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THERAPY AT THE CULTURAL INTERFACE: IMPLICATIONS OF AFRICAN COSMOLOGY FOR TRAUMATIC STRESS INTERVENTION

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Abstract.
Within the field of psychotherapy the topic of intercultural or multicultural therapy continues to stimulate much debate. One of the key themes that is constantly revisited is whether psychotherapies derived primarily from Eurocentric and essentially Western orientations are applicable to people from non-Western cultures. Such questioning concerns not only the theoretical premises upon which understanding of pathology and distress are based, but also aspects of the style and process of intervention. Based upon clinical experience of direct intervention and supervision in the trauma field in South Africa over some 20 years, this paper seeks to contribute to this debate by examining a specific kind of dilemma and a specific arena of intervention. The dilemma arises out of critical observations of circumstances in which conventional African wisdom, as understood by clients presenting for trauma counselling, appeared to be counterproductive for their recovery in terms of western intervention principles. Almost invariably intercultural counselling training emphasizes respect for cultural beliefs as a core dimension of appropriate intervention. The therapist is thus confronted by a particularly difficult dilemma when faced with a clinical situation in which the non-challenging of cultural belief systems seems counter-therapeutic. How does one subscribe to the imperative to respect alternative cosmologies whilst retaining therapeutic integrity in terms of being informed by rigorous theory and pursuing the best interests of the client? Within the arena of psychotherapy for traumatic stress, including traumatic bereavement, such tensions appear to arise particularly strongly because of the inevitable search for meaning in the face of extraordinary life events. Focusing particularly on aspects of meaning making, cognitive intervention, schema realignment and reframing within trauma therapy, the paper elaborates areas of potential conflict with reference to both theory and clinical case material. Aspects of causal attributions for misfortune and their implications as understood both within African cosmology and within Western trauma theory frameworks are counterpoised. Having highlighted central points of tension in working at this cultural interface, the paper concludes with some suggestions as to how to manage such complexities in intercultural therapeutic work. A clinical case example is drawn upon to illustrate how a particular therapist-client dyad negotiated this tension in the course of a short-term psychotherapy.

INTRODUCTION.

South Africa is a complex country in which to practice psychotherapy. Not only are therapists confronted with the historical legacy of apartheid that still contributes to a range of sensitivities in across-race relationships, but many authors have observed the prevalence of traditional African belief and healing systems that exist side by side with Western systems of healing (Airhihenbuwa, 1995; Bodibe, in Uys, 1992; Buhrmann, 1984; Korber, 1990; Nzimande, 1989; Swartz, 1998; Van Dyk, 2001). Whilst subscription to traditional African beliefs is more prevalent in rural and under-developed areas of the country, studies and experience indicate that such beliefs are also widely held by people living in urban settings. In many instances Western-acculturated African people develop the ability to hold to hybridized explanatory systems which allow for the incorporation of both Western and traditional African premises (Bodibe, in Uys, 1992; Hamber, 1995). Sometimes these alternatives exist in harmony, sometimes they make an uneasy truce and sometimes they are split and employed within circumscribed domains of operation. For example, a traditional healer may be consulted for anxiety related to rejection by a lover, whereas a Western doctor might be consulted for heart palpitations. The psychological-physiological split suggested in this example by no means characterizes how such decisions are made on a personal basis and in the mental health arena it is very difficult to predict which types of problems will be taken to which type of healer and on what basis such choices are made. In a study of schizophrenic patients attending an urban, psychiatric outpatient clinic in a black township (suburb) it was found that 80% of families interviewed had initially sought assistance from a traditional healer when the index patient first displayed signs of disturbance. Only later had they sought psychiatric assistance when the problems persisted despite such intervention (Hamber, 1995). This paper is not concerned to pursue the fascinating material on cultural presentations of pathology but rather seeks to emphasize that traditional and Western cosmologies exist side by side in contemporary South Africa and that this duality needs to be borne in mind by psychotherapists conducting therapy with African clients.

A further dimension of South African society that has relevance for psychotherapists is the exposure of the population to high levels of violence, both historically and contemporarily. The apartheid political system was implemented and maintained via extreme forms of repression, much of which was described during the vivid testimonies of victims to the national Truth and Reconciliation Commission (TRC) during the late 90ties. In keeping with other societies in which there has been a dramatic transition from a repressive state system to a fledgling democracy, and against a background of extreme inequities of wealth, violent crime in South Africa has burgeoned alarmingly over the last 10 years. Rape, armed robbery, murder and attempted murder statistics indicate that members of the South African population are at more severe risk for exposure to violence than the citizens of the majority of other countries in the world, other than those at war. Given this context, most psychotherapists have come into contact with victims of violence, often suffering from forms of acute stress or posttraumatic stress disorder.

Over some 20 years of work specializing in the traumatic stress field as both practitioner and supervisor of psychotherapy and counselling, the author has been exposed to a broad spectrum of South African clients. Many of the clients presenting for counselling with Western-trained black and white psychotherapists have been African people whose

world-views reflect subscription to aspects of traditional African cosmology, despite their simultaneously engagement with Western healing resources. Given the often profoundly challenging nature of traumatic stress events, it is common for traumatized clients to search for explanations and meaning in the aftermath of such events, as will be elaborated in later sections of the paper. In many instances this search involves a turn to tradition and for westernized African clients may require the reconciliation or co-existence of different explanatory systems. Where these are in harmony this presents few problems for the client and the therapist. Indeed, as argued in another paper (Eagle, 1998), it may well be that formal therapeutic and indigenous interventions prove complementary, each reinforcing shifts in the other domain and allowing for redress of different aspects of the traumatic stress experience. For example, the working through of unresolved guilt in individual psychotherapy gave a middle-aged woman the courage to return to her family of origin to perform a traditional healing ceremony to allow her murdered son to be at peace with his ancestors, in turn consolidating her reparative impulses towards him. In addition to such complementary interventions however, there have been many cases in which tensions have arisen with respect to traditional beliefs and practices. Such instances pose particular difficulties for therapists wishing to assist clients ethically and with sensitivity.

The following brief case synopses provide some examples of the kinds of tensions being alluded to.

A middle-aged African woman presented for psychotherapy following the brutal murder of her adult son by unidentified attackers. His body had been so badly mutilated that members of her community decided, against customary practice, not to allow her to view the body prior to burial. On consulting a traditional healer (*isangoma*) about her bereavement difficulties and concerns that her son was not a peace, the woman reported that he had told her that her son was indeed still alive. If she paid him (the *sangoma*) a large amount of money and travelled to a neighbouring country her son would be restored to her. She presented with considerable ambivalence about whether to pursue this course of action, concerns about her ability to meet the financial demands and doubts about the reality of her son's death and her obligations to him.

Another middle-aged woman, engaged in volunteer counselling work herself, described the difficulties she had in negotiating the sudden grave illness and death of her husband. Her acute stress response was compounded by the fact that her in-laws accused her of having used bewitchment to poison him. Although she was angry about their response, she felt unable to engage with their accusations in the face of an apparently random and inexplicable illness. Such accusations, against women in particular, are not uncommon in African culture in relation to sudden or traumatic death, even occurring in another instance in which a man was shot dead by two unknown assailants. In this instance the wife had been excluded from involvement in burial arrangements by her in-laws. In addition, the father of the murdered man had not performed certain rituals related to ensuring that spirits rest at peace in the aftermath of violent death. The wife had been having dreams signifying to her that her murdered husband's spirit was not at rest. In terms of cultural practice it was a male elder, and his father more particularly, who should perform the necessary rituals. Thus this woman felt helpless to act to ensure that her murdered husband was at peace.

In a fourth instance, a child was brought to a clinic with suspected sexual abuse, the circumstances of which were unclear. It appeared that the girl had been abused more than once despite being moved to a new school. The professional staff and her mother were concerned that the perpetrator might be someone in her home or neighbourhood environment. However, the father, a traditionalist with strong patriarchal tendencies, insisted on taking his daughter to see a traditional healer and viewed the abuse as a misfortune visited upon himself and his family, rather than primarily upon the little girl. He had little concern with her psychological distress but was rather preoccupied with tracing the more mystical source of the problem. Against the clinic therapist and mothers' wishes he withdrew his daughter from treatment.

