



## A Phenomenological Case Study of the Therapeutic Impact of Imagery: Rescripting of Memories of a Rape and Episodes of Childhood Abuse and Neglect

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### Abstract

*This is a systematic case study of the assessment and treatment of Anna (43), a woman presenting with posttraumatic stress disorder (PTSD) following a drug-facilitated sexual assault that occurred over twenty years earlier. She was also diagnosed with avoidant personality disorder. Treatment with cognitive therapy for PTSD and social phobia was supplemented by imagery rescripting (IR) of memories of childhood trauma within a schema therapy approach. The study documents how her intrusive memories of the rape were potentiated by early maladaptive schemas that developed in response to abusive and neglectful parenting. Within a broader narrative, three examples of IR are described which show how, as an emotion-focused intervention, this approach discloses deeper memories and emotional states that are distressing and traumatic and allows them to be transformed through a healing process that is organic and displays what Bohart and Tallman (2010) call “self-organizing wisdom.”*

This paper presents a systematic case study of the psychological assessment and treatment of Anna, a 43-year-old white health professional who, as a child, had experienced neglect and emotional abuse and, at age 18, had been the victim of a drug facilitated sexual assault (DFSA). In terms of the DSM-IV-TR (American Psychiatric Association, 2000) she met criteria for Posttraumatic Stress Disorder (PTSD), Major Depressive Disorder (MDD), Social Phobia (SP) and Avoidant Personality Disorder (APD) (see Diagnostic Considerations section).

Fosha (2009, p. 173) has emphasised the importance of “elucidating the phenomenology of emotion-based transformational experience” which is an open ended organic process that is set in motion by experiential interventions. These were used with Anna within an integrative model that incorporated cognitive therapy and Schema Therapy (ST). Psychotherapy provides a

naturalistic setting in which therapists collaborate with clients in investigating the nature and underlying processes contributing to problematic experiences. Systematic case studies provide a means of studying psychotherapy. Moreover, at the heart of a systematic case study is a narrative that portrays significant features of the phenomenology of the client’s problematic experiences, of the experience of working with them in therapy and of the impact of aspects of the therapy on the client’s evolving sense of self. Such studies document a process in which the client’s initial experience, which is often opaque and not understood, is investigated and allowed to unfold in a manner that discloses its deeper nature (Finlay, 2011).

In systematic case studies, following an initial assessment, a case formulation is derived that is based on existing theory, where appropriate. This

formulation guides the therapist's approach to working with the client. As the story of the case develops, it allows for an examination of the existing theory and the extent to which it does justice to the phenomenology of the client's emerging experience. This means that such studies are of significant practical utility in that they can directly inform future clinical practice (Padmanabhanunni & Edwards, 2012).

### **Anna: A brief history**

In order to provide a context for what follows, a synopsis of Anna's history and presenting problems is presented here. Anna (43) was raised in a punitive and neglectful home environment where her narcissistic mother persistently criticised and shamed her at home and in public while her father dismissed or belittled her need for comfort and reassurance. To preclude criticism and ridicule, Anna relinquished activities she enjoyed, including drawing and painting, and often secluded herself in her bedroom. As a child, she sought companionship with her older brother, Paul, but he was emotionally and physically abusive towards her. He regularly inflicted bruises on Anna which her mother ignored, attributing them to her daughter being a clumsy child. In school, Anna had difficulty approaching or initiating social interactions, fearing she would 'stuff up', say something 'stupid' and 'be laughed at'. She also dreaded being asked questions in class by her teachers. Anna experienced early physical maturation and was either mocked by her peers or exposed to inappropriate sexual remarks. To avoid the possibility of being called upon in class and the unwanted attention from peers, she started absconding from school and studied at home. During adolescence, she developed no close friendships and experienced this time as an intensely lonely period in her life.

After completing high school, and in order to escape her home environment, Anna visited a holiday resort where she was invited to a party. Despite feeling socially anxious, she decided to attend and savour the experience of being away from home. She drank one soft drink, spent time on the dance floor and tried to interact with some of the people present. She was approached by an older man who asked about her age and whether she was alone. Her next memory was of momentarily regaining consciousness and realising that she was being raped by the man in her hotel room. She had no memory of returning to her room. During the assault, Anna had felt disoriented, confused and physically paralysed and, at one point, had experienced sexual arousal. Upon waking, she felt intensely nauseous and disorientated. She also felt confused about what had happened and did not disclose the rape to anyone, fearing she would be blamed and expecting little support. A few years later,

she researched the symptoms she experienced that night and recognized that she had been the victim of a DFSA.

At college, she developed few close relationships, believing she was unattractive and socially inept and anticipating being shamed or rejected. However, during this time she met her partner and, surprised and flattered that someone would find her attractive, decided to pursue the relationship. However, she later found him to be controlling and verbally abusive and left him following the birth of her second child, 14 years previously. She had not been involved in any further romantic relationships.

Anna obtained a qualification as a health professional and subsequently worked in private practice. She lived with her two children. Two years before Anna entered therapy her brother, Paul, who had treated her so abusively while they were growing up, became ill with cancer. At her parents' request, Anna temporarily relocated to support her family while he underwent medical treatment. Paul was hospitalized for eight months before he died.

### **Central concepts in the literature**

This section reviews central concepts in the literature that informed the conceptualization of Anna's experience. First, Anna was troubled by intrusive memories of the rape that had occurred over 20 years before she entered therapy. Intrusions in PTSD consist of highly detailed sensory memories of the traumatic event that intrude into awareness uninvited, accompanied by a strong sense of current threat (Ehlers & Clark, 2000). They vary from mildly distressing images to flashbacks where the trauma survivor is completely absorbed in the memory and experiences it as if it were happening in the here-and-now (Holmes & Mathews, 2010).

