotional and nonverbal (Krystal, Bremner, Southwick & Charney 1998). Somatic symptoms can manifest in flashbacks through stomach aches or bed-wetting, or they can serve as a trigger of something seen, heard or smelled (Levine & Kline 2007; Rothschild 2000).

2.5 TREATMENT MODALITIES FOR TRAUMA

2.5.1 Eye movement desensitization and reprocessing

EMDR on adolescents is well researched abroad and shows some promising possibilities. There is however a difference in view between some quantitative and qualitative studies.

Quantitative studies

A quantitative study by Ahmad, Larsson and Sundelin-Wahlsten (2007) consisted of 17 participants in the treatment group and 16 to a waitlist control group. The participants varied between ages 6-16 and in addition to PTSD diagnosed some (78.8%) participants experienced comorbid disorders such as depression (45%), attention deficit hyperactive disorder (30.3%), conduct disorder (12.1%), separation anxiety (18.2%), autism spectrum disorders and anxiety disorders (3%). The participants experienced at least one traumatic experience whereas 36.4% experienced maltreatment, 21.2% sexual abuse, 15.2% road accidents, 12.1% witnessed unnatural death. The participants received 8 sessions of forty-five minutes each. The EMDR protocol was adjusted to the developmental age of the participants and the finger-tapping method was implemented. Results indicated significant changes in the PTSD symptoms and both groups improved in non-PTSD related symptoms. The results indicated that the non-PTSD symptoms improved with or without EMDR and that further testing on EMDR should be done as this study had a small sample size. Only 10 of the 33 participants completed the treatment sessions. The second quantitative study was conducted by Rubin, Bischofshausen, Conroy-Moore, Dennis, Hastie, Melnick, Reeves and Smith (2001) and included children and adolescents varying in ages from 6 to 15. Thirty-nine participants were selected (20 females and 19 males); 13 of the 39 participants were on medication for a mental illness. Comorbid diagnosis such as ADHD, dysthymia, adjustment disorder, relational disorder, anxiety disorder and reading difficulties was identified. The treatment group received at least five sessions of EMDR and the control group received their treatment as usual. This included play, group and family therapy. The results indicated that EMDR was not more effective than the other therapies included. Scheck, Schaeffer and Gillette (1998) included 60 females ranging from 16-25 with their education levels

spanning from 9 to 15 years. Thirteen therapists were trained in EMDR and had 12 years of psychotherapy experience. The Active Listening (AL) group consisted of eleven therapists who had 8 years of psychotherapy experience. The results showed that EMDR and AL showed no different outcome at pretesting. EMDR and AL showed improvement. The limitations in this include that only 36% completed the study and the use of multiple therapist could influence the results.

EMDR is also compared with other therapies. EMDR was compared with PE for their efficacy in treating PTSD. Ironson, Freud, Strauss and Williams (2002) analysed the data of 22 participants between the ages of 16-62 who were victims of rape and crime.

After four sessions the results showed both approaches produced a significant reduction in PTSD and depression symptoms. The results were maintained at a three-month follow up. Successful treatment was faster with EMDR (7 out of 10 people showed a 70% reduction in symptoms after three sessions) than with PE (2 out of 12). Another study compared EMDR with CBT. Jaberghaderi, Greenwald, Rubin, Zand and Dolatabadi (2004) compared CBT and EMDR for sexually-abused Iranian girls. The researchers included 125 sixth grade females (ages 12-13 years) of which 123 completed pretesting. The Child Report of Post Traumatic Symptoms (CROPS) was used to assess PTSD symptoms. The results showed that 62 scored high enough to indicate PTSD. The 62 females then completed the Lifetime Incidence of Traumatic Events and 24 reported having been sexually abused. The females were randomly assigned to the EMDR or CBT group. The EMDR procedure was based on Shapiro's protocol for youth as suggested by Greenwald (1999) and the CBT procedure was based on Deblinger and Heflin's 1996 model. The CBT sessions were limited to 45 minutes and the EMDR sessions 30 minutes with some taking the full 45 minutes. Post testing took place 2 weeks after the intervention phase. Fourteen of the 24 females completed both pre- and posttesting. Three participants in the CBT group were referred for further treatment and none in the EMDR group were referred. Both treatments showed strong positive effects on the post-traumatic symptom outcomes, and a medium positive effect on behaviour outcome, all statistically significant. These findings suggested that both EMDR and CBT can help girls to recover from the effects of sexual abuse.

Other research on EMDR supports the effectiveness of EMDR. Farkas, Lebeau and Lemay (2010) studied the effectiveness of MASTR-EMDR for traumatised adults. MASTR addresses treatment obstacles in youths with behaviour problems and EMDR targets trauma resolution. Their study included 40 adolescents (ages 13-17) with conduct problems, internalising and externalising behaviours, and with exposure to maltreatment. The results indicate that the control group showed significant improvements in their trauma symptoms and behavioural problems compared to the control group. The effects were maintained at a three-month follow-up. Zaghrou-Hodali, Alissa and Dodgson (2008) did a study focusing on building resilience and dismantling fear in children in an area of ongoing trauma using EMDR. The study consisted of seven children who had repeated traumas during the course of the EMDR intervention, using a group protocol. The results showed that EMDR can be effective in a group setting and in acute situations, reducing symptoms of post-traumatic stress and building resilience in a setting of ongoing conflict and trauma.

Soberman, Greenwald and Rule (2002:17), used EMDR as treatment for boys with behavioural problems. Their study consisted of twenty-nine boys between the ages of 10 to 16 years. After three EMDR sessions there was a reduction of memory-related distress and post-traumatic symptoms. The limitations the authors highlighted were using a single therapist, sample size too small and the treatment was too short. In spite of the scepticism, the EMDR group showed a significant reduction of problem behaviour, whereas the control group showed only slight improvement after a two-month follow-up.

Greyber, Dulmus and Cristalli (2012) did a review of Randomized Controlled Trials with children and adolescents. They found that current studies do indicate that youths up to ages of 25 do benefit from EMDR, but they are of opinion that as children and adolescents are a vulnerable population, more studies are needed. They suggested that future research should focus on conducting true RCTs with larger samples, comparison groups should be made as soon as possible at pretesting, and structural equation modeling could be useful in evaluating the affects of mediating and moderating variables which includes the type of trauma, diagnosis and the number of EMDR sessions as well as the severity of the symptoms. The authors' final suggestion was to broaden the inclusion criteria and recruit more heterogeneous samples to

improve external validity. Although not all the quantitative studies showed promising results for EMDR, qualitative studies seemed to provide a different picture.

Qualitative studies

EMDR was illustrated as a successful intervention in a qualitative study by de Roos and de Jongh (2008:201). Their study included four children and adolescents and no standardized assessment measures were administered. Positive outcomes were achieved in one or two sessions. Stress factors and complaints stemming from the phobia were weight loss due to decreased intake of food, withdrawal, insecurity, fatigue and fear. Results after EMDR were: eating patterns normalised, increase in weight, happier mood, more independent, energetic. Another case study by Bae, Kim and Park (2008) focused on EMDR for adolescent depression. Their research consisted of two cases of two females, 14 and 16 years old. Both participants presented with symptoms of depression and were not in favour of using medication as treatment procedure. EMDR was chosen as method of treatment. The 14-year-old participant completed seven sessions of EMDR and her symptoms improved to complete remission. The 16-year-old participant had three sessions of EMDR and her symptoms were indicative of complete remission. An eight-week follow-up showed the remissions were maintained. Although the results in this study cannot be generalised, both cases suggest that targeting early memories can resolve current negative symptoms such as depression.

Another case study on behavioural problems by Greenwald (2000) revealed new positive insights into the EMDR protocol and will be discussed in more detail. This study links with the trend among South African youths, which is a major cause of concern in South Africa. The study consisted of two male participants, both 15 years old. The first case was a boy adjudicated to an open residential four-month programme after two months in medium-security placement on multiple charges including car theft, truancy, selling marijuana and fighting. His family history included an alcoholic father and parental discord prior to divorce, and before incarceration he lived with his mother in a poor urban area. Sessions 1 and 2 focused on motivation, sessions 3 and 4 addressed skill building, focusing on the idea that choices have consequences and that his responses and fighting were a problem for him. Eye movements were introduced while he was recalling an event which got him into

trouble. The standard EMDR protocol was introduced only in session 5, as in the case of impatient adolescents the preparation takes longer (Greenwald 1999). In session 5 a trauma incident was addressed. In the next session (session 6) the boy reported that he wasn't getting into any trouble anymore. The previous traumatic incident didn't bother him and he did not have anything else to talk about or work on. Additional trauma work, regarding memories of parental discord or more practice with the notion that choices have consequences were suggested, but he was not interested. Session 6 lasted 15 minutes. The boy was successful in the programme and was released several weeks early. It was reported that 6 months after he had returned home, he was attending school and making passing grades and that he did not get involved in further legal trouble. He was supposed to see a therapist but did not keep his appointments.

The second case involved another 15-year-old boy who was sentenced to 4-5 months in an open residential programme following a month in a medium-security setting. He had an extensive history of assault charges, targeting his stepfather as well as peers. He had a bad temper and poor self-control. The boy's treatment lasted 15 sessions over four months. The first two sessions focused on history taking and motivation. Session 3 focused on skill building and included play therapy, reframing and choosing role models. During session 4 EMDR was introduced. Eight EMDR sessions were implemented. The outcome was that the boy was able to keep some of his pre-existing friendships alive. He distanced himself from friends whose only interests were substance abuse and other illegal activities. A number of conflicts with his stepfather were defused and they started to build a positive relationship. He went back to school with a positive attitude. At a three-month follow-up he was doing well in school and developing new friendships. It seems thus that the protocol is sufficiently flexible to tolerate changes to respond to client needs, which is an important aspect in South African culture with its diversity. The study also shows that the preparation phase is extremely important to prepare the client for EMDR.

The research discussed addressed situations similar to those found in the broader South African context. The South African adolescent is also exposed to situations of ongoing trauma, depression, conduct problems, trauma, behaviour problems and sexual abuse. Research discussed in Chapter One highlights the high level of trauma

our youths experience and are exposed to. The above research on EMDR suggests promising possible treatment in the South African context, an area that seems worthwhile exploring in local research.

Eye movement desensitisation and reprocessing is considered as a variant of CBT. EMDR combines components of exposure and cognitive therapy with eye movements (Cohen, Berlinger & March 2000; Shapiro 2010). The efficacy of eye movement desensitisation and reprocessing for the treatment of PTSD in children is being explored. The aim of EMDR is to process traumatic memories neuro-physiologically with dual attention tasks. The literature on the efficacy of EMDR is sparse and more research is needed for evaluation of the compatibility with, and usefulness for, children. EMDR consist of eight phases in the treatment process.

The eight treatment phases of EMDR

The background to EMDR and what it entails are discussed in Chapter One and form the basis for applying the eight treatment phases. Effective treatment with EMDR demands knowledge both of how and when to use it. For many adolescents and some older children, the standard adult protocol may be used. However, with young clients some steps may be modified to maintain engagement with the process. Sometimes children compartmentalise their experiences somewhat less than adults, so that the full protocol might not be needed for full effectiveness (Greenwald 2001).

With the adult protocol image, cognition, emotion and sensation are all identified as simultaneous focal points for processing in order to gain a holistic, or comprehensive, access to the memory. With children, concentrating on the image alone, or the image and the emotion, often seems to be sufficient to access the entire memory. The younger the child the more abbreviated the protocol (Greenwald 2001).

All the following authors agree on the eight phases for the EMDR process as discussed below (Adler-Tapia & Settle 2008; Greenwald 2001; Shapiro 2001).

Phase 1 - History Taking and Treatment Planning

This phase includes the initial clinical interview and assessment to determine if the client is suitable for EMDR treatment. The therapist needs to determine if the client has the ability to deal with the possibly high levels of disturbance when processing

dysfunctional information. Evaluation therefore involves family, current life constraints, school and other potentially significant contextual factors. For example, an adolescent might be facing major deadlines at school and would not want to be distracted by the ongoing processing until such deadlines are met.

In the discussions with the parents, the child's developmental history, behaviours and their view about why the adolescent has the problem can be explored. The adolescent's view about the problem is worthwhile knowing, e.g. the circumstances under which the problem occurs. The trauma history and the problem history can be compared to identify possible issues that could be targeted in therapy. It is often possible to trace the onset of the presenting problem to a specific event in the adolescent's life.

Phase 2 - Preparation

This includes an explanation of both EMDR and the possible effects of treatment. Explaining EMDR to parents is a process of educating parents about EMDR. This involves explaining what it is, how it works and what it can do for their child. The depth of the explanation needs to be appropriate to the parents' and adolescent's comfort level and needs. Only then can informed consent from the parents and the adolescent be given to use EMDR.

Possible obstacles such as fears or secondary gains are explored and worked through. The therapist needs to screen for risk factors, so that appropriate precautions can be taken prior to using EMDR, e.g. respiratory problems, use of medication. This phase also involves helping the adolescent feel that he/she is in control and therefore safe in the process. From this base of safety the traumatic material can be worked through. To ensure that the client is able to cope with possible high levels of stress, it may be necessary to discuss problem-solving options should he/she become upset, or to teach relaxation or self-soothing skills to enhance the sense of safety and control.

A safe/calm place can be created which the child can use at any time to self-soothe and contain intense emotional experiences. A safe/calm place is often a relaxed, comfortable place. It can be used during the session if reprocessing becomes overwhelming and the adolescent is unable to proceed. It can also be used to end the session in a positive manner and to practise self-soothing in between sessions.

The stop signal is intended to empower the adolescent to signal the therapist when the client wants to stop the desensitisation process, because the client needs a break or because the process is becoming too overwhelming. The therapist may need to encourage the client to keep going even when processing becomes difficult.

Phase 3 - Assessment

This phase involves a detailed assessment of the targeted memory, including the following: the selected image, the negative cognition, the positive cognition and the VOC, the emotions and SUDS, and the physical sensation, which was fully discussed in the previous section on basic components of EMDR.

Phase 4: Desensitisation

To desensitise means to make something less sensitive or to remove a disturbance which is the goal of the EMDR process (Shapiro 2001). In this phase the rapid bilateral stimulation is combined with concentration on the targeted memory, as the client works through the various aspects of the memory, including negative effect, imagery, cognition and sensation. This is continued until every aspect of the memory is completely neutralised, measuring 0-1 on the SUDS. Deep breathing is emphasised between sets to teach a calming skill and to enhance a sense of self-efficacy in the procedure itself. The desensitisation phase begins when the therapist asks the adolescent: "Focus on the image and negative cognition. Notice where you feel it in your body and follow my fingers" (Shapiro 2001:145).

Rapid bilateral stimulation (BLS) is used to facilitate the accessing, reprocessing and integration of the target memory. There are several types of bilateral stimulation, e.g. eye movements, tapping and auditory stimulation. Eye movements are induced by having the client visually track the therapist's moving fingers. Two or more fingers can be used as a focal point. The therapist should evaluate the adolescent's ability to track the moving fingers by starting slowly and then increasing the rate to obtain the maximum comfortable sustainable speed. Other possible eye movements are to move the eyes in a vertical, circular or figure-eight direction. The first set consists of 24 bidirectional movements, where a right-to-left-to-right shift equals one movement and some clients need 36 or more movements per set for the image to be processed. The therapist should not proceed if the client reports eye pain (possibly due to weakness in

their eye muscles), dryness or anxiety caused by the procedure self. See Figures 2.3, 2.4 and 2.5 for different eye movements (Shapiro 2001:65-66).

Eye Movements

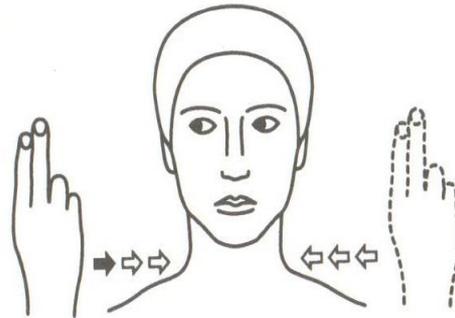


Figure 2.3: Horizontal hand movements used in performing EMDR



Figure 2.4: Diagonal hand movements used in performing EMDR

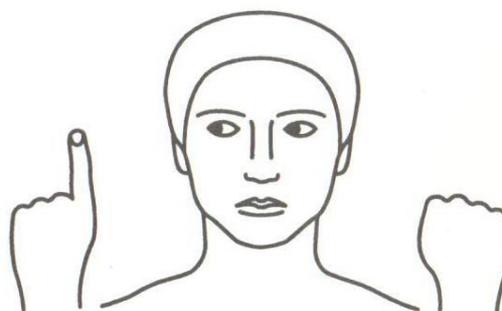


Figure 2.5: Two-handed version of performing EMDR

In the case of discomfort with the eye movements, the therapist should use hand taps or auditory stimuli instead of directed eye movements. Hand tapping is done by having

the client sit with his hands palm upward on his knees. The therapist then rhythmically taps the client's palms (with one or two fingers), alternating right and left, at the same speed at which sets of eye movements would be conducted. Auditory stimuli entail having the client keep her eyes open or closed while the therapist alternately snaps fingers next to each ear at a rate comparable to that used with sets of eye movements (Greenwald 2001; Shapiro 2001). At the end of a set of BLS the therapist says. "Let it go" or "Rest" and "Take a deep breath"; the therapist then stops the BLS. She then asks the adolescent "What are you getting now?" Shapiro (2001) indicates 4 reasons why this is important:

1. The BLS links information to the targeted traumatic image. Stopping the BLS allows time for the dysfunctional information to be released (let go) and adaptive information to be consolidated;
2. The interruption also allows the therapist to re-evaluate the adolescent's progress and to judge if reprocessing has taken place;
3. The adolescent's concentration and intensity of focus are interrupted during the break, which allows the adolescent to rest, reorient and verbalise what happened during the set, providing the client with a sense of control;
4. It provides the adolescent with an opportunity to verbalise his/her internal process and understand whatever changes have taken place more readily.

Phase 5: Installation

The installation is used to enhance the positive cognition and to link it with the original target image (NC). Usually by this point the adolescent has progressed in the ways he/she feels about the original image. Therefore the PC needs to be re-evaluated. The therapist can then ask: "When you bring up that original incident, do the words (PC) still fit, or is there another positive statement you feel would be more suitable?" When the adolescent chooses a new PC, the therapist links it to the original target with successive sets of BLS. The installation continues until there are no changes and the VOC stays a 7.

If the VOC does not progress, the therapist may ask: "What is preventing it from being a 7?" The client's answer usually indicates a blocking belief that needs to be

addressed, which can require an EMDR session on its own. In this case the therapist can skip the body scan and move to the closure phase. The new memory can then be treated in the next session. Only then does the therapist move to the body scan.

Phase 6: Body Scan

Dysfunctionally stored material often manifests itself somatically. After installation the therapist asks the adolescent to reassess his/her body from head to toe for residual body tension, tight muscles or any unusual sensation. If any unusual physical sensations are reported, they are targeted with further sets. They may disappear after few successive sets. Focusing on body sensations at this point can also open other channels for information that must be processed. Therefore if the physical sensations do not dissipate, another channel or memory may be present and will need to be processed before the current session will be considered complete. It is important for the therapist to remember that no treatment is successful without completing the body scan. Positive sensations that emerge are reinforced with short sets of BLS (4-6 BLS) (Hensley 2009; Shapiro 2001).

Phase 7: Closure

The closure phase refers to either properly ending a complete session or shutting down an incomplete session. Regardless of whether the session ended completed or incomplete, the therapist must remind the adolescent that additional processing may occur between sessions – disturbing material in the form of images, thoughts or emotions may arise. The therapist must instruct him/her to maintain a journal between sessions by writing down the additional information experienced in between acts as an emotional distancing technique. The negative material written down in their journal may serve as targets for future sessions. The therapist must remind the client to do relaxing exercises every day and use their safe place once a day or as needed.

Strategies for closing down complete and incomplete sessions

Complete Session

Formula for a complete session:

(SUD = 0) + (VOC = 7) + (Clear body scan)

Once the SUD level is 0 and the VOC a 7 and the body is clear of any feelings, the session is successfully completed. When a session is successfully completed, the therapist can indicate that it is time to terminate the sessions.

Incomplete Session

Formula for an incomplete session:

SUD is greater than 0

(SUD = 0) + (VOC less than 7)

(SUD = 0) + (VOC = 7) + (No clear body scan)

A session is incomplete when the time set for the session is running out, the SUD is greater than 0, VOC less than 7 and there are still some feelings or emotions felt in the body. When it is necessary to close down an incomplete session and the therapist feels that she is at a good stopping point, the client is notified, told why and asked for permission. The therapist can suggest some relaxation and breathing exercises to bring the client to his/her normal functioning. The client's safe place may also be strengthened here. The client may be assured that he/she can call between sessions, if needed.

Phase 8: Re-evaluation

Each session after the first is opened with a re-evaluation. The therapist then assesses how well the previously targeted material has been resolved and determines if the client requires any new processing and if the original target has been resolved. The type of questions asked would be:

- What changed?
- Have any emotions, memories or sensations emerged?
- What were your responses to these changes?
- Have new dreams or other material surfaced as a result?

The process lends itself to being a comprehensive psychotherapy approach and as a psychological treatment for trauma. Taking the developmental stage of the adolescent

into consideration, it is challenging to get maltreated adolescents to engage in trauma therapy. Not only could they present with a low motivation for treatment, but they usually believe that benefit is unlikely, they mistrust adults, and prefer to avoid confronting emotions and trauma memories (Greenwald 2009). This leads to behavioural problems stemming from a fear of losing one's freedom and being controlled. The consequence is then not developing an insight into their problems and moving deeper into survival mode, affecting all dimensions of development. The adolescent in South Africa is no different. Shapiro (2001) motivates EMDR therapy as trauma treatment for youths, because the adolescent is not required to disclose details of the trauma, and no homework, personal insight or exceptional intelligence are required to apply the treatment successfully. Other approaches for treating trauma experienced by children and adolescents will be discussed below.

2.5.2 Psychodynamic Therapies

The theoretical underpinning of psychodynamic approaches entails using the therapist-client relationship to understand the unconscious expression of emotions as a result of traumatic experiences. The therapist then uses the expressions of the disturbing emotions within the therapeutic relationship to help the child to contain these emotions. A study by Downing, Jenkins and Fisher (1988) compared psychodynamic and reinforcement intervention in the treatment of sexually abused children and their parents. Reinforcement intervention showed efficacy in behaviour change, where psychodynamic treatment showed a gradual improvement. In contrast, Cohen et al. (2000) state there is little evidence that psychodynamic psychotherapy is effective for PTSD.

2.5.3 Exposure-based Interventions

Exposure therapy is a behavioural therapy and is a component of almost all trauma therapies. Some therapies start with the most distressing event and others with a moderate event. The client is exposed to the distressing stimulus until he or she feels less anxious or shows a reduction of symptoms (Shapiro 2010). Exposure-based therapy was adapted to treat children who have been exposed to trauma. The adolescent may also imagine the feared situation by revisiting the feared situation in their imagination and confronting the fear in such a way (González-Prendez & Resko

2012). The underlying theory of exposure therapy is that *‘if a child re-experiences aspects of the traumatic event in a controlled and safe environment, the memories associated with the trauma will no longer be connected to distressing psychological and emotional reactions’* (Saxe, MacDonald & Ellis 2010:361). Interventions are thus focused on a safe, structured exposure to stimuli of the trauma to be able to extinguish the traumatic stress response. It therefore addresses avoidance, which is one of the criteria of PTSD diagnosis (Shapiro 2010).

2.5.4 Cognitive Behaviour Therapy

Cognitive behavioural therapy is the most studied treatment modality and seems to provide the strongest empirical support for efficacy in treating children and adolescents with PTSD (Cohen et al. 2006:22-23; Rothbaum, Foa, Riggs, Murdock & Walsh 1992; Saxe et al. 2010; Seedat 2009). Shapiro (2010:83) describes CBT as having a *“behavioral lineage ... If thoughts are behaviors, reinforced by classical and operant conditioning, then trauma survivors can learn to change their thoughts, thus changing their internal experience and external behaviours”* Individual cognitive behavioural therapy includes cognitive coping, muscle relaxation, thought stopping and psycho-education. It is flexible, and can be altered to suit the child’s or adolescent’s specific trauma history (Saxe et al. 2010). Seedat (2009) states that TF-CBT (Trauma Focused Cognitive Behavioural Therapy) and CBT show efficacy in children 3 to 17 years with symptoms ranging from PTSD, anxiety, mood and behavioural disorders, and adds that TF-CBT provides the best empirical evidence as favourable treatment for children and adolescents diagnosed with PTSD (Cohen et al. 2006). A study by Feather and Ronan (cited by Seedat 2009:156) also indicated that TF-CBT is effective for youths exposed to complex trauma. Their study included four youths aged 9 to 13 who were multiply traumatised. They were exposed to childhood physical abuse, childhood sexual abuse, emotional abuse, and interpersonal and domestic violence. There was a decrease of symptoms in all four children.

Group cognitive behavioural therapies aim to integrate children’s traumatic memories within their self-concept through group-based exposures and cognitive exercises. Multimodality trauma treatment is a cognitive-behavioural group and trauma-focused treatment for children who developed PTSD following a single-incident trauma experience such a car accidents, severe storms, severe illness, accidental and

criminal gunshot injury and fires. Results showed an improvement in symptoms of PTSD, anxiety and depression. However the small size, lack of a control group and exclusion of children with clinically significant behaviour problems limited the generalisability of this study (Saxe et al. 2010).

2.5.5 Parent Training

Parent training does exactly what it states. It involves psycho-education where training is given to parents on the impact of traumatic experiences on children as well as the symptoms they are likely to experience. Parent training also has a behavioural component which allows the parent to work in conjunction with the therapist. The parents learn how to reinforce lessons the child learned in therapy as well as techniques to manage the child's behaviour. The exposure-based component in parent training involves an opportunity for parents to express their own feelings regarding their child's trauma. Parent training is a critical component for younger children and a secondary component for older children and adolescents with PTSD (Cohen et al. 2000; Saxe et al. 2010).

2.5.6 Eye Movement Integration (EMI)

Eye movement integration was developed by Connirae Andreas and Steve Andreas in 1989 to treat traumatic memories. According to Struwig (2008:40-41), EMI has its roots in neuro-linguistic programming (NLP). EMI focuses on the unconscious aspects of the trauma and facilitates multisensory integration and involves 22 different eye movements (following a comfortable speed for the client).

2.6 CONCLUSION

This chapter has outlined how complex our bodily functions are. It examines the way different parts work together as a whole and how others are shut down for the sake of survival. Every human being has layers of possibilities waiting to unfold. Our lives are influenced by so many factors for example, biology, experiences, relationships and challenges we face. While developing, we learn to adapt to the world at its challenges.

In this chapter it was indicated that adolescence is a phase during which many changes take place, which could make this transition difficult for the individual. The

adolescent with positive resources may struggle in this phase, but their available resources could help them to cope and to transform overwhelming experiences into a positive learning curve. Yet the adolescent with a history of trauma, chronic stress exposure and those growing up in a negative environment may have fewer or no positive resources to help them cope. According to the discussion in this chapter, it is evident that these adolescents are often the ones who are showing attention problems, mood disorders, oppositional behaviour, experience rejection, aggression and shame or guilt and who are referred for treatment.

When these behaviours manifest, our body communicates that there is no harmony on the inside of our body and that it needs help. As discussed earlier in the chapter, different parts in our brain work together for optimal functioning. In the case of trauma the body needs to protect itself, which results in an over-activation of different parts and a shutdown of others, making the communication necessary for integration not occurring as needed for support. In the event of repeated trauma or chronic developmental stressors, the adolescent can become stuck, always being in a state of survival that results in less or no integration, leaving the body feeling unsafe with a chronic need to defend and protect itself. This has an impact on how the adolescent faces every new situation, the way they engage in relationships and feel about themselves.

Chapter One elaborated on EMDR as a therapeutic technique for traumatic stress and PTSD. The literature review in Chapter Two showed the need for therapy for the adolescent exposed to trauma – a need this study aims to address. A more detailed description on how I plan to implement the strategies will be discussed in the next chapter.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter One outlined broad aspects of the research method and EMDR. This chapter will provide a more detailed discussion on the research design and procedures employed to explore how the adolescents experienced EMDR for treating trauma. My role as researcher and psychologist in practice will be defined, and the ethical principles and guidelines will be discussed.

3.2 RESEARCH DESIGN AND PROCEDURES

Research designs are plans and the procedures for research that include the decisions on the detailed methods of data collection, analysis and report writing (Creswell 2009; Creswell 2008; Henning 2004; Merriam 2002). Below is a diagram of the research design for this study.

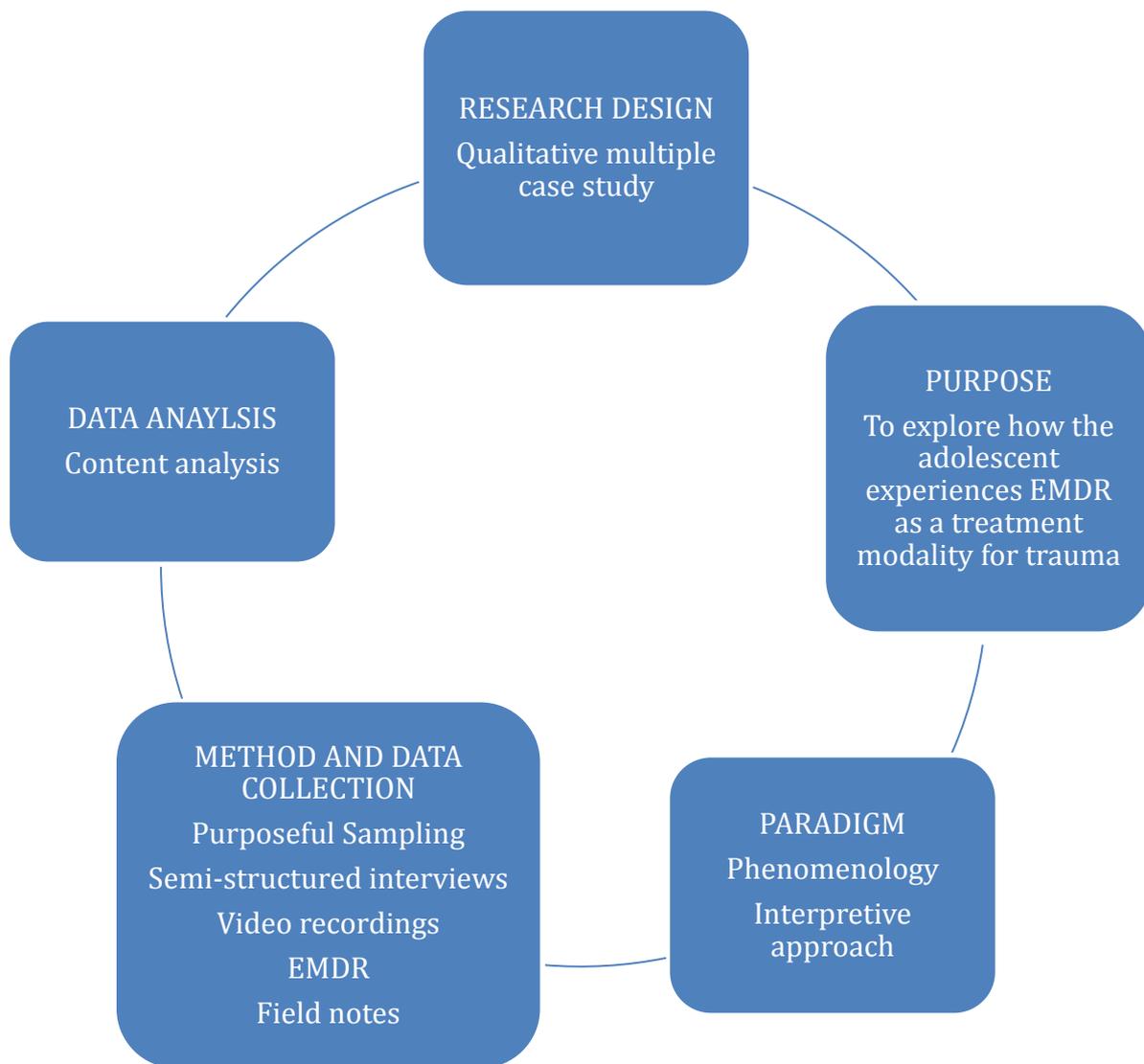


Figure 3.1: Research design

Babbie and Mouton (2001:74) state that the research design is the plan or “blueprint” for conducting research and this blueprint is tailored to address the research question. It can then be argued that a qualitative research design is one where the researcher will, during the research process, create the research design that is best suited to the research (De Vos 1998). The main function of a research design is to enable the researcher to anticipate what the appropriate research decisions should be, in order to maximise the validity of the eventual results (Mouton 2001). Creswell (2008) states the importance of a researcher choosing an approach based on his or her personal experience and training when constructing a research design. The researcher also needs to decide between undertaking macro research or micro research. Stake (2010:18) explains the difference between macro research and micro research as ‘the

big picture versus the close up' and states that qualitative research usually entails micro studies. Micro studies tend to focus on the individual, whereas macro studies usually focus on large groups. This study can then be seen as a micro study, because the focus is on the way individuals experienced EMDR as therapeutic modality.

Denzin and Lincoln (1998) argue that it is difficult to define qualitative research clearly, as it can be seen as 'a field of inquiry in its own right' and has no fixed truth. Strauss and Corbin (1998:12), however, define qualitative research as "*a type of research that produces findings not arrived at by statistical procedures or other means of quantification*". This means that in qualitative research the researchers' attempts to produce deeper meanings and make sense of the phenomenon under study, which is not easily converted into numerical terms (Denzin & Lincoln 2005; Ruben & Babbie 2001). It can refer to research about a person's life, lived experiences, behaviours, emotions and feelings (Padgett 2004). The main difference between quantitative and qualitative study therefore is:

- In quantitative research the variables are controlled; therefore respondents are not free to share any other data than what is determined beforehand. This approach seeks to explain the causes of change through statistics which the researcher attempt to be detached and avoid bias;
- In qualitative research the variables are not controlled. The participants have the freedom to express their views and demonstrate their actions (Henning 2004). As discussed, the purpose is to understand what is happening and how situations are viewed by participants. The qualitative researcher attempts to understand the whole environment and help others to understand how individuals see a situation (Padgett 2004).

There are many valid reasons for doing qualitative research. The two main reasons for conducting this study are firstly the preferences and experiences of the researcher as mentioned earlier in this chapter (Creswell 2008). The researcher conducting this study works in private practice and tends to be more oriented towards qualitative research. Her experience in private practice complements the nature of the research problem, which attempts to understand the meanings of experiences of persons who have experienced trauma (Strauss & Corbin 1998). The second reason is that it offers

a way to explore areas about which little is known, or which is known but not researched and written about (Strauss & Corbin 1998). In the South African context a lot is known about trauma and ways to treat it. As discussed in Chapter One, however, there are a limited number of studies on EMDR with adolescents abroad with, no research in our context; this is what the present study aims to address. To gain novel understandings of the participants, the study will be undertaken within the interpretive paradigm as its theoretical orientation.

3.3 PARADIGM

3.3.1 Interpretative

Generally the researcher's motivation for doing the research will be evident in the paradigm he/she chooses (Henning 2004). Thus, a paradigm is the researcher's perception or belief that forms the basis to investigate a certain phenomenon; therefore different methods are appropriate for different situations (Guba 1990; Patton 2002). The researcher's beliefs define the enquiry in terms of three dimensions: ontology, epistemology and methodology.

Ontology specifies the nature of the reality that is to be studied and what can be known about it (Denzin & Lincoln 1998). The reality to be studied in this context is the participant's subjective experiences of the external world relating to the trauma experienced. I adopted an inter-subjective stance towards the participants' reality and used methodologies (such as interviewing or participant observation) that are based on a subjective relationship between me as the researcher and the adolescent as the participant. Epistemology describes the relationship between the researcher and the participant and addresses how knowledge is created. According to Newman (2005), the creation of knowledge occurs during interaction and people's interpretations of interactions. People perceive things differently from each other, which means that their social reality will be understood differently. Therefore different meanings will be produced. Epistemology therefore lays the foundation for the knowledge-building process through the questions (conscious and unconscious), the assumptions and beliefs that the researcher brings to the research situation. The search for knowledge is then conducted through analysis. This means that I will concentrate on the situation then examine the information in discrete sections and put it back together again, using

analysis and synthesis. In this way meaning emerges that can be interpreted (Denzin & Lincoln 1998; Newman 2005; Terre Blanche & Kelly 2002). To gain the knowledge needed multiple methods to collect data will be used with the aim to understand the participant's perceptions (Denzin & Lincoln 1998).

Phenomenology is an interpretive approach. Phenomenologists believe there is more than one reality. The phenomenologist Husserl (cited by Henning 2004:37; Hesse-Biber & Leavy 2006:19; Patton 2002:104) was specifically interested in *human consciousness*, meaning he wanted *to understand how an individual interprets his or her experience on a conscious level* and hence create an understanding of his/her own life. The aim is to understand what impact the negative experience had on each individuals' behaviour, self-concept and how they perceive themselves in connection with the rest of the world: e.g. "I am not worthy" or "I am stupid". Only in the mid-20th century was there a shift away from positivism to studies that aimed to capture the lives of participants in order to understand how they interpret their reality.

Positivism differs from the interpretive approach in the sense that it argues for a knowable reality which can be proven and explained, whereas the interpretive approach, as previously discussed, states that phenomena and events are understood through mental processes of interpretation. Interaction in the social context influences interpretation. The interpretive researcher analyses texts to look for the way in which people make meaning in their lives, but 'not just that they make meaning, but what meaning they make'. Thus, the interpretive researcher is therefore extremely sensitive to the role of context (Denzin & Lincoln 2008). These aspects mentioned are too complex to define and measure with standard instruments (Ruben & Babbie 2001).

Interpretive paradigms involve the use of theory. The interpretive paradigm focuses on the theory of understanding. Creswell (2009:9) explains this as "inductively developing a theory or pattern of meanings". In the context of this study it means exploring the 'how and why' in the research field where there is a gap in the literature. Interpretive theory is also micro research, therefore focusing on smaller groups in society with the focus on understanding. As mentioned before, this is only possible when the researcher studies the data in depth and repeatedly until meaning emerges. By doing this, the researcher will attempt to put himself in the participants' shoes to be able to provide a richly detailed description of their beliefs, motives and actions (Eisenhardt &

Graebner 2007). The aim would be for the theory to make sense to the participant. Furthermore, it may be useful in helping the readers to see the world through the eyes of the people studied more effectively.

3.4 METHODOLOGY

3.4.1 Case study

As mentioned in Chapter One, a multiple case study was selected for this research. Mouton (2001:149) defines a multiple case study as *qualitative in nature and aims to provide an in-depth description of a small number of cases*. Simons (2009:21) defines a multiple case study as a unique, in-depth exploration of a particular phenomenon in its context. He elaborates by stating that a case study's primary purpose is to develop an in-depth understanding and adds that it can have an influence on policy development.

In case study research the researcher examines many features of a few cases in depth over time. This may include individuals, groups, institutions, movements, events or a society. Case studies usually produce detailed data providing the researcher with a thick description of the participants in their context. It is suggested that a case study is not a research method in itself, but is part of the qualitative research design, using more than one method to collect data (Hesse-Biber & Leavy 2011; Punch 1998). Stake (2010) identifies three types of case studies:

- An intrinsic case study entails understanding a case holistically;
- An instrumental case study entails generalising and providing insight into a larger topic;
- A multiple case study (collective case study) refers to the study of multiple cases together to investigate a phenomenon.

Punch (2005:142) states that one characteristic of a multiple case study is that "it needs to be a case about something"; therefore this approach was selected with the purpose of intensively investigating and comparing a limited set of cases, focusing on several factors causing trauma. Five cases were selected to illustrate the trauma experienced in adolescents. Each case was studied in detail. I considered the specific

context of the cases and examined how the experience influenced the participants' lives. The role that EMDR played in developing new cognitions was analysed and interpreted. According to Vaughn (cited by Newman 2005), it helps researchers connect to the macro level, penetrating situations in ways that are not always possible in numerical analysis (Cohen, Manion & Morrison 2001) to seek understanding (Babbie 2007).

3.4.2 Selection of participants

For the selection of the participants, purposeful sampling was used. Researchers conducting a qualitative study often use purposive sampling as it is a kind of sampling for special situations. It involves selecting cases with a specific purpose in mind (Babbie 2007; Newman 2005). Cohen, Manion and Morrison (2007:115) describe purposeful sampling as "*a way to acquire in-depth information from those who are in a position to give it*". Thus individuals participating in the study must have the combination of characteristics and/or behaviours that are relevant for the study (Dodd & Epstein 2012; Creswell 2008). McMillan and Schumacher (2001) state that one strength of purposeful sampling is that it usually has a high participation rate and is less costly and time consuming. Generalisation is mostly possible to similar subjects, while results depend on unique characteristics of the sample. Terre Blanche and Durrheim (2000) argue that, rather than insisting that participants should be representative, participants should be chosen with the purpose of ensuring that findings are transferable – i.e. they help to understand other contexts or groups similar to those studied.

In this study five cases were chosen for this purpose. As discussed earlier, Yin (1994) suggested that 4-9 cases is acceptable. Five cases were chosen as the aim is to explore the adolescents' experience of EMDR to convey a more valid view of their experience as well as the modality in order to inspire wider use and possible further research in this field. Furthermore, Baxter and Jack (2008) and Merriam (2002) argue that multiple cases allow for analysing each case and subsequent analysis across cases provides the reader with in-depth data on the similarities and differences between the cases. This is important to make the research valid in the context and provide the reader with possibilities for further research to fill the gaps in the literature (Patton 2002). The participants for this study were five adolescents who experienced

developmental or a single-incident trauma. Participants did not need to meet the criteria for post-traumatic stress disorder. The adolescents who took part in the study were in an Afrikaans High School. The participants were of both genders in the age group 13-19 years. This age group falls within the parameter of the WHO (2009:1) definition of an adolescent as an 'individual in the 10-19 years age group'. The adolescent needed to have been exposed to one traumatic experience or trauma that developed over time. Invitations were handed out and the first five adolescents who responded to the invitation and met the selection criteria for this study were included. An interview with the parent and the adolescent was conducted to identify possible cues that needed to be desensitised.

3.4.3 Data collection

3.4.3.1 *Semi-structured interviews*

The research question and research goal define the type of interview. According to Merriam (2002), interviewing in qualitative investigations is more open-ended and less structured. The semi-structured interview was selected for this study as it allows for all the questions to be flexibly worded. The interview can be a mix of more and less structured questions. This type of interview provides room for the researcher to explore new areas in the adolescents' context and permits the adolescent to communicate freely about their experiences so that conversations can flow more naturally (Hesse-Biber & Leavy 2011).

We interview people to find out from them those things we cannot directly observe. We cannot observe thoughts and intentions, behaviours that took place at some previous point in time, or the meaning people attach to what goes on in their world. Questions need to be asked about those things (Cohen, Manion & Morrison 2007). The purpose of interviewing, then, is to allow us to enter into the other person's perspective. Interviews enable participants to discuss their interpretations of the world in which they live, and to express how they regard situations from their own point of view. Qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable and able to be made explicit. We interview to find out what is in and on someone else's mind, to gather their stories. Tuckman (1998:237) describes this by saying: "By providing access to what is 'inside a person's head'

makes it possible to measure what a person knows (knowledge or information), what a person likes or dislikes (values and preferences), and what a person thinks (attitudes and beliefs)". The interviewer faces the challenge of making it possible for the person being interviewed to bring the interviewer into his or her world. The quality of the information obtained during an interview is largely dependent on the interviewer. An interview is therefore not simply concerned with collecting data about life: it is part of life itself (Patton 2002).

A qualitative interview is an interaction between an interviewer and a respondent in which the interviewer has a general plan of inquiry, but not a specific set of questions that must be asked in particular words and in a particular order. It is essentially a conversation in which the interviewer establishes a general direction for the conversation and pursues specific topics raised (Ruben & Babbie 2001; Terre Blanche & Kelly 2002). Cohen et al. (2001:267) define an interview as "a two-person conversation initiated by the interviewer for the specific purpose of obtaining research-relevant information". Kvale (1996) offers two models for interviewing. Firstly he describes the interviewer as one engaging in conversations with people, asking questions that lead to sharing the stories of their experiences in life. In contrast, the second model assumes that the participant possesses specific information and the researcher has the necessary skills and methods to apply for specific information to be elicited and shared. Obtaining specific information (experiences of trauma) as described by the second model applies to this study.

The EMDR protocol created the needed structure for the interviews with the participants. In Chapter One a detailed discussion was given on what EMDR entails. The EMDR protocol is the phase where the researcher can begin to know the participant in greater depth. Information is gathered to check the participant's readiness, willingness, stability and ability to engage in the EMDR process. The history-taking phase entails an evaluation of the entire case. This phase provides the information needed to design a treatment plan and helps to identify potential treatment targets that emerge from examining the positive and negative events in the participant's past, present and future (Shapiro 2001; Hensley 2009).

3.4.3.2 Observations, field notes and video recordings

Newman (2005) states that field notes are the researcher's experiences and views recorded during the process. They become indispensable when analysing the data. The researcher therefore becomes an instrument that absorbs all sources of information, using all the senses and noticing what is seen and heard.

When looking at the same scene or object, different people will see different things. What people "see" is highly dependent on their interests, biases and backgrounds. Our culture shapes what we see, our childhood socialisation forms how we look at the world and our value systems tells us how to interpret what passes before our eyes (Patton 2002:260-261). Thus Babbie (2007) suggests that empirical observations and the researcher's interpretations should be written down – to record what the researcher "knows" has happened and what he/she "thinks" has happened.

The aim of a qualitative enquiry is to record the respondent's answers as fully as possible (Terre Blanche & Durrheim 2000). A digital voice recorder was therefore used to ensure verbatim recording, but also to free me as the interviewer to focus on the respondent, to communicate that I am listening to what is being said, and to probe into important cues. Digital voice recordings allow for one return to the data in the original form as often as needed (Silverman & Marvasti 2008).

Notes were taken during the interview so that I could refer back to something important being said earlier in the interview to facilitate later analysis of the recordings (Patton 2002). Notes were used as a stimulus to re-create as many details of the interview or session as possible (Babbie 2007). Patton (2002:289) alerts us to the power of language used during the data-collection process. Field notes should include the exact language used by the participants. Capturing the adolescents' precise language accords with the emic approach. This approach draws on the language the participants used to explain their experiences. It is their internal point of view of the meaning they made of their experiences. Cohen et al. (2007) caution against the researcher believing that transcriptions of interviews reveal everything that took place in an interview. However, it is not possible to observe everything (Patton 2002). Video recordings of each interview and sessions were made to gather information-rich data. The video recordings of each interview and session enabled me to comment on all of

the non-verbal communication that was taking place (Denzin & Lincoln 2008). According to the authors, non-verbal communication gives more information than the verbal communication.

The EMDR protocol includes a number of component tools that assist in the processing of maladaptive material and therefore the EMDR process forms part of the data-collection procedure. Clinical observations of EMDR sessions reveal that once the traumatic material has been resolved, these physical sensations and affective states are no longer evident (Shapiro 1999). Therefore, the EMDR session is not considered complete until all physical sensations generated by thoughts of the trauma have been appropriately reprocessed. By the end of the treatment a mental scan of the body by the client should reveal no residual tension or atypical physical sensations. The body scan is part of the eight treatment phases of EMDR which will be discussed later in this chapter. Although the basic components of EMDR were defined in Chapter One, the way to implement the components as a way to gain more descriptive information will be elaborated on below.

As discussed in Chapter One, when determining the Validity of Cognition Scale (VOC) the participant is asked to rate the positive cognition on a 1-7 scale, with 1 as completely false to 7 as completely true. The rating should reflect the “felt truth” rather than what the client may know intellectually but not fully believe (Adler-Tapia & Settle 2008:149; Greenwald 2001:124).

The Subject Unit of Disturbance Scale (SUDS) assesses the level of emotional disturbance. The SUD is taken after the client has identified what emotions he/she is feeling during the assessment phase and at the end of the desensitisation phase to indicate whether processing is complete (Hensley 2009).

Greenwald (2001) suggests that the adolescent must report his current affective reaction to the selected memory image. Common emotions include fear, anger and sadness. The current intensity of the negative emotion needs to be rated on a scale from 1-10, where 0 indicates no disturbance to 10 as the most intense disturbance. Rating the intensity of the emotion helps the client and therapist to track progress during and after the EMDR session. SUDS may rise and fall as the client progresses through the memory and different emotions arise. It might be assumed that if the

client's SUD level remains unchanged by the end of a given session, and with no specific emotion identified, the treatment for that session has been unsuccessful. Shapiro (1999) states that this is not necessarily true, however, since clinical progress may have actually occurred, although not in terms of a change in the numerical value of the SUD level, but rather in the form of the type of emotion being represented (e.g. a switch from shame to anger). Hensley (2009) provides a graphic description on how to implement the VOC and the SUD:

Totally False				Totally True		
1	2	3	4	5	6	7

Figure 3.2: Validity of Cognition (VOC) scale

Neutral/ No Disturbance							Highest Disturbance			
0	1	2	3	4	5	6	7	8	9	10

Figure 3.3: Subjective Units of Disturbance (SUD) scale

Shapiro (2001) states that the *physical sensations* generated when clients concentrate on a traumatic memory are very useful focal points for treatment. These sensations may be associated with emotional tension, such as tight neck muscles or increased heart rate. Other physical sensations may be part of the sensory experience of the target trauma itself, such as the sensation of feeling the grip of the perpetrator's hand. Pronounced physical sensations are also associated with negative cognitions. Greenwald (2001) agrees with Shapiro and states that there is often, but not always, considerable overlap between the VOC, SUDS and physical sensations, which is why it is important to identify and desensitise each one.

3.4.4 Data management

3.4.4.1 Analysis

In an interpretive study there is no clear point when data collection stops and analysis begins. Rather, there is a gradual fading out of the one and a fading in of the other, so that at first you are mainly collecting data and towards the end you are mainly

analysing what you have collected (Terre Blanche & Kelly 2002). Cohen et al. (2007) comment that qualitative data analysis is a cyclical, continuous process that goes through data organisation, analysis and data interpretation. From the first interview data were collected and content analysis started to determine what targets needed to be focused on and required desensitisation. The interaction between data collecting and content analyses throughout the process assisted in making sense of the data. It provided information on how the participants define their situation and hence theme regularities could be identified.