In a fifth case, a young woman in her early twenties presented for traumatic stress therapy following an attempted rape. During the course of the first interview she disclosed that her response to the potential attack had been exacerbated by a prior rape experience. During their high school years, she and a female friend had been gang-raped whilst playing truant from school. She had managed to escape after the rape but her friend had been stabbed to death. Severely traumatized, shamed over the rape experience and blaming herself for having abandoned her friend, she did not report the event to anyone at the time. She subsequently heard that at her friend's funeral, the family had put a curse on the gravesite, stating that anyone visiting the grave who had undisclosed knowledge of the circumstances of her death would be bewitched and punished. The client had severed all ties with her friend's family and had not been to visit her burial site. She had fairly recently consulted a traditional healer who had prescribed that she needed to carry out the sacrifice of a goat, a performance beyond her financial means and capabilities. Early on in the therapy the client described having nightmares that entailed re-living the experience and hearing her friend's screams and cries for help as she fled with her own survival in mind. She had many other posttraumatic stress symptoms, such as irritability, loss of concentration, social withdrawal and intrusive recollections of the event. The therapeutic work with this last-mentioned client will be further elaborated as aspects of therapeutic intervention are debated and discussed.

What should be apparent from these case examples is that there are instances in which traditional belief systems appear to contribute to psychological distress and to complicate aspects of traumatic stress and traumatic bereavement responses. It is apparent that the invocation of traditional beliefs led to reinforcement of denial in the first case; to alienation and added social withdrawal in the second case; to helplessness and exacerbation of loss of control in the third case; to cessation of treatment in the fourth case; and to pathological avoidance of stimuli associated with the incident in the fifth case. It must be acknowledged that traditional beliefs may tend to be more strongly entertained in individuals who are psychologically vulnerable to the suggestions implicit in particular cultural attributions. However, such attributions are widely held amongst African people and the kinds of cases cited here are not unrepresentative of clients presenting at many therapeutic services in South Africa. It is evident that in some instances in therapy there may be a clash of wisdoms or explanatory systems that warrants further exploration. In the following sections of the paper aspects of African cosmology that relate to causal attributions for misfortune will be counterpoised with aspects of Western-based psychotherapeutic wisdom with respect to traumatic stress

treatment. Each of these different sets of knowledge will be elaborated in some detail in order to highlight possible points of contestation.

AFRICAN COSMOLOGY AND CAUSAL ATTRIBUTIONS FOR MISFORTUNE.

Although it is somewhat presumptuous to suggest that there is a common belief system held by people across the African continent despite differences in urbanization, class, tribal affiliation, religion and geographical location, many authors have nevertheless written of an African cosmology or worldview (Airhihenbuwa, 1995; Bodibe, in Uys, 1992; Buhrmann, 1984; Prince, in Kiev, 1964; Shutte, 1994; van Dyk, 2001). As Buhrmann notes, the world-view and customs of African people "naturally are not exactly the same for all of Black Africa, but certain basic themes are universal." (1984:26). Drawing upon the writing of all of the above authors, but most centrally on the work of Buhrmann (1984) and Shutte (1994), several key premises tend to emerge as central in underpinning some of the differences entailed in a so-called Western and African world-views and are summarized as follows:

- Within African cosmology human beings are viewed as part of a holistic system which includes relationships with elements of nature, social networks and the supernatural. The self is seen not as "inside" but "as 'outside', subsisting in relationship to what is other, the natural and the social environment. In fact the sharp distinction between self and world, a self that controls and changes the world and is in some sense 'above' it, … disappears." (Shutte, 1994:47).
- The individual is understood to exist as an element of a broader social unit or system, being part of a family, an extended family system and a broader community. This is enshrined in the common Xhosa expression, "*umuntu ngumuntu ngabantu*", which translates broadly as "a person is a person through persons", one's personal existence is only realized as part of a collective existence. Personal achievement is valued less highly than respect for what is of common interest. The integrity of the group comes before the interests of the individual.
- Developmental has an ethical aspect that entails becoming "more worthy of reverence and respect as one ages" (ibid:50), hence the great respect shown for elders in traditional communities. Shutte (1994:50) quotes Mkiti as writing "personhood is something at which individuals could fail". In terms of moral evil, this "involves the real destruction of the personality of the guilty person. It is not merely the incurring of a conventional penalty." (ibid:50).
- There is a non-dualistic understanding of mind-body functioning. "Western medicine divides illness into the different categories of somatic, psychological and psychosomatic; the black people do not: they say that 'when part of me is ill, the whole of me is ill', irrespective of what the illness is." (Buhrmann, 1984:26). In similar vein, more broadly put, Shutte reflects: "the inextricable connection envisaged between the voluntary and the determined, the deliberate and the habitual, the will and the body, is a salutary corrective to the dualistic emphasis of European medicine and psychotherapy." (1994:57).
- The ancestors are understood to have a central place and to play a pivotal role in African society. They are viewed as having considerable agency in the afterlife and their beneficience is crucial to the existence of their offspring and future generations. "A symbiotic relationship exists between the living and their ancestors, the role of each being to keep the other happy, healthy and viable." (Buhrmann, 1984:29). The ancestors are accorded considerable reverence and remembrance and many

traditional ceremonies and practices are designed "to learn their wishes, to be guided by their wisdom and to have communion with them". (ibid:27). To be alienated from one's ancestors or to incur their displeasure is cause for considerable disquiet or anxiety.

- The primary means of communication between the living and the ancestors is through the mechanism of dreams, which therefore take on a particular interpretive significance. "Dreams therefore play an important role in the lives of Black people. They are treated like fragments of reality, can give direction to their lives and the instructions or advice contained in the dreams are usually acted on." (Buhrmann, 1984:30).
- The rituals involved in death, burial and bereavement are intricate and are seen as crucial to the foundation of a peaceful existence as part of the ancestral community. Additional rituals are often required in the case of sudden or violent deaths. Although not well documented, clients have referred to the notion that individuals who have died under violent or mysterious circumstances and have not been put to rest by the execution of appropriate rituals, may exist in a kind of limbo state, somewhere between being alive or dead. Such "living dead" may appear as "zombies" who are both feared and viewed as objects of pity.
- Given the notion of ubiquitous forces operating in the world, of which every individual is a part, allowance is made for the operation of supernatural forces. Individuals may be affected not only by the ancestors, but also indirectly by other living beings. When such forces are negatively motivated, persons may be understood to be "bewitched", often via the medium of a traditional "witchdoctor", a person who employs supernatural powers in a destructive capacity. (Buhrmann, 1984; Prince, in Kiev, 1974).
- The role of traditional healers has been central in many African societies, and such healers continue to practice in urban, developed locations as well as rural settings. There are different categories of healers, some of whom tend to deal in physical ailments and herbal remedies and others of whom appear to have skills beyond this in terms of divining, communication with the ancestors and intervention in relation to a range of personal, interpersonal and existential problems. Such people are often "called" to become healers through dreams and other significant experiences and serve a fairly lengthy apprenticeship before qualifying. *Sangomas* are viewed as powerful healers in many sectors of South African society and perform complex roles as social mediators and mediums between the spirit world and the living. Some clinical psychologists and western-trained therapists have also trained as *sangomas* and practice an ecosystemic form of psychotherapy.

Having provided a backdrop against which to appreciate elements of African belief systems that have relevance for psychotherapy, it is useful to elaborate on those aspects of belief pertaining specifically to misfortune and trauma intervention.

