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OLDER PEOPLE'S PERSPECTIVES ON THE EFFECTIVENESS OF EYE MOVEMENT INTEGRATION (EMI) THERAPY AS TREATMENT INTERVENTION FOR THEIR TRAUMA SYMPTOMS

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2020

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Submitted in partial fulfilment of the requirements for the degree of

Magister Artium Socialis Scientiae (Clinical Social Work)

in the

Department of Social Development Professions

of the

Faculty of Health Sciences

To be awarded at the

Nelson Mandela University

April 2020

Supervisor: Dr Anneline Keet

DECLARATION

NELSON MANDELA
UNIVERSITY

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DECLARATION:

In accordance with Rule G5.6.3, I hereby declare that the above-mentioned treatise/ dissertation/ thesis is my own work and that it has not previously been submitted for assessment to another University or for another qualification.

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DATE: 25/10/2019

Acknowledgements

I want to express my gratitude to everyone who directly and indirectly influenced and contributed to this study. I am especially thankful for and value the following people:

First of all, to Jesus Christ, for making it all possible through His unconditional and unending love, continuous provision and for being my source of strength.

To my extremely reliable husband, Hendré Visagie, thank you for your truthfulness, for trusting and truly loving me. Your support and confidence in me have seen me through to the conclusion.

To all my family, thank you for the endless supply of love and prayers.

To Dr Lindy Bosman, whom I regard as a true mentor. Through your inspiring words, wisdom and enthusiasm that is contagious, this study came to life. You saw potential and believed in me, and I thank you for that.

To Jan and Annette Kirsten, just being in your presence is inspiring. Thank you for your commitment, positive influence in my life and for showing a real interest throughout this journey.

To Dr Hilda du Plooy for so selflessly conducting the interviews. The ideas that she has shared have been extremely useful to me.

To my supervisor, Dr Anneline Keet, for your enthusiasm towards this study. Throughout the last three years, she has been instrumental in sharing expert knowledge, providing thoughtful guidance and feedback.

To my friends and my colleagues who motivated and encouraged me, you have helped me to persevere.

Also, I wish to thank every participant from the bottom of my heart for committing their precious time towards this project and for trusting me during the process. Undoubtedly, I could not have done it without you.

A special thanks to Marion Pfeiffer for her timeous responses, thoroughness, professionalism and working her editorial magic.

Abstract

Many research studies propose that we have an ageing population with an increased number of people living past the age of 85 years. Ageing is accompanied by a gradual decline in physical, mental and sensory abilities. Older people may have experienced trauma throughout their lives, and very often, their symptoms of trauma are regarded as part of the ageing process rather than actual symptoms of trauma. In addition, older people often do not seek help throughout their lives for various reasons.

While there is research available about older people and trauma, little is known about Eye Movement Integration (EMI) therapy as a treatment intervention in treating symptoms of trauma in older persons. The purpose of this research was an explorative and descriptive study of older people's responses to EMI therapy as a treatment intervention for their symptoms of trauma. More specifically, the study was designed to determine how older people process their symptoms through EMI therapy and whether they view it as valuable. This qualitative study used an exploratory-descriptive research design with a non-probability, purposive sampling method. The EMI therapy sessions were offered to older adults in the Knysna area who presented with symptoms of trauma. From this group, only those who were able and willing to engage in therapeutic interviews formed part of the research. As part of the study, they consented to the use of their inventories from the EMI sessions as a qualitative document analysis and taking part in qualitative interviews to explore their views on the usefulness of EMI therapy to deal with their trauma.

The findings emphasise that older people are not familiar with EMI. However, they view their experience of it in a positive light and regard it as a useful treatment intervention for treating their symptoms. Moreover, EMI seems to be a brief and cost-effective trauma intervention with practical benefits for older adults. The results from this study can assist social work professionals, specifically those working with older people, to address and improve the overall health and emotional wellbeing of older people. Data verification methods ensured the validity of this study.

Key words: Age; Ageing; Eye Movement Integration (EMI) therapy; Older person; Post-Traumatic Stress Disorder (PTSD); Trauma

TABLE OF CONTENTS

LIST OF TABLES

List of Acronyms

ANS	Autonomic Nervous System
CBT	Cognitive Behavioural Theory
CNS	Central Nervous System
EMDR	Eye Movement Desensitisation and Processing
EMI	Eye Movement Integration
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency System
LCT	Life Course Theory
NLP	Neuro-Linguistic Programming
NPO	Non-Profit Organisation
PTSD	Post-Traumatic Stress Disorder

Chapter 1: Introduction to the research study

1.1 INTRODUCTION

Many people overcome trauma without any treatment intervention. However, there are still many older people who present with symptoms of trauma from their childhood years. It is important to consider the impact of previous exposure to trauma on health and wellbeing in the older population in addition to the normal gradual deterioration in health as people age (Sadock, Sadock & Ruiz, 2015: 1334). Older people may accordingly be a more vulnerable age group in terms of their health and wellbeing (Turner & Lloyd, 1995: 2). With life expectancy predicted to lengthen in the future (Henslin, 2007: 363; Stuart-Hamilton, 2011: 14-18), the focus is to find an effective treatment modality for treating older people's symptoms of trauma. The first chapter serves as a planning document for the researcher and highlights the value of the implementation of the research study.

1.2 BACKGROUND TO THE STUDY

Life expectancy has drastically increased during the past few decades. According to Henslin (2007: 363) and Stuart-Hamilton (2011: 14-18), only about 25% of the population reached ages of 50-65 in the 1900s. Globally, it is estimated that today's population living longer than 60 years of age, will increase by 70% and those that will live up to 80 years and older will increase by 30-40%. The prediction is that about half of the population will live to be older than 85 years of age. According to Dunn and Craig (2013: 443), the increasing older population can be attributed to lower birth rates, better health care and a decrease in early mortality. The growth in the greying population is estimated to continue in the next three decades.

South Africa is described as a developing country (O'Dowd, 2014). It means that there are limited resources available with low socioeconomic development. According to Henslin (2007: 363), people in developing countries have no obligation to pay taxes on social security. Therefore, families do not receive assistance from the government with regards to their older relatives. In South Africa, citizens who are 60 years and older with no other means of financial income, qualify for an older person's grant (DSD,

2017). In 2018, the older person's grant amounted to R1695 per month for those individuals who qualify (National Treasury, 2018). This amount is only paid out to the older people personally. Families, therefore, have the responsibility to care for older family members, including those who need assisted living and frail care, putting enormous strain on the family. This is because even though the state makes provision for institutional care, there is not the capacity to care for the entire older population. Furthermore, Gallaher et al. (2016: 2655) highlight that there is a significant increase in the number of hospital admissions relating to traumatised older people. This aspect is especially true for those countries with limited resources.

Due to physical constraints and financial limitations, many families struggle to take care of their older relatives successfully, and physical needs may be the focus when facing resource limitations. Hiskey et al. (2008: 497) assert that many older adults live with memories of traumatic events that happened earlier in their lives. Olofsson (2014: 9) states that early-life events influence different physical and psychological health problems in later life. According to Hendricks (2012: 228), those early stressful events can refer to social experiences and do not have to be physical to affect health in later life. However, many older adults do not receive any treatment for their symptoms, including those living in institutional facilities.

Kaiser et al. (2016: 392) add that it is not uncommon for older people to live with multiple traumatic experiences for an extended period, which can negatively affect both their mental and physical health. It is not surprising then that depressive, cognitive, as well as alcohol use disorders and phobias are the most common mental conditions diagnosed in old age. Older people are also more likely to present with drug-induced psychiatric and suicidal symptoms for various reasons, including depression (Sadock et al., 2015: 1345). In their study of older adults, Ogle et al.(2014: 1) suggest that there is a strong correlation between cumulative exposure to traumatic events throughout the life course and Post-Traumatic Stress Disorder (PTSD).

As a person ages, there is a gradual decline in their physical and mental abilities. Myers (2008: 125) confirms this by stating that there is a noticeable decline in older persons sensory abilities. Stuart-Hamilton (2011: 33-35) reports that older adults process their visual stimuli slower, with the result that they must look at an object for a longer period before they identify it accurately. Older people cannot move their eyes

as far as younger adults; therefore, older people turn their entire head left to see an object to their left, while younger adults can see the same object by only moving their eyes. Wittekind et al. (2017: 252) state that the physical and cognitive aspects of any given individual largely influence the degree to which that person reacts to their trauma.

Since trauma is stored in our sensory modalities (Beaulieu, 2012: 5), the physical reactions of a person who experienced trauma can be controlled by their distressing memories from their past (Van der Kolk, 2014: 67). Being exposed to adversity throughout a lifetime of adverse events may also make older people more vulnerable to negative post-traumatic outcomes during their lifetime (Ogle et al., 2014: 2). Olofsson (2014: 11-12) adds that continual exposure to traumatic events over the life course may influence the functioning of the immune system negatively. This can cause unnecessary distress in older people, compromising their health and wellbeing. According to Scaer (2007), physical illness and other body-related complications can occur when the Autonomic Nervous System (ANS), which regulates our emotional and physiological state, works too hard.

Eye Movement Integration therapy is based upon guided eye movements to help assist people to access their multisensory, cognitive and emotional information after a traumatic experience to integrate and resolve problematic psychological consequences (Beaulieu, 2003). According to Beaulieu (2012: 6), Connirae and Steve Andreas developed this therapy in 1989, and Danie Beaulieu modified it in 2003 with their permission. It is said to be a neuro- and psychotherapy that has its roots in Neuro-Linguistic Programming (NLP).

Neuro-Linguistic Programming proposes that our thought processes are neurologically based. This approach implies that our nervous system continuously sends out information to and from our brain. Our five senses help to gather, filter and store information. Our perceived reality is a result of how information processes through our nervous system leading to our understanding of the experience. Therefore, there is a direct link between our thoughts and experience of reality and how information is received through our senses (Beaulieu, 2012: 9). Because eye movements depend primarily on our thoughts, Connirae and Steve Andreas wanted to discover whether it could work the other way around and so EMI therapy was developed. Eye Movement

Integration therapy focuses on the relationship between eye movements and thought processes (Struwig & Van Breda, 2013: 31). Eye movements are part of our built-in resilience, and a natural way to process the information on a subconscious level. In EMI therapy, the psychotherapist works with the client to consciously address their symptoms of trauma by accessing and integrating multi-sensory information from their memories (Beaulieu, 2012:15).

Due to the significant increase in older persons, treatment centres with low resources must start planning to meet the growing needs of ageing trauma patients (Gallaher et al., 2016: 2655). Van der Spuy (2014: 63) emphasises that EMI therapy is a brief intervention method enabling social workers to attend to more clients in a shorter period. This cost-effective, short-term treatment intervention can contribute to healthier ageing communities.

1.3 PROBLEM FORMULATION AND MOTIVATION FOR THE STUDY

Research studies indicate that there is a large amount of information available on older people previously exposed to trauma (Ogle et al., 2014: 8; Sadock et al., 2015; Turner & Lloyd, 1995: 2). However, there is a lack of knowledge concerning effective intervention strategies for the treatment of trauma in older persons. According to Beaulieu (2012: 14-15), symptoms of trauma may be the result of sensory information that failed to integrate after a traumatic incident properly. Given that older people may have encountered some form of trauma in their lives, these untreated symptoms of trauma, in turn, affect their overall health and wellbeing negatively. Considering Life Course Theory (LCT), a combination of early and midlife events has a significant influence on later life (Hendricks, 2012: 228). According to Ogle et al. (2014: 3), older adults are an ideal population from whom to extract information for research purposes in terms of the study. They have typically lived long enough to potentially have experienced some form of trauma and mostly able to describe their experiences.

Due to traumatic events that cumulate over time, an increase in PTSD symptoms, chronic medical conditions and illness are seen in older people (Olofsson, 2014: 14-15). Sadock et al. (2015: 1341) highlight that there is a clear correlation between mental and physical health in older people. Symptoms of trauma can get worse if the

individual avoid seeking help for mental health issues (Hiskey & McPherson, 2013: 695). This study aimed for an explorative and descriptive investigation of older people's responses to EMI therapy as a treatment intervention for their symptoms of trauma, as well as determine its value as an area for further investigation.

The co-founder of EMI therapy, Dr Danie Beaulieu, shared EMI as treatment intervention with many social workers and psychologists throughout Canada, America, the Caribbean, European countries, China and South Africa. Therefore, it is already an international concept. In the context of South Africa, there are currently only two accredited training facilitators in EMI therapy. Research on EMI therapy is available online; however, there is not much information available in academic terms. Still, two research studies on the effectiveness of EMI therapy were conducted and documented in South Africa. Both researchers are practising social workers and focused their studies on treating symptoms of trauma in children. The results of the application of EMI therapy on children reflected a drastic reduction in their symptoms (Van der Spuy, 2014: 70). No research on the use of EMI therapy on older people is documented at this time in South Africa or internationally.

This study determines whether there is a positive response in older people in terms of processing their symptoms of trauma through EMI therapy. Furthermore, it questions whether they experience it as useful. This brief, cost-effective intervention, if found useful by older people, could enhance their overall health and emotional wellbeing. Professionals often overlook symptoms of trauma experienced by older people (Hiskey & McPherson, 2013: 589). Feedback on the personal experience of older people concerning the effectiveness of EMI therapy is essential. In the South African context, this may provide social workers with material for appropriate trauma treatment interventions for these individuals.

1.4 RESEARCH QUESTION

The primary research questions for this study are as follows: 'How do older people experience EMI therapy as a treatment modality for their symptoms of trauma?' and 'What are the views of older people on how EMI therapy facilitates the processing of their symptoms of trauma?'

1.5 RESEARCH GOAL AND OBJECTIVES OF THE STUDY

The goal of this study is to determine older people's experience of EMI therapy as a treatment modality for their symptoms of trauma. A further goal was to determine the views of older people on how EMI therapy facilitates the processing of these symptoms.

The objectives to achieve the research goal are as follows:

- To explore and describe how older people experience EMI therapy as a treatment modality.
- To explore and describe older people's views on how EMI therapy facilitates the processing of their symptoms.
- To determine whether EMI therapy is useful as a cost-effective tool for older people's symptoms of trauma.

1.6 THEORETICAL FRAMEWORK

Life Course Theory was used as a theoretical lens to discuss the experience of trauma with older people. This theory is a multidisciplinary approach, also used appropriately in Social Work to understand the mental, physical and social health of individuals, incorporating a focus on both life span and life stage concepts that determine health trajectory. However, Elder Jr. et al. (2003: 4) clarify that these terms, while used in life course vocabulary are not synonymous with the life course. The life course approach in its broader context examines an individual's life history and investigates, for example, how early events influenced future decisions and events concerning marriage and divorce, engagement in crime, or the incidence of disease.

Furthermore, the order in which individuals partake in events and roles that are socially defined over time is referred to by Elder Jr. et al. (2003: 4) as a life course. The life course emphasises the effect of historical and socioeconomic circumstances on later life. Olofsson (2014: 10) indicates that although individual life is unique, everyone goes through the same basic sequence consisting of a beginning, a middle and end phase. For this study, Life Course Theory provides a lens for understanding how early-life experiences shape health across an entire lifetime as it systematically directs attention to the role of the social and physical context along with biological factors over time.

Therefore, Life Course Theory is an example of a developmental perspective that can be used to conceptualise processes through which earlier life experiences influence later health and wellbeing.

When looking at trauma in older people, Ogle et al. (2014: 2) focus on the cumulative exposure to traumatic events over the life span for older people and their significance. They indicate that some events that occurred during the life of the older person can increase their vulnerability to negative post-traumatic outcomes. They are likely to experience certain types of trauma like the unexpected deaths of people close to them, loss of a life partner that signals diminishing social support networks, other normative life events like retirement and changes in their living arrangements. All these aspects can be associated with a resurgence or triggering of PTSD symptoms. The researchers allude to the fact that there is a relationship between the health status of older people and cumulative trauma exposure.

1.7 DEFINITION OF KEY TERMS

The following key terms are continually used throughout the study and were carefully defined to ensure the reader's understanding.

Age & Ageing: Age indicates the time passed since a person's birth (Reber & Reber, 2001: 15) and is the chronological age which measures the age of a person (Stuart-Hamilton, 2011: 23). Ageing refers to the prospect of acquiring the specific characteristics of later life (Stuart-Hamilton, 2011: 23). Reber and Reber (2011: 18) add that ageing is the process of growing old. This implies that physiologically the individual experiences change progressively with time that cannot be reversed. According to Stuart-Hamilton (2011: 25-26), there is not an exact certain stage in a person's life when they start to become "old". Also, ageing cannot be measured by a person's chronological age.

Eye Movement Integration (EMI) therapy: A neurotherapy where the therapist uses guided eye movements to help the client integrate and process suppressed information nonverbally by accessing multisensory representations of their traumatic experience (Beaulieu, 2012: 14). It leads to a reduction in symptoms of trauma (Van der Spuy, 2014: 22).

Older person: A person in late adulthood, starting between the ages of 60 and 65. Late adulthood is usually associated with a transitional phase (Louw & Louw, 2009: 160-161). The primary developmental task of late adulthood is both an evaluation and acceptance of life (Ogle et al., 2014: 8). Individuals in their later adult years are a diverse group of people, therefore, Dunn & Craig (2013: 445) divided them into four subgroups of older people, ranging from the active 65-year-old to the weaker 90-year-old person and older, based on the most important aspects relating to their transitional years.

The first subgroup of individuals is identified as individuals who are between 60-69-years-old and face the issue of coping with new roles in their retirement. The second group has been identified as the 70-79-year-olds who face coping with illness, loss of loved ones and social isolation. The third subgroup is identified as 80-89-year-old individuals who encounter the challenges of increased deterioration in their health and continuing to engage in meaningful social and cultural engagements. The fourth subgroup is identified as individuals 90 years and older. This age group commonly faces the challenge of maintaining their abilities and positive attitudes (Dunn & Craig, 2013: 447).

Trauma: An experience of physical or psychological injury caused by a direct external force or extreme emotional assault (Reber & Reber, 2001: 764). Traumatic experience refers to any experience that leads to repeated negative effects and recurrences in a person's sensory, emotional or cognitive systems due to an imprint caused by the experience (Beaulieu, 2012: 28).

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013: 272) refers to trauma as the experience of an event that includes exposure to actual or threatened death, serious injury or sexual violence, including: Directly experiencing or being a witness to such an event, learning that it happened to family or friends, or being exposed to repeated or extreme averse details of the traumatic event. Trauma is when the exposure to a traumatic event causes a significant amount of distress to the individual which impedes their social, occupational and other areas of functioning.

PTSD: A trauma- and stressor-related disorder characterised by symptoms due to exposure to a psychologically distressing or traumatic event (Reber & Reber, 2001:

551). It includes intrusive symptoms such as recurrent distressing memories and dreams, avoidance behaviour, negative adjustments in mood and cognitions such as feelings of detachment and reactivity adjustments such as hypervigilance. The symptoms are typically present for more than one month and cause substantial distress or impairment in the individual's social, occupational or other important functioning areas (DSM-5, 2013: 271-272).

1.8 ROLE AS RESEARCHER

Researchers often take on different roles when conducting research. Maree (2010: 41) points out that some of those include being a sensitive listener and the ability to observe objectively and raise the necessary questions to analyse the data obtained from the study in its purest form. The researcher worked closely with the participants in preparing them for the study and debriefing them afterwards.

Since completion of her training in EMI, the researcher has been using EMI therapy extensively on her clients while working in a Non-Profit Organisation (NPO) with positive results. It is easy to observe more objectively during the EMI process because the therapist does not ask questions concerning what the client is thinking and feeling but allows for the natural process to unfold for the client. The researcher established that it is a rapid and effective means of helping clients to overcome their trauma.

The use of EMI therapy with older people is a relatively new path for the researcher who seeks through this research to explore and describe its usefulness for the older population. Throughout this study, the researcher reflected on her engagement in the research. A reflective discussion on the researcher's position as both practitioner and researcher at the same time is included in Chapter 5 under the heading Limitations of the study.

1.9 ETHICAL CONSIDERATIONS

Ethics in any given profession refers to the principals that act as a guideline in the form of rules to establish behaviours in people that are the most correct (Strydom, 2011:

114). Special attention was given to the following ethical aspects in conducting the study:

1.9.1 AVOIDANCE OF HARM

According to Stuart-Hamilton (2011: 233), older people are a vulnerable age group because later life is a time of deterioration. The inclusion of older persons, who have experienced trauma in any research could potentially expose them to emotional harm. However, EMI therapy was already offered as an intervention strategy to those older people who experienced trauma in their lives previously and could still engage in therapy. During the assessment, the potential therapeutic effects were discussed with each recipient who wanted to receive the therapy.

Eye Movement Integration therapy is mainly an intervention strategy for treating older people's symptoms of trauma and supporting their wellbeing. A counsellor, who works with older people, referred these older people from a local NPO, as well as private individuals from Knysna. It was from this group that the researcher recruited participants for her research by inviting them to participate and requesting that their clinical data captured be used for research purposes. Therefore, those who were already recipients of the therapy and agreed to take part, gave their consent for the use of their pre- and post-inventories from the therapy sessions conducted. Also, in giving their informed consent, participants agreed to an interview. Participants had the option to withdraw from the study if they wished to do so at any time. In this manner, they were protected from any harm, including emotional discomfort (Strydom, 2011: 8).

The therapy was provided to enhance the welfare of those who wanted to receive therapy, but only the consenting participants took part in the research study and agreed to participate in the two components. No therapy was only for research purposes, and no older person seeking therapy was denied treatment. The EMI therapy was not part of the research study and, therefore, there was no risk of harm to the participants of the study. As a usual practice, the researcher offering EMI therapy undertakes a thorough assessment with each recipient to eliminate those not

suitable for this treatment. All the participants were debriefed after receiving EMI therapy, and those needing additional emotional assistance after the qualitative interview were referred to a psychologist or local NPO. Nonetheless, a clinical psychologist and local NPO working with older people were recommended to all participants should they require further support.

1.9.2 VOLUNTARY PARTICIPATION

Voluntary participation means that the participants could choose to participate in the study and withdraw at any stage if they wished to do so (Strydom, 2011: 116). The participants had already received EMI therapy, so they had the option of consenting to the use of their inventories and taking part in an interview. Before studying their inventories for data analysis and arranging the interview to capture their experiences of EMI therapy, the researcher first obtained the written permission from those who agreed to participate in the study. Nobody chose to withdraw from the study.

1.9.3 INFORMED CONSENT

Another ethical issue relevant to the study is informed consent relating to voluntary participation and no harm (Strydom, 2011: 117). The researcher explained to possible participants the purpose and reasons for the study and the process involved in participating. After that, they were provided with an informed consent letter for their signature to ensure that they understood the possible risks and benefits of participating in the study (Stangor, 2011: 45).

1.9.4 CONFIDENTIALITY

All personal information revealed during the study remained confidential (Strydom, 2011: 119). For example, different numbers were assigned to each person representing them on their pre-and post-inventories from before and after their EMI therapy session. Using this method, it is not possible to identify the participant from the records or interview (Stangor, 2011: 52). Furthermore, to maintain confidentiality,

information revealed during the EMI therapy sessions was not available to the research assistant who conducted the qualitative interviews with participants. In this manner, no personal information was revealed. It has also contributed to conducting the interviews in an objective manner.

1.10 LAYOUT OF THE STUDY

The research is divided into the following five chapters:

Chapter 1: Introduction to the study

Chapter 1 provides an outline of the study. It is a detailed plan that Fouché and Delport (2011: 101) refer to as a research proposal. This chapter describes how the study was undertaken to answer the research question and includes the background and motivation for the study.

Chapter 2: Literature Review and Theoretical framework

The second chapter gives an overview of available literature. By researching the existing knowledge relevant to this study, it assisted the researcher to avoid replicating previous studies. Fouché & Delport (2011: 134) highlight that reviewing the literature also helps the researcher to put the study into perspective. The material concerning how trauma is stored, the physical deterioration of older people and their ability to engage with therapy, as well as EMI as a treatment intervention and its use in different contexts were further explored.

Chapter 3: Research Methodology

This chapter provides an in-depth description of the research strategy. It discusses the research design, population and sampling, methods for data collection and instruments, the strategy for data analysis as well as quality assurance (Maree, 2010: 34).

Chapter 4: Research results

Chapter 4 details the raw data collected for the study. The researcher analysed, discussed and interpreted the findings from the study. Furthermore, it includes the visual representations of the data gathered from the research (Maree, 2010: 191).

Chapter 5: Conclusions and recommendations

After interpretation of the results, this chapter provides a summary and the conclusions drawn from the study. Furthermore, based on these results, it makes recommendations for further research studies. The limitations of the study are considered and discussed.

1.11 SUMMARY

The first chapter introduces the research study, problem formulation and reason for conducting the research leading to the goal and objectives, as well as the ethical considerations that guided the researcher throughout the entire process. The focus population was older adults because of early-life experiences impact on health in later life (Hendricks, 2012: 228). They have also lived long enough to potentially have experienced previous adversity or some form of trauma in their lives (Ogle et al., 2014: 3). The primary developmental task of older adulthood is both evaluation and acceptance of life (Ogle et al., 2014: 8). Therefore, older people may benefit from a brief treatment intervention such as EMI therapy. This study highlights the need for empirical evidence in terms of treatment interventions suitable for treating trauma in older people (Böttche et al., 2012: 231).

The next chapter offers a more detailed review of the available literature on the research topic and includes the chosen theoretical framework to put the study into context.

Chapter 2: Literature Review and Theoretical framework

2.1 INTRODUCTION

The second chapter is a review of available literature relevant to the research topic to assist the researcher and reader to put the study into perspective. The goal of a literature review is to assist the researcher to gain a better understanding of available information in order not to replicate studies already conducted (Fouché & Delport, 2011: 134). The researcher believes that the points of discussion included in this chapter lead to a more comprehensive view of how the available literature fits into the context of this research and in answering the primary research questions of this study.

With the high crime rate in South Africa (Africa Check, 2018), different people, including older people, are exposed to various forms of trauma, and the psychological effects may, for some people, be permanent. This chapter defines trauma and provides an overview of different types of trauma that are the most prevalent in the South African context. Also, the traumatic symptoms experienced as a result of exposure to trauma are significant because they are the foundation for understanding the impact of trauma on older people's lives and wellbeing. What follows is a description of the neurobiology of traumatic experience to explore the specific pathways that the brain follows when trauma occurs, resulting in traumatic memories. A discussion on the impact of ageing on neurobiology and traumatic memory follows to raise the readers' awareness of the influence of ageing on older people's traumatic experiences.

Since EMI therapy for older people was a new path for the researcher, there is a discussion on EMI as a treatment intervention and its application in this study. The researcher also considered the potential of EMI therapy in addressing trauma in older people. The Life Course Theory was used as a theoretical lens in this study because it describes the relationship between traumatic experiences throughout life and health in old age (Ogle et al., 2014: 2).

2.2 TRAUMA

The word trauma arising from a traumatic experience is continuously referred to throughout this chapter. In order to put the study into perspective, it is essential to first look at some definitions of what the word trauma entails.

2.2.1 DEFINING TRAUMA

Even though human beings are generally very resilient, no one is protected from traumatic experiences. It is, therefore, not unusual for people to describe some experiences as traumatic. The word trauma originates from the Greek word, which means ‘a wound’ (Herbst & Reitsma, 2016: 2), indicating that the person experienced physical or psychological injury or damage caused by a direct external force or extreme emotional assault (Reber & Reber, 2001: 764). In this case, Beaulieu (2012: 28) refers to it as any experience that leads to chronic negative effects and recurrences in a person’s sensory, emotional or cognitive systems due to an imprint caused by the experience.

Brandell (2011: 348) highlights the following definition of trauma: ‘A person’s sense of vulnerability to harm that is suffering due to the memories of an extraordinary, catastrophic experience that occurred which led to an emotional state of discomfort and stress’. The person needs to make an extraordinary effort to cope with the event(s). This definition includes both once-off incidences such as natural disasters as well as every day, ongoing situations such as domestic violence. Van der Kolk (2014: 1-2) summarises it well when he defines trauma as intolerable and excruciating, and states that it affects both the people directly exposed to it as well as those around them.