Content analysis is a technique for gathering and analysing the content of text. Patton (2002:452) describes content analysis as 'a method used to refer to any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings' The content refers to words, meanings, ideas and themes that were communicated. The text is anything visual or spoken that serves as a medium for communication (Newman 2005). The data generated by the participants was coded and categorised, and themes constructed from the categories (Henning 2004). The aim in the data analysis of this study is to understand the participant's categories and to see how these are used, lived and have an influence in their everyday life (Silverman & Marvasti 2008).

A key principle of interpretive analysis is to remain close to the data, to interpret them from a position of empathic understanding. Clifford Geertz (1973) said the purpose of interpretive analysis is to provide a 'thick description', by which he meant a thorough description of the characteristics, processes, transactions and contexts of the phenomenon being studied. The EMDR process assisted in collecting a thick description of the participant's experience of trauma. It also assisted the participant to experience the treatment modality that aimed to desensitise the intensity of the traumatic experience to help them see the traumatic experience in a newly integrated perspective (Terre Blanche & Kelly 2002).

Cohen et al. (2007) identify four stages in data analysis:

- Generation of natural units of meaning;
- Classifying, categorising and ordering these units of meaning;
- Structuring narratives to describe the content;

- Interpreting the data.

All the conversations that took place during the interviews were audio and video recorded. The audio recordings were transcribed verbatim and all the information was used for analysis. The transcribed data were read at least twice, to pin down their key themes, so that a clear idea was formed of the types of information produced (Denzin & Lincoln 2008). The video recording assisted in the non-verbal communication that took place. The EMDR protocol was analysed qualitatively using content analysis and will be discussed below.

The SUD (Subjective Units of Disturbance Scale) levels of distress of each participant were noted and compared to see what changes took place (if any). The Subjective Units of Disturbance Scale (SUD 1-10) was used to measure the level of distress associated with a memory, where 1 is no disturbance/neutral and 10 is the highest disturbance/distress (Shapiro 2001). The VOC (Validity of Cognition Scale) of each case was compared to determine whether the technique produced change and what change (if any) did take place. The Validity of Cognition Scale (VOC 1-7) is a measurement of how valid or true the positive cognition feels as one focuses upon the target, where 1 is completely false and 7 is completely true. Themes were then identified by using the SUD levels, which were compared to determine any correlation.

The interview schedule was organised into pertinent areas that made categorising the data easier. This included the history-taking phase and the EMDR sessions. The transcribed data from all the interviews were organised and categorised and coded until themes were identified. A detailed discussion and presentation of the analysis appears in Chapter Four.

3.4.4.2 Verification of Qualitative Data

Leedy and Ormrod (2001) state that the concepts of internal and external validity, and their relevance to qualitative research, have been questioned by researchers such as Creswell (2008) and Lincoln and Guba (1985), as these concepts are consistent with positivism (Denzin & Lincoln 1998). The authors argue that a set of criteria needs to be developed unique to qualitative research, which is consistent with post-positivism. Maxwell (1992) agrees with Lincoln and Guba (1985) on the need to replace positivist notions of validity in qualitative research with the notion of authenticity. Maxwell

(1992), echoing Mishler (1990) and Hammersley and Atkinson (1983), suggests that 'understanding' is a more suitable term than 'validity' in qualitative research and argues that researchers are part of the world and cannot be completely objective about it. Other people's perspectives are equally as valid as our own, and the task of research is to uncover these perspectives. This meaning the respondents give to data and inferences drawn from the data are important. Verification is therefore a *process*. It is the aim of the researcher to earn the interest and confidence of the participants' so that they agree and gain insight in their own world (Hesse-Biber & Leavy 2011).

Babbie and Mouton (2001) provide a list of aspects for judging the quality of qualitative research, based on Lincoln and Guba (1985). The researchers suggested that such words as credibility, dependability, confirmability, verification and transferability should rather be used instead of the term validity.

Credibility

Babbie and Mouton (2001) describe credibility with the question "Does it ring true?" Is there compatibility between the constructed realities that exist in the minds of the respondents and those that are attributed to them? Sandelowski (1993) is of the opinion that a study can be considered credible when it presents such accurate descriptions or interpretations of human experience that people who also share that experience would immediately recognise the description. Credibility in this study is achieved by following the procedures set out by Creswell (2009).

- *Prolonged and substantial engagement*: Meetings were held with each participant and their parents to discuss the research process. This session served as the clinical intake, where rapport building took place and relevant background information was gained and possible targets for the therapy sessions were identified. The procedure of EMDR is then explained to participants. Four to eight therapy sessions were conducted which gave me an in-depth understanding of each participant that adds to the credibility of this study.
- *Peer debriefing*: Regular conversations with research peers were held. Before each session communicative validity was implemented by revisiting the previous cognitions and confirming the SUD and VOC with each participant. If

there was a difference, we adapted accordingly in our session as seen fit at that moment. If there was a disagreement on the Positive Cognition (PC) and Negative Cognition (NC) scale, alternative points of views or targets were explored.

- *Triangulation*: The notes from observations and video recordings of therapy sessions and interviews served as additional sources of data to which the interview data could be compared to assess for data convergence. Newman (2005) explains that the validity of research increases when interconnections between diverse data are sought and a dense connectivity in details is recognised.

Transferability

Transferability pertains to the applicability of the study to other contexts and settings. With respect to transferability, Henning (2004) states that the researcher has the responsibility to provide a “thick description” to be able to give a “thick explanation”. Terre Blanche and Durrheim (2000) describe this as data needing to be understandable by many other people in new contexts. Creswell (2009) states that the more detail in which the perspectives of participants are given, the more realistic and richer the results become.

Dependability

Lincoln and Guba (1985) use ‘dependability’ in qualitative research as the equivalent of ‘reliability’ in quantitative methods. Reliability is the degree to which the results are repeatable (Babbie & Mouton 2001). Interpretive researchers do not expect to find the same results repeatedly. They expect individuals will behave differently and express different opinions in changing contexts. In place of the criterion of reliability, they propose that findings should be dependable (Terre Blanche & Durrheim 2000). In this study, where meanings are constructed as the process of research is embarked on, change is to be expected. A variety of techniques (interviews, field notes, audio and video recordings) were used to record observations consistently, which adds to the reliability of the study (Newman 2005).

Confirmability

Confirmability is the qualitative parallel of objectivity. For Lincoln and Guba (1985) the key criterion of good qualitative research is found in the notion of trustworthiness: the neutrality of its findings or decisions. The 'neutrality' of the data is plausible when others reach the same interpretations of meaning and significance as the researcher (Babbie & Mouton 2001).

3.4.4.3 Role as researcher

The role of the researcher is determined by the paradigm of the study. As mentioned, an interpretive paradigm was applied in this study. Terre Blanche, Durrheim and Painter (2006) state that listening and interpreting are among the skills an interpretive researcher requires. Another skill required is for the researcher to interpret his/her own presence in the research process. According to the authors, the subjectivity is not the challenge, but rather to show how the researcher shows his/her subjective capacities in making sense of the data. These approaches were applied in this study. My role as a therapist will complement the findings of this study. Henning (2004:11) states that the researcher is the main instrument of research: "*the instrument of research in qualitative research is the human mind.*" Therefore the researcher needs to have an inquiring mind, conveying the views of participants to people interested in the topic. Seeing that the researcher is the main instrument, the quality of the knowledge produced in the process, together with the knowledge produced by the participants, is critical; thus findings will be presented in the way it was understood by the researcher.

Creswell (2009) and Hesse-Biber and Leavy (2006) state that the researcher and the respondent often come to the interview situation with different backgrounds in terms of gender, sexual preference and class status. Difference has an impact on all phases of the research. The acknowledgment of difference will allow the researcher to take account of difference and its impact on the interview situation. The personality and skills of the researcher is, according to Merriam (2002), of the utmost importance as it can also affect the interview situation. Henning (2004:1) agrees and states that "*Who interviews matters.*" Morse (1994) elaborates further on their view that the quality of a qualitative study is only as good as the researcher.

Kelly (2006:349) adds to “subjective meaning” the importance of the context when reading text data and writing about them. Reading the text data helps the researcher to make meaning of the text, but Kelly is of the view that “*the text can mean more than the author meant it to mean,*” which in return can influence the understanding of events. Kelly’s approach was implemented, which means that when the researcher reads the text data, he/she is “in” the situation and context with the participant. It is also important to “*view it from a distance*”. Discussing the data with my supervisor assisted me to ‘view it from a distance’ and made it possible to become aware of even more objective information.

3.5 ETHICAL CONSIDERATIONS

The essential purpose of ethical research planning is to protect the welfare and the rights of research participants (Terre Blanche & Durrheim 2000). The research is guided by the ethical principles for psychologists set out by the HPCSA (2005). The ethical clearance by Stellenbosch University (HS610/2011), a copy of the invitation to participate in the research, clinical intake and the EMDR protocol are available in the addendum.

The principle of informed consent was applied. Consent was voluntary and informed. Informed consent implies that all participating adolescents as well as non-participating parents or guardians received a clear explanation of the purpose and process of the research, so that they could make an informed decision to participate (Terre Blanche & Durrheim 2000). Written consent was given by the participants. The research was done according to the ethical guidelines in health research as stipulated by the HPCSA. The rights of the participants were protected. As mentioned in Chapter One, an educational psychologist was appointed to oversee the participants’ rights. If the research had adverse impact on a participant, room was made for debriefing and addressing any need that might arise. Secondly, the research was conducted in an ethical manner. The informed consent form signed by participants and parents assured them of the confidentiality of the information supplied by them. The process of data collection, the use of data for examination purposes and publication was explained. The personal identity of each participant was not revealed. Questions from participants were answered. Another guideline is scientific contribution. The research

also made a contribution to participants by desensitising their trauma symptoms and filling the research gap.

Competence is a basic principle underlying this study. As a professional who is qualified and trained in the use of EMDR, I am competent in the treatment procedure and therefore competent to conduct this study. I applied my skills as a trained professional and provided the needed guidance and comfort for each participant. Debriefing after completion is an important factor and, although room was made for it, implementation was not needed.

3.6 CONCLUSION

The focus in this chapter was on giving a clear picture of how the research was conducted. Working from an interpretive paradigm, it is understood that the researcher's aim is to collect information-rich data from individuals who have directly experienced trauma. The methods discussed in this chapter were specifically chosen to provide the reader with extensive information to understand the participants' lived experiences of trauma and EMDR as treatment for trauma. The methods to analyse the data were indicated and described. The chapter concluded with a consideration of the role of the researcher and the ethical guidelines concerning the rights and protection of the participants. The following chapter will discuss the implementation of the study.

CHAPTER FOUR

DISCUSSION OF FINDINGS

4.1 INTRODUCTION

This study attempts to offer information on how the adolescents in the study experienced their unique trauma experience. It provides an insight into the changes that took place after the EMDR process, giving the participants hope and providing another possible technique to apply in further research or practice.

As discussed in Chapter Three, the interpretive researcher's aim is to understand the phenomena under study. Chapter 4 examines the transference of the data to text to convey the participants' perceptions as well as their understanding to the reader. To understand the participant's view and experiences a description of the context of the participant is needed.

Therefore an interview was conducted with each parent to understand the participants' background to gain an understanding of the trauma the adolescent experienced. Four sessions were conducted. The first session served as an intake to determine possible targets that needed to be desensitised. The parent interview and the EMDR sessions were transcribed. Examples of the participants' own expressions are included, field notes were taken, and data derived from video recordings were added to provide the reader with a thick description of experiences. The data was coded and relevant themes were identified. The chapter will conclude with a discussion of the results which will also be presented according to the themes identified.

4.2 CASE STUDIES

The study involved five adolescents in an Afrikaans high school in Johannesburg. As discussed in Chapter One, the criteria for the participants' taking part in this study were that they had to fall into the category of the adolescent phase (13-19 years old) and had experienced trauma (developmental or single-incident). A clinical intake with

the parents and the participants identified possible targets for the EMDR sessions. Data were collected using interviews, observation, field notes and video recordings. Content analysis was done to derive meaning from the data. Codes were identified and dominant themes were selected and discussed. The data were translated directly from Afrikaans to English. Examples of the data are available in the addendum. The rest of the data are available on request.

Table 4.1 presents the five participants who gave their consent to take part in the research. For the sake of confidentiality the participants' names were changed.

Table 4.1: The 5 participants who gave their consent to take part in the research

Participant	Age	Gender	Trauma
Charl	18	Male	Developmental trauma
Linda	15	Female	Developmental trauma
Danie	17	Male	Developmental trauma
Erik	18	Male	Developmental trauma
Babs	16	Female	Single-incident trauma

Table 4.2 presents an example of the data analysis.

Table 4.2: An example of the data analysis

No.	Interview	Codes	Themes
B2.29	Will it be the same for you? Do you feel that if your mother and father devote more attention to you that you would feel less alone? Sal dit dieselfde met jou wees? Voel jy as jou ma en pa meer aandag aan jou gee sal jy ook minder alleen voel? Yes, because my brother does everything right. I hate him. Ja want my boetie doen alles reg. Ek haat hom	H ATT COMP REL	Hate – towards brother Attention - Brother positive feedback from parents. Comparison - brother Relationships – negative relationship with brother.
B2.30	I can see you are angry. Does that image in ICU say: I am not getting enough attention? Ek kan sien jy is kwaad. Sê daai prentjie in ICU. Ek kry nie aandag nie? Nods head. Yes ... Silence Knik kop. Ja ... Stilte	ANG ATT	Anger- no attention Attention – negative behaviour to receive attention.
B2.31	If you had to place the intensity of that image on a scale of 1-10, where 1 is not intense at all and 10 is		

No.	Interview	Codes	Themes
	<p>VERY intense, where would you place the image that says: I am alone and I need attention?</p> <p>As jy die intensiteit van daardie prentjie op 'n skaal van 1-10 sit, waar 1 is dit is glad nie erg nie en 10 is dit is BAIE erg. Waar sal jy die prentjie sit wat vir jou sê. Ek is alleen en soek aandag?</p> <p>10</p>	<p>NC SUD</p>	<p>Negative cognition Disturbance level</p>
B2.32	<p>If you don't want to feel alone in yourself, how would you prefer to feel?</p> <p>As jy nie alleen in jouself wil voel nie. Hoe sal jy dit dan graag wil hê.</p> <p>I want to feel OK within myself. I want to feel happy inside.</p> <p>Ek wil OK voel binne myself. Ek wil gelukkig voel binne myself</p>	<p>PC ACC</p>	<p>Positive cognition Accept the self</p>
B2.33	<p>Are you telling me that you want to be OK with who you are?</p> <p>Sê jy vir my jy wil OK wees met wie jy is?</p> <p>Yes, I ... I don't really know who I am.</p> <p>Ja ek ... ek weet nie eintlik wie ek is nie.</p>	<p>ID</p>	<p>Negative self-concept – no belonging</p>
E2.30	<p>Good. What did you feel with the tests when you felt that you had no control.</p> <p>Goed. Watter gevoel is met die toetse as jy voel jy het nie beheer nie?</p> <p>Frightened, Bang.</p>	<p>F</p>	<p>Fear – no control</p>
E2.31	<p>And with the burglary?</p> <p>En met die inbraak?</p> <p>Also frightened.</p> <p>Ook bang.</p>	<p>F</p>	<p>Fear – armed robbery- no control.</p>
E2.32	<p>If you had to place this on a scale of 1-1- where 10 is very serious and 1 is not serious at all. where would you place the situation where you have write a test and you have no control?</p> <p>As jy dit op 'n skaal van 1-10 moet sit waar 10 is baie erg en 1 is glad nie. Waar sal jy die situasie as jy toets gaan skryf en jy het nie beheer nie.</p> <p>I think Number 3. Not so serious as I am already quite used to it.</p> <p>Ek dink so 3. Nie so erg nie ek is dit darem al gewoon.</p>	<p>SUD</p>	<p>Disturbance scale for tests</p>
E2.33	<p>Good. And the burglary?</p> <p>Goed. En die inbraak?</p> <p>No. That is not even comparable. Definitely a 10.</p> <p>Nee dis nie eers vergelykbaar nie. Defnitief 'n 10.</p>	<p>SUD</p>	<p>Disturbance scale for robbery</p>
E2.34	<p>Good. I can believe that. If you don't want to feel like about that image, what would you like it to be?</p>		

No.	Interview	Codes	Themes
	<p>Goed. Ek kan glo. As jy nie so oor daai prentjie wil voel nie hoe sal jy dit wil hê?</p> <p>Well, I don't think I can ever change it to my being in control, because who can control something like that?</p> <p>Wel ek dink nie ek kan dit ooit verander na ek is in beheer nie want wie kan so iets beheer?</p>	<p>COGN</p> <p>CONTR</p>	<p>Cognition – still cannot control that situation.</p> <p>Control – no control</p>
E2.35	<p>I agree that you don't have control over what others do. What do you think you do have control over in such a situation?</p> <p>Ek stem dat jy nie beheer het oor wat ander doen nie. Waaroor dink jy het jy wel beheer in so situasie?</p> <p>Hmm, that's a difficult one. I have control over what I do, yes?</p> <p>Hmm ... dis 'n moeilike een. Hmm. Ek het beheer oor wat ek doen ja?</p>	<p>COGN</p>	<p>Control – own behaviour</p>
C3.31	<p>If you had to place that incident on a scale of 1-10?</p> <p>As jy daardie insident op 'n skaal van 1-10 moet plaas?</p> <p>20? Laughs</p> <p>20? Lag</p>	<p>SUD</p>	<p>Disturbance level</p>
C3.32	<p>Good. 20. What would you like to be like not to be pathetic?</p> <p>Goed. 20. Hoe wil jy wees as jy nie pateties wil wees nie.</p> <p>I'm OK.</p> <p>Ek's OK.</p>	<p>NC</p> <p>PC</p>	<p>Negative cognition – I am pathetic.</p> <p>Positive cognition</p>
C3.33	<p>I'm OK to be me?</p> <p>Ek's ok om ek te wees?</p> <p>Yes</p> <p>Ja.</p>	<p>PC</p>	<p>Positive cognition.</p>
C3.34	<p>If you had to put it on a scale of 1-7, where 7 is: it is true?</p> <p>As jy dit op 'n skaal van 1-7 moet sit waar 7 is dit is waar?</p> <p>A 2. I feel quite pathetic.</p> <p>'n 2. Ek voel nogal 'pathetic'</p>	<p>VOC</p>	<p>Validity of cognition</p>
C3.35	<p>Good. What do you feel if you look at that image?</p> <p>Goed. Wat voel jy as jy na daai prentjie kyk?</p> <p>Pathetic, headache, Sad.</p> <p>Pathetic, hoofpyn. Sad.</p>	<p>EMO</p>	<p>Emotions.</p>
A2.39	<p>If you look at that image, what part was the worst for you?</p> <p>As jy na daardie prentjie kyk watter deel was vir jou die ergste?</p> <p>There where I had to stand up and read in front of the class and I started to stutter and my best friends</p>	<p>HUM</p>	<p>Worst part – memory</p> <p>Humiliation</p>

No.	Interview	Codes	Themes
	laughed at me. Daar waar ek moes opstaan om te lees voor die klas en vashak en my beste vriende lag vir my.		
A2.40	Good. If you look at that part of the image, what message do you get? What does that image say to you? Goed. As jy na daardie deel van die prentjie kyk watter boodskap kry jy. Wat sê daai prentjie van jou? HmMMM. I struggle to read. HmMMM Ek sukkel met lees	NC	Negative cognition
A 2.42	I struggle to read? Ek sukkel met lees? Yes, so I am stupid. I can't read, so I am stupid. A person must be able to read. Ja so ek is dom. Ek kan nie lees nie so ek is dom. Mens moet kan lees	NC	Negative cognition I am stupid
A2.42	You say you are stupid, but to speak is not a problem? Jy sê jy's dom maar om te speech is nie 'n probleem nie? Speaking I have never felt stupid. But with the reading everyone laughed at me and made me feel stupid and ashamed. Speech het ek nog nooit stupid gevoel nie. Met die lees het almal vir my gelag en my dom en skaam laat voel.	SHA HUM	Shame Humiliation
A2.42	How true does this feel in the rest of your life? Hoe waar voel dit in die res van jou lewe? It is true in everything. I don't know why not in the speeches. Reading is in everything. Learning, writing, everything. It influences my marks. I'm extremely angry at that teacher. In alles is dit waar. Ek weet nie hoekom nie in die speeches nie. Lees is in alles tannie. Leer, skryf, alles. Dit beïnvloed my punte. Ek is woedend vir daai juffrou.	ANG	Very upset and speaks with a lot of emotion. Hurt and anger. Almost cried. Anger towards teacher

4.3 CASE STUDY 1

4.3.1 Context – Interview with parent

Charl is an 18-year-old male in Grade 12. He is one of 3 children. He has 2 sisters. His older sister is 22 years of age and his younger sister 12 years old. His mother never married again after her husband's death. She was in two relationships. From the

first relationship his younger sister was born. The second relationship was with a person who was an alcoholic.

Charl was a planned baby. The father worked as a representative for a clothing company. The mother describes the time of Charl's birth as traumatic. The mother was writing her final exams and the same year the father was retrenched. The parents decided that Johannesburg has more career opportunities and they moved in with her mother in Midrand. The mother describes this as such a stressful period in their life. Her husband did any possible job to put food on their table. The mother was still pregnant with Charl and worked at a psychiatric institution. The family moved into their own home ("a cottage") in February of that year and Charl was born in April. The mother stated that although this was a traumatic period in their lives, her pregnancy with Charl was without any complications. Charl was born in April. Charl was breastfed and at the age of 3 months his father died. He had an epileptic seizure, fell into the bath and drowned. The mother says that her body stopped producing milk on the day of her husband's death. Therefore she was forced to bottle feed Charl.

Her husband's death was a very traumatic experience for her. She had to resuscitate him and he was taken to hospital, where he was connected to life support. The doctor gave his view possible prognosis and, given her knowledge of medicine, she decided to disconnect his life support. After she signed the needed documentation, the doctor advised her to go home, 'because then I sat and cried the whole day next to that bed' (*Want toe sit ek die hele dag en huil langs daai bed*). The loss of her husband caused a lot of strain and the mother needed to work longer hours. The children had no routine. She explains that the children had three homes with three different sets of rules: her own, her mother's and her in-laws'. Her mother and mother-in-law supported her with the children's upbringing while she was working and, according to her, Charl moved through his developmental milestones with ease. The first two years Charl was in hospital four times with asthma. The last visit was the longest, 6 days, and after that he was a healthy boy.

He had some confusion at primary school translating words directly into Afrikaans, e.g. 'smoke becomes smook'. The mother has no explanations for this, as they have no background of education in English other than at school. To this day he still mixes the two languages. Charl was referred for occupational therapy in Grade 2. The

occupational therapist stated that he has low muscle tone and orientation problems and had therapy to address those problems. His eyes were tested and he had to wear a pair of glasses. He had reading support at Tina Cowley, which the mother states had a positive effect. One day (when he was approximately age 12) she realised that Charl was not wearing his glasses anymore and tested his vision again. The results came out normal. She experiences him not concentrating well; 'You know he grasps half a word and then he makes his own word' (*Jy weet, hy snap 'n halwe woord en dan maak hy sy eie woord*) and it is a concern.

The mother says Charl always talks about himself as the middle child who is the forgotten child, but she states that it is not true: 'he is actually the crown prince' (*hy is maar die kroonprins*). He is her 'gentle giant'. He is up early and goes to bed early. He 'hates' discipline and 'time out' is seen as the 'worst' consequence for his actions. He experiences himself as doing everything wrong. Charl loves social interaction and they communicate a lot. She describes their relationship as either 'very good' or 'very bad', depending on the situation. In situations of anger they scream at each other. The mother states they all scream at each other and then they all feel much better. Charl's anger sometimes leads to negative behaviour and he will hit the wall with his fist or kick something. The rugby helps a lot, but it is a matter of concern that he is getting involved in confrontations at school.

4.3.2 EMDR sessions

4.3.2.1 Session 1

Charl entered the therapy room relaxed as if he visits me every day. He is verbally very strong and in his third sentence already told me what his goal for this process is. He appeared uncomfortable when he agrees that he struggles with anger: 'I really struggle with anger' (*Ek sukkel verskriklik met kwaad word*), but rationalises his behaviour: '... but I feel if people look for trouble with me, they will get it' (*1.3 ... maar ek voel as mense met my sukkel kry hulle dit*). He uses his finger to show strongly he feels if he is offended by someone. He experiences himself otherwise as peaceful. Rugby seems to be a sport he cannot go without: 'There I can express my anger at everyone' (*1.4 Daar kan ek my kwaad op almal uithaal*). Charl seemed not to settle on the couch. While I was explaining the EMDR process, Charl sat quietly but not

completely at ease. He is very tall with long legs. His pants are becoming too short and they were pulling up exposing his socks and he kept pulling them down. He is in Grade 12 and I could understand that he needed to stick with his school uniform till the end of the year. Although he was restless, he was paying attention to what was being explained and he engaged in the conversation.

I explained trauma and the EMDR process by using the metaphor of the energy flow in our homes. I explained that there is a flow in the electricity in our homes. Sometimes we overload a plug in our house, resulting in a failure in the flow of the energy. To restore the flow we need to determine what caused the interruption. Most of the time we connect too many objects to one plug. To go to the main switch will not resolve the problem. We need to remove the unwanted plugs. Our emotions work in the same way. Sometimes we experience so many negative situations that serve as plugs. They stay connected in our bodies and use energy. We get to a certain stage that we have anger outbursts of crying and we struggle to stop, which are all warning signs from our bodies that we have too many plugs drawing energy. In EMDR we determine which of those plugs are of no relevance in our life at this stage and just draw energy from us – and so we remove them. Removing the unwanted plugs restores the body's energy flow, resulting in our taking control of our lives again. He understood the concept and stated: 'I can keep you very busy. I have a LOT of "plugs"' (1.16 *Ek kan tannie baie besig hou. Ek het BAIE 'plugs'*) and 'My fuse is fairly short' (1.16 *My 'fuse' is nogal kort*), which contradicted his previously stated view that he was peaceful. 'Plugs' can be seen as 'triggers' in his life.

While exploring his anger, it became clear that Charl needs routine and does not like change at all: 'I have a certain routine at the school that I walk, for example, to line up in the morning. If something is not in my routine then the whole day is mixed up ... then I become out of control (1.19 *Ek het 'n sekere roetine by die skool wat ek loop om bv. aan te tree in die oggend. As iets nie in my roetine is nie dan is my dag helemal deurmekaar ... dan hak ek uit*). He also appears to be very sensitive to criticism: 'If someone says something negative about me, it affects me' (1.19 *As iemand iets negatief van my sê dan affekteer dit my*). The type of comments that upset him are 'You look weird' and he pulls his face to show weird, and 'Your hair is funny', then 'I don't feel good about myself ... later I just get very angry at myself'

(1.20 *Ek voelie dan goed oor myself nie ... ek is sommer woedend later vir myself*). He feels angry with himself for acting on such comments and states that it is childish of him.

When I asked Charl about his behaviour when he is angry, he replied that he screams: 'I shout at my friends and I shout at my mother. We all shout at one another at home' (1.23 *Ek skree vir my vriende ek skree vir my ma. Ons almal skree vir mekaar by die huis*). This is confirmed in the parent interview, as the mother said the same thing. In acknowledging his strategy he appeared a bit uncomfortable, possibly knowing it is not the ideal way to handle these anger situations: 'Look, I know it's not right, but I don't know how to handle it' (1.24 *Kyk ek weet dis nie reg nie maar ek weet nie hoe om dit te 'handle nie'*). At home the outbursts of anger are focused on everybody and they seem to be more intense and associated with negative behaviour: 'I have even hit my fists against the wall. Rather ask who at home does not make me angry' (1.25 *Ek het al my vuig teen die muur geslaan. 1.26 Vra liever wie by die huis maak my nie kwaad nie*). He keeps on blaming others for his anger. A positive action is the fact that he sets definite boundaries on aggression towards females. His strategy is to hit an object or do physical exercise: 'I wish I could hit her, but I may not, so I hit the wall or go an exercise' (1.27 *Ek wens ek kon haar slaan, nou mag ek nie so nou slaan ek die muur of gaan oefen*). Charl admits that at this stage he has no control over his anger and after an outburst he feels stupid and angry with himself.

In exploring earlier situations where he thinks the anger started, he stated without any hesitation: 'If I think back to it now, I'm sure as hell still angry at my teacher who forced me to read' (1.30 *As ek nou terugdink is ek wragtig nog steed kwaad vir my onderwyser wat my gedwing het om te lees*). Charl had to read in front of the class and started to stutter. This memory was traumatic for Charl. He made no eye contact, lay back, resting his head on the couch and almost reliving the moment of shame and humiliation. In asking him about the intensity of the situation on a scale from 0-10, he came back to reality. He started laughing uncomfortably, still no eye contact and said 200. This traumatic experience happened when he was in Grade 2 and decided that reading is not safe: 'I was angry and ashamed, and from that day on never wanted to read in front of a class again' (1.32 *Ek was kwaad en skaam en wou van daai dag af nooit voor 'n klas weer lees nie*). For the rest of his school career Charl refused to

read in front of the class, which resulted in teachers having a negative attitude towards him: 'I refuse to read; they don't like me and I get nought; they threaten me and I say it's alright; I will not budge' (1.34 *Ek weier om te lees; 1.35 Hulle hou nie van my nie en ek kry nul; 1.36 Hulle dreig my dan sê ek dis oraait; 1.37 Ek sallie 'budge nie'*). He then stresses the fact again that this is the reason he needs to play rugby, because that is what made him feel "OK" again after the traumatic experience: 'I remember that day well and it's about the only I remember from school at that time. After the story in class we went to play rugby. That made me feel MUCH better ... I'm telling you, I can't go without rugby' (1.39 *Daai dag onthou ek goed en dis al wat ek omtrent van skool onthou in daai tyd. Na die storie in die klas het ons gaan rugby speel. Dit het my BAIE beter laat voel ... Ek sê vir tannie ek kan nie sonder rugby nie*).

By this time I did not need to probe Charl at all. He was telling his life story and it seemed that he really needed someone to talk to. Another memory that was negative was the birth of his younger sister. His mother got into a relationship and fell pregnant. He stated that he knows that, although they did not get married, he perceived him as his stepfather. He was looking forward to having a friend, but could not accept her being a girl.

Moving on to other situations that felt were traumatic, he stated that he hated his Grade 8 year in Secondary School. He expressed his hate by pulling his face and mouth. His face become red and he leaned his upper body to the front and waved his arms up and down. He felt like a failure and had to repeat Grade 8. Again his body language expressed avoidance of me and he was not making any eye contact and seemed shy. Although his academic performance was low, his aggressive behaviour also seemed to a problem. He only remembered pieces of the incident. He remembers that another boy was blaming him for something. He then seemed to have lost control over his behaviour, blanked out and cannot recall what happened, but knew that when he came back to reality he was already in the principal's office. His sister was there too and said they told her 'he lost it' and was blind with anger. To this day he cannot remember that. He said it's a 10/10, although he cannot remember all the details.

His mother decided to end the relationship with his 'stepfather' and they moved to JHB in his second year of Grade 8. He struggled to fit in, feeling exposed because he was repeating the year. His body size did not make easier, seeing that he was almost as

tall as the Grade 12 boys: ‘... one guy said to me “You are too tall” and it felt to me as if everyone knew I had failed’ (1.55 ... *een ou het vir my gesê ‘Jy is te lank’ dit het vir my gevoel almal weet ek het gedruip*). Again rugby again supported him in becoming part of the group: ‘Once I started playing rugby everything changed and I fitted in’ (1.55 *Toe ek eers begin rugby speel het alles verander en het ek ingepas*).

We discussed his life in Johannesburg and he shared his feelings about the ‘new guy’ his mother was in a relationship when he was 16. This man moved into their home and seemed to bring only trouble: ‘that man ... I hate him’ (1.56 *Daai man tannie ... ek haat hom*). He remembers a traumatic incident that caused tremendous amount of anger for Charl. He stated that they were not allowed to leave anything lying around. Charl left a cable on the table in the sitting room. While having supper he by accident spilled something on the tablecloth and his mother’s boyfriend got mad. He screamed at Charl about leaving his cable on the table and messing around all day long and never taking responsibility for his chores. The situation got out of hand and he pushed Charl with his shoulder. Charl screamed back at him, packed his bags and left: ‘He said I was worth fuck all ... then I screamed at him what I think of him and slammed the door off its hinges and walked away’ (1.59 *Hy sê ek is fokkol werd. Toe skree ek vir hom wat ek van hom dink en slaan die deur uit die skarniere uit en loop*). Charl was visibly upset in sharing this experience. This time he made good eye contact with a lot of emotion in his voice and using his arms while talking. He stayed with a friend, but unfortunately had to go home after a week. He explained the situation at home: ‘We did not talk much with one another. It’s just that when he gets so hammered, things become tight. He took out his anger on my mother. We then moved to my grandmother and then he started his sweet-talking and then my mother moved back again’ (1.63 *Ons het min met mekaar gepraat. Dis net as hy so ‘hammered’ raak het dit ‘tight’ geraak. Hy het die anger op my ma uitgehaal. Ons het toe na my ouma toe getrek en toe praat hy weer mooi praatjies en toe trek my ma weer terug*). His mother deciding to move back created a lot of frustration for Charl and he appeared helpless in the situation as his mother’s boyfriend is an alcoholic and could not see any solution for their situation. When he turned 17, they left and moved in with their grandmother.

On an academic level he said that every year he just passed, but that he is worried about this year. He is failing Mathematics and Afrikaans and therefore at the moment

he is actually failing his year. He cannot repeat another year and feels stupid and states that he struggles to remember: 'I'm probably just stupid! I learn but I can't remember anything' (1.84 *Ek is seker maar dom! Ek leer maar kan niks onthou nie*). He feels stressed out and anxious: 'I'm sooo scared I'm going to fail' (1.81 *Ek is soo bang ek dop*). I questioned him about his sleeping patterns; he stated that he wakes regularly and then struggles to fall asleep again. He has a good appetite but always feels tired.

After becoming more relaxed Charl could not stop talking and it seemed that he kept these situations in for so long and was desperate to let it out. He described a situation of rejection and anger with a girlfriend he had: 'Now I suddenly remember something else that made me the hell in' (1.67 *Nou onthou ek sommer nog iets wat my die hel in maak het*). He invited her to his grandmother's wedding and on the day of the wedding there was a misunderstanding and he felt rejected and angry: 'My grandmother was getting married and what was supposed to be the happiest day was the worst day of my life, because my girlfriend chose me but also didn't' (1.68 *My ouma het getrou en wat die lekkerse dag moes wees, was die slegste dag in my lewe, want my vriendin het my gekies maar het ook nie*). This situation caused feelings of anger and shame on a scale of 9.

Charl's father died when he was only 3 months old: 'I never knew him. All that my mother tells me or that I hear is how he died. I don't want to talk about how he died. I also can't talk to my mother about my father. I don't want to talk about my father' (1.74 *Ek het hom nooit geken nie; 1.75 Al wat my ma my vertel het of wat ek hoor is hoe hy dood is. Ek wil nie oor hoe hy dood is praat nie. Ek kan ook nie met my ma oor my pa praat nie. Ek wil nie oor my pa praat nie*). This situation seemed very traumatic for Charl and I respected his feelings, so we did not discuss it any further. We created a safe place and he reacted positively to it: 'Gee, I really like this at lot. I will do it; VERY peaceful. I actually want to sleep now' (1.119 *Jis, ek laaik die kwaai. Ek sal dit doen; 1.121 BAIE rustig. Ek wil eintlik nou slaap*) and I suggested that he used his safe place, rather than the earphones, when he goes to bed. He preferred to name it his 'happy place'. With this we ended the session.

4.3.2.2 Session 2

Charl appeared much more familiar as he entered the therapy room. He started communicating spontaneously and could not wait to tell me that, although he still wakes often during the night, he does not need the earphones and music anymore to fall asleep. He just used his 'happy place' with good results: 'I can't believe that I go to sleep without the earphones and music. It's weird' (2.9 *Ek kan nie glo ek gaan slaap sonder die oorfone en musiek nie. Dis 'weird'*). He is still tired when he wakes up in the morning. Charl mentioned that he implements his happy place in situations of anger, but it still seems to be a challenge: 'I just need to practise this a bit more ... like it takes me a little while to cool down once I'm there' (2.3 *Ek moet hom net bietjie meer oefen*; 2.5 *... soos dit vat my 'n rukkie om af te koel as ek daar is*).

In questioning Charl about whether he became aware of possible other memories that were traumatic, he said no, but that he was thinking about our discussion in the previous session: 'It felt as if I scratched open old wounds. I was angry with everyone all over again' (2.12 *Dit voel of ek ou wonde oopgekrap het*; 2.13 *Ek was kwaad van voor af vir almal*). I explained to him that in our sessions our goal is to remove the negative emotion and cognitions about the memory. An explanation and demonstration of the BLS followed. He chose the tapping option: 'I think the tapping. I can't move my eyes that quickly. The thing with the ears ... no ... that feels weird' (2.19 *Ek dink die 'tapping'. Ek kan nie my oë so vinnig beweeg nie. Die ore ding ... nee ... dit voel weird*). I was surprised that he did not choose the auditory option as he seemed to function strongly on an auditory level.

Charl decided that he wants to work on the image of when he was in Grade 2 and had to read out loud. Just mentioning that situation of humiliation and anger made him comment on his stubbornness at school: 'I don't like being forced to do anything; ... if someone says to me you have to, I say I have to nothing' (2.29 *Ek hou nie daarvan om gedwing te word nie*; 2.30 *... as iemand vir my sê ek moet dan sê ek, ek moet niks*) and at home: '... even my mother. If my mother says to me I must do this or that ... I will simply just not do it' (2.31 *... 'even' my ma. As my ma vir my sê ek moet dit of dit doen. Ek sal dit net plein weg nie doen nie*).

Returning to the traumatic reading memory, Charl pointed out the most difficult part of that image: 'There where I had to stand up to read in front of the class and started stuttering and my best friends laughed at me' (2.39 *Daar waar ek moes opstaan om te lees voor die klas en vashak en my beste vriende lag vir my*). Charl shared that image with a lot of emotion and almost cried: 'Reading is in everything, you know. Learning, writing, everything. It influences my marks. I'm extremely angry at that teacher' (2.42 *Lees is in alles tannie. Leer, skryf, alles. Dit beïnvloed my punte. Ek is woedend vir daai juffrou*). He decided on an NC 'I am stupid' with a SUD of 10. His PC stated 'I can do it' with a VOC of 3. When thinking of the image he feels shame, humiliation and anger in his head.

I moved Charl back to the most difficult part of the memory and spontaneously he started at the morning his mother dropped him off at school. I decided to stay with his process and went with that image. He divided the memory in an orderly way into different steps:

1. Then the teacher said I must read and I stand up - *Toe sê juffrou vir my ek moet lees en ek staan op. 2.61*
2. And I stutter on the word and everyone starts to laugh at me - *En ek hak op die woord en almal begin vir my lag. 2.62*
3. Then I sat down and felt humiliated - *Toe sit ek en voel verneder. 2.64*
4. The tears ... the tears started flowing like ... like I was sad - *Die trane ... die trane begin loop soos ... soos ek was 'sad'. 2.65*
5. Then I just remained seated and then the teachers started saying I must stand up again and read, and then I basically just said no in my actions because I remained seated - *Toe hou ek net aan met sit en toe begin die juffrou sê ek moet weer opstaan en lees toe sê ek 'basically' nee in die aksies wat ek gedoen het want ek bly sit het 2.66*

This traumatic experience created a 'sadness in his heart' and anger, and at that moment he felt like he wanted to hit something. He made a fist in both hands and appeared tense. His face was full of anger and his voice over-controlled. After another set of BLS he felt frustration and anger, still wanting to hit something to release the anger. Another set of BLS released the anger and he smiled: 'gone!' (2.66 'Gone!').

He seemed amazed while staring at his hands. The anger was released, but he was still aware of some sadness in his hands.

Another memory that he could connect with sadness was in high school in the accounting classroom. He was doing homework. He asked a friend for a pen when the teacher made a comment that he must do his homework. According to Charl, he explained the situation in a decent matter: ‘... then I said to her I’m busy I’m just getting a pen’ (2.66 ... *toe sê ek vir haar ek is besig ek’t net gou ‘n pen gekry*). She replied: ‘yes ... your marks show you’re actually stupid’ (*Ja ... jou punte wys jy’s eintlik dom*). The situation confirmed his own NC and created more anger: ‘It feels ... feel that urge just to break something.’ (2.68 *Dit voel wee ... Voel daai uurgg om net te breek*). After a set of BLS he was amazed again at the quick results and moved his SUD to a 3. He stated a need for himself to believe in himself again and shared another memory of when he felt stupid.

Charl hurt his ankle in a rugby match. His coach believed that he could keep on playing. Charl kept on lying on the rugby field and felt like he cannot do this and that it would be stupid to try. He feared another humiliation. After the game he walked around with no sign of being hurt. His teammates were angry and this again resulted in his feeling humiliated and angry: ‘angry and stupid, it was stupid’ (2.75 *Kwaad en ‘stupid’*; 2.77 *Dit was dom*). Charl stated a new NC of ‘I do not have confidence’. The SUD level was a 4. His PC for this image was ‘I am confident’ with a VOC of 6. Following BLS Charl’s SUD dropped to a 2.

In asking Charl what needs to happen for the SUD to drop to a 0, he answered: ‘I need to do it. Yes, I must, I must do something’ (2.92 *I need to do it. Ja ek moet, ek moet iets doen*). We did another set of BLS. Charl became aware of his shoulders feeling ‘weird’. Following a set of BLS Charl moved his shoulders to make sure he knew what he was feeling. He stated: ‘It felt as there was a weight lifted from my shoulders’ (2.00 *Dit voel of daar ‘n gewig van my skouers afgehaal is*). His SUD dropped to a 0 and his VOC to a 7. He confirmed his decision by stating: ‘Definitely a 7; I actually still have it every day. When I’m at school with my friends, speeches, social life’ (2.103 *Definitief ‘n 7; 105 Ek het dit nog eintlik elke dag. As ek by die skool is tussen my vriende, speeches, my social life*). Charl scanned his body for any

sensations and answered in a strong, calm, controlled voice: 'It's quiet. Very quiet and OK' (2.107 *Dis stil. 'Very quiet and OK'*).

We moved back to the image in the accounting class. Charl immediately made a comment: 'I don't like her' (2.110 *Ek hou nie van haar nie*) and stated that the image is a 4/10 and that he still feels stupid when looking at that image. He explained feeling stupid as sadness on a level of 6. I decided to ask Charl if we can put the sadness and the unresolved images in a safe place and deal with them in our next session. He agreed and we ended the session with him going to his safe place.

4.3.2.3 Session 3

I asked Charl for feedback on his life during the past week and if he had become aware of new memories. He was excited and seemed more positive: 'Really good; you will be proud of me because I still go to sleep without my earphones and music; Erna still pushes my buttons at home but at least I did not want to hit a wall; go to my happy place' (3.6 *'Flippen' goed*; 3.8 *Tannie sal trots wees want ek gaan slaap nog steeds sonder my oorfone en musiek*; 3.11 *Erna druk nog steeds my knoppies by die huis maar ek wou darem nie 'n muur slaan nie*; 3.13 *Gaan na my 'happy place' toe*). Charl was proud of this achievement: 'It was so cool. I did not fight back. Just turned around and walked away and felt fine; never thought I would be able to' (3.14 *Dit was so cool. Ek het nie terugbakei nie. Net omgedraai en geloop en 'fine' gevoel*; 3.15 *nooit gedink ek kan nie*). He expressed, with a friendly face, being aware of more positive emotions: 'Nothing in my life is different but I feel different. I feel light' (3.18 *Niks in my lewe is anders nie maar ek voel anders. Ek voel lig*).

I reminded him about the situation of sadness the accounting teacher caused. He replied that he knows that he is not stupid, but that he is still aware of an emotion and he is not sure whether it is sadness or something else. He could not explain the feeling in words and said that it is something he never felt before and that he is feels it in his whole body. I decided to go with the unfamiliar feeling. As I did a set of BLS, he stopped me but he did not seem upset: 'Wait. Sorry I'm stopping you; I have something' (3.29 *Wag. 'Sorry' ek stop tannie*; 3.30 *Ek het iets*). He seemed amazed that a memory could just enter his consciousness: 'Gee, this stuff is weird, I just now thought of this randomly' (3.31 *Jis, hierdie goed is 'weird' ek het sommer 'randomly'*

nou hieraan gedink). The image of his grandmother's wedding came up and we stayed with that. In looking at that image he felt the same emotions of humiliation and sadness as in the accounting classroom. The NC of this image moved back to 'I am stupid'. In talking about his experience, Charl's girlfriend Jana agreed to be his partner at his grandmothers wedding. On the day of the wedding they went to pick her up. Jana's friend, Tanja, told Charl that Tanja decided not to join him anymore. Charl was devastated and humiliated and felt stupid. After a set of BLS he got stuck on the image of her friend, Tanja, telling him that Jana will not be joining him to the wedding. I asked him to tell Tanja how he felt while doing the BLS. He confirmed: 'Really ... here? I can say what I want to?' (3.59 *Regtig ... hier?* 3.60 *Ek kan sê wat ek wil?*). I nodded my head and he expressed his real feelings in a strongly emotional way: 'Tanja, you are a stupid fat bitch. If I ever see you again, then I'm going to ... I don't hit women but I'll throw a brick at you and don't ever try to talk to me again. It's your fault that I feel stupid/You're stupid, man! That's why no one wants to be seen with you. You are jealous, take you fat body and everything and push it, stick it where the sun doesn't shine' (3.61 *Tanja jy is 'n dom vet 'bitch' ...* 3.62 *As ek jou ooit weer in my pad kom dan gaan ek jou ... ek slaan nie aan vrouens nie ma jou sal ek slaan met 'n baksteen en moet net nie weer met my probeer praat nie. Dis jou skuld dat ek dom voel. Jy's dom man! Dis oor niemand saam jou gesien wil word nie. Jy is jaloers, vat jou vet lyf en alles en druk dit, steek dit weg wa die son nie skyn nie!!*). He was almost out of breath and said that he feels good and he does not feel stupid anymore. He scanned his body and said he still feels some anger in his hands. His hands were shaking and I thought it might not be because of the anger, but more about the situation being so tense. We did a set of BLS and he made a comment: 'It's gone. It's really amazing. I feel 'normal' (3.67 *Dis weg. Dis 'flippen' 'amazing'. Ek voel 'normal'*). Charl moved his SUD to a 0 by shouting it out loud and throwing his hands up in the air, as if he had just won a rugby match.

We moved back to the image in the accounting class and he said that it is gone. We moved back to the situation in Grade 2 where he had to read in front of the class. He moved his SUD to a 0 but the VOC was a 6. In asking him what needs to happen for the image to move to a 7 and he explained: 'I must stand in front of a class and read' (3.70 *Ek moet voor 'n klas staan en lees*). I asked him to set a future template where he was successful in reading. It was possible and he said in his visualisation he reads

fluently: 'I read fluently, no stuttering' (3.69 *Ek lees voluit, niks hakkel nie*). Charl seemed content and I decided to end the session at this point.

4.3.2.4 Session 4

Our fourth session started with excitement. Charl reached his goal: 'I did it; I read. I proved I can do it' (4.5 *Ek het dit gedoen*; 4.6 *Ek het gelees. Ek het bewys ek kan dit doen*). Charl felt so good about finally taking action and in doing so, achieving his goal. He elaborated on the whole event: 'It was so weird. We were sitting and Sir was reading and we had to follow in our books' (4.8 *Dit was so weird. Ons het gesit en meneer het gelees en ons moes volg in ons boeke*). He laughs and continues: 'it was like ... he was reading and then I put up my hand and said "Hey Sir, can I read the piece please?"' (4.9 *dis soos ... hy lees en toe steek ek my hand op en sê; "Haai meneer kan ek die stuk lees asseblief?"*). The teacher and his classmates knew about Charl's fear of reading and the teacher replied by asking him: 'OK Charl, are you sure?' (4.10 *Ok dis reg Charl, is jy seker?*). Charl read without stuttering and confirmed that his reading struggles are in the past and confirmed a SUD of 0 and a VOC of 7: 'It's nought. Yes, it's nought; For sure a 7. I proved it after all' (4.12 *Dis nul. Ja dis nul*; 4.13 *'For sure' 'n 7. Ek het dit dan bewys*).

We revisited Charl's image of self-confidence during a rugby game. He replied: 'Oh, that's also over. Done and dusted' (4.15 *O, dis ook verby. 'Done and dusted'*). Again he was exposed to a situation to prove it to himself. He explains the situation dramatically: 'On Saturday at the rugby ... I hurt my knee ... I went to sit on my bottom about three times and then I stood up and then it was the scrum and then the ref said "OK, are you in or are you out?". And then I saw the paramedics come running and I was just NO I'm not going to talk to them and I was in there. It was sore ... and then I stood up and a few metres further ... I did not have any pain, and I no longer had an excuse and so played on and then forgot about it completely' (4.16 *Ons het Saterdag by die rugby ... ek het my knieg seergemaak ... ek het so 3 keer op my boude gaan sit en toe staan ek op en toe is dit 'scrum' en toe sê die ref "OK is jy in of is jy uit?" toe sien ek die 'paramedics' begin hardloop toe's ek net van NEE ek gaan nie met julle praat nie toe's ek da in. Dit was seer ... toe staan ek op en so paar meter verder ... ek't nie meer pyn nie, ek het nie meer 'n verskoning nie en toe speel ek verder en toe vergeet ek heeltemal daarvan*). He was pleased with himself. He shared more

achievements and stated that he searched on Facebook for Tanja. He found her and left her a message 'Somewhere out there's a guy that hated you but now he's over it'. He felt good about himself. He confirmed the incident with Tanja at his grandmother's wedding as a 0. He shared a comment on the whole process of EMDR: 'I like this stuff. It's cool. It works' (4.25 *Ek laaik die goed. Dis cool. Dit werk*).

Charl experiences positive changes in his everyday life. The same routine isn't an issue anymore and he feels comfortable to go with the flow and changes do not affect his day negatively: 'Yes, it's nice ... almost as if every day is something new' (4.33 *Ja dis lekker ... dis so half van elke dag is iets nuut*). He elaborates on the changes: 'Before I was jolted out of my long-term sleep sleep, hibernation, my life was boring ... the only thing I looked forward to was rugby on Saturday ... now I look forwards to everything ... even going to Afrikaans' (4.34 *voor ek wakker geskrik het van my langtermynslaap, hibernasie, was my lewe 'boring' ... al waarvoor ek uitgesien het was Saterdag se rugby ... nou sien ek uit na als, sien 'even' uit daarna om Afrikaans toe te gaan*).