- Firstly it is noteworthy that in African society there is little entertainment of notions of chance. The "quest is for an explanatory theory which is basically one of a unity underlying the diversity of experiences. They are always searching for a 'cause', for the how, why and by whom of events that have befallen them." (Buhrmann, 1984:32). If some kind of misfortune befalls an individual the search for causality tends to exclude the possibility of such an event being random or purely fortuitous. Traumatic events, the kinds of events outlined as stressor criteria in the fourth

edition of the Diagnostic and Statistical Manual for psychiatric diagnoses (DSM-IV) (American Psychiatric Association, 1994), would generally be understood as severe forms of misfortune. The unexpected and unanticipated nature of traumatic events would also tend to entail a search for causality, although this is of course not peculiar to people from an African cultural background. The African approach to psychological problems "not only provides an explanation of how the person is being affected by particular problems but also why the person has been chosen for affliction and why she/he has been afflicted at any one particular point in time." (Gumede, cited in Straker, 1994:459).

- In terms of explanations for misfortune, three central sets of possible causes tend to be entertained, namely "mystical, animistic and magical" (Hammond-Tooke, cited in Straker, 1994; Ngubane, 1977). (Prince, in Kiev (1974) refers to natural, preternatural and supernatural causes of misfortune (cf:88)).

  i) Mystical causation is associated with the notion of being in a state of "pollution". When an individual is in such a state they are viewed as more vulnerable to negative forces or afflictions, without any sense of a direct agent seeking to harm them. People who are newly bereaved, menstruating women, women who have just given birth and men who have just had sex are understood to be in this state. It is as if the expenditure of energy in these endeavours leaves the individual more vulnerable or exposed. "These persons are required to observe certain taboos and to perform a variety of rituals to protect themselves and others from the effects of their pollution." (Straker, 1994:459).

  ii) When animistic causation is entertained, this usually involves notions of having incurred ancestral displeasure or of having lost ancestral protection for a variety of reasons. Via supernatural channels the ancestors have visited their condemnation on the person or community by means of experienced misfortune. Such understandings can be viewed on a spectrum ranging from ancestral aloofness and withdrawal of concern, to more active meting out of punishment. The search for the origins of ancestor alienation may involve consideration of sins of both commission and omission, for example failing to perform certain expected rituals. Propitiation of the ancestors is viewed as a potential mechanism for overcoming misfortune and avoidance of future harm. There are often strict rules about the actors and places of performance of such rituals, men being accorded more rights in this respect and particularly older men or first born sons.

  iii) Magical causation tends to be associated with witchcraft and the working of what could be termed curses, spells, bindings or enchantments. The subject of the bewitchment is understood to be under the influence of some malevolent force, inflicted upon them because of the ill wished upon them by another. "One is in the power of omnipotent and omnipresent evil spirits who can see and hear everything you do or say and whose aim is one's extermination." (Buhrmann, 1984:36). The unleashing of these forces is usually understood to be the work of a witchdoctor and the cure involves being "unbewitched" by a herbalist or healer. The motive for the bewitchment may be jealousy, envy, rivalry or revenge. Accusations of witchcraft and the practice or sorcery may have dire consequences for the identified perpetrator, as evidenced in the assaults and killings of so-called witches in some parts of South Africa (Lebakeng, Sedumedi & Eagle, in Hook & Eagle, 2002).

> Witchcraft beliefs are still widely entertained as evidenced for example in current, South African news media stories. Bewitchment "is a very common condition and is based largely on the view that there is no such thing as 'chance'. In other words, untimely deaths, accidents, illness and other misfortunes are 'brought on' by witches." (Buhrmann, 1984:35). There is thus an almost symbiotic relationship between the entertainment of notions of witchcraft and the occurrence of traumatic events, the one verifying the existence of the other.

It should be apparent that the understanding of trauma exposure in terms of "pollution" is less problematic for individuals, since causality tends to be more personal, less obscure and does not involve the potential interpretation of the motives of other beings or individuals. However, Burhmann (1984) suggests that most severe illnesses and misfortune tend to be attributed either to ancestor activity or to witchcraft.

From this abbreviated synopsis of African cosmology and misfortune, it should be apparent that within a traditional African worldview there are strongly held explanations for the kinds of events encompassed under the rubric of traumatic stress. There are also sets of practices that allow for the restoration of harmony and balance that are strongly regulated by custom. In the clinical cases described previously, it appears that tensions have arisen because of the particular ascription of meaning and causality to certain events and actors and also, in some instances, because of the constraints that prevent the performance of healing or undoing rituals.

IMPLICATIONS FOR COGNITIVE ATTRIBUTIONS AND MEANING-MAKING IN TRAUMATIC STRESS.

Turning to therapeutic considerations inherent in Western-oriented understandings of traumatic stress, it is useful to state that the emphasis will be primarily on cognitive frameworks and aspects of intervention. Not only are such dimensions most relevant to the discussion of points of potential tension in multicultural work and differing attributions, but they also represent a central framework of understanding within the traumatic stress literature (Joseph, in Yule, 1999). Numerous authors have argued that one of the cardinal responses to traumatic events is the search for meaning, usually involving some sort of causal attributional quest (Bulman & Wortman, 1977; Figley, 1985; Herman, 1992; Joseph, in Yule, 1999; McCann & Pearlman, 1990; Meichenbaum & Fitzpatrick, in Goldberger & Breznitz, 1993; Wilson, 1989). In order to integrate and reconcile with such experiences people need to be able to think about their trauma in a coherent manner and to come to some satisfactory answer for themselves about why the event took place and why it happened to them in particular (Kreitler & Kreitler, 1988). Within Western conceptualizations it is quite possible that such explanations may encompass ideas of chance or reconciliation with some randomness in events. It seems that a lack of closure in relation to such questions and the ongoing pursuit of causal explanations is associated with higher levels of pathology (Winje, 1998). Most models of psychotherapy for traumatic stress incorporate the facilitation of cognitive integration of the experience. (Prout & Schwarz, 1991).

Cognitive models of traumatic stress presentations range from information-processing frameworks (Creamer, Burgess & Pattison, 1992; Horowitz, 1992) to those that incorporate more existential concerns such as Lifton's (in Wilson & Raphael, 1993) emphasis on the "death imprint". In addition to theorizing about how thinking processes

per se are impacted on by trauma exposure (Freud, 1920/1995; Horowitz, 1992), most of these models incorporate the understanding that people's working models, cognitive schemas or pre-existing beliefs and assumptions are disrupted by traumatic events (McCann & Pearlman, 1990). Within information-processing models of post-trauma adjustment, individuals are understood to employ both assimilation and accommodation in coming to terms with events. However, given the almost inevitable turmoil entailed in traumatic events, the pressure is to accommodate rather than assimilate, requiring fundamental alterations to schematic systems and representations of the world (Dagliesh, in Yule, 1999; Horowitz, 1992). More behaviourally oriented explanations of cognitive aspects of disturbance view the avoidance of mentally anxiety-provoking stimuli as problematic, as well as the consequent generalization of anxiety to trauma-related stimuli (Foa & Riggs, 1993; Foa, Steketee & Rothbaum, 1989). Psychotherapy is aimed at identifying and deactivating the fear networks (Dagliesh, in Yule, 1999; Foa & Kozack, 1986) that have arisen in response to the trauma.

Several authors have noted that trauma-related difficulties with regard to cognition go beyond these more constrained models of disturbance, emphasizing the intricate manner in which individuals interpret or *construct* events (Herman, 1992; Kreitler & Kreitler, 1998; McCann & Pearlman, 1990; Turner, McFarlane & van der Kolk, in van der Kolk, McFarlane & Waisaeth, 1996). Kreitler and Kreitler (1998:38) cite work emphasizing that it is not necessarily the characteristics of the event per se which determine vulnerability to symptomology, but "their *meaning* for the individual", and also that "complex cognitive processes, including evaluations, judgements, beliefs, planning, fantasy, and so on are involved in determining trauma and PTSD". Thus, although all cognitive models of traumatic stress processing acknowledge the role of the "coding" of the informational content, depending on whether his/her theoretical orientation is neurological, behavioural, cognitive, psychodynamic, existential or constructionist, the therapist will attach more or less weight to the subjective interpretation of events, including the kinds of meanings that individuals appear to construct for themselves. It appears that in order to fully appreciate the role that cultural interpretations of events might play in traumatic stress outcomes, it is necessary to embrace more hermeneutically oriented paradigms, yet even these do not always fully embrace cultural idioms and meaning systems.