DSM-5 (2013) refers to certain kinds of experiences that would lead to traumatic stress and highlights some symptoms as a result (Herbst & Reitsma, 2016: 2). Events that may cause traumatic stress to an individual include the following: Direct experience or witness to someone else exposed to actual or threatened death, or exposure to a severe injury or sexual violence. Learning of a traumatic event occurring to a close relative or experiencing repeated or extreme exposure to aversive details of the

traumatic event, for example, the collection of human remains after an accident (DSM-5, 2013: 271).

According to Beaulieu (2004), trauma is something that one perceives or experiences as traumatic, including adverse life events occurring over a life span and accepted as 'normal' in the context of our daily experience. The individual's perception of the event rather than the actual event itself is, therefore, the focus (Van der Spuy, 2014: 9). Because of the definitions above, for this study, an event is described as traumatic if the person who experienced it perceives it as traumatic and has physical or psychological consequences that were not present before the incident occurred. The researcher agrees with Van der Spuy (2014: 9) that the type of trauma is irrelevant but what is relevant is the fact that the person has experienced a sense of trauma.

People in South Africa have frequent exposure to different forms of trauma, and the following section will focus on some of these.

2.2.2 TRAUMA IN SOUTH AFRICA

There are many types of traumas that a person may potentially experience during their lifetime. According to Ogle et al. (2014: 2), older adults are especially vulnerable to certain types of traumas. Some of the factors contributing to trauma that are international phenomena are those related to poverty, illness, violence, sexism and racism and particularly overwhelming in South African society. Women, children, disabled people and the elderly are the most vulnerable groups, and traumatic events may impact them severely. Despite the change to a democratic South Africa, there remains a lack of professional resources in the communities where trauma is most prevalent (Morkel, 2011: 486). Consequently, people become involved in a cycle of continuous problems. The different types of trauma affecting the broader South African community and the effects on older people follow in the next section: natural disasters, poverty, crime and violence, sexual assault and rape, as well as HIV/AIDS.

2.2.2.1 Natural Disasters

According to Briefly Team (2018), it is possible to prepare for a natural disaster, but its impact is immeasurable before the time. When death is the result, the extent of a natural disaster is usually larger. Landslides, floods, fires, earthquakes, hurricanes and other extreme weather conditions are all regarded as natural disasters (Kanel, 2012: 172). Some of the most recent natural disasters in South Africa include wildfires, floods, earthquakes, sinkholes and drought. In 2017, and again in 2018, people, including participants in this study, saw some of the most massive open wildfires ever taking place in and around the Knysna area. The fires spread rapidly over a significant distance and destroyed homes and businesses as well as lives were lost (Briefly Team, 2018).

Residences, including old age homes and retirement villages, had to evacuate without any warning. It left vulnerable older people, including those with physical constraints, completely dependent on the Knysna community for help and support to escape the fires. Most of those in Knysna stayed in a communal hall for a few days without any personal belongings until it was declared safe to return home. Brandell (2011: 427) highlights the vulnerability of older adults both during and after natural disasters and mentions that even those that are more independent may stretch their limits during these difficult times.

Those Knysna residents who were not directly affected by the fires were most likely indirectly affected because of the enormous impact that the fires had on the entire town. The researcher believes that this traumatic event left deep imprints in many people's lives that are not easily forgotten. Also, there may still be people, including older people, who have not received any form of assistance to help them integrate their traumatic experience. In 2018, another severe fire in the area filled the air with smoke for days afterwards, reminding residents of what happened in 2017. The experience might have triggered some symptoms of trauma in those older people who have not yet worked through their previous traumatic experience. Some of the participants in this study identified these events as significant stressors in their lives.

2.2.2.2 Poverty

Roos et al. (2014: 12) indicate that there is an increase in research to support the quality of life and social inclusion of older people. One approach to improving quality of life is by providing an old age grant to older people as an attempt by the government to reduce poverty (Statistics South Africa, 2017: 8). Despite these attempts, South Africa remains a country with one of the highest unemployment rates in the world (Africa Check, 2018). Even though the country has seen sustained economic growth for the past two decades, there is not an equal reduction in the poverty rate compared to the economic growth, due to Africa's lack of structural change (Page & Shimeles, 2015: 17).

According to Statistics South Africa (2017: 26), South Africa's poverty rate increased from 53,2% in 2011 to 55,5% in 2015. It amounts to approximately 30,4 million poor South Africans. Poverty causes urbanisation, overpopulation and competition for scarce resources, especially in the South African context (Sartorius et al., 2013: 104). Van der Spuy (2014: 21) reports that these South Africans may have a higher risk of being exposed to distress because poverty increases the risk of traumatic exposure. Many older people have at some stage in their life suffered due to poverty and its social ills.

Zastrow (2010: 123) adds that retirement is one cause of poverty due to the remarkable shift in the dependency ratio, that is the number of working people that help to sustain vulnerable groups of people such as children and older people (Henslin, 2007: 374). With the high number of unemployment, it may be fair to assume that there is a decrease in the number of working individuals that can support retired dependent older people. Many older people may also be forced to retire involuntarily due to the change in employment patterns (Stuart-Hamilton, 2011: 175). When people are forced to retire but cannot afford it financially, they become dependent in old age, increasing the risk of being exposed to trauma (Brandell, 2011: 417). Retirement, therefore, exposes older people to higher levels of poverty, affecting their mental and physical health (Stuart-Hamilton, 2011: 175). The impact of retirement should not be overlooked as one participant identified it as a significant stressor in their life during this study.

2.2.2.3 Crime and violence

Poverty can translate into crime and violence, and this affects everyone in South Africa to some extent. Although crime and violence are relatively common terms in all countries across the world, according to Herbst & Reitsma (2016: 51-53), a tremendous amount of crime and violence occur daily in South Africa. The high crime rate reflects in the statistics presented by Africa Check (2018) indicating that South Africa is an extremely violent country (Herbst & Reitsma, 2016: 52; Africa Check, 2018). Crime affects whole communities, including older people.

Brandell (2011: 429) states that there are reports of high incidents of domestic elder abuse, neglect and financial exploitation. Being vulnerable and isolated makes older people an easy target for crime and violence. Being a victim of crime and violence or even a witness to it can have a lasting physical and emotional effect on individuals (Africa Check, 2018). According to Zastrow (2010: 462), older adults are less likely than younger adults to be victims of crime, but they prefer to stay indoors due to their fear of getting mugged or someone breaking into their house while they are away.

Brandell (2011: 411) reports that many older people present with stress, anxiety, fear, anger and depression due to the uncertainty of their environment. Being in a vulnerable age group increases the uncertainty and concern regarding their surroundings, which may lead to feelings of despair and helplessness as well as psychological symptoms like anxiety and depression. Olofsson (2014: 12) affirms the correlation between stress concerning the fear of being exposed to crime and ill health in both men and women.

2.2.2.4 Sexual assault and rape

Some of the most prevalent increases seen in South African statistics for committed crimes in the year 2017/18 are sexual offences (Africa Check, 2018). Despite poverty being a risk factor, sexual abuse occurs in normal and dysfunctional families (Townsend & Dawes, 2004: 64). According to Herbst & Reitsma (2016: 108-109), the victim often knows the perpetrator and most incidences of rape occur within intimate relationships (Herbst & Reitsma, 2016: 108-109; Olofsson, 2014: 12). Typical targets for sexual abuse are women and children (Herbst & Reitsma, 2016: 55). Victims of sexual abuse may develop symptoms of trauma that last a lifetime (Kanel, 2012: 188).

In general, older people are less comfortable to talk about sexual issues in the past as well as those that are relevant to the present because of how they grew up (Stuart-Hamilton, 2011: 187). If left untreated, the older person who experienced sexual abuse in their childhood may present with PTSD symptoms in old age. If the older individual has previous experience of intimate partner abuse or sexual abuse in their childhood years, it affects their wellbeing by causing harm and distress and impacts their relationships (Kanel, 2012: 188; Herbst & Reitsma, 2016: 56).

2.2.2.5 HIV/AIDS

Human Immunodeficiency Virus/Acquired Immunodeficiency System (HIV/AIDS) is one of the world's biggest challenges (Van Dyk, 2008: 6-8; Kanel, 2012: 248-249) with the largest number of people infected with the virus living in South Africa (Demmer, 2010: 1-2). Stuart-Hamilton (2011: 188) proposes that these statistics exclude older people despite being just as likely as any other age group to be infected by the virus. Older people living with HIV/AIDS are often untreated because of health professionals' lack of awareness concerning the fact that older people might be infected. Health professionals tend not to pay attention to older people's sexuality, and therefore, may easily miss the signs and symptoms.

As people age, the chances are that they have already experienced numerous losses in their lives. According to Van Dyk (2008: 8), not only do more women (52%) live with the virus than men, but they are also more likely to care for those infected with the virus even if they do not have the virus themselves. Therefore, they take on a large part of the AIDS burden. Older people may feel restricted due to their limited choices and quality of life when deciding to care for their infected children or grandchildren whose parents have already passed away. Demmer (2010: 1-2) reports on a study conducted in 2010 in KwaZulu-Natal, where it was found that there is a profound impact on the significant surviving others of people who died because of AIDS.

Furthermore, there is not enough AIDS-related bereavement counselling and support provided to the remaining adults and children due to a lack of resources and bereavement training, as well as avoidance by community members in seeking support and professional help about their emotional issues and poverty. Fear of the stigma attached to HIV/AIDS also has a role in older people's avoidance to seek help,

increasing their stress levels (Kaiser et al., 2016: 392). A lack of support can leave them feeling helpless and depressed (Brandell, 2011: 430).

The types of traumas discussed above are only a few of many that older people encounter daily, not to mention those that occurred during their life span. The following describes what happens in the brain when we experience something as traumatic. This discussion is particularly important in light of EMI therapy being a neurotherapy and psychotherapy (Van der Spuy, 2014: 10).

2.3 EXPLORING THE NEUROBIOLOGY OF TRAUMATIC EXPERIENCE

An overview of the neurobiological effects of traumatic experiences and how memories form is provided to consider the impact that trauma can have on older people, even years after the traumatic incident. It also provides an understanding of the potential of EMI therapy in treating trauma in older people.

The brain is a complex system of interconnected parts (Siegel, 1999: 10). The left hemisphere of the brain explains and puts our experiences in order (for example, remembers facts, statistics and vocabulary). The right hemisphere automatically reacts to verbal and non-verbal communication and external stimuli (for example, stores memories of our sensory intake and the emotions that they stimulate) (Van der Kolk, 2014: 44-45). Furthermore, Van der Spuy (2014: 10) highlights that the two hemispheres of the brain can be divided into three main parts as follows:

i. The first is the primitive part, called the reptilian brain. It is the instinctive part of the brain that regulates everything in our bodies below consciousness. There are no emotions associated with this part of the brain. It keeps us alive and is responsible for things like our breathing, temperature, blood sugar, among others. According to Van der Kolk (2014: 56), the primitive part is in place when we are born and positioned in the brain stem, just above the place where our spinal cord enters the skull. Together the brainstem and hypothalamus (that sits directly above it) control the body's energy levels to ensure continual basic life-sustaining systems for homeostasis.

ii. The second part of the brain is located right above the reptilian brain, called the limbic system (Van der Kolk, 2014: 56). This area manages our emotions (Beaulieu, 2012: 36). For example, if we cannot breathe it triggers our emotions, in this case, fear, which activates the primitive/instinctive part of our brain to help us react in a way to protect us from danger and helps keep us alive. Van der Kolk (2014: 42-61) refers to the reptilian brain and the limbic system together as the emotional brain. Our senses are always on the lookout for danger. An area inside the limbic system, at the top of the brainstem, is called the thalamus. Sensory information enters here, and all our perceptions combine into an integrated, coherent experience of what is happening. The thalamus has widespread connections to other parts of the brain, including the neocortex (Siegel, 1999: 10).

Whenever a traumatic incident occurs, we experience intense emotions. According to Myers (2008: 64), the more intense the emotion experienced, the more likely it is that the individual presents with intense recollections of that experience. These intense emotions activate the limbic system, specifically an area called the amygdala. The amygdala is formed of two small almond-shaped structures positioned deeper in the limbic, unconscious brain, and up to the frontal lobes, where they reach our conscious awareness (Van der Kolk, 2014: 42-61). It acts as an alarm in a sense because it senses the danger for the first time and informs the brain of the danger. It quickly and automatically identifies whether incoming input is relevant for survival with the help of feedback from the hippocampus (Van der Kolk, 2014: 42-61).

The hippocampus coordinates short-term recall of events by connecting all the new information to comprise a memory (Beaulieu, 2012: 36). The amygdala is also responsible for triggering stress hormones and nerve impulses, including cortisol and adrenaline. These increase our heart rate, blood pressure, among others, acting as a mobilisation system and preparing us to fight, flight or freeze during perceived threatening situations (Van der Kolk, 2014: 42-61). Because the limbic system spreads extensively to different areas in the brain, it may be primarily responsible for integrating brain activity (Siegel, 1999: 11).

iii. The third part of the brain is situated just above the thalamus, called the neocortex (Siegel, 1999: 10) consisting of a left and right hemisphere. The

> neocortex is also known as the thinking brain that is the rational, logic and creative part of our brain (Van der Kolk, 2014: 58).

In brief, there are two different pathways of information to the amygdala (Chou et al., 2014: 237). During ordinary, non-threatening circumstances the circuit is as follows: *Stimuli – Thalamus – Cerebral Cortex – Hippocampus – Amygdala – Emotional Response* (Beaulieu, 2012: 5). In other words, different organs send sensory information to the thalamus and from there to different parts of the brain. The visual information goes to the occipital lobe, auditory and verbal information to the temporal lobe and information is processed and integrated with other stored knowledge to form a perception in the frontal lobe. The frontal lobe then sends the signals back down to the limbic system and the amygdala. This is where it attaches an emotional connotation to the perception. The hippocampus has connections with all the parts of the brain and is responsible for short-term recall as well as long-term consolidation of memories. The hippocampus enables the activation of all the parts of sensory, cognitive and affective information to create an integrated memory, (Beaulieu, 2003: 3).

Trauma has a different effect on the brain compared to ordinary experiences and, therefore, the brain has evolved an alternative emergency pathway (shortcut) for a quick reaction that dominates during dangerous circumstances. In this case, unprocessed sensory information goes from the thalamus directly to the amygdala via a synapse, which initiates survival behaviour (fight, flight or freeze) and emotional responses (Beaulieu, 2003: 3). LeDoux (1999) mentions that it happens in a split second before it reaches the frontal lobe to form a clear perception. Metaphorically speaking, if the ‘snake’ does, however, turn out to be a curved stick, then the frontal cortex will send out signals that permit the body to relax and heart rate and breathing return to normal (Levine, 2015: 41; Van der Spuy, 2014: 12; Beaulieu, 2003: 3). Traumatic memories are formed through the emergency pathway that can be summarised as follows: *Stimuli – Thalamus – Amygdala – Emotional response* (Beaulieu, 2012: 36-37). During trauma, the brain becomes overwhelmed with all the sensory information (visual, auditory, kinaesthetic, olfactory, taste). The brain does not integrate this information or experience because processing by the thalamus breaks down. The cortex shuts down, and all our blood goes into our muscles, preparing us to fight, flight or freeze (Beaulieu, 2012: 36-37).

Two memory systems in the brain are involved in traumatic memories entitled explicit and implicit memory, and the traumatic memories are implicit (Levine, 2015: 17). Explicit memory is processed by the hippocampus, which is vulnerable to stress (Struwig & Van Breda, 2012: 30). The hippocampus is suppressed, and sensory information is encoded as isolated, dissociated fragments and there is a breakdown in the normal processing of memory. It results in recurrent dreams and involuntary, intrusive memories (American Association of Psychiatry, 2013: 271) because the experience repeats through the brain. The brain tags and files information as we sleep keeping it in the present tense for survival because it does not know how to save the trauma when we sleep. This information becomes imprinted but fragmented like a puzzle scattered on the floor as part of the freeze response – the information imprints in the short-term memory for future reference as part of our survival instinct. The primitive brain cannot distinguish between reality and fantasy. It only recognises images, resulting in the body reacting as if it is true (Beaulieu, 2012: 35-39; Van der Kolk, 2014: 42-61; Van der Spuy, 2014: 11-12; Struwig & Van Breda, 2012: 30).

From this, we can see a clear link between memory processing and how individuals react to traumatic experiences (Siegal, 1999: 52). Ageing causes a gradual decline in our bodily functions, among others, changes in our brain, cognitive changes and a gradual deterioration in the functionality of our senses. It is, therefore, vital to consider how neurobiology, including memory, is affected by ageing in general.

2.3.1 THE IMPACT OF AGEING ON NEUROBIOLOGY AND TRAUMATIC MEMORY

Because the Central Nervous System (CNS) intertwines with all multiple bodily systems (Bouchard & Villeda, 2015: 9), trauma affects body, mind and brain (Van der Kolk, 2014: 53). Both physical and cognitive aspects play a role in how people react to trauma (Wittekind et al., 2017: 252). It is evident that the entire human organism gradually declines with age (Myers, 2008: 125; Stuart-Hamilton, 2011: 33-35). This deterioration includes a decline in the functioning of the regions of our brain as well as physical changes like alterations in the frontal lobes and hippocampus (Bouchard & Villeda, 2015: 9). These physical changes cause a decline in the effectiveness of

learning and memory tasks in older people as they age, which affects functioning and overall emotional wellbeing (Stuart-Hamilton, 2011: 128-129). Bouchard and Villeda (2015: 9) even suggest that ageing may affect the CNS, and, in turn, also serve as a central regulator for ageing.

According to Myers (2008: 125), there is a noticeable decline in older persons sensory abilities. Khan, Singer and Vaughan (2017: 628) support this noting that ageing influences many changes within, among others, our sensory and behavioural systems. A study by Stuart-Hamilton (2011: 33-35) indicated that older adults process their visual stimuli more slowly than younger adults and children. For example, older people must look at an object for a longer period before they can identify it accurately. Moreover, this decline in sensory abilities influences the working of the brain because Louw & Louw (2009: 54-62) remind us that we connect with the world through our senses. Stuart-Hamilton (2011: 128) mentions a study that concluded that a decline in older people's memory is due to a lack of sensory input and also, physical changes in the body.

Significantly, not every person of the same age displays the same age-related decline (Khan et al., 2017: 624). Changes in the brain and body lead to a decline in neural functions. Physical decline, brain changes and cognition, health and wellbeing may be influenced by many different factors such as an individuals' general lifestyle, environment and how they use their mental abilities (Stuart-Hamilton, 2011: 129). This is more obvious in individuals who present with high levels of stress over a long period, that is cumulative exposure to trauma, causing an increase in certain hormone levels resulting in a degeneration of the hippocampus (Myers, 2008: 264). Another study by Kaiser et al. (2016: 392-399) examined differences concerning factors such as the health-related quality of life, functional impairments and included treatment-seeking stigma or shame in older persons. Their findings indicate some form of impairment in older adults diagnosed with PTSD.

Also, Levine (2015:4: 55) adds that mood, emotions and feelings subconsciously determine the images looked at in the surroundings, bringing up memories from the past. Possibly, this may mean that if someone is continually feeling down or anxious, they may train their brain to keep focusing on hurtful memories from the past. Ogle et al. (2014: 2) infer that repeated traumatic exposure may lead to physical and emotional

changes that can fast-track a decline in physical health and mobility. Olofsson (2014: 13) adds that it may also desensitise a person to stress and influence wellbeing and relationships in later life.

Despite the decline in bodily functions, Sadock et al. (2015: 1334) assert that the cognitive decline in older people is not as significant as many people perceive it to be and that older adults constantly adjust to the physical declines they experience (Dunn & Craig, 2013: 467-469). This is evident in a study by Stuart-Hamilton (2011: 129) that illustrates a difference in brain activity patterns during memory tasks involving younger and older adults. The study implies that different people make use of different strategies by using different parts of their brain during memory tasks to compensate for their physical changes. Bouchard and Villeda (2015: 11-12) suggest that simple life changes such as exercise or improving your surrounding environment help to extend the decline of ageing on the older CNS, including a reduction of age-related diseases such as dementia.

2.4 THE IMPACT OF TRAUMA ON OLDER PEOPLE

The exposure to trauma impacts on health and wellbeing, although not all individuals who experience trauma have difficulty integrating the memory (Senneseth et al., 2011: 403). There may be older people who are left with traumatic symptoms years after the incident occurred due to the specific pathway followed by the brain, as previously discussed.

Whenever a stressful situation occurs, our bodies release stress hormones such as adrenaline causing an increase in our heart rate and blood pressure. According to Van der Kolk (2014: 45-46), a threat under normal conditions causes a temporary increase in stress hormones, which return to normal when the threat is over. However, a slightly stressful situation can cause a traumatised person’s stress hormones to increase rapidly and to an unreasonably high level. It may result in long-term health issues such as memory and attention problems, irritability and sleep disorders. Inexperienced professionals often overlook these symptoms of trauma because they sometimes regard it as part of the ageing process (Hiskey & McPherson, 2013: 589). Instead, older people make use of different coping strategies to deal with their symptoms.

Böttche et al. (2012: 231) confirmed that although there seems to be an overall decline in PTSD severity in older persons over time, there also appears to be an increase in avoidance behaviours as a coping strategy. It helps older people's recurrent and disturbing memories to remain under control to some degree.

Dulin and Passmore (2010: 296) observed a relationship between avoiding memories and situations related to trauma in older people and mental health factors such as depression and anxiety. Moreover, they also found that trauma built up over a period results in both depression and anxiety in later life. Anxiety and depression are both examples of psychological symptoms caused by trauma, which significantly influence older people's health, especially concerning Life Course Theory which maintains that early experiences and environmental influences could have a lasting impact on an individual's genetic predispositions. It, in turn, has a detrimental effect on how the brain develops, resulting in health problems in later life (Olofsson, 2014: 13).

Turner and Lloyd (1995: 2) highlight the strong link between cumulative exposure to traumatic events and both psychological distress and mental disorders, including PTSD in older people. Ogle et al. (2014: 8) create the awareness that there is a higher prevalence of older people with PTSD symptoms due to cumulative exposure to lifetime trauma rather than a single severe traumatic incident. Past traumatic memories that remain in the sensory modalities in later years may feel threatening. These memories are often accompanied by intense and highly vivid components that cause unnecessary distress in older people (Hiskey et al., 2008: 494-497).

In conclusion, different people will encounter and experience different types of trauma during their lives. Because people are so unique and diverse, what may be perceived as traumatic by one individual may not be experienced as stressful by the next person. The exposure to trauma impacts on wellbeing and may lead to symptoms of trauma and coping strategies like avoidance behaviours, feelings of despair and depression in older people. Since there are many types of symptoms of trauma that older people may present with, the focus will be on some of the most common symptoms of trauma that may result from unresolved traumatic memories.

2.4.1 SYMPTOMS OF TRAUMA

The brain's neuroplasticity enables us to naturally integrate our traumatic experiences (Van der Kolk, 2014: 3). However, when our experience of trauma is left unintegrated (Kanel, 2012: 162) and untreated, we can develop different types of symptoms. Rechsteiner et al. (2015: 312) highlight the role that cumulative exposure to trauma plays in the severity of symptoms presented by people, including anxiety, depression, anger and somatic complaints. It is essential to assess the presence and intensity of the individual's symptoms initially to measure the effectiveness of any trauma treatment, establish progress and evaluate change (Beaulieu, 2012: 124). A pre- and post-inventory (See Appendix D) measures the impact of EMI therapy on older people's symptoms of trauma. Some of the most common indications are physical symptoms, psychological symptoms, depression and post-traumatic stress.

2.4.1.1 Physical symptoms

The body can store trauma (Van der Kolk, 2014; Levine, 2015) that may manifest in the form of physical symptoms, also called somatic symptoms. Psychosomatic symptoms refer to when both mental and somatic (bodily) components are present, and influence each other (Reber & Reber, 2001: 538; 585). In other words, psychological stress may manifest in the form of physical symptoms (Lickerman, 2010). Some examples of physical symptoms due to trauma include headaches, chest pain, fatigue, back pain, constipation, aching muscles (Rosenbloom, Williams & Watkins, 2010: 36).

According to Wahlström et al. (2013: 1-2), many older people present with physical symptoms of trauma but no psychological ones. The body's Autonomic Nervous System activates to release cortisol which is a stress hormone produced when we have a traumatic experience. It triggers our psychological experiences (thoughts and emotions) to interact with our physical reactions. As time goes by, the thoughts and intense emotions about the trauma may subside. Years later, older people with physical symptoms of trauma may not be able to link their previous exposure to different types of trauma to their presenting physical symptoms such as headaches, fatigue, tense muscles, among others. Therefore, older people may be unable to explain the possible causes of their physical symptoms to professionals. The physical

symptoms are, therefore, often either medically unexplained and regarded as signs of general distress or part of the ageing process (Hiskey & McPherson, 2013: 589).

2.4.1.2 Psychological symptoms

Psychological symptoms may also be called emotional reactions. Altogether, physiological arousal, behaviour and conscious experience determine our emotions (Myers, 2008: 371). Trauma can manifest in emotions. Some of the most prevalent psychological symptoms of trauma presented by people, including older adults, are anger, fear and anxiety, low self-esteem, sadness, feeling numb, and being easily startled (Lickerman, 2010). Reber and Reber (2001: 35) refer to anger as a strong emotional reaction. Additionally, the authors distinguish between fear and anxiety as follows: When we perceive an existing stimulus as dangerous, it leads to an emotional reaction called fear while anxiety is an emotional state resulting from anticipated danger.

Dretsch et al. (2012: 363) suggest that symptoms of both anxiety and depression may impact on the brain. Furthermore, there is a link between factors such as symptoms of depression and an increased risk of heart failure in older adults (Gustad et al., 2014: 868). Despite cumulative exposure to trauma, there seems to be a lower rate of anxiety symptoms in older people compared to younger adults. In contrast, for the most part, older people's anxiety stems from phobias rather than anxiety disorders (Stuart-Hamilton, 2011: 224). Nevertheless, Cook et al. (2017: 529) advise that although there is an overall reduction in depression and anxiety symptoms in older people after receiving psychotherapy, few indicated complete recovery from their symptoms of trauma.

2.4.1.3 Depression

Depression is generally associated with mood changes including feeling empty, sad or irritable as well as other related symptoms such as a decrease in activity, loss of interest, inappropriate feelings of worthlessness and guilt and having suicidal thoughts (American Association of Psychiatry, 2013: 155; Reber & Reber, 2001: 189). When a person is affected to the extent that it interferes with their normal daily functioning and causes distress, they may present with clinical depression (DSM-5, 2013: 161). Stuart-Hamilton (2011: 220) emphasises the lack of mental and physical energy in depressed people. Because of this lack of energy, Beaulieu (2012: 128) suggests that the client

might find it difficult to actively focus on their memories of the traumatic incident during an EMI therapy session.

Due to the loss of loved ones and illness, most older people may at some stage in their life have experienced a sense of loneliness that makes them feel depressed (Zastrow, 2010: 464). However, it may not necessarily last and spill over into clinical depression. The suggestion is that the EMI session is postponed for people with clinical depression unless it will help resolve an issue that can prevent harm or projected dangerous situations (Beaulieu, 2012: 128). According to Stuart-Hamilton (2011: 220), clinical depression is less common in older adults. However, they may present with more isolated and physical symptoms of depression, such as heart problems (Gustad et al., 2014: 866). It may be due to more frequent encounters of traumatic incidents such as the death of significant others or illness (Stuart-Hamilton, 2011: 220). Also, self-blaming behaviour and a negative internal working model (i.e. views about themselves, others and the world) have a significant role in depression severity (Held et al., 2017: 702). It is, therefore, not recommended that older people with clinical depression that significantly affects their ability to function receive EMI therapy. Proper assessment before the EMI session is essential to determine the intensity, frequency and severity of depression (Struwig & Van Breda, 2012: 31).

2.4.1.4 Post-traumatic stress disorder

Having been severely traumatised by a psychologically distressing event, symptoms of trauma- and stressor-related disorders such as PTSD may develop (Reber & Reber, 2001: 551). The experience can lead to an impairment in the person's daily functioning (Kanel, 2012: 162). Heart rate plays a role in intrusive memories and is one of the most significant indicators of PTSD. Moreover, an increase in heart rate during involuntary trauma memories predicts the severity of PTSD (Chou et al., 2014: 236). Other PTSD symptoms include avoidance behaviour related to the traumatic event, re-experiencing the trauma through nightmares, flashbacks and negative adjustments in cognition, mood, arousal and reactivity related to the trauma (DSM-5, 2013: 271-272).