I confronted Charl with the image he shared in our first session of anger towards Hannes, his mother's boyfriend. His initial SUD was 200. He stated an NC of 'I can't control anger in conflict situations' and his SUD on a scale of 1-10 was 8. His PC was 'I handle conflict situations calmly' with a VOC of 2.

The most difficult part of the image for Charl was when Hannes pushed him with his shoulder: 'There where Hannes was walking down the passage and shoved past me ... he half pushed me with his shoulder and then we began exchanging words' (4.67 *Daar waar Hannes in die gang afstap en 'shuff' by my verby ... hy't so half so skouer stamp vir my gegee en toe begin die woorde verruiling*). The following images emerged after a set of BLS. The next image was when he was packing his bag, followed by an image where his mother tried to convince him to stay, but with no success. The next image was when he told Hannes what he thinks about him as a person. He preferred to only think about it and not verbalise it: 'Sorry, can't sat the words because it's very ugly' (4.68 *Sorry, kan nie die woorde sê nie want dis baie lelik*) and: 'then I walked away and yanked open the second door of the place and slammed it shut so that its hinges bust' (4.69 *toe loop ek en die tweede deur van die erf ruk ek oop en ek slaan hom toe laat sy skarniere bars*). Charl concluded with an

image of where he stayed with his friend for a week, but had to go home afterwards. The SUD of the traumatic situation moved to a 4.

We explored another situation that communicates the same NC. Another image surfaced where Charl was in Grade 7. He was bullied by his best friend. He explained that he had a Biba box over his head and his friend stuck his fingers through the holes in his eye and pushed his knee in his back. The situation got out of hand with both boys displaying aggressive behaviour. A set of BLS cleared that incident and for a moment Charl was quiet. He hesitantly shared his next image: 'I see something completely different'; it's about my father; everyone has a father. I don't know how it feels (4.73 *Ek sien iets heeltemal anders; 4.74 dit kom op oor my pa; 4.74 Almal het 'n pa. Ek weet nie hoe dit voel nie*). His first reaction to my asking him how this affected his emotions was 'angry' following by a comment: 'Oh, actually I'm already so used to it' (4.75 *Ag, eintlik is ek al so gewoond daaraan*). His voice was quiet, looking down and he just stayed in this quiet moment for a while. I allowed him the moment and when he made eye contact again I could see he regained self-control. He started talking about memories of other kids talking about their fathers. He specifically remembers one situation where a child made a comment about Charl not having a father, which led to aggressive behaviour: 'Yes, you won't know what we're talking about because you don't have a father' (4.74 *"Ja jy sal nie weet waarvan ons praat nie want jy het mos nie 'n pa nie"*). Charl shared this incident with a lot of emotion in his voice. We did a set of BLS with no effect. After another set of BLS he stated: 'I'm bullied' (4.77 *Ek word geboelie*). He is very sensitive about conversations about his father and stated that he has a father but he died and it is not his fault. The emotion he connects with that incident is loneliness. There was silence again for a few seconds and he continued with more aggression in his voice: 'I don't want to talk about how my father dies. I hate it when my mother and them talk about it. I don't want to talk about it' (4.81 *Ek wil nie oor hoe my pa dood is praat nie. Ek haat dit as my ma-hulle daaroor praat. Ek wil nie daaroor praat nie*). We did a BLS and Charl mentioned that he is aware of a stiff neck and he rubs his neck with his hand. Another set of BLS relieved the pain, but the energy shifted to his heart as a feeling of sadness. We gave the sadness a voice and confirmed sadness for feeling lonely. In exploring other possible situations of loneliness that created sadness, Charl became aware of the day his sister was born.

The day she came home Charl avoided her and went to his room. He felt life is a bully and he is not important anymore and stated a SUD of 10: 'Yes, so there's a new baby, there is something new, I'm no longer in the future' (4.91 *Ja soos daar is 'n nuwe baba, daar is iets nuuts, ek is nie meer in die toekoms nie*). After a set of BLS that image disappeared. When checking the SUD, Charl moved it to a 2 and said that he realises his mother loves him too and that he does not need to feel inferior. It seemed to be the same feeling he felt when other children talked about their fathers. Although he had a father, he did not know anything about him. When his mother talks about his father, they always talk about how he died and Charl avoids those situations: 'I always walk away when they talk about him' (4.100 *Ek loop altyd weg as hulle oor hom praat ...*). I questioned Charl about whether he feels comfortable talking to his mother and he confirmed that he did: 'I can talk to my mother about anything. We have a good relationship. I just never have' (4.101 *Ek kan oor enigiets met my ma praat. Ons het 'n goeie verhouding. Ek het net nog nooit nie*). We decided that he is going to ask his mother positive things like the personality, likes and dislikes of his father to learn to know him. Charl seemed very excited about that and never thought that he actually just needed to ask. He was so involved in connecting the image of his father to feeling inferior and lonely. He was much more open to have a discussion about his father. He made a future template on his planned discussion with his mother and it had positive results. We decided to end the session at this point. Charl had other responsibilities and left the therapy room peaceful and contented.

4.3.3 Findings

4.3.3.1 Emotions

Under the category of emotions these themes derived from the session with Charl: Anger, shame humiliation, sadness and body sensations connected with emotions felt during the EMDR sessions.

Charl seems to be experienced as a gentle person by most people, but with a short fuse. Charl expressed that he thinks he is born that way: 'Maybe I was born this way' (1.28 *Miskien is ek so gebore*), but that he is struggling to handle situations positively. Playing rugby seemed to be a positive outlet: 'There I can express my anger' (1.39 *Daar kan ek my kwaad uithaal ...*), but Charl becomes aware that his anger is

escalating. His strategy of sport does not seem to be effective enough anymore: 'My fuse is very short ... and I get into trouble at home and at school' (1.16 *My fuse is baie kort ... en ek kry moeilikheid by die huis en skool*). His earliest recollection of feeling angry was when he was humiliated in front of his classmates in Grade 2. The shame he experienced created anger. Every other situation in his life where he experienced shame and humiliation, his anger surfaced. Charl's coping mechanism was to avoid reading in front of the class at all costs: 'I refuse to read' (1.34 *Ek weier om te lees*). His strategy would be to ask the teacher if he may read in private" '... then I say to the teacher, listen can I please read after the period?' (2.32 ... *dan sê ek vir juffrou luister kan ek asseblief na die periode lees?*). If she agrees, he reads with difficulty but he reads. If she disagrees, he becomes stubborn: 'At Uitspan they had a problem with that. They said I must read or I get nought. So I just accepted the nought' (2.32 *in Uitspan het hulle 'n probleem daarmee gehad. Hulle het gesê ek moet lees of ek kry nul; 2.34 Ek het ma nul gevat*). In his first year in high school his anger seemed to get out of hand at school. The teachers were not sensitive to his problem of not wanting to read in front of the class, which created negative attachments towards the school and being humiliated in front of the class.

On the playground in primary school Charl was involved in two situations of negative aggressive behaviour that he could remember: experiencing anger towards other children making comments about his not having a father: 'I was angry and hit him' (4.74 *Ek was kwaad en het hom geslaan*) and being bullied by his best friend: '... and it ended with both of us actually hitting one another' (4.73 ... *toe eindig dit op waar ons 'actually' mekaar slaan*). The aggression Charl was experiencing escalated in high school and negative behaviour towards peers developed, resulting in his losing control over his aggressive behaviour: '... I hit a guy there ... he accused me of something ... when I came back to reality I was in the principal's office. I just remember how I hit the guy' (1.45 ... *daar het ek 'n ou geslaan ... hy het my beskuldig van iets ... toe ek terug na realiteit toe, was ek in die hoof se kantoor; 1.46 ek onthou net hoe het ek die ou geslaan*).

The feelings of anger were peaking in Grade 10 because of his mothers' boyfriend. He did not get along with him. His anger was visible in bodily sensations and he described the intensity of how traumatic this incident was for him by comparing his situation with

Mr Bean in his movie. Mr Bean experienced a situation in Mozambique that ended negatively. Recalling the memory triggers bodily sensations. Charl feels a shivering in his fingers filled with aggression when recalling the traumatic event with Hennie: '... it probably sounds stupid but it's true that when I think about Hennie I begin to feel it and especially in my pinky. It's like a shudder' (4.43 ... *dit klink seker stupid maar dis nogal so as ek aan Hennie dink begin ek so voel en my pinkies veral. Dis soos 'n rilling*). He could not control his anger: 'I could not think, I should have remained calm and peaceful but then I exploded' (4.52 *ek kan nie dink nie, ek moes kalm en rustig geraak het maar toe ontplof ek*). He released his anger by screaming: '... screaming; then I told him what I think of him; second door ... I slammed it that its hinges basically bust' (4.63 *screaming*; 4.68 *toe sê ek vir hom wat ek van hom dink*; 4.69 *tweede deur ... ek slaan hom toe laat sy skarniere 'basically' bars*).

Charl is experiencing feelings of hopelessness at not being able to change his actions and taking control: 'I can't get it right. Can't manage to change my mindset' (2.53 *Ek kan dit nie regkry nie. Kry nie my 'mindset' verander nie*), resulting in feeling a sadness about himself: '... sad for myself' (2.55 ... *'sad' vir myself*).

Charl's body sensations also indicated the emotions he felt. The traumatic memory when he was humiliated created 'sadness in his heart', and 'anger in his hands', his hands were shaking, his shoulders felt strange and he had a stiff neck. Bilateral stimulation lifted the negative sensations from his body.

4.3.3.2 Self-concept

Although it appears as if Charl has a lot of self-confidence, certain dimensions of his life have been exposed to loss and humiliation. The loss of his father created a rebellious character in the forming of his identity. He knows only anger to protect his self-concept and feelings of inferiority. He avoids situations when his father is discussed, because only his death is the point of discussion and not his father and who he was as a person. Therefore Charl struggles to attach to his father and to identify with him. The pain of only learning of his death is too intense, with the result that he avoids those situations in protecting his self-image. The image of the way his father died is not one of a hero's death. He drowned while having an epileptic seizure.

In primary school he was labelled as a person not having a father. He struggled with that view as he feels he has a father, but he died, and did not get credit for having a father. On his development path Charl constantly had emotions triggered that affected his self-concept. Comments from teachers, rejected by friends, bullied by friends, failing academically all strengthened his negative view of himself.

In the sessions three themes emerged that influenced his self-concept.

Theme one: 'I am stupid'

'I am stupid' is the first negative cognition identified in Charl's sessions. Reading in front of the class and being humiliated made him feel stupid, which created a stubbornness in him at school ('I don't like being forced to do anything; ... if someone says to me you have to, I say I have to nothing' (2.29 *Ek hou nie daarvan om gedwing te word nie*; 2.30 ... *as iemand vir my sê ek moet dan sê ek, ek moet niks*) and at home: '... even my mother. If my mother says to me I must do this or that ... I will simply just not do it' (2.31 ... *'even' my ma. As my ma vir my sê ek moet dit of dit doen. Ek sal dit net plein weg nie doen nie*). During the EMDR sessions, when the traumatic memories were resolved, Charl's negative cognition 'I am stupid' changed to a positive cognition of 'I can do it', shifting the SUD from 10 to 0, and the VOC from 3 to 7. In moving from 'I am stupid' to 'I can do it', six clusters memories were targeted that were feeding the negative cognition of 'I am stupid'.

Theme two: 'I do not have confidence'

Feeling stupid affects one's confidence. Charl identified the traumatic memory when he hurt his ankle in a rugby match and did not want to carry on playing as he feared humiliation. He felt that this incident showed he did not have confidence and this resulted in stupid behaviour. After a set of BLS, Charl's SUD moved from 4 to 0. His cognitions changed from 'I do not have confidence' with a VOC of 6, to 'I am confident' with a VOC of 7.

Theme three: 'I can't control anger in conflict situations calmly'

Not being able to control his anger in conflict situations started with a SUD of 200. It seemed that Charl's started off with situations that had to do with other people in his

life such as Hannes (4.67 *Daar waar Hannes in die gang afstap en 'shuff' by my verby ... hy't so half so skouer stamp vir my gegee en toe begin die woorde verruiling*) and a friend who stuck his fingers through the holes of a Bibo box in his eyes. He then dives deeper into the core of being angry, not having a father like the other children and experiencing their comments as being bullied: 'Yes, you won't know what we're talking about because you don't have a father' (4.74 "*Ja jy sal nie weet waarvan ons praat nie want jy het mos nie 'n pa nie*"). He moved to a SUD of 4 after BLS.

4.3.4 Interpretations of the findings of case 1

In case one Charl started his EMDR process feeling mostly stupid, humiliated, angry and sad. He was on the verge of failing Grade 12, which led to a tremendous amount of stress and low motivation. After the first EMDR session Charl already felt positive changes and expressed positive comments about the EMDR procedure: 'It felt as if a weight was lifted from my shoulders' (2.00 *Dit voel of daar 'n gewig van my skouers afgehaal is.*), (2.66 *'Gone'!*). The negative cognitions identified during sessions one to four were desensitised and replaced with positive cognitions. Interestingly, after the trauma was lifted Charl had the urge to do something. He felt like taking action and applying the new positive cognition: 'I must stand in front of a class and read' (3.70 *Ek moet voor 'n klas staan en lees*) and also went onto Facebook and made a comment on his experience with Tanja at his grandmother's wedding, which was a good indication of him letting go of the negative attachments to the memory '*Somewhere out there's a guy that hated you, but now he's over it*'. This made him feel good about himself and taking control of his thoughts and behaviour in a positive way, affecting his self-concept positively. All the negative cognitions were resolved and replaced with positive cognitions. The SUD gives a good indication of how intensely Charl experienced the traumatic situations and the VOC indicates the level of where the positive changes occurred. In all the negative cognitions addressed with the EMDR process Charl's SUD levels dropped and his VOC level rose, resulting in body sensations connected with the negative cognitions cleared, producing a positive outcome, which is confirmed by Charl on the way he experienced EMDR as a therapeutic modality: 'I like this stuff. It's cool. It works' (4.25 *Ek laaik die goed. Dis cool. Dit werk*).

4.4 CASE STUDY 2

4.4.1 Context – Interview with parent

Linda's mother entered the room and I sensed it was as if she is just attending another meeting. Although it appeared that she was in control of her emotions, her breathing was irregular and her hands were restless. She described Linda's birth history and stated that Linda was a planned baby. In her first pregnancy she expected twins. She lost the first baby in the first trimester and the second baby at 30 weeks and had to go through the whole labour process. She experienced that as very traumatic. Her pregnancy with Linda was stressful in the sense that she feared another miscarriage. The mother suffered from pre-clumsia and therefore Linda was an emergency Caesarean at 34 weeks. She was a perfectly healthy baby, but because of the premature birth she was kept in the incubator for two days for observation. Other than needing grommets at the age of 1, Linda was a healthy child.

The mother describes Linda as a lovely but busy, inquisitive baby. Although she did not have regular sleeping patterns, she was not a difficult baby at all. She did not have any tantrums and did not respond well to discipline. She would just go through the motions when the mother disciplined her. Time out was never an option; she would just play in her room. The only thing that had an impact was to deprive her of privileges. She was just always busy and in need of something to do. Her brother, on the other hand, kept himself busy. To this day it is the same. Linda needs to be kept busy and her brother does his own thing.

Linda does not finish what she starts. She will start scrapbooking and then they have to buy all the necessities and then she will get bored. Before exams she will draw up a schedule, but never stick to it. ADHD was not diagnosed in Linda until Grade 8.

Linda's developmental milestones were on par. In Grade R the teacher suspected low muscle tone. She went for occupational therapy and the problem was resolved. Six months into Grade 1 they moved to Cape Town and her teacher suspected a reading problem. They took Linda to an eye specialist and he diagnosed her with low muscle tone of the eye. Linda had to wear glasses and the mother organised an au pair who worked with Linda on her problems. In her Grade 4 year they moved to Johannesburg and her scores dropped from 80s to the 40s. The teachers mentioned

that Linda might suffer from dyslexia. The mother did learning support with her child, which affected their relationship negatively: 'Then we decided, no, we can't carry on or I am going to murder Linda, or she is going to take her stuff and run away, but this home tuition thing is not working' (*Toe besluit ons nee, ons kan nie, of ek gaan Linda vermoor, of sy gaan haar goed vat en wegloop, maar hierdie tuisonderrig ding werk nou nie*). She then searched for a tutor. The tutor referred her to an educational psychologist. The mother decided to take both her children. She was shocked with the results, which showed that her son tested as gifted and Linda tested even higher than her brother. The psychologist advised them to stimulate her more and suggested more reading. The only book Linda loved reading was *Breaking Dawn*. She would read it in four hours. Nothing in her scores changed at school.

The mother's biggest concern is Linda that went through so many doctors, psychologists and it seems that things are getting worse. The family environment is not positive. She explains that the parents do not agree on anything. The only thing that she and her husband have in common is having the two children. They do not have a relationship. She wants to talk about issues and sort them out. The husband's background is one of keeping quiet and the problem will go away. There is either an atmosphere of pretending they are happy or huge outbursts of anger. The mother feels it is very dysfunctional and must be confusing for the children.

She elaborated more on Linda's background. In Grade 8 Linda went to a private school. The parents felt there is more discipline and structure, which Linda needed. According to the mother, Linda's life fell apart in high school. She got involved with the wrong group of children, her scores dropped even more and she became rebellious: 'She did everything that other children did in their entire high school careers' (*Sy het alles gedoen wat die ander kinders in hulle hele hoërskool loopbaan doen*). According to the mother, she is thankful that Linda did not fall pregnant and is not a drug addict. The depression got worse and although the mother read all the possible literature of depression, she felt helpless. The situation seemed to have gotten worse and that the mother had desperate thoughts and reached a dead end: '... at one point I thought perhaps death is the solution, perhaps it is better if Linda commits suicide and ends her life. Perhaps we just need to stop judging, when one gets to a point where you say I don't want to live any longer. Perhaps we must ask who gives us the right to say you

must if you don't want to' (... *ek het op 'n kol gedink, dalk is dood die oplossing, dalk is dit beter as Linda selfmoord pleeg en haar lewe beëindig. Dalk moet ons net ophou 'judge', as mens by 'n punt kom waar jy sê dat 'ek nie meer, wil nie lewe nie'. Dalk moet 'n mens sê 'wie gee ons die reg om te sê jy moet as jy nie wil nie*). The mother started crying at verbalising her true thoughts.

After Linda's fifth attempt to commit suicide, she was admitted into a psychiatric institution. The mother had only negative memories of Linda's stay there and said that Linda's emotional state was worse after the 8 weeks than before: 'In the first place, it's a dump, my servant's rooms don't even look like that. The people there who call themselves therapists did nothing. They kept my child there for 8 weeks. She came out of Panorama and she was smoking and cutting herself' (*Dit is nommer een 'n 'dump', my bediende kamer lyk nie eers so nie. Die mense daar wat hulle self terapeute noem het niks gedoen nie. Hulle het my kind vir 8 weke daar gehou. Sy het uitgekóm uit Panorama en sy het gerook en haarself gesny*). After 8 weeks Linda discharged herself. Two weeks later the social worker phoned and they wanted to start family therapy: 'She said they now finally discussed this as group and think they now know what the problem is' (*Sy sê hulle het nou uiteindelik in groepsverband gepraat en hulle dink hulle weet nou wat fout is*). The mother was furious and decided to take matters in her own hands to help Linda.

She ended up at Dr Francois Esterhuizen in Pretoria. He diagnosed her with ADHD and depression. She was referred by a friend to a psychologist doing NLP. The psychologist said that she cannot help Linda until the depression cleared. The mother was highly upset, so they lost another therapist. Going back to school was traumatic as there were rumours that Linda had an abortion. The mother inspected the rumour and learned that it was spread by her friends and their daughters. For mother and daughter it was a shock and they both felt rejected and humiliated. They decided to change schools.

According to the mother, Linda is very happy in the new school. She was accepted from the start and the mother is thankful for that and the school referred them to me for a possible inclusion in the research process.

4.4.2 EMDR sessions

4.4.2.1 Session 1

Linda is a petite-looking girl with big beautiful eyes. Although she was very open to the sessions, her uncertainty about what to expect was evident. Her hands appeared restless and stressed, but she expressed her need for intervention: ‘... I need to see someone now. After I left Panorama things have not improved and I now want to talk to someone.’ (1.11 ... *ek moet iemand nou sien. Nadat ek uit Panorama is gaan dit nie beter nie en ek wil ook met iemand praat*). She also made it clear that feeling depressed is a problem for her: ‘I become very depressed and I don’t know why’ (1.11 *Ek raak baie ‘depressed’ en ek nie weet hoekom nie*).

While establishing rapport, I learned a lot from Linda and her relationships within her family. Her relationship with her brother seems to be negative as long as she can remember: ‘My brother and I are not mad about each other; and I think I never liked him’ (1.5 *Ek en my broer is nie mal oor mekaar nie; 1.7 Ek kan nie dink ek het ooit van hom gehou nie*). According to Linda, her mother and brother have the same personalities: ‘They think alike. They plan everything’ (1.8 *Hulle dink net dieselfde. Hulle beplan alles*), while she herself and her father seem to be more relaxed, peaceful, creative, love music and struggle to be on time. When I questioned Linda about her perception of her relationship with her mother, seeing that her brother and mother share the same type of personality, she stated: ‘My mother and I are NOW getting on well’ (1.8 *Ek en my ma kom NOU oor die weg*). She also stated that their relationship changed possibly of all the traumatic experiences she has experienced: ‘I think it’s about everything that happened to me’ (1.8 *Ek dis oor alles wat met my gebeur het*) and Linda expresses the need to let go of the negative emotions and gain control over her life: ‘I need to get this stuff out of me. I can’t go on like this’ (1.20 *Ek moet hierdie goed uit my kry. Ek kan nie meer so aangaan nie*).

We discussed a metaphor used for when things happen in our life which we cannot change, but which we can do something about. The metaphor is of an egg that breaks. Leaving it can result in a rotten smelly egg. We can either leave it to become smelly or we can do something with it, meaning bake a quiche or omelet so that it has a positive outcome. She commented: ‘Yes, that makes sense. I think I dropped a

dozen aggs' (1.24 *Ja, dit maak sin. Ek dink ek het 'n dosyn eiers wat geval het*) and seemed hopeful that there is hope: 'Yes definitely. I sounds cool' (1.26 *Ja, definitief. Dit klink cool*).

The three options of the EMDR desensitisation process were discussed and demonstrated. Linda preferred the auditory stimulation for her process. While exploring possible targets Linda said without hesitation that her experience of Panorama is the most difficult one at this stage. I questioned Linda about whether her memories of her stay in Panorama were the only traumatic experiences she had She responded: 'No, more stuff from before and after Panorama also' (1.35 *Nee nog goed voor en na Panorama ook*). She then made a conflicting statement saying that nothing really happened in Panorama. The behaviour she learned while staying in Panorama was negative and her mother had a problem with that: 'Not much happened there. My mother says I learned more wrong things there than before I went to Panorama and she is right' (1.36 *Daar het nie veel gebeur nie. My ma sê ek het meer verkeerde goed daar geleer as voor ek Panorama toe was en sy is reg*). This is the second time Linda made a comment about her mother being correct. The negative behaviour she learned in Panorama was to start smoking and to use self-mutilation as a way to handle her stress: '... then I became friends with this one guy. He then said it helped to relieve stress' (1.38 *... toe raak ek vriende met die een ou. Toe sê hy dit help om die stres te hanteer*). Her stay in Panorama seemed to be a present trigger. I probed Linda on some background information to identify past triggers.

Linda remembers moving from Pretoria to Cape Town because of her father's career and she struggled to fit in. They had to return to Johannesburg when she was in Grade 4 again because of her father's career. She remembers feeling angry and she had negative feelings of the school she had to attend. Her first day in her new school was traumatic and was exposed to verbal abuse from her peers: 'The first day I arrived there one of the girls said I'm a bitch, I struggled with school work and it was just horrible. I could not adapt' (1.50 *Die eerste dag wat ek daar aankom toe sê die een meisie ek is 'n 'bitch, ek het met skoolwerk gesukkel en dit was net aaklig. Ek kon nie aanpas nie*) as well as humiliation, which resulted in feelings of shame and anger: 'I was the only one who spoke with a Cape accent. Everyone laughed when I spoke ... it was horrible' (1.50 *ek is die enigste een wat met 'n Kaapse aksent praat. Almal het*

gelag as ek praat ... dit was 'horrible'). In Grade 5 her grades dropped traumatically. In Grades 6 and 7 she adapted to her new environment and felt like she belongs. When choosing a high school she rebelled against her parents' choice. The parents chose a government school (this is not consistent with the parent interview), but Linda preferred to follow her peers to a private school and they allowed her, it was her choice. When looking back she states that she made a 'big mistake'. In high school her grades dropped again; she got involved with the wrong friends. She started abusing alcohol and was caught out by their domestic worker: 'We drank a lot of alcohol ... drank real brandy. Our servant found a bottle in my room and told my parents. It was awful' (1.51 *Ons het baie alkohol gedrink ... regte brandewyn gedrink. Ons bediende het 'n bottel in my kamer gekry en my ouers vertel. Dit was erg*).

The alcohol was not the end of behaviours having a negative ending. Halfway through her Grade 8 year she got involved in a relationship with a boy of 18 years. She describes the relationship as an 'emotional one' and therefore did not spend much time with her own friends any more. Her mother did not agree with the relationship: 'She felt he manipulated me and was a bad influence, but I loved him a lot' (*Sy het gevoel hy manipuleer my en is 'n slegte invloed maar ek was baie lief vir hom*). Her mother's negative attitude made her more rebellious and then she would organise a date with him during weekdays to take her out for coffee. When he arrived to pick her up, her mother would be angry and not allow her to go: 'That was horrible. I was very angry' (1.52 *Dis aaklig. Ek was baie kwaad*). The whole situation then led to anger from both parties and Linda said that she would then be the one humiliated: 'So looked like the idiot' (1.53 *Toe lyk ek soos die paw-paw*) and her parents expected her to end the relationship with Koos. Although she knew that Koos was more mature than she was, she stated that he made her feel good about herself and decided to commit suicide: 'I felt very depressed. That was the first time I drank pills' (1.54 *Ek het baie 'depressed' gevoel. Dis waar ek die eerste keer pille gedrink het*). She took 5 Panado tablets but they had no effect. She then decided to take 10 Panado tablets, still with no effect. She rationalised her behaviour by stating that she knew that her mother's decision was right to end the relationship, but she felt that Koos was the only one there for her and now 'they' took that away from her.

Her anger towards her parents escalated into more negative behaviour which was intensified by not having friends anymore, because they had been rejected during her relationship with Koos: ‘... my parents and I fought a lot. I was always in trouble’ (1.59 ... *ek en my ouers het baie baklei. Ek was altyd in die moeilikheid gewees*). Examples of her rebellious behaviour would be to deliberately not answer her phone. Her life felt empty and at her third attempt to commit suicide she took a whole packet of Panado tablets and ended up in hospital. Her experience in hospital was not pleasant: ‘It was awful’ (1.60 *Dit was erg*). The only positive thing she can remember and never will forget is her brother showing some affection by asking her not to die: ‘I think that the friendliest thing he ever said to me’ (1.60 *Ek dink dis die vriendelikste ding wat hy nog vir my gesê het*). She stayed in hospital for one week and had nightmares of her mother and brother trying to kill her by slaughtering her and throwing her into a fire.

Life seemed to be even more empty than before: ‘Life was awful. I did not want to live any longer’ (1.64 *Die lewe was aaklig. Ek wou nie meer lewe nie*). Her fourth attempt followed by putting a cable around her neck, but her mother caught her, resulting in negative outcomes: ‘From then on I was not allowed to be alone. So I just drank pills again’ (1.64 *Ek mag toe nie meer alleen wees nie. Toe drink ek maar weer pille*). This was her fifth attempt to end her life. Linda was sharing her traumatic experiences as if they were an everyday routine without any emotion.

Linda was admitted into Panorama Psychiatric Hospital and has only negative memories of her stay. She was allowed to go home on weekends. This was the only positive experience in that time. There were no fights at home and the family did spend time together. She hated going back after the weekend. In Panorama Linda learned quickly how discipline was implemented. After her first attempt at cutting herself, she received a ‘white letter’ as a warning. The more ‘white letters’, the more difficult the consequences. She explained consequences as not being allowed into the garden or you become responsible for washing the dishes. During her stay she received only one letter. She was relieved when she could go home and was positive about starting to face the world. Linda did not go back to school immediately, but she and her mother decided that they needed to spend some time together. Her mother travels frequently and Linda went with her on her business trips: ‘Things went better. I did not go to school immediately and accompanied my mother on trips she went on for

work. We had a good relationship then' (1.71 *Dit het beter gegaan. Ek is nie dadelik skool toe nie en het saam my ma op 'trips' gegaan met haar werk. Ons het toe 'n goeie verhouding gehad'*).

When Linda went back to school, her first day was very traumatic and she was exposed to situations that created feelings of humiliation and shame: '... but when I went back to school there was rumour that I was pregnant. I wanted to run away. I did not talk to anyone and just sat in the bathroom and cried' (1.72 *... maar toe ek terug gaan skool toe was daar 'n 'rumour' ek is swanger. Ek wou weghardloop. Ek het met niemand gepraat nie en net in die badkamer gesit en huil*). What made the situations worse was that the rumors were coming from her own friends: 'They were friendly at first but then they loved gossiping afterwards' (1.73 *Hulle was vriendelik vooraf maar dan skinder hulle lekker saam*). In this difficult time a friend, Jannie, came to her rescue and they ended up in a romantic relationship: If it had not been for Jannie ... I don't know; Jannie got me out of a hole (1.73 *As dit nie vir Jannie was nie ... weet ek nie; 1.74 Jannie het my uit die gat gehaal*). She could connect with him and he gave her emotional security: 'He understood me better ... he knew everything about me. He understood' (1.74 *Hy't my beter verstaan...hy weet alles van my. Hy verstaan*). Jannie was in his first year at university and was 19 years old. Although her mother had a problem with his age, she did like him, but still did not allow the relationship: 'I had to leave him. My mother said so because I had to focus on my academic work now' (1.76 *Ek moes hom los. My ma het so gesê want ek moet nou fokus op my akademie*) and she agreed: '... he could go out during the week and I couldn't, I could not go with him to everything. So I understood that it was not really working out' (1.77 *... hy kan in die week uitgaan en ek nie, en ek kan nie saam hom na alles toe gaan nie. So ek verstaan dat dit nie regtig uitwerk nie*).

Jannie got involved with her friend and tried to make her jealous, which created anger and negative behaviour in Linda: 'I was so angry I gave him the middle finger and my friend too' (1.79 *Ek was so kwaad toe wys ek vir hom middelvinger en vir my vriendin ook*). This action created negative feelings as their mothers were friends. Jannie was very aggressive towards her and she was frightened: 'He was very angry, you know. He also had a problem with aggression. When he became angry then I was frightened of him' (1.81 *Hy was baie kwaad tannie. Hy het ook 'n probleem met aggressie. As hy*

eers kwaad word dan word ek bang vir hom). She made eye contact, her face was serious and her eyes were filled with fear.

While discussing Jannie's aggressive behaviour, I asked Linda to elaborate a bit more on her feelings of anger: 'I just sometime blank out and I don't know why' (1.82 *Ek 'blank' partykeer uit dan weet ek nie hoekom nie*). She described more details about the types of situations that create anger in her life. The relationship between her parents seems to be filled with tension. Situations, which were supposed to be family times, always resulted in fights: 'I think my mother and father don't love each other' (1.83 *My ma en pa dink ek is nie lief vir mekaar nie*). Her mother goes on a lot of business trips and she is hardly home, and Linda adds that her father does not talk much. One situation she remembers was when her mother told her that it was a big mistake marrying her father: 'My mother told me she wishes that she had not married my father' (1.83 *My ma het my al vertel sy wens sy het nie met my pa getrou nie*). She started crying and I could see her feeling helpless and angry. She was making fists and just stared down on the carpet. She then continued on more triggers of anger towards her mother. She needed attention and love, but her actions did not show it: 'Nothing is ever my brother's fault. On Sundays when everyone slept a bit late she would ask him how he slept, but not me because I had sleeping pills, you see!' (1.84 *Niks is ooit my broer se skuld nie. Sondae as almal bietjie later geslaap het sal sy hom vra hoe het hy geslaap, vir my nie want ek het mos slaappille!*).

Most of the situations mentioned showed anger towards her mother, but she denied this and closed her eyes and moved her arms up and down in what seemed desperation: 'I am angry at everyone. This is why I don't want to live any longer. No one is interested in me ... all that I see is that I do everything wrong, but don't know how to be any different' (1.85 *Ek is kwaad vir almal. Dis hoekom ek nie meer wil lewe nie. Niemand stel in my belang nie ... al wat ek sien is ek doen alles verkeerd maar weet nie hoe om anders te wees nie*). She cried again while continuing to let go, describing situations where boys were interested in her looks but not in her as a person: 'No one is interested in ME' (1.86. *Niemand stel in MY belang nie*). Her anger towards life also makes her feel guilty. She described a memory in ICU that led to her wanting to change her life for the better: 'There was girl also lying next to me. She had red hair. They switched off her machines. I thought: I wish those were my machines. I

was the one who wanted to die, but I was living. She was innocent and wanted live, but died. That was awful for me and I will never forget it' (1.87 *Daar was 'n meisie wat ook langs my gelê het. Sy het rooi hare gehad. Hulle het haar masjiene afgesit. Ek het gedink "Ek wens dit was my masjiene". Ek wat wou doodgaan bly leef. Sy was onskuldig en wil leef en gaan dood. Dit was vir my erg en ek sal dit nooit vergeet nie*). The atmosphere in the therapy room was tense and we focused on breathing for a few moments. Linda slowly stopped crying and after a while it seemed that she had control over herself and her emotions seemed stabilised.

I shifted our discussion to why her choice was to move to Hoërskool Penfield. Linda replied that she did not want to go back because of the rumours. She did not want to go to Linden so decided on Penfield. She stated that she feels comfortable in the school: 'No, gee, it's different. The people are different. They are not so cliquey and are more normal. I'm glad I came here' (1.92 *Nee, jis dis anders. Die mense is anders. Hulle is nie so 'clicks' nie en is meer 'normal'. Ek is bly ek het hiernatoe gekom*). It seemed the right moment to end the session.

4.4.2.2 Session 2

Linda was 15 minutes late for this session. She blamed the traffic for her being late. We started the session creating a safe place. Lydia chose a place on the beach. Her hair is blowing in the wind and she is peaceful. She sits on the warm sand while looking at the waves.

While she was at peace I asked if she became aware of any new memories during the past week and she replied no, nothing changed. We discussed her traumatic experiences in ICU and at Panorama. ICU seemed to have had a bigger impact on her life.

Moving to that traumatic image in ICU, the worst part for Linda was when she heard what was going to happen to the girl lying next to her: 'I thought then that I realised that were switching off that girl's machines and she wants to live but is dead, while I want to die but carry on living' (2.15 *Ek dink toe ek besef hulle sit daai meisie se masjiene af en sy wil lewe maar is dood en ek wil dood en bly lewe. Ek onthou sy het nog sulke rooi hare gehad*). Linda struggled to decide on a negative cognition. She

ended up with 'I am alone' with a SUD of 10. Her PC for this image was 'It is OK to be myself' with a VOC of 2 feeling sadness, guilt and anger.

We started the BLS while focusing on the image in ICU. Nothing changed. After another set of BLS there were still no changes. I asked her about another situation where she was feeling the same. She replied: 'I think always when my mother goes away' (2.38 *Ek dink altyd as my ma weggaan*). Her image of those situations was one of her mother talking to her just before she leaves: 'But you know I love you, and then she turns around and walks away' (2.42 *Jy weet mos ek is lief vir jou en omdraai en loop*). After a set of BLS she said she does not get an image, but when we focused on her body's emotions she replied that she knows her heart is pumping but she could not see it. She could only see hurt where her heart should be. We did a set of BLS and then she said with more enjoyment: 'I see my heart. I have a heart' (2.45 *Ek sien my hart. Ek het 'n hart*). We went back to the image of her mother leaving and Linda said it does not feel intense at all and that she can see her turning around and walking away and she feels 'OK' about it. Her body scan on this image was clear. We revisited the image in ICU and her SUD moved to a 7. On exploring her view of what should happen to move the SUD to a 1, she replied that her depressed feelings must stop. Her image of depression was one of being in a dark hole and not knowing how to get out. Her NC stayed the same and we did BLS.

The next image that surfaced was of Panorama and cutting herself. A set of BLS followed and she started laughing while saying: 'It's actually stupid. I can't believe I did that' (2.55 *Dis eintlik stupid. Ek kan nie glo ek het dit gedoen nie*). After a body scan she reported not feeling anything, but she could see that the black hole changed. She could see herself still in the hole, but it is full of different colors: 'The hole is now painter full of colours' (2.57 *Die gat is nou vol kleure geverf*) and that fear keeps her inside. She could feel the fear in her throat, but could not say what she was scared of. We tried to give the fear a voice, but had no results. I went with another set of BLS and then another image surfaced of a situation in Grade 4. She was talking with a Cape accent and the rest of the children were laughing at her. She changed her NC to 'I am different and stupid' with a SUD of 9. Her PC was 'It is OK to be different', and her VOC was 6 because she also has the need not to be different but to be OK with it: 'I always wanted to be different, but don't want to feel so bad about myself if I am

different' (2.70 *Ek wou nog altyd anders gewees het maar wil nie so 'bad' oor myself voel as ek anders is nie*). We did BLS again and nothing else came up, but after the body scan she said she feels at peace. Returning to the image of the classroom and feeling embarrassed, she laughed and said it is not embarrassing at all. We ran out of time and I asked Linda if we could put all the unresolved images and feelings in a container and carry on next week. She was comfortable with that and we ended the session.

4.4.2.3 Session 3

Linda was on time for her session this week but I could see that something was bothering her. She had no new memories, but said that she had feelings of irritation and frustration the whole week long. She could not explain it and she couldn't think of anything that might have triggered it: 'Everything and everyone irritates me' (3.4 *Alles en almal irriteer my*). We took some time to focus on her breathing, going to her safe place until it seemed that she could focus.

We revisited the images of the previous week. The image we ended off with in session 2 was of her feeling stupid and embarrassed because of her Cape accent. She moved her SUD to a 2. The hole of depression changed to one colour – orange, which is her favourite color. When talking about her feelings of fear, she said that although she is still in the hole there is no more fear.

We moved back to the image of herself in ICU where she had feelings of loneliness. She confirmed that although the image does not feel as threatening, she still feels lonely but with anger. Her anger was towards everyone involved that day in saving her life: 'Why did they not leave me alone? I feels to me as if everyone is making decisions for me' (3.13 *Hoekom het hulle my nie gelos nie. Dit voel vir my almal besluit alles vir my*). Linda started letting go on different situations surfacing. I allowed her to let it out. She spoke about her boyfriends and how she was told to end the relationships: 'No one cared how I felt' (3.16 *Niemand het omgee hoe ek voel nie*). Another situation was when the family moved from Cape Town to Johannesburg. Again she feels her views were of no importance: 'No one asked or told me. It was just said that we were moving' (3.16 *Niemand het my gevra of gesê nie. Daar is net gesê ons trek*). She elaborates on the image of moving to Johannesburg: 'I just want her to

allow me to say how I feel about it. I wasn't allowed to say anything. That's the way it was and that's the end of it. The same with my boyfriends' (3.19 *ek wil net hê sy moet my toelaat om net te sê hoe ek daaroor voel. Ek mag niks gesê het nie. Dis so en klaar. Dieselfde as met my 'boyfriends'*). She made a new NC for that image. Linda decided on a NC of 'I am not important' with a SUD of 10. Her PC was 'My thoughts and feelings are important' with a VOC of 4 and body sensations of anger in her head and sadness in her heart.

The most difficult part of the image is where her mother does not give her a chance to share her thoughts and feelings: 'My mother said so and that was the end of it. She didn't want to hear anything else' (3.27 *My ma sê dit is so en klaar. Sy wil niks verder hoor nie*). A set of BLS was done and her next image was a situation of conflict between her parents and she did not know what to do: 'I lie on my bed and want to cry but nothing comes out' (3.30 *Ek lê op my bed en wil huil maar niks kom uit nie*). After another set of BLS she shared an image of being in the shops with her brother and mother. Her brother bought deodorant. When they got home, her brother took off his shoes and she was complaining of the terrible smell coming from his shoes. He took his deodorant and sprayed his shoes. She immediately felt angry, because it was the same deodorant that Koos used and the smell triggered her memory of Koos. She experienced feelings of anger and sadness. We did another set of BLS and the image was gone and she felt peaceful. Moving back to the image of her mother telling her they are moving to Johannesburg, she replied that she still did not want to move, but that the image felt like a 1. She moved her PC to a 7: 'If I were to be honest I would have to say I know it is important for my parents. I actually don't know why I felt like that' (3.36 *As ek eerlik moet sê dan weet ek dit is vir my ouers belangrik. Ek weet eintlik nie hoekom ek so gevoel het nie*).

I asked Linda to revisit the image in ICU where she felt loneliness. She seemed embarrassed but relieved: 'I see the image but don't feel alone ... if I look at what [happened] to that girl who is dead ... I don't really want to die and I'm pleased that those are not my machines. It is true ... and I can't believe I'm saying this' (3.40 *Ek sien die prentjie maar voel nie alleen nie ... as ek kyk wat met daai meisie wat dood is ... ek wil nie regtig doodgaan nie en ek is bly dis nie my masjiene nie. dit is regtig ... en ek kan nie glo ek sê dit nie*). Her experiences in Panorama when she cut herself

was the next image to revisit and she just felt relieved and happy that this is not an issue for her anymore. She remembered the hole of depression and was very excited to inform me that she is not in the hole any longer: I no longer see the hole. I am out of it' (3.42 *Ek sien nie meer die gat nie. Ek is uit hom uit*). When we discussed the incident in the classroom, she started laughing. She realised that if she looks at the situation right now, nobody meant to embarrass her. Her accent was actually funny and interesting and she got a lot of attention. She thinks that she handled the situation badly: '... I just handled it wrongly. I think I was looking at it wrong' (3.43 *... ek het dit net verkeerd hanteer. Ek dink ek het verkeerd daarna gekyk*).

I explored her feelings of irritation that she mentioned in the beginning of our session. She replied that she does not feel that anymore and if she thinks about the past week, it actually was a week with a lot of positive things that happened. She was not aware of this at the start of the session: 'I don't actually know what to say. Things are going well with me, really. I went to audition for the school choir and I'm in' (3.45 *Ek weet nie eintlik wat om te sê nie. dit gaan so goed met my, regtig. Ek het gegaan vir oudisies by die skool se koor en ek is in*). Linda enjoys ballet dancing and wanted to attend the school of art, but her life took a different direction and she stopped her lessons. Her mother knows of her love for ballet and organised for her to have lessons again. She was thrilled. I was happy for her as well. She then said that she does not want to feel that irritation again.

Her comment of hoping not to feel the irritation again bothered me. It seemed that although she did not feel it at that moment, it is not resolved. I asked her if she can think of another image of irritation. She said she did feel irritation in Panorama when she went for a session with the psychologist. She shared all her feelings and thoughts about her parents with the psychologist, who then told her parents all about it: 'She went to talk to my mother and told them everything about how I feel. I did not trust her again' (3.53 *Sy het met my ma-hulle gepraat en hulle alles vetel hoe ek oor hulle voel. Ek het haar nie weer vertrou nie*). I asked her if she could feel the irritation when looking at that image and she confirmed. We did a set of BLS. Linda shook her hands as if she wanted to get rid of something and explained that the irritation moved to her hands. Another set of BLS was done and another image of conflict between her parents surfaced. In this image the parents were fighting about Linda and the financial

and emotional strain it brought onto them. It seemed that her mother lost control over her behaviour and shared her true thoughts and feelings with Linda and her brother: 'She said she is finished with me ... if something were to happen again it would be in my hands, she is not going to worry about it any longer. To my brother she said she is not going to care any more; if he fails then it is his fault' (3.59 *Sy het vir my gesê sy is klaar met my ... as its nou weer gebeur is dit in my hande, sy gaan nie meer daaroor 'worry' nie. Vir my broer het sy gesê sy gaan nou nie meer omgee nie, as hy nou druij, dan is dit sy skuld*). Linda started crying and shared the true reason for all her negative behaviours: '... sometimes I do these things just so that I can get her to come and help me with my ... with everything' (3.60 *... partykeer doen ek hierdie goed net sodat ek haar kan laat kom om te help met my ... met alles*).

She continued verbalising the anger that she felt that day: '... I felt so angry that day that I literally took a magazine and tore it up into small pieces, and it made me feel good' (3.61 *... ek het so kwaad gevoel dat ek soos letterlik 'n tydskrif gevat het en dit in klein, klein stukkies opgeskeur het, en dit het my so goed laat voel*). She said that it was positive but scary, because she could remember her starting to tear a magazine, but came back to reality after the whole magazine was torn apart and ripped and torn into small pieces: 'I went completely blank. It's actually scary' (3.63 *Ek het so 'blank' geslaan. Dis eintlik 'scary'*). Her NC for this image was 'I do not have control' with a SUD of 5. A PC of 'I can stop think and then do' was decided on with a VOC of 4.

We started with the BLS focusing on the part of the image where she realised she tearing the magazine into pieces without being aware of it. The next image she shared was of her mother entering the room and seeing all the papers lying all over her room. We stayed with that and then she said her hands feel funny. Another set of BLS allowed an image of the day their domestic worker found the alcohol in her room and told her mother. Her NC stayed the same and we did a set of BLS. The image faded and Linda was left with a numb feeling. The next set of BLS helped her to let go of the numbness: 'It's gone. Phew, just gone' (3.80 *Dis weg. Sjoie, Net weg*).

The image of being caught with alcohol in her room is not an issue anymore. We moved to the image of her mother entering the room while she was tearing the magazine; she laughed and said: 'She probably thought it's better than cutting!' (3.81a *Sy't seker gedink dit is beter as sny!*) When I asked her about how she felt about the

image of tearing the magazine, she said: 'I think I shall not cut again. That I'm sure of' (3.81b *Ek dink so, ek sal nie weer sny nie. Dit is ek seker van*). Linda felt that she had a new strategy for releasing anger: 'Tearing the paper was rather nice for my hands. I will want to do it again. It's not something negative for me. Not any longer' (3.81b *Die papier skeur was vir nogal lekker vir my hande. Ek sal dit weer wil doen. Dis nie vir my negatief nie. Nie meer nie*). When returning to the image of the psychologist sharing confidential information with her mother, she acknowledged that she wanted her parents to know, but did not want to tell them:

'So it's OK. It actually helped me' (3.84 *So dis OK. Dit het my eintlik gehelp*). Linda then moved her SUD of the image 'I am not in control' down to a 2. I asked her what needed to be done to bring the SUD down to a 1; she replied that it is weird. She feels at peace, but somehow it is not a 1 and she does not know why. I sensed that Linda had enough for one day and decided to end the session. She agreed and she went to her safe place until she felt peaceful and in control.

4.4.2.4 Session 4

Linda entered the therapy room looking vibrant. Her body language was much more positive and she seemed content. She had a positive week. She enjoys being part of the school choir and she feels more positive about her focus when studying. She decided to hold on with the ballet classes and wanted to finish the school exams first. I experienced it as positive as she made that decision and not her mother. It seemed that she is starting to gain more confidence and taking control of her life. Linda shared more positive information. She was invited to play in a hockey match and it made her feel important as the one being chosen out of many of her peers. Her parents were very positive and they decided to go and watch her play: 'My mother and father came to watch. It is so weird. Something like that never happened before.' (4.8 *My ma en pa kom kyk. Dit is so 'weird'. So iets het nog nooit gebeur nie*).

Although so many positive changes were evident in Linda's life, she shared her concerns about her anger: 'I just know how I feel. The feeling is still there' (4.10 *Ek weet net hoe ek voel. Die gevoel is nog daar*). I asked her to focus on the feelings of anger only. She replied: 'I actually see again the papers that I'm tearing, but it's just that I look more evil and redder' It's as if I'm just sitting and laughing and tearing the

stuff. And it is half scary' (4.11 *Ek sien 'actually' weer die papiere wat ek skeur dis net ek lyk net meer 'evil' en rooier; 4.13 Dis asof ek net sit en lag en die goed skeur. En dit is half 'scary'*). The part of the image that was troubling her was the evil look on her face. I asked her what message this image gives her and she said that she is evil. Her SUD of the image was a 5 or 6. I asked her what she would like it to be so that it could be a positive and she replied and gave the PC 'I am peaceful and chilled'. Her VOC was a 3 or 4.

She continued that at the moment she preferred to feel depressed if she needed to feel something negative. She did not like this evil feeling. She experienced this as a problem, seeing that she does not have anything to be depressed about anymore. Her relationship with her mother has changed dramatically. They spend a lot of time together: 'We chat and so it's very nice. I said to my mother that my family is great, my marks are up, my school, my whole environment are like the best they have ever been, but I'm like evil and not soft and chilled' (4.18 *Ons 'chat' baie en soos dit is baie lekker. Ek het vir my ma gesê my gesin gaan 'great', my punte op, my skool, my hele omgewing is soos die beste wat dit nog ooit was maar ek's soos 'evil' en nie sag en 'chilled' nie*).

I asked Linda to focus on the worst part of the image: 'It feels like that evil laugh. My eyeball is like fire and I'm bigger than everything and I feel really very powerful but in an evil way' (*Dit voel soos daai 'evil' lag. My 'eye ball' is soos vuur en ek is groter as als en ek voel regtig baie powerful maar op 'n 'evil' manier*). After a set of BLS Linda shared a new image. She had an image of a house built out of lego blocks. She was standing in the middle of the house and there were different doors for each part of her life. On the family door there was a correction mark; on the door representing the school, her marks; her whole environment was perfect. The only cross in the house was on her. The image did not give her the message that she was evil, but instead that she did not belong there. Her SUD for that NC was 9. Her PC was 'I want to belong' and she chose a VOC of 2.

I asked Linda what part of the image was the most difficult part. She replied seeing all the correction marks and then her having a cross. We did a set of BLS, focused on letting it go; the image of her tearing the magazine appeared again together with feelings of being restless. Another set of BLS was done and Linda saw an image of

her being alone in her bed at home. After another set of BLS she only saw the color grey. She loved the feeling connected to the color grey: 'I'm mad about the feeling. I know it's a feeling that helps you not to worry. It helps me not to worry about what is wrong with me' (4.31 *Ek is mal oor die gevoel. Ek weet dis 'n gevoel wat jou help om nie te 'worry' nie*; 4.32 *Dit help my om nie te 'worry' oor wat met my fout is nie*). Linda acknowledged that this feeling always helps her, but that she knows that she needs to stop using it as it is not positive anymore and she does not know why. We did a set of BLS and nothing changed. I realised that this is where Linda gets stuck and this could be a block that needed to be removed. I asked her if she wants to keep this feeling or let it go. She wanted to let it go, but did not know how as it seemed to be part of her life. I asked her if it is possible to talk to this feeling. She agreed and while the BLS was continuing I helped Linda with cognitive statements.

