

**SHIP® WITH A CLIENT EXPERIENCING MEIGE'S SYNDROME:
A HERMENEUTIC SINGLE-CASE EFFICACY STUDY**

by

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SUMMARY

Meige's syndrome is classified as a rare form of focal dystonia characterized by the following clinical features:

- Facial, lingual, masticatory, pharyngeal, laryngeal and cervical dystonia.
- Involuntary lower facial and jaw movements, including lip pursing, grimacing, jaw opening and closing and chewing. These movements may be tremor-like.
- The symptoms typically begin focally and then spread to contiguous muscles.
- The average onset occurs after 50 years of age.

The aetiology of Meige's syndrome remains unclear. It is currently considered to be multifactorial and to include genetic, psychogenic, neurological and environmental factors. Most of the current treatments for Meige's syndrome require medical intervention. This is inherently invasive and has several possible side effects. At the time of writing the researcher was not aware of any studies investigating the efficacy of psychotherapy as a treatment for Meige's syndrome. Furthermore, no publications have appeared on SHIP® as a treatment for Meige's syndrome. Meige's syndrome is often accompanied by depression and a marked reduction in quality of life. Psychotherapeutic interventions are generally focused on addressing the debilitating effect of Meige's syndrome on a person's life and not on treating the symptoms of Meige's syndrome which are the result of unresolved psychological trauma. Given the probability that the symptoms may have a psychogenic origin, it was decided to investigate psychotherapy as a treatment option for alleviating Meige's syndrome symptoms.

SHIP® is described as a modality that contains both theoretical and practical components. SHIP® works according to a trauma-spectrum model which views all types of trauma, including PTSD and complex PTSD, as situated on a spectrum. The scope of trauma is seen to be broader than is presently recognized in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition. Traditional psychological and physiological symptoms are classified as trauma-spectrum manifestations (TSM) in SHIP® theory. Examples of TSM range from loss of spontaneity, fragmentation of memory, compromise in personality structure, depression and anxiety to physiological symptoms like headaches or neurological dysfunctions. From a SHIP® perspective, the physical manifestations of Meige's syndrome are conceptualized and treated as TSM. In order to investigate the efficacy of SHIP® as a treatment modality for Meige's syndrome, the hermeneutic single-case efficacy design (HSCED) was chosen.

The HSCED is a naturalistic design that makes use of multiple quantitative and qualitative data sources to draw inferences about the efficacy of psychotherapy. The HSCED design, which is flexible and compatible with different psychotherapeutic modalities, was judged to be a good fit for investigating the efficacy of SHIP® as a treatment modality for Meige's syndrome.

In accordance with the HSCED framework, the research addressed these questions:

- 1) What data collection methods within the HSCED framework can be utilised to compile a rich case record?
- 2) Does the data analysis show a change in Meige's syndrome symptoms over the course of SHIP®?
- 3) Does the data show evidence for the causal role of SHIP® in the change of symptoms?
- 4) What factors (including moderator variables) could be accountable for the change?
- 5) What conclusions and recommendations can be made based on the results of the study?

The following data collection methods were used: idiographic case information, Rorschach inkblot method (RIM) pre- and post-SHIP®, a customized questionnaire pre- and post-SHIP®, a change interview post-SHIP®, weekly outcomes measures and records of psychotherapy sessions. After the collection and analysis of data, evidence of the change brought about by psychotherapy was considered. The researcher then considered eight possible non-psychotherapy explanations for the change in symptoms, as recommended by Elliott (2002).

After considering evidence, both an affirmative and a sceptic's case are presented. The affirmative case argues that post-psychotherapy changes are the result of SHIP® and the sceptic's case argues alternative explanations for change. After both cases have been presented, the conclusions are drawn, the limitations of the research are considered and recommendations are made for future research.

Table of contents

Chapter 1: Introduction and Overview.....	10
1.1 Orientation.....	10
1.2 Problem statement.....	11
1.3 Purpose of the study.....	11
1.4 Chapter overview.....	12
Chapter 2: Meige’s Syndrome.....	14
2.1 Meige’s syndrome as a craniocervical dystonia.....	14
2.2 Clinical features of Meige’s syndrome.....	14
2.3 Aetiology of Meige’s syndrome.....	15
2.3.1 The psychogenic argument.....	16
2.4 Treatment of Meige’s syndrome.....	18
2.4.1 DBS.....	18
2.4.2 Botulinum toxin injections.....	19
2.4.3 Oral-medication.....	19
2.4.4 Psychotherapy.....	20
Chapter 3: A Brief Introduction to SHIP®.....	22
3.1 The development of SHIP®.....	22
3.2 The psycho-biodynamic model.....	22
3.3 Autonomic regulation.....	23
3.4 Pathology as conceptualized from a SHIP® perspective.....	23
3.4.1 The trauma-spectrum model.....	23
3.5 Spontaneous healing reactions (SHRs).....	25
3.6 Coping style.....	25
3.7 Intra-translators.....	26
3.8 Inter-translators.....	26
3.9 Distractors.....	27
3.10 Genetic constitution.....	27
3.11 Literature review.....	27
Chapter 4: Methodology.....	29