There is considerable consensus about the cognitive mechanisms that underlie intrusions in PTSD. Most theorists agree that, under conditions of extreme emotional arousal and shock evoked by a traumatic event, there is a disturbance in the way information about the event is encoded that disrupts its integration into autobiographical memory (Brewin, Gregory, Lipton, & Burgess, 2010). Conway and Pleydell-Pearce (2000) conceptualized autobiographical memory (AM) as an implicit integrative system that contains information about life-time periods (e.g. high school years), memories of general events (e.g. learning to drive) and event specific memories (e.g. graduation day). This provides the knowledge base from which individuals construct representations of self, others and the world. Under normal circumstances, people are able to incorporate life experiences into AM in spatial and temporal order

and, when brought to mind, these experiences are remembered with an awareness that they happened in the past (Klein, German, Cosmides, & Gabriel, 2004). It is hypothesised that trauma overwhelms the system, preventing these processing steps from taking place. The result is that information remains encoded as sensory impressions that are not fully integrated in temporal and spatial order. These are subsequently prone to being triggered by stimuli that resemble those present at the time of the trauma (Brewin et al., 2010).

Most interventions that are effective in treating PTSD involve promotion of experiential engagement with the trauma memory so that it can be integrated into AM (Edwards, 2013). Anna's treatment was based on Ehlers and Clark's (2000) cognitive therapy (CT) for PTSD which includes psycho-education, helping the client give up avoidances, reliving and rescripting the trauma memory, and focusing on rebuilding a life after trauma. During the assessment phase, an examination is made of the nature of the trauma memory, problematic appraisals of the traumatic event and/or its sequelae, and avoidant coping strategies that maintain symptoms. Clients are given psycho-education about PTSD and mechanisms underlying the disorder and a rationale for treatment.

In the treatment phase the focus is on discrimination of triggers, helping the client drop dysfunctional coping strategies, reflecting on and elaborating the trauma memory so that it can be incorporated into AM, and modifying negative appraisals of the trauma. Some appraisals need to be addressed using imagery rescripting within reliving of the memory (Arntz, Tiesema, & Kindt, 2007; Grey, Young, & Holmes, 2002; Hackmann, 2011; Hackmann, Ehlers, Speckens, & Clark, 2004), which is discussed further below. Clinical factors that require special attention in PTSD following DFSA are discussed by Gauntlett-Gilbert, Keegan and Petrak (2004).

This specific treatment for PTSD associated with a single trauma can be relatively brief (less than 10 sessions) (Edwards, 2013). However, the presence of a personality disorder (PD), as in the case of Anna, is likely to complicate treatment. APD is characterised by avoidance of interpersonal contact owing to fears of being ridiculed, criticized or rejected and perception of self as socially inept, unappealing or inferior. Although APD clients crave interpersonal contact, their preoccupation with being shamed in interpersonal situations leads to avoidant behaviour contributing to social isolation and feelings of loneliness (APA, 2000). Although APD is classified as a PD, there is considerable overlap with SP, and a significant proportion of those who meet criteria for the one also meet the criteria for the other (Alpert et al., 1997).

Clark and Wells (1995) argued that SP is maintained by avoidant and self-protective behaviours (safety behaviours) which create self-defeating cycles in social interactions and prevent disconfirmation of negative cognitions about self. CT based on this model provides training in dropping avoidances and safety behaviours and in realistically evaluating negative beliefs about oneself as perceived by others. It has proved to be an efficacious brief treatment for SP and treatment trials have included those meeting criteria for APD as well. In these trials, those with APD have been shown to respond well to CT (Clark et al., 2006).

In SP and APD, negative cognitions include images of self as weak or shamed, often related to memories of being bullied or humiliated. Such negative images associated with painful childhood memories are common in all PDs so that there is a parallel between the processes underlying PDs and those underlying PTSD (Arntz, 2011). Although people with PDs rarely report intrusions or discrete traumas, they often present with a history of adverse childhood experiences in the form of neglect, and verbal or emotional abuse (Padmanabhanunni & Edwards, 2012). Pervasive themes commonly present as a result of such adverse childhood events are called early maladaptive schemas (EMs) which are "reality-based representations of the child's environment" (Young, Klosko, & Weishaar, 2003, p. 9) and include cognitions, emotions, kinaesthetic, olfactory and physiological sensations experienced at the time of the event. As with the memories that give rise to intrusions in PTSD, these memories have not been sufficiently processed due to, for example, lack of safety in the early environment or the absence of a warm and responsive caregiver who could help the child regulate distress and make sense of what happened to him/her (Arntz, 2011). When such memories are triggered by situational cues, they are not typically experienced as memories of clearly demarcated episodes, but as emotional and somatic experiences which seem exaggerated and out of place.

Phenomenologically then, such individuals are confused about their own experience, which is generated by implicit psychological systems they do not understand. Many forms of therapy help clients engage with these implicit systems and so transform the experience in two ways: firstly, by helping them make explicit sense of it; and, secondly, by altering the content of the implicit system. There is increasing evidence that imagery rescripting (IR) can achieve this. IR involves evoking the memory with all its emotional and physiological aspects, identifying the problematic meanings, and then actively modifying them using psycho-dramatic enactment in imagery (Smucker & Dancu, 1999). Reliving the memory allows a return to the implicational level of cognitive

representation, where it was encoded in childhood, and therefore corrective information can be inserted directly into the specific cognitive structure where the distressing meanings are encoded (Teasdale, 1993; Weertman & Arntz, 2007). IR is a central intervention in ST (Rafaeli, Bernstein, & Young, 2011; Young et al., 2003) and has been shown to have a positive impact on a range of clinical presentations including depression, eating disorders, SP and other anxiety disorders, and several PDs (Arntz, 2011, 2012; Cooper, 2011; Cooper, Todd, & Turner, 2007; Hackmann, 2005; Wheatley et al., 2007; Wild, Hackmann, & Clark, 2007).