4.37 You prevent me from growing - *Jy verhinder my om te groei.*

4.38 Thank you for being there when I could not cope - *Dankie dat jy daar was as ek nie kon 'cope' nie.*

4.39 It was necessary but I now want to carry on with my life - *Dit was nodig maar ek wil nou aangaan met my lewe.*

4.40 I want to work through the stuff - *Ek wil deur die goed werk.*

4.41 So I'm asking you to stand back a bit - *So ek vra jou om bietjie terug te staan.*

4.42 Thank you that you'll be behind me and not in front of me to stop me - *Dankie dat jy hier agter my sal wees en nie voor my om my te stop nie.*

This was difficult for Linda but she allowed the process. After a couple of breaths Linda replied that she feels like going on an adventure and shared an image: 'I see this thing ... a little cloud floating behind me. Usually I just sat on it and just 'flowed' through all the trouble. Now I climb off and I stand in front of him and then in front of me there is this path of fire through which I must go and then I walk and then I talk to him so that he first has to remain there and in front of me there is this huge long road but there is a light at the front' (4.45 *Ek sien hierdie ding ... 'n wolkie wat agter my 'float'. Gewoonlik het ek op hom gesit en net deur al die moeilikheid 'geflow'. Nou klim ek af en dan staan ek voor hom en dan voor my is dit hierdie pad van vuur waardeur*

ek moet gaan en dan stap ek en dan praat ek met hom dat hy eers daar moet bly en voor my is hierdie' huge' lang pad maar daar is 'n lig daar voor).

We did another set of BLS together with that image and then Linda said that she is not getting another image. We went back to the image of 'I am evil', she said. She said 'I am not evil' and moved her SUD to a 1. She made a comment that she now has the courage to carry on. She moved to the image of her evil laugh, but she said it is gone. She feels calm and chilled. Her PC moved to a 7. We did a body scan and she repeated: calm and chilled. When revisiting her image of the house made of lego pieces, she said there were no more crosses. It is her house now and she feels at home. Her SUD moved to a 1 and her VOC of belonging moved to a 7. Linda seemed very tired and I asked her if she wanted to carry on. She said that although she had a lot of energy, she suddenly feels tired. I agreed on ending the session. We did a future template for being calm and relaxed. She chose an image of a possible conflict situation at home with her brother: 'Perhaps if my brother throws me a "chirp" again or talks about his good marks' (4.56 *Miskien as my broer my weer 'n 'chirp' gooi of van sy goeie punte vertel*). She did a role play in her mind and said that she feels calm, chilled and that she thinks her brother is childish and it doesn't bother her at all. Her reaction was to walk away feeling calm and chilled. Her reaction to the future template was positive (4.58 *Wow, tannie dit is regtig 'nice'*).

4.4.3 Findings

4.4.3.1 Emotions

Under the category of emotions these themes derived from the sessions with Linda: Anger, shame humiliation, sadness and body sensations connected with emotions felt during the EMDR sessions.

Feelings of depression and anger seem to form the base in Linda's case: 'I become very angry and depressed and don't know why (1.11 *Ek raak baie kwaad en depressed en nie weet hoekom nie*). Her image of feeling depressed is one of being in a dark hole: 'I am in a hole and don't know how to get out. A dark hole' (2.51 *Ek is in 'n gat en ek weet nie hoe om uit te kom nie. 'n Donker gat*). She is aware of her feelings of anger since they moved in Grade 1 from Pretoria to Cape Town. Anger is also

expressed in the form of hate towards her brother: 'My brother does everything right. I hate him' (2.29 *My boetie doen alles reg. Ek haat hom*). Linda experiences the atmosphere at home as one of anger: '... everyone is always fighting in our house; My mother and father were fighting about me again' (3.30 ... *almal baklei altyd in ons huis; 3.57 My ma en pa het weer oor my baklei*). Linda felt irritation and anger towards the psychologist in Tara for not keeping shared information confidential: 'Actually I was not only irritated but very angry. I did not trust her again' (3.53 *Eintlik was ek nie net geïrriteerd nie maar baie kwaad. Ek het haar nie weer vertrou nie*). Sometimes her anger made her blind and she experienced it as 'scary': 'I just went blank. It's actually scary' (*Ek het so 'blank' geslaan dis eintlik 'scary'*). There is conflict in her feelings when she was in ICU after an attempt to commit suicide. She was angry toward everyone involved for saving her life, but at the same time feeling guilty for wanting to die: 'Why did they not leave me alone. It seems as if everyone is taking decisions for me. I have everything but don't want to live' (3.13 *Hoekom het hulle my nie gelos nie. Dit voel vir my almal besluit alles vir my. Ek het alles maar wil nie lewe nie*).

Feelings of sadness: 'I lay on the bed and wanted to cry but nothing comes' (3.30 *Ek lê op die bed en wil huil maar niks kom uit nie*) were the result of being lonely and feeling rejected. She feels lonely in herself. Her loneliness seems to be created for not having any attachments, not even with herself: 'I want to feel OK inside myself; I don't actually know who I am; always when my mother goes away; But you know that I love and then she turns around and walks away' (2.32 *Ek wil 'OK' voel binne myself; 2.33 Ek weet nie eintlik wie ek is nie; altyd as my ma weggaan; 2.42 'Jy weet mos ek is lief vir jou en omdraai en loop*).

Feelings of fear were experienced when she was in a situation where she did not have any control. The situation on her first day in Grade 4 in Johannesburg led to feelings of humiliation: 'Everyone's eyes are on me and I see them laugh' (2.67 *Almal se oë is op my en ek sien hulle lag*). Feelings of humiliation also surfaced when she showed rebellious behaviour and organised a date to have coffee without her parents' consent: '... I was angry, very angry. Then I looked like the idiot' (1.53 ... *ek was kwaad, baie kwaad. Toe lyk ek soos die paw-paw*).

The body sensations gave a clear picture of the emotions Linda was experiencing in traumatic situations. She experienced a feeling of sadness in her heart, a pain in her

heart, anger in her head, irritation in her hands and a feeling a strange numbness. The bilateral stimulations cleared these body sensations.

4.4.3.2 Self-concept

Linda is desperately trying to form attachments in relationships and it seems to fail her in her family, friends and opposite sex. She describes her brother in a negative sense, but adds her mother in the same category: 'Actually no one gets on with him. Well, he and my mother have the same kind of personality' (1.6 *Eintlik kom niemand met hom oor die weg nie. Wel hy en my ma het dieselfde persoonlikheid*). She struggles to identify with her mother. Her perception of her mother is that she is always on a business trip: 'If my mother goes away; Sometimes two weeks at a time' (2.38 *As my ma weggaan; 2.40 Partykeer twee weke op 'n slag*) and she does not show any affection: 'But you know I love you and then she turns round and walks away' (2.42 *Jy weet mos ek is lief vir jou en omdraai en loop*) and that Linda does everything wrong that makes her feel insecure not knowing who she is: 'I was always in trouble' (1.59 *Ek was altyd in die moeilikheid gewees*). She acknowledges that her negative behaviour is an attempt to get her mother's attention: 'Sometimes I do these things just so that I can get her to come and help me with my ... with everything' (3.60 *Partykeer doen ek hierdie goed net sodat ek haar kan laat kom om te help met my ... met alles*).

Linda's self-concept had been deteriorating since a young age and this created confusion about her abilities. In Grade R she was struggling with low muscle tone, which affected her performance at school. In Grade 1 they moved to Cape Town and although Linda knows her parents had no control over this, she feels that they did not allow her to speak her mind about moving. In Cape Town she struggled with reading. The moment Linda's life and emotions seemed to stabilise the family had to move to Johannesburg. She experienced moving to Johannesburg as very traumatic and struggled to fit in. In the beginning she did not fit in and at school her scores dropped from 80s to 40s. Again Linda had to receive learning support.

Her brother, on the other hand, was performing well at school and she was comparing herself with him and she feels that he never does anything wrong: 'They are unfair, well my mother is, because nothing is ever my brother's fault' (*hulle is onregverdig, wel my ma is want niks is ooit my broer se skuld nie*), result in a perception that 'I am

different' and that she experiences boys are attracted to her not because of who she is, but because of her beauty: 'No one is interested in ME' (1.86 *Niemand stel in MY belang nie*). Linda perceives her mother as making decisions on her behalf without taking her feelings into considerations. In high school she had 2 relationships with older males. She was in need of an attachment and she could connect with them and they made her feel secure: 'Jannie ... he knows everything about me. He *understands*' (1.74 *Jannie ... hy weet alles van my. Hy verstaan*). Her mother did not approve and again her mother decided that she must end the relationships: 'I only have Koos and now they are also taking him away from me; I had to leave him. My mother said so' (1.58 *Ek het net vir Koos en nou vat hulle hom ook van my af weg; 1.76 Ek moes hom los. My ma het so gesê*). Linda's attachment problems resulted in a low self-concept, which led to her attempting to commit suicide five times. Her only wish is for her family to be 'close': 'I would have liked us to be a close family' (2.21 *Ek sou wou hê ons moet 'n 'close family' wees*).

Linda feels that she does not fit in: 'I could not adapt. I am the one marked with a cross. I don't fit in, I am different' (1.50 *Ek kon nie aanpas nie; 4.21 Ek is die een wat 'n kruis merk die het; 4.22 Ek pas nie in nie, ek is anders*). She could not resist peer pressure and got involved in numerous situations resulting in negative behaviours: 'I actually learned to smoke there; ... and I also cut fro the first time there; I mixed with the wrong friends. We drank a lot of alcohol. Drank real brandy' (1.37 *Ek het actually daar geleer rook; 1.38 ... en daar het ek ook vir die eerste keer gesny; 1.51 ek het met verkeerde vriende gemeng. Ons het baie alkohol gedrink. Regte brandewyn gedrink*). She has no control over her identity: 'I don't actually know who I am' (2.32 *Ek weet nie eintlik wie ek is nie*), nor does she have control over her behaviour.

During the sessions with Linda four themes derived that influences her self-concept:

Theme one: 'I am alone'

'I am alone' was identified as her first negative cognition. Linda described her feeling of loneliness as wishing she was the girl in ICU whose machines were about to be switched off. 'I thought then that I realised that they were switching off that girl's machines and she wants to live but is dead, while I want to die but carry on living' (2.15 *Ek dink toe ek besef hulle sit daai meisie se masjiene af en sy wil lewe maar is*

dood en ek wil dood en bly lewe. Ek onthou sy het nog sulke rooi hare gehad). During the EMDR sessions four clusters for the negative cognition 'I am alone' were desensitised and moving her SUD of 10 to 1, and changing her PC of 'It is Ok to be myself' from 1 to 7.

Theme two: 'I am different and stupid'

Linda always wanted to be different, but situations with her peers made her feel stupid being different. When her family moved from Cape Town to Johannesburg, the children in her class laughed at her accent. 'I always wanted to be different, but don't want to feel so bad about myself if I am different' (2.70 *Ek wou nog altyd anders gewees het maar wil nie so 'bad' oor myself voel as ek anders is nie*). The EMDR process helped Linda to feel at ease with this negative cognition of 'I am different and stupid', lowering the SUD from a 9 to a 2, and lifting the VOC for the positive cognition 'It is ok to be different, to a 6.

Theme three: 'I am not important'

The NC of 'I am not important' was identified with a SUD of 10. Moving to Johannesburg seemed to have impacted more on her emotionally as expected by her parents. 'No one asked or told me. It was just said that we were moving' (3.16 *Niemand het my gevra of gesê nie. Daar is net gesê ons trek*). She elaborates on the image of moving to Johannesburg: 'I just want her to allow me to say how I feel about it. I wasn't allowed to say anything. That's the way it was and that's the end of it. The same with my boyfriends' (3.19 *ek wil net hê sy moet my toelaat om net te sê hoe ek daaroor voel. Ek mag niks gesê het nie. Dis so en klaar. Dieselfde as met my 'boyfriends'*). After the bilateral stimulation her SUD went down to a 1, and her VOC for her positive cognition 'My thoughts and feelings are important' lifted from a 4 to a 7. Three cluster memories were needed to desensitise her negative images to clear the negative cognition.

Theme four: 'I do not have control'

Linda shared an incident where her mother seemed to have lost control over her own emotions and behaviour: 'She said she is finished with me ... if something were to

happen again, it would be in my hands, she is not going to worry about it any longer. To my brother she said she is not going to care any more; if he fails then it is his fault' (3.59 *Sy het vir my gesê sy is klaar met my ... as its nou weer gebeur is dit in my hande, sy gaan nie meer daaroor 'worry' nie. Vir my broer het sy gesê sy gaan nou nie meer omgee nie, as hy nou drui, dan is dit sy skuld*). This resulted in her also losing control over her behaviour: '... I felt so angry that day that I literally took a magazine and tore it up into very small tiny pieces, and it made me feel good' (3.61... *ek het so kwaad gevoel dat ek soos letterlik 'n tydskrif gevat het en dit in klein, klein stukkies opgeskeur het, en dit het my so goed laat voel*), 'I went completely blank. It's actually scary' (3.63 *Ek het so 'blank' geslaan. Dis eintlik 'scary'*). She identified a SUD of 5 for this traumatic memory. After the EMDR process she could see the positive cognition to stop, think and do by tearing magazines as she could link the behaviour with the PC: 'Tearing the paper was rather nice for my hands. I will want to do it again. It's not something negative for me. Not any longer' (3.81b *Die papier skeur was vir nogal lekker vir my hande. Ek sal dit weer wil doen. Dis nie vir my negatief nie. Nie meer nie*).

Theme five: 'I am evil'

The theme I am evil evolved from the previous negative cognition of 'I do not have control'. Again Linda used the image of tearing the magazine, but identifying another negative cognition with the same image: 'I actually see again the papers that I'm tearing, but it's just that I look more evil and redder'. It's as if I'm just sitting and laughing and tearing the stuff. And it is half scary' (4.11 *Ek sien 'actually' weer die papiere wat ek skeur dis net ek lyk net meer 'evil' en rooier; 4.13 Dis asof ek net sit en lag en die goed skeur. En dit is half 'scary'*). The worst part of the image made her feel evil: 'It feels like that evil laugh. My eyeball is like fire and I'm bigger than everything and I feel really very powerful but in an evil way' (*Dit voel soos daai 'evil' lag. My 'eye ball' is soos vuur en ek is groter as als en ek voel regtig baie powerful maar op 'n 'evil manier*). The intensity of that image was placed as a 5 or 6 on the SUD scale. The positive cognition was identified as 'I am peaceful and chilled' with a VOC of 3 or 4. A set of bilateral stimulations cleared this image and led to the last theme identified.

Theme six: 'I do not belong'

Not belonging affects Linda's self-concept with the image presenting different parts of her life. Of all the aspects involved in her life she herself seemed to be the one who had a burden to bear of not belonging. Her SUD for this event was a 9. She identified a PC of 'I want to belong' with a VOC of 2. Three clusters were connected with this image, which was resolved with bilateral stimulation. Cognitive statement was also used in helping to resolve the trauma. Her SUD dropped to a 1, and her VOC moved to a 7, indicating the issue is resolved.

4.4.4 Interpretations of the findings of case 2

Linda's biggest goal was to be successful in committing suicide: 'Life was awful. I did not want to live any longer' (1.64 *Die lewe was aaklig. Ek wou nie meer lewe nie*). Different images are connected with different emotions felt, e.g. anger, shame humiliation and sadness, which was dominating her life. Her attachment with her mother also seemed to be negative: 'I always think when my mother goes away' (2.38 *Ek dink altyd as my ma weggaan*). Her image of those situations was one of her mother talking to her just before she leaves: 'But you know I love you, and then she turns around and walks away' (2.42 *Jy weet mos ek is lief vir jou en omdraai en loop*). The EMDR process was able to desensitise all Linda's negative emotions, images and body sensations: 'If I were to be honest I would have to say I know it is important for my parents. I actually don't know why I felt like that' (3.36 *As ek eerlik moet sê dan weet ek dit is vir my ouers belangrik. Ek weet eintlik nie hoekom ek so gevoel het nie*); 'I see the image but don't feel alone ... if I look at what [happened] to that girl who is dead ... I don't really want to die and I'm pleased that those are not my machines. It is true ... and I can't believe I'm saying this' (3.40 *Ek sien die prentjie maar voel nie alleen nie ... as ek kyk wat met daai meisie wat dood is ... ek wil nie regtig doodgaan nie en ek is bly dis nie my masjiene nie. dit is regtig ... en ek kan nie glo ek sê dit nie*); 'I am out of it' (3.42 *Ek sien nie meer die gat nie. Ek is uit hom uit*); 'It's gone. Phew, just gone' (3.80 *Dis weg. Sjoe, Net weg*).

The positive changes after the EMDR process also had a positive impact on her behaviour: 'I don't actually know what to say. Things are going well with me, really. I went to audition for the school choir and I'm in' (3.45 *Ek weet nie eintlik wat om te sê*

nie. dit gaan so goed met my, regtig. Ek het gegaan vir oudisies by die skool se koor en ek is in). She also identified a positive strategy to replace her need for self-mutilation: 'I think I shall not cut again. That I'm sure of' (3.81b *Ek dink so, ek sal nie weer sny nie. Dit is ek seker van*). Linda felt that she had a new strategy for releasing anger: 'Tearing the paper was rather nice for my hands. I will want to do it again. It's not something negative for me. Not any longer' (3.81b *Die papier skeur was vir nogal lekker vir my hande. Ek sal dit weer wil doen. Dis nie vir my negatief nie. Nie meer nie*). Another positive reaction after the process was Linda engaging in sport (hockey), which she is not fond of, and also experiencing some positive reaction from her family: 'My mother and father came to watch. It is so weird. Something like that never happened before.' (4.8 *My ma en pa kom kyk. Dit is so 'weird'. So iets het nog nooit gebeur nie*).

The whole process of EMDR and seeing the changes it brought into her life gave her hope for her own life: 'I see this thing ... a little cloud floating behind me. Usually I just sat on it and just 'flowed' through all the trouble. Now I climb off and I stand in front of him and then in front of me there is this path of fire through which I must go and then I walk and then I talk to him so that he first has to remain there and in front of me there is this huge long road but there is a light at the front' (4.45 *Ek sien hierdie ding ... 'n wolkie wat agter my 'float'. Gewoonlik het ek op hom gesit en net deur al die moeilikheid 'geflow'. Nou klim ek af en dan staan ek voor hom en dan voor my is dit hierdie pad van vuur waardeur ek moet gaan en dan stap ek en dan praat ek met hom dat hy eers daar moet bly en voor my is hierdie 'huge' lang pad maar daar is 'n lig daar voor*). Hope has a positive impact on one's emotions and self-concept, impacting positively on behaviour. The EMDR process thus desensitised all Linda's negative cognitions and replaced them with positive cognitions, ending her sessions with: (4.58 *Wow, tannie dit is regtig 'nice'*).

4.5 CASE STUDY 3

4.5.1 Context – Interview with parent

Danie's mother came to the interview and seemed very emotional. In initiating the conversation she started crying: 'Sorry, man. I didn't want to become emotional and we haven't even started yet' (*Skuus man. Ek wou nie graag emosioneel raak nie en*

ons het nog nie eers begin nie). Her biggest concern was Danie's reactions recently and she noted things such as his not being involved in family matters anymore, avoiding communication and becoming very quiet which, according to his mother, is very different from his usual nature: 'He is too quiet, this child of mine. He is not as noisy as usual' (*Hy is te stil die kind van my. Hy is nie so raserig soos altyd nie*). She feels uncomfortable because he is asking questions like: 'If I say I'm gay how would you feel about that, mother?' (*p3.5 As ek sê ek is gay hoe sal ma daaroor voel?*). She immediately came to the conclusion that this might be a possibility and knows that she will need to handle it somehow, but it did not make it easier: 'It will be difficult for me ... but if I think about our conversation now it seem to me an ever greater possibility. Oh, Erika, this is awful for me' (*Dit sal vir my moeilik wees, ... maar nou dat ek oor ons gesprek dink klink dit vir my al hoe groter moontlikheid; Ai, Erika dis vir my erg*).

Danie is the second of two boys. In exploring his background Danie's mother stated that neither of her children was planned. She explains that the reason was that her marriage with their father was very unstable. Financially they could not afford it and she did not want her children to be exposed to such unhappiness, regarding it as unfair towards the children. An interesting point is that her first child was rejected by the father, who stated that it is not his child. Danie was not rejected as someone else's baby and was accepted as his own. The perception from the father of Jacob not being his son caused a lot of turmoil and domestic violence for the mother and Jacob. Another fact is that after Jacob's birth the abuse of mother was only verbal but physical abuse also became part of their lives.

The mother's pregnancy with Danie was not pleasant: 'In short, it was not easy or pleasant for me' (*Kortom, dit was nie maklik of lekker nie*). The doctor stated that she is expecting a girl and six months into the pregnancy he realised this was not so. During those 6 months they had conversations with this unborn child as if it were a girl: 'For 6 months of my pregnancy the doctor thought it was a girl, and that's how we already started talking to 'her' and, yes, then we all had make a u-turn' (*Die dokter het vir 6 maande van my swangerskap gedink dit is 'n dogtertjie so ons het al met 'haar' begin gesels en ja toe moes ons almal ons koppe swaai*).

Four months after his birth Danie became ill. He had chest problems and high fevers, and was a colic baby. She explains that he was taking so much antibiotics and

cortisone but with little effect. At 10 months of age his one lung collapsed and he was hospitalised. To this day no reason was given as an explanation except that it was a virus. Danie was in and out of the hospital often and was taking cortisone for the first two years of his life: ‘... he was more in the hospital then anything else’ (... *hy was meer in die hospital as enigiets anderster*). She remembers that he was in hospital on his 1st birthday. That was the last time he was admitted to hospital, but it was also the longest period of 18 days. She stated that he hated to go there, because he was hurt so many times with needles that needed to be inserted in his body that to the day he has a phobia of needles. To nebulise him became part of their daily routine and the mother decided to quit her job to stay with him.

Danie struggled to eat and could not consume milk, which was replaced with rooibostee. After 6 months she decided to go back to her job on a temporary basis and she found a daycare facility that took care of him. They accepted him with love, although he still needed to be nebulised every four hours but the mother was at peace with leaving him there.

As a baby Danie was restless and unhappy when there was conflict at home: ‘... and if Jurie and I fight, then he became vry hysterical’ (... *as ek en Jurie baklei het, dan het hy baie histeries geraak*). Situations of conflict at home arose very often and included physical abuse from the father: ‘Very often, at least once every day’ (*Baie gereeld, ten minste elke dag*). The tension at home seemed intense and in a situation of conflict the mother always tried to keep Jacob (Danie’s brother) away from Jurie (Danie’s father), because of his dislike of the child. He favoured Danie and made it obvious: ‘... He would play with Danie, but when Jacob came he would push Jacon away, and if he drove to the café then only Danie could go with him and not Jacob’ (... *hy sal met Danie speel en as Jacob kom, dan stoot hy vir Jacob weg en as hy kafee toe ry mag net Danie saamry en nie Jacob nie*). This created jealousy and conflict between the brothers. In situations of violence the father would keep Danie away from his mother: ‘If we fight he says he will take Danie and go. Then Danie would cry terribly ... and his father doesn’t want him to come to me, and so then he becomes completely hysterical’ (*Hy sal as ons baklei sê hy vat nou vir Danie en gaan ry. Dan huil Danie verskriklik ... en sy pa wil nie hê hy moet na my toe kom nie, so ja, dan raak hy skoon histeries*).

The parents separated when Danie was 4 years of age, but his father moved back when Danie was in his Grade R year. The mother realised this was not the right decision and life became difficult and unstable again, with many incidents of physical abuse towards her and Jacob. Their unstable life continued and at the age of 9 Danie suddenly had an epileptic attack with no warning. Taking him to a neurologist the mother was puzzled as there was no history of epileptic seizures in their family. The neurologist explained that it can be caused by genetics, head injury and stress. He was put on medication to treat the seizures. In ruling out genetics and a possible head injury, she was left knowing that stress possibly caused this to happen. She took action and divorced their father. After the divorce the seizures suddenly just stopped. She explains that the negative experiences at home must have been too traumatic for Danie to handle, although he himself was never physically abused. He had to witness Jacob and the mother being hurt. The mother blames herself for allowing it to carry on for so long and feels very emotional and sad. She struggled to control her emotions and cried silently: 'I don't know why I allowed it to carry on for so long' (*Ek weet nie hoekom ek toegelaat het om dit so lank aan te hou nie*).

His mother describes his personality as: 'He is amiable and comes across as a child who needs recognition. If you praise him, you can actually accomplish the world with him' (*Hy is liefvallig en hy kom voor as 'n kind wat erkenning soek. As jy hom prys kan jy 'actually' die wêreld met hom uitgerig kry*). She experiences him as being somewhat impulsive, very talkative and sometimes not thinking before saying something. He is emotional and a pleaser and she feels 'it is not a good thing' as it makes him vulnerable and affects his self-concept, because he does not trust his own judgement. She concludes that she thinks that Danie is an under-achiever and that confidence, laziness and motivation appears to be his challenges.

4.5.2 EMDR sessions

4.5.2.1 Session 1

Danie appeared very insecure as he stepped into my therapy room: 'I don't really know what to expect' (*C1.2 ... ek weet nie eintlik wat om te verwag nie*). He is a very dramatic and verbal person and uses his whole body to communicate. He appears as if he is very happy and that he has nothing bothering him he said: 'I don't think I was

ever really happy. I laugh, but it's actually my mask' (C1.16 *Ek dink nie ek was al ooit gelukkig nie. Ek lag maar dis eintlik my masker*). I decided to have an introduction about ourselves to give him the opportunity to relax. It seemed to help because in his introduction he already gave an idea of his feelings towards his father: 'I also have a father but prefer not to see him again. I hope I never have to' (C1.3 *Ek het ook 'n pa maar verkies om hom nie weer te sien nie. Ek hoop nie ek moet ooit nie*). He rates his relationship with his father on a scale from 0-10 as a 0. He sees his father as a drunkard (*suiplap*) and a jailbird (*tronkvoël*) (C11.47). While talking about his father there was a visible anger on his face and his lips became white as he pulled them tight. His body appeared tense and he seemed uncomfortable in his chair. He asked me for some water. He finished two glasses one immediately after the other.

I learned more of Danie's personality from his discussion about himself. He loves food and Hospitality Studies is one of his subjects which he clearly enjoys. When talking about food, specially cooking, he relaxed more, changing his body posture and crossing his legs. It was clear that this was his domain of feeling successful. He loves cooking with his mother and feels like he has a good relationship with her: 'I get on very well with my mother' (C1.35 *Ek kom baie goed met my ma oor die weg*). He would not mind an occupation as chef, but was honest in stating that although he loves cooking, design and visual art are his first choices and therefore he was thinking of a possible career in graphic design. On an academic level Danie seems to struggle and the emotional problems were not helping. He was not keen at all to talk about his academic performance and answered those questions too briefly.

Danie decided to become part of this study because he was identified by one of his teachers with whom he regularly communicates about his problems. On an emotional level Danie seemed to deteriorate and his teacher initiated the action. Danie agreed not only because he knew that his teacher was not really qualified to help him any further, but he also felt that he was not coping anymore and felt powerless: 'I can't handle the pressure any longer. I have no energy' (C1.12 *Ek kan nie meer die 'pressure' 'handle' nie; C1.14 ... ek is sonder krag*). In questioning him about being powerless and what he think the reason is, he replied: 'Life' (C1.15 *Die lewe*). Danie took a while before he answered this question. It seemed that he was not sure what the core is and 'life in general' explained it in a nutshell. Life therefore appears to be a

battle which he feels he is losing and needs help. It was difficult for Danie to articulate where the trauma he was experiencing actually originated and he could not give enough factual detail or descriptions: 'But I don't know what it's all about; Just don't ask me now, but I cannot remember anything now' (C1.22 *Maar ek weet nie wat dit alles is nie; C1.24 Moet my net nie nou vra nie want ek kan nie nou iets onthou nie*). His face seemed troubled and worried.

I explained to him that sometimes we are not happy but do not know why. Our emotions are like clouds and situations in our life are like raindrops. A cloud consists of water and is created by tiny drops of water blown together by the wind. When you look at a very dark cloud you cannot see the different drops making the cloud – you only see the result (storm). We sometimes cannot see the drop of water but can only see the result, not being happy. Danie seemed to understand the metaphor and appeared more relaxed for not knowing why he feels as he does.

When I demonstrated the different forms of BLS, Danie seemed sceptical. He made a comment: "Gee, I have been to a psychologist before but never did anything like this' (C1.32 *Jis, ek was al by 'n sielkundige maar nog nooit sulke goed gedoen nie*), but decided to take the risk: 'I was a little scared, but no, it's cool. I will do it' (C1.33 *Ek was so bietjie 'scared' gewees maar nee dis 'cool'. Ek sal dit doen*). Danie has an older brother, but sees them as the opposite personalities. Danie describes himself as the 'arty' one and his brother seems to be excellent with numbers. Danie's perception is that numbers (and his brother) are superior to the ability to be creative (himself): 'He is brilliant at maths and I can't do maths' (C1.38 *Hy is briljant in wiskunde en ek kan nie wiskunde doen nie*). He rates his relationship with his brother as a 6/10. His relationship with his father is very poor and puts it on a scale of 0/10: 'No, if I never have to see that ... again it will be too soon' (C1.1.45 *Nee as ek daai ... nooit weer hoef te sien nie is dit te gou*). and he blames his father for the negativity in him and his mother's life: 'He is the cause of all my problems and my mother's. It's his fault that we ... are like this' (C1.46 *Hy is die oorsaak van al my probleme en my ma. Dit is sy skuld dat dit so ... met ons gaan*). Negativity and anger were easily visible. He raised his voice in becoming excited, moved his arms while expressing his feelings.

Danie elaborates on his feelings about his father as being an alcoholic who just wants to receive without giving: 'He doesn't pay child support and just asks for airtime. His

own family wants to have nothing to do with him' (*Hy betaal nie 'child support' nie en vra net 'airtime'. Sy eie familie wil niks met hom te doen hê nie*). There appears to be anger towards the father for projecting his uncertainties on him about who the father of his brother is. Danie's father told Danie that his mother does not love him, but only loves his brother. His mother realised what is happening and told Danie it is not true. After realising this is not true, he lost his faith in his father and it created feelings of shame because he had believed him: 'I think I hurt my mother very much and my brother too to believe that' (*Ek dink ek het my ma baie seergemaak en my broer ook om dit te glo*) and looks down, not making any eye contact and lowering his tone of voice; he feels stupid and angry shaking his head: 'I wish he will die. He must go to hell' (*1.48 Ek wens hy wil vrek. Hy moet hel toe gaan*).

As mentioned earlier, Danie's life seems to deteriorate on all levels life. His academic performance is poor and he is very insecure and does not know who he is. It was difficult for Danie to verbalise the uncertainty about his gender preference. He never told anyone before. He does not know what to think or what to do: 'I'm not sure how to handle this' (*1.65 Ek is nie seker hoe om dit te 'handle' nie*). He just knows it is affecting him negatively and creating confusion about his identity: 'I can probably say this but I don't know who I am, and it's driving me crazy' (*C1.56 Ek kan dit seker maar sê maar ek weet nie wie ek is nie. Dit maak my mal*) and: 'For the first time I have this weird feeling about guys. I can't keep it in any longer and it confuses me' (*C1.1.57 Ek het vir die eerste keer die 'weird' gevoel oor ouens. Ek kan dit nie meer langer inhou nie en dit maak my deurmekaar*). For Danie to think about telling his family specially his brother creates fears of rejection from the family: 'You know, he is like people who are racist, he is like that about gays. He will never talk to me again. It will be a big thing in our family' (*C1.63 Tannie hy is soos mense wat rassisties is, is hy oor gays. Hy sal nooit weer met my praat nie. Dit sal 'n groot ding in ons familie wees*). This is because he already experiences himself as being the one who does everything wrong: 'I am the one who is always wrong and not my brother. And my mother always takes my brother's side. It's always been like that' (*C1.64 Ek is die een wat altyd verkeerd is en nie my broer nie. En my ma vat altyd my broer se kant. Dit was nog altyd so*). He seemed desperate, with eyes wide open and looking me straight in the eye, not to allow that to happen.

In probing his primary school years Danie could sum it up in one word 'boring' and seems to have only negative emotions about experiences at primary school: 'I was at Fonties and hated it. That's a really crap school' (C1.67 *Ek was in Flarries gewees en ek het dit gehaat; C.69 Dis nou 'n 'crap' skool*) and: '... I never fitted in' (C1.69 ... *ek het net nooit ingepas nie*). When thinking about primary school a dominant theme seems to be 'I do not fit in'. 'Do not fit in' included information about being bullied: 'You're really stupid' (C1.79 *Jy's lekker dik*) and being labeled as gay without himself sharing the same idea about his identity. It is only now that he seems to be trying try and accept it and he struggles to know whether he is really gay or not, because that was the message he received over years. He shares such an incident: 'Who asked your opinion, rather go stand with the girls' (C1.79 *Wie't jou opinie gevra, gaan staan liewer by die meisies*). Again he struggled to recall similar situations and felt uncomfortable for not be able to do so. He fell back on the couch and sighed in disappointment for knowing there are so many things to recall but failing to do so.

In high school the situation doesn't seem to be any different. In a more recent incident he was humiliated in front of a group by his peers: 'We were all sitting at the steps ... I was also talking and the one guy says to me "Keep quiet you, what do you know?" It was sooooo humiliating!' (C1.84 *Ons het almal by die trappe gesit ... Ek het ook gepraat en toe sê die een ou vir my "Sjuut jy, wat weet jy?" Dit was sooooo 'humiliating gewees!'*) This incident seemed to be the last straw and created feelings of rather dying. This situation was the one we decided to start off with in our next session, as he could not think about other traumatic incidents that caused feelings of insecurity and the depressed mood.

4.5.2.2 Session 2

At the beginning of our session Danie seemed uneasy and uncomfortable. In questioning him about his week his comments was: 'I got back some of my marks and they are a disaster. My mother is like way beyond furious. I don't know' (C2.3 *Ek het van my punte teruggekry en dit is 'n 'disaster'. My ma is soos 'way' verby woedend. Ek weet nie*). Danie needed to be calmed down and relaxed to be able to continue with the session. We did some relaxing exercises and created a safe place while soft music was playing in the background. His emotions stabilised and he appeared relaxed and focused. Knowing that he can go to his safe place whenever he needed

to was reassuring and his comment on this experience was positive: 'It's awesome!' (C2.18 Dis 'awesome!'). Danie appeared to be ready for EMDR, but knew he may stop at any given time when he feels the need to.

In our previous session the image at school where Danie felt humiliated was chosen to target first. Although I knew, after the parent interview, of several other situations that might be the main target, I had to respect and guide Danie to feel safe enough to share what he feels comfortable with or could remember. The image he chose was a recent event where he was humiliated in front of his friends: 'We were all sitting at the steps and everyone was sitting and chatting about, I can't even remember what, what the one guy says to me "Keep quiet you, what what do know?"' (1.84 *Ons het almal so by die trappe gesit en almal sit en gesels oor, ek kan nie eers onthou nie. Ek het ook gepraat en toe sê die een ou vir my "Sjuut jy, wat weet jy?"*). Danie stated a NC for this incident, 'I am not important' with a SUD of 1. I asked Danie how he would like to change the NC into a positive (PC) and he decided on 'I am important with a VOC of 2.

After a set of BLS (he chose the tapping procedure) with the image, he reported that there is no change and does not get any other image or feeling. He appeared worried that no change took place and I could see that he thought that maybe he was doing something wrong. I explained that we continue with what is given and there is nothing to worry about and that it is normal. He sighed out of relief but was not completely relaxed and we continued. The fact that there was no change gave me an indication that this could be a blocked belief. The blocked belief was addressed by giving that humiliated emotion a mouth to speak. In this experience Danie avoided conflict and did not set his boundaries but kept quiet. When we gave 'humiliation' a mouth, he verbalised and took action (BLS) while verbalising.

I initially had to guide Danie to voice comments:

(2.43 Stop doing that - *Hou op daarmee*)

(2.44 Stop doing that - *Hou op daarmee*)

In releasing some energy with the BLS, he was able to continue with his own expression of his inner feelings, setting a boundary and facing the conflict: 'I hate you

all! You think you are better than others. This ... this ... just stop it. Stop humiliating me like this! (2.45 *Ek haat julle! Julle dink julle is beter as ander. Dis ... dis ... hou net op. Hou op om my so te 'humiliate'!*). After the BLS Danie's feelings of hatred and humiliation were less intense and he moved his SUD level to a 4.

He then gave an image of a situation of domestic violence: 'I remember when my mother and my father were angry with one another and he hit her. I try to get him off of her because he usually listens to me. This time the dude did not! I screamed at him "Leave her along". He did not listen and pushed her into the cupboard. Yes, it was really hectic. I hated him' (2.50 *Ek onthou toe my pa my ma kwaad was vir mekaar en hy haar geslaan het. Ek het probeer om hom van haar af te kry want hy luister gewoonlik na my. Hierdie keer het die 'dude' nie! Ek het vir hom geskree "Los haar uit". Hy het nie geluister nie en haar in die kas gedruk. Ja, dit was baie 'hectic'. Ek het hom gehaat*). BLS. An image surfaced of another domestic violence situation, but this one was different in the sense that his mother blamed him for what happened: 'I remember another fight when my mother said to me after the fight you are the reason why we got stuck into one another and why we are fighting' (2.51 *Ek onthou 'n ander 'fight' waar my ma vir my na die 'fight' gesê het jy is die rede hoekom ons nou vasgesit het en hoekom ons nou 'gefight' het*). The NC for this image was 'I am stupid and do everything wrong'. His NC was 10 and his VOC was a 4 for the PC 'I am creative, take initiative and can think.' I asked Danie if he is aware of any body sensations and he said: 'I feel shivers here in my arms and here in my neck and then in my hands ... they are literally shaking' (2.60 *Ek kry rillings hierso in my arms en hierso in my nek en dan my hande ... dit skud letterlik*). Danie expressed the effect this image had on his body with a lot of sincere emotion.

Danie's next image was where he states he feels: 'half depressed.' (C2.62 *Half 'depro'*). Lying on his bed and wondering why God allowed him to be alive. After a set of BLS he just expressed feelings of sadness and sees himself cry. The feelings of sadness seemed to be relieved after another set of BLS: 'I still feel sad but not so hectically sad' (C2.64 *Ek voel nog 'sad' maar nie so 'hectic sad' nie*). This situation also appeared to block further progress. I guided him to face his mother with this sadness that was caused in the situation and allowed him to express his true emotions. He needed to be heard and not be silenced again. This time Danie used his

own words from the start: 'Mom, you are making me feel heartsore. It's like a knife if you say it. I just wanted it to stop. It hurt me a lot' (2.65 *Ma jy maak my hartseer. Dis soos 'n mes as jy dit sê. Ek wou net hê dit moet stop. Dit het my baie seer gemaak*).

The confrontation with mother relieved the sadness, but his body became shaky as an aftershock, which gave an idea of how difficult it was to face his hurt: 'I don't feel sad any longer but ... hmmm shaky?' (2.67 *Ek voel nie meer sad nie maar ... hmm 'shaky'?*). The body sensation he expressed was described as an internal feeling, but to me it was visible from the outside. His whole body was shaking and he appeared very pale. After another set of BLS the shaky feeling disappeared. He seemed tense, though.

When returning the image where mother blamed Danie for the fighting in their house, Danie stated that the SUD was 1 and that he knows it was not his fault. He said: 'I actually always knew but it's as if I did not believe it. Now I believe it. She was also just coping herself' (2.69 *Ek het eintlik altyd geweet maar dis asof ek dit nie geglo het nie. Nou glo ek dit. Sy het maar net self ook 'gecope'*).

Shifting to the image of domestic violence where his father tried to push his mother into the cupboard, he says it was a bad situation, but it does not bother him anymore and moved his SUD to a 1. When looking into his PC of wanting to be creative, taking the initiative and be able to think for himself, he moved his VOC to a 7. He realised that he is actually cool, because it seems that he has always been like that: 'Well, 7, because I am creative and, yes, I show a lot of initiative in my art and I can think for myself. It actually feel cool. It was actually always like this' (2.72 *Wel 7 want ek is kreatief en ja ek het baie inisiatief in my kuns en kan vir myself dink. Dit voel 'actually cool'. Dit was eintlik nog altyd so*). At this moment in time Danie's body reached a state of equilibrium and he seemed to have gained control.

Moving back to the image of where Danie felt humiliation, he said that the humiliation was gone. He was amazed because he was rationalising that he knew they said it and he cannot change it, but somehow it does not bother him anymore. His PC of 'I am important' and moved to a VOC of 7 and his comment was: 'I am important and I feel good that I could say what I feel' (*Ek is belangrik en ek voel goed dat ek kon sê wat ek voel*).

Following the body scan his comment was: 'No, I am peaceful, very peaceful' (2.76 *Nee ek is 'peaceful', baie 'peaceful'*). The future template that Danie chose was almost the same scenario where his peer group might want to ignore him. In his mind he did a 'role play' imagining what he would do: 'I said to them, no, just stop this. It is very rude to talk when someone else is talking. I don't like it and stop it now' (2.79 *Ek sê vir hulle nee stop net hierso. Dis bitter ongeskik om te praat as iemand anders praat. Ek hou nie daarvan nie en dit stop nou*). He laughed and confirmed that they apologised and stopped and mentioned that he feels 'awesome'. End of session.

4.5.2.3 Session 3

In session 3 positive reactions in Danie's life already became evident. Danie appeared much more relaxed. He was sending out signals of feeling secure, happy and contented. His face was blooming and could not wait to tell me about what he experienced. In questioning him about the past week he was just smiling. While smiling he told me about good and bad things that happened. He shared the good first, which came as a shock to me because this was the very last thing I was expecting. He was in love and it was with a girl. He also seemed surprised but contented: 'It's a girl. But just wait. I can't believe it myself, but yes it's the first time that I feel like this. She is now my girlfriend. It's sooo funny. Everyone at school look at me weirdly, because we hold hands during break. Because everybody thinks I'm gay' (C3.5 *Dis 'n 'girl'. Wag nou tannie. Ek kan dit self nie glo nie, maar ja dis die eerste keer dat ek so voel. Sy is nou my meisie. Dis soo snaaks. Almal by die skool kyk my 'weird' uit want ons hou hande vas pouse. Almal dink mos ek is 'gay'*). He warns, though, that it does not mean that boys are not 'sexy' anymore: 'They are still sexy, but I think it's only now that I'm in love' (3.6 *Hulle is nog steeds 'sexy' maar ek dink ek is nou eers verlief*). It seemed that he enjoyed the new attention he was receiving and I sensed a feeling of belonging. At home his mother, brother and grandmother are excited about this new direction.

When recapping Danie said that he hasn't had a nightmare again and we discussed last week's images again. The image 'I am stupid and do everything wrong' with the image of his mother blaming him for the fight with father was clear. His SUD was a 1 and his VOC a 7. Danie confirms that he has been successful this whole week. He

elaborates by stating that there was an overflow of creativity. This week he started his project immediately.

The bad thing that happened to Danie this week was an earlier memory that came to his consciousness. It was a memory of a bully in primary school. He describes him as acting as if he is good, but in fact is Satan: 'I did not like him at all. He always acts as if he's the good guy, but he is actually Satan' (3.20 *Ek het niks van hom gehou nie. Hy het altyd 'geact' asof hy die 'good guy' is maar hy is eintlik die Satan*). This was his first memory of being bullied in primary school. The memory of this boy triggered an incident in primary school which was disturbing for Danie. He was in Grade 6 or 7 at that time.

The image he described was of the whole class who were watching a video in Art period. This bully was seen as a 'jock' who pretends to be good but instead he is bad, Satan. They did not realise he was sitting in front of them and they were talking about him. The boy wasn't expecting Danie and Danie turned around and then left the classroom. He went to the men's room and started crying; on his way there thoughts were crossing his mind and he was seeking answers for being here: 'Why? Why am I here?' (3.27 *Why? Hoekom is ek hier?*). He chose an NC of 'I am pathetic'. The SUD was on a level 20. Danie stated a PC of 'It is OK to be me' with a VOC of 2 and expressed emotions of sadness, feeling pathetic and having a headache.

After a set of BLS the image in the boy's room remained the same. I repeated BLS and he confirmed changes: 'It feels as if the chair is going round in circles; I am no longer spinning' (3.38 *Dit voel asof die stoel in die rondte draai; 3.39 Ek spin nie meer nie*). When checking the SUD of the image 'I am pathetic', Danie confirms a 4. In asking him what he think needs to be done to change the 4 to a 1, he replied that he does not know (this could be a blocked belief and, by using a cognitive interweave, the block might be lifted).

A cognitive interweave was implemented. I suggested we give that 4 a voice to tell us why this is not a 0: 'He says I am emotionally damaged' (3.43 *Hy sê ek is 'emotionally damaged'*). Danie states that primary school was a big part in his life of being emotionally damaged, but unfortunately he cannot remember many incidents leading to this feeling. He mentions an image of sadness but did not seem confident about

claiming it as an image of being emotionally damaged. The same image of lying on his bed and questioning his existence became prominent again. He gave a SUD of 10 for the sadness. After a set of BLS he said he feels tense and feel impulses down his back. After another set of BLS, Danie mentioned that the tense feeling in his back is replaced with a weird feeling in his feet. Danie experienced the changing of the somatic feelings in his body as funny but interesting. The whole process of EMDR, with emotions that can change or disappear immediately, became more natural and familiar. After another set of BLS he felt nothing in his body and no more sadness. The image of sadness felt 'far away'.

Bringing his mind back to primary school, he says he can only think of du Toit, the bully, and that he has no effect on him anymore. In fact he claimed, with confidence, that du Toit is the one that seems pathetic and not him, and that du Toit is actually not important in his life: 'I mean he has no effect on who I am' (3.59 *Ek bedoel hy het geen effek op wie ek is nie*). Moving back to the term 'emotionally damaged' did not trigger such a high rating on the SUD. Danie decided on a 4/10, which is a shift of 6.

Danie seemed puzzled and in my mind I was wondering if Danie knows what the term 'emotionally damage'd meant and that it might help to use other words to try and identify a target to bring the SUD down completely. Therefore I asked him to explain the meaning of the term 'emotionally damage'. He hesitated and replied after a while: 'Hmmm, I think it is to be hurt and it's not your fault and you don't know how to repair the damage. There are scars' (3.63 *"Hmmm ek dink dis om seergemaak te word en dis nie jou skuld nie en jy weet nie hoe om die 'damage' weer reg te kry nie. Daar is 'scars'*). Danie struggled to find an image, but gave explanations such as 'it's confusing' and 'Bruin modderspul'. I decided to stay with the 'modderspul'. We did a set of BLS and he said it's gone. After the body scan, Danie replied that he does not feel anything. The moment I asked him to focus on the term 'emotionally damaged' he said he suddenly feels angry.

After one set of BLS he got an image where he experiences frustration from his mother: 'I'm getting where my mother and father are fighting again and she is irritating me because she gets a restraining order against this dude and the next day she goes and picks him up at the police station. What mixed messages doesn't that send? I mean she gets a restraining order against him that says to him "Listen, stay out of my

life, I don't want you near me", and then she goes and fetches him at the police!' (3.71 *Ek kry waar my ma en pa baklei weer en sy irriteer my want sy kry 'n 'restraining order' teen hierdie 'dude' and dan die volgende dag gaan tel sy hom op by die polisie. Watse 'mixed signals' gee dit nie net vir jou nie. Ek bedoel sy kry 'n 'restraining order' teen hom, wat vir hom sê "luister, bly uit my lewe uit. Ek soek jou nie naby my nie" en dan gaan tel sy hom op by die polisie!)). The mixed signals create confusion and cause damage: 'It is so uncertain; And it damages a person' (3.72 *Dit is so onseker*; 3.73 *En dit 'damage' mens*). His SUD for the NC 'I am emotionally confused' was 10. He stated a PC of 'I am emotionally secure' with a VOC of 4. After a set of BLS Danie replied: 'I think my mother is more emotionally confused. She is confused, not me' (*Ek dink my ma is meer emotionally confused. Sy is 'confused', nie ek nie*).*

Danie said that he feels much more relaxed, but it is not a 1 yet. His SUD moved to a 2. He moved his PC to a 5. He elaborates by saying that his emotional security is much stronger and has no more feelings of rather being dead; he is happy and successful at school in his art and design subjects. He feels that there is such a big change in his life already that he cannot think of anything that still needs to change. We did a body scan, which was clear. I decided to end the session at this point.

4.5.2.4 Session 4

There was a two-week interval between sessions 3 and 4. In those two weeks a lot of changes took place. I could see that Danie became more confident because he was experiencing some successes in his life. He was head chef at a restaurant evening and he felt very successful. His maths scores improved by 10% and he had a distinction for Art. He was very impressed with himself as this was his very first distinction in high school.

In the two weeks Danie made a discovery that, although he likes his girlfriend very much, he doesn't feel the spark any longer: '... so there we were in my room kissing and what not. There was just not that sparks feeling' (4.10 *... toe is ons daar in my kamer en gesoen en wat ookal. Dit was net nie daai 'sparks' gevoel nie*), but was in a situation of not knowing how to end the relationship. His first thought was to just send her an sms in trying to avoid conflict. His whole body showed that he knew that this option was the wrong one; he gave a shy smile and seemed ashamed for considering

it. He then decided to do the right thing. He stated it as; 'I need to face up to it' (4.13 '*I need to face up to it*'). He faced the difficult situation and had a honest open discussion and shared his true feelings. She was hurt but accepted it and thanked him for being honest. Being successful in facing up to difficulties had a positive effect on his self-concept. He started verbalising positive comments about himself: '... that cool, isn't it? Oh, I'm stunning, aren't I?' (4.16 ... *dis 'cool' né? Ai, ek is 'stunning' is ek nie!*), just as his mother described him to have been earlier. It seemed that Danie was beginning to become the friendly, talkative person again. Another positive change was that Danie did not feel that life is not worth it anymore. He was not thinking about suicide anymore and still has no more nightmares.