According to Kanel (2012: 163), traumatised people often make use of coping mechanisms to help them deal with their symptoms. Dissociation is a memory disturbance after exposure to extreme trauma (Malmo & Laidlaw, 2010: 24) and a way

in which a person can detach from their perception of time and reality (Struwig & Van Breda, 2012: 31). Disassociation used as a survival mechanism may form a pattern of behaviour that is a maladaptive or pathological coping strategy (Malmo & Laidlaw, 2010: 24). Cook et al. (2017: 522) maintain that only 4.5% of older people are diagnosed with PTSD, lower than the figure for younger adults. The rate is low despite a high occurrence of lifetime exposure to trauma. In contrast, Böttche et al. (2012: 10) reported on groups of older adults who generally presented with higher PTSD symptoms severity compared to younger adults. Again, a gradual decline in senses and cognition may impact assessment and treatment intervention, and so, symptoms of trauma in older adults may continue to be left untreated or misdiagnosed.

In conclusion, professionals often overlook symptoms of trauma for various reasons, and the influence of these symptoms on the older adult should not be underestimated. Despite this, there is an overall lower rate in the severity of trauma seen in older people, as many have developed increased coping mechanisms such as avoidance behaviours to help them deal with their distress. According to Cook et al. (2017: 529), older adults who have received psychotherapy have, in general, showed a decrease in symptoms of trauma, but this does not guarantee a complete recovery. Resilience plays a role in how older adults managed to adapt to severe adversity over the life course (Rutten et al., 2013: 4).

The following is a discussion on EMI as psychotherapy. Specifically, the working of EMI, how it is applied and its potential as a treatment intervention for treating symptoms of trauma in older people.

2.5 EYE MOVEMENT INTEGRATION THERAPY

EMI therapy is known as both a neurotherapy and psychotherapy (Van der Spuy, 2014: 10). Connirae and Steve Andreas developed this treatment intervention in 1989 in their search to discover whether the movement of our eyes can determine thoughts since eye movements depend mostly on our thoughts (Struwig & Van Breda, 2012: 31). Their research led to the development of EMI therapy. With the permission of the founders, it was modified by Danie Beaulieu in 2003 (Beaulieu, 2012: 6). The aim of EMI therapy is to integrate traumatic memories resulting from unintegrated sensory information from a traumatic experience and reduce symptoms and distress (Beaulieu,

2012: 14; Struwig & Breda, 2012: 30). More specifically, EMI assists people to integrate their explicit memories from the hippocampus with their implicit memories in the amygdala to enhance their emotional wellbeing (Struwig & Van Breda, 2012: 3).

2.5.1 THE ORIGIN AND WORKING OF EMI

Since eye movements are part of our built-in resilience, it is a natural way to process the information on a subconscious level (Beaulieu, 2012: 15). In EMI, the therapist uses 22 guided eye movement patterns to assist the client to integrate and process suppressed information nonverbally and resolve problematic psychological consequences (Beaulieu, 2003; Van der Spuy, 2014: 24). This method accesses and integrates their multisensory, cognitive and emotional representations from their memories of the traumatic experience (Beaulieu, 2012: 14-15). This process leads to a reduction in symptoms (Van der Spuy, 2014: 22). Eye Movement Integration therapy has its roots in Neuro-Linguistic Programming; therefore, a brief discussion about Neuro-Linguistic Programming is necessary to understand the origin and working of EMI therapy.

The collaborative work of John Grinder and Richard Bandler led to the field known as Neuro-Linguistic Programming. Grinder and Bandler (1975a) were particularly interested in investigating the behavioural strategies used by the following three psychotherapists, each of whom utilises effective methods of communication to lead their clients to make positive life changes. Milton H. Erickson (1976) known for his work in the field of hypnotherapy who also developed three mainstays of Neuro-Linguistic Programming; Fritz Perls (1969), the originator of Gestalt therapy focusing on sensory experience; and Virginia Satir (1967), who specialises in family therapy and interpersonal dynamics (Beaulieu, 2012: 8). The following discussion on representational systems and accessing cues in Neuro-Linguistic Programming is mainly concerned with awareness of this approach.

2.5.1.1 Representational systems

Neuro-Linguistic Programming concentrates on the connection between the representation of our worlds in language and neurology, and the interaction between these representational systems leading to behaviour (Struwig & Van Breda, 2012; Van

der Spuy, 2014: 23). It suggests that our thought processes are neurologically based. According to Siegal (1999: 216), the brain is responsible for certain fundamental functions allowing for the processing of information. Information is collected through our senses (Van der Kolk, 2014: 60) and continuously sent back and forth to our brain through the Autonomic Nervous System (Siegal, 1999: 216). It is then stored by the five sensory modes (visual, auditory, gustatory, olfactory and kinaesthetic) (Beaulieu, 2012: 9). How we perceive reality is from a combination of the selected information gathered by our senses together with related emotional and cognitive connections and how our internal representational system processes it (Siegal, 1999: 166). This view implies a direct link between our thoughts and experience of reality and how our senses receive information.

Beaulieu (2012: 9) adds that there are sequences and networks of sensory information involved in all our mental processes. Taking this into consideration, Van der Spuy (2014: 23) proposes that people can reprogramme their brains to facilitate change. The subsequent discussion on accessing cues follows to understand why this may be possible.

2.5.1.2 Accessing cues

Beaulieu (2012: 10) refers to an accessing strategy as the mental process whereby information is accessed and associated in different sensory modes and neuroanatomical sites, which can be affected by subtle changes in behaviour and emotions. When these subtle changes occur, they are referred to as accessing cues. Van der Spuy (2014: 23) states that the founders of Neuro-Linguistic Programming, John Grinder and Richard Bandler (1979) established that observable behaviours such as gestures, facial expressions, tone of voice and eye movements affect the mental processes involved in storing information in different sensory modalities. Also, these include physiological changes that are less prevalent, such as altered heart rate, respiration, perspiration, and muscular tension. Beaulieu (2012: 10) further indicates that eye movements occur automatically during the thought processes that activate different sensory modalities. The result is a consistent involuntary pattern of eye movements. Beaulieu (2012: 11) identifies the following eye accessing cues of Neuro-Linguistic Programming, adapted with permission from Grinder and Bandler (1985) as described in their book, Trance-formations. These accessing cues mainly apply to right-handed people. It may be the opposite pattern for left-handed people:

i. Up and left: Nondominant hemisphere **visualization**, i.e. **remembered** imagery;
ii. Up and right: Dominant hemisphere **visualization**, i.e. **constructed** imagery and visual fantasy;
iii. Lateral left: Nondominant hemisphere **auditory** processing, i.e. **remembered** sounds and words, and tonal discrimination;
iv. Lateral right: Dominant hemisphere **auditory** processing, i.e. **constructed** sounds and nonsense words;
v. Down and left: Internal **auditory dialogue**, or inner self-talk;
vi. Down and right: **Kinaesthetic** feelings, both tactile and visceral;
vii. Straight ahead but defocused or dilated: Quick access to almost any sensory information, but usually visual.

Struwig & Van Breda (2012: 31) highlight the relationship between eye movements and accessing cues. According to Beaulieu (2003: 2; 2012: 11-15), despite the pattern followed by the individual, the dominant sensory mode in memory or during thought processing can be determined by the direction of the eye movement. Further suggestions are that the problems people struggle with may be the result of habitual subconscious modes of thought (accessing sequences). Therefore, by consciously changing our eye movements, we can change our habitual processing modes which enable the client to gain new perspectives on their problems. This method utilises 22 guided eye movement patterns (Van der Spuy, 2014: 24).

2.5.2 APPLICATION OF EYE MOVEMENT INTEGRATION

Beaulieu (2012) gives a very descriptive explanation in her book on the entire process and protocol of EMI, whereas Struwig & Van Breda (2012: 31-32) provide a summary. Based on their explanations, an overview of the application of EMI therapy follows. However, proper training in EMI is of vital importance before attempting any practise of this therapy.

Assessment:

An in-depth clinical assessment is essential before conducting an EMI session to determine if EMI therapy is the best option for the client seeking help. During the assessment interview, the EMI practitioner considers the physical condition (e.g., eye problems or pain; heart conditions; epilepsy; drugs and alcohol) and emotional state (e.g., level of distress and symptoms of trauma) of the client. An assessment of the client's coping strategies as well as the support system must be included in the assessment interview (Beaulieu, 2012:1 15-152). The conditions for conducting an assessment are stated by the researcher in Appendix I. Furthermore, an inventory (see Appendix D) was utilised during the assessment to assist in capturing the client's level of symptoms of trauma. Struwig and Van Breda (2012: 31) remind us that a minimum of four to six weeks passes after the traumatic incident to allow for natural processing before considering therapy. For all participants in this study, a minimum of one year passed since their trauma occurred and before receiving EMI therapy. Chapter 4 discusses the critical role that the timeframe between the traumatic experience and therapy plays in the outcome of EMI.

Preparation:

After the assessment and concluding that EMI is suitable for the client, the process is explained to the client. The researcher prefers to clearly explain the technique after the assessment interview, rather than the beginning. There are different ways of explaining how EMI works, and the researcher prefers to use the analogy of number '3' into number '8' as provided by Danie Beaulieu. The clinician can draw the number 3 and explain that the number 3 represents the client's traumatic memory. The traumatic incident cannot be undone or erased, but information can be added to it. Then the number '3' is changed into the number '8' by adding to it. The clinician then explains that EMI therapy does not take any information away. However, the eye movements help integrate the information for the brain to identify it and where it fits, and only adds information to the original memory. With the reactivation of the memory, the client gains a new perspective on the problem. Therefore, once the brain assimilates the material, the traumatic memory is no longer in the present tense, but in the past tense. Therefore, the brain can pick up the pieces and dream or think about it again afterwards but will not have the same reaction as previously experienced.

Furthermore, the clinician creates and use a secure anchorage by deciding along with the client on ways of anchoring for times when the client might need to be grounded as a result of the memory of the traumatic incident that becomes too overwhelming during the EMI session itself (Beaulieu, 2012: 164-176).

The client then identifies a troubling memory. If the client has experienced many traumatic events in life, it is essential to start with the first or worst event. In the case of one trauma incident with a memory of many distinct images or fragments, the clinician assists the client to identify the image that is the most intense with the highest emotional charge (Beaulieu, 2012: 183). By drawing the client's lifeline, they get the opportunity to rate each incident identified on their lifeline according to its emotional intensity. This process also applied to the participants in this study and assisted them in identifying the troubling memory that they found to be the first or the worst for them (see Appendix I).

After the client has identified a disturbing memory, the next step is to describe the internal representation of that memory. The client describes it in his or her own words from their perspective as they recall the traumatic event (Beaulieu, 2012: 210). From this description, the client selects verbal cues (i.e. keywords or phrases) to assist them in keeping focused on the incident. These verbal cues must capture the troubling memory and remind the client of the incident (Struwig & Van Breda, 2012: 31). Each participant described their traumatic memory in their own words, and this was captured in each person's pre-inventory, as well as in their notes from their EMI session (see Appendix J, the section called poison words).

Next, the clinician determines the client's visual range, the distance of the hand from the eyes that is comfortable for the client during therapy as well as the speed of eye movements. In the sessions, the therapist utilised a specific pen with a face on the tip as a tool to assist them in following the eye movements, instead of using two fingers or a hand. Struwig & Van Breda (2012: 31) refer to the visual range as the frame in which the client's eyes can easily follow the guided eye movements. Visual hotspots are those areas within the visual range that elicit discomfort, and beneficial quadrants those within the visual range that calms the client. By moving an open hand across the client's visual range, the clinician can determine these two areas. This is done while repeating the verbal cues selected by the client. The client must communicate

their level of distress or comfort during this procedure for the clinician to identify these two zones. For example, the client may physically hear the perpetrator's voice or show discomfort when the eye movements enter in a specific quadrant or corner on the left, right, top or bottom side. In the sessions, clients should communicate any discomfort, and this also applied to the participants when they received EMI before volunteering to participate in the study.

Implementation:

During the therapy sessions, the clinician makes use of the 22 eye movements patterns to assist the client in providing new patterns to access cues. The eye movements help to enable the client to access information about the traumatic incident stored in the relevant multisensory modalities. To help the brain remember, we make the eye movements in all the visual fields. The EMI protocol specifies some aspects in terms of the sequence, number, duration, rhythm of the movements and technical details of the hand movements. However, the therapy is not entirely rigid and allows for some modifications to fit the needs of the client. The clinician stops after each pattern of eye movements to gather information by asking them 'What came up for you during the eye movement pattern?' Alternatively, 'Did you hear, see or smell anything?' Then the clinician asks the client, 'Where do you feel it in your body?' This helps bring the human brain 'online', and the clinician requests that the client note this and continues with the next eye movement pattern. The clinician does not ask any additional questions to elicit more information because the brain can 'fix' itself. Levine (2015) suggests that by asking the client to 'take note' and to 'notice what happens next' without discussing the details, helps to activate brain pathways that connect the rational and emotional parts of the brain. In this way, the client can deliberately rearrange the perceptual brain system.

The clinician knows that the integration of the trauma material has taken place (implicit and explicit memories have reconnected and integrated) when there is a transformation in the content. That is, there are no changes in effect, no new information, all information that arises is positive in every sensory modality, and there are no further alterations in the internal representation (Struwig & Van Breda, 2012: 32; Beaulieu, 2012: 225-254). About two hours per EMI session were allocated to each older person to ensure the complete integration of the trauma memory. The EMI

sessions with this older age group took longer than the anticipated 60-90 minutes to complete.

Closure:

Struwig & Van Breda (2012: 32) advise ending the session by answering any questions that the client may have and explaining what to expect after the session. A follow-up meeting after two weeks is recommended to assess the changes and determine whether additional therapy is necessary (Beaulieu, 2012: 288-289).

2.5.3 THE POTENTIAL OF EMI IN ADDRESSING TRAUMA IN OLDER PEOPLE

According to Papanikolopoulos & Prattos-Spongalides (2017:1), everyone can deal with and overcome their traumatic experiences. There are a few common age-related issues dealt with in therapy when working with older people. These subjects include depression, losing their independence, coping with recurrent losses, accepting new roles and adapting to a constantly changing environment (Zastrow, 2010: 453-465; Dunn & Craig, 2013: 499; Henslin, 2007: 377-385). Several participants identified a few as some of the forms of trauma that they have previously experienced. Brandell (2011: 421) asserts that the receptiveness of older adults to therapy depends mostly on factors such as generational and cultural differences.

Previous studies have found that many mental disorders of old age are treatable and can even be prevented, considering an accurate diagnosis and psychotherapy as a treatment intervention in a reasonable time after diagnosis. Beneficiaries may also include older people with some impaired cognition (Sadock et al., 2015: 1350-1351). However, despite older people's ability to make the necessary adjustments to adapt to their circumstances, there are exceptions. Alzheimer's disease is a form of dementia and only one example of where cognitive degeneration is more severe than other physical deterioration in ageing (Sadock et al., 2015: 1334). Individuals with dementia usually present with memory loss (Stuart-Hamilton, 2011: 212) and may not be suitable candidates for EMI therapy, therefore, the researcher excluded individuals suffering from any form of dementia for treatment and this study.

When we consider the potential of EMI therapy in treating symptoms of trauma in older people, it is important to first reflect on other forms of trauma therapies, since there is a lack of research on EMI therapy concerning older adults. A study on addressing older people's symptoms of trauma recorded by Boals et al. (2012: 158) found significantly reduced distress concerning an adverse life event using a memory questionnaire. The authors suggested that questionnaires are free of stigma and by reliving their trauma in a safe environment, it helps to process the trauma.

Another study by Sadock et al. (2015: 1350-1351) found that psychotherapy helps improve older people's physical and mental symptoms. According to Lenferink et al. (2017: 1), Eye Movement Desensitisation and Reprocessing (EMDR) is one form of psychotherapy suitable for treating trauma in adults. Although EMDR and EMI therapy are two completely different forms of trauma therapies, there are some similarities. Despite these, EMI depends on facilitated multisensory integration during the protocol and EMDR does not. It may predict that EMI therapy has the potential to treat symptoms of trauma in adults, but in this study, the focus is on older adults (Beaulieu, 2012: 19). In addition to psychotherapy, Böttche et al. (2012: 231) adds narrative therapy and Cognitive Behavioural Therapy (CBT) to the list of suitable therapies for use when addressing symptoms of trauma in older people.

The psychiatrist, Scott Rauch (1996), and one of the world's foremost experts on traumatic stress, Dr Bessel van der Kolk (2014) studied what happens inside the brain of people with flashbacks. The results indicated that the brain's right hemisphere (the intuitive, emotional, visual, spatial, tactual, artistic side) is activated through images of past trauma while the opposite happens in the brain's left hemisphere (linguistic, sequential and analytical, rational, logic) that deactivates (Van der Kolk, 2014: 44-47).

For this reason, people find it difficult to talk about distressing feelings because the traumatic experience itself is in the way and prevents its description. Despite comprehension and having insight into the problem, the emotional brain stays in its reality, and the rational brain cannot do anything about it. People seem to find it less challenging to talk about what has been done to them than to take note of, feel and verbalise the reality of what they experienced internally (Van der Kolk, 2014: 44-47). This EMI therapy may be more successful in treating symptoms of trauma than usual

talk therapies because taking note of one's inner processes rather than analysing them is applicable.

In EMI sessions, including those with older people, the client is secure and focused on the present, creating a sense of safety and security. The words 'notice that' or 'just take note of it' are often used during EMI protocol. According to Levine (2015), those are important sentences in effective therapy because they help the client to notice what is going on inside of them. This observation allows the left (rational) and right (emotional) parts of the brain to connect.

In conclusion, some older people might find it difficult to talk about their distressing feelings and invasive thoughts, and it may even leave them feeling distressed. Eye Movement Integration therapy is not a form of exposure, desensitising or talk therapy; therefore, it may have the potential to treat symptoms of trauma in older people. Instead, it has an element of neurologically based therapy not included in typical talk therapies (Struwig & Van Breda, 2012: 30). By helping the client take note of their inner processes, EMI has the potential to assist older people with troubled memories by consciously rearranging their brain's perceptual system (Levine, 2015) without feeling distressed or overwhelmed. Concerning older people exposed to trauma during their lives, Beaulieu (2003: 4) is confident that EMI is suitable for treating symptoms when the first or the worst trauma can be identified. The real potential of EMI for the treatment of older people's symptoms is revealed through the experiences and views recorded by older people on how EMI facilitates the processing of their trauma made known through the empirical evidence.

Referring to the theory when conducting research is good practice because it assists the researcher in understanding how several different findings and thoughts combine to assist in guiding the research and so, an overview of the Life Course Theory follows (Delport, Fouché & Schurink, 2011: 298-299). Life Course Theory helps to explain how cumulative exposure to trauma can impact health in later years, and the next section describes this.

2.6 LIFE COURSE THEORY

Life Course Theory were used as a theoretical lens to speak to the experience of trauma for older people. It is a multidisciplinary approach appropriately used also in Social Work to understand the mental, physical and social health of individuals with a focus on both life span and life stage concepts that determine their health trajectory. Elder Jr. et al. (2003: 4) do however clarify that these terms, while used in life course vocabulary, are not synonymous with the life course. Life course can be referred to as 'lifetime existence' (Benson & Kerley, 2001: 3) and is regarded by Elder Jr. et al. (2003: 4) as a sequence of socially-defined events and roles within society that the individual enacts over time. This approach implies that people go through different stages of life divided into socially-defined transitions where they are expected to follow certain events at a specific stage during their lifetime. The life course approach in its broader context examines an individual's life history and investigates, for example, how early events influenced future decisions and others such as marriage and divorce, engagement in crime, or disease incidence.

Olofsson (2014: 10-13) indicates that although individual life is unique, everyone goes through the same primary sequence with a beginning, a middle and end phase. Of interest for this study is that Life Course Theory provides a lens for understanding how early-life experiences can shape health across an entire lifetime. This theory systematically directs attention to the role of social and physical context, along with biological factors over time. Hatch (2005: 132) refers to prenatal exposures due to the mother's nutrition during her pregnancy as an example of a biological factor that may impact on later health. Elder Jr. et al. (2003: 7-11) further indicate that what has predominantly inspired Life Course Theory, is a greater understanding of social pathways referring to the trajectories or routes that individuals follow through society concerning education, work, family, residences and career. These concepts are shaped by historical events and biographical context, which, in turn, control the quality of how people live their life.

According to Olofsson (2014:10-13), Life Course Theory is an example of a developmental perspective that can be used to conceptualise processes through which earlier life experiences influence later health and wellbeing, including brain development. Furthermore, influences from the environment have a role to play in

future health. According to Hatch (2005: 130-131), individual behaviour along with experiences and activities within social institutions over time either leads to benefits or disadvantages. The suggestion is that inequality develops over time because one disadvantage can lead to further shortcomings. The same applies to opportunities. Hatch (2005) further points out that factors such as being born in poverty or growing up in a single-parent household predispose a person to a specific social class and plays an active role in future opportunities and access to resources. Being at a disadvantage in life contributes to the enormous gap seen in social statuses and strengthens the heterogeneity in trajectories, highlighting the health differences in individuals in later years. Elder Jr. et al. (2003: 7-11) indicate that a person's life course depends on the decisions that they make within the given opportunities and limitations within societies. Therefore, the approach mainly focuses on connections between individuals and the impact of the historical and socioeconomic context in which they live.

Benson and Kerley (2001: 3) specify that not only do environments vary from one another but understandably, so do people and their circumstances. Dannefer and Sell (1988: 2) refer to the fact that people become more diverse as they age. For example, it is evident in primary school children who start to read and write approximately at the same age and share the same interests as they start to learn how to interact with others and learn acceptable behaviour in society socially. The same group of people will have developed different skills and interests by the time they finish school. The environment, according to Dannefer & Sell (1988: 5), is one of the most significant influential factors for this remarkable diversity. Therefore, it is said that people in their more senior years, are more heterogenous than a group of younger people, especially considering their health, emotional wellbeing, finances and social interactions. Furthermore, because older individuals are so heterogeneous, Dannefer (2003: 329) suggests that ageing is not a normative process and should not be treated as such. Nevertheless, concerning older people's physical health, they seem to share an increased sense of vulnerability in their health as they age.

Herbst & Reitsma (2016: 48) add that the ecosystemic model is another example of a developmental approach to traumatic life events. Furthermore, concerning Life Course Theory, the authors suggest that an individual's life course interprets the role and impact of the different ecosystems (including the nanosystem, microsystem,

mesosystem, macrosystem and exosystem of the individual). People's careers are usually based on role histories and an example of one concept that can be used to link roles across the life course (Elder Jr. et al., 2003: 7-11).

Hatch (2005: 132) indicates that just as there are limitations, so are there protective factors that may increase positive health and may help individuals to overcome the impact of hardships. The timing and sequence of significant life transitions, such as entering the workforce early, are critical in considering cumulative adversity or advantage. Therefore, forced retirement may lead to harmful effects on health.

Vondracek and Hartung (2002: 376) continue by stating that looking through the lens of the life course, organisations should attempt to recognise how people fit work into their lives to develop personal skills within their careers, instead of entirely focusing on the work itself which may impact on health. To summarise, Benson & Kerley (2001: 3) highlight that ageing and developmental change are an ongoing process occurring throughout life. Furthermore, social and historical conditions and changes impact on ageing and development. The person's developmental phase and life stage influence how an individual perceives and reacts to traumatic events. Hence, the interaction between the different systems contributes to the impact of the trauma on the individual. Our thoughts about time are also developmental, and health status, life experiences and personalities are reflected through it (Hendricks, 2012: 230).

Scaer (2007) refers to trauma as when a person has experienced various traumatic events throughout their life span. It does not exclude events regarded as normal. When observing trauma in older people, significant work by Ogle et al. (2014: 2) focus on the cumulative exposure to traumatic events over the life span for older people. They indicate that several events related to the life of the older person can increase their vulnerability to negative post-traumatic outcomes. They are expected to experience certain types of trauma like the unexpected deaths of people close to them, loss of a life partner that signals diminishing social support networks, and other normative life events like retirement and changes in their living arrangements. All of these aspects can be associated with a resurgence or triggering of PTSD symptoms. Ogle et al. (2014: 2) allude to the fact that there is a clear relationship between early

childhood developmental traumatic experiences, that is cumulative trauma exposure and health status (both physical and mental wellbeing) in later life.

2.7 SUMMARY

It is clear from this chapter that people experience different forms of trauma, and it does not necessarily have to be a severe or extreme event for it to be perceived as traumatic by the individual. For example, Zastrow (2010: 123) refers to circumstances such as poverty and retirement that may be normal in the context of everyday life, which can severely impact on a person's health and wellbeing. No matter if the trauma exposure was a once-off traumatic event or ongoing, it could cause the pathway of the brain to follow a shortcut in terms of information processing, resulting in the formation of traumatic memory (Beaulieu, 2012: 36-37). Consequently, it may lead to different aftereffects, called symptoms of trauma.

The role that ageing plays in terms of neurobiology and traumatic memory is relevant and a discussion are included in this chapter. Moreover, because the study is concerned with older people's experience of EMI therapy and whether it is beneficial to them, the chapter includes a description of the origin and application of EMI. From the provided literature, it seems that EMI has potential to address trauma in older individuals. More importantly, in considering older people, the researcher has examined Life Course Theory closely, essentially highlighting the link between people's past and how it influences their decisions on their future, as well as their current status of health and wellbeing (Olofsson, 2014: 10-13).

The next chapter describes the in-depth research strategy to answer the research question and ultimately, to work to fulfil the primary purpose of the study.

Chapter 3: Research Methodology

3.1 INTRODUCTION

Research is defined by Sadaña (2018: 2039) as the commitment to undertake a study that involves critically and carefully investigating or examining a topic of interest in the pursuit of discovering new facts. The methodology provides a detailed outline of the approach to and conducting the research. Hence, included in this chapter is an in-depth discussion on the strategy and processes followed to produce the findings of the study. The aim of this research is an explorative and descriptive study of older people's responses to EMI therapy as a treatment intervention for their symptoms of trauma. More specifically, the study was designed to determine how older people process their symptoms of trauma through EMI therapy and whether they view it as a useful intervention.

Mackenzie and Knipe (2006: 2) established that a few terms in research are used interchangeably and refer different meanings to the same words. The words paradigm, methodology and method are all examples. To avoid confusion, the researcher has specifically allocated a subsection on the paradigm, theory and approach utilised in the study under the heading called research design. In addition to the chosen research design, the chapter also covers the study population and sampling, the pilot study, methods for data collection, including instruments applied, as well as the strategy for analysing and interpreting the collected data (Maree, 2010: 34). To conclude the chapter, quality assurance for the study, and the objectivity of the researcher were carefully monitored.

3.2 RESEARCH DESIGN

Since introducing EMI as a treatment modality in assisting older people to process their symptoms of trauma, an explorative and descriptive research design is appropriate for this research as it engages with older people's experiences of and views on the treatment method. According to Fouché and De Vos (2011: 95), exploratory research designs are ideal when little is known about a specific situation or phenomenon. Research on EMI therapy is available online; however, there is

minimal documentation in academic terms. While EMI therapy has been used extensively with young children, only two research studies documented its usefulness for treating symptoms of trauma in children. Even less is known about its use with older people. The question, 'What are the views of older people on how EMI therapy facilitates the processing of their symptoms of trauma?' fits well into an exploratory study because the answer to the question provides further insight into older people's views on its usefulness as a treatment modality.

Furthermore, a descriptive research design offered a more in-depth examination on older people's experience of EMI therapy as a treatment modality for their symptoms by utilising their inventories (Rubin & Babbie, 2005: 125).

Research can be quantitative or qualitative. The study applied a qualitative research approach (Fouché & Schurink, 2011). This approach was suitable because it helped to determine how older people process their symptoms of trauma through EMI therapy and explored the views of older people on the usefulness of EMI therapy in more detail (Setia, 2017: 367). 'What', 'How' and 'Why' questions are common in qualitative research. It seeks to answer questions about a phenomenon to describe better and understand it (Isaacs, 2014: 318). The approach is holistic with themes emerging as the process unfolds and suitable to determine the extent of the problem and ultimately, to understand the magnitude of the situation (Fouché & Delport, 2011: 64).