Finally, clinical levels of depression are experienced by up to 50% of individuals with PTSD (Shalev et al., 1998) and are common in most PDs, including APD (Grant et al., 2005). A significant contributing factor is the social isolation that is characteristic of PTSD and APD and hopelessness about being able to function effectively because of the disruptive experience of anxiety in PTSD, and with respect to meaningful personal relationships in APD.

### Methodology

This is one of a series of systematic case studies that examined the transportability of Ehlers and Clark's (2000) CT for PTSD to South African conditions (Edwards, 2009, 2010, 2013; Padmanabhanunni, 2010). It is one of three cases of PTSD following DFSA presented by Padmanabhanunni and Edwards (2013). Systematic case study research is a mixed methods approach in that the qualitative aspects are supplemented by data gathered from the repeated administration of self-report measures (Edwards, 2010; Dattilio, Edwards, & Fishman, 2010). The aim is to generate a phenomenologically trustworthy narrative account of the assessment and treatment process. The self-report measures are useful in tracking changes in symptomatic reactions across sessions and evaluating the impact of specific interventions (Padmanabhanunni, 2010). They can also inform the therapist's decision-making since in responding to them clients may acknowledge problematic experiences that they have not disclosed verbally, due to shame or uncertainty (Edwards & Young, 2013). For a case example of this, see Padmanabhanunni and Edwards (2012). This will also be illustrated in Anna's case (see sessions A6-A11).

The case study is presented in the spirit of hermeneutic phenomenology (Finlay, 2011). The phenomenological aspect is a commitment to inviting the reader into some of the dimensions of Anna's experience as she went through the therapy process, as well as some dimensions of the therapist's experience. Given the length of the psychotherapy and the length of an article such as this, the narrative

is thematically selective, with a focus on the role of IR within the treatment process. IR as an intervention fits well with the aims of hermeneutic phenomenology because, as Finlay (2011, p. 111) puts it, "phenomenology is concerned with meanings which are often implicit and hidden" and seeks "methods that allow the concrete, mooded, sensed, imaginative, aesthetic, embodied and relational nature of experience to be revealed." IR can be considered not only a therapeutic intervention, but also, like many other therapeutic interventions, a means of opening up and elucidating the underlying nature of experience.

The study is hermeneutic in two ways. First, the case formulation and planning of interventions was based on the treatment models reviewed above (Ehlers and Clark's CT for PTSD, Clark and Wells' CT for SP, and Young's ST) and the broader literature on IR. These constitute the theoretical fore-structures which we believe are professionally appropriate in light of current clinical knowledge. Second, the narrative itself is written to explicate Anna's experience. In addition, aspects of her process as it evolved through the therapy are examined theoretically with respect to the support they give to particular theoretical propositions.

### *Recruitment, ethical procedures and course of therapy*

Anna responded to a poster describing the study that had been placed in the town. She was motivated to engage in treatment and signed written consent to participate in the project in terms of ethical procedures approved by Rhodes University. She was assessed and treated by the first author (AP) under the supervision of the second author (DE). There were 43 sessions in total, across a one year period. The first 11 are classified as the assessment phase (A1-A11) as they predominantly focused on gathering information. The remaining 32 are classified as treatment sessions (T1-T32).

### *Data collection and data reduction*

The case study is based on the following data sources:

- *Session records:* After each session (of assessment or therapy), AP created a session record from memory summarising the events of the session, including her experience of the session and the client's process and observations relevant to the research project.
- *Audio recordings and transcripts:* Verbatim transcriptions were made of all sessions from voice recordings. One transcript, randomly selected by an independent assessor, was

evaluated against the audio recording. No distortions or omissions were reported.

- *Self-report scales:* These were administered regularly during the assessment and treatment process. Information about the sessions at which they were used is shown in the graphical displays in Figures 1-3. The Post-traumatic Diagnostic Scale (PDS) - Part 3 (Foa, Cashman, Jaycox, & Perry, 1997) comprises 17 items assessing the nature and severity of PTSD symptoms. The Beck Anxiety Inventory (Beck & Steer, 1993) and the Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996) are 21-item measures of clinical symptoms of anxiety and depression respectively. The Young Schema Questionnaire (YSQ-3; Young, 2005) is a 90-item questionnaire for identifying EMSs. This questionnaire was administered once after session 19. Each of these scales has been validated and used in previous research with English speaking people.
- *Supervision notes:* Notes were kept on issues discussed and suggestions made during case supervision.

These sources were used as a basis for several interpretative data reductions: At step 1, the notes and recordings of the assessment phase were used as a basis for writing a case history, an assessment narrative, and an assessment summary. At step 2, these served as a basis for writing a case formulation and treatment plan. At step 3, the notes on and recordings of the treatment sessions were used to write a comprehensive treatment narrative. The assessment and treatment narratives were written as first person accounts by the therapist. Finally, at step 4, scores on the self-report scales were presented graphically. These are presented in full in Padmanabhanunni (2010). For the present article the material has been selected and abbreviated.

### **Getting to know Anna: The assessment process**

#### ***Sessions A1-A5: Promoting trust and promoting self-disclosure***

The assessment phase involved 90-minute sessions, twice a week, for 11 sessions. Initially, I experienced Anna as patronising. She commented on my small office size and reflected on how this was indicative of my junior position in the department and, when asked to complete self-report scales, asked if I had designed the questionnaires as the grammar was “clearly sub-standard”. Realising that she was probably feeling ambivalent about therapy, I responded factually.

During assessment sessions, Anna fluctuated between being somewhat candid about her experiences to completely avoiding any introspection. Her avoidance manifested in her repeatedly changing the topic, interspersing her narratives with anecdotal stories, sharing jokes and asking numerous questions about my professional background. When I suggested that she was feeling distressed at the prospect of self-disclosure, she acknowledged that she was a “closed person” who tended to “keep people at arm’s length” and that this was the first time she was sharing her life in any detail. She was subsequently better able to engage with me but often reverted to avoidant coping when feeling threatened by the material she was sharing. During these moments, I would gently guide her back to the original topic. She tentatively shared her childhood experiences of neglect and the punitive nature of her home environment, where she was consistently criticised and belittled. She also shared a narrative account of the rape.