The NC of 'emotionally damaged' moved to a SUD of 1. Emotionally secure moved to a 6. The image of mother sending out mixed signals still creates confusion in Danie about whether she is happy about his behaviour or disappointed: 'Like this gay thing. Sometimes it seems as if it does not worry here and other times it seems as if it is unacceptable to her' (4.33 *Soos hierdie gay ding. Partykeer lyk dit of dit haar nie pla nie ander kere lyk dit of dit vir haar onaanvaarbaar is*). This uncertainty prevents him from having an open discussion with his mother or anyone else. Thus being a disappointment became his next image with an NC 'I am a disappointment'. The recalling of his next memory came with no delay. He shared an experience in a shopping mall. He was with his father while his mother waited at a coffee shop. Danie collects action figures and his father agreed to buy him one. He chose a female action figure like before: '... when I was small I looked for a toy, but then I usually went like for the female action figures' (4.43 ... *toe klein was dan soek ek 'n speedling, maar dan het ek gewoonlik soos vir die meisie 'action figures' gegaan*). When returning to his mother and showing her the action figure, her face seemed disappointed: 'When I took it out and showed it to her, she gave me this half dirty look, half sort of like disappointment' (4.44 *Toe ek dit uithaal en ek wys dit vir haar, toe gee sy vir my hierdie half vuil kyk, half soos van 'disappointment'*). His SUD for the image is a 10. Danie struggled to state a PC and only knew that he does not want to experience that look on his mother's face again. At this time Danie needed to drink some water again and I could sense that this is a difficult and stressful situation. He ended up needing to choose whether rejection or accepting fitted the image best. He rationalised that acceptance from others he had no control over. 'It's probably not up to me, is it? It's up

to the people around me' (4.53 ... *dis seker nie 'up to me' nie, is dit? Dit is 'up to people' om my*). For me this was a good change in his cognition, because previously he seemed to be a pleaser and now he is not willing to play along. After discussions he came up with a PC which he feels comfortable with 'It is OK to be myself.' His VOC was a 3.

After two sets of BLS together with his NC 'I am a disappointment', he became aware of a body sensation - 'tingles' in his neck, moving to his fingers until they vanished and the body scan was clear. He experienced these sensations with much more seriousness on his face than in previous sessions. In returning to the NC of being a disappointment, the SUD remained a 10 and activated an experience when he was in primary school on a choir camp. It was his first camp, but interestingly, although the experience was 'horrible', he was not the disappointment but someone else disappointed him: 'I did not disappoint anyone; I mean it was a horrible experience, but someone disappointed ME' (4.65 *ek het nie iemand 'disappoint' nie ek bedoel dit was 'n 'horrible' ervaring maar iemand het MY 'disappoint'*).

He described his experience as being bullied. They were six boys sharing a room. When he and another boy entered their sleeping quarters the other four were there already. He knew the one was a bully. As they entered the room the bully shouted: 'Arses against the wall! Be careful if the gays get hold of you' (4.66 *Gatte teen die muur! Pasop as die gay's jou beet kry*). At first Danie could not grasp what was going on, but when the other four were standing against the wall with their backs leaning against the wall, he knew what they meant. The four boys were laughing and the feeling of humiliation and disappointment towards the three boys sharing this view with the bully was difficult to handle. The moment the bully left the room, the other three boys stopped the bullying and were friendly: 'When Gert walked out the others were friendly again with us as if nothing had happened, but the moment Gert came in they laughed and mocked together' (4.66 *Toe Gert uitloop toe is die ander weer vriendelik met ons asof niks gebeur het nie maar die oomblik wat Gert inkom lag hulle saam en spot saam*). He mentioned that: 'Chris was also a friend but then he dropped me. He caved in to peer pressure' (4.67 *Chris was ook vriende maar toe het hy my 'gedrop'. Hy het geval vir die 'peer pressure'*). After a set of BLS, Danie moved to an image where he was a disappointment. The disappointment was not for being gay, but

rejecting a friend, just as Chris did because of his low self-concept of not being in his 'league'.

He made friends in Grade 8 with a guy who did not judge him at all. Danie constantly lacked trust that this boy really wanted to be friends with him because of who he is. He knew he wasn't gay, although a lot of people thought he was. Danie liked him because he was a 'cool dude' but also thought, 'I am not in his league' and therefore he rejected the friendship: 'I always have to be on my guard. I cannot believe that someone likes me. I feel I'm not in their league' (4.71 *Ek moet altyd op my hoede wees. Ek kan nie glo dat iemand van my hou nie. Ek is mos nie in hulle 'league' nie*). This experience haunted him for a long time and it surfaced again in Grade 9 when they watched a video at school of almost the same situation he was in and he could identify with the character. Feelings of despair towards himself for ruining an honest friendship were disappointing. He felt sadness for his behaviour and this resulted in a new cognition of 'I am not worthy'. His SUD level was a 7 and his VOC for the PC 'I am worthy' was a 4.

During the session and BLS he experienced feelings of depression, which were desensitised. His SUD moved to a 1 and his VOC to a 7. After his body scan he said his body is at peace: 'I am at peace; Gee, I must tell you a mountain has been lifted from my body' (4.87 *I am at 'peace'*; 4.88 *Jis tannie 'n berg is van my lyf af*). Every image and cognition identified was clear except deciding about his gender preference. He did not feel ready to make that decision yet: 'I'm not sure but I feel OK about what we discussed about not deciding now. I'm not fretting about that anymore. I don't have to decide now. At the moment I don't want to go into a serious relationship and I find the girls and the guys are cool and sexy (Tannie ek is nie seker nie maar ek voel OK met wat ons gesels het om nie nou te besluit nie. Ek tob nie meer daaroor nie. Ek hoef nie nou te besluit nie. Op die oomblik wil ek ook nie in 'n 'serious' verhouding gaan nie en die 'girl's' en die ouens is vir my 'cool' en 'sexy'). He expressed his need to go and make peace with this friend and we made a future template to clear the air and to see himself in a similar situation: 'Easy. It's going to be easy; I'm positive and handle things positively. It's the new me' (4.91 *easy. Dit gaan maklik wees*; 4.94 *I am positive and handle things positive. It's the new me*).

4.5.3 Findings

4.5.3.1 Emotions

Themes under the category of emotions Anger, hate, humiliation, sadness, rejection, fear and body sensations connected with emotions felt during the EMDR sessions.

In our first session Danie expressed that he feels he is drowning and cannot handle the pressure anymore: ‘... I always deal with my issues and I have many ... But I feel as if I’m drowning and I can’t handle the pressure any longer’ (1.12 ... *ek ‘handle’ nog maar altyd my ‘issues’ en ek het baie ... Maar ek voel ek verdrink en ek kan nie meer die ‘pressure handle’ nie*) and it makes him angry: ‘I think angry. I don’t fit in and that makes me angry; that’s why it’s beter if I’m rather dead (1.87 *Ek dink kwaad. Ek pas nie in nie en dit maak my kwaad dis hoekom dit beter is as ek liewer dood is*). In exploring the triggers for feeling powerless, the theme of anger became central to a lot of situations and various other emotions that Danie was exposed to.

Danie’s anger was initially directed towards his father: ‘He is the cause of all my problems ... it’s his fault that everything is so shit with us. I wish he will die. He must go to hell’ (1.46 *Hy is die oorsaak van al my probleme ... dit is sy skuld dat dit so kak met ons gaan. 1.48 Ek wens hy wil vrek. Hy moet hel toe gaan*). He feels anger towards father for not supporting their family. He as an adult does not give but only wants to receive: ‘He does not pay child support and just asks for airtime’ (1.49 *Hy betaal nie ‘child support’ nie en vra net vir ‘airtime’*). Domestic violence increased the feelings of hate towards his father: ‘... I screamed at him “Leave her alone”. He did not listen to me and pushed her into the cupboard ... I hated him’ (2.49 ... *ek het vir hom geskree ‘Los haar uit’. Hy het nie na my gelusiter nie en haar in die kas gedruk ... Ek het hom gehaat*). Danie’s father knew that he feels jealous about the attention mother gives to his brother. He used that as a weapon to bring conflict between him and his mother, resulting in anger towards his mother: ‘He knows I always felt my mother gives too much attention to my brother. He said to me my mother does not love me, she just loves my brother’ (1.49 *Hy weet ek het altyd gevoel my ma gee te veel aandag aan my boetie. Hy het vir my gesê my ma is nie lief vir my nie sy is net lief vir my broer*). He then shifts his anger towards himself for believing his father after a

discussion with his mother: 'Now I want nothing to do with him. I believed him' (1.51 *Nou wil ek niks met hom te doen hê nie. Ek het hom geglo*). Anger towards his mother was raised again after an incident of domestic violence and mother sends out 'mixed signals'; '... she irritates me because she gets a restraining order against that dude and the next days she picks him up at the police station. What mixed signals does that not send?' (3.71 *... sy irriteer my want sy kry 'n 'restraining order' teen hierdie 'dude' en dan die volgende dag gaan tel sy hom op by die polisie. Watse 'mixed signals' gee dit nie net vir ou nie*). Situations like this incident created confusion in Danie and he explained this as being 'emotionally damaged': 'And that damages a person' (3.73 *En dit 'damage' 'n mens*). He then internalises the anger and a perception of 'I do not fit in' evolved after having been bullied in primary school several times and labeled as gay: 'They were talking about me andsiad I'm gay' (3.26 *Hulle het van my gepraat en gesê ek is gay*). A negative cognition of not being important: 'I think ... I'm pretty much not important' (2.25 *Ek dink ... ek's 'pretty much not important'*) developed.

Feeling humiliated is the first emotion Danie decided to explore that made him feel angry. The first incident of humiliation he mentioned was in high school in this current year (*Ek het ook gepraat en toe sê die een ou vir my "Sjuut jy, wat weet jy?" ... dit was sooo 'humiliating' gewees*). In sharing this incident Danie's face appeared upset. He raised his voice to express the intensity of the experience. He moved his body forward and used his hands while talking. Stress was evident around his mouth and his lips were shaking. He almost cried: 'Angry too. I mean, they are not better than I am!' (2.30 *Kwaad ook. Ek meen hulle is nie beter as ek nie!*).

Danie's memory of primary school is of hate and humiliations and sadness, also eliciting feelings of anger: 'I was at Fonties and hated it! That's a crap school' (1.67 *Ek was in Flarries gewees en ek het dit gehaat!*; 1.68 *... dís nou 'n 'crap' skool!*). One specific child he described with a lot of disgust and anger: 'He always acted as if he is the good guy but he is actually Satan; He was a bully. He bullied me' (3.20 *Hy het altyd 'geact' asof hy die 'good guy is maar hy is eintlik die Satan*; 3.21 *Hy was 'n boelie. Hy het my geboelie*). An earlier memory of humiliation by his peers was of primary school: 'They talked about me and said I was gay ... so I sat down just there and cried ... with my hands over my eyes in a crouching position; Damn, where did I ever give you the idea that I was gay? It was so humiliating; ... we were friends but

then he dropped me!' (3.26 *Hulle het van my gepraat en gesê ek is gay; 3.26 ... toe gaan sit ek net daar en ek huil; 3.27 ... met my hande oor my oë in 'n 'crouching position'; 4.66 'Flip waar het ek jou al ooit die idêe gegee dat ek gay is? Dit was so 'humiliating'; 4.67 '... ons was vriende maar toe het hy my 'gedrop'!*).

Danie experienced fear mostly of rejection for disappointing himself and others. Although Danie does not have a good relationship with his brother, he fears being rejected by him if he told him he is gay: '... if my brother ever had to find out ... He will never talk to me again' (1.63 *... as my broer moet uitvind. Hy sal nooit weer met my praat nie*). He feels he has been disappointing his mother and fears another disappointment if he reveals his own fears about his possible gender preference: '... this gay thing. Sometimes it seems as if it will not worry her, but at other times it seems as if it will be unacceptable to her; I'm frightened by how she will react; I really just don't want to disappoint her. And I already have so much' (4.33 *... hierdie gay ding. Partykeer lyk dit of dit haar nie sal pla nie ander kere lyk dit of dit vir haar onaanvaarbaar is; 4.36 Ek is bang oor hoe sy sal reageer; 4.37 Ag ek wil net nie haar 'disappoint' nie. Ek het al so baie*) and rejection: 'that she will not accept me' (4.47 *Dat sy my nie aanvaar nie*). Danie also felt disappointment towards a friend who could not resist peer pressure in a situation where he was bullied: 'Chris and I were also friends but then he dropped me. He caved in to peer pressure' (4.67 *Ek en Chris was ook vriende maar toe het hy my 'gedrop'. Hy het geval vir die 'peer pressure'*). Being rejected by others became part of his life but when a situation arose where he realised he also rejected a friend, he said feels 'bad' and that he 'ruined a honest friendship' and the rejection was because of him not feeling worthy: '... I pushed Freek away from ME juist because I could not believe he wanted to be friends with ME. I feel I'm not in their league' (4.72 *... ek het Freek van MY af weggestoot net omdat Ek nie kon glo hy wil met MY vriende wees nie; 4.75 Ek voel nie in hulle 'league' nie*).

Danie feels sad in a situation where he tried to support his mother during an incident of domestic violence and blamed by her as his fault for what happened: 'I tried to stop it ... and then my mother says to me "Do you see what you've done now". I was so sad and just cried' (2.62 *Ek 'try' om dit te stop ... en toe sê my ma vir my 'Sien jy nou wat jy gedoen het; 2.63 Ek is so 'sad' en huil net*) and: 'My mother makes me feel heartsore. It's like a knife if you say it. I just wanted it to stop. It hurt me very much'

(2.65 *Ma jy maak my hartseer. Dis soos 'n mes as jy dit sê. Ek wou net hê dit moet stop. Dit het my baie seer gemaak.*) Feelings of depression were mentioned: 'I feel depressed' (1.12 *Ek voel 'depressed'*) and: 'I just know I'm not coping' any longer (1.13 *Ek weet net ek 'cope' nie meer nie*). He also feels depressed when he does not see any reason for being created: 'Why was the Lord so keen to give me life? What is its purpose?' (2.62 *'Why' het die Here my so graag in die lewe ingebring? Wat is die doel daarvan?*). Being bullied by his peers, several times created an enormous amount of sadness: 'Everything was awful but what was most awful, what stands out, is where I'm sitting in the bathroom and crying' (3.30 *Alles was erg maar die ergste was of wat uitstaan is waar ek in die badkamer sit en huil*). His behaviour explains the intensity of the sadness he experienced: '... I could feel how I started crying ... so I sat just there and cried; I sat there with my hands over my eyes in a crouching position' (3.27 *... ek kon voel hoe ek begin huil ... toe gaan sit ek net daar en ek huil; 3.27 Ek het net daar gesit met my hande oor my oë in 'n 'crouching position'*).

Danie experienced intense body sensations during the EMDR process. The body sensations connected with Danie's traumatic experiences were: shivers down his neck, arms and hands; headache; feels if his chair spins around; tense prickles in his neck and a weird feeling in his neck; confusion; tingles in his neck. Bilateral stimulation cleared the negative sensations in his body and he mentions a positive sensation of the whole body being peaceful.

4.5.3.2 Self-concept

Danie seemed to experience a crisis not knowing who he is: 'I can probably say this but I don't know who I am' (1.56 *Ek kan dit seker maar sê maar ek weet nie wie ek is nie*). His identity was in danger and he was pondering on the thought of being gay: 'For the first time I had this weird feeling that I feel something for guys ... it confused me; I don't know whether I'm gay or not; ... and I've been wondering for a long time actually' (1.57 *Ek het vir die eerste keer hierdie 'weird' gevoel dat ek iets voel vir ouens ... dit maak my deurmekaar; 1.61 Ek weet nie of ek gay is nie; 1.81 ... ek wonder al van lankal af eintlik*) which creates an enormous amount of confusion: 'It really confuses me' (1.57 *... dit maak my baie deurmekaar*). His confusion about his identity intensifies when he gets involved in a relationship with a girl, but still

experiences males as 'sexy': 'They are still sexy but I think it's only now that I'm in love' (3.6 *Hulle is nog steeds 'sexy' maar ek dink ek is nou eers verlief*).

Danie does not seem to be happy in relationships. Relationships with significant others influence Danie's self-concept negatively. Although he describes his relationship with his mother as 'good': 'I get on very well with my mother' (1.35 *Ek kom baie goed met my ma oor die weg*) their relationship is negatively influenced by perceiving himself as a disappointment for her: 'The disappointed look from my mother' (4.46 *Die 'disappointing look' van my ma*). Danie's low self-esteem is also illustrated in how he perceives himself in connection with his brother: 'He is brilliant in maths and I can't do maths; and I'm the one who is always wrong, not my brother ... my mother always takes my brother's side. It has always been like that' (1.38 *Hy is briljant in wiskunde en ek kan nie wiskunde doen nie; 1.64 ... en ek is die een wat altyd verkeerd is en my broer nie ... my ma vat altyd my broer se kant. Dit was nog altyd so*). Not feeling part of something creates insecurity and affects your self-concept negatively. He never felt part of the group in primary school: 'Why, why, how did I sin to end up like this?' (3.46 *Why, why, wat het ek gesondig om hier te beland*).

During the sessions with Danie several themes emerged that influence his self-concept.

Theme one: 'I am not important'

Humiliation in front of his friends made Danie feel that he is not important, because everyone else's comments were attended to, but not his: 'We were all sitting at the steps and everyone was sitting and chatting about, I can't even remember about what. I was also talking, then the one guy says to me "Keep quiet you, what do know?"' (1.84 *Ons het almal so by die trappe gesit en almal sit en gesels oor, ek kan nie eers onthou nie. Ek het ook gepraat en toe sê die een ou vir my "Sjuut jy, wat weet jy?"*). Danie experienced this incident as with an intensity of 10 on the SUD scale. He stated the positive cognition 'I am important' with a VOC of 1. After a set of bilateral stimulations, there were no changes. It was clear that this was a very painful experience that got stuck and it was difficult for Danie to let go of the negative energy connected with this experience. This experience resulted in Danie not being able to set boundaries to protect himself. Giving a voice to the feeling allowed him to move

closer to the PC 'I am important' with a SUD of 4. One feeder memory was needed to resolve the negative cognition, affecting his self-concept positively.

Theme two: 'I am stupid and do everything wrong'

In a situation of domestic violence, his mother blamed him for the situation. Feeling responsible for his mother being hurt made him feel he is stupid and does everything wrong. He stated the intensity of that cognition as a 10 and provided a PC of 'I am creative, take the initiative and can think' with a VOC of 4. 'I remember another fight when my mother said to me after the fight you are the reason why we got stuck into one another and why we are fighting' (2.51 *Ek onthou 'n ander 'fight' waar my ma vir my na die 'fight' gesê het jy is die rede hoekom ons nou vasgesit het en hoekom ons nou 'gefight' het*). Another memory connected with this NC was lying on bed and feeling depressed because he actually tried to stop his mother being hurt, not causing her to be hurt, which made him feel responsible and therefore experiencing himself as stupid and doing everything wrong. His mother's comment silenced him, affecting his view about himself negatively. Expressing his true feelings and intentions lifted the blocking belief and his SUD moved to 1 and his PC to a 7: 'I actually always knew, but it's as if I did not believe it. Now I believe it. She was also just coping herself'. (2.69 *Ek het eintlik altyd geweet maar dis asof ek dit nie geglo het nie. Nou glo ek dit. Sy het maar net self ook 'gecope'*).

Theme three: 'I am pathetic'

Viewing himself as pathetic is a cognition affecting Danie's self-concept negatively wondering what his purpose in life is: 'Why? Why am I here?' (3.27 *Why? Hoekom is ek hier?*). The image for this NC was in art class, overhearing a boy who was talking about him being gay. He expressed his view about this boy as being Satan himself. 'I did not like him at all. He always acts as if he's the good guy, but he is actually Satan' (3.20 *Ek het niks van hom gehou nie. Hy het altyd 'geact' asof hy die 'good guy' is maar hy is eintlik die Satan*). This incident led to him experiencing himself as pathetic. He desperately wanted to be OK to be himself. His SUD was stated as a 20, indicating that this experience is viewed as one with a high intensity and really touching the core of the problems affecting his identity.

Bilateral stimulation brought the SUD down to a 4. Two more feeder memories needed to be cleared with BLS for Danie to put his PC of 'It is OK to be me' on a 7.

Theme four: 'I am emotionally confused'

Danie's image for being emotionally confused was the mixed signals his mother was sending out. 'I'm getting where my mother and father are fighting again and she is irritating me because she gets a restraining order against this dude and the next day she goes and picks him up at the police station. What sort of mixed signals does that send? I mean, she gets a restraining order against him that says to him "Listen, stay out of my life, I don't want you near me", and then she goes and fetches him at the police!' (3.71 *Ek kry waar my ma en pa baklei weer en sy irriteer my want sy kry 'n 'restraining order' teen hierdie 'dude' and dan die volgende dag gaan tel sy hom op by die polisie. Watse 'mixed signals' gee dit nie net vir jou nie. Ek bedoel sy kry 'n 'restraining order' teen hom, wat vir hom sê "Luister, bly uit my lewe uit. Ek soek jou nie naby my nie" en dan gaan tel sy hom op by die polisie!*). His SUD for this image was a 10, and PC a VOC of 4. One set of BLS cleared this cognition. 'I think my mother is more emotionally confused. She is confused, not me' (*Ek dink my ma is meer emotionally confused. Sy is 'confused', nie ek nie*).

Theme five: 'I am a disappointment'

Danie felt that his mother sometimes seems fine with him being gay and sometimes not, which prevents him from having an open discussion with her, which led to the NC identified as 'I am a disappointment' with an image of choosing a female action figure: (4.43 *... toe klein was dan soek ek 'n speelding, maar dan het ek gewoonlik soos vir die meisie 'action figures' gegaan*). When returning to his mother and showing her the action figure, her face seemed disappointed: 'When I took it out and showed it to her, she gave me this half dirty look, half sort of like disappointment' (4.44 *Toe ek dit uithaal en ek wys dit vir haar, toe gee sy vir my hierdie half vuil kyk, half soos van 'disappointment'*). His SUD was a 10 with a PC of 'It is OK to be myself' with a VOC of 3. One feeder memory surfaced and was cleared.

Theme six: 'I am not worthy'

'I am not worthy' was identified as his last NC in the process. He met a boy who wanted to be friends with him. He rejected the friendship believing that he is not worthy, because he did not feel he is in the same league as that boy: 'I am not in his league' and therefore he rejected the friendship: 'I always have to be on my guard. I cannot believe that someone likes me. I feel I'm not in their league' (4.71 *Ek moet altyd op my hoede wees. Ek kan nie glo dat iemand van my hou nie. Ek is mos nie in hulle 'league' nie*). Bilateral stimulation was applied and cleared the negative cognition to a view of 'I am worthy' 'I am at peace. Gee, I must tell you a mountain has been lifted from my body' (4.87 *I am at 'peace'*; 4.88 *Jis tannie 'n berg is van my lyf af*).

4.5.4 Interpretations of the findings of case 3

Danie struggled throughout his sessions with his identity, thinking of suicide and always wearing a mask: 'I don't think I was ever really happy. I laugh, but it's actually my mask' (C1.16 *Ek dink nie ek was al ooit gelukkig nie. Ek lag maar dis eintlik my masker*). The same as cases 1 and 2, Danie experienced positive changes after the first session: 'No, I am peaceful, very peaceful' (2.76 *Nee ek is 'peaceful', baie 'peaceful'*). When Danie arrived for his second EMDR session, he shared positive changes. He was in love. 'It's a girl. But just wait. I can't believe it myself, but yes it's the first time that I feel like this. She is now my girlfriend. It's sooo funny. Everyone at school looks at me weirdly, because we hold hands during break. Because everybody thinks I'm gay' (C3.5 *Dis 'n 'girl'. Wag nou tannie. Ek kan dit self nie glo nie, maar ja dis die eerste keer dat ek so voel. Sy is nou my meisie. Dis soo snaaks. Almal by die skool kyk my 'weird' uit want ons hou hande vas pouse. Almal dink mos ek is 'gay'*). Although he made a comment that he still thinks boys are sexy, he felt content and a sense of belonging, affecting his self-concept positively. Danie also mentioned that he wasn't having nightmares anymore and had an overflow of creativity and energy. After the second EMDR session Danie did not have suicidal thoughts anymore and experiences school more positively.

His maths scores improved by 10% and he had a distinction for Art.

Danie's emotions towards his first love changed and he would usually try and avoid conflict, but he faced the situation and handled it perfectly, which affected his self-

concept positively and he started making positive comments about himself: ‘... that’s cool, isn’t it? Oh, I’m stunning, aren’t I?’ (4.16 ... *dis ‘cool’ né? Ai, ek is ‘stunning’ is ek nie!*). Danie also started to confront other possible situations with self-confidence.

4.6 CASE STUDY 4

4.6.1 Context – Interview with parent

Erik is one of four children. Erik and his older sister have the same mother. Erik’s other two brothers are his stepmother’s children. When Erik’s mother and father divorced, his father married again and adopted his wife’s two sons.

Erik’s mother stated that Erik was a planned baby. At first she did not want to fall pregnant. The father wanted a son and she agreed, Erik was born at 34 weeks. He was a healthy baby. Erik was breastfed until 20 months and he did not accept a bottle. Stopping breastfeeding was traumatic for Erik. The mother states that he did not eat for a week. Erik’s developmental milestones were on par, although he only started talking at the age of 2. According to the mother, he skipped the baby talk phase: ‘The first words he said to me were “I want a sandwich”’ (*Die eerste woorde wat hy vir my gesê het was “Ek soek ‘n broodjie”*). She describes him as a quiet, peaceful baby. He kept himself busy: ‘He sat on his own. He wasn’t much interested in friends ... he never really cried’ (*Hy het so op sy eie gesit. Hy het nie ‘gemind’ vir maatjies of so nie ... hy het nooit regtig gehuil nie*). During the day Erik went to work with his mother. At the age of 2 it became difficult for her and she decided on a crèche and Erik struggled to fit in. If he was without his mother, he screamed.

Erik was 9 months old when the parents separated and in November the same year the parents got divorced. The mother describes it as a very difficult time. The mother stated that at first she did not want to get divorced. The situation at home turned from bad to worse and she did not want Erik to experience the thing his sister had to go through: ‘You know Erik never experienced that thing that Anet had to, where is father would hit me to the ground. I had to take out and cook twelve eggs and then he forced me and Anet to eat them’ (*Jy weet Erik het nooit daai ding gekry soos Anet, waar sy pa my teen die grond vas slaan. Ek moes twaalf eiers uithaal, kook en dan dwing hy my en Anet om dit op te eet*). She did not want that for Erik: ‘When he was drunk his

father would phone my mother in the middle of the night and tell her to say goodbye to me, because he was going to kill me and Anet' (*Sy pa sal my ma bel as hy dronk is in die middel van die nag en sê sy moet my nou groet, want hy gaan my en Anet nou doodmaak*).

When he was 5 the mother struggled to make ends meet. She did not get any financial support from his father. When asking for financial support he just commented: 'If you can't look after the children, give them to me' (*As jy nie vir die kinders kan sorg nie, gee hulle vir my*). She decided to do just that. She went to Europe and phoned the children every second day. After six months Erik's father phoned. She must take the children back as his wife does not get along with them. She states that after Erik came back he was aggressive and had a rebellious attitude and, to make things worse, her discipline was not consistent: 'I say keep quiet, keep quiet and then when I became angry I probably went overboard sometimes' (*Ek sê bly stil, bly stil en as ek dan kwaad geraak het, het ek dan seker partykeer oorboord gegaan*). She shares an example which she thinks Erik experienced as traumatic: 'He had a golf ball. I told him to put the thing down. He did not listen and then smashed the rear window of another man's car. I was furious and went up to the man and asked him for his belt and hit Erik with it. I could not stop hitting him. The man eventually stopped me. At home my anger had still not subsided. I took a knife and said to him I was going to cut off his ear because he didn't listen. He started screaming terribly. I put a bandage there and told him if he removed the bandage he would bleed to death' (*Hy het 'n golfbal gehad. Ek het vir hom gesê om die ding neer te sit. Hy het nie geluister nie en gooi toe 'n ander man se agterruit van sy kar uit. Ek was woedend en stap toe na die man toe en vra sy belt en slaan vir Erik. Ek kon nie ophou slaan nie. Die man het my naderhand gestop. By die huis het my woede nog nie bedaar nie. Ek vat toe 'n mes en sê vir hom nou sny ek sy oor af omdat hy nie luister nie. hy het verskriklik geskreeu. Ek het 'n verband omgedraai en vir hom gesê as hy daardie verband afhaal gaan hy hom doodbloei*). The incident had a negative consequence for the mother. The next day at school his teacher asked him about the bandage. He told her what happened. He was very upset while telling the story. A social worker took the case and the mother had to defend her behaviour. The mother said that Erik is not a naughty child, just an angry child. The mother told of more incidents of disciplining him because of alcohol abuse: 'I took his clothes, he just had his school clothes, and I gave him just a bed, and I removed the

door of his room' (*Ek het sy klere gevat, hy het net sy skool klere gehad, en ek het hom net 'n bed gegee, en ek het die deur afgehaal van sy kamer*). Another incident occurred when she picked him up at school and he was drunk: 'I tied him up. He went crazy' (*Ek hom vasgemaak. Toe raak hy mal*). This was the mother's first time seeing him drunk: 'It made me totally flip' (*Dit het my net 'totally' laat 'flip'*).

Erik did not have a good relationship with his stepbrothers. They bullied Erik and in one incident the mother said that after an argument his father took his stepbrothers' side and Erik got on the bus and returned to his mother. He was only 12 years old then. At this stage Erik hated his father. Although Erik was bullied by his stepbrothers when they were younger, they do get along now. Werner, his one stepbrother, was in a car accident and is paralysed. His father bought him a bed in supporting him, divorced their mother and decided to remove him from his medical aid. Erik hates his father for not supporting them in such a difficult time.

The mother is in a relationship with someone who is taking very good care of her but also abuses alcohol. Erik does not get along with Frans. The mother describes Erik as a very loveable child who wants his mother by his side. They have a very good relationship and can talk for hours about anything in life, except when Frans joins them. Erik always wanted to go to the movies and go out to dinner with her alone and it is becoming a problem in her relationship and she does not know how to handle it. Frans has two children staying with their mother. When the children visit them Frans is very strict without showing anger towards them: 'He and his children never fight' (*Hy en sy kinders baklei nooit nie*). She and Erik, on the other hand, are more verbal: 'My child and I fight like cat and dog. I mean, he would kick my door down and we carry on like a bunch of trailer park trash' (*Ek en my kind baklei soos kat en hond. Ek meen hy skop my deur stukkend en ons gaan soos klomp 'trailer park trash' tekere*).

The mother's biggest concern with Erik is his outbursts of anger. He cannot control his anger and it is becoming a problem at school and in her relationship with Frans.

4.6.2 EMDR sessions

4.6.2.1 Session 1

Erik is a 17-year-old male. He has friendly eyes and I could not imagine him losing control over his temper. He appeared confident but reserved. I sensed that he was not sure whether he could trust me. I asked him about his interests and he said that he loves reading and playing rugby and pool. He loves hanging out with his friends. We discussed his future and he said he wants to become a lawyer. He has a need for righteousness. I probed him and he said that life is full of unfairness and it makes him angry. I asked him for examples he replied: 'The school, people, the whole of life' (1.11 *Die skool, mense, die hele lewe*).

In questioning him about his reason for being part of this process, he said that he struggles with anger and the school is 'fed up' with him. They do not want him there anymore: 'They wanted to suspend me. Let them, see if I care' (1.15 *Hulle wil my skors. Hulle moet maar wat sal ek omgee*). He told me how unfair the teachers are and that he is labelled. He does nothing wrong, it is them bugging him. He is not going to keep quiet if he is offended. He almost attacked one of the teachers: 'It's his fault if he looks for trouble with me. Everyone knows, you don't look for trouble with me. If there is trouble, the others call me to come and sort it out. I'm not scared of anyone' (1.17 *Dis sy skuld as hy met my sukkel. Almal weet, hulle moet nie met my sukkel nie. As daar moeilikheid is roep die ander my om dit uit te 'sort'. Ek is nie bang vir enigiemand nie*). At this stage of the interview Erik was more relaxed and I decided to explore his background. He spoke about his parents being divorced. When I asked him about his relationship with his father, he was surprisingly calm. He did not make any eye contact and he lowered the tone in his voice: 'My father and I don't have a relationship. My father never really wanted me there' (1.18 *My pa en ek het nie 'n verhouding nie. My pa wou my nooit regtig daar gehad het nie*). Domestic violence was taking place even before his birth: 'All my aunts tell me that my father hit my mother and how he wanted to shoot her and how he carried on when my mother was pregnant with me' (1.18 *Al my tannies het my vertel my pa het my ma geslaan en hoe hy haar wou dood skiet en hoe het hy tekere gegaan terwyl my ma swanger was met my*). He lifted his head and looked at me and said: 'I think for me it was like from the very beginning always just fighting. Maybe I just got used to it' (1.19 *ek dink dit was vir*

my soos van die begin af altyd net 'n bakleiery gewees. Miskien het ek dit net gewoon geraak). Erik said it was very difficult for him to experience his father's violent behaviour, but he thinks he accepted it because he did not know anything else: 'Felt like it's our lifestyle; if you are raised that way, then you later become half like that (1.20 *Gevoel dis ons leefstyl; 1.24 ... as jy so grootgemaak word, dan raak jy half later so*). He is angry with his father, but also at himself: 'I just accepted it, I should never have accepted that my father is like that, that he is such a violent person (1.21 *Ek het dit net aanvaar, ek moes dit nooit aanvaar het dat my pa so is nie, dat hy so gewelddadige mens is nie*).

He elaborated further that he had to survive: 'If you want to survive you must fight' (1.25 *As jy wil 'survive' moet jy 'fight'*). With a sad look in his eyes he struggled to admit that sometimes he did not cope: 'It breaks you after a while; later you are just, you are like half dead on the inside and you just fight to remain alive' (1.26 *Dit breek jou na 'n ruk; 1.27 later is jy net, jy is soos half dood binnekant en jy 'fight' maar net om aan die lewe te bly*). In Grade 9 he realised that life should not be like that and he felt lost: 'It's just something you live your whole life and ... yes, I felt half lost at that moment in my life ... it was difficult for me' (1.42 *Dis maar iets wat jy jou hele lewe leef en ... ja ek het half verlore gevoel op daai oomblik in my lewe ... dit was vir my moeilik*). He compared his life with others around him and felt jealous of their 'easy life': 'I looked a lot at the lives of others and thought "Gee, you know, they have it easy" ... and I think I was jealous of what other people have' (1.44 *Ek het baie na ander se lewens gekyk en gedink 'Jis jy weet, hulle het dit maklik' ... en ek dink ek is jaloers op wat ander mense het*). Erik shared his views comfortably and I realised he needed someone to talk to.

Life for Erik was the same everyday: 'People assault one another and his and carry on and throw stuff, and swear and curse, and the next day it was half OK; what happened last night happened last night and today we leave it behind. Then it just happens again' (*Almal rand mekaar aan en slaan en gaan tekere en gooi met goed, en vloek en skel en dan die volgende dag was dit so half OK, wat gisteraand gebeur het, het gisteraand gebeur, vandag los ons dit. Dan gebeur dit net weer*). Although Erik experienced only violence and rejection from his father, he always hoped that this would change: 'I knew what my father is like but half didn't want to accept it. I wanted

to give him a chance to prove me wrong' (1.44 *Ek het geweet hoe my pa is maar wou dit half nie aanvaar nie. Ek wil hom 'n kans gegee het om my verkeerd te bewys*). He expressed his hope that he also wanted to prove others wrong in their image about his father. After a long silence Erik said with great difficulty: 'I wanted him to show that he wanted me there' (1.46 *Ek wou gehad het hy moes wys hy wou my daar gehad het*). Erik was rejected by his father, but Erik never rejected him: 'I said to him, no, it's OK, don't worry about it. He never said sorry, but I was always there, doesn't matter what he did' (1.47 *Ek het vir hom gesê nee dis OK moenie daarvoor worry nie. Hy't nooit jammer gesê nie maar ek was maar altyd daar gewees, maak nie saak wat hy gedoen het nie*). In surviving he has irrational thoughts and hopes that maybe one day his father will realise that he wants to be with him. Erik struggled to control his emotions. The atmosphere was filled with his sadness. Erik was just looking straight as if he was somewhere else, reliving the moment of lost hope.

Moving back to his Grade 9 year, he stated he started his school career in Hoërskool Rademeyer: 'I was lost. I walked into a school where I did not know anyone. I was not the kind of guy to follow rules. I did my own thing' (*Ek was verlore gewees. Ek het in 'n skool ingestap waar ek niemand geken het nie. Ek was nie 'n ou vir reëls nie. Ek het my eie ding gedoen*). He agrees that this is where he started having problems: 'I think because I was so alone and lonely, I was very aggressive and that is also very heartsore' (*Ek dink oor ek so alleen en eensaam was, was ek baie aggressief gewees en dit is ook baie hartseer*). His life felt like a roller coaster and he did not want to change and avoided people: 'I no longer wanted people near me, because all that the people who were near me did was hurt me' (1.47 *Ek wou nie meer mense naby my gehad het nie, want al wat mense wat naby my was al gedoen het is my seer maak*).

I asked Erik if he sleeps well. He said no, not at all. Sometimes he is so tired at school that he cannot focus on anything. He described a nightmare he had of his father. He dreamt that he was a baby and that his father, in a state of anger, wanted to throw him over the balcony. He asked his mother and she confirmed that it was true. He hates his father for doing that: 'I hate him for that. How can you do something like to a small child?' (*Ek haat hom daarvoor. Hoe kan jy so iets aan so klein kind doen?*). According to Erik, his mother told him that this was when she decided to divorce his father. His

anger towards his father just kept on growing as he got older. He realised that his mother was only 22 years old when he was born. She had two children, no job, no money: 'I blame my father for that. To this day I feel angry at him for that' (1.50 *Ek verwyf my pa daarvoor. Tot vandag toe het ek 'n baie kwaad gevoel vir hom oor dit*). Erik therefore does not trust people easily: 'Because it feels like, yes, people care about you the one day, the next day they turn round and kick you in the back and walk away' (1.50 *Want dit voel ja mense gee eendag om vir jou, die volgende dag dan draai hulle om en skop jou in die rug en loop weg*). He was referring to his mother and shared his feelings of anger towards her for rejecting him at a time when he struggled to cope: 'My mother was also all that I had. My mother was overseas like for two years when she just left me with my grandfather' (1.60 *My ma was ook al wat ek gehad het. My ma was oorsee gewees soos vir twee jaar wat sy my net gelos het by my oupa*).

While engaging in conversation Erik said that he understands that his mother never had a life of her own and that is why she left them, but that it hurts. His feelings of hurt intensified his hate towards his father: 'I feel sorry for her and I think that pity for my mother just intensifies my hatred of my father. There is literally hatred for what he did' (1.66 *Ek voel jammer vir haar en ek dink daai jammerte vir my ma maak my net soveel erger haat teenoor my pa. Letterlik is daar haat vir wat hy gedoen het*). He continued describing his father as one running away when life is pressuring him: 'As soon as things are not going well, then he runs away. The only time in his life when my father thinks he is a man is when he is drunk' (1.67 *Sodra dinge nie lekker is nie, dan hardloop hy weg. Al wanneer my pa ooit in sy lewe, dink hy is 'n man is wanneer hy gesuip is*).

Erik took a breath and it was as if he realised that he was sharing these details without thinking. He apologised for letting go and talking so much: 'I'm sorry, I spoke so much now that I'm exhausted' (1.68 *Sorry tannie ek het nou so baie gepraat, ek is skoon moeg*). I decided to focus on relaxation exercises. We did some breathing exercises and when he seemed more in control, I ended the session.

4.6.2.2 Session 2

We started this session creating a safe place for Erik. He chose a place in a forest where there are big trees, a campfire. Lots of birds and a little stream that's flowing

close by. He says there is just enough sun shining through the trees, but not too hot either. I reminded him that he can go to this place any time when he needs to feel calm and relaxed. While he was in a relaxed state, I asked him to tell me more about himself. He said he had so much baggage.

He described an incident that happened recently. He told me about the car accident involving Werner, his stepbrother, and how upset he was. He spoke about his father who decided to divorce his stepmother at such a critical time and that he was furious. He felt like stepping in, but his religious beliefs stopped him: ‘... my faith has gotten me through a lot of things. That’s why I will never lift a hand to my father, even though it’s difficult. I look at him and think, “Man I could take you out”, but why would I want to sit with more baggage for the rest of my life’ (2.12 ... *my geloof het my deur baie goeters gebring. Dis hoekom ek nooit my hande vir my pa sal lig nie, al is dit moeilik. Ek kyk na hom en dink ‘Man ek sal jou uithaal’ maar hoekom wil ek die res van my lewe met nog ‘baggage’ sit?’*). In probing him more about the baggage he is carrying around, he replied: ‘I’m the last thing my father would ever choose. When I was with my mother, he was the one who chose to run away. He hit my mother into a box, then he chose a new wife and wanted nothing to do with us’ (2.13 *Ek is die laaste ding wat my pa ooit sal kies. Toe ek by my ma was het hy gekies om weg te hardloop. Hy het my ma kas toe geslaan. Toe kies hy ‘n nuwe vrou en hy wil niks met ons te doen gehad het nie*) He continued that when he was older, suddenly his father wanted to make contact with him, but that ended in domestic violence. His stepmother called his mother a slut and a whore, and he retaliated. His father stepped in and started beating Erik: ‘I was crying and then he kicked me and he just carried on kicking’ (2.13 *Ek het gehuil en toe skop hy my en hy het net aangehou skop*). He shook his head while stating that he developed such a hate towards his father that he won’t be able resolve it in his lifetime.

Erik’s hate was not just towards his father, but also towards himself. He is angry that he stayed with his father hoping that he might change: ‘I was stupid. I should have returned to Johannesburg immediately. I was stupid because I had that unconditional love for my father. That was my father and I loved him’ (2.24 *Ek was stupid. Ek moes onmiddellik teruggekom het Johannesburg toe. Ek was ‘stupid’ want ek het daai ‘unconditional love’ gehad vir my pa. Dit is my pa en ek was lief vir hom gewees*). He

makes his fists and you can see the hate in his eyes while he was commenting on this: 'But unfortunately, if you kick a dog long enough, at some time or other he is going to bite you. He kicked me enough in my life' (*Maar ongelukkig, as jy 'n hond lank genoeg skop, een of ander tyd gaan hy jou byt. Hy het my genoeg geskop in my lewe*).

I asked him about more baggage, but he replied that there were so many times he has been beaten by his father he can't even remember them all. He did, however, describe more incidents. He spoke about many times that he was thrown out of his father's house and was told that if he should come back he will be killed (*2.24 Dan het ek op die strand gaan slaap*). He then realised that his father is not going to change; he will stay the same till the day he dies and Erik was of the opinion that he was going to die all alone. Erik had a lot of people who knew about the abuse, but telling him not to hate his father, including his mother, but he feels that they would not understand as they were not the ones experiencing all the abuse. Erik explained his feelings of hate: 'I think you first blame ... and then later it becomes more and more of an anger and then, anger is probably the same hatred, I suppose' (*2.27 Ek dink jy verwyf eers ... dan later dan word dit net meer van 'n kwaad en dan, kwaad is seker maar dieselfde as haat*).

It seemed that the incident when he was 12 years old and his father was beating and kicking him was the most traumatic experience for him at this stage and we decided to start the EMDR with that image. I reminded him on my explanation on how EMDR is implemented and I demonstrated the the options of BLS for Erik. Erik felt comfortable with the tapping.

I moved back to the image of abuse at his father's house and asked him what that image told him about himself as a person and he replied 'I am worthless' and a SUD of 10 was given for that image. He chose a PC of 'I am worthy' with a VOC of 3. He expressed feelings of hate and sadness over his whole body.

While focusing on the image I did a set of BLS. He took a deep breath in ... and out ... and I asked him what image does he see now? He saw how his stepmother is telling him his mother is a slut and a whore. We stayed with that image and did a set of BLS.

His next image was where Erik reacted to her comment. His comments flowed spontaneously and I did BLS in between:

2.41 It was my father who raised your children. My mother had nobody, she had nothing, she did not have furniture or a car - *Dis my pa wat jou kinders grootgemaak het. My ma het niemand gehad nie, sy het niks gehad nie, sy het nie meubels of 'n kar gehad nie.*

2.43 We did not have food, we ate fucking dog food with other people - *Ons het nie kos gehad nie, ons het fokken honde kos ge-eet saam met ander mense.*

2.44 My father looked after your children and paid their school fees - *My pa het vir jou kinders gesorg en hulle skoolgeld betaal.*

2.45 He gave the money that he should have given us to you all - *Hy het die geld wat hy vir ons moes gee vir julle gegee.*

2.46 You must rather keep quiet. You had it good - *Jy moet eerder stilbly. Julle het dit lekker gehad.*

2.47 Then my father came and then he hit me and then I fell - *Toe kom my pa en toe slaan hy my en toe val ek.*

2.48 Then I lay down and I cried and then he kicked me and I said please stop, stop, I'm sorry - *Toe lê ek en ek het gehuil en toe skop hy my en ek vra asseblief stop, hou op ek is jammer.*

2.49 He just carried on kicking - *Hy het net aangehou skop.*

There was silence for a while and then he said 'That's all'. I did another set of BLS and did more breathing. I asked him if he was aware of any feelings or sensations in his body. He replied just sadness. We stayed with the sadness and did a set of BLS. Another image came up where he had to go to hospital for cracked ribs: 'Two weeks later I had to go to hospital because I could not breathe. He had cracked my ribs that night' (2.53 *Twee weke later moes ek hospital toe gaan want ek kon nie asem haal nie. Hy het my ribbes gekraak daai aand*). After another set of BLS Erik just made a comment: 'For any child it is a gift if his parents love him unconditionally. A time will

come when your parents will disappoint you. Unfortunately in mine there was never a time when they did not disappoint me' (2.54 *Vir enige kind is dit 'n dank as sy ouers hom 'unconditional', liefhet. Daar kom 'n tyd wat jou ouers jou gaan teleurstel. Ongelukkig in myne was daar nooit 'n tyd wat hulle my nie teleur stel nie*). I did another set of BLS and he said 'now he is OK'. I asked him to look at the image of 'I am worthless' on a scale of 1-10 and he moved the SUD to a 7 and said: 'It's already easier but there is a lot of hatred' (2.56 *Dis al makliker maar die haat is baie*). I asked him if he thinks of the hate, what image appears in his mind. Erik answered: 'I feel weak and helpless' (1.57 *Ek voel swak en hulpeloos*). He explains that he did not know how to get himself out of that situation. He only wanted to defend his mother because he knew how she suffered. I stayed with those feelings and did a set of BLS.

The next image was when his mother was in a relationship with a man called Wian. Wian used drugs and they did not get along and again he had to go back to his father: 'When Wian and I did not click, my mother said, no, now I have to go back to my father. So then my mother did not want me and my father hit and kicked me like a dog' (2.58 *Toe ek en Wian nie 'click' nie toe sê my ma nee maar ek moet nou terug gaan na my pa toe. So toe wou my ma nie gehad het nie en my pa skop en slaan my soos 'n hond*). A set of BLS followed and Erik said after that he started avoiding people. I did more BLS and he said there is nothing at the moment. I asked him about his NC stating 'I am worthless' and he said it is still there, but not as painful and he moved his SUD to a 6.

Erik seemed very tired but stable and I decided this is a good place to end this session. I asked him if we can keep all those images and feelings in a container to carry on in our next session. He agreed and we ended the session going to his safe place.

4.6.2.3 Session 3

Erik seemed comfortable and contented when he came for his next session. I asked him about the past week and he told me about an incident of aggressive behaviour. He said he did go to his safe place and it worked well until he saw his sister's nose is bleeding. Erik's aggressive behaviour was directed towards Frans, his mother's new boyfriend. I asked him if he wanted to talk about it and he agreed by nodding his head.

It was his sister's birthday party over the weekend: 'He always provokes me when he is drinking. I went to my safe place and said just leave it and walked away. My sister saw that he was trying to cause trouble and said to him that it's her party and he must please leave me alone. Then he gave her a head butt so that her nose was bleeding' (3.6 *Hy tart my altyd uit as hy drink. Ek het net na my 'safe place' toe gegaan en gesê los dit net en toe geloop. My suster het gesien hy probeer moeilikheid maak en gaan se toe vir hom dis haar partytjie en hy moet asb vir my uitlos. Toe slaan hy haar met die kop dat haar neus bloei*). The last thing he remembered was seeing her nose bleeding. When he came back to his senses he was sitting on top of Frans with a bottle of Jack Daniels in his hand busy hitting him. He struggled to control himself.

Erik feels disappointed in himself that he could not stay calm right through the whole situation. He said he felt so good when he used his safe place, but he could not pull it through in the situation with Frans. I comforted him by congratulating him in applying the safe place and feeling that it really works and that when as we carry on with the EMDR he will have even more and lasting results in a situation similar as the one with Frans. It seemed that apart from this incident the rest of his week went without Erik getting into trouble at school.

We went back to the memory where his father beat and kicked him. His NC was 'I am worthless'. His SUD level dropped to 2. He was surprised and said he knows that he hates his father, but this incident is not such an issue anymore. I asked him what needs to happen to be able to drop the SUD to a 1 to feel worthy. He answered that he thinks we need to work more on anger and hate. Experiencing such a shift in a week's time was just amazing for Erik and he seemed positive and more hopeful for the future.

We explored more incident of anger in his past. He described an experience of when he was 5 years old. He stayed with his father. His father got drunk and when he is drunk he blames everybody for everything and the abuse starts. He does not like his stepmother, but comments on her life with his father: 'Yes. look, he also often hit Marie. It was also quite difficult for her' (3.17 *Ja kyk, hy het baie vir Marie ook geslaan. Sy het dit ook maar moeilik gehad*). He remembers this specific incident where he was beating Marie: 'He then hit Marie very hard. Danie and Werner and I asked him why he hit her. Then he hit all of us' (3.19 *Hy het toe vir Marie baie hard geslaan. Ek en*

Danie en Werner het hom gevra hoekom slaan jy haar. Toe slaan hy ons almal). I asked him if his father was using his fists and he replied: 'At that time he would just, he would not slap us, but he gave us like a real hiding' (3.22 *Daai tyd het hy ons sommer, hy sou ons nie geklap het nie, maar hy het ons soos regtig pak gegee*). Soon his father changed his way of abuse: 'When we were about 10 years old he said "You are now a man, so now you are going to get a hiding like a man'. Then he hit or smacked us with his first' (3.23 *Toe ons so 10 jaar was het hy gesê 'Jy is nou 'n man, so jy gaan nou pakslae kry soos 'n man.' Dan het hy ons met die vuig geslaan of geklap*). We discussed a suitable NC and again he said 'I am helpless'. The SUD level for this image was 8. The PC he chose was 'I can decide' with a VOC of 3. I asked what part of that image was the worst for him. He answered the part where his father actually turned around and started beating them.