3.2.1 PARADIGM, THEORY AND APPROACH

A qualitative research approach typically forms part of an interpretivism research paradigm, whereas a quantitative approach aligns with a positivists research paradigm (Mackenzie & Knipe, 2006: 3-5). A research paradigm is a major approach comprised out of beliefs, values and assumptions that researchers deliberate and select for their research. The entire research process, including the choice of theory and methods applied to the study, are all steered by the chosen research paradigm (Adulkareem et al., 2017: 25-26). In this study, an interpretivism research paradigm was selected. According to Mackenzie & Knipe (2006: 5), the interpretivism paradigm seeks to understand how people interpret and make sense of their experiences in the world

and mainly relies on the views of the participants on the research topic. Fouché & Schurink (2011: 309-311) add that in this type of research paradigm, participants express their views through language and the meaning requires interpretation to discover older people's perspectives of EMI therapy as a treatment intervention for their symptoms of trauma.

Following the choice of research paradigm is the theory, which is different from the paradigm (Mackenzie & Knipe, 2006: 2). Nonetheless, there is a connection between the two (Adulkareem et al., 2017: 26). Isaacs (2014: 319) explains that theory places emphasis on the specific objectives that the researcher seeks to explore. It is a concept repeatedly tested and recognised to explain and understand situations and events (Adulkareem et al., 2017: 27). Life Course Theory was used as the theoretical lens to address the experience of trauma for older people because it provides a lens for understanding how early-life experiences shape health across an entire lifetime. This theory systematically directs attention to the role of the social and physical context, along with the biological factors over time (Olofsson, 2014: 10-13).

Because the researcher applied a qualitative research approach which refers to the data-collection methods and analysis relied upon in the study (Mackenzie & Knipe, 2006: 7), the collection of data took place primarily through semi-structured one-on-one interviews in addition to document study and secondary data analysis. However, for the most significant part of the process, the researcher relied upon the process of qualitative content analysis as described by Schurink et al. (2011: 402) to analyse and interpret the data from the inventories used in therapy together with the semi-structured one-on-one interviews. The literature was then compared and confirmed against the findings from the analytical process by placing it in the broader research paradigm.

3.3 STUDY POPULATION, SAMPLING AND RECRUITMENT

According to Strydom (2011: 223), the population establishes the boundaries on the study units and is further referred to as a collection of individuals who all possess similar characteristics. A sample on the other hand can be described as a smaller part of a population and represents the study population. Since older adults can be

classified in a combination of subgroups ranging from 60-90 years of age and older (Dunn & Craig, 2013: 447), the study population purposely contained older adults aged between 60 and 75 years old. Ethical considerations guided this consideration as well as attention to the specific inclusion and exclusion criteria for the study. Consequently, the subgroup of older people between the ages of 60-75 years who live in George, Knysna or Plettenberg Bay was most suitable for this research. The study population in this age subcategory also had to meet the following inclusion and exclusion criteria:

I. Older persons who experienced a traumatic incident in the past can relate and engage with therapy.
II. Are engaging with EMI therapy.
III. Participants without any cognitive impairment such as dementia.
IV. Participants with functional eyesight who can follow the pen with their eyes during the EMI therapy session.
V. If participants are on any medication, they should be compliant with that medication for at least two weeks before conducting the EMI sessions. If they have stopped any medication, two weeks must pass before conducting the EMI sessions (Beaulieu, 2003).

Those participants who met the criteria mentioned above and volunteered to participate were included in the study. The sample size for this study included ten older adults between the ages of 60 and 75 years.

3.3.1 SAMPLING

The chances of selecting an individual to participate in the study were unknown; therefore, the study employed a non-probability sampling technique (Maree, 2010: 178). This method infers that not everyone had an equal chance of being selected to participate (Strydom & Delport, 2011: 391). The researcher aimed to understand all aspects concerning the research topic, so individuals were approached based on specific preselected criteria to participate in the study voluntarily (Maree, 2010: 79; Denzin & Lincoln, 2000: 370; Isaacs, 2014: 319). Moreover, the type of non-probability sampling technique used in the study was a purposive sampling method where the

sampling has a specific purpose (Maree, 2010: 178). By inviting these participants (Setia, 2017: 368), the researcher could collect the richest possible data because it was possible to do an in-depth study on the participating individuals' experiences and views of EMI therapy (Strydom & Delport, 2011: 391; Isaacs, 2014: 319).

3.3.2 RECRUITMENT AND SAMPLE SIZE

According to Patton (2002: 244), there is no set sample size when it comes to qualitative research, and the nature of the research should lead it. The critical factors that often influence the sample size are the time and resources available to the researcher (Maree, 2010: 79). Isaacs (2014: 320) advises that the size of a sample should be determined by whether it can answer the research question. In the study, the researcher did not know how likely it was that the individuals, who had EMI therapy, would participate and could not anticipate the size of the sample. It was initially planned to recruit older people from old age homes for the study, but eventually, older people in the community who had received EMI therapy formed the sample group.

The researcher initially approached five old age homes within the Knysna area, where EMI therapy is offered as an intervention strategy for the recruitment of participants for the research component specifically. During this process, the researcher expected to draw participants from two or more residences for older people within the George, Knysna or Plettenberg Bay area. Those in charge received an explanation about the research and an invitation to invite potential participants from the relevant age group who might be suitable. These gatekeepers later informed the researcher about changes in the proposed participant's health, and some showed a reluctance to partake in a study for research purposes. Since participation should never be enforced (Strydom, 2011:116), involvement was entirely voluntary, and their choice to not participate was respected.

Instead, one of the local NPOs who work with older adults in Knysna provided a sample. The researcher recruited participants from an existing group of older people to whom EMI therapy was offered. The research was explained to those who qualified to participate and were willing to engage in the study. The researcher obtained written

permission from those who consented so that their inventories could be used for the research and would engage in an interview. A sample of ten participants formed an adequate number to assure the viability of the study.

3.4 PILOT STUDY

According to Strydom (2011: 237), the purpose of a pilot study is to test and validate the methodology, sample, instrument for data collection as well as the data analysis strategy. An interview schedule was compiled by the researcher to guide the research assistant during the semi-structured one-on-one interviews with participants (Stangor, 2011: 352). The content was tested in an interview with one individual with the same characteristics as the sample population. Testing the content is also one of the reasons for conducting a pilot study (Strydom & Delport, 2011: 394). Since the sample was small, only one participant who volunteered to take part was involved in the pilot study.

The researcher described the requirements for the study to the participant and provided her with an informed consent letter for her signature to confirm voluntary participation (Strydom, 2011: 116). The participant was already a recipient of EMI therapy, and debriefed after the evaluation session. The participant consented to the use of the pre- and post-inventories from the EMI sessions, and the recorded semi-structured interview. A qualitative interview like that designed for the main study to test the instrument took place.

From the pilot study, the researcher established that the questions in the interview schedule did not fully capture the participant's view concerning her experience of EMI therapy as a treatment modality. The reason was that questions in the interview schedule were not well formulated and did not allow for the conversation to flow. The practical way to eliminate the problem was by adjusting and adding follow-up questions to the schedule. By adding detail to several sentences, this eliminated any confusion. Attached is the final interview schedule used (See Appendix G). To test and adjust the questions in the interview schedule, ensures that the interviews that form part of the research are of good quality (Strydom & Delport, 2011: 394).

Another problem identified from the pilot study and eliminated was the participant seeming uncertain about what was expected. To resolve this issue in the main study, a more comprehensive explanation was given before the interview about the link between the EMI therapy already received and the interview conducted by an independent research assistant which were two separate processes. There were some adjustments in the methodological considerations. Participants were recruited by approaching and inviting private individuals who received EMI therapy to voluntarily participate in the study, instead of recruiting participants from old age homes as was originally planned. After the necessary adjustments, the researcher continued with the empirical study.

3.5 DATA-COLLECTION METHOD

Utilising more than one method of collecting data assists with the validation of the study (Patton, 2002: 306). Therefore, the researcher used a combination of data gathering techniques, that is qualitative interviewing, document study and secondary analysis. Mohd Noor (2008: 1604) advises that people's actions do not always match their descriptions and, therefore, a qualitative interview in addition to textual evidence increase the validity and reliability of the study.

3.5.1 DOCUMENT STUDY AND SECONDARY ANALYSIS

According to Strydom & Delport (2011: 376), data collection from the review of available literature and secondary analysis refers to the written material that holds information relating to the research topic. These written materials or documents are collected and examined for data analysis. In this study, the researcher utilised primary sources of written data that were unpublished. In the delivery of EMI therapy, an inventory is already used before and after treatment, providing information to the therapist on how EMI therapy impacts on older people's symptoms of trauma.

A post-inventory was completed in the follow-up session with each older person to evaluate the change in their trauma symptom intensity after receiving EMI. The post-inventory consisted of sections C and D of the inventory (see Appendix D). All

participants were debriefed in the follow-up session, and both a clinical psychologist as well as a local NPO working with older people were recommended should further emotional support be necessary. These documents (inventories) can be regarded as the original source documents according to Maree (2010: 82-83) because they are directly gathered from the research participants and utilised as qualitative document analysis to interrogate their substantive content (Strydom & Delport, 2011: 380).

Strydom & Delport (2011: 383) refer to secondary analysis as a data-collection method whereby existing data documents are re-analysed for the following reasons: To clarify or suggest a new explanation for existing data, ensure that all the data were thoroughly analysed and form a reference point for the comparison of newly-collected data. This process should not merely modify or repeat the contents of the existing data but instead provide new perspectives (Strydom & Delport, 2011: 384).

The process of secondary analysis and data verification actively involved the research supervisor who ideally evaluates the work as advised by Strydom & Delport (2011: 383) because re-analysis should preferably be done by another researcher with a more objective approach to the content analysis of the existing data. Also, the researcher involved in this process of secondary analysis should have no direct control or involvement in the primary data analysis.

3.5.2 INTERVIEWING

Another means of collecting data in qualitative research is through interviews (Isaacs, 2014: 320). Qualitative interviews, more specifically, semi-structured one-on-one interviews were utilised as the primary method because these provided more details on the topic (Greeff, 2011: 351) and, therefore, suitable for exploring the views of the participants on the effectiveness of the therapy. Since the researcher provided the therapy, a research assistant, who is a practising clinical psychologist, and competent and experienced in conducting interviews, assisted the researcher. Hence, the research assistant conducted the qualitative interviews and participants could be confident in answering honestly as to whether they benefitted from the EMI therapy or not.

The semi-structured one-on-one interviews are flexible in that they allow for unique conversations with each participant while still gathering the relevant data (Mohd Noor, 2008: 1604). Although time consuming, Stangor (2011: 107) states that one-on-one interviews have the advantage of establishing better rapport and building a sense of trust with participants. Consequently, these were most suitable for exploring older people's personal experiences of EMI and whether they found the therapy to be useful.

Setia (2017: 369) advises that the researcher uses a translated topic guide with open-ended questions for the qualitative interviews. Accordingly, in this study, an interview schedule guided the research assistant to avoid losing focus on the theme in describing older people's personal experiences of EMI therapy (Stangor, 2011: 352).

The participants first gave their permission to record their interviews by signing a consent form. With their consent, the interviews were audio-recorded with a tape recorder for data analysis and verification. According to Mohd Noor (2008: 1604), audio recordings of the interviews also help to avoid the loss of data. Each recording was labelled according to a code system and sent back by the research assistant to the researcher after the interview, for a transcription of the recorded interviews (Setia, 2017: 369).

The principal of theoretical saturation was applied. Isaacs (2014: 320) and Setia (2017: 369) state that theoretical saturation is the point in the process of data collection when no new information arises related to the research question. Setia (2017: 369) explains that during data collection, new themes might emerge after an interview and as a result, the researcher might add questions concerning these concepts not included initially in the first interview. These questions are added to the next interview with the next participant. This process continues by adding questions until no new information arises from the interviews. Maree (2010: 79) points out that in qualitative research using a purposive sampling method, the most effective way of reaching theoretical saturation is by reviewing the literature, collecting the data and analysing the data simultaneously. This process applied to this study.

The above methods of data collection each have different strengths and challenges in conducting research. Triangulation is more feasible when involving a combination of data collection techniques because the advantages of one method can compensate

for the challenges of the other methods. It also helps with the validation of the data through cross verification (Strydom & Delport, 2011: 377).

3.6 DATA ANALYSIS AND INTERPRETATION

The process of data analysis included critical examination by the researcher of the collected data who sought to accurately capture the true meaning of the results (Wong, 2008: 14; Strydom & Delport, 2011: 380). Vogl et al. (2017: 188) infer that researchers are often unclear about their data analysis strategies, which lessens the potential of verifying qualitative reports and testing credibility. To analyse and interpret the collected data from the document study (inventories) and qualitative interviews, the researcher employed a data analysis and interpretation strategy called the qualitative content analysis process (Schurink et al., 2011: 402; Maree, 2010: 101). It is an inductive process to assist the researcher in examining and summarising all the content gathered from the inventories as well as the transcripts from the interviews. By analytically processing the collected data, the researcher analysed and broadened her understanding of the raw data to enable interpretation and produce findings (Wong, 2008: 14; Maree, 2010: 101; Schurink et al., 2011: 397).

3.6.1 ANALYSING DOCUMENTS

A content analysis of the inventories was applied to interpret the meaning of the documents (Strydom & Delport, 2011: 381). In this case, it refers to the different components and processes in the inventories, focusing on older people's description of their traumatic experiences, their emotional responses to these events as described by them before and after the treatment and finally, the effect of the trauma on their interpersonal relationships as described by them before and after the treatment. A practical approach to analysing the documents is as follows:

Step 1: Critically read and interrogate the documents using the guidelines. In this instance, the guidelines refer to the three broad areas highlighted above (their description of traumatic events, their emotional responses to these events and impact on their relationships).

Step 2: Coding of emerging themes.

Step 3: Examine the regularity and variability of the data and form tentative findings.

3.6.2 QUALITATIVE DATA ANALYSIS

An analysis of the data collected during interviews also requires a step-by-step process. A summary of the description from the process of qualitative data analysis by Schurink et al. (2011: 402-419) is provided below. It was also an ongoing and non-linear process; therefore, the following key steps were implemented but did not always occur in a fixed linear manner (Maree, 2010: 99).

Step 1: Identification and classification of data related to the research question and aims of the study.
Step 2: Obtaining and storing data to promote analysis.
Step 3: Scrutinising data concerning what is relevant and applicable, and what is not related to the research question.
Step 4: Sorting and coding of data focused on the outcome, and this implies the division of the data into sections that helped to identify relevant themes.
Step 5: Developing an understanding of the information produced assisted in developing the theory.
Step 6: Findings were written up and reported (Schurink et al., 2011: 403-419).

Isaacs (2014: 321) and Maree (2010: 103-113) offer a more detailed summary of the data analysis strategy applied:

The researcher started by actively listening to the interview recordings and transcribing them. By listening to the recordings and continuously and intensively reading through the interview transcripts, the researcher started to make sense of what has been said (Isaacs, 2014: 321). During this process of listening to the recorded interviews, general impressions were written down. This method was an ongoing process throughout the research study called ‘memoing’ (Maree, 2010: 104). The researcher started to identify what was most talked about by the participants. This process of understanding the

data combined with revisiting the aim of the study and theoretical framework, assisted in not losing track of the research question as the answer to this question is what motivates the research study essentially (Isaacs, 2014: 321).

Following this step, data were divided into multiple sections with a code assigned to each meaningful section. For an all-inclusive coding scheme, the researcher utilised a constant comparative method (Schurink et al., 2011: 402-403). This process required taking each transcription of data individually and dividing it into different sections. Each section received a code and where necessary, more than one code for those sections of data that covered more than one crucial element relating to the research topic (Isaacs, 2014: 321). The researcher continuously added more data (transcribed interviews) and compared it with the previous sections of data (transcribed interviews), thus creating additional sections or categories (Schurink et al., 2011: 402-403).

Subsequently, all the sections that belonged together were placed into a group and linked to existing literature. After that, all the codes were categorised into tentative themes and then redefined based on the literature to fit the research study. These final redefined sections are called themes (Isaacs, 2014: 321). The themes were verified by ensuring that the coding and categorisation process captured all the relevant ideas. All the different sections were compared to each other so that the researcher could examine the correlations between them, and conceptualisations developed from these relationships (Isaacs, 2014: 321), as well as the comparison of different ideas (Maree, 2010: 105; Schurink et al., 2011: 402-403).

After the different themes or categories were combined, a visual representation of the data was developed to make sense of and interpret the data. Lastly, findings and conclusions were drawn relating to the research topic (Maree, 2010: 110-113). This process helped the researcher to clarify and describe in detail the views of older people on the usefulness of EMI therapy (Isaacs, 2014: 321; Setia, 2017: 369).

The final phase of the research entailed coding the data to determine the trends between the document analysis and information collected from interviews, and the initial literature research to establish how older people experience and view EMI as a treatment modality to process their symptoms of trauma. An independent coder

followed a similar process in parallel to the researcher, adding additional attention to the data analysis process.

3.6.3 ASSESSING THE QUALITY OF QUALITATIVE RESEARCH

As with any research, this study needed to comply with a criterion to ensure standard and good qualitative research. Trustworthiness, validity and credibility were some of the most vital fundamentals taken into consideration throughout the study.

3.6.3.1 Ensuring trustworthiness

Trustworthiness is critical in research as it can profoundly impact the outcome of the study. Without it, the quality of the data analysis, findings and conclusions can be brought under question (Maree, 2010: 113). Document analysis required the researcher to consider the authenticity, credibility, representativeness and meaning of the document to enhance trustworthiness (Strydom & Delport, 2011: 380). Document analysis is a systematic procedure of reviewing or evaluating documents, which can be in the form of advertisements, newspapers, brochures, government papers and more (Bowen, 2009). In establishing the credibility of the documents under review, the author of the document, method of information collection, the type of document, its purpose and the entirety were under consideration (Strydom & Delport, 2011: 380). Since the documents in this study were actual therapeutic inventories, the textual analysis assisted the researcher in interpreting the numerical representation of data according to their substantive and qualitative meaning. The research supervisor was actively involved in the process of data verification and read all the data, which ensures the credibility of interpretations.

3.6.3.2 Validity

To ensure the validity of the study, the researcher used more than one method of collecting data, that is qualitative interviewing, document study and secondary analysis (Patton, 2002: 306). Triangulation using qualitative interviews in addition to the textual evidence contributes to cross verification and adds to the legitimacy of the study (Strydom & Delport, 2011: 377), as well as increases the reliability of the study (Mohd Noor, 2008: 1604; Strydom & Delport, 2011: 377).

3.6.3.3 Representativeness

Representativeness was measured by establishing whether the information accurately examined the objective of the study in relation to the literature and aim of the study (Schurink et al., 2011: 419-421). To ensure the meaning, the researcher based the data-collection procedure on literature, a theoretical basis and an anecdotal knowledge of the phenomenon.

3.6.3.4 Credibility

The credibility of the data-collection process involves establishing whether similar results can be obtained if the process were repeated elsewhere. Credibility was achieved by standardising the conditions for the data-collection procedure, moderating the degree of difficulty, minimising the effects of external events, standardising instructions, maintaining persistent evaluation procedure and finally, the use of a pilot study. These aspects were considered throughout the design and implementation of the data-collection procedure (Schurink et al., 2011: 419-420).

Interviews, the second data-collection strategy for this study, formed a trustworthy source of data considering the following four elements:

3.6.3.5 Authenticity

Authenticity means that the selected participants were within the boundaries as set out in the sampling procedure and theoretical framework (Schurink et al., 2011: 419-20). In this case, it was older people who agreed to participate in the research, agreed to make their inventories available for the research and who participated in the interviews.

3.6.3.6 Transferability

Again, the data collected from the interview should be similar if it were to be replicated in another setting (Schurink et al., 2011: 420). This is complex in a qualitative study, but by ensuring the parameters and referring to the theory enhanced its transferability.

3.6.3.7 Dependability

Dependability means that the data collected from the interview should be similar if it were to be duplicated in the same setting (Schurink et al., 2011: 420-421). As a qualitative study conducted in a changing environment, dependability is problematic.

However, the research process followed the prescribed steps in data collection and ensured a maximum level of dependability.

3.6.3.8 Conformability

This concerns the objectivity of the researcher in collecting and analysing the data and remaining impartial, if the results were to be analysed later by another researcher. Auditing corroborates the evidence of the findings (Schurink et al., 2011:421). The research supervisor, as well as the independent coder, contributed to the rigour of this process.

Throughout the entire research study, the researcher focused on maintaining objectivity and how this was achieved will be explored further.

3.7 OBJECTIVITY OF THE RESEARCHER

Concerning qualitative research studies, Maree (2010: 79) highlights that the researcher is directly involved in conducting the study, and at the same time, keeping records of what happens throughout the entire project. The researcher is, therefore, also regarded as an instrument for gathering data. Researchers may find it difficult to reach full objectivity qualitatively, which is an essential part of any study. The researcher remained objective throughout the study for the following reasons:

The researcher worked closely with the participants in preparing them for the study and debriefing them afterwards. During the EMI therapy sessions, it was not necessary to ask the participants any questions concerning their thoughts and feelings, because EMI therapy is known as a neurotherapy (Van der Spuy, 2014: 10). Van der Spuy (2014: 7) further suggests that reflective notes during the data collection contribute to maintaining objectivity. The EMI practitioner keeps a record of each session as the natural process of each client unfolds by making notes during the entire EMI protocol (Appendix J). Referring to the notes from the sessions supported the researcher's objectivity.

By volunteering to participate in the study after receiving the EMI therapy, the participants consented to participate in a qualitative interview and agreed to make their pre-and post-inventories available for the study. An independent and objective research assistant, who is a practising clinical psychologist, conducted the qualitative

interviews so that participants could have the confidence to answer truthfully about their experience of EMI therapy and whether they have benefitted from it.

The researcher believes that by using an objective person to conduct the interviews participants can share their genuine views on the effectiveness of EMI therapy from their perspective. The research assistant could take a neutral stance in conducting the interviews because she is not a trained EMI practitioner, nor does she have a personal interest in EMI therapy. Furthermore, all information remained confidential, so that the research assistant did not receive any information about the participants prior to or after conducting the interviews. This has allowed participants to confidently answer questions in a truthful manner about their experience of EMI therapy. The data collected from the interviews has allowed the researcher to gain a more objective view on the effectiveness of EMI therapy when treating trauma symptoms in older people.

By analytically processing the collected data, the researcher could analyse the raw data and broaden her understanding thereof to interpret and produce findings (Wong, 2008: 14; Maree, 2010: 101; Schurink et al., 2011: 397). Apart from the researcher, an independent coder separately sorted and coded the data from the results obtained from the qualitative interviews and divided them into segments that helped to identify relevant tentative themes (Schurink et al., 2011: 403-419). After that, a discussion with the researcher, independent coder, and research supervisor confirmed the findings against the results obtained by the researcher and independent coder. Themes were verified by ensuring that all the relevant ideas were captured throughout the coding and categorisation process (Appendix M). Next, the researcher redefined these tentative themes based on the literature to suit the study (Isaacs, 2014: 321).

Since the documents in this study are actual therapeutic inventories, the analysis strategy assists the researcher in interpreting the numerical representation of the data in these documents according to their substantive and qualitative meaning. Throughout the process, the research supervisor was actively involved in data verification and read all the data to ensure the credibility of interpretations (Strydom & Delport, 2011: 380).

3.8 SUMMARY

This chapter discusses the research strategy used to answer the research question. The study employed an explorative and descriptive research design that is suitable for engaging with older people to get their views on their experience of EMI therapy since little is known about its usefulness for people aged 60 years and older. It is clear from this chapter that a qualitative approach was appropriate to determine the views of older people on EMI therapy.

The emphasis is on the clear connection between the research paradigm and theory, although they are different from each other. The interpretivism research paradigm underpinned the entire study. However, Life Course Theory was the theoretical lens used to speak to the experience of trauma for older people and guided the research strategy and methods. A specific criterion was established to include and exclude a specific study population. At all times, the study adhered to the ethical guidelines of research in the social sciences and human professions. Participation was voluntary, and confidentiality agreements made with each participant. Throughout this study, the emphasis was on maintaining the quality of the research. Data were collected predominantly using semi-structured one-on-one interviews in addition to document study and secondary data analysis. Triangulation, a term used when two or more methods are used to collect data, offered the advantage of increasing the validity of the research and applied to this study (Strydom & Delport, 2011: 377).

The researcher discovered that there is not one specific data analysis strategy that fits the research design. Consequently, in the process of analysing and interpreting the collected data, the researcher used her discretion and implemented qualitative content analysis requiring a step-by-step procedure. A guideline to this step-by-step process for the analysis and interpretation of the inventories and transcribed interviews to produce the findings is provided in this chapter. This was an ongoing process and occurred mostly in a cyclical manner rather than in a rigidly linear process. This chapter also assessed the researcher's objectivity throughout the study. The next chapter provides a comprehensive discussion of the findings produced.

Chapter 4: Research results

4.1 INTRODUCTION

This chapter discusses the data obtained from the empirical investigation following the literature study. More importantly, there is an analysis of the data about Life Course Theory used as a theoretical lens to communicate older people's experiences of trauma (Olofsson, 2014: 10-13) as well as an interpretation of the data. Different themes were identified from the data and then compared and redefined based on the literature (Isaacs, 2014: 321) to relate to the aim of the study. Subsequently, three main themes developed. Each theme was divided into different subthemes according to the participant's replies, which translated to their experiences of EMI therapy as a treatment modality for their symptoms of trauma and understanding of how EMI therapy facilitates the processing of these symptoms. The data obtained from the interviews and inventories are presented interchangeably in the discussion. Visual representations in the form of tables highlight some of the data from the inventories (Maree, 2010: 191).

4.2 RESULTS

Ten semi-structured one-on-one interviews were conducted with a total number of ten participants who were recipients of EMI therapy and volunteered to participate in the study. Those who agreed to engage in an interview gave their written permission for the use of their inventories from the EMI therapy sessions for document study and qualitative analysis (Strydom & Delport, 2011: 380).

Data obtained from the empirical investigation provides meaning to the results. The data were divided into different categories for a more logical interpretation. Data included biographical information from the inventories, forms of trauma experienced by participants and a discussion concerning the results from both the inventories and qualitative interviews in the discussion.

4.2.1 BIOGRAPHICAL INFORMATION

Ten participants took part in the study. The size of the sample was led by finding the answer to the research question (Isaacs, 2014: 320). All were private individuals within the selected age group who received EMI therapy and subsequently volunteered to participate in the study. The gender, age and civil status of these individuals gave the reader a broader understanding of the context of the participating participants.

4.2.1.1 Gender

Table 1 indicates that the majority of the participants were females. The outcome of the study is, therefore, more representative of females than males.

Gender	Number of participants	Percentage (%)
Male	1	10
Female	9	90
Total	**10**	**100**

Table 1: Gender N=10

4.2.1.2 Age

The effect of age is an important factor to consider concerning people's physical and emotional wellbeing when working with individuals and treating their trauma. Stuart-Hamilton (2011: 233) highlights that older persons are a vulnerable age group because later life is a time of deterioration. From Table 2, it is evident that the majority were aged 66-70 years, and this accounted for 50% of participants. Only one participant was between the ages of 71 and 75 years. This study deliberately excluded people over the age of 75 to avoid working with individuals who may be more vulnerable in terms of their health and wellbeing.

Age	Frequency	Percentage (%)
60-65 years	4	40
66-70 years	5	50
71-75 years	1	10
Total	**10**	**100**

Table 2: Age N=10

4.2.1.3 Civil status

Table 3 indicates that an equal number of participants are either married (30%) or divorced (30%) equalling 60%. Having been exposed to the unexpected deaths of people close to them and/or experiencing the loss of a life partner is not unusual for people in this age group (Ogle et al., 2014: 2). Almost half (40%) are unattached since their spouses have passed away. The presumption is that nearly half of the participants encountered at least more than one major trauma in their life.