Although acknowledging that both prior and altered schemas are inevitably culturally embedded and that personal construction of meaning is socially influenced, a number of *universal* models of the cognitive impact of trauma have been proposed and have gained considerable credibility in the field. Such understandings tend to provide the backdrop against which Western-trained traumatic stress therapists formulate their interventions.

Janoff-Bulman's (1985, 1992) work on the rupturing of what she terms "basic assumptions" offers a widely cited and respected framework for traumatic stress psychotherapy. Janoff-Bulman argues that on the basis of a reasonably normative upbringing, most human beings develop three core assumptions about the operation of the world and about themselves. These three assumptions are summarized as follows: i) The world is benign; ii) The world is meaningful (implying notions of controllability, predictability and justice); and iii) The self is worthy. Associated with these basic assumptions is also the notion that the self is invulnerable, (Janoff-Bulman, 1992) (see

also Meichenbaum & Fitzpatrick, in Goldberger & Breznitz, 1993). Although fairly self-explanatory it is worth noting that these assumptions tend to be based on a particular world view that entails a largely rationalist perspective. The idea of a benign world in which one is safe from harm is predicated upon a notion that others are generally trustworthy and that the world is not controlled by a malevolent agent or destructive forces. The belief in a meaningful world is predicated upon beliefs that outcomes are predictable and generally fair as exemplified in "Just World" premises; people get what they deserve and deserve what they get (Lerner, 1980). The sense of self-worth is tied to humanist ideas about the intrinsic value of human beings and is primarily based upon early experiences of good caretaking (Janoff-Bulman, 1992). Whilst it seems possible to marry this conceptual framework with much of the African world-view described previously, it is apparent that the substance of these premises may be rather different in alternative cosmologies. For example, the sense of a benign world may be significantly predicated upon ancestral intercession, self-worth may be inextricable from communal worth and meaningfulness may incorporate understandings of supernatural forces and more holistic sets of relations. Such reinterpretations of basic assumptions need to be fully appreciated in multicultural trauma work. Exposure to a traumatic event involves rupture to one or more of these basic assumptions leading to bewilderment, anxiety, panic and despair. Part of the role of the therapist is to assist the individual to restore these assumptions, to heal or repair the rupture, sometimes entailing some modification of these core assumptions. However, Janoff-Bulman proposes that the restoration of the basic assumptions in some form is necessary to mental health, since despite their somewhat illusory basis, they enable individuals to operate effectively in the world (1985; 1992; 1995).

Extending Janoff-Bulman's framework somewhat, McCann and Pearlman have developed what they call "Constructivist Self-Development Theory" (CSDT) as a basis for informing traumatic stress intervention (1990). They propose that seven cardinal schematic representations are impacted upon by trauma, those for *safety*, *trust*, *independence*, *power*, *self-esteem*, *intimacy* and *frame of reference*, the last-mentioned referring largely to existential beliefs such as the entertainment of hope and locus-of control (McCann & Pearlman, 1990). Again, an interrogation of these schemas may reveal some Western bias in the formulation of the impact of traumatic stressors. For example, the discussion of ruptures to self-esteem tends to emphasize the individual's judgments of their self-efficacy as opposed to their sense of social disconnection. Like Janoff-Bulman they view central dimensions of psychotherapy as entailing examination of how these schemas have been affected by the individuals' traumatic experience and assisting clients in the reconstruction of a schematic system which will allow them to live satisfying and engaged lives.

In addition to her work on **Shattered assumptions**, Janoff-Bulman has also conducted research into self-blame (a form of self-attribution) in the aftermath of trauma. The phenomenon of self-blame, as opposed to the more constricted notion of "survivor guilt" (Kubany, 1994), has been widely observed in survivors of traumatic stress incidents (Bulman & Wortman, 1977; Dagleish, in Yule, 1999; Janoff-Bulman, 1979; Miller & Porter, 1983). In a seminal paper Janoff-Bulman (1979) proposed a distinction between "characterological" as opposed to "behavioural" self-blame, and argued that the latter was not necessarily damaging to mental health and might in fact serve an adaptive function for individuals in the aftermath of trauma. Essentially her argument hinged

around the fact that if a person could view the source of his/her traumatization as within his/her control and as modifiable, anxiety about future traumatization would be reduced. Janoff-Bulman cited research with college students that appeared to support a link between characterological self-blame and vulnerability to depression and the absence of such a link in the case of behavioural blame. Whilst the same link was not demonstrated amongst a sample of rape counsellors reporting on their clients' responses, they did report a predominance of behavioural blame amongst clients that appeared to be linked to a need to maintain a perception of avoidability of future occurrences and that did not appear to be as damaging to self-esteem as might have been anticipated. It is suggested that characterological self-blame implies global and stable attributions of causality, those kinds of attributions associated with vulnerability to depression in the revised learned helplessness model (Abrahamson et al, 1978). "Self-blame appears to be a label for two very different self-attributions, characterological self-blame being esteem related, and behavioural self-blame being control related. Self-blame as a predictor of good coping and self-blame as a concomitant of depression are no longer inconsistent in light of the two types of self-blame." (Janoff-Bulman, 1979:1806). Janoff-Bulman suggests that this conceptualization may have implications for psychotherapy, proposing that "a cognitive therapy that entails reattributing the focus of one's attributions (e.g., from character to behavior) might be of value in treating depressives." (ibid:1807). She even goes as far as to propose that rape counsellors should perhaps refrain from alleviating the behavioural self-blame of clients, since this may in fact be functional for them in terms of regaining a sense of personal control over future outcomes and render them less vulnerable to feelings of powerlessness.

Later studies conducted with a range of populations have tended not to confirm Janoff-Bulman's assertion that behavioural self-blame may be adaptive (Dagliesh, in Yule, 1994). What is apparent in Jonoff-Bulman's hypothesis however, is the powerful association between perceptions of controllability of events and better adjustment. This association has also been confirmed in the quite extensive literature on locus-of-control (Rotter, 1966) and mental health. In the main it is accepted that an internal locus-of-control, that us, the perception that one can personally control the likely outcomes of events, is associated with better adjustment. In the traumatic stress literature, findings with regard to locus-of-control are not clear cut and it is proposed that the effects of locus-of-control may be moderated by the intensity of the actual event (Joseph in Yule, 1999). Nevertheless, treatment would tend to encourage a more internal locus-of-control in order to cultivate greater optimism in relation to future positive events and in order to provide a basis for increased self-efficacy.

One of the cardinal dimensions of traumatization is the experience of loss of control or in Herman's (1992:55) terms "disempowerment". There is a general assumption in the traumatic stress treatment literature, including that cited thus far, that the restoration or instantiation of a sense of personal control over life events, particularly those anticipated in the future, is an important goal of psychotherapy. Therapists are not tasked primarily with helping their clients accommodate to the whims of fortune, but rather with instilling a sense of personal efficacy that it is believed will also generate a greater sense of optimism and meaning. The traumatic event may have been outside of one's control, but as a client one is invited to reframe one's behaviour as a form of adaptation (Eagle, 2000; Hoyt, in Scott & Palmer, 2000) and also to embrace an expectation that future outcomes will be largely within one's control and life therefore worth living (Brende, in

Everly & Lating, 1995; Herman, 1992; Lifton, in Wilson & Raphael, 1993; Ochberg, in Everly & Lating, 1995). Such expectations are not always explicit, but are clearly implicit in psychotherapy. The pursuit of such outcomes has intrinsic therapeutic appeal.

However, the reframing of traumatic experiences and support of more optimistic future orientations tends to reflect a usually un-interrogated notion of value in individual achievement, an internal locus-of-control and self-efficacy. These goals may not always be compatible with cultural belief systems that emphasize surrender to forces beyond oneself, dependence on a greater social fabric, or the interpretation of negative events as important communications or learning experiences. In the rebuilding of assumptions and adaptive cognitive schemas there are many premises, or even presumptions, about what constitutes good mental health and adjustment, premises which it is being suggested in this instance, may run counter to fundamental elements of traditional African belief systems. As a responsible therapist, how does one reconcile one's theoretical and clinical sense of what is in the therapeutic interest of a traumatized client whilst simultaneously empathically engaging with their frame of reference and assisting them to reconcile with their culturally-embedded sense of what a cure might entail?