I did a set of BLS and we focused on his breathing. I asked him if he has another image and he nodded his head. Not long ago, about 4 months earlier this year, his father was drinking again. His stepbrother, who was paralysed, was lying in his bed in the lounge in their house in Cape Town. His father became aggressive again and his brother Werner asked him please to calm down because there were other family members visiting and they all wanted to enjoy their company. Apparently his father turned around and shouted: 'Tonight I'll show you how I'll hit someone right out of their wheelchair' (3.33 *Ek sal julle wys hoe slaan ek vanaand iemand uit hulle rolstoel uit*). Although Erik was not there at the time of the incident, hearing about it over the phone made him feel angry and helpless. We stayed with that thought and did another set of BLS. When asking him what is happening now he just said that he feels the anger in his hands for not being able to do anything at that moment. We stayed with the feeling in his hands and did BLS.

Another image surfaced of an incident this year, where Erik heard that his father left his stepmother and is already in a new relationship with someone else. She has two children who have diabetes. He informed his stepmother that he is going to remove his brother Werner, who is paralysed, from his medical aid. Erik was furious as he knows that his brother's medical care is very expensive and his stepmother cannot afford it. Again Erik felt helpless in the situation. We did BLS and he said he does not

see anything at the moment. I asked him to scan his body and he said he feels 'quiet', and does not feel any anger anymore.

We went back to his NC which stated 'I am helpless'. Of both situations he said actually he was not helpless. He did what he had control over and that was to listen to his brother and comfort him. If he thinks back of those situations, he realises that his brother never expected him to do anything. He felt relieved. Moving to the image of his father beating Marie and then turning around and beating him, Danie and Werner, he replied that he knew he did not do anything wrong and he was helpless because he was only 5 years old. He does not feel helpless anymore and moved his SUD to 1. He can decide and moved his PC to a 7: 'I can now decide and it feels good. I just felt lame for such a long time, but I feel much stronger and in control. I am no longer 5' (3.45 *Ek kan nou besluit en dit voel goed. Vir so lank het ek net lam gevoel, maar ek voel baie sterker en in 'control.' Ek is nie meer 5 nie*). He moved his SUD of 'I am worthless' to 1 and his VOC for 'I am worthy' to a 7 and said that he is worthy and can make decisions for himself. Erik made a future template for 'I am worthy'. He shared his image of receiving another phone call from his brother telling him of their father's unfair aggressive behaviour. It was possible for Erik to listen intently and handle the situation with the needed empathy. Erik smiled and again stated that he is amazed and shakes his head. Erik seemed contented and we decided to end the session at this point. I reminded him of his safe place and to take note of possible new images that might surface and to call me if he needs to.

4.6.2.4 Session 4

Erik was chirpy as he entered for our session. I asked him if he had any new images that surfaced and he shook his head for a 'no'. He wanted to share that he is calm and relaxed and he sleeps well. He is less tired and luckily does not fall asleep during class anymore. He said: 'I've been clamer for the past while and I'm sleeping much better; I no longer fall asleep in class' (4.2 *Ek is rustiger die afgelope ruk en ek slaap baie beter; 4.3 Ek raak nie meer in die klas aan die slaap nie*).

I recapped on our previous session and his scores were still intact. He said that he feels much more in control and did not have an outburst this week. He used his safe place constantly and he is committed to carry on using it. He did, however, comment

on the situation of his brother, Werner, and Erik's new insight into the situation: 'Werner's situation is not like when my father hit me. That I can bury. Werner is always there and such things are still going to happen. There's nothing I can do about it. I think that all I can really do is to be there for him through his bad days and that's OK' (4.8 *Werner se situasie is nie soos toe ek deur my pa geslaan is nie. Dit kan ek begrawe. Werner is altyd daar en daar gaan nog sulke goed gebeur. Ek kan niks daaraan doen nie. Ek dink al wat ek maar kan doen is om daar te wees vir hom deur sy slegte dae en dis OK*).

I probed Erik on other memories he mentioned in our first session. I asked him about an incident he mentioned when it was difficult at home and they did not have food to eat and had to eat dog food. He nodded and shared the traumatic memory. He was 12 years old. He hated the school he attended in Pretoria. His mother suffered financially and at some stage they had to eat dog food as there was nothing else available.

This one specific day, he and his sister went to visit their neighbours after school. They had a pool table and while they were playing their domestic worker came running and said that people are busy taking their 'stuff'. They ran home and they explained to his sister that his mother could not pay her bills and now they needed to take everything in the house. It was difficult for Erik: 'Now I'm just standing there and just looking at how they're carrying out your things, you know. That's also not nice' (4.14 *Nou staan ek maar daar en kyk maar hoe dra hulle al jou goed uit, jy weet. Dis ook nie lekker nie*). In asking him what part of that image is the most difficult he said the part where they were just standing next to each other looking how the people were emptying their home. He stated a NC of 'I am afraid' with a SUD of 7. Erik's PC for this situation was 'I am safe' with a VOC of 2. He felt the fear in his heart. We did BLS and Erik took a couple of breaths and stated that an image of that same day surfaced: 'I remember I went in. I had a sword that I had inherited from my grandfather. I was so scared that they would take the sword that I grabbed it and gave it to the neighbours' daughter' (4.16 *Ek onthou ek het ingegaan. Ek het 'n swaard gehad wat ek by my oupa ge-erf het. Hy het dit by sy oupa ge-erf. Ek was so bang hulle vat die swaard toe gryp ek hom en gee dit vir die bure se meisie*). After another set of BLS Erik remembers that there was a man from social services who wanted to take them away from their mother: 'I remember how long she spoke to him and how frightened my

sister and I were. We thought we were never going to see my mother again. Then my mother had to phone my father to come and fetch us' (4.19 *Ek onthou hoe lank sy met hom gepraat het en hoe bang ek en my suster was. Ons het gedink ons gaan nooit weer my ma sien nie. Toe moes my ma my pa bel om ons te kom haal*).

A set of BLS followed and Erik stated that he does not get an image, but his body is shaking inside. We stayed with that body sensation and after a set of BLS Erik replied that he feels afraid. We did another set of BLS, but with no results. I asked Erik if he knew what he was afraid of, but he did not know. I asked him if we could give that fear a voice to tell us what he is afraid of. He said he think he is afraid of his father. We stayed with that and did a set of BLS. Erik described another image of the incident. He remembered his father arriving at their house to pick them up: 'Then I remember again, I see that my father drove a blue Toyota RSI. He came driving round the corner and I was frightened' (4.26 *Dan onthou ek weer, ek sien dat my pa hy het so blou Toyota RSI gery. Hy het so om die draai gery gekom en ek was bang*). On their way to the Cape he gave them a 'speech' that made them scared: 'Then he still said to us, yes, things are going to change now, you must realise that you are now going to be living under my rules. We were frightened and heartsore' (4.27 *Toe sê hy nog vir ons, ja dinge gaan nou verander, julle moet nou weet julle gaan onder my reëls bly. Ons was bang en hartseer*). They were scared because they knew how violent their father could become and they were sad about leaving their mother and knowing how hard she worked and suffered to build up a home and then just to lose it again.

I moved back to the first image for this session where the bailiff emptied their house. He stated that the fear is gone. The image feels far away. His SUD moved to a 1 and his PC to a 7. His body scan was clear. Erik just smiled and said: 'I can't believe that it honestly does not worry me any longer. I have been struggling for such a long time not to feel like that' (4.34 *Ek kan nie glo dit pla my wragtig nie meer nie. Ek sukkel al so lank om nie meer so te voel nie*).

I probed Erik again on more situations of anger and hate and he shared more traumatic memories. He said he always hated it at his father's house. A couple of months after the incident in Pretoria when they had to move to their father's house, Erik missed his mother very much. He could not stand it with his father and the abuse any more: 'I phoned my mother and said I want to come back to you. I'm not worried,

I'll struggle with you, it's fine' (4.38 *Ek het my ma gebel en gesê ek wil terugkom na jou toe. Ek 'worry' nie, ek sal saam met jou swaar kry, dit is 'fine'*). He could hear his mother was hesitant as she had a new boyfriend, but he was desperate. She agreed and when he and his sister came back to Johannesburg he was shocked. She lived with her boyfriend in a huge house in Bryanston: 'They live in a huge house in Bryanston, great big-screen TVs, drive a BMW, a life of luxury I'm telling you. My mother tells us, no, they're struggling, we can't come and live with her. Meantime the man's daughter is staying with them; I was really angry and upset' (4.45 *Hulle bly in 'n moerse huis in Bryanston, groot 'big screen' tv's, ry BMW, luukse lewe hoor. My ma sê vir ons nee dit gaan swaar ons kan nie by haar kom bly nie. 'Meantime' bly die man se dogter by hulle; 4.46 Ek was die donner in*). He was angry with his mother and her boyfriend and they did not get along. Erik said he was devastated. I asked Erik what does that image say about him as a person. He said: 'Nobody wants me' (4.49 *Niemand wil my hê nie*). His NC of 'I am not wanted' had a SUD of 10. His PC was 'I am wanted'. When I asked Erik what he feels when he looks at that image of his mother in this big house, he replied: 'Angry. Fucking angry and so disappointed that my mother did not want us there. She knows how difficult it is with my father' (4.53 *Kwaad. Fokken kwaad tannie en so teleurgesteld dat my ma ons nie daar wil hê nie. Sy weet hoe swaar is dit met my pa*). The body sensation was of anger in his hands and his whole body was shocked by what he saw. He focused on the most difficult part, which was stepping into the house and seeing all the luxury they lived in and then realising his mother did not want him to be part of it. We did a set of BLS and he said he still sees the same image. I did another set of BLS and still nothing changed. I asked him what he is feeling at that moment and he said with great difficulty: 'Now my mother also doesn't want us any longer. We are probably rubbish' (4.60 *Nou wil my ma ons ook nie meer hê nie. Ons is seker 'rubbish'*). I asked him if we could tell his mother how he felt. He agreed and he started spontaneously while I was continuing with BLS. He started crying while talking to his mother telling her how painful it is for him to see the luxury she lives in and she knows that they were beaten by his father every day. He told her how angry he was and that he hated her for rejecting them like that and that she is just like his father; she might not beat him, but seeing what he saw is as good as a slap in the face or a kick in the ribs. After a set of BLS he stated: 'Gee, that feels a lot better. I feel a lot lighter' (4.67 *Jis, dit voel sommer beter. Ek voel sommer baie ligter*). When we returned to the image of seeing his mother in his big

house, he stated that his NC of 'Nobody wants me' is not true at all. His mother was in a difficult situation. She did not own one of those luxuries. They did not belong to her, so she it was not a case of her not wanting them anymore and that felt good seeing it in that way now. He moved his SUD to a 1 and said his mother loves him very much and he knows it. The VOC moved to a 7. The body scan was clear and he said: 'This stuff is really cool. I don't think I have ever felt this calm in my whole life' (4.72 *Hierdie goed is 'flippen cool'. Ek dink nie ek het al ooit in my lewe so rustig gevoel nie*). Erik made a future template of looking at a situation and not jumping to conclusions and he was successful.

Although Erik felt very light and relaxed and at peace, I could see that the session facing all those difficult memories had been intense. I decided to end the session for the day.

4.6.3 Findings

4.6.3.1 Emotions

Under the category of emotions the following themes derived from the sessions with Erik: Anger, hate, rejection, sadness, feeling lost and body sensations connected with emotions felt during the EMDR sessions.

Erik was born into an environment where domestic violence was taking place every day: 'My aunts told me ... how my father hit my mother ... while she was still pregnant with me' (1.18 *My tannies het my vertel ... hoe het my pa my ma geslaan ... terwyl sy nog swanger was met my*) and is confirmed with the mother: "You know Erik never experienced that thing that Anet had to, where is father would hit me to the ground. I had to take out and cook twelve eggs and then he forced me and Anet to eat them. His father would phone my mother in the middle of the night when he is drunk and tell her she must say goodbye to me, because he is going to kill me and Anet' (*Jy weet Erik het nooit daai ding gekry soos Anet, waar sy pa my teen die grond vas slaan. Ek moes twaalf eiers uithaal, kook en dan dwing hy my en Anet om dit op te eet. Sy pa sal my ma bel as hy dronk is in die middel van die nag en sê sy moet my nou groet, want hy gaan my en Anet nou doodmaak*). Exposure to domestic violence created feelings of anger in Erik's life and anger became his way of living: 'I got used to it; it

was a lifestyle' (1.21 *Ek het dit gewoonnd geraak; 1.20 ... dis 'n lewensstyl*). The moment his father abused alcohol he became aggressive and as he became older his father made a comment that now he can take a hiding like a man: 'He said to us, "Now you are are a man, you will get a hiding like a man"' (3.23 *Hy vir ons gesê, jy is nou 'n man, so jy gaan nou pakslae kry soos 'n man*), meaning that he will use his fists. His father carried out this promise: 'Then my father came, then he hit me, the I remember that I was lying there' (2.48 *Toe kom my pa toe slaan hy my, toe val ek, toe onthou ek toe lê ek*). His anger towards his father led to hate. Hate towards his father increased with every experience of physical abuse: 'There is literally hatred for what he did' (1.66 *Letterlik is daar haat vir wat hy gedoen het*). Erik's father's aggressive behaviour was also directed at his sister: 'He even hit Anet with his fist, he hit her just as he hit us' (3.28 *Hy het selfs vir Anet met 'n vuig geslaan, hy het haar geslaan soos wat hy ons geslaan het*). The aggressive physical abuse from his father became evident in Erik's way of handling conflict: 'As we got older we were hit often and I think that Werner and I took that violence and then expressed it somewhere else' (3.30 *Toe ons ouer word was ons baie geslaan en ek dink dan het ek en Werner daai geweld gevat en dit dan iewers anders gaan uithaal*). They feared to show their feelings of anger at home so they had to release it out in the world; 'My father would have hit me to death; so we fought a lot more outside and at the schools and so on' (3.23 *My pa sou my dood geslaan het; 3.30 So ons het dan baie meer baklei buitekant en by die skole en so aan*). The most aggressive time in his life was between Grades 7 and 9 and in high school his feelings of anger became evident in rebellious behaviour towards teachers: 'If you are going to shove me I'm going to shove you back and if you are going to hit me I'm going to hit you back' (1.17 *As jy aan my gaan stamp gaan ek jou terug stamp en as jy aan my slaan gaan ek jou terug slaan*).

Rejection in Erik's life goes hand in hand with the anger: 'I'm the last thing my father would ever choose. When he was with my mother he decided to run away ... Then he chose a new wife and wanted nothing to do with us' (2.13 *Ek is die laaste ding wat my pa ooit sal kies. Toe ek by my ma was het hy gekies om weg te hardloop ... Toe kies hy 'n nuwe vrou en hy wil niks met ons te doen gehad het nie*). Erik remembered two situations of rejection from his mother. The first situation was when his mother decided to take them to his father at the age of 5 and she went overseas; the second incident was when they stayed with their father and he and his sister wanted to come home.

His mother was already involved with another man and Erik sensed that she did not want them there. When they eventually arrived, he saw the luxury she lived in, despite knowing how they suffered: ‘... they lived in a huge house in Bryanston ... meantime my mother says to me, no, they were struggling, and we could not go and live with her’ (3.38 ... *hulle bly in ‘n moerse huis in Brayonston ... ‘meantime’ sê my ma vir my nee dit gaan swaar ons dan nie by haar kom bly nie*). For Erik sadness seems to be the core feeling, resulting in aggression: ‘... when I feel heartsore and hurt, those are the days when I’m most aggressive’ (1.17... *as ek hartseer en seer is, dit die dae wat ek die aggressiefste is*). Sadness followed after feelings of rejection: ‘It hurts to know that it is easy for a mother and father just to throw you away and shunt you to one side for their own things that they want to do’ (1.65 *Dit maak seer om te weet dat dit is maklik vir ‘n ma en ‘n pa om jou net so weg te gooi en jou net so eenkant toe te skuif vir hulle eie goeters wat hulle wil doen*). Erik also experiences sadness for his brother being paralysed at such a young age and experiences rejection from his father wanting to remove him from his medical aid.

Erik’s father never apologised for any abuse. Erik always hoped that his father will accept him and love him unconditionally, as he loved his father, but his hope ended in feeling lonely: ‘... I want to give him a chance to prove me wrong. Not that he ever said sorry, but I was always there, didn’t matter what he did ... thought that maybe one day he will realise that he really wants to be here with me. Lost. Yes, I felt half lost’ (1.44 ... *en ek wil hom ‘n kans gegee het om my verkeerd te bewys; 1.47 Nie dat hy ooit jammer gesê het nie, maar ek was maar altyd daar gewees, maak nie saak wat hy gedoen het nie ... gedink eendag sal hy besef hy wil regtig hier by my wees; 1.42 Verlore. Ja ek het half verlore gevoel*).

The following body sensations were experienced by Erik during the EMDR process: sadness over his whole body, anger in his hands, fear in his heart, his body shaking in fear, whole body is shocked. These sensations were desensitised with bilateral stimulation.

4.6.3.2 Self-concept

Erik was very aggressive and being feared in school as the one ‘that sort things out’ appeared to others as his having a very good self-image. Eriks’s life seemed to be one

of not being accepted by his identification figure, his father. Not feeling accepted by the primary caregivers results in attachment problems developing and this therefore had a negative effect on Erik's self-concept: '... he will realise one day that he wants to be here with me, or something like that' (1.47 ... *hy sal eendag besef dat jy wil hier by my wees of so iets*). The only identification Erik had was one with aggressive behaviour and rejection 'I just accepted it; felt it is a lifestyle' (1.22 *Ek het dit net aanvaar; 1.21 Gevoel dit is 'n lewensstyl*). This resulted in a self-image of not being worthy, which was intensified by realising that he was the only one who loved his father unconditionally and therefore that he will never experience unconditional love himself. His father choosing to take his stepmother's side added to his perception of 'I am not worthy': 'I just wanted him to stand up, instead of hitting me' (2.35 *Ek wou net gehad het dat hy moes opstaan, plaas van om my te slaan*).

Erik had feeling of being weak. According to Erik, feeling weak is almost an indication of not being able to take responsibility and that you are helpless: '... it's not good. I want to be able to defend myself and can then be independent' (3.57 ... *dit is nie goed nie; 3.58 ek wil myself kan verdedig en dan kan, onafhanklik wees*). This made him sad and lonely, knowing that he is not safe and he is not loved. Feeling unsafe and sad was also intensified by the domestic violence Erik was exposed to. There seemed to be no stability in their household. Not experiencing stability affects 'feeling safe' to explore his own identity. It seemed that Erik only as an identity of being angry and that life is a 'fight' and nothing else.

The following themes derived were during the sessions with Erik.

Theme one: 'I am worthless'

Viewing himself as worthless is clear in the image Erik shared: 'I'm the last thing my father would ever choose. When I was with my mother, he was the one who chose to run away. He hit my mother into a box, then he chose a new wife and wanted nothing to do with us' (2.13 *Ek is die laaste ding wat my pa ooit sal kies. Toe ek by my ma was het hy gekies om weg te hardloop. Hy het my ma kas toe geslaan. Toe kies hy 'n nuwe vrou en hy wil niks met ons te doen gehad het nie*). The intensity of that image was placed on a 10 on the SUD scale with a PC of 'I am worthy' on a VOC scale of 3.

Four feeder memories surfaced, which were desensitised to clear his view of being worthless.

Theme two: 'I am helpless'

Experiencing himself as helpless was triggered by an image where his stepmother, brothers and he himself were beaten by his father. Although he did not get along with his stepmother, he knew her life was difficult with his father. The stepmother, Erik and his brothers were beaten. 'Yes, look, he also often hit Marie. It was also quite difficult for her' (3.17 *Ja kyk, hy het baie vir Marie ook geslaan. Sy het dit ook maar moeilik gehad*). He remembers this specific incident when he was beating Marie: 'He then hit Marie very hard. Danie and Werner and I asked him why he hit her. Then he hit all of us' (3.19 *Hy het toe vir Marie baie hard geslaan. Ek en Danie en Werner het hom gevra hoekom slaan jy haar. Toe slaan hy ons almal*). I asked him if his father was using his fists and he replied: 'At that time he would just, he would not slap us, but he gave us like a real hiding' (3.22 *Daai tyd het hy ons sommer, hy sou ons nie geklap het nie, maar hy het ons soos regtig pak gegee*); 'When we were about 10 years old he said "You are now a man, so now you are going to get a hiding like a man". Then he hit or smacked us with his fist' (3.23 *Toe ons so 10 jaar was het hy gesê 'Jy is nou 'n man, so jy gaan nou pakslae kry soos 'n man.' Dan het hy ons met die vuis geslaan of geklap*). His SUD level was 8 and his VOC a 3 for 'I can decide'. Two feeder memories that linked with the target memories that needed to be addressed with EMDR to clear the negative cognition.

Theme three: 'I am afraid'

Erik remembered being afraid the day the bailiff emptied their house. Their mother could not care for them, so they had to go and stay with their father: 'I remember how long she was talking to him and how frightened my sister and I were. We thought we were never going to see my mother again. Then my mother had to phone my father to come and fetch us' (4.19 *Ek onthou hoe lank sy met hom gepraat het en hoe bang ek en my suster was. Ons het gedink ons gaan nooit weer my ma sien nie. Toe moes my ma my pa bel om ons te kom haal*). The fear was connected with his father. One more feeder memory involving his father was desensitised and the negative cognition was clear.

Theme four: 'Nobody wants me'

Erik desperately wanted to go back to his mother, but was shocked when he realised in what condition she lived while she knew how they suffered at their father's home: 'They live in a huge house in Bryanston, great big-screen TVs, drive a BMW, a life of luxury I'm telling you. My mother tells us, no, they're struggling, we can't come and live with her. Meantime the man's daughter is staying with them; I was really angry and upset' (4.45 *Hulle bly in 'n moerse huis in Bryanston, groot 'big screen' tv's, ry BMW, luukse lewe hoor. My ma sê vir ons nie dit gaan swaar ons kan nie by haar kom bly nie. 'Meantime' bly die man se dogter by hulle; 4.46 Ek was die donner in*). The situation was viewed by Erik as a rejection and that nobody wants him. After the EMDR session, the memory was cleared and a new cognition was chosen 'I am wanted'.

4.6.4 Interpretations of the findings of case 4

Erik started the EMDR process experiencing a high intensity of anger, hate and sadness. After the first EMDR session Erik already felt that his negative feelings towards his father that made him feel worthless were less intense. Erik usually got involved in violent situations but at his sister's party he tried to control his anger. It seemed to work until he saw his sister's nose bleeding: 'He always provokes me when he is drinking. I went to my safe place and said just leave it and walked away. My sister saw that he was trying to cause trouble and said to him that it's her party and he must please leave me alone. Then he gave her a head butt so that her nose was bleeding' (3.6 *Hy tart my altyd uit as hy drink. Ek het net na my 'safe place' toe gegaan en gesê los dit net en toe geloop. My suster het gesien hy probeer moeilikheid maak en gaan se toe vir hom dis haar partytjie en hy moet asb vir my uitlos. Toe slaan hy haar met die kop dat haar neus bloei*).

After the second EMDR session Erik said that he feels he has the ability to choose, which made him feel in control: 'I can now decide and it feels good. I just felt lame for such a long time, but I feel much stronger and in control. I am no longer 5' (3.45 *Ek kan nou besluit en dit voel goed. Vir so lank het ek net lam gevoel, maar ek voel baie sterker en in 'control.' Ek is nie meer 5 nie*). During the third session Erik gave positive feedback on his EMDR process: 'I've been calmer for the past while and I'm sleeping

much better; I no longer fall asleep in class' (4.2 *Ek is rustiger die afgelope ruk en ek slaap baie beter*; 4.3 *Ek raak nie meer in die klas aan die slaap nie*) and shared new insights into his brother's situation: 'Werner's situation is not like when my father hit me. That I can put behind me. Werner is always there and such things are still going to happen. There's nothing I can do about it. I think that all I can really do is to be there for him through his bad days and that's OK' (4.8 *Werner se situasie is nie soos toe ek deur my pa geslaan is nie. Dit kan ek begrawe. Werner is altyd daar en daar gaan nog sulke goed gebeur. Ek kan niks daaraan doen nie. Ek dink al wat ek maar kan doen is om daar te wees vir hom deur sy slegte dae en dis OK*). The image of fear faded completely: 'I can't believe that it honestly does not worry me any longer. I have been struggling for such a long time not to feel like that' (4.34 *Ek kan nie glo dit pla my wragtig nie meer nie. Ek sukkel al so lank om nie meer so te voel nie*).

All Erik's negative cognitions were replaced with positive cognitions. The SUD for Eiks's negative cognitions dropped and his VOC for the positive cognitions shifted positively, while his negative emotions and body sensations cleared. These changes are already evident in his behaviour. He does not get into trouble at school anymore and he sleeps better at night. Erik experienced the EMDR process as positive: 'This stuff is really cool. I don't think I have ever felt this calm in my whole life' (4.72 *Hierdie goed is 'flippen cool'. Ek dink nie ek het al ooit in my lewe so rustig gevoel nie*).

4.7 CASE STUDY 5

4.7.1 Context – interview with parent

Babs is one of two children. She has an older brother in Grade 11. According to the mother, Babs was a planned pregnancy. Hers was a Caesarian birth and her birthweight was 3.2 kg. The mother was not sure whether she had had a miscarriage before her pregnancy with Babs. She elaborated and said that at her first appointment with the doctor, her pregnancy test was positive. At her second visit she tested negative. The mother states that she was healthy during her pregnancy and after the birth Babs was breastfed for only 2 months as the mother developed mastitis. The mother struggled emotionally and was diagnosed with post-natal depression.

Babs's developmental milestones are on par. Babs was in hospital in Grade 5 when her tonsils were removed. The mother states that Babs does not like new things and situations and therefore the experience in hospital was not pleasant. The mother describes Babs as an introvert who prefers socialising in smaller groups. She limits herself regarding social activities and loves being at home. Babs bit her nails as a toddler and still does. She is a sensitive child and can become stubborn. She describes her relationship with Babs as positive. She states that Babs is not a verbal child, so they do not talk that much. They love doing shopping together, having lunch and going for facials. The mother describes her relationship with her father also as positive. They share the same interests and have the same personalities. Her brother, on the other hand, is the opposite. He loves socialising.

Although the mother does most of the disciplining, the parents do have a discipline structure and support each other in applying it. The mother prefers to take privileges away and the father just gives 'the look'.

According to the mother, Babs's 'normal' academic functioning is between 70-80%. But her results for her recent tests were between 40-50% after the traumatic experience they had. The mother appeared very emotional and stated that she can see how her daughter struggles to recover from the incident. She said that her classmates are also used to her being a top achiever. She feels humiliated for scoring low marks and it feels as if everybody is constantly looking at her.

She said for her it feels as if it is tearing their family apart. Her husband feels guilty for not being able to help. Her son says he is OK, but she is not so sure about that. The mother is concerned about Babs and states that, although she is an introvert and does not talk much, suddenly she does not talk at all. She stays in her room. The mother elaborates on the traumatic incident.

The mother, Babs and her brother were involved in an armed robbery at home one morning before school. The father had already left for work. Three black men forced Babs and her brother into her room. They held firearms against their heads. They wanted money and asked for the keys to the safe. The one perpetrator pushed Babs on the bed and touched her breasts and looked at the mother and said he is going to rape Babs if they do not give them the keys. The mother froze in shock and did not

know what to do. She was so afraid and her son responded and gave them the keys to the safe. She stated that they took R6 000 and some jewellery. The three of them were instructed to lie on the bed and their hands were tied behind their backs. The mother stated it was frightening as she did not know where the perpetrators were. They were instructed to stay there and keep quiet or otherwise they would be shot. After a while they heard their domestic worker in the kitchen and called for help. They phoned her husband and the police.

The mother went for debriefing and said it helped a lot. Babs and her brother did not. When discussing the experience with Babs the mother said that the only comment Babs had was her fear of being raped. She said it is as if Babs got stuck on that one image.

4.7.2 EMDR sessions

4.7.2.1 Session 1

Babs entered the therapy room seeming to be very uncomfortable. There was no eye contact and she was clutching her skirt. I invited her to sit down and she sat on the tip of the chair. She gripped her hands together, appearing very stressful. After we introduced ourselves, Babs started to make eye contact. While talking about her family, she was relaxed. She describes her relationship with her mother as very good. They do mosaics together and she places this relationship on a 9/10. Her relationship with her father is an 8 or 9/10 and her brother a 7/10. She laughed when she said that she loves doing accounting when she is bored. In confirming her consent and willingness to take part in this study she stated: 'That's right' (*1.14. Dis reg tannie*) and indicated her reason for taking part: 'Oh, it's just that I'm struggling a bit to sleep and to concentrate on my schoolwork' (*1.15 Ag dis net ek sukkel bietjie om te slaap en op my skoolwerk te konsentreer*). She is tired the most part of the day and everytime she enters their home she is reminded of the armed robbery. She stated that she knows her peers are aware of what happened, but she is thankful they do not confront her about it. She only discusses the experience with her family, friend and one teacher at school.

We discussed the previous meeting we had when her mother signed the consent forms. I gave the mother the EMDR website for further reading on the process. Babs

also read the information on the website but struggles to picture the process: 'It's just that I can't really come up with an image of how it actually happens' (1.20 *Net dat ek nie kan regtig 'n prentjie maak van hoe dit eintlik gebeur nie*). I demonstrated the three different options for the bilateral stimulation and she decided on the eye movement and commented: 'That's quite interesting' (1.24 *Dis nogal interessant*). She had no other questions and I decided to recap on our discussion on how EMDR works. Babs replied that when she and her mother read about EMDR on the internet, it sounded too good to be true. I assured her that I felt the same and had to experience the process to believe it myself. She laughed and said she is willing to participate: 'I'm ready to try this because my academic work is very important to me and it's all falling flat now and nothing is happy' (1.30 *Ek is bereid om dit te probeer want my akademie is vir my baie belangrik en dit val als nou plat en ek is niks gelukkig nie*).

We created a safe place successfully. She decided on a place between the mountains next to a small stream with fresh clean water and lots of trees. We secured her safe place even more with a magnetic field surrounding it. We practised her safe place in different emotions to see the effectiveness. Babs decided on a memory of being irritated: 'I feel irritated' (1.4 *Ek voel geirriteerd*). Her safe place seemed successful as she commented: 'I can't believe I'm so calm. It's really very nice. I wish I could always feel like this' (1.51 *Ek kan nie glo ek is so kalm nie. Dit is regtig baie lekker. Ek wens ek kan altyd so voel*). We discussed the importance of using her safe place regularly for prompt activation.

Babs appeared more relaxed, spontaneous and I decided to confront her with the traumatic situation. Although she shared willingly, moving back to the traumatic memory was difficult for Babs. She talked slowly and stated that she was packing her books for school. Her brother was in his room. She then saw two black men and her brother entering her room. The one held a rifle against her brother's head and the other one pointed his rifle in her direction. She elaborated: 'I felt completely lame. They showed me to keep still' (1.60 *Ek het heeltemal lam geraak. Hulle het vir my gewys om stil te bly*). Babs stated that the only thing she could think of was of her father's advice: 'My father always said do what they tell you' (1.60 *My pa het altyd gesê doen net wat hulle sê*).

The one man grabbed her arm and they were forced to their mother's room. She said: 'I could not even cry' (1.62 *Ek kon nie eers huil nie*) and was surprised when suddenly there were three men and not two: 'I don't know where the other one came from' (1.62 *Ek weet nie waar die ander een vandaan gekom het nie*). He pointed his rifle at my mother's head. As this happened, Babs started feeling emotional and cried. She stated: 'So many things go through your mind' (1.62 *So baie dinge gaan deur jou kop*). There was silence for a while.

She then continued and said they asked for money and the keys to their safe. Babs demonstrated their reaction. She pulled her face and said: 'Where's the money? Where's the money?' (1.63 *Where's the money? Where's the money?*), while moving her hand as if she was holding on to a rifle. She continued and said that then she was thrown on her mother's bed. Babs was quiet and then shared what seemed to be the most difficult part of the experience: 'The guy who was holding me then threw me down on my mother's bed and said to my mother that he is going to rape me if she does not tell them where the money is' (1.6 *Die ou wat my vashou het my toe op my ma-hulle sê bed neergegooi en vir my ma gesê hy gaan my verkrag as sy nie vir hulle sê waar die geld is nie*). There was silence again and Babs struggled to control her emotions and cried. She continued and said that luckily her brother reacted and gave them the keys. She stated that they took all the money and her and her mother's jewellery. According to Babs, the men then tied their hands behind their backs and they were instructed to lie on her mother's bed, head facing down. They were lying quietly and then heard their domestic worker and called for help. Their cellphones were taken, but luckily they could call their father and the police from their domestic worker's cellphone. I instructed Babs to move to her safe place and decided to end the session at this moment.

4.7.2.2 Session 2

Babs seemed more relaxed entering the therapy room. She sat down without instruction and seemed much more comfortable. When I asked her about her safe place, she reacted positively and smiled that she used it when she had a nightmare and it worked. I asked her to share her dream with me and she replied: 'I dream I'm walking down the road and then men want to catch me. I try to run away, but can't get away and just as they grab me I wake up' (2.5 *Ek droom ek loop in die pad af en dan*

wil mans my vang. Ek probeer weghardloop maar ek kom nie weg nie en net soos hulle my gryp word ek wakker). She did not have new memories surfacing, but still feels scared when entering their home everyday.

I referred her back to the traumatic memory and asked her if she wants to continue with the process. She replied that, although she feels she is ready, she is scared: 'I'm ready. I'm also a bit scared' (2.10 *Ek is reg. Ek is bietjie bang ook*). In asking her to elaborate on her fear, she stated that she was not sure why: 'I don't know. Probably of thinking about it?' (2.11 *Ek weet nie. Seker om daaraan te dink?*). It appeared that it was not only when entering their home that Babs was confronted with the traumatic event: 'At home, school, when they talk about it on the news' (2.13 *By die huis, skool, as hulle oor die nuus praat*). When I asked Babs what emotion she feels when thinking about the memory, she stated: 'Frightened' (2.17 *Bang*). I explained to Babs that in the process we are going to divide the memory into sections. Just as a movie is divided into scenes, we are going to do the same. I comforted her by stating that she did not need to worry about the scenes. I will divide them. An explanation and demonstration on her breathing and letting go after the BLS followed. Babs then looked at the camera. I assured her that we can delete the process together when we are done and Babs agreed.

I asked Babs to recall the event and share what message this image gives her. She said: 'I am in danger' (2.25 *Ek is in gevaar*). I asked Babs if one has control over a situation when you are in danger? She replied 'no.' I asked if that situation tells her that she does not have control and she agreed. We explored other situations like writing a test and came to the conclusion that not being in control is a concern for Babs. When writing a test, she does not know what to expect and it creates fear: 'Yes, if I'm writing a test because then I don't have control over what will be in the test paper' (2.29 *Ja, as ek toets skryf want dan het ek nie beheer oor wat in die vraestel gaan wees nie*). She experienced the same fear in the traumatic experience as she did not know what was going to happen and she did not have any control over the outcome. Her negative cognition 'I do not have control' was rated as a 10/10. We discussed what she has control over in a situation such as a robbery and she replied: 'I have control over what I do' (2.35 *Ek het beheer oor wat ek doen*). She decided on a

positive cognition of 'I am OK with myself in situations that I cannot control'. Her VOC for this image was a 3.

I asked Babs to recall the traumatic experience and to tell me what happened. She described a scene where she was busy packing her books for school and saw movement at her door. I instructed her to stay with that scene and did BLS. We focused on her breathing and to let go. Her next image was seeing one man with a rifle against her brother's head. We stayed with that and I did a set of BLS. Her next image was when she was grabbed by her arm and asked to be quiet while walking to their mother's room. I followed with a set of BLS. I instructed her to take a deep breath in ... and out. Her next image was in her mother's room. She stated that suddenly she saw three men and not two, and did not know where the third man came from. We stayed with this scene and did a set of BLS. After breathing and letting go of that image, she continued on to her next image – the men asking for money: 'Now the third one screams "Where's the money? Where's the money?"' (2.4 *Nou skree daai een wat 3rde is "Where's the money, where's the money!"*). I did a set of BLS, while Babs focused on that scene. Her next image was being thrown on her mother's bed and being told that they are going to rape her if they do not give them the keys to the safe.

While sharing this image, Babs started to shiver. I gave her a blanket and she covered herself. I did a set of BLS and then Babs struggled to express her next image. She swallowed with difficulty and said: 'I smell him. It's awful' (2.50 *Ek ruik hom. Dis erg*). After a set of BLS I focused on breathing. She continued and said that he started touching her. I did a set of BLS and asked Babs to breath in ... and out and then go to the next image. In this image Babs said she that she started crying and her brother gave them the keys to the safe. We stayed with that image while doing a set of BLS. She took a deep breath in ... and out and then she shared the following image again with difficulty and said: 'The black guy holds his hand on my breast and his face is so ... so uhhh ... sneering. As if he knows I can do nothing and he looks at my mother with that face' (2.52 *Die swarte hou sy hand op my bors en sy gesig is so ... so uhh ... smalend. So asof hy weet ek kan niks doen nie en hy kyk vir my ma met daai gesig*). I did a set of BLS and allowed the image to go while she was breathing. The men then instructed them to lie on their mother's bed: 'We had to lie on our stomachs and close our eyes' (2.53 *Ons moes op ons maag lê en ons oë toemaak*). We did a set of BLS

and Babs shared her feelings and thoughts while she was crying: 'I was so scared they would shoot us. I was just waiting for the shot' (2.54 *Ek was so bang hulle skiet ons. Ek het net so gewag vir die skoot*). While doing the set of BLS, Babs appeared uncomfortable and emotional. The tears were running down her cheeks. I comforted her with words such as 'Keep at it Babs. You are doing well' ('*Byt vas Babs. Jy doen goed.*')

Babs shared the next image of the event as one where the perpetrators were talking in a foreign language. For Babs it sounded as if they were quarrelling about something. One man stayed with them and the other two were through moving through their house. We stayed with that image while doing BLS. The next image was when they were screamed at while lying on the bed: 'He was screaming all the time that if we moved he would shoot us' (2.56 *Hy het heeltyd geskree as ons beweeg skiet hy ons*). This created fear in Babs. She pushed her face into the mattress and struggled to breathe, but was too scared to lift her head: 'I was too scared to turn my head, what if he shoots me?' (2.56 *Ek was te bang om my kop te draai, netnou skiet hy my*). After another set of BLS Babs said that then the other two men came back and tied their hands behind their backs. I decided to stay with that image and did a set of BLS. Babs took a deep breath in ... and out and then shared the next image of the men telling them not to move and then they left. Babs was not sure how long they were lying there, but after a while they heard their domestic worker and then shouted for help. At first they were scared to call their domestic worker as they were scared the burglars were still in the house. I followed with BLS and Babs took a deep breath in ... and out. Babs shared her last image of the traumatic event: 'So we phoned my father with the maid's phone because ours was taken and then the police and then my father came and the police' (2.60 *Ons het toe my pa gebel met my ousie se foon want ons s'n was gevat en toe die polisie en toe kom my pa en die polisie*). I asked Babs to scan her body for any feelings or sensations. She replied: 'I just feel shivery and extremely tired' (2.62 *Ek is net bewerig en bitter moeg*). I did BLS and some breathing with her to let go. Babs replied that she did not feel shaky anymore.

We returned to the traumatic experience with the NC 'I do not have control'. She moved her SUD to a 7 and stated that she was not sure if the shift was because of her feeling tired. I questioned her on her PC of 'It is OK to be relaxed in situations where I

do not have control', and her VOC moved to a 4 and we then followed with BLS. Babs appeared very tired and I decided to end the session at this point. I instructed Babs to go to her safe place. When she was calm and contented, we discussed some relaxation exercises. Her next session was the following day.

4.7.2.3 Session 3

Babs entered the therapy room with a smile. She had a good night's rest and said: 'I thought I would be worn out but I'm not' (3.3 *Ek het gedink ek gaan op wees maar ek is nie*). We moved back to the image of not being in control. Her SUD moved to a 6. Her VOC moved to a 4.

When I asked Babs which part of the event is the most disturbing, she replied: 'I think the part when he touched me and I could smell him and also when he held his hand on my breast and looked at my mother like that' (3.7 *Ek dink die deel waar hy aan my vat en ek ruik hom en ook waar hy sy hand op my bors hou en so vir my ma kyk*). She stated that all those images were equally disturbing and the NC stayed the same 'I do not have control'. The first memory that surfaced was where the perpetrator was lying on top of Babs and she explained the experience as: 'Creepy' (3.11 *Grillerig*). Babs re-experienced the body sensation. After a set of BLS another body sensation surfaced. She could smell the perpetrator. A set of BLS was done and Babs stated that she felt nauseous. After desensitising, Babs stated that she can see the perpetrator lying on top of her and her whole body appeared tense. BLS did not clear that target and we did another set of BLS. No change took place and Babs started crying and said that she struggles to let go of that image. I comforted her and asked her if she could say something in that situation what would it be? Babs replied: 'I would shout at him to leave me alone. He does not have the right to touch me like that. It's humiliating in front of everyone' (3.17 *Ek sou vir hom wou skree los my uit. Hy het nie die reg om so aan my te vat nie. Dis vernederend voor almal*). We did a set of BLS and the image still stayed the same. I asked Babs if we could give that feeling of humiliation a mouth; she agreed, but asked to continue the BLS with the tapping as her eyes were tired. While desensitising her, I supported Babs in verbalising her feelings: 'Who do you think you are? It's my body and I say no. It must stop now. I stop this humiliating feeling now' (3.21 *Wie dink jy is jy. Dit is my liggaam en ek se nee. Dit stop nou. Ek stop hierdie vernederende gevoel nou*). Babs then verbalised, with intense emotion,

using her own words: 'I hate you. I hate you. Stop, it's humiliating in front of everyone. You are disgusting. Who do you think you are to do this? You are sickening and you stink! You are worthless! I hate you! I hate you!' (3.22 *Ek haat jou. Ek haat jou. Stop dit is vernederend voor almal. Jy is vieslik. Wie dink jy is jy om dit te doen? Jy is walglik en jy stink! Jy is 'n nikswerd! Ek haat jou! Ek haat jou!*). Babs looked down and there was silence for a while. She then looked up and said: 'That's all' (3.23 *Dis al*). The image was gone: 'Nothing. It's gone' (3.23 *Niks nie. Dis weg*) and I decided to go with the comment 'Nothing' ('*niks*') and did BLS.

Her next image then surfaced where she saw how the perpetrator looked at her mother. We desensitised that image. Again Babs made a comment 'Nothing' ('*niks*') and I decided to stay with that and did BLS. She then shared another image of feeling the perpetrator's hand on her breasts. Babs started crying and struggled to breath. I comforted her with words such as 'Keep at it, you are doing well. Well done. You are doing very well' (*Byt vas jy doen goed. Mooi so. Jy doen baie goed*). Babs then mentioned that her body feels dead. We stayed with that while doing BLS. The target was clear, but Babs felt uncomfortable in her body. She moved her upper body side to side in trying to determine what she was feeling and concluded with a comment: 'I feel stiff and uncomfortable' (3.31 *Ek voel styf en ongemaklik*). Another set of BLS cleared the body sensation and she felt peaceful.

We moved back to the image of the perpetrator lying on top of Babs. She replied: 'I see it but for some reason or other it's not nearly as awful. It's really strange' (3.33 *Ek sien dit maar om een of ander rede is dit glad nie meer erg nie. Dis regtig snaaks*). We moved to the image of the perpetrator touching her breasts. She replied: 'I feel nothing' (3.34 *Ek voel niks*). I asked Babs to re-evaluating her image and NC of 'I am not in control'. She moved her SUD to a 2. In questioning her on what needs to happen to move the SUD to a 1, she replied: 'I think I must first be insode the house and it must not bother me' (3.36 *Ek dink ek moet eers in die huis wees en dit pla my nie*).

I asked Babs to focus on the image of being at home and being aware of what she experiences. She replied that it feels as if she is not safe, which became her next NC 'I am not safe'. She decided on a SUD level of 5. Her PC for this image was 'I am safe' and her VOC was 5 and she commented on feeling scared.

We focused on the image that made her scared and after one set of BLS, the target was clear. We re-evaluated her image of walking into their home and Babs replied that she was not scared anymore. Her SUD moved to a 1. We moved back to the first NC of 'I am not in control' and Babs replied that her SUD level is 1 and commented: 'It doesn't bother me at all. I can't believe it' (3.45 *Dit pla glad nie. Ek kan dit nie glo nie*). When I asked her about her PC of being calm and relaxed in situations she has no control over, she replied her VOC was a 7 and said: 'It's strange because I know the burglary was scary, but it's no longer scary in my body' (3.46 *Dis snaaks want ek weet die inbraak is 'scary' maar dis nie meer 'scary' in my lyf nie*). Babs did a body scan and it was clear. I asked Babs to make a future template of a possible situation where she would need to feel relaxed in a situation which she does not have control over. She decided on a test situation. I asked Babs to be clear in her image of what she wants to feel, hear and do in that situation. She made an image of a test situation where she struggles to relax: 'I have an image of where I'm writing a test or just before and while I'm writing, because I know that I'm always uncertain about what is in the question paper' (3.51 *Ek het 'n prentjie van waar ek toets skryf of net voor en terwyl ek skryf want ek weet mos ek is altyd onseker oor wat in die vraestel is*). After implementing the future template, Babs commented: 'Well, for me it is peaceful and really calm before and while I'm writing. It really is like they write on the internet. I can't believe I experience it like this' (3.51 *Wel vir my is dit rustig en regtig kalm voor en terwyl ek skryf. Dis regtig soos hulle op die internet skryf. Ek kan nie glo ek beleef dit so nie*).

Again I referred back to the initial image of the armed robbery and Babs said: 'It's rather strangely calm' (3.54 *Dis nogal vreemd rustig*). We revisited the image of the perpetrator lying on top of her. She replied: 'Nothing' (3.55 *Niks*), and regarding the part where he was touching her she said: 'I see it but it's really really strange that it does not bother me' (3.56 *Ek sien dit maar dis regtig vreemd dat dit nie my pla nie*). For the image of where the robber looked at her mother, Babs explained: 'It's as if I feel sorry for him that he has to do this to have control. It doesn't bother me any longer. I can't believe I'm saying this' (3.57 *Dis asof ek voel ek is jammer vir hom dat hy dit moet doen om beheer te hê. Dit pla my nie meer nie. Ek kan nie glo dat ek dit sê nie*). This seemed like a good place to end the session. I instructed Babs to move to

her safe place. Before she left the therapy room, I asked Babs to be aware of any memories that surface and reminded her to do her relaxation exercises.

4.7.2.4 Session 4

Babs appeared full of energy entering the therapy room. When I questioned her about my perception of this, she said: 'I wrote a class test and got full marks ... and everything is really just going well' (4.2 *Ek het 'n klastoets geskryf en vol punte gekry ... en ag dit gaan somer net beter*). Babs also mentioned that she had no nightmares and only woke once but fell asleep again with no effort and her safe place is working well. We moved back to the memory of the traumatic incident. The overall memory of the event did not create fear anymore, so I moved to different images which were isolated as disturbing. The memory of the perpetrator touching her seemed to have cleared. She explained the change as: 'You know, it's strange, I see it but it is not awful. I don't know how to explain it. It's really like *there*' (4.10 *Tannie dis snaaks maar ek sien dit maar dit is nie erg nie. Ek weet nie hoe om te verduidelik nie. Dis regtig soos daar*). On probing her on the memory of the perpetrator's smell, she stated that it is not disturbing anymore and that she does not smell it at the moment. On the image of the perpetrator touching her breasts, she commented: 'It remains nasty to see it, but I no longer feel as if I am frightened and panicky' (4.12 *Dit bly goor om dit te sien maar ek voel nie meer so dat ek bang is nie en paniekerig voel nie*). Another disturbing memory was the look the perpetrator gave her mother. Babs said that she does not really see that anymore. I checked the NC of 'I do not have control.' Babs stated: 'I did not have control over the day but I think we said last time it's the thing that controls me afterwards and now I am fine. I feel he does not control me' (4.14 *Ek het nie beheer in die dag gehad nie maar ek dink ons ek het laas gesê dis die ding wat my beheer agterna en nou is ek reg. Ek voel nie hy beheer my nie*).

I asked Babs to rate on a scale of 1-10 where she would place 'I do not have control over my emotions'. She stated 1. I checked the VOC for 'I am calm and relaxed' and she put it on a 7. We moved to the image of her entering their home that indicated 'I am not safe'. Babs rated the image on a 2 and stated that it is much easier, but that she still thinks about it. This target of 'I do not have control' seemed to be desensitised.

We stayed with the image of entering their home making her feel that she is not safe. I did BLS and Babs stated that she mostly feels scared and uncertain, and explained: 'You know, like when you don't know what lies ahead?' (4.26 *Tannie weet soos wanneer jy nie weet wat voorle nie?*). We therefore stated an NC of: 'I am scared of and uncertain about the unknown' (4.31 *Ek is bang en onseker oor die onbekende*). Her SUD was a 4 and her PC was 'I am calm and have self-confidence'. Her VOC was a 4. We desensitised the image of being scared and uncertain about the unknown and Babs stated that the feeling of uncertainty is still there. I did another set of BLS and an image of uncertainty and the color grey surfaced. We stayed with that and did a set of BLS. She replied that it feels lighter, but still feels uncertain. I probed Babs on another image where she felt the same. She replied: 'Axctually a lot of times already' (4.41 *Eintlik al baie keer*). I asked her to share the memory of what she sees when thinking about feeling uncertain. Babs shared a image of having low scores on tests. It was not possible to think of one single situation as the image was: 'All the tests' (4.43 *Al die toetse*). One set of BLS did not clear the image. After the second set of BLS Babs singled out an image of a incident in class when she was receiving her test results. A set of BLS cleared that image and she stated that she feels calm and shared her view of why the image cleared: 'I think it was about what happened, nothing else' (4.47 *Ek dink dit was oor wat gebeur het, niks anders nie*). She could say it with confidence as she realised that during the week her good results in her test confirmed that change had taken place.