Civil status	Frequency	Percentage (%)
Married	3	30
Divorced	3	30
Widow/Widower	4	40
Total	**10**	**100**

Table 3: Civil status N=10

Following an analysis of the biographical information, the forms of trauma that these participants experienced is relevant to the study as Zastrow (2010: 453-465), Dunn and Craig (2013: 499) and Henslin (2007: 377-385) agree in that common age-related issues may be prevalent when working with older people.

4.2.2 FORMS OF TRAUMA

Since most older adults have probably experienced some form of trauma in their lives, some of the participants may have been more vulnerable to adverse post-traumatic outcomes compared to others considering cumulative exposure to traumatic events (Ogle et al., 2014: 2-3). During the assessment session, each participant had the opportunity to identify a troubling memory that they felt needed reviewing. According to Table 4, the forms of trauma that these participants encountered differed significantly from one to another, except for three participants who shared a similar traumatic experience – the Knysna fires in 2017.

Compared to some identified forms of trauma, one might be mistaken thinking that retirement is not something to address in therapy. Interestingly, retirement came up as a form of trauma not integrated by one of the participants that had a considerable impact on both her physical and emotional wellbeing, as seen in Table 5. Beaulieu (2004) reminds us that trauma is anything that one perceives or experiences as traumatic. It includes negative life events believed to be ‘normal’ in the context of our daily experience, such as retirement. According to Brandell (2011: 417), forced retirement increases the risk of exposure to trauma because older people are exposed to higher levels of poverty which may impact on their mental and physical health (Stuart-Hamilton, 2011: 175).

Participants	**Presenting problem**
Participant 1	Knysna Fires
Participant 2	Daughter's eating disorder which is a life-threatening disease
Participant 3	Daughter given up for adoption
Participant 4	A work-related incident where a client committed suicide
Participant 5	Son committed suicide
Participant 6	Violent partner relationship
Participant 7	Knysna Fires
Participant 8	Knysna Fires
Participant 9	Retirement
Participant 10	Death of wife

Table 4: Forms of trauma that to which participants have been exposed

As can be seen from Table 4, participants identified different traumatic incidents that significantly affected their wellbeing on which they chose to work. The following is an analysis of the results obtained from the data collection.

4.2.3 RESULTS OBTAINED FROM THE QUALITATIVE INTERVIEWS AND THE PRE- AND POST-INVENTORIES

The data produced were divided into three main themes linked to the first two objectives of the study to assess the results more comprehensively and accomplish the aim of the research. The following is a comprehensive discussion of each theme.

4.2.3.1 Theme 1: Older people's experience of EMI therapy

Previous studies on EMI therapy suggest that it is useful as a treatment intervention for treating trauma in adolescents (Struwig & Van Breda, 2012: 36), and young children aged five to seven years previously exposed to trauma (Van der Spuy, 2014:

57). This study was mainly concerned with the perspectives of older people and the usefulness of EMI therapy. During the qualitative interviews, participants could reflect on their experience of EMI therapy as a treatment intervention leading to the first central theme.

Referring to the three objectives of this study, this first theme fits well into the first objective, which is to explore and describe how older people experience EMI therapy as a treatment modality. According to the participants and their experiences of the treatment intervention, different subthemes emerged as follows: It was a completely new and different experience compared to past experiences of therapy or their expectations; some enjoyed the experience, and the repetitiveness of the technique impacted the experience. Finally, some of the participants reported feeling exhausted after the therapy, another subtheme included under their experience of EMI as a treatment intervention. A more comprehensive discussion of the identified subthemes encompassed in the first central theme follows.

4.2.3.1.1 Subtheme 1: Completely new and different from previous experiences or expectations of therapy

Although EMI therapy has already been introduced internationally, it seems to be a relatively unfamiliar concept to many people in the South African context. Only two studies concerning EMI therapy have been conducted and documented in South Africa to date. The focus of both were children. No research is yet available on the use of EMI therapy on older people. It is, therefore, not surprising to consider that most participants viewed EMI therapy as a completely new and different experience compared to previous experiences or expectations that they have of therapy. Therefore, it is a subtheme under older people's experience of EMI therapy.

Nine of the ten participants indicated that they were unfamiliar with EMI as a treatment intervention having never heard of it before. Only one knew about EMI therapy prior to her receiving the therapy session and described her experience as follows: 'It was just refreshing to find something different from what I've been trying' (Interview B3:2). Five participants (Interviews B5-B9) reported that they had not had any therapy before EMI and, therefore, did not have anything with which to compare it. Those who had

therapy before reported that they experienced EMI as something completely different compared to other therapeutic interventions. EMI therapy was further described as ‘unusual…’ (Interview B1:4), ‘an unexpected technique…’ (Interview B2:3), and ‘…certainly interesting…’ (Interview B9:10). Furthermore, two participants admitted to feeling ‘sceptical in the beginning’ (B3:3; B4:1;13) because it was so new to them. Participant 5 indicated that ‘… it was something completely new and totally different for me and I… perhaps a bit cynical as to whether it would really work’ (Interview B4:1).

4.2.3.1.2 Subtheme 2: Enjoyed it

The researcher became cognizant of the fact that several participants indicated that they enjoyed the experience of receiving EMI therapy. Seven individuals specifically pointed out that EMI has been positive for them and that the therapy was beneficial. For example, one described her experience as having an ‘Aha’ moment by sharing that ‘Different… because I didn’t expect it to have the results that it did have. That I found was quite a sort of an “Aha” moment’ (Interview B4:1).

According to Van der Kolk (2014: 44-47), the reason that people usually find it hard to talk about their symptoms is that the traumatic experience itself blocks them from doing so. The emotional brain stays in its reality, and the rational brain cannot do anything about it despite having an insight into the problem. People find it easier to take note of, feel and verbalise the reality of what they experienced internally than to talk about what occurred. An important part of EMI therapy is not to try and elicit more information but rather to help the brain to integrate their troubling memory. This is done by asking the client to take note of their inner processes and not analyse what came up for them after each eye movement and notice where they feel it in that specific moment physically.

Levine (2015) suggests that by asking the client to ‘take note’ and to ‘notice what happens next’ without discussing details, helps to activate brain pathways that connect the rational and emotional parts of the brain. In this way, the client can deliberately rearrange the perceptual brain system. This process seems to have happened for participant 4, who elaborated on her experience of EMI therapy as being positive in saying that she ‘…was not forced to go into depth/detail… So, exceeded any

expectations I ever had… There was an emotional release that… I never ever experienced… with counselling' (Interview B3:1;4). Participant 2 shared that it was easy for her to express herself ,and participant 10 (Interview B9:2;5) said '…certainly, it makes you relax and gets you to talk', while another said that the therapy made her focus on herself for a change.

Some other aspects that also appeared to add to the positive experience was the fact that the participants felt that a safe space was created (Interviews A1:2 and B2:1). Also, the therapist came across as organised and professional (Interviews B5:10; B6:6 and B8:1).

4.2.3.1.3 Subtheme 3: The repetitiveness has had an impact on the experience

The continuous following of the eye movement patterns, and the experience of the participants led to this subtheme. As part of the EMI protocol, the clinician uses 22 eye movement patterns to assist the client in providing new patterns of accessing cues. The eye movements help to enable the client to access information about the traumatic incident stored in the relevant multisensory modalities. To help the brain remember, in each of the visual fields there is an eye movement. The eye movements repeat until the clinician knows that the integration of the trauma material has taken place (implicit and explicit memories have reconnected and integrated) when there is a transformation in the content (Struwig & Van Breda, 2012: 32; Beaulieu, 2012: 225-254).

It became evident from the content analysis that the repetition of the EMI protocol is one of the most influential factors in how the participants viewed their experience of EMI therapy. Concerning the repetitiveness of the eye movements as part of the protocol is twofold because some participants felt they needed more of a challenge. In contrast, others reported that it helped them to focus and concentrate. The former suggests that even though they had an overall positive experience, there are still some aspects to the therapy that were less enjoyable while the latter implies a more positive connotation to the experience.

Three participants reported becoming bored with all the repetition of following the eye movements, and one fell asleep during the EMI protocol and explained it as follows

'...I actually fell asleep watching it, and I felt terrible!' (Interview B1:1). It was then further concluded from the other two interviews that they needed a break during the protocol and also needed a bit more of a challenge. Moreover, because of the amount of repetition required during the procedure, participant 10 inquired whether EMI had a hypnotic aspect. He added that he would not have minded, but the repetition of the eye movements made him wonder about it.

Despite these more negative experiences, the main suggestions from the two participants who viewed the repetitiveness as a positive experience was that it had helped them to focus and concentrate. According to participant 8 (Interview B7:1;5), '... I found I was focusing...*'* and '...it made me concentrate ALL THE TIME...' Interestingly, participant 9 compared the therapy to brain gym that she used as a teacher in the classroom to help the children to focus and concentrate. She felt that EMI therapy was based on the same principle and, therefore, she could easily relate to it. She realised her work as a teacher impacted on the lives of those she taught previously, which provided her with a sense of purpose. The EMI therapy facilitated that aspect for her as an individual by revealing that '…so, this I think helped me to concentrate on me for a change and not worry about everything else' (Interview B8:3).

Beaulieu (2012: 80) refers to the same idea when she mentions that work done by Bandler and Grinder (1979) demonstrated the connection between guided eye movements and thought processes when they could successfully assist children with their mathematics and spelling by merely redirecting the direction of the children's gaze.

4.2.3.1.4 Subtheme 4: Very tired afterwards

Eye Movement Integration therapy requires a lot of physical and emotional energy from the client (Beaulieu, 2012: 209) as confirmed by the two participants who reported feeling tired the next day after receiving therapy. Participant 1 indicated that '...I actually felt tired the next day after we had our last session' (Interview A1:2) and participant 6 stated that '...I was exhausted!... and I slept extreme...in the afternoon which I never do' (Interview B5:2).

During an EMI session, a large amount of information will arise for the client. It causes much of their energy to be directed towards the physical symptoms and emotions they experience during the session and is the reason for feeling extremely tired after the session. Despite feeling tired, as soon as the troubling memory of the traumatic experience integrates, the client feels a sense of emotional release (Beaulieu, 2012: 63).

From the above subthemes, it becomes evident that older people experienced EMI therapy as an unfamiliar and unexpected technique. However, it impressed them as useful for treating their symptoms of trauma because of the results that it has produced. The second theme that emerged is now further explored.

4.2.3.2 Theme 2: Older people's perceptions of the benefit of EMI therapy (How EMI facilitates the processing of trauma)

The second theme considers whether EMI therapy holds any benefit for older individuals. This theme emerged from the many responses from the participants from their perspectives. According to the content analysis, most indicated that the therapy was beneficial to some extent. The importance of understanding the value of the therapy for older people for treating their symptoms of trauma can be associated with the second objective of the study. This is to explore and describe older people's views on how EMI therapy facilitates the processing of their symptoms of trauma.

The subthemes in the second main theme are as follows: EMI therapy enables a person to go beyond the obvious; It brought relief from the (physical) distress of the trauma; Emotionally freeing; EMI assists in exploring client's thoughts; Improved interpersonal relationships; and EMI created an awareness.

This subtheme further divided into eight sub-categories from the awareness that arose as follows:

- EMI provides the opportunity to speak about suppressed and hidden emotional issues of the past;
- Refrain from avoiding the topic of the trauma;
- Realised that it is her own responsibility to work on things;
- Awareness that there is still emotional work to be done;

- There are still feelings of anger or sadness at aspects relating to the loss; Therapy is sometimes necessary;
- An awareness that other issues can cloud the initial trauma; and
- Realised that there were also positive aspects as a result of the trauma;

Lastly, the subtheme of those who experienced no real change in their physical symptoms was identified.

Each subtheme that emerged from the perceptions of the participants concerning the benefit of EMI therapy is further explored.

4.2.3.2.1 Subtheme 1: Enables you to go beyond the obvious

From the content analysis, EMI therapy facilitates a process that enables participants to go beyond the obvious. More specifically, nine participants indicated that the therapy made them reflect on their past experiences and stimulated new ideas for them. Participant 10 mentioned that the therapy allowed him the opportunity to return to the past and address unfinished business. Others have shared similar experiences. participant 7 (Interview 6:4) stated that:

> *...it actually brought up a lot of things again that I had been going through. But it actually helped to really think at length about some of the things and things that I had already put to bed, but it actually made me realise, I was still very much aware of it all…*

Another participant shared the following: 'What it made me do is really think about things. I actually found myself thinking about things… that it made me see or made me realise... ' (Interview B7:3).

Participant 9 (Interview B8:4) also commented that 'it really made me look back and see all the things that I've been keeping inside... that definitely brought it to the fore...'.

Participant 1 (Interview A1:1) reported that certain eye movements triggered flashback images and stated that '...I could see it and it was amazing. I thought that gee, I haven't thought about that for a while…'. While participant 6 (Interview B5:1) mentioned that '…a lot of things have come up for me that I have forgotten about'. Experiencing the

triggering of memories during EMI is not unusual. Beaulieu (2012: 179) advises that strong reactions during EMI are how the memory was recorded in the first place when the trauma occurred. These intense reactions are then released from the memory utilising following guided eye movements. The client may first re-experience the strong responses associated with the traumatic memory. This process then allows new information to combine with this memory and ultimately to fully integrate the traumatic experience during the process of EMI.

It possibly explains why none of the participants reported feeling re-traumatised by the experience despite getting these images. Instead, the therapy enabled them to look deeper into the situation and one participant confirmed this by highlighting the fact that she had to address the issue in the therapy and could not ignore it. Ultimately, the therapy brought out aspects that needed to be dealt with and created an awareness of those things of which they were previously unaware. This seems to have helped them to link the experience and process the trauma. The following statement by participant 4 (Interview B3:2) reflects the connection: '…without you realising it changed… it linked things that I wasn't aware… So, it joined the dots between current things and previous things…'.

4.2.3.2.2 Subtheme 2: Brought relief from the (physical) distress of the trauma

Trauma and psychological stress can manifest in the form of physical symptoms, also called somatic symptoms (Reber & Reber, 2001: 538; 585; Lickerman, 2010). According to Van der Kolk (2014: 67), troubling memories from the past impact on a person's physical reactions. A study by Chou et al. (2014: 243) revealed a decrease in older people's heart rate as their troubling memories started to develop. Physical symptoms caused by trauma can, among others, present as recurrent headaches, chest pain, fatigue, back pain, constipation and aching muscles (Rosenbloom et al., 2010: 36). From the content analysis, it appears that regardless of how long ago the traumatic incident occurred, it does seem to impact the participant's physical health to some extent. Nine out of ten indicated that their traumatic event has indeed affected their physical health in one way or another. This confirms the theory of life course with a reminder from Ogle et al. (2014: 2) that cumulative exposure to trauma over a life span can fast-track a decline in physical health and mobility.

The scores after receiving EMI therapy across the group of participants show that there was overall a 50% sense of relief in their physical symptoms. Moreover, the researcher became increasingly aware of the fact that the therapy has brought relief to seven participants in terms of physical distress caused by the trauma (refer to Table 5). Only one participant reported not having any physical symptoms either before or after EMI therapy. The content analysis also indicates that seven participants alluded to the same idea in that the therapy has created an awareness for them of previous trauma stored in the body. Participant 3 (Interview B2:5) expressed it by saying that '…I was very aware during the process of… areas of my body where stuff was held and then suddenly it wasn't there anymore'.

Bouchard & Villeda (2015: 9) suggest that all our physical systems work together and interlink with our CNS. It simply means that there is a connection between mental health and the immune system (Sadock et al., 2015: 1341). This connection helps to clarify why diminished physical symptoms and specific areas of tension that felt more relaxed after the process are some of the most prevalent physical outcomes reported. Participant 8 claimed that her psoriasis cleared up and a pain that concerned her was gone after the therapy. Participant 9 mentioned that the clenching of her teeth has improved.

Interestingly, participant 5 indicated that the impactful area of the trauma was on her left-hand side. After her traumatic experience, she was unable to turn and look to the left. However, after receiving EMI therapy, she was able to make this movement and stated that '…the trauma hit on that specific side, so you react in that way. I've never been able to circulate my head like that. I've been able to go that far and no further. Now I can' (Interview B4:3).

Furthermore, two participants felt that it was too soon to tell whether the outcome will be positive for them. Participant 4 (Interview B3:4) stated the following: 'Your physical it would be difficult to look at now. I kind of wished it was available then because it would have prevented the thyroid dysfunction'. This statement may imply that she is not sure about the outcome in terms of her physical symptoms, but at the same time believes it will be positive. This belief is suggested in her statement that it could have possibly prevented her thyroid dysfunction if she had EMI therapy years ago just after

the traumatic experience to help her integrate the memory. The same individual also shared a similar experience to participant 5, saying:

> *It was very marked. So, for me, I could actually see the change by the end. Literally!... my whole traumatic incident happened in front of me… left-hand side and every time we moved to the left-hand side, that was when the eyes jumped or didn't follow. And it's also my weaker side…. by the end that was gone. So, it was for me that was amazing* (Interview B3:2).

Participant 6 (Interview B5:7) added that '…it's early days, but you know I think that that will get better. I think that that will be as I'm not so tight'.

4.2.3.2.3 Subtheme 3: Emotionally freeing

Psychological symptoms may or may not develop after a traumatic event. According to Rutten et al. (2013: 4), resilience causes people to adapt more successfully to difficult circumstances over the life course. Those who do, however, present with psychological symptoms may benefit from therapeutic interventions (Senneseth et al., 2011: 403) such as EMI therapy to help them integrate the sensory information from the traumatic event (Beaulieu, 2012: 14-15) and enhance their overall health and wellbeing. A notable finding based on the content analysis is that EMI therapy has altogether had a significant positive impact on the participant's emotional wellbeing. Therefore, the EMI therapy seems to have promoted an emotional release for nine participants referred to as a subtheme of 'emotionally freeing'.

According to Table 5, the extent to which the traumatic events impacted on their emotional wellbeing seems to be greater in comparison to the effect on their physical symptoms. Wahlström et al. (2013: 6) noticed the relationship between physical and psychological symptoms. The authors maintain that they established that there was a decline in the physical symptoms of victims of trauma as time passed after the incident. However, their advice is to be cognizant of the link between cumulative exposure to trauma and its long-term impact on older people's current physical health, because older people may not be aware of the connection between the trauma and their physical constraints.

The most prominent emotional manifestations of trauma as witnessed in the scores across all the participants were psychological distress, sadness and fear. Nightmares appear to be the least prevalent indicator of trauma for these participants.

Furthermore, according to Table 5, the scores after receiving EMI therapy for this sample shows an improvement in the intensity of their symptoms of trauma. The most significant being their levels of fear with an almost complete overall improvement, following sadness and anger which is referred to as a strong emotional reaction by Reber & Reber (2001: 35), with high levels of positive change. The reduction in their scores correlates with the experiences that these participants shared in their interviews. Participants 1 and 6 specifically mentioned a reduction in their anger and fear levels, while others described feeling less paranoid and sad. Despite cumulative exposure to trauma, Stuart-Hamilton (2011: 224) states that there is a lower rate of anxiety symptoms in older people compared to younger adults, whereas for the most part, older people's anxiety stems from phobias rather than anxiety disorders.

Participant 10 discussed the improvement in his emotional wellbeing and indicated that there was a dramatic change in his stress scores compared to his pre-inventory. Participants 3 and 10 referred to associated aspects that have a lesser impact after therapy by stating that '…there has been a distancing of the pain and the associative things…' (Interview B2:8) and 'I feel better about a lot of aspects' (Interview B9:8). Four participants reported feeling calmer or more at peace as a result of the therapy. Participant 6 shared that 'I feel different… I feel calmer and I feel more angled' (Interview B5:8). Participant 3 mentioned that 'I feel more at peace about the whole thing and how I fit into that scenario now…' (Interview B2:7) and described the emotional outcome of the therapy for her as follows: 'Whisper there rather than a scar…' (Interview B2:4).

Table 5 further indicates a real emotional release for two participants (participants 4 and 9) across all nine emotional manifestations of trauma measured on their pre- and post-inventories. Other emotional outcomes were described as follows: Participant 2 indicated that she realised that some aspects of her traumatic experience can now belong to the past. Participant 4 felt that the therapy brought closure of an event many years later. Furthermore, participant 5 explained that she started to experience healing for the first time after the EMI and participant 9 felt that she started to see things in

perspective. Participants 6 and 8 reported that they sleep better since receiving the therapy with no more sleep disturbances.

Seven participants indicated increased self-esteem. The scores of two of the remaining participants stayed the same, while participant 5 reported an escalation in the intensity of her symptoms of trauma concerning three emotional manifestations of trauma after treatment. Furthermore, she said that here has been an increase in her lack of self-esteem, feelings of anger and sleep disturbances after EMI. Subsequently, after the debriefing session, the participant returned to counselling at her church, where she went before the EMI therapy.

According to Böttche et al. (2012: 10), older people may often block out disturbing memories in order to cope by making use of avoidance behaviours and might not be aware of doing so. An interesting phenomenon is that the therapy has had the least impact in terms of avoidance behaviours, that is the least improvement in their scores. However, there has been a significant reduction in the intensity of symptoms compared to how the participants felt prior to therapy. The scores of four participants remained the same concerning avoidance behaviours after the therapy, and one reported not presenting with any avoidance behaviour at all, both before and after EMI.

The numbers in Table 5 indicate the extent to which the participants have experienced symptom intensity with a total test score out of 10. Number 1 means ‘not at all’ and 10 means ‘worst imaginable’. If the post-test indicates a decrease in scores from the pre-test, it means that there was a reduction in their symptom intensity after therapy. Similarly, an increase in the score on the post-test compared to the pre-test indicates an increased intensity in symptoms after receiving EMI. The blocks highlighted in green and yellow emphasise that there were no changes recorded in the scores after the therapy. The difference is that the green indicates those symptoms not present at the start and remaining unchanged after the therapy. The yellow blocks signify that there were symptoms present before the therapy but no changes in their severity measured in the scores after treatment. The red blocks highlight an increase in the scores or symptom intensity experienced after the therapy. The rest of the scores show a clear decrease in the numbers from the pre-test compared to the post-test, indicating a reduction in the symptoms of trauma experienced. R1 to R10 represent the scores for participants 1 to 10.

Symptom		R1	R2	R3	R4	R5	R6	R7	R8	R9	R10
Physical symptoms	Pre-test	1	5	5	6	3	9	3	5	5	3
	Post-test	1	6	3	2	2	4	1	1	4	3
Psychological distress	Pre-test	5	4	4	8	7	8	8	4	7	6
	Post-test	3	3	4	1	5	1	3	3	3	3
Depression	Pre-test	1	3	4	3	6	5	1	3	6	6
	Post-test	1	1	2	1	4	2	1	2	3	4
Sadness	Pre-test	9	6	6	7	5	6	10	5	7	5
	Post-test	5	1	2	2	4	1	4	2	2	3
Aggression	Pre-test	8	5	3	8	1	7	1	8	5	4
	Post-test	1	2	2	1	3	2	2	1	2	4
Fear	Pre-test	5	2	7	3	8	8	5	8	5	2
	Post-test	1	1	1	1	5	2	1	1	2	4
Avoidance	Pre-test	9	1	5	8	2	9	2	2	8	8
	Post-test	8	1	5	1	2	1	2	3	3	5
Nightmares	Pre-test	1	1	1	5	1	5	1	1	7	2
	Post-test	1	1	1	2	1	2	1	1	1	2
Sleep disturbances	Pre-test	1	3	2	8	1	7	3	3	7	8
	Post-test	1	1	5	1	2	1	1	1	4	2
Lack of self-esteem	Pre-test	2	8	3	7	1	8	1	6	7	9
	Post-test	1	2	1	2	6	3	1	6	3	2

Table 5: Participant's pre- and post-symptoms of trauma scores

4.2.3.2.4 Subtheme 4: EMI assists in exploring client's thoughts

It became evident that EMI assists in exploring people's thoughts and it was added as a subtheme under the perceptions of older people concerning the benefits of EMI therapy. Four of the participants' thoughts led to a conscious decision being made as

a result of receiving EMI therapy. After receiving the therapy, participant 6 realised that the traumatic memory infiltrated too much of her life. She discussed the effect of her past traumatic experience and realised she has more control over her life than she initially thought she had before therapy.

According to Levine (2015:4: 55), our present mood, emotions and feelings can subconsciously determine the images we look at in our surroundings bringing up memories from the past. Possibly, this means that if we are always feeling down or anxious, we train our brains to focus on the hurtful memories from the past. In a study conducted by Rangaprakash et al. (2017: 2860), the authors illustrate that intrusive memories decrease the working of the hippocampus that forms part of the limbic system and is mainly associated with memory. This means that there is a shift away from explicit memory and towards dependent memory leading to habitual thinking. It verifies that the hippocampus is vulnerable to stress (Struwig & Van Breda, 2012: 30).

Furthermore, Beaulieu (2012: 13-14; 213) explains that many of our limitations start from our internal processes. In other words, we use the same accessing sequences repeatedly from habit. Guided eye movements help to change the accessing sequence and allow the client access to other internal resources often neglected because of the habitual thought patterns previously established. This process in EMI inevitably helps the client to access their memories more objectively and gain new perspectives on the problem.

As a result of EMI therapy, participant 8 has a renewed sense of drive and started doing things for herself again. She stated that: ‘Much better frame of mind. I’m making things again…. I think what happened was the therapy started something good and maybe I’m carrying it through’ (Interview B7:13). Participant 5 has identified some specific goals to work towards as a result of the therapy which she indicated as: ‘…now there has been a conscious decision in that now that we’ve dealt with it… there’s been a conscious decision to actually keep working at it’ (Interview B4:2). For participant 9, it meant improved concentration. She stated that: ‘Being able to concentrate… it made me deal with things, focus and… just made me get things in more perspective… and help me to sort myself out’ (Interview B8:5).

4.2.3.2.5 Subtheme 5: Improved interpersonal relationships

Rutten et al. (2013: 14) assert that interpersonal relationships strongly influence a person's internal working model (how they view themselves, others and the world) as well as their resilience. Hendricks (2012: 229) adds that social relationships with others are a resource in difficult times and, therefore, it seems essential in the life course because people need to have positive and healthy interpersonal relationships. One participant shared her experience by saying that: 'It seems logical that it might. Emotionally I think it helped me tremendously. I think that the way I'm dealing with the other people in my life who I need to deal with is different…' (Interview B5: 8).

Across this group, the data suggest that EMI therapy leads to improved interpersonal relationships and, therefore, included as another subtheme that emerged. Participant 2 said that: '… the impact was my interpersonal relations… it has improved' (Interview B1:6). The most significant improvement for participants after the treatment were their relationships with their children, then better relationships with their friends, and finally, an overall improvement in their relationship with their spouse or partner.

As per Table 6, participant 7 claimed that her traumatic experience had no negative impact on any interpersonal relationships. Also, the EMI treatment did not influence her relationships in any way. Therefore, her scores remained unchanged and were not considered in terms of the adverse effects of trauma on the participant's interpersonal relationships.

Olofsson (2014: 13) believes that repeated exposure to trauma may desensitise a person to stress. This may influence wellbeing and relationships in later life. According to Hendricks (2012: 228), stressful incidents in early life can refer to social experiences and do not only have to be physical to affect health in later life. The impact of EMI on the relationship with their spouse/partner, children and friends is further explored as follows:

Relationship with their spouse/partner:

According to Table 6, five participants were single. One participant reported that her traumatic experience did not affect her relationship with her spouse negatively and remained unchanged after EMI. For the remaining four participants, the levels of impact that their traumatic experience had on their relationship with their spouse or

partner seems to be relatively high. Also, EMI therapy for these four individuals (participants 2, 3, 6 and 9) appears to have had a positive influence on their relationships with their spouse or partner after the treatment.

Relationship with their children:

One participant reported not having any children and the scores for two others remained unchanged since they both reported that the trauma had no negative impact on their relationship with their children from the start. For the seven remaining participants, their traumatic experience had a less negative impact on their relationship with their children compared to the impact on their relationship with their spouse or partner. The pre- and post-inventory from participant 9 shows an increase in her scores after receiving EMI, suggesting that EMI did not improve her relationship with her children, but that it further deteriorated. The same applies to her relationship with her friends. Participant 9 was encouraged to go for further therapeutic intervention to address and work on the issue of her relationship with her children and friends. For six others, the impact of EMI therapy on their relationship with their children seems to have been positive.