#### ***Sessions A6-A11: Building a narrative of the trauma***

In A6, Anna described how she had been to a restaurant which had resembled the place she had been before she was raped all those years ago. This had triggered a distressing intrusive memory of the night of the rape. I explained to Anna how developing a detailed narrative would be the first step in the process of ending these flashbacks and then guided her to draw the layout of the room and narrate what had occurred that night, including her thoughts and feelings. She felt angry as she realized that the rape “had put the stamp on any mistrust [she] did have of social situations” and sadness that her expectations for her future had been dampened. On the self-report scales she reported shame and guilt and, when I gently enquired about this, she hesitantly disclosed experiencing sexual arousal during the rape and feeling ashamed and guilty believing that something was wrong with her body and that other people would think negatively of her. I explained that sexual arousal was not indicative of her wanting to experience sex through rape and, since she had been drugged, her reactions were involuntary. Hearing this from someone else validated her own tentative assumption that her reactions were normal and her guilt and shame resolved.

Before leaving the session, Anna thanked me for helping her face the trauma memory. In a later session, she told me that other memories of being victimised in her family, particularly by her mother and brother, had been evoked in the process of retelling the rape. When I invited her to share these memories and the feelings they elicited, Anna was reluctant and wanted to discontinue the therapy. However, she agreed to continue, after I acknowledged that this was difficult for her and

emphasised that we would proceed at a pace with which she was comfortable.

### **Case Formulation, diagnosis and treatment plan**

After these sessions, the history summarised earlier was written, as well as a case formulation, diagnosis and treatment plan.

#### ***Case formulation***

Having been raised in a neglectful and punitive home environment, Anna concluded that her family's hurtful behaviour was related to her being unlovable and unattractive. These beliefs were reinforced by her experiences within the school environment and contributed to her developing EMSs involving emotional deprivation, mistrust/abuse, abandonment/instability, vulnerability to harm and defectiveness/shame (Young et al., 2003). She coped by avoiding social contact to a large extent and was already an isolated and avoidant person when she left school. The rape, when she was 18, served to consolidate Anna's belief that she could not trust other people to care about her or respond with respect, compassion or empathy. Since the rape occurred after her entry into a social setting, it also confirmed Anna's assumption that social situations were dangerous and that if she allowed other people into her life, she would get hurt. These beliefs were reinforced by her one experience of an intimate relationship with the father of her children. She was therefore extremely wary of other people and maintained mostly superficial connections, which left her socially isolated and lonely. Her experience of sexual arousal during the rape, which generated confusion, shame and guilt, also reinforced her avoidant behaviour. As a result of her chronic avoidance and having to cope with the flashbacks of the rape, Anna felt chronically frustrated, lonely and unfulfilled, leaving her vulnerable to episodes of depression.

#### ***Diagnostic considerations***

Although a formal psychiatric diagnosis does not provide the basis for planning treatment, it does have value in providing an index of the nature and severity of the problems with which Anna was dealing. All diagnoses were checked against the criteria of the DSM-IV (APA, 2000) and reviewed by the supervisor (DE). Anna met criteria for chronic PTSD. She felt jumpy and overly alert, had difficulty sleeping, and an intrusive image of the party prior to the rape would be triggered when she entered social settings or heard stories of sexual abuse. Her PDS score of 30 indicated a moderate to severe level of PTSD symptoms and her BAI score of 37 represented a severe level of anxiety.

Anna was also suffering from MDD (recurrent). She reported experiencing symptoms of depression as a child and adolescent in response to loneliness and neglect. A depressive episode following the rape abated somewhat, once she began college, two months later. She experienced further episodes related to her abusive relationship with the father of her children and following the death of her brother. The current episode, which had lasted a month, arose from reflecting on her life and recognizing her feelings of being unfulfilled. Her BDI score of 20 indicated a moderate level of clinical depression. She felt sad about the negative impact of the rape on her life, guilty for the sexual arousal she had experienced during the assault, and angry that there had been no one to care for or support her at the time.

Anna also met criteria for SP. She reported social isolation related to marked social anxiety and shame when in social settings (e.g. shops, social events). Believing that other people would scrutinise her, she avoided these settings and occasionally experienced panic attacks when compelled to be in these contexts. Her avoidance often prevented her from obtaining goods she needed (e.g. groceries, new clothes) and attending important events (e.g. parent-teacher functions). Anna was also guarded in her interactions and avoided sharing her needs and feelings with others, as she expected to be shamed, criticised, belittled or controlled. This inhibited her from developing the close relationships she craved. After T4, it became apparent that there was a strong longstanding characterological component to her social avoidance and that she also met criteria for APD, a category that has considerable overlap with SP (Alpert et al., 1997).

#### ***Treatment plan***

The treatment approach drew on the four sources reviewed earlier. These were Ehlers and Clark's CT for PTSD and Clark and Wells' CT for SP. The third source was a broader integrative treatment approach for ST and the fourth involved the literature on IR. These were employed within a collaborative relationship with Anna who set her own goals, indicated what she was ready for and how she felt about engaging with the active interventions.

Initially when I attempted to share the treatment plan with Anna and indicated how her problems could be addressed, she repeatedly avoided the topic. After direct empathic confrontation, she became tearful and disclosed feeling intimidated by the discussion as it brought home to her the real and disabling nature of her problems. She had been aware of their presence for many years but as she faced them now she felt angry and ashamed that she had not addressed them

earlier and that she was still being affected by them. I comforted her by pointing out that she had not had the opportunity to tackle these difficulties previously owing to her life circumstances but that now that the opportunity had arisen she had taken the initiative to do so. Anna became calmer and we reviewed her goals for therapy. She wanted to address her PTSD, SP and her unresolved grief over the loss of her brother. She wanted to begin with her social anxiety as this was having the greatest negative impact on her quality of life and contributed to her loneliness and isolation. She added a further goal, to reclaim her artistic abilities by resuming the drawing and painting she had previously enjoyed and had given up in response to the critical and disparaging attitude of her mother.