We moved back to the image of her entering their home and she moved her SUD to a 1. Her VOC for 'I am calm and have self-confidence' was stated as a 7: 'I feel calm about my marks and, yes, the image is gone ... the feeling is no longer frightened' (4.51 *Ek voel rustig oor my punte en ja die prentjie is weg ... die gevoel is nie meer bang nie*). She did a body scan and stated that she feels calm and relaxed. I asked Babs to again look at the image of the traumatic event and Babs said: 'I know it happened and it was awful ... but it does not bother me any longer' (4.54 *Ek weet dit het gebeur en dit was erg ... maar dis so pla nie meer nie*). Babs did another body scan and she replied feeling calm and I concluded with a set of BLS. Babs made a future template of being calm relaxed with confidence. I gave markers to add into her image to be specific on how she wants to feel, what she looks like when she is excecuting the future template, and how she wants to feel about herself. Babs shared

her image and stated that she visualised how she was going to enter their house today and it felt calm and relaxed. It felt right to end the session at this point. I reminded Babs to be aware of possible new memories that might surface during the week.

4.7.3 Findings

4.7.3.1 Emotions

Under the category of emotions these themes derived from the sessions with Babs: fear, anxiety, sadness and humiliation and body sensations connected with emotions felt during the EMDR sessions.

Babs is an introvert, who does not like changes and feels comfortable knowing what to expect in situations. An example would be situations such as writing tests, where she has no control over the contents. Every test situation elicits fear. Therefore every situation where she feels she has no control elicits fear. The single traumatic incident experienced allowed the fear to surface as she felt she did not have control over the situation. It was fearful not knowing what is going to happen and fear was part of every target in the traumatic experience. Her fear increased and she appeared anxious about the possibility of being raped and about the perpetrator touching her breasts. This incident led to feelings of sadness and humiliation in front of her brother and her mother. Again she had no control. Her memory of the traumatic event intensified her feeling fear about entering their home and resulted in feelings of uncertainty and not feeling safe. Every day since the event when Babs enters their home, she feels uncertain about whether it is safe to enter.

Babs's body sensations also spoke of the emotions she felt during the traumatic experience. The body sensations she experienced during the EMDR process were: fear over her whole body, shivering in her body, feeling nauseous, her whole body feeling tense and uncomfortable, struggling to breathe and stiffness in her body. Bilateral stimulation lifted the negative sensations in her body.

4.7.3.2 Self-Concept

Although Babs is an introvert, it seemed that she had a positive self-image. The impact that the traumatic event had on Babs was evident in her overall functioning. Not only did she communicate less, her grades dropped traumatically, affecting her self-concept negatively.

The themes identified from the sessions with Babs which influenced her self-concept are discussed below.

Theme one: 'I do not have control'

Babs not feeling that she is in control was the first negative cognition she identified from her experience. Babs could connect this experience of not being in control with other situations also making her feel fear and insecure: 'Yes, if I'm writing a test, because then I don't have control over what will be in the test paper' (2.29 *Ja, as ek toets skryf want dan het ek nie beheer oor wat in die vraestel gaan wees nie*). During the EMDR process the traumatic memories were resolved and Babs's negative cognition of 'I do not have control' shifted her SUD for this image from a 10 to a 1. Her negative cognition of 'I do not have control' was replaced with a positive cognition: 'It is OK to be myself'. 'I am OK with myself in situations over which I do not have control' with her VOC shifting from 3 to a 7.

Theme two: 'I am not safe, and scared and uncertain about the future'

Babs identified 'I am not safe' as her next negative cognition. This cognition followed from the first cognition of 'I do not have control'. The image was to be at home: 'I think I must first be inside the house and it must not bother me' (3.36 *Ek dink ek moet eers in die huis wees en dit pla my nie*). Her SUD for this cognition was 5. After bilateral stimulation Babs moved her SUD to a 1 and replaced her negative cognition with a positive cognition of 'I am calm and have confidence' with a VOC that shifted from 4 to 7.

4.7.4 Interpretations of the findings of case 5

Babs started the process not making eye contact and appeared to be very stressed and uncomfortable sitting on the edge of her chair and gripping her hands together. During the first session the whole incident was addressed with bilateral stimulation. After the first session her SUD moved from a 10 to a 6. During the second EMDR session she identified the worst parts of the memory and it was desensitised. For Babs to be able to move her SUD to a 1, she commented: 'I think I must first be inside the house and it must not bother me' (3.36 *Ek dink ek moet eers in die huis wees en dit pla my nie*). Creating a positive image and doing bilateral stimulation cleared the cognition. The bilateral stimulation desensitised all her negative cognitions and feelings as well as body sensations connected with the traumatic memory. During the sessions Babs shared her view on the effect the process had on her cognitions, feelings and body sensations: 'You know, it's strange, I see it but it is not awful. I don't know how to explain it. It's really like *there*' (4.10 *Tannie dis snaaks maar ek sien dit maar dit is nie erg nie. Ek weet nie hoe om te verduidelik nie. Dis regtig soos daar*); 'It remains nasty to see it, but I no longer feel as if I am frightened and panicky' (4.12 *Dit bly goor om dit te sien maar ek voel nie meer so dat ek bang is nie en paniekerig voel nie*); 'I did not have control over the day, but I think we said last time it's the thing that controls me afterwards and now I am fine. I feel he does not control me' (4.14 *Ek het nie beheer in die dag gehad nie maar ek dink ons ek het laas gesê dis die die ding wat my beheer agterna en nou is ek reg. Ek voel nie hy beheer my nie*).

4.8 MAIN THEMES IN CASE STUDIES

The main themes identified across the five cases under the heading of Emotions and Self-concept will be presented. Cases 1-4 involve developmental trauma and case 5 experienced a single-incident trauma.

EMOTIONS: anger, fear, sadness, humiliation, rejection, lonely, guilt, shame, powerless, inferior and body sensations.

All participants expressed feelings of *anger*. The participant who experienced the single-incident traumatic event expressed her anger in her behaviour when she faced

the perpetrator and could share her feelings verbally using the word '*hate*.' The participants experiencing developmental trauma stated during their sessions that they experience *anger*.

Only three participants experienced *fear*. Two participants experienced *fear* in situations where they did not have control and both participants are female. The other participant, a male, had *fear* of possible *rejection*. *Humiliations* were evident in four of the five cases. In all four cases *anger* was experienced because of being *humiliated*. Three participants indicated feeling *hate* towards the person they feel is responsible for their trauma.

Rejection was experienced by four participants who experienced developmental trauma. Two of those participants expressed feeling *lonely* because of *rejection*. One participant felt *irritation* and *guilt*. Feelings of *shame* were indicated by three participants. And only one stated feeling *inferior*. Feeling *powerless* was evident in one case.

Body sensations were evident in all 5 cases:

Feeling sadness in their hearts	: 2 participants
Fear in heart	: 1 participant
Pain in their heart	: 1 participant
Fear in their throat	: 1 participant
Irritation in hands	: 1 participant
Sadness in hands	: 1 participant
Hands feel funny	: 1 participant
Sadness in heart	: 2 participants
Anger in head	: 2 participants
Anger in hands	: 2 participants
Shivers down neck arms and hands	: 1 participant
Shivers through whole body	: 1 participant
Shoulders feel weird	: 1 participant

Tense and prickles down neck	: 1 participant
Weird feeling in the neck	: 1 participant
Impulse in neck	: 1 participant
Headache	: 1 participant
Whole body shocked	: 1 participant
Hate and sadness over whole body	: 1 participant
Body shaking of fear	: 1 participant
Body feels tense	: 2 participants
Body feels stiff and uncomfortable	: 1 participant
Fear over whole body	: 1 participant
Tingles in the neck and fingers	: 1 participant
Creepy	: 1 participant
Feels if chair spins around	: 1 participant

SELF-CONCEPT: comparison, attachment, academic functioning, identity, relationships.

Different aspects contribute to a low self-concept. Attachment problems seemed to be the part of the cases experiencing developmental trauma. Lower academic functioning was evident in all five cases. Two participants compared their abilities with their siblings', affecting their perception of themselves as well as of siblings experiencing favoured treatment while they were 'always doing things wrong.' Development of a healthy identity is the crucial part of the developmental phase and any negative action or perception can influence their self-concept negatively. All five cases therefore showed a struggle in developing a healthy identity. The participants experiencing developmental trauma also struggled with positive relationships. In the case of all five participants their negative views of themselves, which were developed by the traumatic experience, were changed into positive perceptions. The SUD and VOC indicated the level of intensity and the positive changes that took place in their view of themselves. The negative view the participants had of themselves resulted in negative

behaviour patterns such as aggression, withdrawal, sadness. After the EMDR sessions there was a positive change in all the participants' behaviour. They presented with an attitude of hope for themselves and their future.

EMDR as therapeutic tool for dealing with trauma addresses the cognitive, behavioural, emotional and physical difficulties experienced by the adolescents. The themes identified shared data of those difficulties. The difficulties were connected with a target in the past and present. The image of the target provided the negative cognitions stored dysfunctionally. Some of the difficulties were identified during the EMDR intake interview. Those difficulties identified were addressed during the EMDR sessions and were desensitised using BLS. The interaction with the participants' commenting on their SUD level, VOC level and body scan added to the insights gained into the participants' experiences and the positive changes that took place. The insight gained in the process assisted me to categorise the data into themes in order to present the findings.

4.9 CONCLUSION

This chapter presented the data collected for this study. It started off with an example of how the data were analysed. A discussion of the context and sessions of each case were given. The main themes were identified and interpreted.

The findings show that trauma (developmental or single-incident) affects all areas of the adolescents' lives. Trauma disrupts emotions and cause sensations in the body affecting the self-concept which formed the main themes in the study. The data showed that a negative self-image has a negative effect on the development of a positive identity, which in turn influences relationships. Furthermore, trauma always seems to affect the individuals's academic performance. The findings indicated that EMDR supported the participants in the processing of distressing images, facilitating relief of emotions and sensations in the body and enhancing the self-concept. EMDR was also positively experienced by the adolescents. Chapter 5, the final chapter, will offer a summary of the study and the findings.

CHAPTER FIVE

DISCUSSION OF THE FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The purpose of this study was to determine whether EMDR could serve as a therapeutic tool for adolescents who had endured trauma. Chapter Five begins with a synthesis of the study in order to reassert the focus of the study. After that the most important findings will be summarised, interpreted and discussed with the aim of ascertaining the relevance of EMDR for adolescents. The limitations of the study and recommendations for future research are also indicated in this chapter.

5.2 SYNTHESIS OF THE STUDY

The study attempted to answer the following research question. How does the adolescent experience EMDR as a treatment modality for trauma?

The research design as discussed in Chapter Three was a qualitative, multiple case study with an interpretive perspective, and formed the basis from which the research was carried out. As discussed in Chapter One this study ties in with Punch's (1998) view that case studies contribute to the research field where there is non-existent knowledge in an area, which is the case with EMDR in the South African context. An interpretive paradigm is concerned with understanding and interpreting the lived experiences of the participants in the study. An attempt was made to understand the participants' feelings, thoughts and actions related to a traumatic event, in other words what their lived experiences were and how they experienced EMDR as therapeutic modality. The methods of data collection complemented the aim. Semi-structured interviews, EMDR sessions, observation, field notes and video recordings were utilised to assist in the process of understanding. As an interpretive researcher, I used the methods to collect data to obtain an "insider's" view of the participants' traumatic

experiences. Interpretive research does not focus on one reality; this approach enabled me to create an atmosphere where the participants could share their judgments, perceptions, values, concerns and actions regarding themselves and others connected to their experiences (Henning 2004:20). It also enabled an atmosphere where new realities were created as maladaptive cognitions were resolved, and where participants could share their views on their experience of the EMDR procedure. The EMDR sessions thus served as a space where the voice of the participants' experiences of trauma could be heard (Greig, Taylor & MacKay 2007:56). An educational psychologist in private practice monitored the study to determine if the participants' needs were taken care of.

The literature shows that there is a critical attitude towards case studies concerning their generalisability (Reinharz 1992). Punch (1998), however, takes a different view that ties in with this research focus. The author states that a case study could make a valuable contribution in situations where there is shallow or non-existent knowledge. He further elaborates on his view that what can be learnt from a case study is unique; it can contribute to the research field and provide understanding of important aspects of novel research. By doing this research much can be learnt on each participants' experience of their trauma after applying the method. The participants' experiences have contributed to understanding complex social behaviour and it is important to develop this. It provides a platform for further study, which Punch (1998) argues is best achieved through a case study strategy. He argues that quantitative research does not give the full picture of understanding of the phenomena studied.

Content analysis and analysis according to the EMDR procedure provided information-rich data. By way of coding, the data themes were generated and the data were presented according to the emerging themes.

During the process it was learnt what impact the traumatic experiences had on the participants' emotions and views about themselves. These negative experiences influenced the adolescents functioning in relationships, the development of a positive identity and day-to-day behaviour. The EMDR process assisted in alleviating distressing cognitions, emotions, bodily sensations and behaviours with bilateral stimulation. The findings suggest that EMDR was experienced positively by the

participants. It can therefore be assumed that EMDR was effective in treating participants who were exposed to trauma.

5.2.1 Summary of the study

Chapter One provided an orientation to the study and the relevant background information related to the study was introduced, noting the shortage of research in the field of EMDR in South Africa, specifically focusing on the adolescent and trauma. The research design and paradigm were presented. Clarifications of terms as well as ethical concerns were discussed. After that a brief outline of the chapters was provided.

The literature review on trauma and adolescents was discussed in Chapter Two. The adolescent phase and its challenges were discussed, followed by the symptoms and impact of trauma on adolescent functioning. The effect of traumatic stress on the brain was presented. The influence of traumatic stress on emotions was also discussed. This chapter concluded with possible treatments for trauma.

Chapter Three focused on the research design and procedures to meet the aim of the study. The use of more than one data-collection method assisted me to obtain a thick description of the participants' experiences of traumatic events. The data-collection methods that were used in this study included semi-structured interviews with the parents and the participants, which served as the clinical intake. EMDR sessions according to the EMDR protocol with participants were implemented, video recordings were made and field notes were taken.

The implementation and the presentation of the data analysis and findings are presented in Chapter Four. This entailed a discussion on the adolescents' views and experiences of trauma, following a synopsis of the main themes that emerged from their experiences.

5.3 DISCUSSION OF FINDINGS

The next section will discuss the findings and the key themes which emerged from the data. Working from an interpretive perspective, the focus was on understanding the participants' views on their experiences of trauma and the EMDR process (Henning

2004). The EMDR concepts, the SUD and the VOC assisted in understanding the participants' level of disturbance as well as their progress (Shapiro 2001). The data from the clinical intake and EMDR sessions with participants are integrated and presented in Chapter Four.

The central themes identified in this study were:

- emotions;
- self-concept;

5.3.1 Discussion of significant findings

5.3.1.1 *Emotions*

According to the literature, emotional difficulties are one of the symptoms of trauma. The mind, brain and body are connected; therefore the self, the mind and the body interact and are influenced by emotions (Wilkinson 2010). Adolescence is the phase during which the child moves into adulthood and it is seen as a high-risk developmental phase (Casey, Jones & Hare 2008). Problematic childhood experiences may serve as a trigger for emotional difficulties in adulthood. Unresolved issues therefore influence the way the adolescent adapts to challenges faced in this developmental phase (Prachett & Yehuda 2011). Geldard and Geldard (2010) view attachment problems as one of the unresolved issues that may influence the adolescent in all areas of his or her life and in later adult functioning. It can then be argued that emotional, behavioural, cognitive and physical challenges are interrelated and affect the holistic development of the adolescent presenting with challenges at school and in relationships (van der Kolk & van der Hart 2003). Behaviour as a result of emotions experienced will form part of this phase and feelings of hate and irritability in this study are interpreted as a way in which anger is expressed.

Anger was observed in the participants and may have developed as a result of shame, sadness, humiliation and rejection. According to Cohen et al. (2006), anger is the result of the perception that an experience is unfair. A child has no control over family stress and it became evident that exposure to domestic violence as a source of anger was evident in two cases. Erik and Danie were exposed to domestic violence. Danie was exposed to seeing how his father abused his mother. Erik experienced the

violence on a physical level and was beaten by his father. The literature describes domestic violence as child maltreatment and may result in delinquency, substance abuse and suicidal tendencies (Deardorf et al. 2003; Wenar & Kerig 2006). Erik presented with substance abuse at school and at home, and with delinquent behaviour such as getting involved in violent situations with peers at school. Danie's exposure to violence provoked negative thoughts such as committing suicide. Both Danie and Erik showed a lower interest in schoolwork and both expressed feelings of hatred towards their fathers because of maltreatment.

Danie also expressed anger towards bullies in primary school. He experienced their claims of his being gay as unfair and humiliating. He stated that at that time he did not experience himself as gay. Anger towards his mother sending out mixed signals in an attempt to stop domestic violence created confusion and, together with negative input from the school environment, this resulted in Danie internalising his anger. He then developed a negative perception of 'I do not fit in', which is a result of cognitive trauma. Danie's reaction corresponds with what the literature indicates, namely that in situations where no rational explanation is found, an irrational belief may develop as a way to gain control. This negative perception also raised the possibility in his mind that he might be gay, as believed by his peers. During the intake interview Danie struggled to share memories of possible trauma; this links with Cohen et al. (2006), who state that attempting to avoid thoughts of negative emotions generates behavioural symptoms of trauma. Fear of possible rejection was also part of Danie's trauma. Danie struggled to decide on his gender preference and feared rejection by his family. Danie knew his brother had negative feelings about gay persons and that he had disappointed his mother in the past. He fears that to acknowledge that he is gay will lead to rejection. Shapiro's (2001) explanation of trauma suggests that Danie is experiencing small-t traumas and that these trauma clusters can have a negative impact on the self, others and the world, which can have a long-term consequence of the possibility of developing PTSD (Forgash & Copeley 2008).

Although domestic violence is an integral part of Erik's case, the sadness created a feeling of loneliness, which was expressed by Erik as the core of his anger. His sadness grew because he was hoping that his father would accept him and love him unconditionally. He experienced his father's behaviour as rejection. His mother also

created sadness in his life as she rejected him and chose her boyfriend over him in situations that he felt she knew were traumatic. Feelings of rejection from his parents resulted in problems with attachment. Geldard and Geldard (2010) are of the view that the kind of attachment a child develops with his caregiver affects his development and the way he deals with traumatic situations. Erik's mother's way of handling stressful situations and his father's abuse were experienced as rejection by Erik. The literature states that a nurturing environment is the key to emotional wellbeing, and the care and security given by the parent's reflects their own experience of being cared for (Wilkinson 2010). Erik grew up in a negative family environment in which he was exposed to child maltreatment. Such an environment produces negative outcomes for children that have a profound impact on the adolescent's functioning, as seen in Erik's case. There was no parental monitoring and, according to the literature, this could result in an increase in conflict (Sagrestano et al. 2003). He struggles to control his anger and engage in aggressive behaviour, which could become the norm in his later relationships, focusing on power and control, as the case of Erik's father. Erik struggles with alcohol abuse and presents with academic deficits.

Babs expressed her anger towards the perpetrator who invaded her personal boundaries and created fear of possible rape. The creation of such fear can produce symptoms of affective trauma, which can reinforce anxiety (Cohen et al. 2006). Babs struggled to cope with the trauma and her fears intensified her feeling generally unsafe. She feels unsafe each time she has to enter their house, which triggers the fear of the trauma experienced. According to Cohen et al. (2006), her fears developed into a general anxiety, which is the core of psychological disorders and usually is stimulated by something within the self (Rothschild 2000). Babs struggles in situations over which she has no control. She experiences fear during tests and exams, and expressed fear because of the uncertainty of not having control over the contents of the tests. The traumatic event also triggered the same difficulty of not being in control.

Linda expressed the core emotions in her life as being depressed and angry, which are symptoms of trauma (Shapiro 2010). Cohen et al. (2006) state that depression may appear after loss of trust in other people and the world, and this may include guilt and suicidal tendencies. Linda made five attempts to commit suicide, and lost her trust in the world and people. An example occurred when Linda expressed her true feelings

to a psychologist, who broke their agreement of confidentiality and shared the information with her parents. She experienced guilt in a situation in ICU where she wanted to die, but feels guilty, as she has no concrete reason for this feeling. Making wrong choices of peers and romantic partners, alcohol abuse and cutting are seen as symptoms of depression, all which are symptoms seen in Linda's case. Linda also experienced emotions such as sadness, feelings of loneliness, hyperactivity and rebellious behaviour. Linda's symptoms were evidence of behavioural disorders. Simeonsson (1994) divides behavioural symptoms into internal and external disorders. The symptoms experienced by Linda correspond to his description. Internalised behaviours involve feelings of loneliness, depression and anxiety. Externalising behaviours show symptoms of aggression, hyperactivity and acting out.

Charl provided his earliest memory of anger when he was humiliated in front of his classmates. He struggled to read and everybody laughed at him. Shame and humiliation triggered the anger in him. During his school years he was exposed to the same threat of having to read in front of the class. Exposure triggered the earlier shame and humiliation, resulting in negative behaviour of stubbornness and refusing to read in front of his classmates. According to Rothschild (2000), shame is a disappointment with the Self. Charl tried to overcome the shame, but was not successful, which created feelings of hopelessness at not being able to change his actions and taking control. The feeling of losing control intensified his anger. According to the literature, such symptoms are a result of trauma (van der Kolk & van der Hart 2003). Smith and Carlson (1997) state that there is a relationship between psychological trauma and behaviour problems, which was evident in Charl's case. He became sensitive to situations that expected change of him and would get irritated and angry if he could not walk the same route to assembly. Perry and Pollar (1998) explain this kind of behaviour as the result of trauma. Intense emotions as a result of the trauma cause the body's coping mechanism to become over-active and therefore struggle to restore homeostasis. The body then creates a new state of equilibrium which is not flexible.

The body scan assesses the body for any sensations that surfaced in relation to the traumatic experience, e.g. the sensations may be associated with emotional tension, a sensory experience or physical sensation related to the traumatic memory (Shapiro

2001). Body sensations are somatic sensations which are involved in expressing emotions (Rothschild 2000). Van der Kolk (2007:214) explains it as 'the body keeping the score'. All five participants experienced physical sensations as a result of the traumatic event. Examples of the body sensations the participants' experienced during the process were: irritation and sadness in their hands, and anger in their minds. Some experienced shivers down their neck with their arms, hands and their shoulders feeling weird. Others felt prickles down their neck and some developed a headache. Others mentioned their body shaking with fear and feeling tense. Tingles in the neck and fingers were also felt. All the body sensations were cleared with bilateral stimulation. The body and brain are thus connected and this not only influences emotions and behaviour but also cognitions, which can affect the self-concept (Solomon & Siegel 2003).

5.3.1.2 Self-concept

Shapiro (2001) is of view that trauma clusters have an impact on beliefs about the self and others, affecting self-esteem, self-definition and self-confidence. Kardiner (as cited by van der Kolk 2010) states that in the case of trauma a person may become fixated on the trauma, causing an alteration in the perception of the self in relation to the world. Attachment problems are one of the unresolved issues of childhood that affect the self-concept and are evident in the cases experiencing developmental trauma. The adolescent phase involves an exploration of identity. Problems with attachment may influence a positive development of the self (Perry 2002).

Linda struggled to identify with her mother. She is in need of affection and attention from her mother. Her perception is one of her doing everything wrong, making her feel insecure and not knowing who she is. Her problems with attachment also surfaced in choices of peers and romantic relationships (Cohen et al. 2006). She struggled to resist peer pressure and engaged in numerous negative behaviours such as alcohol abuse. In romantic relationships Linda chose individuals who were much older than she was, and she confirms her reason for her choices as experiencing a sense of safety and feeling secure.

Erik, Danie and Charl struggled with attachment problems, resulting in negative self-concepts and disrupting their development of a positive identity. Charl grew up without

his father and is in need of a male role model to identify with. The only information he had about his identity figure was the horrible way his father died and Charl experienced that as intensely negative and therefore struggles to connect with his dead father. Danie struggles with attachment from both his mother and his brother. Although he has a good relationship with his mother, he states that his mother always takes his brother's side. He is jealous of the attention his brother receives from his mother, and he experiences his brother as superior to him, which results in negative self-esteem. His negative self-esteem and his father as a negative role model disrupted Danie's perception of his identity. Experiences in primary school of being perceived by his peers as gay intensified his struggle with identity formation. Negative experiences in high school confirmed his negative self-image in such a way that he also started to question his gender preference.

Erik only had rejection, aggression and violence to identify with. This resulted in his feeling 'not worthy'; the literature states that secure and loving care is needed to develop to your full potential (Wilkinson 2001). Although Erik is an intelligent adolescent, his attachment problems and lack of security and love constrain his development. The domestic violence and maltreatment that Erik was exposed to can become the norm in later relationships focusing on power and control (Swick & William 2006; Wenar & Kerig 2006).

Babs, however, had a good self-concept before her traumatic experience. The traumatic event disrupted her overall functioning at home and at school. This case also confirms what is indicated in the literature, namely that when an adolescent experiences developmental or single-incident trauma, it can interfere with the way the adolescent handles challenges in his or her life, which in turn influences adult functioning in the future. Levine and Kline (2007) also state that traumatised teens may experience anxiety, which leads to poor grades.

The self-concept of all the participants was influenced by negative experiences in the past. As discussed in Chapter One, EMDR is a three-pronged approach drawing on the past, present and future, as the past lays the foundation for the participants' presenting problem in the present, which can have an impact on future cognitions and behaviour (Hensley 2009). Therefore desensitisation usually begins with memories

from the past. The findings will be presented according to this approach, but the discussions will commence with the presenting problem for the sake of interpretation.

Present

As discussed in Chapter Three, the present problem is the issue which the participant struggles with at the moment that brought them to therapy (Oras et al. 2004). Charl presented with aggressive behaviour at school and at home, and struggles to talk about his father. Danie stated that he feels he is losing the battle against life, struggles to cope and needs help. He also struggles to decide on his gender preference. Linda decided to take part in the process because she is experiencing feelings of depression and not knowing why. Aggression was Erik's present issue as his aggressive behaviour was becoming a problem at school. Babs struggled with feelings of fear resulting from a single-incident trauma.

Past

The present problem is connected with past events. The past events are the target to address during the EMDR process. During the interview with the parents and participants, possible targets were identified, e.g. where Charl had to read in front of the class and where Erik was confronted aggression from his father. The targets were presented by the participants as an image, feeling, smell, touch or sound (Shapiro 2001). Four of the participants presented developmental trauma (trauma that developed over a period of time) and one participant (Babs) with a single-incident traumatic experience. The targets identified are explained by the Adaptive Information Processing (AIP) model as memories that are dysfunctionally stored (Shapiro 2001) and it appears as if the person is fixated on the traumatic event and struggles to find an adaptive resolution (Hensley 2009). The maladaptive cognitions are also called the touchstone event (Shapiro 2001). After the targets of the participants were identified, the maladaptive storage was expressed by the Negative Cognition (NC) and the adapted resolution by the Positive Cognition (PC). A new NC connected with the touchstone memory may surface, and in between the NCs images surfaced that connected with the maladaptive cognition. Those images are the different channels or cluster memories connected with the NC. They had to be cleared before a target was seen as adapted (Shapiro 2001).

According to the literature, trauma is a complex phenomenon. The intensity of the traumatic experience can be influenced by the source, context, temperament and developmental phase of the individual (Blaustein & Kinniburgh 2010). The SUD level gives an indication of how intensely the individual experienced the event. The VOC gives an indication of what progress was made. The VOC also indicates how close the individual is to reaching an adapted resolution for an image. The participants' maladaptive and adaptive material as well as the images or clusters connected to the NC will be presented and interpreted below.

CHARL

Maladaptive	Adaptive
I am stupid Five cluster memories	I can do it
I do not have confidence Four cluster memories	I am confident
I cannot control anger in conflict situations Nine cluster memories	I handle conflict situations calmly

LINDA

Maladaptive	Adaptive
I am alone Four clusters	It is ok to be myself
I am different and stupid	It is ok to be different
I am not important Three clusters	My thoughts and feelings are important
I do not have control Two clusters	I can stop, think and do
I am evil	I am peaceful and chilled
I do not belong	I want to belong

DANIE

Maladaptive	Adaptive
I am not important One cluster memory	I am important
I am stupid and do everything wrong One cluster	I am creative, take initiative and can think.
I am pathetic Two clusters	It is ok to be me
I am emotionally confused	I am emotionally secure
I am a disappointment One cluster	It is ok to be myself
I am not worthy	I am worthy

ERIK

Maladaptive	Adaptive
I am worthless Twelve clusters	I am worthy
I am helpless Two clusters	I can decide
I am afraid Four clusters	I am safe
Nobody wants me Five clusters	I am wanted

BABS

Maladaptive	Adaptive
I do not have control Whole image of the single incident trauma 21 clusters	I am ok with myself in situations which I do not have control on
I am not safe No clusters	I am safe
I am scared and uncertain about the future Three clusters	I am calm and have self-confidence

Linda and Erik presented with fewer NCs but with the most clusters (feeding memories connected with the target). According to the literature discussed earlier, a target has not been resolved if the SUD of the NC does not drop down to 1. All the clusters that surfaced indicated that Linda and Erik had more dysfunctionally stored material connected to the specific target that had to be desensitised (Shapiro 2001). In the interview Danie struggled to recall traumatic memories; van der Kolk and van der Hart (2003) explain this as one of the symptoms of trauma. Carrion et al. (2009) state that sometimes distressing memories are too painful and then the adolescent may numb them out as a means to protect himself.

The results show that EMDR had a positive effect on trauma, whether developmental or single-incident. Not one of the presented issues was superior to the other. All five participants showed improvement in all areas of their life.

The findings demonstrated that when the adolescents' memories of a negative event become less vivid, they start to interact positively with their environment (Shapiro 2001).

Positive changes:

Charl

After the 2nd session positive changes in Charl's life were evident. The moment Charl's traumatic memory of struggling with reading was desensitised, his behaviour and attitude towards reading changed positively. He went to his English teacher and asked permission to read out loud in class. He searched on Facebook for Tanja, who had humiliated him at his grandmother's wedding. He found her and left her a message: "Somewhere out there is a guy who hated you but now he's over it." He also experienced less anger. He became more flexible and open to change. Walking the same road to assembly was not an issue anymore. His confidence in playing rugby is restored, as he stated: "Done and dusted". After the fourth and final session Charl was more open to talk about his father and realised that he only needed to ask his mother about his character. Previously he was fixated on avoiding comments about how his father died. After the data were collected, Charl continued with EMDR treatment and his grades improved by 10-30% and he has a positive outlook on life.

Linda

After the third session Linda appeared more energetic and her body language was more positive. She went for auditions to sing in the school choir and the results were positive. She appears more responsible and in control of her life. She decided to stop with her ballet classes and to focus on her schoolwork – she made the decision herself. She was invited to play in a hockey match for the school. She never takes part in any sporting activity, but agreed and enjoyed it. Her grades improved dramatically and self-mutilation stopped. Linda decided to continue with therapy. Her grades improved dramatically. She sang in the Eisteddfod and received a gold certificate and was one of the finalists for the school's beauty competition.

Danie

He appeared more relaxed. He did not have any nightmares again. Negative thoughts and wishes to die disappeared. He was successful as head chef at a restaurant evening at school. His mathematics scores improved by 10% and he obtained a distinction in Art – his first distinction in high school. His self-concept improved and he

started to make positive comments about himself. Danie decided to continue with therapy. There are more issues regarding his gender preference and he wants to work on his relationship with his brother.

Erik

His involvement in violent behaviours decreased. He shows more respect for his teachers and appears more positive. He expressed that he feels much more calm and relaxed. His sleeping patterns improved and he does not fall asleep in class anymore and feels less tired. Erik is still continuing with therapy. His grades are improving and he is in a stable relationship with a girl. He handles conflict situations with more patience. Substance abuse is still a problem.

Babs

The traumatic event has been desensitised completely. Her grades improved. Her fear disappeared and she can enter their home with confidence and is more socially active. Babs did continue with therapy.

The following comments reflect the participants overall view on their EMDR experience:

'I like this stuff, It's cool. It works (4.25 *Ek laaik die goed. Dis cool. Dit werk.*

'Wow, this is really nice (4.58 *Wow, tannie dit is regtig 'nice'*).

'This stuff is really cool. I don't think I have ever felt this calm in my whole life' (4.72 *Hierdie goed is 'flippen cool'. Ek dink nie ek het al ooit in my lewe so rustig gevoel nie*).

'You know, it's strange, I see it but it is not awful. I don't know how to explain it. It's really like *there*' (4.10 *Tannie dis snaaks maar ek sien dit maar dit is nie erg nie. Ek weet nie hoe om te verduidelik nie. Dis regtig soos daar*);

'It remains nasty to see it, but I no longer feel as if I am frightened and panicky' (4.12 *Dit bly goor om dit te sien maar ek voel nie meer so dat ek bang is nie en paniekerig voel nie*);

This diagram below is an illustration of the summary of the findings in the study. The central theme of this study was to explore EMDR as therapeutic modality for trauma. Participants experiencing developmental trauma and trauma with a single incident were included in the study.

Babs was the only participant exposed to a single-incident trauma; Charl, Linda, Danie and Erik experienced developmental trauma. The participants were exposed to the same treatment procedure, resulting in positive outcomes for them all. For example, Charl presented with a maladaptive cognition of 'I am stupid', which created anger in him. After desensitisation the negative cognition was not valid anymore and shifted to a positive cognition of 'I can do it' and letting go his anger. Linda viewed herself as being alone. After intervention she stated her cognition as 'It is OK to be me'. Babs experienced a single-incident trauma. Her presenting problem was fear and her negative cognition of the event was 'I do not have control'. After the EMDR sessions she stated her adapted cognition as 'I am OK with myself in situations over which I do not have control'. The EMDR process seemed to be effective in treating trauma from a single incident as well as from incidents over a longer period of time, resulting in positive outcomes in all cases as presented below:

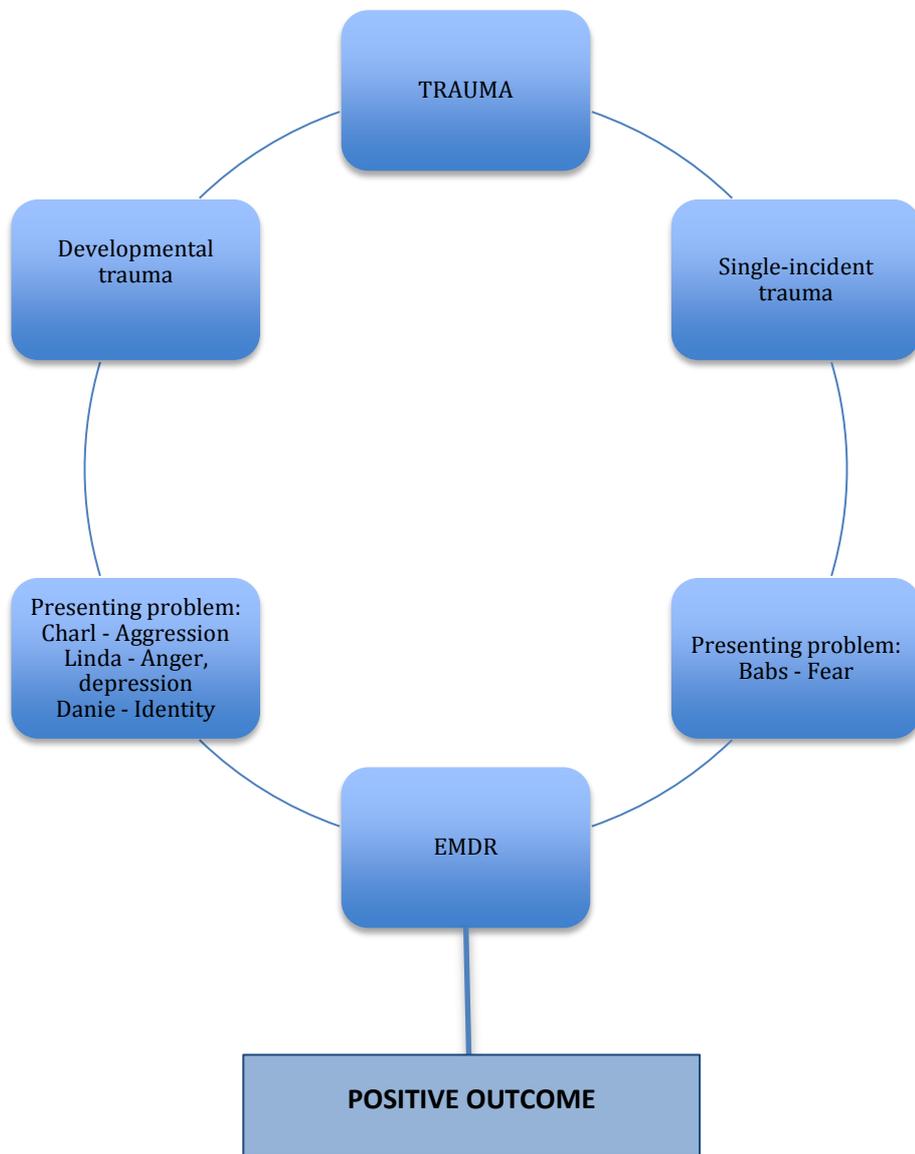


Figure 5.1: EMDR treatment of two types of trauma

5.4 CONTRIBUTION OF THIS STUDY

The purpose of the study was to explore EMDR as therapeutic tool to address trauma symptoms in adolescents.

Research on EMDR in other countries showed the effectiveness of this method for dealing with traumatic stress and PTSD (González-Prendez & Resko 2012; Ironson et al. 2002) Application of this method is well researched on adults and children, and has proved to be effective worldwide. Research on the efficacy of EMDR in South Africa has not been explored yet. The literature provided a detailed view of the need for trauma intervention among adolescents. The findings in this study showed that EMDR has potential as an effective therapeutic technique for supporting adolescents exposed to recent incidents of trauma or incidents of trauma in the past. The study therefore contributes to the body of research by introducing EMDR as an effective treatment for trauma in adolescents in South Africa.

5.5 LIMITATIONS OF THE STUDY

In this study a case study approach was the strength of the research. The study provided detailed information on five adolescents who experienced trauma. Methodologically speaking, the focus of a qualitative study is on understanding and not on generalising. A recommendation would be to have interviews with the participants' significant others to provide a deeper understanding of the participants and their behaviour. A small sample like this study makes it more difficult to generalise the findings to the broad population. A bigger study might address this limitation.

As researcher, I entered the research situation with my own background and perceptions, which can in itself be viewed as a limitation of the study. The use of a video recording created stress in some participants and distracted their attention from the process. I assured them of the principle of confidentiality and they agreed that we could erase it together after data collection. Not involving the adolescents' parents is another limitation. Their involvement could have added benefits to the results.

5.6 RECOMMENDATIONS FOR FURTHER RESEARCH

The number of cases participating in this study was not representative of the different cultures and contexts in South Africa and it is recommended that this be addressed in further research. Another recommendation would be to do follow-up interviews after 6 months with participants and their parents to determine if the EMDR therapy had lasting effects. It would also be valuable to do research on the use of the EMDR technique on younger children in the South African context.

5.7 CONCLUDING REMARKS

In order to meet societal needs and growing challenges, this study attempted to conduct research on how the participants experienced EMDR and to identify knowledge that may be utilised in addressing the trauma that adolescent's experience. In the literature review the social changes and their negative implications for communities were discussed. It seems that trauma affects all areas of adolescents' lives and hence the need for trauma intervention is evident.

In the USA EMDR as a therapeutic tool has proved to be effective in the treatment of trauma (Greenwald 2002). In this study I attempted to explore EMDR as an intervention tool for trauma experienced by adolescents in South Africa.

REFERENCES

- Abram, K.M., Teplin, L.A., Charles, D.R., Longworth, S.L. McClelland, G.M. & Dulcan, M.K. 2004. Posttraumatic stress disorder and trauma in youth in juvenile detention. *Archives of General Psychiatry*, 61:403-410.
- Abram, K.M., Washburn, J.J., Teplin, L.A., Emanuel, K.M., Romero, E.G. & McClelland, G.M. 2007. Posttraumatic stress disorder and psychiatric comorbidity among detained youths. *Psychiatric Services*, 58:1311-1316.
- Ackerman, C. 2001. Promoting development during adolescence. In P. Engelbrecht & L. Green. *Promoting Learner Development. Preventing and Working with Barriers to Learning*. pp. 101-108. Pretoria: Van Schaik.
- Adler-Nevo, G. & Manassis, K. 2005. Psychosocial treatment of pediatric posttraumatic stress disorder: the neglected field of single-incident trauma. *Journal of Depression and Anxiety*, 22(4):177-189.
- Adler-Tapia, R. & Settle, C. 2008. *EMDR and the Art of Psychotherapy with Children*. New York: Springer.
- Ahmed, A., Larsson, B. & Sundelin-Wahlsten, V. 2007. EMDR treatment for children with PTSD: Results of a randomized controlled trial. *Nordic Journal of Psychiatry*, 61(5):349-354.
- Ainsworth, M.D.S., Blehar, M., Waters, E. & Wall, S. 1978. *Patterns of Attachment. A Psychological Study of the Strange Situation*. Hillsdale NJ: Erlbaum.
- Amen, D.G. & Routh, L.C. 2003. *Healing Anxiety and Depression*. California: The Berkley Publishing Group.
- Amen, D.G. 1998. *Change Your Brain, Change your Life*. New York: Three Rivers Press.
- Amen, D.G. 2004. *Images of Human Behaviour*. USA: Mindworks Press.

- American Psychiatric Association. 2000. *Diagnostic and Statistical Manual of Mental Disorders. DSM-V* (5th Edition). Arlington, VA.: American Psychiatric Association.
- American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders* (5th Edition). Arlington VA: American Psychiatric Association.
- American Psychological Foundation. 2002. *Developing Adolescents. A Reference for Professionals*. 1-35. Retrieved from www.apa.org/pi/families/.../talking-teens.pdf.
- Babbie, E. & Mouton, J. 2001. *The Practice of Social Science Research*. Cape Town: Oxford University Press.
- Babbie, E. 2007. *The Practice of Social Research* (11th Edition). USA: Wadsworth.
- Babbie, E. 2010. *The Practice of Social Research* (12th Edition). Belmont: Wadsworth.
- Bae, H., Kim, D. & Park Y.C. 2008. Eye movement desensitization and reprocessing for adolescent depression. *Journal of Korean Neuropsychiatric Association*, 5:60-65.
- Bagot, R., Parent, C., Bredy, T.W., Zhang, T., Gratton, A & Meaney, M.J. 2008. Developmental origins of neurobiological vulnerability for PTSD. In L.J. Kirmayer, R. Lemelson & M. Barad (Eds.). *Understanding Trauma. Integrating Biological, Clinical, and Cultural Perspectives*. pp. 98-118. New York: Cambridge University Press.
- Bailey, K.D. 1994. *Methods of Social Research*. New York: The Free Press.
- Barbarin, O.A., Richter, L. & de Wet, T. 2001. Exposure to violence, coping resources and adjustment of South African children. *American Journal of Orthopsychiatry*, 7:16-25.
- Baxter, P. & Jack, S. 2008. Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report*, 13:544-559.
- Bell, C.C. & Jenkins, E.J. 1993. Community violence and children on Chicago's Southside. *Psychiatry: Interpersonal and Biological Processes*, 5(1):46-54.

- Bernard, H.S. 2000. *Social Research Methods: Qualitative and Quantitative Approaches*. London: SAGE.
- Bernstein, D.A. 2011. *Essentials of Psychology* (5th Edition). Belmont: Wadsworth.
- Blaustein, M.E. & Kinniburgh, K.M. 2010. *Treating Traumatic Stress in Children and Adolescents*. New York: Guilford Press.
- Brett, E.A. 2007. *The Classification of Posttraumatic Stress Disorder in Traumatic Stress*. New York: The Guilford Press.
- Briere, J., & Elliot, D.M. 2000. Prevalence, characteristics and long term sequelae of natural disaster exposure in the general population. *Journal of Traumatic Stress*, 13, 661-679.
- Broad, R.D. & Wheeler, K. 2006. An Adult with childhood medical trauma treated with psychoanalytic psychotherapy and EMDR: A Case study. *Perspectives in Psychiatric Care*, (42)2:95-105.
- Burns, B.J., Phillips, S.D., Wagner, H.R., Barth, R.P., Kolko, D.J., Campbell, Y. & Landsverk, J. 2004. Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43:960-970.
- Camilleri, V.A. 2007. *Healing the Inner City Child*. London: Jessica Kingsley Publishers.
- Campbell, R. 2005. *Jy Kan Jou Tiener Liefhê*. Vereeniging: Christelike Uitgewersmaatskappy.
- Carey P.P., Walker J.L., Rossouw, W., Seedat S. & Stein, D.J. 2008. Risk indicators and psychopathology in traumatised children and adolescents with a history of sexual abuse. *Journal of Child and Adolescent Psychiatry*, 17(2):93-98.
- Casey, B.J., Jones, R.M. & Hare, T.A. 2008. The adolescent brain. *Annals of the New York Academy of Sciences*, 1124:111-126.

- Chrousos, G.P. 1998. Stressors, stress and neuroendocrine integration of adaptive response. The 1997 Hans Selye Memorial Lecture. *Annals of the New York Academy of Science*. pp. 851:311-335.
- Cluver, L. & Gardner, F. 2006. The psychological well-being of children orphaned by AIDS in Cape Town, South Africa. *Annals of General Psychiatry*, 5(8):8-19.
- Cluver, L., Fincham, D. & Seedat, S. 2009. The testimony of political repression as a therapeutic instrument. *American Journal of Orthopsychiatry*, 53(1):43-51.
- Cohen, J.A., Berliner, L. & March, J.S. 2000. Treatment of children and adolescents. In E.B. Foa, T.M. Keane & M.J. Friedman (Eds.). *Effective Treatments for PTSD*. New York: The Guilford Press.
- Cohen, J.A., Mannarino, A.P. & Deblinger, E. 2006. *Treating Trauma and Traumatic Grief in Children and Adolescents*. New York: The Guilford Press.
- Cohen, L., Manion, L. & Morrison, K. 2007. *Research Methods in Education*. London: Routledge.
- Cohen, L., Manion, L. & Morrison, K. 2001. *Research Methods in Education* (5th Edition). New York: Routledge Falmer.
- Coleman, A.M. 2009. *Oxford Dictionary of Psychology*. Oxford: Oxford University Press.
- Costello, E.J., Erkanli, A., Fairbank, J.A. & Angold, A. 2002. The prevalence of potentially traumatic events in childhood and adolescence. *Journal of Traumatic Stress*, 15(2):99-112.
- Cozolino, L. 2010. *The Neuroscience of Psychotherapy* (2nd Edition). New York: W.W. Norton & Company.
- Crabtree, B.F. & Miller, W.L. 1999. *Doing Qualitative Research* (2nd Edition). California: SAGE.

Creswell, J.W. 2008. *Educational Research. Planning, Conducting, and Evaluating Quantitative and Qualitative Research* (3rd Edition). New Jersey: Pearson Prentice Hall.

Creswell, J.W. 2009. *Research Design. Qualitative, Quantitative, and Mixed Methods Approaches* (3rd Edition). London: SAGE.

Crime Stats SA Simplified. Retrieved from www.crimestatssa.com/national.php.

Cuzen, N.L. 2012. Disinhibition in South African treatment-naïve adolescents with alcohol disorders. Study in progress. Cape Town: University of Cape Town.

Dass-Brailsford, P. & Myrick, A.C. 2010. Psychological trauma and substance abuse: The need for an integrated approach. *Journal of Trauma, Violence and Abuse*, 11(4):202-213.

Dawes, A. & Ward, C.L. 2008. Levels, trends and determinants of child maltreatment in the Western Cape province. In R. Marindo, C. Groenewald, & S. Gaisie (Eds.). 2008. *The State of Population in the Western Cape Province*. Cape Town: HSRC Press. pp. 97-125. Retrieved from www.hsrcpress.ac.za.

Dawes, A., Tredoux, C. & Feinstein A. 1989. Political violence in South Africa: Some effects on children of the violent destruction of their community. *International Journal of Mental Health*, 18:16-43.

De Bellis, M.D., Hooper, S.R., Woolley, D.P. & Shenk, C.E. 2010. Demographic, Maltreatment, and neurobiological correlates of PTSD symptoms in children and adolescents. *Journal of Pediatric Psychology*, 35(5):570-577.

De Roos, C. & de Jong, A.D. 2008. EMDR treatment of children and adolescents with a choking phobia. *Journal of EMDR Practice and Research*, 2(3):201-208.

De Roos, C., Greenwald, R., De Jong, A. & Noorthoorn, E.O. 2004. EMDR vs CBT for disaster-exposed children. A controlled study. [Presentation at the 20th Annual Meeting of the International Society of Traumatic Stress studies]. New Orleans. Retrieved from www.emdr.nku.edu/emdr.

- De Vos, A.S. 1998. *Research at Grass Roots. A Primer for the Caring Professions*. Pretoria: Van Schaik.
- Deardorff, J., Gonzales, N.A. & Sandler, I.N. 2003. Control beliefs as a mediator of the relation between stress and depressive symptoms among inner city adolescents. *Journal of Abnormal Child Psychology*, 31(2):205-217.
- Deblinger, E., Steer, R.A. & Lippmann, J. 1999. Two year follow-up study of cognitive behavioral therapy for sexually abused children suffering post traumatic stress symptoms. *Journal of Child Abuse & Neglect*, 23:1371-1378.
- Denzin, N.K. & Lincoln, Y.S. 1998. *The Landscape of Qualitative Research*. London: SAGE.
- Denzin, N.K. & Lincoln, Y.S. 2005. Introduction: The discipline and practice of qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.). *Handbook of Qualitative Research* (3rd Edition). pp. 1-43. London: SAGE.
- Denzin, N.K. & Lincoln, Y.S. 2008. *Collecting and Interpreting Qualitative Materials*. London: SAGE.
- DeVilly, G.J. & Spence, S.H. 1999. The relative efficacy and treatment distress of EMDR and a cognitive-behavior trauma treatment protocol in the amelioration of post-traumatic stress Disorder. *Journal of Anxiety Disorders*, 13(1-2):131-157.
- Dinkmeyer, D. (Sr.), Dinkmeyer, D. (Jr.), McKay, G. & McKay, J. 1998. *Parenting Teenagers. Systematic training for Effective Parenting of Teens*. Circle Pines: American Guidance Services, Inc.
- Dodd, S. & Epstein, I. 2012. *Practice-Based Research in Social Work. A Guide for Reluctant Researchers*. New York: Routledge.
- Donson, H. 2011. Impact of violence on youth in South Africa: Briefing by South African Medical Research Council. Retrieved from www.pmg.org.za.
- Downing, J., Jenkins, S.J. & Fisher, G.L. 1988. A comparison of psychodynamic and reinforcement treatment with sexually abused children. *Elementary School Guidance and Counseling*, 22(4):291-298.