4.1 Introducing the hermeneutic single-case efficacy design (HSCED)	29
4.2 The HSCED structure	29
4.2.1 Rich case record	29
4.2.2 HSCED literature review	33
4.2.3 Sampling method	34
4.2.4 Data analysis	34
4.2.4.1 <i>Basic information</i>	34
4.2.4.2 <i>RIM data</i>	34
4.2.4.3 <i>The change interview</i>	36
4.2.4.4 <i>Weekly outcomes measure</i>	36
4.2.4.5 <i>HAT form</i>	37
4.2.4.6 <i>Questionnaire</i>	37
4.3 Direct evidence	37
4.4 Indirect evidence and alternative explanations for measured client change ..	38
4.4.1 Trivial or negative change	38
4.4.2 Statistical artefacts	38
4.4.3 Relational artefacts	39
4.4.4 Expectancy artefacts	39
4.4.5 Self-correction processes	40
4.4.5.1 <i>Self-report strategies: direct and indirect</i>	40
4.4.5.2 <i>Baseline and pre-test strategies</i>	41
4.5 Extratherapy events	42
4.6 Psychobiological causes	42
4.7 Conclusion	43
4.8 The context	43
4.9 Reflexivity	43
4.10 Ethical considerations	43
Chapter 5: The Curious Case of Mrs M	46
5.1 Presenting complaint	46
5.2 History of presenting complaint	46
5.3 Daily functioning	46
5.4 Medical and psychiatric history	46
5.5 Alternative treatments	47
5.6 Developmental history	47

5.7 The SHIP® psychotherapy.....	48
5.8 Summary.....	49
Chapter 6: Results.....	50
6.1 RIM data.....	50
6.1.1 Quantitative RIM results.....	50
6.1.2 Interpretive hypothesis (RIAP).....	55
6.1.2.1 <i>Affect</i>	55
6.1.2.2 <i>Interpersonal perception</i>	56
6.1.2.3 <i>Information processing</i>	57
6.1.2.4 <i>Mediation</i>	58
6.2 PQ questionnaire results.....	59
6.2.1 Meige’s symptoms; anxiety and depression symptoms.....	59
6.2.2 Distractors.....	60
6.2.3 Associative activators.....	61
6.2.4 SHRs.....	62
6.3 Coping styles questionnaire results pre- and post- SHIP®.....	65
6.4 Change interview data.....	66
6.4.1 11 Significant theme clusters.....	67
6.4.1.1 <i>Desperation and hopelessness</i>	67
6.4.1.2 <i>Medication</i>	67
6.4.1.3 <i>Not being good enough; worthlessness; guilt and shame</i>	68
6.4.1.4 <i>Faith</i>	68
6.4.1.5 <i>The safe space</i>	68
6.4.1.6 <i>The intense, difficult process</i>	68
6.4.1.7 <i>Debilitating physical symptoms</i>	69
6.4.1.8 <i>Anxiety and depression</i>	69
6.4.1.9 <i>Facing and expressing emotions</i>	70
6.4.1.10 <i>Childhood trauma</i>	70
6.4.1.11 <i>Self-worth, peacefulness and freedom</i>	70
6.5 HAT data.....	71
6.6 Summary.....	72
Chapter 7: Discussion.....	73
7.1 Change analysis.....	73