### **Treatment narrative**

#### ***Sessions T1–T4: Challenging social avoidance***

Despite Anna's wanting to address her social anxieties, she repeatedly avoided engaging with tasks that would help her face and change her behaviour. She repeatedly neglected to document her thoughts and feelings while in social settings and, in sessions, diverted attention towards arbitrary issues. When I gently but firmly confronted her with what was happening, she agreed to participate in a behavioural experiment involving visiting a clothing store to monitor thoughts and feelings. She experienced such intense anxiety and nausea that she could only stay in the store for a few minutes. However, this gave rise to important information: while in the store, she had an image of herself with a pronounced stomach and kept pulling down her shirt to cover herself. She recognised that this image and the associated distress were evoked in many social interactions, causing her to flee. At this stage she could only relate the image to a vague memory of her mother accusing her of having a "fat tummy".

#### ***Sessions T5–T7: Working with traumatic intrusions***

Attention was directed to Anna's PTSD after a consultation with a client, who bore a similarity to the perpetrator, triggered distressing intrusions of the rape. I offered psycho-education about the triggering of unprocessed memories and this encouraged Anna to engage in imaginal reliving of the memory in order to facilitate processing. After the reliving, I guided her in a 'then versus now' discrimination involving identifying similarities and differences between the circumstances of the traumatic memory and the current, innocuous trigger. Anna identified several characteristics that differentiated the perpetrator from her patient, including that the rapist was Afrikaans-speaking and would currently be in his sixties

whereas her patient was a young British man. As a result of this, she recognized that her anxiety in social contexts was often due to triggering of the trauma memory by characteristics of men who reminded her of the perpetrator. This realisation provided her with significant relief and contributed to some reduction in her anxiety when in public.

Outside of the sessions, Anna continued to avoid memories of the rape through distraction, believing that engaging with it would lead to her feeling angry and depressed. When invited to share her feelings, she narrated a vivid memory from age 15 where she had felt deeply invalidated after she told her father she was feeling angry and he had laughed at her. I reflected on the possibility that Anna feared receiving a similar response from me. She quickly dismissed this, but then became tearful and acknowledged that this was true. I gently pointed out that not all people would respond in the same way as her father had. Anna was "logically aware of this" but indicated that it did not resonate with her emotionally.

#### ***Sessions T8–18: Working through grief and reclaiming drawing***

Further work on reliving the rape triggered conflicting memories of her brother, Paul. As a child he was the one person she felt she could turn to, yet he had physically and emotionally abused her. He had also been treated neglectfully by their parents and she had painful memories of watching him die from cancer. For several sessions Anna allowed herself to experience these conflicting emotions. I guided her to voice to Paul how much he had meant to her and she wept as she related positive memories of him. Eventually I invited her to express her anger, using the empty chair technique. Despite initial hesitation she engaged with this and expressed how hurtful she had found his treatment of her. By T14, Anna reported that her anger towards Paul had considerably abated and she believed that she had finally grieved and made peace with him.

After this, I proposed that we devote a few sessions towards her goal of reclaiming her artistic abilities. Anna was hesitant to engage with drawing but was willing to as she realised I would not be critical. She drew a picture in bright colours that included an image of a very young child sitting on the grass in a far corner of the garden facing away from everyone. She knew this was related to a memory of her brother's birthday party when she was 3-years-old, but did not know why this image stood out for her and why the scene remained vivid in her mind. The importance of this would emerge several sessions later.

### **Sessions T19-31: Schema therapy and imagery rescripting**

Anna had discussed with her daughter the dangers of not returning home before dark and this had triggered a flashback to the party scene. By now she understood the nature of trauma memories and triggering, had relived the episode several times and built a narrative of the trauma. In supervision, it was suggested that the emotional charge of the memory was exacerbated by childhood experiences of abuse, associated with the expectation that in interpersonal situations she would be emotionally or physically hurt. As a result, I introduced Anna to a ST perspective and explained the links between her negative experiences within her family and her social anxieties and the role of the trauma in reinforcing these assumptions. This made sense to Anna and I suggested she complete the YSQ-3 which taps the 18 EMSs identified by Young (Young et al., 2003). I emailed her an electronic copy and, given her avoidant tendencies, was surprised when she returned the completed questionnaire a few hours later reporting that many of the items resonated with her. The prominent EMSs were mistrust/abuse, abandonment/instability, vulnerability to harm, emotional deprivation, and defectiveness/shame. I reviewed with her how these were related to the repetitive experiences of invalidation in her childhood. Anna became tearful as she realised “how far back these beliefs extended.” As I explained to her how reliving painful memories of childhood and rescripting them could effect change at the schema level, she was excited and motivated to work with imagery rescripting.

The intensive work with three memories that were thematically linked and related to her core schemas of mistrust/abuse, abandonment/instability and shame/defectiveness is summarized below.

#### **Memory 1: Attending her brother's birthday party at age three**

I suggested that Anna relive the scene she had drawn (see T8-18). This evoked feelings of vulnerability, sadness and abandonment, as can be seen in the segment from the transcript of the session:

Anna: It's an incredibly strong textural memory... maybe because I was so close to the ground

AP: What are the textures you're feeling?

Anna: The grass, a very lush grass and quite prickly ... and ... the sky was a Highveld sky ... very dark blue ... our house is a light peach colour ... but I remember ... that was the first time I was conscious of being in a watcher mode ... you know watching things from the outside ... but not taking part ... because if I

took part I would be clobbered or something nasty would happen.