Such observations about the hegemony of Western value systems in psychotherapy are not new, nor are they limited to treatment of traumatic stress cases. However, clashes in value systems do appear to be particularly significant in this arena for two reasons. It is recognized that traumatic stress exposure precipitates a degree of regression, including in the area of cognitive functioning (Freud 1920/1995; Herman, 1992; Kreitler & Kreitler, 1988). This means firstly, that clients are particularly open to suggestion and often very dependent on their therapists for their interpretation of events, including any reframing. Secondly, some research has indicated that under such duress, clients may revert to prior, less sophisticated frameworks of understanding, characteristic of earlier stages of maturation (Freeman, in Dattilio & Freeman, 1992; Horowitz & Kaltreider, in Everly & Lating, 1995; Lebowitz & Roth, 1994), including adopting more magical thinking and culturally dominant systems of understanding. What Freeman (in Dattilio & Freeman, 1992) terms "dormant" or "inactive schemas", and Lebowitz and Roth (1994) refer to as "latent" or "sub-dominant schemas" may re-emerge in the wake of trauma. In a hybrid cultural environment in which Western values have often been imbibed at a slightly later stage of development, it is quite plausible that more fundamental values (for want of a better expression) may re-emerge as significant in attempting to extract meaning from unfathomable situations.

The surfacing of latent schemas in the aftermath of trauma is not limited to particular cultural groups or frameworks. Many people draw on religious or spiritual beliefs, sometimes long abandoned, in attempting to draw meaning from trauma. Whilst recognizing the integrity and complexity of metaphysical belief systems and the beneficial and profound role they may play in people's lives and in their coming to terms with traumatic stress (Meichenbaum & Fitzpatrick, in Golberger & Breznitz, 1993; Ochberg, in Everly & Lating, 1995), it is also important to acknowledge that traumatic stress exposure may invite more reductionistic framing of events, for example that one's assault is a punishment by a higher being for some wrongdoing, or that "all men are not to be trusted". In light of such observations about traumatized clients, it behoves the therapist to tread extremely carefully in engaging with alternative belief systems. What then are the implications for therapeutic intervention?

IMPLICATIONS FOR THERAPEUTIC INTERVENTION AND PRACTICES.

In the traumatic stress treatment field, therapeutic approaches addressing cognitions, schemas and/or beliefs have been informed by information processing theory, by behavioural and cognitive-behavioural understandings and by psychodynamic and constructionist perspectives. However, as is the case with many other anxiety disorders, cognitive-behaviour therapy is often viewed as the treatment of choice, supported by most empirical evidence (Foa et al, 1991; Richards & Lovell, in Yule, 1999). Cognitive-behaviour therapy for posttraumatic stress consists of three major components: exposure techniques, anxiety management techniques and cognitive reframing and restructuring (Rothbaum & Foa, in van der Kolk, McFarlane & Waisaeth, 1996; Richards & Lovell, in Yule, 1999). Since the exposure and anxiety management techniques tend to be more behaviourally-based, discussion will be focused on more strictly cognitive modes of intervention. It should be acknowledged however, that exposure techniques, in assisting the client to approach and re-live aspects of the traumatic event, may facilitate elements of reappraisal on the part of the client (Resick & Schnicke, 1992), although this may be viewed as a by-product of a process designed primarily at anxiety-reduction and limitation of avoidance.

Cognitive therapy is broadly aimed at educating clients "to identify and monitor negative thoughts, beliefs and assumptions; to identify the logical errors contained in these beliefs; and to find more realistic and helpful alternatives to their current ways of thinking" (Richards & Lovell, in Yule, 1999:244). It is apparent that the therapist may play an active role in engaging the client in the scrutiny and evaluation of their beliefs and that there tend to be particular ways of thinking which are construed as more or less positive or negative by the therapist, and hopefully also in turn the client. Although described as a collaborative endeavour the therapy involves "*guided* self-discovery, enabling the clients to view their negative thoughts beliefs and assumptions as hypotheses to be validated in a *scientific* and systematic way" (ibid:244; emphases added). The psycho-educational orientation of the therapy, in which the therapist is sometimes metaphorically seen as playing the role of "coach" (Hoyt, in Scott & Palmer, 1995; Turner, McFarlane & van der Kolk, in van der Kolk et al, 1996), necessarily implies that there is a degree of leading or direction taking place, the "guiding" referred to. Some cognitive therapists might argue that this is a biased take on the role of the cognitive therapist, but many texts on cognitive therapy embrace this kind of description and would readily claim the proactive role of the therapist (Beck, 1976; Ellis, 1962, 1980; Meichenbaum & Fitzpatrick, in Golberger & Breznitz, 1993; Scott, Stradling & Dryden, 1995).

For cognitive therapists, personality is viewed as large synonymous with the individual's cognitive repertoire or phenomenological sense of the world. "Cognitive therapy views personality as being shaped by central values (or core beliefs) that develop early in life as a result of factors in one's environment. These schemas constitute the basis for coding, categorizing, and evaluating experiences and stimuli that an individual encounters in his or her world" (Dattilio & Freeman, in Freeman & Dattilio, 1992:5). Such a conceptualization would clearly fit with the kinds of models of traumatic stress responses discussed thus far. There is also room for entertaining the role of cultural influences in early schema formation and for African clients, the likely impact of aspects of an African ontological framework. "Psychological problems are perceived as

stemming from commonplace processes such as faulty learning, making incorrect inferences on the basis of inadequate or incorrect information, and not distinguishing adequately between imagination and reality" (Kovacs & Beck, cited in Dattilio & Freeman, in Freeman & Dattilio, 1992:5). To elaborate, cognitive therapists are trained to look for particular types of distortion in thinking and to draw the client's attention to these faulty thinking styles by a range of means. Such cognitive distortions include inter alia: *Arbitrary inferences*; *Selective abstraction*, *Overgeneralization*; *Magnification and minimization*; *Personalization*; *Labelling and mislabelling*; and *Dichotomous thinking* (Dattilio & Freeman, in Freeman & Dattilio, 1992). In order to address these maladaptive thought patterns a range of techniques may be employed including: *Downward arrow*, *Idiosyncratic meaning*, *Labelling of distortions*, *Questioning the evidence*, *Examining options and alternatives*, *Reattribution*, *Decatastrophizing*, *Advantages and disadvantages*, *Paradox or exaggeration*, *Turning adversity to advantage*, *Replacement imagery*, *Cognitive rehearsal*, and a range of associated behavioural techniques (Dattilio & Freeman, in Freeman & Datillio, 1992), as well as Socratic questioning (Beck, 1976; Hoyt, in Scott & Palmer, 2000).

In traumatic stress therapy, the focus is "directed towards identifying inappropriate thoughts and beliefs and helping clients reappraise these in order to develop a more helpful view of the traumatic event, themselves and the world" (Richards & Lovell, in Yule,1999:244). The examination of possible cognitive distortions becomes targeted primarily at attributional processes - the questions of why, why me and what does this mean for my sense of self, my relationships, my engagement with the world, with the cosmos and my future. In Resick and Schnicke's (1992:750) Cognitive Processing Therapy (CPT), the focus is on "identifying and modifying 'stuck' points, conflicts between prior schemata and this new information" associated with the trauma. They note that sometimes difficulties are caused by factors beyond problematic appraisal or cognitive distortions. These factors include: "a) negative conflicting schemata are imposed by others (i.e., blaming comments from those expected to provide support), b) the client's coping style is avoidant so she is unable to process the event in a complete manner …, or c) there is literally no relevant schema in which to store this new information …" (ibid:750). Resick and Shnicke (1992:750) argue that "Traditional Beckian therapy was not designed to deal with such circumstances." They thus employ a comprehensive treatment model encompassing psycho-education about traumatic stress, exposure and cognitive therapy. The cognitive component includes "training in identification of thoughts and affect, techniques for challenging maladaptive beliefs, and specific modules for five areas of beliefs: safety, trust, power, esteem and intimacy." (ibid:750). Clearly the last-mentioned intervention draws strongly upon Janoff-Bulman (1992) and McCann and Pearlman's (1990) theoretical conceptualizations and on the kinds of cognitive therapy techniques outlined above. Other cognitive therapeutic approaches to traumatic stress include elements of cognitive restructuring and self-dialogue (Foa, Rothbaum, Riggs & Murdock, 1991) designed to lead to more adaptive appraisal and coping. Cognitive reframing, re-labelling and reattribution are central elements in such interventions, entailing re-evaluation of behaviour, symptoms, responsibility and blame (Dattilio & Freeman, in Freeman & Dattilio, 1992; Kubany, 1994; Hoyt, in Scott & Palmer, 2000; Scott, in Scott & Palmer, 2000).