- Duncan, N. & Rock, B. 1997. Overview. In B. Rock (Eds.). *Spirals of suffering: public violence and children*. pp. 31-42. Pretoria: HSRC Publishers.
- Eagan, G. 2002. *The Skilled Helper. A Problem-Management, and Opportunity-Development Approach to Helping* (7th Edition). Belmont: Cole Thomson Learning.
- Ensink, K., Roberson, B.A., Zissis, C. & Leger, P. 1997. Post traumatic stress disorder in children exposed to violence. *South African Medical Journal*, 87:1526-1530.
- Fairbank, National Centre of PTSD. 2008. Vol 19(1) retrieved from:
<http://www.ptsd.va.gov/professional/newsletters/research-quarterly/V19N1.pdf>
- Fargher, M. & Dooley, H. 2011. *How Children Experience Trauma and How Parents Can Help Them Cope*. New York: Penguin Books.
- Farkas, L., Cyr, M., Lebeau, R.M. & Lemay, J. 2010. Effectiveness of MASTR/EMDR therapy for traumatized adolescents. *Journal of Child and Adolescent Trauma*, 3(2):125-142.
- Flannery, R.B. 1995. Psychological trauma and Posttraumatic Stress Disorder: A review. *International Journal of Emergency Mental Health*, 77-81.
- Flick, U. 2009. *An Introduction to Qualitative Research* (4th Edition). London: SAGE.
- Foa, E.B., Keane, T.M. & Friedman, M.J. 2000. *Effective Treatments for PTSD. Practice Guidelines from the International Society for Traumatic Stress Studies*. New York: Guilford Publications.
- Forgash, C. & Copeley, M. 2008. *Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy*. New York: Springer.
- Garland, C. 2002. *Understanding Trauma: A Psychoanalytic Approach* (2nd Edition). London: Karnac Books.
- Geertz, C. 1973. Thick description. Toward an Interpretive theory of culture. In C. Geertz. *The Interpretations of Cultures: Selected Essays*. pp 3-30. New York: Basic Books.

- Geldard, K. & Geldard, D. 2010. *Counselling Adolescents. The Proactive Approach for Young People* (3rd Edition). London: SAGE.
- Goenjian, A.K., Molina, L., Steinberg, A.M., Fairbanks, L.A., Alvarez, M.L. & Pynoos, R.S. 2001. Posttraumatic stress and depressive reactions among adolescents in Nicaragua after Hurricane Mitch. *American Journal of Psychiatry*, 158(5):788-794.
- González-Prendes, A. & Resko, S.M. 2012. Cognitive behavioral theory. In S. Ringel & R.B. Brandell. *Cognitive Behavioral Theory in Trauma. Contemporary Directions in Theory, Practice and Research*. pp. 14-40. USA: SAGE.
- Gorman-Smith, D., Tolan, P.H. & Henry, D.B. 2000. A developmental-ecological model of the relation of family functioning to patterns of delinquency. *Journal of Quantitative Criminology*, 16(2):169-198.
- Green, J. & Thorogood, N. 2009. *Qualitative Methods for health Research* (2nd Edition). London: SAGE.
- Greenwald, R. 1999. *Eye Movement Desensitization and Reprocessing (EMDR) in Child and Adolescent Psychotherapy*. Northvale: Aronson.
- Greenwald, R. 2000. A trauma-focused individual therapy approach for adolescents with conduct disorder. *International Journal of Offender Therapy and Comparative Criminology*, 44:146-163.
- Greenwald, R. 2001. *Eye Movement Desensitization and Reprocessing (EMDR) in Child and Adolescent Psychotherapy*. New York: Rowman & Littlefield Publishers.
- Greenwald, R. 2009. *Treating Problem Behaviours: A Trauma-informed Approach*. New York: Routledge.
- Greyber, L.R., Dulmus, C.N. & Cristalli, M.E. 2012. Eye movement desensitization reprocessing, posttraumatic stress disorder, and trauma: A review of randomized controlled trials with children and adolescents. *Child Abuse Social Work Journal*, 29:409-425.

- Guba, E.G. & Lincoln, Y.S. 1982. Epistemological and methodological bases of naturalistic inquiry. *Educational Communication and Technology Journal*, 30(4):233-252.
- Guba, E.G. 1981. Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology Journal*, 29(2):75-91.
- Guba, E.G. 1990. *The Paradigm Dialogue*. Newbury Park: SAGE.
- Gunter, R.W. & Bodner, G.E. 2009. EMDR works. But how? Recent progress in the search for treatment mechanisms. *Journal of EMDR Practise and Research*, 3(3):161-168.
- Hamel, J., Dufour, S. & Fortin, D. 1993. *Case Study Methods*. Newbury Park: SAGE.
- Hamilton-Green, N. 2012. The influence of resilient behaviour on the academic performance of poverty stricken adolescents in Gauteng. *Study in progress*. Cape Town: University of Cape Town.
- Health Profession Council of South Africa (HPCSA) 2005 form 223: Rules of Conduct Pertaining Specifically to Psychology. Pretoria: HPCSA.
- Henning, E. 2004. *Finding Your Way in Qualitative Research*. Pretoria: Van Schaik.
- Hensel, H. 2009. EMDR with children and adolescents after single-incident trauma. *Journal of EMDR Practice and Research*, 3(1):2-9.
- Hensley, B.J. 2009. *An EMDR Primer. From Practicum to Practice*. New York: Springer.
- Hesse-Biber, S.N. & Leavy, P. 2006. *The Practice of Qualitative Research*. London: SAGE.
- Hesse-Biber, S.N. & Leavy, P. 2011. *The Practice of Qualitative Research* (2nd Edition). London: SAGE.
- Holmes, E. 2005. *Teacher Well-being*. Oxon: Routledge Falmer.

- Ironson, G., Freud, B., Strauss, J.L. & Williams, J. 2002. Comparison for two treatments for traumatic stress: A community-based study of EMDR and prolonged exposure. *Journal of Clinical Psychology*, 58(1):113-128.
- Israel Centre for the Treatment of Psychotrauma. *Stress versus Trauma*. Retrieved from www.traumaweb.org.
- Itano, N. 2003. South Africa begins getting tough on rape. Retrieved from: www.womenseneneews.org
- Jaberghaderi, N., Greenwald, R., Rubin, A., Zand, S.O. & Dolatabadi, S. 2004. A comparison of CBT and EMDR for sexually-abused Iranian girls. *Journal of Clinical Psychology and Psychotherapy*, 11:358-368.
- Jewkes, R., Levin, J., Mbananga, N. & Bradshaw, D. 2002. Rape of girls in South Africa. *The Lancet*, 359:319-321
- Jordaan, W. & Jordaan, J. 1998. *People in Context* (3rd Edition). Johannesburg: Heinemann Higher & Further Education (Pty) Ltd.
- Kaminer, D. & Eagle, G. 2010. *Traumatic Stress in South Africa*. Johannesburg: Wits University Press.
- Kaminer, D., Grimsrud, A., Myer, L. & Williams, D.R. 2008. Risk for posttraumatic stress disorder associated with different forms of interpersonal violence in South Africa. *Social Science and Medicine*, 67(10):1589-1595.
- Kelly, K. 2006. Lived experience and interpretation: The balancing act in qualitative analysis. In M. Terre Blanche, K. Durrheim & D. Painter. *Research in Practice. Applied Methods for the Social Sciences*. pp. 345-370. Cape Town: University of Cape Town Press.
- Kirmayer, L.J., Lemelson, R. & Barad, M. 2008. *Understanding Trauma*. New York: Cambridge University Press.
- Kriel, M. 2009. Child raped every three minute. Downloaded from www.news24.com

- Krystal, J.H., Bremner, J.D., Southwick, S.M. & Charney, D.S. 1998. The emerging neurobiology of dissociation: Implication for treatment of post-traumatic stress disorder. In J.D. Bremner & C.R. Marmar (Eds.). *Trauma, Memory and Dissociation*. pp. 321-364. Washington: American Psychiatric Press.
- Kvale, S. 1996. *Interviews. An Introduction to Qualitative Research. Interviewing*. Newbury Park: SAGE.
- Laba, D. 2005. Psychotherapy for post-traumatic stress disorder in a young rape survivor: A case study. *Journal of Psychology in Africa*, 15(2):77-184.
- Langa, M. & Eagle, G. 2008. The intractability of militarised masculinity: A case study of former combatants in the Kathorus area, South Africa. *South African Journal of Psychology*, 38(1):152-175.
- Lanius, R., Lanius, U., Fisher, J. & Ogden, P. 2006. Psychological trauma and the brain: Toward a neurobiological treatment model. In P. Ogden, K. Minton & C. Pain. *Trauma and the Body. A Sensorimotor Approach to Psychotherapy*. pp. 139-161. London: Norton & Company.
- Lee, C., Garriel, H., Drummond, P., Richards, J. & Greenwald R. 2002. Treatment of post-traumatic stress disorder: A comparison of stress inoculation training with prolonged exposure and eye movement desensitization and reprocessing. *Journal of Clinical Psychology*, 58:1071-1089.
- Leedy, P.D. & Ormrod, J.E. 2001. *Practical Research: Planning and Design* (7th Edition). New Jersey: Merrill Prentice Hall.
- Levine, P.A. & Kline, M. 2007. *Trauma Through a Child's Eyes*. Lyons: ERGOS Institute Press.
- Levine, P.A. 2010. *In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness*. California: North Atlantic Books.
- Lewis, A. & Ngqela, N. 2012. Exploring adolescent learners' experiences of school violence in a township high school. *Child abuse research: A South African Journal*, 13(1):87-97.

- Lewis, A. 1992. Individual and community needs as aspects of the education crisis in South Africa. Unpublished MEd thesis. Stellenbosch: University of Stellenbosch.
- Lewis, A. 2009. Assessing childhood trauma: a holistic perspective. *Child Abuse Research: A South African Journal*, 10(1):14-26.
- Lewis, S. 1999. *An Adult's Guide to Childhood Trauma. Understanding Traumatized Children in South Africa*. Claremont: David Philip Publishers.
- Lincoln, Y. & Guba, E. 1985. *Naturalistic Enquiry*. California: SAGE.
- Lincoln, Y.S. & Guba, E.G. 1994. Competing paradigms in qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.). *Handbook of Qualitative Research*. pp. 105-117. London: SAGE.
- Lindegger, G. 2006. Research methods in clinical research. In M. Terre Blanche & K. Durrheim. *Research Practice: Applied Methods for the Social Sciences*. pp. 251-268. Cape Town: University of Cape Town Press.
- Loewenstein, R.J. 1993. Dissociation, development and the psychobiology of trauma, *Journal of the American Academy of Psychoanalysis*, 21(4):581-603.
- Luxenberg, T., Spinazzola, J. & van der Kolk, B.A. 2001. Complex and disorders of extreme stress (DESNOS) diagnoses, Part 1: Assessment. *Directions in Psychiatry*, (21) lesson 25.
- Lytle, R.A., Hazlett-Stevens, H. & Borkovec, T.D. 2002. Efficacy of eye movement desensitization in the treatment of cognitive intrusions related to a past stressful event. *Journal of Anxiety Disorder*, 16:273-288.
- Margolin, G. & Vickerman, A. 2007. Post-traumatic stress in children and adolescents exposed to family violence: 1. Overview and Issues. *Professional Psychology, Research and Practice*, 38(6):613-619. Downloaded from www.ncbi.nlm.nih.gov.
- Marks, B.J. 2012. Psychotherapy with an adolescent girl in a mixed-race stepfamily in post-apartheid South Africa. *Study in progress*. Cape Town: University of Cape Town.

- Maxwell, J. 1992. Understanding and validity in qualitative research. *Harvard Educational Review*, 62(3):279-300.
- Mayer, E.A. & Collins, S.M. 2002. Evolving pathophysiologic models of functional gastrointestinal system. *Gastroenterology*, 122:2032-2048.
- Mayer, E.A. 2008. Somatic manifestations of traumatic stress. In L. Kirmayer, R. Lemelson & M. Barad (Eds.). *Understanding Trauma*. pp. 142-170. New York: Cambridge University Press.
- McGregor, J., Schoeman, W.J. & Stuart, A.D. 2002. The victim's experience of hijacking: an exploratory study. *Health SA Gesondheid*, 7:33-45.
- McLoyd, V.C. 1990. The impact of economic hardship on black families and children: Psychological distress, parenting, and socio-emotional development. *Journal of Child Development*, 61:311-346.
- McMillan, J.H. & Schumacher, S. 2001. *Research in Education. A Conceptual Introduction* (5th Edition). New York: Longman Publishers.
- Merriam, S.B. 2002. *Qualitative Research and Case Study Applications in Education*. San Francisco: Jossey-Bass Publishers.
- Meyer, W.F., Moore, C. & Viljoen, H.G. 2003. *Personology: From Individual to Ecosystem* (3rd Edition). Johannesburg: Heinemann.
- Morse, J.M. 1994. *Critical Issues in Qualitative Research Methods*. Thousand Oaks: SAGE.
- Mouton, J. 2001. *How to succeed in your Master's and Doctoral Studies – A South African guide and Resource Book*. Pretoria: Van Schaik.
- Newman, W.L. 2005. *Social Research Methods. Quantitative and Qualitative Approaches* (5th Edition). Boston: Pearson Education, Inc.
- Ntshangase, M. 2012. Juvenile delinquency amongst adolescents in secondary schools in Soshanguve: A socio-educational perspective. *Study in progress*. Cape Town: University of Cape Town.

- Ogden, P., Minton, K. & Pain, C. 2006. *Trauma and the Body*. London: Norton & Company, Inc.
- Oras, R., de Ezpeleta, C. & Ahmad, A. 2004. Treatment of traumatized refugee children with eye movement desensitization and reprocessing in a psychodynamic context. *Nordic Journal of Psychiatry*, 58(3):199-203.
- Padgett, K.D. 2004. *The Qualitative Research Experience*. London: SAGE.
- Parnell, L. 1997. *Transforming Trauma: EMDR. The Revolutionary New Therapy for Freeing the Mind, Clearing the Body, and Opening the Heart*. New York: Norton & Company.
- Patton, M.Q. 2002. *Qualitative Research and Evaluation Methods*. California: SAGE.
- Perry, B.D. & Pollard, R. 1998. Homeostasis, stress, trauma, and adaptation. *Child and Adolescent Psychiatric Clinics of North America*, 7(1):33-51.
- Perry, B.D. 2009. Examining child maltreatment through a neurodevelopmental lens: Clinical applications of neurosequential model of therapeutics. *Journal of Loss and Trauma*, 14:240-255.
- Prachet, L.C. & Yehuda, R. 2011. Foundations of posttraumatic stress disorder: Does early life trauma lead to adult posttraumatic stress disorder? *Journal of Development and Psychopathology*, 23:477-491.
- Prinsloo, E. 2005. Socio-economic barriers to learning in contemporary society. In E. Landsberg, D. Kruger & N. Nel (Eds.). *Addressing Barriers to Learning*. pp. 27-42. Pretoria: Van Schaik.
- Punch, K.F. 2005. *Introduction to Social Research. Quantitative and qualitative approaches*. London: SAGE.
- Putnam, F.W. 1997. *Dissociation in Children and Adolescents: A Developmental Perspective*. New York: Guilford Press.

- Reiman, E., Lane, R.D., Ahern, G., Schwartz, G. & Davidson, R. 2002. Position emission tomography in the study of emotion, anxiety and anxiety disorders. In R.D. Lane & L. Nadel (Eds.). *Cognitive Neuroscience of Emotion*. pp. 389-406. New York: Oxford University Press.
- Reinharz, S. 1992. *Feminist Methods in Social Research*. New York: Oxford University Press.
- Rothbaum, B.O., Foa, E.B., Riggs, D.S., Murdock, T. & Walsh, W. 1992. A prospective examination of post-traumatic stress disorder in rape victims. *Journal of Traumatic Stress*, 5(3):455-475.
- Rothschild, B. 2000. *The Body Remembers*. London: W.W. Norton & Company.
- Rubens, A. & Babbie, E.R. 2001. *Research Methods for Social Work* (4th Edition). Belmont: Wadsworth Publishing.
- Sadock, B.J. & Sadock, V.A. 2007. *Kaplan and Sadock's Synopsis of Psychiatry* (10th Edition). New York: Lippincott Williams & Wilkins.
- Sagrestano, L.M., Paikoff, R.L., Holmbeck, G.N. & Fendrich, M. 2003. A longitudinal examination of familial risk factors for depression, among inner city African-American adolescents. *Journal of Family Psychology*, 17(1):108-120.
- Saigh, P.A. & Bremner, J.D. 1999. The history of post-traumatic stress disorder. In P.A. Saigh & J.D. Bremner (Eds.). *Post Traumatic Stress Disorder: A Comprehensive Textbook*. pp. 1-17. New York: Allyn & Bacon.
- Sandelowski, M. 1993. Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science*, 16(2):1-8.
- Saxe, G.N., Chinman, G., Berkowitz, R., Hall, K., Lieberg, G., Schwartz, J. & van der Kolk, B.A. 1994. Somatization in patients with dissociative disorders. *American Journal of Psychiatry*, 151:1329-1334.
- Saxe, G.N., MacDonald, S.H. & Ellis, B.H. 2010. Psychosocial approaches for children with PTSD. In M.J. Friedman, T.M. Keane & P.A. Resick (Eds.). *Handbook of PTSD. Science and Practice*. pp. 359-375. New York: The Guilford Press.

- Saxe, G.N., van der Kolk, B.A., Hall, K., Hall, M.D., Schwartz, J., Chinman, G., Lieber, G. & Berkowitz, R. 1993. Dissociative disorders in psychiatric inpatients. *American Journal of Psychiatry*, 150(7):1037-1042.
- Schonteich, M. & Louw, A. In [SS Paper 49]: Crime in South Africa: A Country and Cities Profile. South Africa: Institute for Security Studies.
- Schore, A.N. 2009. Relational trauma and the developing right brain. *Annals of the New York Academy of Sciences*, 1159:189-203.
- Sedlak, A.J. & Broadhurst, D.D. 1996. Executive summary of the third National Incidence Study of Child Abuse and Neglect. (DHHS Publication No 800.394.3366). Washington: US Department of Health and Human Services.
- Seedat, S. 2009. Traumatic stress disorders in children. In D.J. Nutt, M.B. Stein & J. Zohar (Eds.). *Post-Traumatic Stress Disorder. Diagnoses, Management, and Treatment* (2nd Edition). London: MPG Book Ltd.
- Seedat, S., Nyamai, C., Njenga, F., Vythilingum, B. & Stein, D. 2004. Trauma exposure and post-traumatic stress symptoms in urban African Schools: Survey in Cape Town and Nairobi. *British Journal of Psychiatry*, 184:169-175.
- Seedat, S., Nyamai, C., Njenga, F., Vythilingum, B. & Stein, D.J. 2004. Trauma exposure and Post Traumatic Stress symptoms in urban African Schools. *British Journal of Psychiatry*, 184:169-175.
- Seedat, S., van Noord, E., Vythilingum, B., Stein D.J. & Kaminer, D. 2000. School survey of exposure to violence and posttraumatic stress symptoms in adolescents. *South African Journal of Child and Adolescent Mental Health*, 12(1):38-44.
- Seley, H. 1993. History of the stress concept. In L. Goldberger & S. Breznitz (Eds.). *Handbook of Stress. Theoretical and Clinical Aspects* (2nd Edition). p. 7. New York: The Free Press.
- Shapiro, E. 2009. EMDR Treatment of recent trauma. *Journal of EMDR Practice and Research*, 3(3):141-151.

- Shapiro, F. 1999. Eye movement desensitization and reprocessing (EMDR) and the anxiety disorders: Clinical and research implications of an integrated psychotherapy treatment. *Journal of Anxiety Disorders*, 13(1-2):35-67.
- Shapiro, F. 2001a. *Basic Principles, Protocols, and Procedures*. London: The Guilford Press.
- Shapiro, F. 2001b. *Eye Movement Desensitization and Reprocessing* (2nd Edition). New York: The Guilford Press.
- Shapiro, R. 2010. *The Trauma Treatment Handbook*. New York: W.W. Norton & Company.
- Silver, S.M., Rogers, S. & Russell, M. 2009. Eye movement desensitization and reprocessing (EMDR) in the treatment of war veterans. *Journal of Clinical Psychology*, (64)8:947-957.
- Silverman, D. & Marvasti, A.B. 2008. *Doing Qualitative Research: A Comprehensive Guide*. London: SAGE.
- Simons, H. 2009. *Case study Research in Practice*. London: SAGE.
- Singh, D. 2005. Children who witness adult domestic violence: Part 1 – The impact and effects. *Child Abuse Research in South Africa*, 6(2):29-35.
- Smith, C. & Carlson, B.E. 1997. Stress, coping, and resilience in children and youth. *Social Service Review*, 71(2):231-256.
- Soberman, G.B., Greenwald, R. & Rule, D.L. 2002. A controlled study of eye movement desensitization and reprocessing (EMDR) for boys with conduct disorder problems. *Journal of Aggression, Maltreatment and Trauma*, 6(1):217-236.
- Solomon, E.P. & Heide, K.M. 2006. The biology of trauma. Implications for treatment. *Journal of Interpersonal Violence*, 20(1):51-60.
- Solomon, M.F. & Siegel, D.J. 2003. *Healing Trauma*. New York: W.W. Norton & Company.

South African Police Service. Crime Report 201/2011. Downloaded from:

<http://www.pmg.org.za>

Stake, R.E. 2010. *Qualitative Research. Studying How Things Work*. New York: Guilford Press.

Stein, B.D., Zima, B.T., Elliot, M.N., Burnam, M.A. Shahinfar, A. & Fox, N.A. 2001. Violence exposure among school-age children in foster care: Relationship to distress symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40:588-594.

Sternberg, R.J. 2009. *Cognitive Psychology* (5th Edition). Belmont: Thomson.

Straker, G. 1992. *Faces in the Revolution: The Psychological Effects of Violence on Township Youth in South Africa*. Cape Town: David Philip.

Strauss, A. & Corbin, J.M. 1998. *Basics of Qualitative Research* (3rd Edition). Thousand Oaks: SAGE.

Struwig, E. 2008. An exploratory study on the usefulness of eye movement integration therapy in overcoming childhood trauma. Masters Dissertation. Auckland Park: University of Johannesburg.

Swick, K.J. & Willilams, R.D. 2006. An analysis of Bronfenbrenner's bio-ecological perspective for early childhood educators: Implications for working with families experiencing stress. *Journal of Early Childhood Education*, 33(5):371-378.

Taylor, S.J. & Bogdan, R. 1998. *Introduction to Qualitative Research Methods. A Guidebook and Resource* (3rd Edition). USA: Wiley & Sons.

Taylor, T.L. & Chemtob, C.M. 2004. Efficacy of treatment for child and adolescent traumatic stress. *Pediatric Adolescence Med.* 158:786-791. Downloaded from: <http://archpedi.jamanetwork.com>.

Terre Blanche, M. & Durrheim, K. 2000. *Research in Practice: Applied Methods for the Social Sciences*. Cape Town: University of Cape Town Press.

- Terre Blanche, M. & Kelly, K. 2002. Interpretive methods. In M. Terre Blanche & L. Durrheim. *Research in Practice: Applied Methods for the Social Sciences* (Eds.). pp. 123-146. Cape Town: University of Cape Town Press.
- Terre Blanche, M., Durrheim, K. & Painter, D. 2006. *Research in Practice. Applied Methods for the Social Sciences*. Cape Town: University of Cape Town Press.
- Traut, A., Kaminer, D., Boshoff, D., Seedat, S., Hawkrigde, S. & Stein, D.J. 2002. Treatment utilization and trauma characteristics of child and adolescent inpatients with posttraumatic stress disorder. *Curationis*, 25:67-72 (PubMed Abstract).
- Tuckman, B.W. 1998. *Conducting Educational Research* (5th Edition). Fort Worth, TX: Harcourt, Brace.
- Tufnell, G. 2005. Eye movement desensitization and reprocessing in the treatment of pre-adolescent children with post-traumatic symptoms. *Clinical Child Psychology and Psychiatry*, 10(4): 587-600.
- U.S Department of Health and Human Services. Administration on Children, Youth and Families. 2007. Child Maltreatment 2005. Washington: US Printing Office. Retrieved from <http://www.acf.hhs.gov/programs/cb>.
- Van der Kolk, B.A. & Pynoos, R.S. 2009. Proposal to include a developmental trauma disorder diagnosis for children and adolescents in DSM-V. Retrieved from: www.traumacentre.Org/.../DTD_pages_October
- Van der Kolk, B.A. & McFarlane, A.C. 2007. Trauma and its challenge to society. In B.A. van der Kolk, A.C. McFarlane & L. Wisath (Eds.). *Traumatic Stress. The Effects of Overwhelming Experience on Mind, Body, and Society*. pp. 24-46. New York: Guilford Publications.
- Van der Kolk, B.A. 2005. Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, 35(5):401-408.

- Van der Kolk, B.A. 2007a. The body keeps the score. Approaches to the psychobiology of posttraumatic stress disorder. In B.A. van der Kolk, A.C. McFarlane & L. Weisaeth (Eds.). *Traumatic Stress. The Effects of Overwhelming Experience on Mind, Body and Society*. pp. 214-241. New York: Guilford Publications.
- Van der Kolk, B.A., van der Hart, O. & Weisaeth, L. 2007b. History of trauma in psychiatry. In B.A. van der Kolk, A.C. McFarlane & L. Weisaeth (Eds.). *Traumatic Stress. The Effects of Overwhelming Experience on Mind, Body, and Society*. USA: Guilford Publications.
- Van der Kolk, B.A. 2003 Posttraumatic Stress Disorder and the nature of trauma. In M.F. Solomon & D.J. Siegel (Eds.). *Healing Trauma: Attachment, Mind, Body and Brain*. pp. 168-189. New York: W.W. Norton & Company.
- Van Niekerk, J. 2009. The Parenting Project: Promoting alternatives to corporal and humiliating punishment. Childline. South Africa. Downloaded from www.childlinesa.org.za.
- Vickers, B. 2005. Cognitive model of the maintenance and treatment of post-traumatic stress disorder applied to children and adolescents. *Clinical Child Psychology and Psychiatry*, 10(2):27-234.
- Wanders, F., Serra, M. & de Jongh, A. 2008. EMDR Versus CBT for children with self-esteem and behavioral problems: A randomized controlled trial. *Journal of EMDR Practice and Research*, 2(3):180-189.
- Wastell, C. 2005. *Understanding Trauma and Emotion*. England: Open University Press.
- Wenar, C. & Kerig, P. 2006. *Developmental Psychopathology. From Infancy to Adolescence* (5th Edition). New York: McGraw Hill.
- Widom, C.S., DuMont, K. & Czaja, S.J. 2007. A prospective investigation of major depressive disorder and comorbidity in abused and neglected children grown up. *Archives of General Psychiatry*, 64:49-56.

Wilkinson, M. 2010. *Changing Minds in Therapy*. New York: W.W. Norton & Company.

World Health Organization. 2009. Downloaded from:
www.search.int/en/.../Section1245_4986.ht...

Yin, R. 1994. *Case Study Research: Design and Methods* (2nd Edition). London:
SAGE.

Zaghrou-Hodali, M., Alissa, F. & Dodgson, P. 2008. Building resilience and dismantling fear: EMDR group protocol with children in an area of ongoing trauma. *Journal of EMDR Practice and Research*, 2(2):106-113.

APPENDIX A



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

Exploring EMDR as a technique for the treatment of adolescents suffering from depression caused by trauma.

You are asked to participate in a research study conducted by Erika Hendriks, a Doctoral student from the Educational Psychology Department, at Stellenbosch University. The results will contribute to the completion of a thesis. You were selected as a possible participant in this study because you are an adolescent between 12-18 who has experience of trauma.

1. PURPOSE OF THE STUDY

The purpose of the study is to explore the use of EMDR as a therapeutic technique with adolescents who experienced trauma.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

- Set up an interview at a suitable time for approximately 2 hours.
- Agree to 5-8 sessions where the EMDR therapy technique will be implemented.

3. POTENTIAL RISKS AND DISCOMFORTS

Therapeutic processing of trauma will take place and will be contained by the researcher and external monitor. The researcher will use her professional skills as a psychologist to ensure that levels of discomfort are kept to the minimum.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

Participant receives therapeutic support

5. PAYMENT FOR PARTICIPATION

No payment will be asked or given.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of:

- Participants' stay anonymous.
- Participants' information and data produced will stay confidential.

- Information that participants are not comfortable with for publication will not be published.
- Informed consent will be obtained whereby the content and intentions will be clarified. A consent format will be used to obtain the participants' formal decision to participate in the study.
- Participants will be assured that participation in the research study is voluntary.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact the researcher:

The researcher: Erika Hendriks

Cell phone:

Home:

E-Mail:

The Supervisor: Prof. Rona Newmark

Cell phone:

Office:

E-mail:

The Co-Supervisor: Dr. Andrew Lewis

Cell phone:

Office:

E-Mail:

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to
by Erika Hendriks in Afrikaans and I am in command of this language. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

.....

1 Name of Subject/Participant

.....

Name of Legal Representative (if applicable)

.....

2 Signature of Subject/Participant or Legal Representative

Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to
He/she was encouraged and given ample time to ask me any questions. This conversation was conducted in Afrikaans and no translator was used.

.....

2.1 Signature of Investigator

Date

APPENDIX B

CLINICAL INTAKE

TIME INTERVIEW BEGAN:

TIME INTERVIEW ENDED:

LENGTH OF INTERVIEW:

1 IDENTIFYING PARTICULARS

Surname:

First Names:

Date of Birth: Chronological Age: Sex: (M) (F)

Home Language:

Assessment Language:

Present School:

Present School Grade:

2 HISTORY

This history is supplied by:

• Pregnancy and Birth

Was the child planned: Yes () No ()

Was the child wanted: Yes () No ()

Problems falling pregnant: Yes () No ()

If yes, please explain:

.....
.....

Miscarriages prior to pregnancy: Yes () No ()

If yes, details of how many, circumstances:

.....
.....

Mother's age at pregnancy:

Were there any complications during the pregnancy? Yes () No ()

If yes, please explain (e.g. German Measles, Hepatitis, Toxaemia, Threatened Miscarriage, persistent vomiting, also include any emotional problems):

.....
.....

Did the mother do any of the following during the pregnancy?

Smoke: Yes () No ()

Drink Alcohol: Yes () No ()

Medication: Yes () No ()

If yes, type and reason:

.....

Position of child in family: of

Full Term: Yes () No ()

Premature: Yes () No ()

If yes, weeks early

Overdue: Yes () No ()

Normal Birth: Yes () No ()

Caesarean: Yes () No ()

Forceps: Yes () No ()

Emergency: Yes () No ()

If yes, reason:

.....

Problems during birth:

.....

Duration of labour:

Cord around neck: Yes () No ()

Colour at birth:

Baby able to suckle at birth: Yes () No ()

Weight at birth:

Problems after birth (post-natal):

.....

Where was the child born?

.....

If at home, who assisted with the birth?

.....

When was the child taken to hospital/a clinic after the birth?

.....

How long with the child in hospital/a clinic after the birth?

.....

Any other relevant birth history:

.....

• **Early Childhood**

How was the child fed and for how long?

Breast-fed: Bottle-fed:.....

If breast-fed for less than two years, reason and circumstances:

.....

When did child begin sleeping through the night?

.....

Describe child's behaviour (what type of child was he/she?)

.....

.....

Emotional traumas or problems in the family during early childhood:

.....

• **Developmental Milestones**

Age at which child:

Sat:

Crawled: Yes () No ()

If yes, age:

Walked:

Potty Trained:

Out of nappies at night:

First Words:

Two/three word sentences:

• **Language Development**

Does the child experience difficulty in expressing him/herself? Yes () No ()

If yes explain:

.....
.....

Did/Does the child experience difficulty in finding words and seems to search for words to express him or/herself?

.....
.....

Does the child understand and comprehend when spoken to?

.....
.....

Does the child speak grammatically correctly?

.....
.....

Does the child experience any articulation problems or pronunciation difficulties?

.....
.....

• **Health**

Has the child ever been hospitalised?

1. Age Length of Stay
2. Age Length of Stay
3. Age Length of Stay
4. Age Length of Stay
5. Age Length of Stay

Was the hospitalisation traumatic for the child? If yes explain.

.....
.....

Did/does your child suffer from any childhood illness which results/ed in exceptionally high fevers or convulsions?

.....

Did/does your child have ear infections and/or grommets?

.....

Number of sets of grommets placed:

.....

Age at the time of placement:

.....

Has your child suffered from any serious head injuries or concussion? If yes explain.

.....

Has the child's hearing been tested?

.....

Any other relevant information:

.....
.....

Did/does your child experience difficulties with any of the following:

FINE MOTOR SKILLS:

- Poor pencil grip and control:
- Difficulty in colouring between the lines:
- Clumsiness and lack of co-ordination with small motor tasks such as tying shoes, sipping or buttoning clothes.....
.....

GROSS MOTOR SKILLS:

- Poor balance:
- Poor co-ordination:
- Difficulty in catching a ball:.....
- Clumsiness:.....

VISUAL INTEGRATION:

- Problems in building puzzles:
- Lying on arm while doing homework:
- Complaints of sore eyes, eyes being tired or headaches:
- Eyes become red or watery when doing homework:
- Skips lines when reading:
- Repeats words while reading:
- Dizziness, headaches, nausea are reported after reading or writing:
- Eyes are rubbed or blinked excessively, exhibiting sensitivity to light:
- Head is turned in an unusual position or repeated efforts to hold paper in just the right position:
- Preferring to sit very close to or far away from the source of material:
- Complaints about looking at the computer screen or following along in text:.....

Does/did your child have any of the following?

Allergies Age Explain

.....

Disabilities Age Explain

.....

Spectacles Age Explain

.....

Diabetes Age Explain

.....

Fainting Age Explain

.....

Blanking spells Age Explain

.....

If yes to blanking spells, how often does blanking occur?

Illness at present:

Epilepsy: Yes () No ()

If yes to epilepsy, how often do epileptic seizures occur?

Is the child on medication at present? Yes () No ()

If yes, type and reason:

.....

.....

.....

Has the child ever been on long-term medication? Yes () No ()

If yes, type and reason:

.....

.....

Please describe any medical, emotional or scholastic problems in the immediate or extended family (e.g. mental retardation, speech or hearing problems, physical handicaps, epilepsy, alcoholism, depression, etc.)

.....

.....

.....

Previous Evaluations / Diagnoses

Educational Age Explain

.....

Psychological Age Explain

.....

Medical Age Explain.....

.....

Neurological AgeExplain.....

.....

Speech AgeExplain.....

.....

Occupational Age Explain.....

.....

Physiotherapy Age Explain.....

.....

Eyes Age ... Explain

.....

Other

.....

.....

.....

2.1 HOME AND UPBRINGING SITUATION

• **Family Composition**

Relation	Name	Age	Marital Status	Scholastic Educational Level	Tertiary Educational Level	Occupation	Place of Residence
Biological Mother							
Biological Father							
Step-mother							
Step-father							

Relation	Name	Age	Marital Status	Scholastic Educational Level	Tertiary Educational Level	Occupation	Place of Residence
Siblings							
Please indicate if siblings are half- or step-							

Give details of where and with whom the child has lived since birth until present:

.....

If the child's parents are divorced or not living together, or the child is not living with the parents, how often does he/she see the parents?

.....

If no member of the family works, how does the family support itself?

.....

Are all the children in the family of the **same biological parents**? Please give details.

.....

• **Scholastic History of the Family**

Has any family member left school early? If yes, who and why:

.....
.....
.....

Did any family member fail at school? If yes, who and why:

.....
.....
.....

Any other relevant scholastic history of the family:

.....
.....
.....

• **Relationships Within the Family**

Are the child's parents:

Married () Divorced () Separated () Single () Traditional Marriage ()

Widow/Widower () Other ()

For the biological mother, is this?

1st Marriage () 2nd Marriage () 3rd Marriage () Co-habitation ()

For the biological father, is this:

1st Marriage () 2nd Marriage () 3rd Marriage () Co-habitation ()

How do the parents describe their marriage/relationship?

.....
.....
.....
.....

If the biological parents are not currently involved in a relationship together, how do they describe their current/other significant relationships/marriage?

.....
.....
.....

Describe the child's relationship with the following family members:

Biological Mother:

.....
.....

Biological Father:

.....
.....

Siblings:

.....
.....

Stepfather of Boyfriend:

.....
.....

Stepmother or Girlfriend:

.....
.....

Others at home:

.....
.....

Describe reaction of child to birth of siblings:

.....
.....

Was the child ever separated from his/her parents for an extended period of time?

Yes ()

No ()

If yes, please explain:

.....

• **Discipline Structure**

Who is the disciplinarian within the family?

.....

How is discipline carried out?

.....

Withdrawal of privileges, i.e. television, gating, etc. ()

Discussion of misbehaviour with child ()

Shouting at the child ()

Smacking the child ()

Physical punishment, i.e. hiding, etc. ()

Other ()

.....

Is the child a naughty child?

.....

What does he/she do that makes him/her naughty?

.....

What is the child's reaction to discipline?

.....

3. PERSONALITY AND BEHAVIOUR

How do the parents describe the child as a person?

.....

.....

.....

.....

Did/does the child display any of the following personality traits?

- | | | |
|-----------------------|---------------------|----------------------------------|
| Happy: | Enthusiastic: | Optimistic/Pessimistic: |
| Shy: | Caring: | Sensitive/Cries easily: |
| Considerate: | Predictable: | Extrovert/Introvert: |
| Co-operative: | Depressed: | Bedwetting/Enuresis: |
| Stubborn Tense: | Aggressive: | Physical Problems: |
| Distrustful: | Tires Easily: | Withdrawn/Isolated: |
| Lying: | Encopresis: | Lack of Concentration: |
| Sulks: | Impulsive: | Physical Tics and Tremors: |
| Shop Lifting: | Regression: | Eating Habits of Concern: |
| Alcohol Abuse: | Mood Swings: | Smoking: |

Did/does the child display any of the following personality traits?

- | | | |
|-----------------------|--------------------|-----------------------------|
| Nightmares: | Fighting: | Stealing: |
| Car Theft: | Nail Biting: | Thumb Sucking: |
| Hyperactive: | Nausea: | Lack of Self Control: |
| Self Injury: | Baby Talk: | Hoarding: |
| Bunking School: | Satanism: | "Dagga" Smoking: |
| Memory: | Suicidal: | |

Does the child smoke? Yes () No ()

If yes, approximate daily quantity:

.....

Does the child drink alcohol? Yes () No ()

If yes, approximate quantity:

.....

Does the child take any other drugs? Yes () No ()

If yes, type and approximate quantity:

.....

.....

What is the client's sexual behaviour? Is he/she sexually active?

.....
.....

Has anything else traumatic happened to the child?

.....
.....

Does the child display any other serious behavioural problems? If yes, please explain:

.....
.....

Are there any other behaviour patterns or traits that are relevant?

.....
.....

Does the child like being hugged?

.....

Does he/she initiate hugging or ask to be hugged?

.....

What do the parents think the child feels about him/herself?

.....
.....

Does the child display any abnormal fears?

.....
.....

What is the child's reaction when driving in a motor vehicle or crossing a road?

.....
.....

Has the child displayed any of the following symptoms of **INATTENTION** for a period of six months or longer in comparison with other children?

.....

He/she often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities?

.....

He/she often has difficulty sustaining attention in tasks or play activities?

.....

He/she often does not seem to listen when being spoken to directly?

.....

He/she often does not follow through on instructions and fails to finish schoolwork, chores, or duties (not due to oppositional behaviour or failure to understand instructions):

.....

.....

.....

He/she often has difficulty in organising tasks and activities:

.....

He/she often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework):

.....

He/she often loses things necessary for tasks or activities, e.g. toys, school assignments, pencils, books or tools:

.....

He/she is often easily distracted by extraneous stimuli:

.....

He/she is often forgetful in daily activities:

.....

Has the child displayed any of the following symptoms of **HYPERACTIVITY** for a period of six months or longer in comparison with other children?

.....

He/she often fidgets with his/her hands or feet, or squirms in his/her seat:

.....

He/she often leaves his/her seat in class or in other situations in which remaining seated is expected:

.....

He/she often runs about or climbs excessively in situation in which it is inappropriate (in adolescents or adults this may be limited to subjective feelings of restlessness):

.....

He/she often has difficulty playing or engaging in leisure activities quietly:

.....

He/she is often "on the go" and acts as if "driven by a motor":

.....

He/she often talks excessively:

.....

Has the child displayed any of the following symptoms of **IMPULSIVITY** for a period of six months or longer in comparison with other children?

.....

He/she often blurts out answers before questions have been completed:

.....

He/she often interrupts or intrudes on others, e.g. butts into conversations or games:

.....

.....

4. INTERESTS, APTITUDES AND ACTIVITIES

Does the child participate in sporting activities? Yes () No ()

Please explain:

.....

.....

What talents does the child have?

.....

.....

Is the child interested in any hobbies?

.....
.....

Does the child participate in activities after school and over weekends?

Yes ()

No ()

Please explain:

.....
.....

5. SOCIAL INTERACTION

How did the child relate to others of his/her own?

Good () Fair () Poor ()

Please explain:

.....
.....

How did the child relate to children younger than him/herself?

Good ()

Fair ()

Poor ()

Please explain:

.....
.....

How does the child relate to children older than him/herself?

Good () Fair ()

Poor ()

Please explain:

.....
.....

How does the child relate to adults?

Good () Fair () Poor ()

Please explain:

.....
.....

6. TRAUMATIC EXPERIENCES

Has the child experienced the death of someone close? Yes () No ()

If yes, please explain:

.....
.....

Has the child ever been abused sexually, physically or emotionally? Yes () No ()

If yes, please explain:

.....
.....

Has the child ever been involved in a serious accident other than the accident?

Yes ()

No ()

If yes, please explain:

.....

Any other traumatic experiences:

.....

7. SCHOLASTIC HISTORY

• Nursery School and Pre-School

At what age did the child start nursery school?

.....

Was this a positive experience for the child?

Yes () No ()

If no, please explain:

.....
.....

Were there any developmental difficulties at nursery school?

Yes () No ()

If yes, please explain:

.....
.....
.....

Has the child attended pre-school Yes () No ()

If yes, which pre-school and were any developmental difficulties noted?

.....

Was the child tested for school readiness? Yes () No ()

If yes, who performed the testing?

.....

• **Schooling History**

At what age did the child start school?

.....

Has the child ever failed? If yes, how many times?

.....

What grade/s has the child failed?

.....

How many schools has the child attended?

.....

What is the child's present level at school?

.....

Any remedial assistance, special or remedial class/school placement?

Which grades?

.....

Reason for placement.

.....

How does the child cope with the schooling environment?

.....

How does he/she get to school?

.....

.....

Did/does the child experience problems in any of the following areas? If yes explain.

Reading:

.....

Spelling:

.....

Mathematics:

.....

Written work:

.....

Studying:

.....

Does he/she do his/her homework?

.....

Any other problems that the child has at school:

.....

.....

.....

.....

10.2.1 Interaction with Teachers

How does the child interact with his/her teacher? Good () Fair () Poor ()

Please explain:

.....

.....

.....

Does he/she work hard in all subjects or only when he/she likes the teacher?

.....

.....

.....

APPENDIX C

DIAGNOSTIC PSYCHOSOCIAL INTAKE INTERVIEW

Collect a history of negative and positive incidents

PAST INCIDENTS

Age	Negative Incidents	Positive Incidents
0-5	<hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/>
6-10	<hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/>
11 -15	<hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/>

Negative Incidents

Positive Incidents

16-19

PRESENT INCIDENTS

FUTURE INCIDENTS (Identify future anticipated negative and positive incidents)

Negative Incidents

Positive Incidents

APPENDIX D

EMDR WORKSHEET

Instructions:

“Often we will be doing a simple check on what you are experiencing. I need to know from you exactly what is going on with as clear feedback as possible. I Sometimes things will change and sometimes they won't. There are no “supposed to's” in this process. So just give as accurate feedback as you can as to what is happening without judging whether it should be happening or not. Just let whatever happens, happen.”

Presenting Issue or Memory:

Image:

Most disturbing: “What picture represents the worst part of the incident?”

If no picture. “When you think of the incident what do you get?”

Negative Cognition:

“What words go best with that picture/incident that express your negative belief about yourself now?”

Positive Cognition:

“When you bring up that picture/incident, what would you like to believe about yourself now?”

Processing and checking for new channels:

Continue processing with several sets of eye movements (tactile or tones) until there is no new disturbing material coming up. Ask, "When you go back to the original experience, what do you get now?" If there is no new, disturbing material, check the SUDs. (SUDs should be 0 before moving to installation.)

Check SUDs:

"When you bring up the experience, on a scale of 0 to 10, where 0 is no disturbance and 10 is the highest disturbance you can imagine, how disturbing does it feel to you now?" (If SUDs is 0, do one more set and move on to installation.)

Installation:

Linking the desired positive cognition with the original memory/incident or picture:

1. "Do the words (repeat the PC still fit, or is there another positive statement you feel would be more suitable?"
2. "Think about the original incident and those words (repeat the selected PC). From 1 (completely false) to 7 (completely true), how true do they feel?"
3. "Hold them together." Do EM.
4. "On a scale of 1 to 7, how true do those words (PC) feel to you now when you think of the original incident?"
5. Continue installation as long as the material is becoming more adaptive,. If client reports a 6 or 7, do EM again to strengthen and continue until it no longer strengthens. Go to Body Scan.
6. If client reports a 6 or less, check appropriateness and address blocking belief (if necessary) with additional reprocessing.

Procedure for closing incomplete sessions:

An incomplete session is one in which a client's material is still unresolved, i.e. she/he is still obviously upset or the SUDs is above 1 and the VoC is less than 6. The following is a procedure for closing down an incomplete session. The purpose is to acknowledge clients for what they have accomplished and to leave them well grounded before they leave the office.

Steps:

1. Give the client the reason for stopping. "We are almost out of time and we will need to stop soon. Give encouragement and support for the effort made. "You have done some very good work and I appreciate the effort you have made. How are you feeling?"
 2. Eliminate the Installation of Positive Cognition and the Body Scan (it is evident that there is still material to be processed).
 3. Do an containment exercise, "I would like to suggest we do a relaxation exercise before we stop. I suggest we do a Safe Place.
 4. Read the Closure/Debriefing the Experience section to the client.
-

Closure: Debrief the experience.

"The processing we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams. If so, just notice what you are experiencing, take a snapshot of it in a log (what you are seeing, feeling, thinking). Use the Safe Place exercise to rid yourself of any disturbance, Remember to use a relaxation technique daily. We can work on this new material next time. If you feel it is necessary, call me."

APPENDIX E

APPROVAL NOTICE



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvenoot • your knowledge partner

Approval Notice New Application

01-Dec-2011
HENDRIKS, Erika Erna

Protocol #: HS610/2011

Title: EMDR as therapy technique for the treatment of adolescents who experienced trauma

Dear Mrs Erika HENDRIKS,

The **New Application** received on **27-Jul-2011**, was reviewed by Research Ethics Committee: Human Research (Humanities) via Committee Review procedures on **28-Jul-2011** and has been approved.

Please note the following information about your approved research protocol:

Protocol Approval Period: **28-Jul-2011 -26-Jul-2012**

Present Committee Members:

Fouche, Magdalena MG
Van Wyk, Berte B
De Villiers, Mare MRH
Hattingh, Johannes JP
Theron, Carl CC
Somhlaba, Ncebazakhe NZ
Viviers, Suzette S
Bitzer, Elias EM
Engelbrecht, Sidney SF
Van Zyl, Gerhard Mkhonto
Van der Walt, Nicolene N

Standard provisions

1. The researcher will remain within the procedures and protocols indicated in the proposal, particularly in terms of any undertakings made in terms of the confidentiality of the information gathered.
2. The research will again be submitted for ethical clearance if there is any substantial departure from the existing proposal.
3. The researcher will remain within the parameters of any applicable national legislation, institutional guidelines and scientific standards relevant to the specific field of research.
4. The researcher will consider and implement the foregoing suggestions to lower the ethical risk associated with the research.

You may commence with your research with strict adherence to the abovementioned provisions and stipulations.

Please remember to use your **protocol number (HS610/2011)** on any documents or correspondence with the REC concerning your research protocol.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:

Please note that a progress report should be submitted to the Committee before the approval period has expired if a continuation is required. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

National Health Research Ethics Committee (NHREC) number REC-050411-032.

This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant parties. For approvals from the Western Cape Education Department, contact Dr AT Wyngaard (awynjaar@pgwc.gov.za, Tel: 0214769272, Fax: 0865902282, <http://wced.wcape.gov.za>).

Institutional permission from academic institutions for students, staff & alumni. This institutional permission should be obtained before submitting an application for ethics clearance to the REC.

Please note that informed consent from participants can only be obtained after ethics approval has been granted. It is your responsibility as researcher to keep signed informed consent forms for inspection for the duration of the research.

We wish you the best as you conduct your research.

If you have any questions or need further help, please contact the REC office at 0218089183.

Included Documents:

Interview Schedule HS610/2011

Application Form HS610/2011

Consent Form HS610/2011

Research Proposal HS610/2011

Sincerely,

Sidney Engelbrecht

REC Coordinator

Research Ethics Committee: Human Research (Humanities)

Investigator Responsibilities

Protection of Human Research Participants

Some of the responsibilities investigators have when conducting research involving human participants are listed below:

1. Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.

2. Participant Enrollment. You may not recruit or enroll participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use. If you need to recruit more participants than was noted in your REC approval letter, you must submit an amendment requesting an increase in the number of participants.

3. Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.

4. Continuing Review. The REC must review and approve all REC-approved research protocols at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period**. Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in REC approval does not occur**. If REC approval of your research lapses, you must stop new participant enrollment, and contact the REC office immediately.

5. Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

6. Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouch within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to the REC using the Serious Adverse Event Report Form.

7. Research Record Keeping. You must keep the following research related records, at a minimum, in a secure location for a minimum of five years: the REC approved research protocol and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC

8. Reports to Sponsor. When you submit the required reports to your sponsor, you **must** provide a copy of that report to the REC. You may submit the report at the time of continuing REC review.

9. Provision of Counselling or emergency support. When a dedicated counsellor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

10. Final reports. When you have completed (no further participant enrollment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the REC.

11. On-Site Evaluations, Inspections, or Audits. If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.