Relationship with their friends:

Two participants reported that their trauma has not impacted on their relationship with their friends. However, for the rest of the participants, the trauma they experienced affected their relationships and interactions with friends to some extent, and as a result, should not be ignored. As previously discussed, the pre- and post- inventories from participant 9 suggests that EMI did not improve, but instead negatively impacted on her relationships with her friends. Also, she indicated during her assessment that she has not made any friends since she relocated at the start of her retirement. Becoming aware of her friendships through EMI may have influenced how she viewed her relationships with the people in her life. As previously mentioned, she was encouraged to go for further therapy to address her relationships with both her children and friends.

	Spouse/partner		Children		Friends	
	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test
Participant 1	N/A	N/A	1	1	9	1
Participant 2	8	1	8	1	2	1
Participant 3	6	3	4	2	3	1
Participant 4	N/A	N/A	5	2	2	1
Participant 5	N/A	N/A	3	1	8	3
Participant 6	8	5	6	3	1	1
Participant 7	1	1	1	1	1	1
Participant 8	N/A	N/A	9	4	8	4
Participant 9	7	5	3	4	5	8
Participant 10	N/A	N/A	N/A	N/A	9	2

Table 6: The negative impact of trauma on interpersonal relationships and the influence of EMI on these relationships

Table 6 works on the same principle as Table 5. A decline in the scores indicated on the post-test compared to the pre-test indicates an improvement in the interpersonal relationships experienced by participants after treatment.

4.2.3.2.6 Subtheme 6: EMI created an awareness

While the participants started to become aware of the fact that trauma can be stored in the body, the data indicates the start of an increased awareness of other aspects as well. People and their experiences are diverse and, therefore, it is not surprising that seven participants realised different things after receiving EMI therapy.

Eye Movement Integration therapy does not remove any information. However, the eye movements help to integrate the information for the brain to see what it is and where it fits, and so adds information to the first memory. With the reactivation of the memory, the client gains a new perspective on the problem (Beaulieu, 2012: 164-176). Because the study attempts to capture older people's views on how EMI therapy

facilitates the processing of their symptoms of trauma, a discussion of each aspect as a result of the therapy follows.

a. *EMI provides the opportunity to speak about suppressed and hidden emotional issues of the past*

Trauma is regarded by Böttche et al. (2012: 5-7) as an element that is liable to change in later life. However, older people also typically take time to think carefully about their past and events that happened earlier in their life. The authors recommend a few treatment interventions to help them make the necessary adjustments, one of which is psychotherapy. Eye Movement Integration therapy seems to have facilitated the release of suppressed information from the past that was subconsciously troubling them.

Two participants reported feeling relief to have been able to speak about things from their past that they either thought they buried or bottled up inside. Participant 6 described this, saying that:

> *I think that the therapy in remembering stuff is stuff I've put in a cupboard, and put away, and you think it doesn't affect you. And this made it all come out. And that was a good thing…* (Interview B5:3-5).

Furthermore, participant 9 stated that:

> *…you brought it more out in the open whereas you keep things inside and when I was doing this, it more came to the fore… I was able to talk about it, and once you've spoke about it, it was like it was lifted from me. It was as if it's not inside bottled up.* (Interview B8:3).

The EMI therapy appears to have provided an opportunity for these individuals to start speaking about their traumatic experiences that they thought they had already worked through and were not aware that still affected them. After speaking about their experiences, they started to realise that they can move on from their past which is evident from the following statement made by participant 6 (Interview B5:3-5)

…I could put down a lot of stuff that I'd been carrying that I was not actually responsible for and was not going to probably happen to me anyway… I realise that I was carrying it and I didn't need to…

b. Refrain from avoiding the topic of the trauma

Two participants mentioned in their interviews that with EMI therapy, they became aware that they could not avoid the topic of the trauma like they do in their everyday lives. Kanel (2012:163) states that traumatised people often make use of coping mechanisms to help them deal with their symptoms of trauma. According to participant 5, she used to find it difficult to work through her trauma experience and reported that: '… because it was painful to approach it, I would make like I managed it… This really brought it out because it wouldn't disappear' (Interview B4:4).

Another participant indicated that: '…since the first interview until now, a lot of things have come up for me that I have forgotten about. Things that was buried and that' (Interview B5:1). Another participant shared that: '… things that I had already put to bed, but it actually made me realise this. It was all still very much… I was still very much aware of it all…' (Interview B6:4). For these participants, EMI has allowed a process whereby they could finally address their issues and work towards finding solutions for them.

c. Realised that it is her own responsibility to work on things

The client should always be in control. Through EMI therapy, the client gains new perspectives (Beaulieu, 2012: 166), but ultimately, it is up to them how they use these to move forward with their life (Beaulieu, 2012: 306). Participant 9 demonstrates insight by explaining that she started to realise that it is her responsibility to start working on the problem to bring about positive change by saying that: 'I think a couple of things that I definitely still have to work on. But it brought it out to me and now it's up to… me… to actually go and do something…' (Interview B8:5).

d. Awareness that there is still emotional work to be done

> *…there were other issues surrounding that which were also quite… unnerving… at the time…I felt in order to close that whole chapter, we could have dealt with that and she said it would have had to be a separate issue.* (Interview B2:1).

The above statement is a clear indication that participant 3 became aware of other emotional aspects that still need addressing in addition to the problem attended to during EMI therapy. Beaulieu (2012: 183) refers to the importance of only focusing on one distressing memory at a time by starting with the first or the most intense memory that causes the highest emotional charge. More sessions on the other remaining issues should rather be arranged than to try and solve all the disturbing issues at once because it can be too intense and exhausting for both the client and therapist with the result that it is less effective.

e. There are still feelings of anger or sadness at aspects relating to the loss

Another important aspect to mention is that despite receiving therapy, other issues surrounding the problem may still need attention. Participant 8 indicated that she became aware that she still feels angry at aspects of her loss as a result of her traumatic experience which she identified as the Knysna fires when she lost her house along with all her valuable belongings.

> *With all this hype with the fires the last couple of days, it's been fine. I'm not saying I don't miss things. I still get pissed off when I think of something I've had. Records are going for R600. I had 550 records…Now. I realised a lot of things. And what I was missing most was space* (Interview B7:7).

Cook et al. (2017: 529) advise that although there is an overall improvement in older people's symptoms of trauma after receiving psychotherapy, few indicated complete recovery. It is essential to understand that the purpose of EMI is not to numb feelings relating to the traumatic incident. Beaulieu (2012: 63) indicates that certain feelings related to the incident may remain and diminish with time after the integration of the traumatic memory. Nevertheless, from this new perspective, the client should have more insight into the issue and able to make peace with the past more easily. This seems to have been the case for both participant 8 and 10, who indicated a positive

outcome after receiving EMI therapy. Both realised that certain aspects surrounding the problem that still caused them to feel emotional, and these could lead to resolute decisions surrounding their current circumstances.

Participant 10 indicated that there are times when he still experiences feelings of sadness which makes him want to cry, but he cannot. He stated that:

> *…then the other day I was thinking well I suppose; you are really sad… you want to burst into tears, but you can't. Then your whole body does get, so perhaps that's the kind of thing she was expecting me to feel in my body…* (Interview B9:4).

Even though both participants indicated a positive outcome after EMI therapy, they realised that certain aspects surrounding the problem still make them feel emotional.

f. Therapy is sometimes necessary

When it comes to mental health in general, many people are reluctant to seek professional help for themselves. Instead, they start to pursue different coping mechanisms (Kanel, 2012: 163). Sometimes people do not realise how much they need help until they receive it and experience its impact. This aspect is evident from what participant 7 shared:

> … *it also made me realise if I ever went through some big trauma again, I think I would instead of saying I don't need to go for therapy, I would look to go for therapy cause it definitely sometimes is necessary* (Interview B6:6-7).

Kaiser et al. (2016: 392) add that stigma may prevent people from seeking help, causing an increase in their stress levels. Brandell (2011:4 30) believes that a lack of support can cause them feeling helpless and depressed.

g. An awareness that other issues can cloud the initial trauma

The awareness that other issues can cloud the initial trauma is significant. Participant 3 reported that it was difficult for her to focus her attention on the identified trauma because she could not separate the identified problem from another more recent incident.

Under normal conditions, Van der Kolk (2014: 45-46) explains that a threat causes a temporary increase in stress hormones that quickly return to normal when the threat is over. However, a slightly stressful situation can cause a traumatised person's stress hormones to increase rapidly and unreasonably high. One participant shared that:

> *… what clouded the issue was that… I had a huge emotional upset with a very close friend the day before my last treatment with her which then would have clouded the whole issue… that really kind of rocked my world a little bit. So, it was quite difficult to be separating the one issue with the one that we worked, tried to work with* (Interview B2:7).

Therefore, traumatised people might find it easier to focus on more current issues presenting as stressful situations, instead of concentrating on resolving their troubling memories from the past.

h. Realised that there were also positive aspects as a result of the trauma

The realisation that positive aspects could emerge as a result of the trauma also appeared important in terms of how older people view EMI therapy with regards to facilitating the processing of their symptoms of trauma. Participant 7 recognised that EMI therapy highlighted some positive aspects that arose from the trauma and that there might be some positive sides after the experience indicating that:

> *… I hadn't realised how much good it would actually do me, because I thought this event was in the past and that I had dealt with it. But it actually made me realise how good it was to, to talk about it in quite a lot of detail and eventually realised that I now have peace with it all and that there were some positives in the end* (Interview B6:2).

Interestingly, research by Rutten et al. (2013: 12) on resilience in terms of the Life Course Theory indicates a strong relationship between positivity and improved future recovery from symptoms of trauma. The authors suggest that consciously focusing on positive aspects during daily life can enhance and attract positive energy and emotions. In turn, this predicts a more lasting effect on how older people recover from previous traumatic events. This may be the case for participant 7, who indicated that her traumatic experience did not negatively affect any of her interpersonal

relationships (Table 6) in terms of her spouse, children or friends. It may also possibly suggest a healthy support system lead her to be more resilient.

4.2.3.2.7 Subtheme 7: Some participants experienced no real change in their physical symptoms

It is apparent from the analysis of the data that most experienced a positive change in their physical symptoms, but not all of the participants. It is, however, essential to consider that physical symptoms can easily be regarded as being part of the ageing process and is evident in what one of the participants have shared: '… I just thought of it as part of getting old… get stiff and get a bit crochety… As I said I've put it down as just being old' (Interview B4:3;12). Hiskey and McPherson (2013:589) allude to the fact that physical symptoms are often medically unexplained or regarded as signs of general distress or overlooked and regarded as part of the ageing process.

According to the analysis, participants 1 and 10 have reported no real change in their physical symptoms. For participant 1, the pre- and post-scores in terms of her physical symptoms, according to Table 5, indicate that she had not had any physical symptoms either before or after the treatment. This may be the reason she did not experience any real changes in her physical wellbeing after the treatment. Conversely, participant 1 also mentioned that older people are better able to cope with trauma by stating that: '…I do think that maybe older people are better at handling certain traumas because they've had more experience, life experience than perhaps a youngster…' (Interview A1:2). A second individual (participant 10) indicated no real change in his physical symptoms in his interview and talked about how he wants to cry but cannot. According to this participant's pre-and post-inventories, there were no changes recorded to his physical symptoms.

Apart from these two, one other participant was uncertain whether she noticed any changes in her physical symptoms. Wahlström et al. (2013: 1-2) and Hiskey and McPherson (2013: 589) suggest that thoughts and strong emotions relating to the trauma may subside as time goes by. Years later, older people with physical symptoms of trauma may not be able to link their previous exposure to different types of trauma to their presenting physical symptoms. Therefore, they are unable to explain possible causes of their physical symptoms to health professionals.

Participant 7 stated that: ‘I don’t think it really affected my physical wellbeing… It was more just… there was a feeling of sadness and that will always be there…’ (Interview B6:5). However, Table 5 does indicate a sense of relief in terms of the physical symptoms for the same participant. The scores on participant 7’s pre- and post-inventories denote a sense of relief in the intensity of her physical symptoms that dropped from a rating of 3 prior to EMI to a 1 on a scale from 1-10 where 1 means ‘not at all’ and 10 means the ‘worst imaginable’. Having experienced physical symptoms only ‘every now and then’ compared to having no physical symptoms at all after EMI might understandably create some doubt about whether the physical symptoms will return and if this relates to the identified traumatic experience.

Beaulieu (2012: 72) advises that the therapist may occasionally come across traumatised clients who experience their EMI session as uninteresting. Despite gaining a new perspective from the added information revealed through the integration process, the client may not experience any notable physical or emotional release and reports not having any conscious discomfort. However, subconsciously successful integration of the traumatic memory still occurs, which can be seen by a decrease in these participant’s symptoms of trauma from their post-inventories (refer to Table 5). This seems to possibly have been the case for participant 1, as revealed in her interview indicating that:

> *…I didn’t find the therapy, you know the actual technique, except that it has released some of those images but otherwise I didn’t, it didn’t make me sad or angry or sore or tired. I actually felt tired the next day after our last session, but you know that could have been 100 things* (Interview A1:2).

The fact that one participant reported a worsening in her physical symptoms after receiving EMI therapy should not be overlooked. The pre- and post-inventories of participant 2 shows an increase in physical symptoms. Participant 2 stated the following:

> *… asking me if I had nightmares and physical symptoms… Obviously I’ve worked through a lot over the years. Coz I can remember, I mean I had a stiff neck the other day and I can remember having terribly stiff necks and headaches and things and that was all to do with the tension at the time.*

And I've learnt to handle that… So, maybe in my case I've learnt how to do it (Interview B1:5).

To clarify, the same participant was asked in her interview whether EMI therapy had any negative effect on her physical being. She indicated that EMI has not caused any negative effects, neither physically nor emotionally, yet in her reflection on symptoms and in her inventories, there was a slight deterioration. To address this issue, the researcher recommended ongoing therapy to this participant at a local NPO that works with older adults.

From the above, the conclusion is that older people seem to benefit from EMI therapy, as most participants reported an improvement in their physical and emotional wellbeing. Furthermore, the therapy allowed for a new or different perspective on their trauma. A discussion on the last theme, which is probably also the most important, is considered in the next section.

4.2.3.3 Theme 3: Suggestions for further use of EMI therapy with older people

The third and final theme covers suggestions for further use of EMI therapy with older people. This idea emerged from the data after participants reported on possible suggestions relating to adjustments/improvements in terms of aspects that may result in a more beneficial experience to integrate their trauma experience.

The subthemes identified and included into the discussion are as follows:

- EMI is not complete in itself and should be part of a post-traumatic stress management package;
- The timeframe between the trauma and therapy has an important role in the outcome of the technique;
- EMI does not always reflect obvious benefits;
- Proper orientation to the technique can be helpful; and
- Use neutral tools to assist focus and the therapist to take the lead in assisting the client to choose the right trauma.

Further exploration of the identified subthemes follows.

4.2.3.3.1 Subtheme 1: EMI is not complete in itself and should be part of a post-traumatic stress management package

Sadock et al. (2015: 1350-1351) states that psychotherapy helps to improve older people's physical and mental symptoms. Cook et al. (2017: 529) agrees but adds that it does not guarantee a complete recovery from their symptoms of trauma. A valid point raised by one of the participants is that EMI therapy is not complete in itself and suggested integrating it with another type of therapy like traditional counselling. Beaulieu (2012: 65) explains that EMI therapy is not a 'cure-all' therapy that replaces all other therapies because there are aspects of human relations that cannot be changed by EMI. Beaulieu (2012: 292) then continues by stating that EMI helps the client integrate traumatic memories but does not result in a sudden change in behaviour that has been customary for an extended period.

In her assessment session, participant 5 reported that before receiving EMI therapy, she started to develop destructive behaviour after the traumatic experience (Appendix I). The EMI therapy enabled the participant to make the connection between her past and the present. However, her experience with EMI therapy did not help her to deal with the core issue of her trauma. The possibility of dissociation should also be considered, and Malmo and Laidlaw (2010: 24) refer to this as a memory disturbance after exposure to extreme trauma. Struwig and Van Breda (2012: 31) state that in this way a person detaches from their perception of time and reality and is a survival mechanism that may with time become a habit and progress into a maladaptive or pathological process (Malmo & Laidlaw, 2010: 24).

For participant 5, the following suggestions for other types of therapies besides psychotherapy may be beneficial: Memory questionnaires (Boals et al., 2012: 158), narrative therapy as well as CBT (Böttche et al., 2012: 231) prove to be effective in treating symptoms of trauma in older adults and equally successful in treating older people's symptoms if used in conjunction with EMI therapy.

It was further proposed by this participant that EMI therapy should be practised in conjunction with a team of people, particularly when dealing with PTSD. Another participant also saw the potential and agreed that EMI has a place in dealing with PTSD by stating that: '… it's a technique that I would refer a lot of people to, to use. Especially with Post-Traumatic Stress Disorder' (Interview B3:5).

The suggestion was made by participant 5, that the client can, for example, start by attending a few counselling sessions with a psychologist or clinical social worker to help them create awareness around their thought processes and emotions associated with those feelings. After these sessions, the individual can then go for EMI therapy with another health professional like a social worker. She further indicated that if it were to be the other way around, the client could be overwhelmed because they have not thought carefully about the process and explained it as follows:

> *… with the repetitiveness, you're repeating, but you're not... actually dealing with it… you do go home and do that but it's a self-realisation and unless you're good at looking at yourself you're going to sit back. That's how I would see it. You would slide back, uhm its purely because I felt that was an area that I needed to work on…* (Interview B4:5-6).

All the participants have received a limited number of EMI sessions before consenting to participate in an interview. Due to the short-term nature of the treatment, sometimes only one session, EMI can be viewed as not complete on its own but shows significant benefits.

4.2.3.3.2 Subtheme 2: Timeframe between trauma and therapy has an important role in the outcome of the technique

The time between the traumatic experience and receiving therapy may be a significant factor to consider concerning the outcome of the treatment. Both Turner and Lloyd (1995: 2) and Dulin and Passmore (2010: 296) refer to the link between cumulative exposure to traumatic events and psychological distress. According to Hiskey et al. (2008: 494-497), traumatic memories from the past can still be relived in the sensory modalities in later years, causing unnecessary distress to older people. Two participants specifically referred to the timeframe between when the trauma occurred and when therapy was received and how it influenced the outcome for them.

Participant 3 recommended that possibly for EMI to be more effective, the trauma to be investigated should be recent rather than something that happened a long time ago. She then talked about how she dealt with her feelings over the years and stated

that her memories are not that vivid anymore because the incident happened years ago. She communicated the following:

> *I'm looking at 50 years back. 51 years and so much has happened in that time. I don't think that the memories are quite as sharp… the things that upset me probably don't upset me quite as much anymore. Its more distant. Its more detached. So, there has definitely been, work done* (Interview B2:1). She then continued saying that: *I have made peace with a lot of it over the years, but maybe not those trigger words that she wrote down…* (Interview B2:7).

In contrast, another participant advised that there is too much going on in the aftermath of the trauma. Therefore, participant 5 suggested that the victim should not go for EMI therapy immediately stating that it would be best if the victim first took time to come to terms with the experience before receiving EMI. Beaulieu (2012: 295) maintains that after exposure to trauma, coping mechanisms may be utilised to help avoid distress. The more time that passes, the more likely the avoidance behaviour is to become habitual behaviour. However, it is advised that EMI should also not be undertaken directly after the traumatic event because the brain has a natural capacity to heal by itself. Instead, it may be best to start EMI at least a month after the trauma (Beaulieu, 2012: 126-127).

4.2.3.3.3 Subtheme 3: EMI does not always show clear benefits

From the experiences shared by two participants, it became apparent that EMI does not always show clear benefits. The following four points raised that can act as indicators to support this subtheme that has emerged. Firstly, participant 1 shared that older people need memory triggers to help them remember. According to Myers (2008: 125) and Stuart-Hamilton (2011: 33-35), the entire human organism gradually declines with age, including the functioning of the regions of our brain as well as physical changes like changes in the frontal lobes and hippocampus (Bouchard & Villeda, 2015: 9). This transformation causes a decline in the effectiveness of learning and memory tasks in older people as they age, which influences their functioning and overall emotional wellbeing (Stuart-Hamilton, 2011: 128-129).

Furthermore, participant 1 also indicated that not being able to remember things might be a normal reaction and part of the ageing process where memory deteriorates with age and further indicated that: '… it's quite a good thing in a way with something like this' (Interview A1:3). This may suggest that the participant feels that EMI therapy triggers traumatic memory that is beneficial, assisting in starting to work through the issue. However, she might not necessarily want this because she tries to avoid the presenting problem in her life. Böttche et al. (2012: 231) indicate that avoidance behaviours as coping strategies are common in old age.

The second point raised is that the need for a debriefing of trauma is a relative concept. Participants 1 and 2 indicated that older people cope better because of their life experience, and both shared that older people naturally have more aches and pains. According to Ogle et al. (2014: 2), cumulative exposure to trauma over the life span can fast-track a decline in physical health and mobility. Participant 1 indicated that:

> *… Its life experience and the more life experience you have I think… obviously the better you can cope with things. And also, the older you are the more ailments you have… if we get out of bed without aches and pains, we check our pulse* (Interview A1:4).

Participant 2 continued by saying that:

> *… I mean at my age, I've got aches and pains and I realise, it happens! Whether you're fit or not… it hasn't gone any better since I started going to her… I sort of peek out of bed and then once I get going then everything is fine* (Interview B1:6).

Thirdly, participant 1 is of the opinion that anybody who listens to you is useful by saying that: 'I think anybody listening to you compassionately is beneficial…' (Interview A1:4). And finally, she continued saying that survivors of the same trauma can support each other and shared that:

> *… still get together with people who have lost their homes and talk about those things that you lost and share…. you've got to be careful… of who you talk to because… a non-fire victim will sort of say… get over it already. But its lovely to have friends who are in the same boat and that you can remember exactly how you felt* (Interview A1:6).

The participant appears to have close relationships with a group of people who went through the same traumatic incident as she did and seems to find it helpful to share her experience with those people with whom she has this in common. Rutten et al. (2013: 14) indicate that close interpersonal relationships and support systems help people to get through difficult times more easily.

4.2.3.3.4 Subtheme 4: Proper orientation to the technique can be helpful

The researcher, who was the therapist, explained the protocol of the eye movement at the end of each assessment session, on concluding that EMI is suitable for the client before starting therapy. To help explain how EMI helps to integrate traumatic memories, the therapist prefers to make use of the analogy called number '3' into number '8' as previously explained in the second chapter of this study (Beaulieu, 2012: 166). However, four participants felt that they did not fully understand the technique and suggested that proper orientation to the therapy is necessary when using EMI therapy to assist older people.

Beaulieu (2012: 164) highlights the importance of correctly explaining the technique to the client as part of the preparation. Beaulieu also suggests repeating some of the information that is part of the explanation. Not only will it help to ensure that the client has a complete understanding of the process, but they will also feel more comfortable and be more fully engaged.

Being unsure of the significance of the eye movements was an aspect suggesting that they did not fully understand the protocol even though it was explained to them. Participant 2 shared her experience by saying that: '… explained it to a point for me… having to look at that pencil and… why I had to do it… and I didn't fully understand it' (Interview B1:1).

Moreover, another significant point raised was that it became apparent from two of the participants' interviews that they seemed to have expected the therapist to read something from their eye movements. One individual said: '... I thought she was reading something by my eye movements...' (Interview B9:4). He then continued by stating that: '... I was expecting her to be looking into my eye movement… and reading something… so maybe I'm misinterpreted that first part that she explained. The brain

and how it works' (Interview B9:9-10). Another participant shared similar thoughts indicating that: 'I didn't fully understand it, obviously she looks at your eyes and you want to know more about it...' (Interview B1:1).

Despite the uncertainty, they seem to have become comfortable with the protocol and started to trust the natural unfolding of their process.

Participant 3 shared that: '… watching the pencil move in different sort of directions and patterns, I didn't quite understand the significance of that. But I could actually feel within me that certain things were being raised' (Interview B2:1).

Participant 9 indicated that:

> *… she put it across very well, and she was very organised, and I thought it was quite beneficial to me… I wasn't sure what it was all going to be about, but once she started, I could see what she was trying to get to* (Interview B8:1).

Participant 10 shared that: '…I don't quite understand the eye movement aspect of it, but the whole procedure, I enjoyed it and I think it helped me in certain acceptance of certain things' (Interview B9:1).

It was suggested that a more in-depth explanation be provided concerning how the EMI works to help solve the problem of being unsure of the significance of the eye movements. This refers to what happens in the brain during and after the EMI protocol, specifically focusing on the relevance of the eye movements as opposed to only explaining how the sensory modalities store trauma. Also, participant 2 suggested that the client receive reading material, for example, an article to read after the assessment and before starting therapy to gather more information about how it works.

4.2.3.3.5 Subtheme 5: Use neutral tools to assist to focus

According to Van der Spuy (2014: 40), the therapist should carefully consider the tool utilised in EMI therapy to assist the client in following guided eye movements. Beaulieu (2012: 252) suggests using two fingers or a marker pen, while Van der Spuy (2014: 40) has found finger puppets to be more useful in her study with children because they

can more easily relate to them. In the sessions with all ten participants, the therapist utilised a specific pen with a face on the tip of the pen to assist them in following the eye movements.

During the assessment session, each client is asked if they are comfortable and whether they would like to proceed with the specific pen assisting them to follow the different movements. The data indicates that only one of the participants experienced the focus instrument, in this case, a pen with a face on it, as something that was not neutral and mentioned that she felt that it was a pen that belongs to a child. Participant 3 recommended that: '… the tool she uses should change. It should be something a little bit more serious or stylish or don't know what' (Interview B2:9). Others were comfortable with the tool.

4.2.3.3.6 Subtheme 6: Therapist to take the lead in assisting the victim to choose the right trauma

One participant indicated that she felt that she did not work on the main problem during her EMI therapy and would have liked the therapist to help her identify the underlying issue that needed to be addressed. Participant 5 shared her experience as follows:

> *There's never ever just one thing. It's usually a series of events or something that's happened that then has led to this, this or this… a really bad thing for me was I was so mad with God. Not because my son had killed himself but because my youngest son found him… And that was far more traumatic… because he was alive and still living and we had to deal with those issues and probably will still be dealing with those issues. Whereas now for somebody else who's listening to it thinks ah it's terrible your son died. I'm focused more on this happened and this shouldn't have happened. As opposed to yes this, this was terrible and it was awful, but it leaves a whole and always leaves a scar tissue… but for me perhaps the issue was not so much the death as it was perhaps it was the, the actual anger about what happened after that (Interview B4:8).*

During the assessment session, each client has the opportunity to identify a troubling memory and decide which traumatic incident they would like to work through. If the

client experienced many traumatic events in his or her life, it is essential to start with the first or worst traumatic event. In the case of one traumatic incident with a memory of many distinct images or fragments, the clinician assists the client to identify the most intense image with the highest emotional charge (Beaulieu, 2012: 183). After the client identifies a troubling memory, the next step is to describe how they remember it. The client describes it in his or her own words from their perspective as they recall the traumatic event (Beaulieu, 2012: 210). From this description, the client then selects verbal cues (i.e., keywords or phrases) to assist them in remaining focused on the incident. The verbal cues must capture the troubling memory and remind the client of the traumatic incident (Struwig & Van Breda, 2012: 31). Some traumas are multi-layered as is the case for the participant above with multiple repercussions for the family.

Participant 5 continues by saying that:

> *… yes, we have a choice to pick on certain things like what are your key factors what are your key words and that. I do think there should be a suggestion from the person who's doing the assessment…. Because they can pick up things that, you can see where there's a problem* (Interview B4:10).

Beaulieu (2012: 63) explains that traumatised people experience different processes in recovering from and overcoming adversity. For some, recovery occurs more naturally than for others. Exposure to more than one trauma may result in experiencing shared emotions for both traumas. Often clients cannot realise the connection between the two traumas based on the facts. The therapist may become aware of some of the distressing thoughts and behaviours that the client experiences while some aspects remain hidden. Therefore, both the therapist and the client may find it challenging to connect the dots after one single EMI session since the focus is on only one specific troubling memory. Essentially, having worked through the first trauma, a strong emotional charge may remain concerning the residual unintegrated traumatic experiences. It is best to work towards addressing and integrating one disturbing memory at a time, suggesting that more than one treatment session may be necessary for multiple traumatic experiences. In this way, the link between the shared emotions and needs of the client should start to be revealed naturally as the process unfolds.