AP: So there's a sense that if you participate something bad is going to happen so you're forced to stay on the outside?

Anna: Ja ... and the knowledge that if something bad does happen it will always be my fault.

AP: Is there anything else happening in that image, you said you're feeling isolated, very alone?

Anna: Hmm ... my mother's back is always towards me ... I don't think she even checked on me once ... even looked at me once during that whole birthday party.

Anna was tearful after reliving this, but once she was calmer, I highlighted the salient emotions contained in the memory and their role in her schemas. She expressed with sadness that, for these beliefs to be present at age 3, they had to have originated at an even earlier stage in her life.

This memory was rescripted three times. Initially, I guided Anna to visualise entering the scene as her adult self but she experienced such intense feelings of anger at how she had been neglected that she was unable to care for her child self. I asked if I could enter the scene and offered Anna's child self the care, attention and validation she had needed. I explained that she too had a right to participate in the party and that it was wrong of her mother and brother to keep her on the side-lines. Anna was tearful afterwards, reporting she had not realised how badly she had been neglected. In the days following this session, she experienced intense anger and sadness but rather than avoiding it, she allowed herself to experience these emotions and was surprised that this did not incapacitate her as she had feared.

Anna reported a recurrent dream, associated with a sense of threat that she described as a feeling of “being suddenly pounced on”. She could relate this to being unexpectedly verbally attacked by her mother during childhood. I used her dream as a cue for rescripting, and in the next two rescripts I confronted Anna's brother and mother respectively for their abusive behaviour. I expressed anger towards them for their treatment of Anna and, after each confrontation, I soothed and comforted her child self. I asked her child self if there was anything she needed or would like to do and responded according to her needs. This instilled a growing sense of safety and protection, and she found that my having expressed anger on her behalf and confronted her abusers led to her experiencing a new sense of agency.

In the segment of the rescripting session below, I approached Anna's mother and confronted her for



neglecting her daughter and failing as a parent. Anna reported that her mother would merely dismiss me and tell me that “it’s none of your business”. I subsequently explained to her mother that I care about Anna and am angry at the way she is being treated and that she needs to be a more responsible parent.

Anna: There’s no ways you would know that she’s failed ... and she never fails ... and it’s none of your business ...

AP: I’m making it my business ... because I care about Anna, I care about what happens to her ... and you are failing her even now ... and each time you fail her, each time you neglect her, each time you hurt her, I will call you out on it ... and I can see that you’re angry ... but that’s nothing compared to how angry I am at the way you treat her ... and if you try to hurt her after I’ve spoken to you ... I will come back and I will call you out on it again ... now I’m going to take Anna and we’re going to go and play ... and you can think about the type of parent you want to be to your daughter ... I realise that as a child you were neglected too but that doesn’t give you the right to perpetuate that abuse ... you need to be a mother to all your children ... And I take your hand Anna and I walk away with you and ...

In schema therapy, it is important to offer the child not only understanding and care but also protection. In this segment, Anna is at first doubtful that I can fulfil my promise to protect her but this changes as the segment continues.

AP: When we’re some distance away from your mother, I kneel down next to you and I say ... Anna, I know that was very difficult for you ... I know that your mom scares you and I know that I was angry with her right now too ... and I realise that could have been scary for you as well but I’m not angry with you ... I see what’s being done to you, I see how you’re hurting ... how you’re being neglected and I don’t want that for you ... what would little Anna say?

Anna: She’s ... flabbergasted

AP: I see you’re looking very surprised at what just happened ... you weren’t expecting that and it’s a shock that someone would say that to your mom ... but I think that your mom is wrong in the things that she does to you ... and it’s time someone called her out on that ... and I’m going to do that ... each time your mom does something to hurt you, I’m going to call her out on it ... because you need to be protected, you’re a beautiful, bright little girl ... and I’m here for you ... and I’m going to

make sure that you are cared for and you are protected ... what would she say?

Anna: Ummm ... I think she’s happy ... but I think ... she ... wouldn’t really believe that it would happen.

AP: So little Anna is feeling happy at what just happened ... but she’s also feeling very doubtful?

Anna: Uh huh

AP: I can see that you’re quite happy with what happened. I think that you’re happy that someone stood up for you ... I think you’re happy that somebody confronted your mother on the things that she doesn’t give you ... because I know that all children need love and care ... and it’s not right that you’re not being given that ... you’re also feeling very uncertain ... you’re very doubtful ... as to whether I will follow through in terms of protecting you ... and caring for and defending you from your mother ... and confronting her on her neglect ... and it will take time before you feel able to trust me but I will be here ... and each time your mother bullies you I will return and I will confront her on that ... what do you feel?

Anna: I think ... protection ... a certain element of protection would creep in there ...

AP: So you’re feeling protected?

Anna: Ja ... a little bit

AP: I know that you’re feeling happy and more protected ... and I’d like you to hold on to that feeling because I will follow through ... and I will not allow you to be bullied like this ... now what would you like to do, why don’t we do something together ... would you like to play ... it’s a birthday party and you’re excited to be here ... what would you like to do?

Anna: Play in the garden

AP: You’d like to go and play in the garden ... shall we do that? ... And I take your hand and we both stroll together down to the garden ... and I’d like you to slowly leave that image ... and come back to the present.

After this, Anna tearfully spoke of not being protected or defended as a child. I emphasised that Anna’s needs as a child were completely valid and it was a tragedy that her mother had treated her in such a hurtful way.

### **Memory 2: Being criticised in public at age four**

The second memory, associated with schemas of defectiveness/shame, involved being criticised in public by her mother at age 4. The negative self-image she had of herself in social contexts originated from the events represented in this memory. Furthermore, Anna believed this memory represented the originating point for her social anxieties because it

represented the first time she believed she was being scrutinised in a public context and felt threatened.