Freeman notes that in conceptualizing any cognitive therapeutic intervention, change may be recommended on a continuum from the "greatest schematic changes to the

least schematic change" (in Freeman & Dattilio, 1992:22). The most dramatic form of change entails "schematic reconstruction" involving "removing, rebuilding or reconstructing old schemas" (ibid:22). Lesser levels of change involve either "schematic modification", ideally attempting "to effect the smallest modification as part of a series of small modifications"; or "schematic reinterpretation", "using the schema in a more effective manner" (ibid). It would seem that traumatic stress treatment almost inevitably entails "schematic reconstruction", given the kinds of arguments already advanced in the paper, and therefore also places more clinical and ethical demands on the therapist. Whilst sometimes noting the important role of culture in schematic constructions and cautioning therapists about assuming the universality of conceptual models (Janoff-Bulman, 1992; McCann & Pearlman, 1990, Richards & Lovell, in Yule, 1999; Scott, in Scott & Palmer, 2000) few authors have explicitly interrogated how such cultural awareness should be incorporated in the therapeutic endeavour.

POTENTIAL STRATEGIES FOR SENSITIVE ENGAGEMENT.

Returning to the initial question posed in this paper, that is, how to engage with traumatized clients whose cultural beliefs appear to be hampering rather than aiding in recovery, it may be useful to propose an overarching framework for intervention as well as a number of strategies that have been helpful in clinical practice in South Africa. No effective therapist is likely to challenge a client's beliefs as a first priority in intervention, however much they may be provoked to express disagreement or even outrage. For example, it would be tempting to suggest that the input of the traditional healer in the first case described constituted malpractice, or to have confronted the father of the abused child with our perceptions of his responsibilities to his child. Such a stance would not only be disrespectful, but would also compromise the formation of a therapeutic alliance and a climate in which the client could feel that their phenomenological world was fully appreciated.

As an overarching framework, a constructivist orientation to cognitive psychotherapy, as opposed to a rationalist style of intervention, is recommended (Hoyt, in Scott & Palmer, 2000). Without a therapeutic model that can encompass subjectivity, alternative logics and even what the therapist might perceive to be irrationality, it would be impossible to engage fully with African clients holding to traditional World-views. A conservative reading and application of either Ellis (1962; 1980) or Beck's (1976) cognitive-behavioural approaches is unlikely to be effective in such cases. Unfortunately more phenomenological approaches to traumatic stress treatment tend to be less well researched (Meichenbaum & Fitzpatrick, in Golberger & Breznitz, 1993) than rationalist approaches that allow for easier qualification and replication (Dagliesh, in Yule, 1999; Richards & Lovell, in Yule, 1999). However, Meichenbaum's constructivist narrative approach (Meichenbaum & Fitzpatrick, in Goldberger & Breznitz, 1993; Hoyt, in Scott & Palmer, 2000) would seem to offer a useful model for multicultural traumatic stress psychotherapy. This approach encompasses elements of both cognitive-behaviour therapy and narrative psychotherapy with an emphasis on collaborative narrative repair and stress inoculation training (Hoyt, in Scott & Palmer, 2000; Meichenbaum, 1979; Meichenbaum & Fitzpatrick, in Goldberger & Breznitz, 1993). As a focus of the therapeutic work "the therapist collaboratively develops a *reconceptualization* of the distress process with the client and significant others" (Meichenbaum & Fitzpatrick, in Goldberger & Breznitz, 1993:718).

Meichenbaum and Fitzpatrick are at pains to emphasize the agency of the client in the therapeutic process: “There are two important features to recognize about this reconceptualization or new narrative reconstruction process. First, the scientific validity of the specific healing theory that is developed is less important than is its plausibility or credibility to the client. Secondly, this entire narrative repair effort is conducted in a collaborative inductive fashion and not imposed upon nor didactically taught to distressed individuals.” (ibid:718). This framework or stance would seem to hold considerable promise for engaging with the kinds of cases discussed at the outset of the paper.

Adopting the constructivist narrative perspective as the broad basis for intervention the following pointers illustrate the manner in which multicultural tensions have been negotiated in psychotherapy with such clients and are further exemplified in the concluding case discussion. It is suggested that the therapist might attempt to:

- Explicitly engage in dialogue about points of discrepancy between their own frameworks and those of the client and the possible implications of this for psychotherapy, without assuming superior validity of either system of understanding.
- Expand the sophistication and subtlety of reconceptualization, reframing and re-labelling to incorporate examination of traditional as well as western explanatory frameworks.
- Work with more individually problematic self-attributions initially, in the expectation that the client will then become better able to challenge detrimental communal/traditional attributions from his/her own base.
- Seek to understand the particular respects in which the client is vulnerable to suggestion and attempt to address the origins of this susceptibility within the psychotherapeutic frame.
- Examine the parameters within which restitution of balance or performance of rituals is prescribed, the intention behind them, and possible alternatives for expression that are acceptable to the client.
- Encourage clients to seek input from other powerful interpreters of events who may allow for some contestation of rigid explanations and provide alternative versions, for example older relatives.
- Under duress, challenge the detrimental explanatory frameworks put forward by others in terms of questioning motives such as self-gain or the possibility of malpractice.
- Acknowledge the importance of cultural embeddedness and cultural reconciliation, whilst at the same time affirming that culture is something that transforms with time and is open to variable interpretations.

BRIEF ILLUSTRATIVE CASE DISCUSSION.

In the case of Nomsa (not her real name), the young woman who presented after her attempted rape experience, the first step, as in all psychotherapies, was to establish a good working relationship. Despite her deep levels of disclosure in the first two sessions, the establishment of a consistent relationship took some time, with Nomsa missing two sessions out of her first six. This was understood to be a consequence of some ambivalence about trusting her therapist to be a consistent and containing presence, a kind of testing process that may have been exacerbated by the fact that her therapist was white, although this was never explicitly raised as an issue. Also, as has

been noted in a range of texts (Brom, Defares & Kleber, 1989; Resick & Schnicke, 1992; Richards & Lovell, in Yule, 1999), dropout in the initial phases of traumatic stress counselling is often high as revisiting the experience and/or its associations produces elevated levels of anxiety, as was the case for Nomsa. Despite Nomsa's apparent ambivalence, the therapist maintained a highly committed presence, reflecting her difficulties in engaging in the therapy and acknowledging the depth of her anxiety about the "curse" and its impact from the outset.

During the course of therapy, in retelling her story of past events and the construction of a coherent narrative, particular attention was paid to Nomsa's self-attributions and the interpretation she placed upon her symptoms and her behaviour. It emerged that she had unconsciously understood the recent attack as a kind of punishment for her previous wrongdoing. She viewed herself, somewhat understandably, as in some way attracting sexual violence from men. Although this did not strictly constitute a form of characterological self-blame (Janoff-Bulman, 1979) Nomsa's explanation for the attempted rape involved stable and global attributions that predisposed her to hopelessness. In addition, she also came to realize that she had attributed her symptoms, such as intrusive recollections of the event and nightmares, to the punishment she deserved for abandoning her friend and her secrecy around the incident. This latter realization came about in part in response to the psycho-educational input of the therapist (Eagle, 2000), who elaborated on the commonality and 'normality' of Nomsa's symptoms as a response to the traumatic incidents. Both the attempted rape and her symptoms had been understood as part of the 'curse' that was being visited upon her, hence Nomsa's visit to the traditional healer following the recent event. Since she was unable to follow his advice for financial and logistical reasons, her symptoms had become even more disabling and she presented at a Western-oriented trauma clinic service with profound feelings of helplessness and desperation.