Furthermore, successful integration of the first traumatic memory should lead the client to pursue further help for the remaining problems (Beaulieu, 2012: 206). This seems to have been the case for the participant 5, who decided to pursue further counselling at her church after receiving EMI therapy.

From the above, it can be concluded that there is a place for EMI therapy when treating symptoms of trauma in older people if the necessary adjustments are made to better address the trauma for individuals in this age group. These suggestions made by the participants are of great value to improve EMI as a treatment intervention when working with older people and should be taken into account.

4.3 SUMMARY

Raw data collected throughout the study is used for this chapter and findings produced from the researcher's analysis, discussions and interpretation. It contributes to achieving the purpose of the research by using the data collected from semi-structured one-on-one interviews and the participants' pre- and post-inventories from the sessions as a qualitative document analysis (Strydom & Delport, 2011: 380). This approach enabled the researcher to address and achieve the two aims of the study. First, to determine how older people process their symptoms of trauma through EMI therapy and explore the views of this group on the usefulness of EMI therapy in more detail. Triangulation was achieved by using qualitative interviews in addition to the documentary evidence contributing to cross verification and adding to the validity (Strydom & Delport, 2011: 377), as well as increase the reliability of the study (Mohd Noor, 2008: 1604; Strydom & Delport, 2011: 377).

The results from the data assist in determining whether EMI therapy is a cost-effective tool for older people's symptoms of trauma. Based on the findings, it appears that older people experience EMI therapy as a treatment intervention that is beneficial to them in terms of integrating their traumatic memories and reducing their symptoms. In conclusion, the necessary recommendations for further research studies are in terms of further expansion of EMI therapy as a treatment intervention for treating older people's symptoms of trauma and discussed in the final chapter.

Chapter 5: Conclusions and Recommendations

5.1 INTRODUCTION

For the purposes of this study, the researcher provided the reader with a review of the available literature relevant to the research topic. After that, an empirical study was conducted. Data were collected using the documents available, in this case, the available pre-and post-inventories from the EMI sessions, using a qualitative research paradigm, and conducting semi-structured one-on-one interviews. The researcher determined older people's experience of EMI therapy as a treatment modality for their symptoms of trauma and their view on how EMI therapy facilitates the processing of their symptoms. Based on the literature, and findings from the empirical investigation, the researcher made conclusions from the research and discusses these here. Furthermore, the limitations of the study were deliberated. Finally, based on the conclusions, the necessary recommendations are provided for future use of EMI therapy in terms of social work practice, training and future research.

5.2 INTEGRATION OF THE AIM AND OBJECTIVES

The aim of a study, according to Fouché and De Vos (2011: 94), is the initial reason for conducting the study. Firstly, this study aimed to determine and describe older people's experience of EMI therapy as a treatment modality for their symptoms of trauma. A further aim was to determine the views of older people on how EMI therapy facilitates the processing of their symptoms. Therefore, the primary research questions that the study sought to answer are: 'How do older people experience EMI therapy as a treatment modality for their symptoms of trauma?' and 'What are the views of older people on how EMI therapy facilitates the processing of their symptoms of trauma?'

Secondly, the objectives of the study are the steps taken towards achieving the overall aim of the research (Fouché & De Vos, 2011: 94). The identified objectives were similar to the research aims. The first objective was to explore and describe how older people experience EMI therapy as a treatment modality. The second objective was to explore and describe older people's views on how EMI facilitates the processing of their symptoms of trauma. The third was to determine whether EMI therapy can be

used as a cost-effective tool for these symptoms. Therefore, the first two objectives of the study were reached through using the findings of the study gained from the pre- and post-inventories, as well as the semi-structured one-on-one interviews. This combination of data-collection methods led to the cross-verification of data and triangulation (Strydom & Delport, 2011: 377). The third and final objective is achieved based on the conclusions drawn and accordingly, discussed in section 5.3.3.

The following discussion concerns the conclusions formulated based on the literature review and findings from the study with the specific focus on achieving all three of these objectives to assist in answering the research question and ultimately, accomplishing the overall aim of the research. In the discussion, the researcher will make use of a combination of words and numbers despite this being qualitative research. Maxwell (2010: 476-477) contends that there is value in using numbers even in purely quantitative research. He argues that quantitative claims are often locked in verbal expressions and numbers assist in making these claims like ‘many, often and typically’ more precise.

5.3 MAIN CONCLUSIONS

The following main conclusions were drawn based on the three identified objectives.

5.3.1 OBJECTIVE 1: TO EXPLORE AND DESCRIBE HOW OLDER PEOPLE EXPERIENCE EMI THERAPY AS A TREATMENT MODALITY

Typically, older people are more likely to have experienced some trauma during their lives (Olofsson, 2014: 10-13). The researcher’s first objective was to investigate older people’s experience of EMI therapy in greater detail and ascertain whether it was a useful intervention for treating their trauma. The researcher established four comprehensive descriptions that captured the view of ten participants concerning their experience of EMI therapy. The following primary conclusions related to older people’s experience:

Older people were unfamiliar with EMI treatment because almost all participants found it to be a new and different experience compared to previous therapeutic interventions

or expectations. The findings correlate with the fact that the researcher could not find any previously documented research on the use of EMI therapy on older people. Böttche et al. (2012: 231) reports a lack of empirical evidence, knowledge and treatment concerning older adults. Half of the participants indicated that they were not familiar with any therapeutic interventions and, therefore, had nothing with which to compare it. This is not an unusual phenomenon. Hiskey and McPherson (2013: 695) advise that avoidance in seeking help is common in older people. Kaiser et al. (2016: 392) emphasises the role of stigma in seeking help. According to Life Course Theory, future decisions are influenced by an individual's life history (Elder Jr. et al., 2003:4).

The findings further suggest that they enjoyed the experience of EMI therapy as a treatment modality and predominantly viewed it as being beneficial for them. Some indicated this by stating that EMI exceeded their expectations; they did not feel forced to talk about their traumatic experience and did not find it hard to express themselves. The therapy was relaxing and provided an emotional release that some participants have not experienced before therapy.

A key factor influencing the participants' experience was the repetitiveness of the technique. Some felt bored and viewed this part of the experience as less enjoyable even though they benefitted from the therapy. On the other hand, the repetition of the eye movements as part of the protocol appears to have contributed to the therapeutic process because others considered that it helped them to focus and concentrate, and so, they viewed it positively. A few participants found that EMI therapy was an intervention that made them feel extremely tired later, which is a normal reaction, according to Beaulieu (2012: 63).

It is deduced from the findings that EMI therapy was generally considered by older people to be a positive and beneficial experience, even though they were initially unfamiliar with the treatment intervention.

5.3.2 OBJECTIVE 2: TO EXPLORE AND DESCRIBE OLDER PEOPLE'S VIEWS ON HOW EMI FACILITATES THE PROCESSING OF THEIR SYMPTOMS OF TRAUMA

Older persons cannot be classified as one group because their life experiences are so varied (Dunn & Craig, 2013: 447), specifically their health, emotional wellbeing, finances and social interactions (Dannefer & Sell, 1988: 5). The second objective enabled the researcher to have a better understanding of the perceptions of older people about the usefulness of EMI and whether it helps to process their symptoms of trauma. Here, the inventories have contributed to cross-verification by confirming the findings from the one-on-one interviews. Three key conclusions were drawn from the findings under the second objective.

5.3.2.1 Firstly, EMI therapy is effective in reducing older people's symptoms of trauma

The findings suggest that to some extent, previous trauma affects older people's current physical and or mental health. It became apparent that awareness started to develop for most participants regarding pains and symptoms as a result of their traumatic experience. These findings confirm the impact of social and historical conditions and change concerning ageing and development (Benson & Kerley, 2001: 3) and the connection between early childhood developmental, traumatic experiences and physical and emotional health status in later life (Ogle et al., 2014: 2). Papanikolopoulos & Prattos-Spongalides (2017: 1) emphasise that everyone, including older people, should be able to deal with and overcome their traumatic experiences. According to the findings, an overall reduction can be seen across all manifestations of trauma on average for these participants. The data obtained from the interviews supported the results from the pre-and post-inventories.

Physical:

The findings suggest that two participants did not notice any difference in their physical symptoms after receiving EMI, and one of them reported never having any physical symptoms initially. The scores from the inventories of one other participant indicated a worsening of her physical symptoms after EMI. Despite this, she reported in her

interview that she did not experience EMI to have any negative impact on her health or wellbeing. Her physical symptoms may have been accepted as something that comes naturally with ageing, as is often the case with people in this age group (Hiskey & McPherson, 2013: 589). According to Benson & Kerley (2001: 3), ageing and developmental change are both an ongoing process that occurs throughout life and may be seen in this context. Furthermore, seven participants experienced relief in the intensity of their physical symptoms. Another important finding is that there was an overall improvement (50%) measured in the physical symptoms experienced by all ten participants.

Emotional:

Two participants experienced a real emotional release across all nine manifestations of trauma noted on their pre- and post-inventories. Also, it was evident that the most significant overall improvements were a reduction in participants' levels of fear, followed by reduced feelings of sadness and a decline in their levels of anger. The least improvements evaluated across all the emotional manifestations of trauma related to avoidance behaviours. However, the data indicates a reduction in avoidance behaviours of more than the average of 50%. The difference in the scores measured, for instance, in fear, as a consequence of trauma compared to avoidance behaviour may suggest that older people do not perceive certain activities to be a strategy of avoidance behaviours or coping mechanisms for their symptoms. Therefore, they find it difficult to identify them as such. This view possibly confirms the statement made by Beaulieu (2012: 295) that as time passes, it is more likely that the avoidance behaviour will become routine.

Interpersonal:

The impact of the therapy on older people's interpersonal relationships is curious because of its importance in the life course (Hendricks, 2012: 229). Eye Movement Integration therapy leads to improved interpersonal relationships. The findings suggest that the most improvements in their relationships with their children, followed by better interactions with their friends and lastly, an improvement in their relationship with their spouse or partner. Therefore, EMI therapy can be regarded as an intervention that influences older people's thinking and perceptions leading to more positive relationships with their significant others.

Despite the various backgrounds of the participants and influences from their environments (Olofsson, 2014: 10-13), an important outcome of EMI therapy for older people is that it leads to a sense of relief in their physical distress related to their trauma, and they experience an emotional release as a result. In conclusion, early-life experiences do impact later health (Olofsson, 2014: 10-13). However, older people do have the capacity to overcome trauma with the necessary support and useful treatment intervention. Further conclusions are that EMI therapy is effective in reducing older people's symptoms of trauma (both physical and emotional) and leads to more positive interpersonal relationships.

5.3.2.2 Secondly, EMI therapy has allowed certain aspects to surface that contributed to the integration of their traumatic memories

According to the results, EMI enabled nearly all the participants to develop an awareness about specific important and relevant aspects that were not as clear or obvious to them before treatment and not previously considered. These participants indicated that EMI brought past experiences into the open, allowing them to reflect on their issues. During this process, new patterns of thinking emerged. It also became evident that EMI led to conscious decision-making and positive shifts in the views of at least 40% of participants concerning themselves, others and the world around them. According to Elder Jr. et al. (2003: 7-11), historical events and biographical context control the quality of how people live their life. However, a person's life course depends on the decisions they make within the given opportunities and limitations within societies. A new perspective on the problem through this therapy seems to have allowed them to move beyond their past.

To summarise, three important aspects emerged. Specifically, EMI therapy created an awareness, assisted in exploring older people's thoughts and enabled older people to look beyond the obvious. Dannefer and Sell (1988: 2) stated that older people are the most heterogenous group and these participants from different backgrounds, seem to concur in the view that EMI therapy allowed trauma that is stored in the unconscious mind to become conscious. This, in turn, facilitates a process enabling older people to integrate their traumatic memories and process their symptoms of trauma. Ultimately,

EMI therapy seems to improve older people's overall wellbeing. The conclusion, therefore, is that EMI is a useful therapeutic intervention for working with senior individuals to integrate their traumatic experience.

5.3.2.3 Thirdly, certain clinical matters arise from the study

In determining older people's experience of EMI therapy and its usefulness in terms of processing their symptoms of trauma, it was obvious from the findings that the outcome of EMI therapy was not as effective for some participants as it was for others. For some, the benefits of EMI therapy were not clear. There were also contributing issues influencing their overall experience of EMI therapy and its outcome. These are important factors to detail the necessary adjustments required for the intervention to be more effective in treating trauma in older people.

5.3.2.3.1 EMI therapy is not complete on its own, and the benefits are not always so clear

The conclusion is that limited EMI sessions may not be enough. Eye Movement Integration therapy is a short-term intervention strategy and may be incomplete on its own. For EMI to produce a more beneficial experience for treating trauma in older people, the findings draw on the suggestion by one participant that it should be used within a team of professional people dealing with PTSD and in conjunction with other types of traditional counselling. The argument by Cook et al. (2017: 529) stating that psychotherapy facilitates an overall improvement in older people's symptoms of trauma but does not necessarily guarantee complete recovery, remains valid. Some older individuals may find EMI therapy to be more beneficial if used in combination with another form of traditional counselling.

Hendricks (2012: 230) also suggests that a person's perception and reaction to traumatic events is influenced by their developmental and life stage. The difference in developmental phases of the participating individuals may account for the findings indicating that EMI does not always provide clear benefits for everyone. Arguments made by two others supported this theme.

The conclusion is that early childhood developmental traumatic experiences impact on older people's wellbeing (Ogle et al., 2014: 2). Although EMI therapy may be beneficial on its own, it is not considered to be the cure-all treatment intervention for every individual because different factors influence people in diverse ways. Also, the benefits of having someone to trust, talk to, and who actively listens and responds with compassion should not be underestimated.

5.3.2.3.2 Challenges experienced that affected the outcomes, leading to suggestions for future use of EMI therapy

The findings suggest that some older people encountered a few challenges relating to the implementation of EMI therapy. This led to suggestions for future use of EMI therapy within this age group.

Hendricks (2012: 230) proposes that people's thoughts about time are progressive, and reflect their health status, life experiences and personalities. The author continues stating that a person's developmental and life stage influences how people perceive and react to trauma. The findings suggest that the timeframe between the traumatic experience and therapy has an important role in the outcome of the technique and that this was one of the challenges experienced. Two different perspectives developed as one individual indicated that the traumatic incident should be relatively recent. In contrast, another participant suggested that EMI should preferably not be directly after the trauma occurred and be postponed to a later stage. For EMI therapy to be most effective in treating older people's trauma, it is assumed that the timeframe of therapy should be according to the preference of the client as with any other therapeutic intervention. However, the ideal timeframe between the traumatic incident and therapy recommended by Beaulieu (2012: 126-127) is more or less a month after the trauma occurred for the intervention to be most effective.

Another challenge was that a few participants did not fully understand the relevance of the eye movements in processing their trauma and, therefore, proper orientation to the technique is vital to the therapy. According to the findings, providing older people with reading material on EMI before they start engaging in the therapy sessions, is suggested as a helpful approach. Not only should an in-depth explanation be provided before EMI therapy, but the therapist should also provide older people with the

opportunity to communicate any misunderstandings and clarify them before starting EMI. It might be necessary to repeat some of the information that forms part of the explanation as advised by Beaulieu (2012: 164).

Some findings, although in the minority, are important to consider. One participant did not feel comfortable with the tool that the therapist used to assist the client in following the guided eye movements. The conclusion was that a neutral tool would be more useful in assisting some older individuals to focus. Lastly, one participant felt like she had not addressed the main problem related to her traumatic experience, because the one she identified is only one symptom and not the core problem. This result suggests that the therapist should take the lead in assisting the client to select the trauma to be considered as this may be more beneficial. If the client has experienced multiple traumas previously, it remains best to address only one problem at a time (Beaulieu, 2012:183), which should lead to an improvement in their wellbeing.

The main conclusions drawn from the second objective are as follows: EMI therapy assists in processing older people's symptoms of trauma because it leads to a reduction in their physical and emotional symptoms and improved interpersonal relationships. Therefore, EMI therapy is perceived by older people as a treatment intervention that facilitates positive change by accessing their traumatic memories and changing their perspectives on the problem (Beaulieu, 2012: 13-14; 213). This process allows them to integrate their traumatic memories and process their symptoms while at the same time gaining insight into the situation. This results in making positive decisions concerning their future.

To treat trauma is complex, especially a trauma that happened many years ago. The outcomes of EMI will not be the same for everyone, and other types of therapeutic interventions may be required in addition to EMI therapy when working with older people. Various challenges will always arise in any form of therapy; therefore, it is advised that the EMI practitioner receives proper training and regular supervision. In addition, support systems are essential, especially in later life. Rutten et al. (2013: 14) indicate that close interpersonal relationships and support systems help people to get through challenging times with less difficulty. With the necessary support systems, positive outcomes may be more feasible.

5.3.3 OBJECTIVE 3: TO DETERMINE WHETHER EMI THERAPY CAN BE USED AS A COST-EFFECTIVE TOOL FOR TREATING OLDER PEOPLE'S SYMPTOMS OF TRAUMA

It is important to discover, develop and consider treatment interventions that are suitable for treating trauma in older people. There has been a drastic increase in life expectancy during the past few decades (Henslin, 2007: 363; Stuart-Hamilton, 2011: 14-18) and a significant increase in the number of hospital admissions relating to traumatised older people (Gallaher et al. 2016: 2655). Therefore, the final objective of this research attempts to determine whether EMI can be used as a cost-effective tool for treating older people's symptoms of trauma.

South Africa is described as a developing country (O'Dowd, 2014). Therefore, this third objective is applicable, particularly in the context of South Africa, where resources are limited with low socioeconomic development. Treatment interventions that are cost-effective and utilise limited resources are essential and apply to treating trauma in people across all age groups. However, because of the significant increase in the older population, it would primarily be beneficial in working with people in this group, being in their senior years. In South Africa with its cultural richness and prevalent different socioeconomic classes, there is no previous research on the influence of culture and gender on the effectiveness of EMI therapy (Van der Spuy & Van Breda, 2019: 23). However, EMI therapy indicates that it can be beneficial for treating trauma in the older population, therefore, suggesting that South Africa may profit from this technique in terms of time, finances and efficacy.

Many people don't work through their traumatic experiences or seek help because they avoid talking about it. Other aspects such as stigma may also prevent them from seeking help (Kaiser et al., 2016: 392), embarrassment and inability to talk about disturbing emotions (Van der Kolk, 2014: 44-47). Furthermore, different therapeutic interventions work for different people. Older people may find EMI therapy easier because it is less embarrassing since it is not a talk therapy and should, therefore, translate well into South Africa's poorer communities.

Working with an older age group can be time consuming, and most EMI sessions for these participants took about two hours to complete instead of 60-90 minutes as

described by Beaulieu (2012). However, each participant had only limited EMI sessions before completing their post-inventories and participating in an interview, suggesting that EMI does not require many resources to show positive results. Undoubtedly, older people may benefit from other different therapeutic interventions as well, but only a few sessions of EMI therapy seem necessary to show the positive outcomes based on this study.

The establishment of mobile clinics may be viable in poorer communities where EMI therapy can be supplied to older people who are already a vulnerable age group in terms of their health and wellbeing (Dannefer, 2003: 329). Dealing with their traumatic memories can be valuable for older people, especially in terms of their health (Hatch (2005: 132). Kukuma et al. (2010: 120-122) discuss stigma relating to mental health in South Africa and how it can be overcome such as raising public awareness and using the media, among others. Raising awareness does not guarantee that older people will change their attitudes and behaviour. However, the authors mention the introduction of new ideas in the South African context that are culturally appropriate to help fight stigma and client testimonies are a highly efficient method of achieving this. Asking beneficiaries to provide testimonies after receiving EMI therapy as treatment intervention for their trauma symptoms anonymously can be effectively implemented into poorer communities.

The conclusion from the results of this study is that the benefits of EMI indicate that it could be more impactful in fewer amount of sessions compared to traditional therapy methods. Furthermore, it potentially leads to be a more cost-effective treatment intervention to address and treat trauma in older people. The researcher, therefore, agrees with Van der Spuy (2014: 63) who states that EMI therapy is ideal as a brief intervention method. In a country like South Africa where many older people may previously have been exposed to trauma during their lives, there are not enough social workers to cater for the demand. Setting up mobile clinics will only be possible if social workers receive proper training in EMI therapy, where they can reach more people in less time. Using EMI therapy, social workers should be able to attend to more clients from various backgrounds in less time with positive outcomes related to relieving their symptoms of trauma and contributing to healthier ageing communities. This suggests possible economic benefits for the South African context.

5.4 LIMITATIONS OF THE STUDY

The researcher considered the possible challenges that might occur throughout the study to ensure its validity (Maree, 2010: 42). However, unexpected limitations may also affect the results.

The researcher is passionate about research and practising EMI therapy. In this study, acting as both practitioner and researcher simultaneously were challenging. Subsequently, the researcher worked through the different emotions ranging from excitement to doubting her abilities while conducting this study. This issue led to the consideration that this could impact the research to a certain degree, even though the researcher made a conscious attempt to avoid any interference from her interest in EMI therapy.

Reflecting on the decision to utilise an independent and objective research assistant to conduct the qualitative interviews was beneficial to obtain objectivity. Having a personal interest in EMI therapy, the researcher was initially excited about the data collected from the interviews. However, by continuously listening to the interview recordings and reading through the interview transcripts, the researcher realised that she became more critical of herself as a trained EMI practitioner when learning about the aspects of the intervention that did not work for the participants based on their experience of EMI therapy. However, as the researcher continued to process the collected data, she became increasingly aware that her interest could affect the research perspective and needed to consider how to keep these separate.

An independent coder assisted by separately sorting and coding the data gathered from the interviews. The themes captured all the aspects that worked and did not work for participants relating to their experience of EMI therapy. Analysis of the captured data guided the researcher in realising that feedback of the technique is no reflection on the researcher in her professional capacity as EMI practitioner. Furthermore, learning about the aspects that did not work for the participants provides the opportunity for further research relating to EMI therapy and older people and creates personal growth opportunities. In the process of collecting the results, the researcher

felt reassured in her ability to conduct research and believes she become more knowledgeable as a researcher, EMI practitioner and individual.

Due to time limitations, the sample size was small, and the research based on a small-scale study. In qualitative studies, it is appropriate to allow the size of the sample to lead the nature of the study (Patton, 2002: 244), providing that the sample size answers the research question. The small sample did answer the research question and was appropriate. However, to increase the transferability of the study and address the limitations of a small sample size, Schurink et al. (2011: 420) advise that future researchers may consider using a larger sample size while at the same time referring to additional literature relating to the chosen theoretical lens when duplicating this study.

The researcher initially wanted to draw the entire sample from two or more old age homes where the participants were already recipients of EMI therapy. However, instead, participants who were already recipients of EMI therapy were recruited from a local NPO as well as private eligible individuals were invited to participate in the study because of the limited access to older people in old age homes who fit the selection criteria. In this way, the sample size was reached. Even though the EMI therapy and research were two separate processes, there is a possibility that the private individuals who already received EMI therapy felt obligated and consequently, agreed to participate in the interview. If this was the case for any one participant, it possibly influenced the answers provided in their interview. The researcher, however, tried to counter this effect by contracting a highly skilled independent interviewer.

The study by Peres, McFarlane and Moores (2008) emphasised that memories change over time, including the recall and description of the event. The authors stress that the recency of a traumatic event should be taken into consideration in therapy because the timeframe between the experience and treatment has a vital role in the outcome. Most participants in this study worked on a traumatic experience from many years ago, with only a few focusing on a more recent event. The impact of the timeframe since their traumatic experience until receiving EMI therapy on the results of their symptoms is unknown.

Furthermore, all participants received the same number of sessions and procedure. However, the two weeks between the EMI session and the follow-up session as

recommended by Beaulieu (2012: 288-289) made it difficult to exclude all other influential factors that might impact the outcome of the results in the follow-up and debriefing session. Olofsson (2014: 10-13) highlights the importance of the environment and its influence on future health. The role of medication is another important factor to consider, particularly with older adults who use non-prescription medicines more often than younger adults.

As with the study of Van der Spuy and Van Breda (2019: 23), this study did not measure the long-term change in the traumatic symptoms of participants. Therefore, the long-lasting effects of EMI are unknown.

Another consideration is that although EMI therapy is partially neurologically-based unlike most talk therapies (Struwig & Van Breda, 2012: 30), the in-depth clinical assessment conducted before an EMI session can start the process of clients addressing their trauma. In other words, the in-depth assessment session can already have some therapeutic value because they could have already begun to deal with their traumatic experiences by verbalising aspects of it. This indicates that some features of EMI therapy can serve as a technique like other therapeutic practices, because it is in combination with another form of traditional counselling.

Also, EMI therapy can be criticised in the same way as the study conducted by Rubin (2014: 9-10) concerning EMDR for its bilateral stimulation component. During the assessment session, keywords or phrases are identified by the client to remind them of their traumatic incident. These keywords or phrases are repeated to the client while they follow the guided eye movements throughout the EMI session. Repeatedly listening to a summary of their traumatic experience, thereby focusing on their distressing memory during the EMI session, has a significant role in the reduction of trauma symptoms without consideration of the bilateral component of the therapy. As with EMDR, it implies that EMI therapy can be regarded as a variant of exposure therapy (Rubin, 2014: 9-10) whereby there is a possibility that eye movements may be less significant than we thought.

By accomplishing the three research objectives, it provided the answer to the research question. The discussion on the limitations of the study provides greater insight into the implementation of the research and recommendations made based on the findings.

5.5 RECOMMENDATIONS

The following recommendations concerning practice and training, as well as future research are described in the next section in considering trauma in older people and the limited resources available such as time and financial constraints in Social Work.

5.5.1 RECOMMENDATIONS FOR PRACTICE AND TRAINING

Eye Movement Integration therapy proves to be effective in treating symptoms of trauma in children, but its usefulness for older people is a new area in research. Too often, symptoms of trauma in older people are overlooked by professionals (Hiskey & McPherson, 2013: 589). In reality, it should be equally as important for the older population as for children, especially with the predicted increase in life expectancy (Henslin, 2007: 363). As EMI proves to be a cost-effective and brief intervention method successful in resolving trauma in older adults, it is necessary to train more social workers in EMI because a single session may be adequate in treating trauma in older people. Proper training and supervision should equip social workers to develop appropriate trauma treatment interventions for working with older people and their symptoms in the South African context.

A proper clinical assessment before EMI therapy is vital to enable the clinician to establish the suitability of EMI for the individual client (Beaulieu, 2012: 164-176). Furthermore, it provides an opportunity to establish whether EMI should be utilised in conjunction with other types of therapies as part of the client's treatment plan. During the assessment phase, aspects such as the timeframe of the trauma, and the impact of the traumatic experience should be carefully considered. A proper measuring instrument such as a pre- and post-inventory assists in creating awareness and seems to have contributed to the positive shifts in older people's perceptions concerning their trauma. Using a measuring instrument, older people can get a sense of their progress.

It is recommended that the professional who conducts EMI therapy provides proper orientation to the client, including information on the working of the brain and the relevance of the eye movements in integrating their traumatic memories. To avoid any

distractions, the researcher recommends that the clinician makes use of a neutral tool when conducting EMI, for example, two fingers as recommended by Beaulieu (2012).

An openness to receive EMI therapy may be helpful, mainly when working with older people as they can be hesitant at first (Kaiser et al., 2016: 392). Also, for therapy to be a more beneficial experience, a therapeutic relationship is vital with an established rapport. In this way, older people may be more confident in communicating their concerns at any stage of the therapeutic process or relationship.

5.5.2 RECOMMENDATIONS FOR FUTURE RESEARCH

In conducting this study, the researcher found limited documented literature on EMI therapy and realised that the few available studies only focused on children to date. Also, there is limited research available on the effectiveness of other forms of psychotherapy or effective treatment interventions specifically focused on older people.