Anna relived an outing to a swimming pool, during which her mother had shouted to her that she “had such a fat tummy” and that she “needs to pull it in because girls don’t have fat tummies”. Anna had felt hurt, ugly and embarrassed, had pulled down her swimming costume to cover her stomach and left the pool area and sat in a corner away from everyone. After the reliving, Anna cried and spoke of having felt deeply wounded. I validated this and expressed my horror at her mother’s behaviour towards her little girl and emphasised that it had been entirely unacceptable.

This memory was rescripted twice. In both sessions, I focused on normalising Anna’s physical appearance so as to challenge EMSs of defectiveness/shame. I emphasised that “all little girls look the way you do” and encouraged her to notice the appearance of the children in the scene. In the memory, Anna believed that everyone was staring at her and scrutinising her. I encouraged her to look around her while in the scene and to notice that no one was scrutinising her. Instead, the people around her were focused on other things.

I further explained to her child self that her mother’s remarks were reflective of her own issues and not due to any deficiency on Anna’s part. Her child self had difficulty reconciling this viewpoint and maintained that her mother was “never wrong”. To address this, after the rescripting, I offered psycho-education on narcissistic personality disorder (NPD), and pointed out how her mother’s behaviour was typical of NPD. Anna could then see that her mother’s behaviour had not been due to anything being inherently wrong with her (Anna). She could also see that her mother’s narcissistic behaviour had stemmed from her own abusive experiences in childhood and felt compassion for her. As a result of this intervention, in the second rescripting, Anna’s child self was more able to accept that she was not physically defective and that her mother’s remarks were inaccurate. In the second rescript, I also focused on confronting Anna’s mother for her hurtful behaviour and admonishing her for not appreciating her daughter.

### **Memory 3: Memory of being rejected by her father**

The third memory chosen for rescripting was associated with schemas of abandonment/instability and defectiveness/shame. It involved a teenage Anna approaching her father to inform him that she had been smoking cigarettes. She had intended for her disclosure to lead to her father acting in a protective way. Instead, he had responded with disgust and disdain, which left Anna feeling ashamed, inadequate and unlovable.

Through reliving of this memory, Anna realised that her intention in disclosing to her father had actually been to obtain attention and affection at a time when she felt severely neglected and alone. This proved to be a significant insight for her in that she realised that her needs at the time had been completely valid. This realisation challenged her feelings of shame and sense of being inadequate and unlovable. In rescripting this memory, I confronted Anna’s father on how hurtful his remarks had been and conveyed to him that his daughter was feeling lonely and neglected. Anna’s adolescent self was surprised that someone would stand up for her and validate her needs. This addressed her two schemas of abandonment and defectiveness/shame and she now appreciated that her father’s response to her had not been malicious but the result of his helplessness when it came to tackling challenging issues. She then felt compassion for him.

### **Sessions T32-33: Endings**

Anna was experiencing significant changes in the symptoms that had brought her to therapy. This was reflected in a dream she reported in which she was “detoxing” the people who had harmed her. I reflected on this being indicative of her purging herself of prior negative experiences. This appealed to Anna who reported that she was now feeling confident and good about herself. Her dreams were also reflective of her memories not only having been stored in a visual format but as bodily experiences. Dreaming of detoxing was essentially a metaphor for purging her body of these stored toxic memories.

In the last two sessions, I invited Anna to reflect on the changes in her life since initiating imagery work. She was now dreaming of houses that were open-plan, light, airy and receptive to the world. She saw this as a new sense of transparency which she attributed to her “feeling less of a need to hide.” This reflected her newly found sense of stability and balance. She reported experiencing a sense of belonging that she had not felt before and started having sexual dreams that she felt was positive and indicative of a new receptiveness to romantic relationships.

Anna had increasingly started spending time drawing and had even agreed to complete a drawing for a friend. At this point, I reflected on her increased sense of confidence and Anna indicated that she was feeling more “grown up” and able to care for and protect herself, and more assertive and able to stand her ground rather than run away from situations. In addition, she no longer saw herself in a negative light and was spending more time tending to her needs.

In the final session, Anna expressed exuberance and confidence about her future and ability to cope with

life challenges. She was more motivated to establish relationships with others and had started inviting people for coffee and was anticipating she would begin dating. Anna could now comfortably visit shops and attend social events and did not feel the urge to flee such settings. I reflected on her growth in therapy and expressed my confidence that she had reclaimed her life in many respects and she affirmed this.

### Graphical Presentation of Self-Report Scales

Anna's scores on the self-report scales, summarized graphically below, document the significant changes in her symptoms. The PDS scores in Figure 1 confirm that her PTSD symptoms diminished over the course of therapy so that by the end she no longer met the criteria for PTSD. The BAI scores in Figure 2 display peaks, particularly after she experienced flashbacks to the rape, but these were no longer occurring after session 25. The BDI-II scores in Figure 3 show a steady remission of her depression. In addition to these changes, Anna also mentioned in session 28 that she was no longer experiencing the regular migraines she had experienced since adolescence.