The core of the therapy involved the reconstruction of the earlier rape experience and a careful examination of Nomsa's role in the events. Because of her avoidance of the terrible imagery associated with the rape and murder, she had never clearly examined her options in the situation. Also, since the girls had been truanting at the time of the attack, Nomsa had further interpreted the event to be a consequence of their misbehaviour and this had cut her off from any immediate social support and potential benign reframing of her escape behaviour. Accounts of the graveside scene had served to exacerbate her guilt and sense of being a social outcast. She also entertained notions that her deeds were somehow magically known by others and that some related malevolence of was both pervasive and justified. She had cultivated virtually no new friendships since the trauma. Over time, with the elaboration of her narrative and judicious use of questions and re-attributions (Dattilio & Freeman, in Freeman & Dattilio, 1992), Nomsa began to understand the impossibility of her choices in the circumstances (Kubany, 1994) and became convinced that her remaining in the situation would not have saved her friend's life and would in all probability have resulted in her murder too. Using role reversal and some guided imagery (Hoyt, in Scott and Palmer, 2000), Nomsa became able to appreciate that her friend would have behaved as she had done, had the situation been inverted. She was also able to imagine her friend's acceptance of her actions, her forgiveness and her wish for Nomsa's survival and future happiness. As Nomsa's appreciation of her misattributions and her insight into the illogical connections she had made developed in the context of therapeutic dialogue, she came to a fairly

dramatic reframing of her understanding of the burial curse. She spontaneously suggested that the curse may have been directed at the perpetrators of the rape and murder rather than at her. She was able to interpret her understanding of the family's bitter attempt to confront or punish the evil doers as a projection of her own guilt. Nomsa was also now able to attribute responsibility for her friend's death to the actual perpetrators and to free herself from her own sense of culpability.

As a consequence of this insight and increasing trust in the therapeutic process, Nomsa agreed to engage in some behavioural tasks that took the form of homework exercises. Her first task entailed sharing some of her traumatic experiences in the context of a recent tentative friendship. Her disclosure was sensitively and supportively received by this friend and further affirmed her nascent sense of blamelessness. Nomsa then volunteered her strong desire to approach the family of her friend in order to tell them what had actually taken place. After some behavioural rehearsal (Dattilio & Freeman, in Freeman & Datillio, 1992; Meichenbaum, 1979), assisting Nomsa to anticipate a range of possible responses from the family, she embarked on this course of action. From a therapeutic point of view the consequences were overwhelmingly positive allowing for a truly reparative experience and profound emotional reprocessing (Rachman, 1980). The family listened to her narrative with deep respect and sympathy, offering her comfort and concern. They mourned for her friend together and at the end of the visit her friend's mother asked her to retain contact, suggesting that she could become a kind of replacement daughter for her. They also agreed to visit the grave together, representing for Nomsa the final release from her bewitchment.

During the session following this visit Nomsa reported that her symptoms had almost completed abated, apart from some hyper-vigilance. She terminated therapy somewhat abruptly, since in her eyes the therapist had helped her to this significant point of reconciliation and further work was no longer required. The therapist accepted her choice, but asked her not to rule out the possibility of follow-up or future longer term therapy should there be any indications of relapse, particularly in light of the fact that there had been some allusions to an earlier history of sexual abuse by a cousin. Given her life history and aspects of her personality style, it was also possible to conceive of Nomsa as suffering from complex traumatic stress (Herman, in Everly & Lating, 1995), a condition usually requiring longer term psychotherapy. Overall however, the treatment appears to have had a beneficial outcome and the fact that the client did not re-present for therapy suggests sustained progress in Nomsa's recovery.

CONCLUSION.

It seems that the respectful stance of the therapist and her willingness to engage sincerely with the felt impact of Nomsa's interpretation of traditional beliefs and practices, created the therapeutic space for Nomsa to re-conceptualize and rewrite her own narrative. In Meichenbaum and Fitzpatrick's words, Nomsa was able to develop a "meaningful and acceptable" interpretation of her traumatic life experiences (in Goldberger and Breznitz, 1993:711), free of personal guilt, social approbation and malevolent forces. If therapists keep these principles in mind, seeking to co-construct with clients narrative versions that are both *meaningful* and *acceptable* in all senses, then they are likely to be able to negotiate the often difficult pathways of multicultural psychotherapy with integrity.

REFERENCES.

Abrahamson, I, Seligman, M & Teasedale, J (1978). Learned helplessness in humans: Critique and reformulation. **Journal of Abnormal Psychology, 87**, 49-74.

American Psychiatric Association (1994) **Diagnostic and statistical manual of mental disorders** (4th ed). Washington DC: American Psychiatric Association.

Airhihenbuwa, C (1995) **Health and culture: Beyond the Western paradigm**. Thousand Oaks, CA: Sage.

Beck, A T (1976) **Cognitive therapy and the emotional disorders**. New York: International Universities Press.

Beck, A T, Emery, G & Greenberg, R (1985) **Anxiety and phobias: A cognitive approach.** New York: Basic Books.

Bodibe, R C (1992) Traditional healing: An indigenous approach to mental health problems, in Uys, J (ed) **Psychological counselling in the South African context.** Cape Town: Maskew-Miller.

Brende, J O (1995) Twelve themes and spiritual steps: A recovery programme for survivors of traumatic experiences, in Everly, G S & Lating, J M (eds) **Psychotraumatology: Key papers and core concepts in post-traumatic stress.** New York: Plenum Press.

Brom, D, Kleber, R J & Defares, P B (1989) Brief psychotherapy for posttraumatic stress disorders. **Journal of Consulting and Clinical Psychology, 57(5)**, 607-612.

Buhrmann, V (1984) **Living in two worlds: Communication between a white healer and her black counterparts**. Cape Town: Human and Rousseau.

Bulman, R & Wortman, C B (1977) Attributions of blame and coping in the “real world”: Severe accident victims react to their lot. **Journal of Personality and Social Psychology, 35**, 351-363.

Creamer, M, Burgess, P & Pattison, P (1992) Reaction to trauma: A cognitive processing model. **Journal of Abnormal Psychology**, **101**, 452-459.

Daglish, T (1999) Cognitive theories of post-traumatic stress disorder, in Yule, W (ed) **Post-traumatic stress disorders: Concepts and therapy.** Chicester: John Wiley & Sons.

Dattilio, F & Freeman, A (1992) Introduction to cognitive therapy, in Freeman, A & Dattilio, F (eds) **Comprehensive casebook of cognitive therapy.** New York: Plenum Press.

Eagle, G T (1998) Promoting peace by integrating western and indigenous healing in treating trauma. **Peace and Conflict: Journal of Peace Psychology, 4(3)**, 271-282.

Eagle, G T (2000) The shattering of the stimulus barrier: The case for an integrative approach in short-term treatment of psychological trauma. **Journal of Psychotherapy Integration, 10(3)**, 301-324.

Ellis, A (1962) **Reason and emotion in psychotherapy**. New York: Lyle Stuart.

Ellis, A (1980) Rational-emotive therapy and cognitive-behavior therapy: Similarities and differences. **Cognitive Therapy and Research**, **4**, 325-340.

Figley, C (ed) (1985) **Trauma and its wake: The study and treatment of post-traumatic stress disorder.** New York: Brunner/Mazel.

Foa, E & Kozack, M (1986) Emotional processing of fear: Exposure to corrective information. **Psychological Bulletin**, **99**, 20-35.

Foa, E, Steketee, G & Rothbaum, G (1989). Behavioural/cognitive conceptualization of post-traumatic stress disorder. **Behaviour Therapy**, **20**, 155-176.