7.2 Direct evidence for change.....	73
7.2.1 Retrospective attribution of change.....	73
7.2.2 Process outcome mapping.....	74
7.2.3 Correlation of within-therapy process outcomes.....	74
7.2.4 Change in chronic symptoms.....	75
7.2.5 Event-shift sequence.....	75
7.3 The affirmative case - a SHIP® formulation.....	75
7.3.1 Associative activators – the link to frozen trauma.....	76
7.3.2 The metaphor of Meige and underlying dynamics.....	76
7.3.3 The resolution of symptoms through SHIP®.....	77
7.3.4 Neutralizing distractors.....	78
7.3.5 The shift in coping style and interpersonal dynamics.....	79
7.3.6 Concluding statement.....	79
7.4 The sceptical case – alternative explanations.....	80
7.4.1 Spontaneous remission and regression to the mean.....	80
7.4.2 Misdiagnosis and relational artefacts.....	80
7.4.3 Botox, homeopathy and other treatments.....	81
7.4.4 Concluding statement.....	81
7.5 Limitations and recommendations relating to current findings.....	81
7.6 Conclusion.....	82
References.....	84
Figures	
Figure 1: Meige's symptoms PQ scores	59
Figure 2: Anxiety and depression PQ scores	60
Figure 3: Distractors	61
Figure 4: Associative activators.....	62
Figure 5: SHRs.....	65
Figure 6: Helpful events.....	72
Tables	
Table 1: RIM Results	51
Table 2: Identified variables for expected change	54

Table 3: Affect variables.....	55
Table 4: Interpersonal perception variables	56
Table 5: Information processing variables.....	57
Table 6: Mediation variables	58
Table 7: Coping styles	65

Chapter 1

Introduction and Overview

This chapter introduces Meige's syndrome as a diagnosis and SHIP® as a psychotherapy. The research question under investigation is then provided and the purpose of the study is delineated. This is followed by an overview of later chapters.

1.1 Orientation

Meige's syndrome is classified as a rare form of focal dystonia characterized by the following clinical features (LeDoux, 2009):

- Facial, lingual, masticatory, pharyngeal, laryngeal and cervical dystonia.
- Involuntary lower facial and jaw movements, including lip pursing, grimacing, jaw opening and closing and chewing. These movements may be tremor-like.
- The symptoms typically begin focally and then spread to contiguous muscles.
- The average onset occurs after 50 years of age.

The aetiology of Meige's syndrome remains unclear. It is currently considered to be multifactorial and to include genetic, psychogenic, neurological and environmental factors (Jinnah et al., 2013). The available literature indicates that psychotherapy is not generally considered as a first treatment option for Meige's syndrome. Given the possibility that the symptoms may have a psychogenic origin, the researcher's curiosity was aroused and he decided to investigate the possibility of psychotherapy as a treatment option for Meige's syndrome symptoms.

SHIP® is described as a psychotherapeutic modality that contains both theoretical and practical components. SHIP® works according to a trauma-spectrum model which views all types of trauma, including PTSD and complex PTSD, as being situated on a spectrum. The scope of trauma is seen to be broader than is presently recognized in the Diagnostic and Statistical Manual of Mental Disorders 5th edition (APA, 2013). Traditional psychological and physiological symptoms are classified as trauma-spectrum manifestations (TSM) in SHIP® theory (Steenkamp, 2014). Examples of TSM range from loss of spontaneity, fragmentation of memory, compromise in personality structure, depression and anxiety to physiological symptoms like headaches or neurological dysfunctions (Steenkamp, 2014).

From a SHIP® perspective, the physical manifestations of Meige's syndrome are conceptualized as TSM.

1.2 Problem statement

In accordance with the HSCED framework, the research will address the following questions (Stephen, Elliott, & Macleod, 2011):

- 1) What data collection methods within the HSCED framework can be utilised to compile a rich case record?
- 2) Does the data analysis show a change in Meige's syndrome symptoms over the course of SHIP®?
- 3) Does the data show evidence for the causal role of SHIP® in the change of symptoms?
- 4) What factors (including moderator variables) could be accountable for the change?
- 5) What conclusions and recommendations can be made based on the results of the study?

The proposed study can be justified on based on several factors. At the time of writing the researcher was not aware of any studies investigating the efficacy of psychotherapy as a treatment for Meige's syndrome. Furthermore, no publications have appeared on SHIP® as a treatment for Meige's syndrome. The proposed study could contribute to creating an awareness of psychotherapy as a possible first option intervention for Meige's syndrome. Most of the current treatments for Meige's syndrome require medical intervention. This is inherently invasive and has several possible side effects (Markaki, Kefalopoulou, Georgiopoulos, Paschali, & Constantoyannis, 2010). Increasing our knowledge of the effects of a psychotherapeutic intervention that is less intrusive and in some cases more cost-effective than medical interventions may prove beneficial. The aetiology of Meige's syndrome is at present unclear. The proposed study would investigate the hypothesis that the aetiology of Meige's syndrome may be psychogenic, thereby providing valuable insight and understanding into the underlying psychological causes of Meige's symptom manifestation as this is lacking in the literature at present.