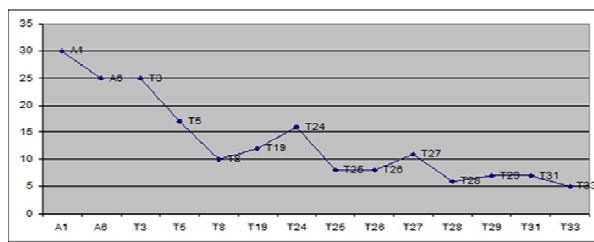


Figure 1: Anna's PDS scores

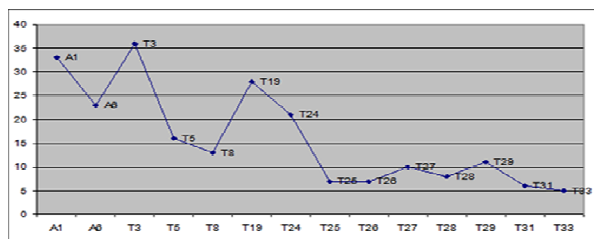


Figure 2: Anna's BAI scores

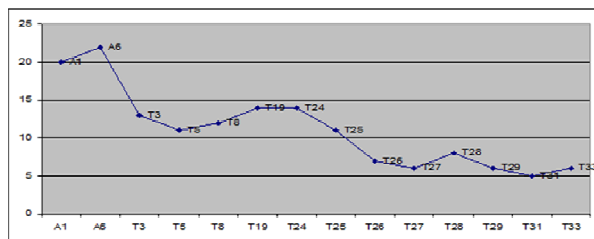


Figure 3: Anna's BDI-II scores

### Discussion

The narrative of Anna's therapy process offers insights into the relationship between intrusive memories of trauma and earlier childhood memories associated with invalidation and abuse. Anna's intrusive symptoms related to the memory of being raped did not remit in response to work with reliving and restructuring the trauma memory. Her intrusive memory of the party at which she was drugged, or her being triggered by men who reminded her of the rapist, accords with the warning-signal hypothesis in terms of which intrusive memories reflect the moment immediately preceding the trauma or the moment where there was an escalation in the sense of threat (Ehlers & Clark, 2000; Ehlers, Hackmann, & Michael, 2004). In terms of this hypothesis, individuals are alert for such warning signals that might indicate impending danger in the future. This gives rise to overgeneralized triggering since not all social gatherings or all men with those facial features will be a precursor to being raped.

In Anna's case, however, the memory of the rape intersected with childhood memories of repeated situations in which social contact of various sorts resulted in her being invalidated, humiliated, or physically abused. The interventions that addressed the memory of the rape failed to impact on her negative core beliefs at the level of EMSs (e.g. I will be criticised, belittled and shamed if I enter social situations) that were driving her intrusive memory and avoidance of social situations. This meant that it was also necessary to engage with and transform the EMSs that formed the basis of her conception of self, influenced her interactions with others and constituted the frame from which she interpreted experiences (Lee, 2006). After this, the intrusive memory of the rape no longer fitted with these deeper self-definitions that had replaced the old ones and, as a result, the intrusion resolved.

The current case study attests to the benefit of working directly with memories in the treatment of chronic conditions with early origins. Anna's relatively rapid treatment gains add to the growing body of evidence on the speed and magnitude of change than can be achieved through the use of IR. Even a single session of IR has been found to lead to clinically significant reductions in PTSD (Ehlers, Clark, Hackmann, McManus, & Fennell, 2005), eating disorders (Cooper et al., 2007) and SP (Wild et al., 2007). More systematic treatments of a longer duration, based on the ST model, have been shown to be efficacious in treating borderline personality disorder in an individual (Nadort et al., 2009) or group format (Farrell, Shaw, & Webber, 2009).

The nature of the processes set in motion by the emotionally focused IR interventions is not mere mechanical restructuring. At the conclusion of therapy, Anna reported that she felt “more grown up”, able to engage in behaviours that she had previously avoided and to assert her needs and stand up for herself. In addition, new positive goals emerged that were reflected in significant changes in Anna’s life. This suggested a transformative process with its own trajectory towards healing. When, in a rescript, the child is offered care and protection, it is as if a lost child comes to life and responds to a new situation in which her needs are being met. This evokes a range of emotions including surprise, relief and hope, as well as grief for the time that was lost and the failed relationships with parents. As Anna allowed herself to

experience these within and outside of sessions, it is as if the child whose development was interrupted, started to grow and develop and find the security and sense of worth that was missing before. One important factor is the therapist’s genuine care and concern not only in the rescripts but as a routine part of the relationship with the client in all aspects of the therapy process. However, the therapist is also offering support for the client’s broader engagement with the transformation process which gives access to what Bohart and Tallman (2010) called ‘self-organizing wisdom’. Anna, like many clients, found, as Fosha (2009, p. 201) put it, “new resources and capacities which could never have been imagined ... at the outset.”

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### About the Authors



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Anita’s research has focused on evaluating the transportability of specialist cognitive-behavioural treatment (CBT) models for post-traumatic stress disorder (PTSD) to the South African context. In this regard, her research has contributed to the creation of a contextualized knowledge base regarding the treatment of vulnerable population groups in the country, particularly survivors of rape. This has gone a considerable way towards providing practitioners with guidelines around the flexible application of efficacious treatments in local clinical settings.

Anita’s research areas include psychotherapy outcome research, CBT, schema therapy, trauma and PTSD, and gender-based violence. She is involved in Master’s clinical training and supervision, and lectures on CBT, qualitative research methods, psychopathology and developmental psychology. Her current research focuses on investigating the therapeutic value of participation in activism against gender-based violence for survivors of rape.

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David Edwards has been a Clinical Psychologist and practising therapist for over thirty years. He is a founding fellow of the Academy of Cognitive Therapy, having trained at Beck's Centre for Cognitive Therapy in Philadelphia in 1984/5 where he attended seminars with Jeffrey Young, the developer of schema therapy.

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David is a Professor at Rhodes University, where, until his recent retirement, he provided professional training and supervision in cognitive therapy for two decades. Over a long career, he has published some 70 academic articles and book chapters, covering areas as diverse as the use of imagery methods in psychotherapy, the history of imagery methods, case studies of the treatment of simple and complex PTSD, guidelines on the treatment of trauma related disorders, case studies of the treatment of other disorders including conduct disorder, ADHD and social phobia, and case study as a research methodology.

Additionally, David has co-edited a first year text book, and is the author of *Conscious and unconscious*, in the series *Core concepts in Psychotherapy* (McGraw Hill). His research for this book led to the publication of two articles in the *IPJP* in 2003 and 2005.

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