Foa, E, Rothbaum, B, Riggs, D S & Murdock, T B (1991) Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counseling. **Journal of Consulting and Clinical Psychology, 59(5)**, 715-723.

Freeman, A (1992) Developing treatment conceptualizations in cognitive therapy, in Freeman, A & Dattilio, F (eds) **Comprehensive casebook of cognitive therapy**. New York: Plenum Press.

Freud, S (1920/1995). Beyond the pleasure principle, in Gay, P (ed) **The Freud reader.** London: Vintage.

Hamber, B (1995) The burden of care: An analysis of the burden of care on caregivers of South African psychiatric outpatients. Unpublished Masters Research Report. University of the Witwatersrand, Johannesburg, South Africa.

Herman, J (1992) **Trauma and recovery: The aftermath of violence – from domestic abuse to political terror**. London: Basic Books.

Herman, J (1995) Complex PTSD: A syndrome in survivors of prolonged and repeated trauma, in Everly, G S & Lating, J M (eds) **Psychotraumatology: Key papers and core concepts in post-traumatic stress**. New York: Plenum Press.

Horowitz, M (1992) **Stress response syndromes** (2nd ed). New York: Aronson.

Horowitz, M, Field, N & Claasen, C (1993) Stress response syndromes and their treatment, in Goldberger, L & Breznitz, S (eds) **Handbook of stress: Theoretical and clinical aspects** (2nd ed). New York: Free Press.

Horowitz, M J & Kaltreider, N B (1995) Brief therapy of the stress response syndrome, in Everly G S & Lating, J M (eds) **Psychotraumatology: Key papers and core concepts in post-traumatic stress**. New York: Plenum Press.

Hoyt, M (2000) Cognitive-behavioural treatment of post-traumatic stress disorder from a narrative constructivist perspective: A conversation with Donald Meichenbaum, in Scott, M & Palmer, S (eds) **Trauma and post-traumatic stress disorder** London: Cassel.

Janoff-Bulman, R (1979) Characterological versus behavioural self-blame: Inquiries into depression and rape. **Journal of Personality and Social Psychology**, **37**, 1798-1809.

Janoff-Bulman, R (1985) The aftermath of victimization: Rebuilding shattered assumptions, in Figley, C (ed) **Trauma and its wake: The study and treatment of post-traumatic stress disorder.** New York: Brunner/Mazel.

Janoff-Bulman, R (1989) Assumptive worlds and the stress of traumatic events: Applications of the schema construct. **Social Cognition, 7(2),** 113-136.

Janoff-Bulman, R (1992) **Shattered assumptions: Towards a new psychology of trauma**. NewYork: The Free Press.

Janoff-Bulman, R (1995) Victims of violence, in Everly G S & Lating, J M (eds) **Psychotraumatology: Key papers and core concepts in post-traumatic stress.** New York: Plenum Press.

Joseph, S (1999) Attributional processes, coping and post-traumatic stress disorders, in Yule, W (ed) **Post-traumatic stress disorder: concepts and therapy**. Chicester: John Wiley and Sons.

Korber, I (1990) Indigenous healers in a future mental health system: A case for co-operation. **Psychology in society (PINS)**, **14**, 47-62.

Kreitler, S & Kreitler, H (1988) Trauma and anxiety: The cognitive approach. **Journal of Traumatic Stress, 1(1)**, 35-56.

Kubany, E S (1994) A cognitive model of guilt typology in combat-related PTSD. **Journal of Traumatic Stress, 7(1)**, 3-19.

Lebakeng, T, Sedumedi, S & Eagle, G (2002). Witches and watchers: Witchcraft beliefs and practices in South African rural communities of the Northern Province, in Hook, D & Eagle, G T (eds) **Psychopathology and social prejudice.** Cape Town: University of Cape Town Press.

Lebowitz, L & Roth, S (1994) "I felt like a slut": The cultural context and women's responses to being raped. **Journal of Traumatic Stress, 7 (3)**, 363-390.

Lerner, M J (1980) **The belief in a just world: A fundamental delusion**. New York: Plenum.

Lifton, R J (1993) From Hiroshima to the Nazi doctors: The evolution of psychoformative approaches to understanding traumatic stress syndromes, in Wilson, J & Raphael, B (eds) **International handbook of traumatic stress syndromes.** New York: Plenum Press.

McCann, L & Pearlman, L (1990) **Psychological trauma and the adult survivor: Theory, therapy and transformation**. New York: Brunner Mazel.

Meichenbaum, D (1977) **Cognitive-behavior modification: An integrative approach**. New York: Plenum.

Meichenbaum, D (2000) What can be done to help clients with PTSD and DES?, in Scott, M J & Palmer, S (eds) **Trauma and post-traumatic stress disorder**. New York: Cassel.

Meichenbaum, D & Fitzpatrick, D (1993) A constructivist narrative perspective on stress and coping: Stress inoculation applications, in Goldberger, L & Breznitz, S (eds) **Handbook of stress; Theoretical and clinical aspects** (2nd ed). New York: Free Press.

Miller, D T & Porter, C A (1983) Self-blame in victims of violence. **Journal of Social Issues, 39(2)**, 139-152.

Ngubane, H (1977) **Body and mind in Zulu medicine**. London: Academic Press.

Nzimande, B (1989) African life and the “hidden abode of mental life”, in Eagle, G, Hayes, G & Bhana, A (eds) (1989) **Mental health: Struggle and transformation.** Proceedings of the Third National OASSSA Conference. Durban: Organisation for Appropriate Social Services in South Africa.

Ochberg, F (1995) Post-traumatic therapy, in Everly, G S & Lating, J M (eds) **Psychotraumatology: Key papers and core concepts in post-traumatic stress.** New York: Plenum Press.

Prout, M & Schwarz, M (1991) Posttraumatic stress disorder, a brief integrated approach. **International Journal of Short-term Psychotherapy**, **6**, 113-124.

Rachman, S (1980) Emotional processing. **Behaviour Research and Processing**, **18**, 51-60.

Resick, P A & Schnicke, M K (1992) Cognitive processing therapy for sexual assault victims. **Journal of Consulting and Clinical Psychology, 60(5)**, 748-756.

Richards, R & Lovell, K (1999) Behavioural and cognitive behavioural interventions in the treatment of PTSD, in Yule, W (ed) ***Post-traumatic stress disorders: Concepts and therapy*****.** Chicester: John Wiley & Sons.

Rothbaum, B & Foa, E (1996) Cognitive-behavioural therapy for posttraumatic stress disorder, in van der Kolk, B McFarlane, S & Waisaeth (eds) **Traumatic stress: The effects of overwhelming experience on mind, body and society**. New York: Guilford Press.

Rotter, J B (1966) Generalized expectancies for internal versus external control of reinforcement. **Psychological Monographs, 80 (1)**.

Scott, M J (2000) Post-traumatic stress disorder: Acognitive-contextual approach, in Scott, M J & Palmer, S (eds) **Trauma and post-traumatic stress disorder**. New York: Cassel.

Scott, M J, Stradling, S G & Dryden, W (1995) **Developing cognitive-behavioural counselling.** London: Sage.

Shutte, A (1994) **Philosophy for Africa**. Cape Town: University of Cape Town Press.

Straker, G (1994) Integrating African and western healing practices in South Africa. **American Journal of Psychotherapy, 48 (3)**, 455-467.

Turner, S, McFarlane, A & van der Kolk, B (1996) The therapeutic environment and new explorations in the treatment of posttraumatic stress disorder, in van der Kolk, B, McFarlane, S & Waisaeth (eds) **Traumatic stress: The effects of overwhelming experience on mind, body and society**. New York: Guilford Press.

Van Dyk, A (2000) Traditional African beliefs and customs: Implications for Aids education and prevention in Africa. **South African Journal of Psychology, 31 (2)**, 60-66.

Wilson, J (1989) **Trauma, transformation and healing: An integrative approach to theory, research and post-traumatic therapy**. New York: Brunner/Mazel.

Winje, D (1998) Cognitive coping: The psychological significance of knowing what happened in the traumatic event. **Journal of Traumatic Stress, 11(2)**, 627-643.