SHIP® was chosen as it is a modality that developed in response to the South African context and challenges, focusing as it does on psychobiological manifestations in response to trauma (Steenkamp, Van der Walt, Schoeman-Steenkamp, & Strydom, 2012). There is little research available on SHIP®, which appears to be a psychotherapeutic approach worthy of

investigation and previous studies on SHIP® have suggested additional case studies on SHIP® as a treatment modality are needed (Sevenster, 2007).

1.3 Purpose of the study

The aim of the research is to investigate the efficacy of SHIP® as a treatment modality for Meige's syndrome by:

- a) Documenting the change in Meige's symptoms before and after completing SHIP®
- b) Evaluating the causal role of SHIP® in bringing about this outcome

The objectives of this study are to:

- a) Select a variety of appropriate data collection methods and compile a rich case record
- b) interpret and analyse the data to determine whether change has occurred
- c) analyse the evidence for the causal role of SHIP® in the change in symptoms
- d) analyse evidence for possible non-psychotherapy explanations of change in symptoms
- e) present the collected information in the form of an affirmative case and a sceptical case

1.4 Chapter overview

Chapter 2 provides a description of Meige's syndrome according to a review of the available literature. The disorder known as craniocervical dystonia is described and the clinical features, aetiology and treatment of Meige are discussed. The psychogenic argument is introduced, followed by the introduction of SHIP® psychotherapy as a possible treatment.

Chapter 3 is a brief introduction to SHIP®. The development of SHIP® and SHIP® as a psycho-biodynamically orientated psychotherapy are presented. This is followed by an introduction to the core constituents of SHIP® that are relevant to the present study. The concepts of autonomic regulation, trauma spectrum manifestations, spontaneous healing reactions, coping styles, intra-translators, inter-translators, distractors and genetic constitution are introduced.

Chapter 4 describes the methodology used to conduct the study. This includes the HSCED and its structure. The sample and sampling method, methods of data collection and data

analysis and research context are described, Researcher reflexivity is then discussed. Ethical considerations are also addressed in this chapter.

Chapter 5 introduces the case of Mrs M. Important case information pertaining to her case is presented, including the presenting problem, Mrs M's medical and psychiatric history, alternative treatments, developmental history, daily functioning and Mrs M's process in SHIP®.

Chapter 6 describes the results of the study following data analysis.

Chapter 7 provides a discussion of the results of the data analysis. The change analysis, affirmative case and sceptic's case are presented. These offer possible explanations for the results. Conclusions are then drawn based on the cases presented. The limitations of the study are described, and recommendations for future research are made.

The next chapter, Chapter 2, introduces the reader to Meige's syndrome.

Chapter 2

Meige's Syndrome

This chapter locates Meige's syndrome within the spectrum of dystonia. The characteristics and aetiology of Meige's syndrome and the various treatments are then discussed and the available literature on the topic is explored.

2.1 Meige's syndrome as a craniocervical dystonia

The term dystonia applies to a group of disorders that share involuntary muscle contractions as a common feature despite differing in their clinical manifestations. The contractions may be intermittent or sustained and can cause abnormal posturing and repetitive or tremor-like movements (Jinnah et al., 2013). People who develop the symptoms of dystonia generally have a normal intellectual capacity (Sabesan, 2008). Meige's syndrome accounts for a combination of dystonic spasms that are limited to the facial, cranial and cervical areas and may include involuntary spasms in the muscles of the face, neck, tongue and eyes (LeDoux, 2009).

2.2 Clinical features of Meige's syndrome

LeDoux (2009) states that there is a lack of clarity in the available literature on the constellation of symptoms that can be classified as Meige's syndrome. Names such as Brueghel's syndrome, blepharospasm-romandibular syndrome, segmental craniocervical dystonia and spasmodic torticollis have been used to describe these symptoms. The author has chosen the term Meige's syndrome for the sake of consistency.

LeDoux (2009) also states that Meige's syndrome typically develops between the ages of 50 and 70 and presents with equal frequency in males and females. The following symptoms form part of the presentation of Meige's syndrome:

Blepharospasm – involuntary spasms of the oculi muscles. Common features may include closure of eyelids due to spasm and frequent blinking. Blepharospasm is most commonly found in Caucasian women. Other characteristics include being a non-smoker, having no history of head trauma and a normal birth history. Seventy-two percent of persons suffering from blepharospasm reported a stressful event immediately prior to the onset of symptoms (Peckham et al., 2011).

Oromandibular dystonia – sustained involuntary spasms in the lower facial muscles, tongue and lower jaw. Common features may include grimacing, facial contortions, jaw opening and/or closing due to spasms, jaw tremors and restricted movement of the tongue. These movements are often patterned and can cause difficulties in swallowing, chewing and breathing (Yaltho & Jankovic, 2011).