The results from this study indicate that EMI therapy is effective in reducing older people's symptoms of trauma and proves to be a useful treatment modality in helping older people to integrate their traumatic experiences. Other studies focusing on a form of psychotherapy called EMDR indicate that it is also effective in treating symptoms of trauma in children and adults (Lenferink et al., 2017: 1). Eye Movement Integration therapy depends on facilitated multisensory integration during the protocol, unlike EMDR (Beaulieu, 2012: 19). However, because EMI and EMDR therapy shares some similarities, it would be interesting to compare the usefulness of each in a study specifically focused on older people.

Even though the small sample size used in this study was adequate to answer the research question, future research studies on this subject might consider using a larger sample size. Furthermore, investigating the relationship between trauma experienced in different timeframes, for example, the effectiveness of EMI in treating symptoms of trauma in older people who experienced recent trauma versus trauma that occurred many years ago should be considered in further research.

According to Van der Spuy & Van Breda (2019: 23), it is recommended that an in-depth evaluative study of EMI therapy be done. In this regard, a comparison between a control group of older people versus an experimental group of older people receiving EMI therapy may increase the credibility of the study and help to determine the influential factors that might impact the results. This will ascertain the effectiveness of EMI therapy.

5.6 FINAL CONCLUSION

The older population is growing and will continue to grow (Henslin, 2007: 363; Stuart-Hamilton, 2011: 14-18). As a result, there is an increase in the demand for healthcare services (Gallaher et al., 2016: 2655) for this age group while facing the reality of limited resources in South Africa. With this in mind, older people are already a more vulnerable age group in terms of their health and wellbeing (Dannefer, 2003: 329). Exposure to any form of trauma can affect older people's wellbeing, including retirement that is considered to be a 'normal' life event. It is concluded that the impact of early-life experiences on older people's health and wellbeing should not be underestimated and regarded as symptoms that are just a result of growing old. Consequently, it is essential to prevent older people's symptoms of trauma from remaining untreated. By creating awareness around the impact of trauma on older people, communities, in general, should be more mindful of this vulnerable age group in terms of their health. Special attention should be given to practices such as clinics, hospitals, churches, among others, who may benefit from becoming trauma-informed institutions. Furthermore, it is critical that appropriate, relevant and effective treatment interventions for treating trauma in older people are further explored, research undertaken and documented as there is a lack of information available.

This study was concerned with older people's view on EMI therapy as a treatment modality for treating their symptoms of trauma. The conclusion is that early-life experiences do affect health and wellbeing in later years, but that older people can overcome their hardships and integrate their traumatic experiences with a practical treatment intervention such as EMI therapy. Older people view this therapy as a positive and beneficial experience. Moreover, EMI therapy can be a short-term, cost effective treatment modality for treating trauma leading to a reduction in older people's

symptoms. Utilising this efficient treatment intervention, health care professionals, including social workers, should be able to reach older people previously exposed to trauma. Furthermore, assisting them in integrating their traumatic experience can lead to a reduction in older people's symptoms of trauma and an improvement in their overall health and wellbeing. This should mean a general improvement in ageing communities; in other words, older people who are healthier and happier.

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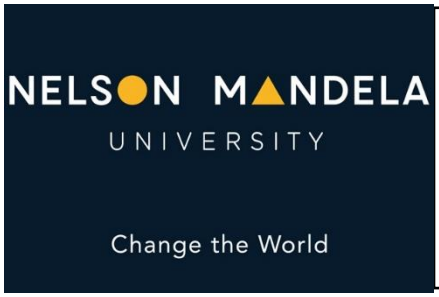
APPENDIX A: LETTER OF APPLICATION TO CONDUCT RESEARCH



Faculty of Humanities: Department of Social Work
P.O. BOX 7700
Nelson Mandela University
Port-Elizabeth
6031
South Africa
Web: www.nmmu.ac.za

Date: _____

To:

Attention:

Dear Sir/Madam

APPLICATION TO CONDUCT RESEARCH

First of all, I wish to thank you for allowing the opportunity to conduct EMI therapy with older people that are able and willing to engage in therapy. As you already know, I am a social worker employed at an NPO in Knysna. I am also a part-time Social Work Clinical Masters Student at the Nelson Mandela University under the study guidance of Dr Anneline Keet.

On behalf of myself, Andrea Visagie, I wish to apply for permission to conduct a research study at your organisation. The title of the study is: '*Older people's perspectives on the effectiveness of Eye Movement Integration (EMI) therapy as treatment intervention for their symptoms of trauma.'*

With this letter, I would like to request your permission to invite potential participants to form part of the research study. The research study is done by means of recruiting older people who has already received EMI therapy and obtaining their consent from those who agree to have their data used for the purposes of this study and engaging

in an interview to determine their views on the usefulness of EMI therapy. Therefore, recipients of EMI therapy need to consent to the following:

1. Give their consent for the researcher to use their pre- and post-inventories from the therapy sessions.
2. Consent to engage in an interview to determine their views on the usefulness of EMI therapy. This can be arranged to suit their availability.

The research study will adhere to the ethical guidelines of the University. Information gained from the study will be handled with confidentiality and participants will participate voluntarily.

Any questions regarding the research study can be directed to the student or research supervisor, Dr Anneline Keet from the Social Work programme in the School of Behavioural Sciences at Nelson Mandela University. The student can be contacted at 0794961026 or info@beatingtrauma.co.za. The supervisor for the research may be contacted at 041-5044917 or Annaline.Keet@mandela.ac.za

Thank you for your consideration. Your kind assistance is appreciated.

Yours sincerely,

_____ _____

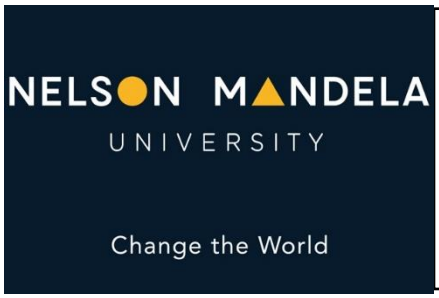
Mrs A. Visagie

Social Work Clinical Masters Student

Dr A. Keet

Research Supervisor

APPENDIX B: LETTER TO PARTICIPANTS



Faculty of Humanities: Department of Social Work
P.O. BOX 7700
Nelson Mandela University
Port-Elizabeth
6031
South Africa
Web: www.nmmu.ac.za

Dear Participant,

PARTICIPATING IN RESEARCH

I am a Social Worker who is employed at an NPO situated in Knysna. Currently, I am also a part-time Clinical Masters Social Work Student at Nelson Mandela University (NMU), where I am required to complete a research study as part of the master's programme.

Since you are already a recipient of EMI therapy, with this letter you are cordially invited to participate in a research study on 'Older people's perspectives on the effectiveness of Eye Movement Integration (EMI) therapy as treatment intervention for their symptoms of trauma.'

The goal of the study is to explore and describe older people's experience and views on whether and how they experience gains from EMI therapy to deal with their symptoms of trauma through documenting the results of your EMI sessions for research purposes.

This study can only be done with your consent towards the following:

1. Your consent for the researcher to use your pre- and post-inventories from the therapy sessions that was conducted.
2. To engage in an interview to determine your view on the usefulness of EMI therapy. This can be arranged to suit your availability.

The researcher will make use of a coding system that will ensure that the inventories from your therapy sessions are anonymous. The interview will be audio-recorded, and

a transcript of the interview may be taken for the sole purpose of data analysis. However, the information will be used for the purposes of this research only and no identifying information will be made available in the report.

The requirements to participate in the study are that you are at least 60 years of age and that you agree to participate in an explorative and descriptive study of older people's responses to EMI therapy as treatment intervention for their symptoms of trauma.

Participation is completely voluntary. It means that you may decline the offer to participate in the study or withdraw from the study at any stage without any penalties or consequences. Likewise, there will be no rewards for your participation. Please be assured that non-participation in the research study will not impact on the current therapy received. Neither the University nor the researcher has a conflict of interest with the research results. The study will conform to the ethical guidelines and requirements of the University.

More information with regards to the study can be directed at the main researcher, Andrea Visagie at 0794961026 or info@beatingtrauma.co.za or towards my research supervisor, Dr Anneline Keet at 044-5044917 or Annaline.Keet@mandela.ac.za

Thank you for taking the time to read through this letter. Your help is much appreciated.

Yours sincerely,

_____	_____
Mrs A. Visagie	**Dr A. Keet**
Social Work Clinical Masters Student	Research Supervisor

APPENDIX C: INFORMED CONSENT FORM

Faculty of Humanities: Department of Social Work
P.O. BOX 7700
Nelson Mandela University
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I, _____, agree to participate in this research study.

I have read through and understand the following:

- Participation is completely voluntary.
- Participants can withdraw from the study at any stage without any penalties or consequences.
- Confidentiality will be ensured in the study and participants' identities will be kept unidentifiable.
- The aim of the study is to explore and describe older people's experience and views on whether and how they experience gains from EMI therapy to deal with their symptoms of trauma through documenting the results of your EMI sessions for research purposes.
- The process to be followed has been explained to me.
- The anticipated duration of the interview is 45-60 minutes and will take place at the Old Age Home.
- Participants reserve the right to ask any questions regarding this study, both now and during the study. All questions regarding the study will be answered by the researcher.
- I have received a copy of this form.

Your signature indicates that you have read through the information; you are at least 60 years of age and that you agree to participate in an explorative and descriptive

study of older people's responses to EMI therapy as treatment intervention for their symptoms of trauma.

I, …… (participant) also gives consent that my interview may be audio-recorded and that a transcript of the interview may be taken for research purposes.

_____	_____
Signature of Participant	Date
_____	_____
Signature of Researcher	Date
_____	_____
Signature of Research Supervisor	Date

APPENDIX D: INVENTORY COMPLETED AT PRE-INTERVENTION SESSION AND TO BE USED AS A DOCUMENT ANALYSIS STRATEGY

CLIENT ASSESSMENT FOR SYMPTOMS OF TRAUMA (To be completed by participants who wishes to partake in the research study only).

- Please complete the inventory below.
- Note that you will complete a similar inventory (Section C and D) at the end of your therapeutic engagement to determine whether Eye Movement Integration (EMI) Therapy assisted you to process your symptoms of trauma.
- The inventory consists out of 18 questions. Please answer all the questions as accurately and honestly as possible.
- Your answers to this questionnaire will be treated confidentially.

Please answer each question by circling the appropriate number in the shaded box or by writing your opinion in the (shaded) space provided.

Participant's number	
Assessment date	

A. BIOLOGICAL INFORMATION (completed by client at pre-intervention session)

1. Gender

Male	**1**
Female	**2**

2. **Age**

60-65 years	**1**
66-70 years	**2**
71-75 years	**3**

3. **Civil status**

Single	**1**
Married	**2**
Divorced	**3**
Widowed	**4**

4. **Do you reside in the Knysna area?**

Yes	**1**
No	**2**

B. TRAUMATIC INCIDENT INFORMATION (completed at pre-intervention session)

5. **Description of trauma or triggering event:**

C. TO WHAT EXTENT HAVE YOU EXPERIENCED THE FOLLOWING SYMPTOM INTENSITY since the incident occurred?

Please use one of the following codes:

1. *Not at all*
2. *Sometimes*
3. *Every now and then*
4. *Often*
5. *Generally*
6. *Very often*
7. *Repeatedly*
8. *Almost always*
9. *Excruciating*
10. *Worst imaginable*

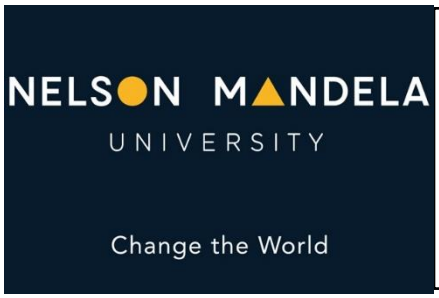
6. Physical symptoms	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
7. Psychological distress	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
8. Depression	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
9. Sadness	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
10. Aggression	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
11. Fear	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
12. Avoidance	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
13. Nightmares	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
14. Sleep disturbances	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
15. Lack of self-esteem	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

D. NEGATIVE IMPACT OF THE TRAUMA ON YOUR INTERPERSONAL RELATIONS WHERE APPLICABLE OR IF ANY.

16. Spouse/partner	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
17. Children	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
18. Friends	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Thank you for your participation in the inventory!

APPENDIX E: GUIDELINE FOR ENGAGING WITH INVENTORIES



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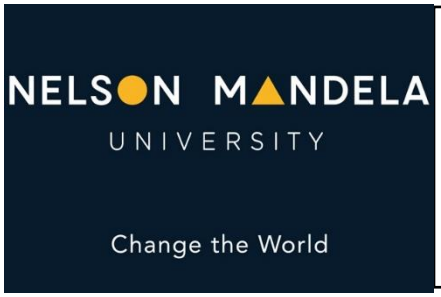
The following questions are used as a guideline to engage with the pre- treatment inventories (that are used for therapeutic purposes only) after participants have given their permission to form part of the research study:

1. What are the forms of trauma that these older people have been exposed to?
2. What are the commonalities in their description/views of these traumatic events?
3. To what extent does these traumatic events have an impact on older people's physical health?
4. To what extent does these traumatic events have an impact on older people's emotional wellbeing in terms of the following manifestations of trauma:
    - Depression?
    - Sadness?
    - Aggression?
    - Fear?
    - Avoidance?
    - Nightmares?
    - Sleep disturbances?
    - Lack of self-esteem?
5. What emotional manifestations of trauma seems to be more prominent than others?
6. To what extent does trauma influence older persons relationships with others in terms of the following:
    - Their relationship with their spouse/partner?
    - Their relationship with their children?
    - Their relationship with their friends?

APPENDIX F: GUIDELINE FOR ENGAGING WITH POST-THERAPY INVENTORIES



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The following questions are used as a guideline to engage with the post-treatment inventories (that are used for therapeutic purposes only) after participants have given their permission to form part of the research study:

1. To what extent did EMI therapy impact on older people's physical health?
2. To what extent did EMI therapy have an impact on older people's emotional wellbeing in terms of the following manifestations of trauma:
   - Depression?
   - Sadness?
   - Aggression?
   - Fear?
   - Avoidance?
   - Nightmares?
   - Sleep disturbances?
   - Lack of self-esteem?
3. Are there any of the above manifestations that shows a significant improvement after the EMI therapy across the group of participants? If so, which of these. Elaborate.
4. To what extent did EMI therapy influence the relationships of older persons who experienced trauma, in terms of the following:
   - Their relationship with their spouse/partner?
   - Their relationship with their children?
   - Their relationship with their friends?

5. Are there any of the above personal relationships across the group of participants that shows a more significant improvement after treatment than the others? Elaborate.

APPENDIX G: SEMI-STRUCTURED INTERVIEW SCHEDULE

Faculty of Humanities: Department of Social Work
P.O. BOX 7700
Nelson Mandela University
Port-Elizabeth
6031
South Africa
Web: www.nmmu.ac.za

Participant's number: _____

Date of interview: _____

PURPOSE AND INSTRUCTION

The researcher has asked for your permission to participate in this research project. It was indicated to you that the researcher is busy with a research study where she is doing an explorative and descriptive study of older people's responses to EMI therapy as treatment intervention for their symptoms of trauma. More specifically, the study is designed to determine how older people process their symptoms of trauma through EMI therapy and whether they view it as valuable.

You have consented that your pre-and post-inventories from the therapy sessions may be used for research purposes and you agreed to engage with an interview as well. The researcher would like to restate that the aim of this interview is to obtain your opinion regarding the usefulness of EMI therapy with regards to processing your symptoms of trauma.

The Permission and Release form are explained. The researcher then enquires about whether the interview may be audio-recorded and if a transcript of the interview may be taken. The interviewer ensures the participant that neither their names, nor any other identifying data regarding the traumatic incident will be made known in the report and information obtained will be used for research purposes only. The interviewer verifies the participant's willingness to be interviewed and asks whether he/she has any questions before the interview starts?

The audio recorder will be switched on and the following questions will guide the interview:

1. **Tell me about your experience of EMI therapy? /** *Vertel my meer oor jou ervaring van EMI terapie?*

2. **How was it different from your expectations compared to other therapy interventions? /** *Hoe het dit verskil van jou verwagtinge in vergelyking met dié van ander terapeutiese intervensies?*

3. **What was the outcome for you after having received the therapy? /** *Wat was die uitkomste vir jou nadat jy die terapie ontvang het?*

4. **What is it about the intervention that works/doesn't work for you? /** *Wat is dit omtrent die intervensie wat werk/nie gewerk het nie?*

5. **How useful do you think the therapy was in terms of processing your symptoms of trauma? /** *Hoe effektief dink jy was die terapie in terme daarvan om jou trauma simptome te verwerk?*

6. **Tell me more about your view on the application of this treatment intervention? /** *Vertel my meer oor jou siening rondom die toepassing van hierdie terapeutiese intervensie?*

7. **What are your thoughts on EMI therapy that created an awareness of previous trauma that is stored in your body? /** *Wat is jou gedagtes rondom EMI terapie wat 'n bewustheid geskep het van hoe vorige trauma ervarings in die liggaam gestoor is?*

8. **What impact do you think EMI therapy has had on both your physical and emotional wellbeing? /** *Watter impak dink jy het EMI terapie gehad op beide jou fisiese sowel as jou emosionele welstand?*

After the interview, the participant is thanked for his/her time and participation.

APPENDIX H: PERMISSION AND RELEASE FORM – RECORDINGS AND TRANSCRIPTIONS

Faculty of Humanities: Department of Social Work
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Nelson Mandela University
Port-Elizabeth
6031
South Africa
Web: www.nmmu.ac.za

PERMISSION TO USE AUDIO RECORDINGS AND TRANSCRIPTS FOR THE RESEARCH OF RESEARCH ONLY

PARTICIPANT CONTACT DETAILS:

Name & Surname: _____

Address: _____

_____

_____

_____

Contact no: _____

Title of research study: Older people's perspectives on the effectiveness of Eye Movement Integration (EMI) therapy as treatment intervention for their symptoms of trauma

Researcher's name: Andrea Visagie

Level of research: _____

Supervisor: Dr A. Keet

DECLARATION:

1. I have received a verbal and written explanation of the aim of this research and the nature of my participation.
2. I agree that my pre- and post-inventories from the therapy sessions be used for this research and I agree to engage in an interview where audio recordings of the interview are to be made.
3. For the purposes of the study, the audio recordings will be transcribed by the researcher only, thereafter the recordings will be destroyed.

Signed by _____ (participant), on _____ (date) at _____ (place).

Participant signature: _____

Researcher signature: _____

APPENDIX I: FORMAL ASSESSMENT BEFORE EMI

Client: B4 Date: 26/03/2019

ASSESSMENT

Reason for help: Son committed suicide.

Family & Social Environment: Friend.

Physical condition:		**Psychological condition**	
Eye problems or pain	No	Level of distress (Assessment Questionnaire)	
Contact lenses	No	Time elapsed since the trauma: 10 yrs	
Heart disease	No	Depression	6
Blood pressure	No	Psychosis, borderline personality disorder, other dissociative disorder	No.
Stroke-depression	No	Medications No.	
Pregnancy	No		
Epilepsy	No		
Fatigue	No		
Drugs and alcohol	Socially		
Other physical problems	Arthritis. Started with destructive behaviour		

Coping strategies for current problems:

General coping skills: Physical exercise, Walk

Trauma-related coping skills: Keep busy; Cope by doing

Family and social structures surrounding the client: Friends.

Memories

Troubling memories: (See trigger words)

Are the memories clear or hazy: Clear

What emotions are associated with the memories? Regret with tears.

What are the associated cognitions? Related to the trigger words

What consequences do these distressing memories have in client's current life?

Self-destructive behaviour.

Strengths and resource zone

Was there a time when you had a distinct feeling of hope, courage or strength?

Always had it

Can you remember an occasion when you were able to get out of a tough situation safely?

Referred back to previous other of adversity

What is the strongest positive force you can think of to heal your wound? Don't think you can.

Is there a place within you that is comfortable and intact, sheltered from your troubles? Yes.

Is there a time or a place where you can go to relax and restore your energy? Bedroom.

APPENDIX J: NOTES DURING EMI SESSION

Client: B4	Date: 02/04/2019

- **Lifeline** – Start with the worst or the first
- **Supportsystems:**
  Friend

Scale the main problem: (T8)

Poison words:

1. Getting the phone call	4. Suicide notes
2. No splatter	5.
3. Youngest son shouldn't have found him dead	6.

Eye Movements

A1	None. Seeing Stars.
A2	None. Wanting to beat me to the point. Sleepiness.
A3	Visual image (Hazy) Sleepless x2. Afraid. (little) (left corner lower).

B1	Feeling centred of apprehension. In gut tummy (nervousness)
B2	No splatter + son shouldn't have found him is triggered. No.
B3	Suicide note. The memory of that. None. Sleep on right hand side of the bed since the incident. Fuzzyness. Hazy feeling

C1	Son shouldn't have found him. Feeling of rollercoaster. None. Happiness. A definite time.
C2	None. No feeling of apprehension. None.

D1	Hazy feeling. Unknown. Head	Heavyness on right side of face.
D2	Nasal feeling. Head (Above)	Sleepiness.
D3	Hazy/Not clear think	Fearful of your sons anger. Light Leaked.
D4	Nasal fuel (Sinuses) Face head.	None.

E1	None. None.	Pencil goes too fast.
E2	Words suicide notes. Stiffness in neck	Sinus feeling
E3	Funny Sensation Light Leadedness in left lower corner.	Sleepiness
E4	None. Sinus Fel (Head)	Eyes are Yellow None.

F1	Dizzy feeling in head.	None None.
F2	Anger feeling Light Leadedness.	None. None.
F3	Sleepiness (Cope by sleeping)	None. Distinct vision of the Pool of blood
F4	Numbness on cheeks. None	None. None.

F1	Words of son startlyt Love found him Funy feely in Head	Felt the anger. Sleepiness (Dizzy) Memory coming up.

Scan and Scale: (T6) Feeling sleepy

G/H	
I	

APPENDIX K: ETHICS CLEARANCE

NELSON MANDELA
UNIVERSITY

PO Box 77000, Nelson Mandela University, Port Elizabeth, 6031, South Africa mandela.ac.za

Chairperson: Research Ethics Committee (Human)
Tel: +27 (0)41 504 2235
charmain.cilliers@mandela.ac.za

Ref: [H18-HEA-SDP-004] / Approval]

27 September 2018

Dr A Keet
Faculty: Health Sciences

Dear Dr Keet

OLDER PEOPLE'S PERSPECTIVES ON THE EFFECTIVENESS OF EYE MOVEMENT INTEGRATION (EMI) THERAPY AS TREATMENT INTERVENTION FOR THEIR TRAUMA SYMPTOMS

PRP: Dr A Keet
PI: Ms A Taljaard

Your above-entitled application served at the Research Ethics Committee (Human) for approval.

The ethics clearance reference number is **H18-HEA-SDP-004** and is valid for one year. Please inform the REC-H, via your faculty representative, if any changes (particularly in the methodology) occur during this time.

An annual affirmation to the effect that the protocols in use are still those for which approval was granted, will be required from you.

We wish you well with the project.

Yours sincerely

CB Cilliers

Prof C Cilliers
Chairperson: Research Ethics Committee (Human)

Cc: Department of Research Capacity Development
Faculty Officer: Health Sciences

APPENDIX L: LETTER FROM INDEPENDENT CODER

PO Box 10718
Linton Grange
Port Elizabeth
6015
07.09.2019

To whom it may concern

This is to confirm that I , Maria M Lourens, ID 6201250072087, acted as the independent coder for Mrs Andrea Visagie for her qualitative study : *Older people's perspectives on the effectiveness of Eye Movement Integration (EMI) therapy as treatment intervention for their trauma symptoms.*

Yours sincerely

M.M. Lourens

Mariana Lourens
Oncology Social Worker
Hons Psych (US), MA Social Work (NMMU)
SACSSP 10-08481

APPENDIX M: CODING AND CATEGORISATION PROCESS

Themes	Subthemes	Categories
1. Older person's experience of EMI therapy	Completely new and different to past experiences of therapy B4:1, B7:2	Nothing to compare EMI therapy with – no past experience of therapy B9:1, B7:2 Was sceptical in the beginning B4:1 A bit unusual B 1:4 (did not understand eye movements B9:1,4
	Enjoyed it B9:2	Client was not forced to go into depth/ detail B3:1 Makes you relax and get you talking B9:2, B9;5 Therapist created a safe space B2:1, A1:2 Therapist professional and organised B8:1 Client had the opportunity to focus on herself and did not needed to worry about others B8:3
	Physical setting had an impact on experience	Light in the office was too harsh B1:8 The pen (focus instrument?) was not neutral
	Repetition helped client to focus B7:1, concentrate B7:5	

	Became bored with all the repetition B7:1- fell asleep B1:1, B5:3, Needed a bit more challenge B4:15 Very tired afterwards B5:2	
2. Older persons perceptions of the benefit of EMI (how EMI facilitates processing of trauma)	Enables client to go beyond the obvious Brought relief from the (physical) distress of the trauma B5:2, B9:1 Emotionally freeing B3:4 (whisper rather than a scar B2:4), Stress scores changed dramatically – before and after B9: 3	• There is a link to hypnosis B9:2 • Went back to the past and addressed unfinished business B9:5 , B1:1 (stuff that were bottled up B8:4,5 Dig deeper B4:1, B9:4 aspects that need to be dealt with B4:7, B4:6, B6:4, B7:4 • Triggered flashback images, but did not re-traumatise A1:1,2, B5:1 • Joined the dots that she was not previously aware of B3:2, B9:5, B8:1, B4:2, B7:3 • Focus was actually on the wrong trauma B4:9 Diminished physical symptoms B3:4, B7:10 certain tense areas relaxed afterwards B2:5, B4:10, psoriasis all cleared up B7:10, HBP B9:17 Clenching of teeth improved B8:3 Realisation that some aspects of her traumatic experience can now belong to the past B1:2, Brought closure of an event many years after it happened B3:1, experience that she is healing B4:12 B9:8 Associated aspects

		have a lesser impact B2:8, See things in perspective B8:5 Less sadness B3:4 Less paranoid, sleeping better B7:11, B5:7 Less anger B1:3 – no need for anger and fear at things that may not happen B5:4, reduced anger & fear B5:2, 4 Distancing from emotional pain B2:8
	EMI assists in exploring client's thoughts B8:2	Ah-ha moment B4:1 Felt more at peace B6:2, calm B5:8
	Improved interpersonal relationships B1:6	Realised that trauma memory infiltrated a too large area of her life B5:6, start doing things again B7:12, B7:15 Realise that she has a lot more control, power than what she thought B5:3
	Aware that there is still emotional work to be done B2:1 own responsibility to work on things B8:5	Identified some goals to work on B4:2 Improved concentration B8:5
	An awareness that other issues can cloud the initial trauma B2:7	Still angry at aspects of the loss B7:7 SAD – wants to cry but cannot B9:4 Spoke about things that was bottled up B8:3, spoke about hidden emotional baggage B5:3

	Realised that there were also positive aspects as a result of the trauma B6:2 No real change in physical symptoms B1:6	Refrain from avoiding the topic of the trauma B4:4, B5:1
3. Suggestions for further use of EMI with older persons	EMI has a place in the team of people dealing with post-traumatic stress B4:13, not complete in itself Technique probably more effective with recent trauma B2:2,9 Do not use directly after trauma – victim first need to organize thoughts, too much reality directly after the trauma B4:14 EMI does not show clear benefits	• More beneficial if used in conjunction with counselling/ psychotherapy B4:5 • Enables one to make the links, but not to deal with the core issues of personal trauma B4:5, 6 • Needs to happen within a team B4:14 Deals with the feelings over the years B2:3 Memories of trauma that happened long ago are not that vivid B2:1, B2:7 • Older people need memory triggers to remember A1:3 • Need for trauma debriefing is a relative concept – older persons can cope better because of their life experience / older persons naturally have more aches and pains A1:3, B1:6 • Anybody listening compassionately is useful A1:4 • Survivors of the same trauma can act as buddies A1:6

	Proper orientation to the technique can be helpful B1:1, 4 Use neutral tools to assist to focus (not a pen that belongs to a child B2:3,9 Therapist to take the lead in assisting victim to choose the right trauma B4:10	