Cervical dystonia – involuntary contractions of muscles in the neck that may result in abnormal movements of the head. Although less frequent, these symptoms may be present in Meige’s syndrome. Dystonia often begins in the oromandibular region and subsequently spreads into the cervical regions (Jinnah et al, 2013).

The functioning of persons who suffer from Meige’s syndrome may be affected in various ways. Onset is normally insidious and symptoms tend to start focally and then expand to surrounding areas. These symptoms are often mistaken for a stroke (LeDoux, 2009), causing the sufferer distress. Stress, talking and chewing all tend to aggravate the symptoms. Aggravated symptoms may result in a disability in speaking and eating, which in turn may lead to weight loss, depression and social isolation (Singer & Papapetropoulos, 2006). LeDoux (2012) indicated that depression is significantly higher among persons who suffer from Meige’s syndrome than among those who do not. In a significant number of cases, depression precedes the onset of dystonia.

2.3 Aetiology of Meige’s syndrome

In Europe, the prevalence of Meige’s syndrome is estimated to be 33 cases per million persons. There is consensus in available literature that the presentation of these symptoms is extremely rare and thus literature on the aetiology of Meige’s syndrome is limited (LeDoux, 2009). Several hypotheses have been postulated regarding the aetiology of Meige’s syndrome, none of which is conclusive at present.

It has been found that there is a 10 percent likelihood that persons with Meige’s syndrome symptoms may have a first or second degree relative who suffers from dystonia, which suggests that a heredity component may be present (Maniak, Sieberer, Hagenah, Klein, & Vieregge, 2003). Additionally, neuroimaging studies in humans and rats have yielded results that have led some researchers to conclude that Meige’s syndrome may be a neurodevelopmental network disorder characterized by abnormal sensorimotor integration (LeDoux, 2009). There is a general trend among researchers towards implicating the basal ganglia area of the brain in Meige’s syndrome (Kirton & Riopelle, 2001).

Movement disorders such as Meige's syndrome can be associated with hyperthyroidism. A study by Miao, Liu, Li, Du, Zhang & Li (2010) found that the involuntary movements of Meige's syndrome subsided when a patient was given medication for hyperthyroidism. As a result of the clinical course of the patient's symptoms in response to treatment, the association between Meige's syndrome and hyperthyroidism was suggested.

Research by Ananth, Edelmuth and Dargan (1988) suggests that Meige symptoms can occur as a side effect of neuroleptic medication such as haloperidol and thioridazine. Hayashi et al. (1998) provide supportive evidence for the hypothesis that pharmacological treatments that cause of change in central dopaminergic activity may play a role in the development of secondary Meige's syndrome. Lastly, head trauma and organic brain disease have been associated with the development of secondary Meige's syndrome on various occasions (Kirton & Riopelle, 2001).

2.3.1 The psychogenic argument

The psychogenic argument is listed separately and discussed more thoroughly as, according to SHIP® theory, the participant's presentation of Meige's syndrome symptoms is conceptualized as being of psychogenic origin. In cases where facial spasms were found to be psychogenic, the following characteristics were normally present (Yaltho & Jankovic, 2011):

1. Acute onset
2. Incongruent features
3. Lessening or dissolution of symptoms with distraction
4. Associated somatizations
5. Good response to a placebo or psychotherapy
6. Normal neuroimaging
7. Spontaneous remission of symptoms

The mean age of onset was found to be 37 years, which is much younger than the usual age of onset of Meige's syndrome. Psychogenic cases are more commonly found in women aged 37–50. Depression and headache are common features (up to 38% comorbidity) associated with psychogenic facial movement disorders and these women generally respond well to antidepressants (Yaltho & Jankovic, 2011; Fasano et al., 2012; Morgante, Edwards, & Espay, 2013). Fasano et al (2012) indicate that psychogenic facial movement disorders have several other characteristic features.

The most common feature is smirking: “Involvement of the lower lip with downward deviation at the angle of the mouth combined with ipsilateral platysma co-contraction” (Fasano et al, 2012, p 1548). In most cases the subject had asymmetric, unilateral smirking of facial muscles and *gestes antagonistes* (a sensory “trick” or gesture that can typically interrupt dystonia) were ineffective. In organic facial movement disorders the involvement of the lower face is more common than the involvement of the upper facial muscles and there tends to be an absence of facial spasms during sleep (present in 80% of subjects with organic facial dystonia). In the majority of subjects, speech is often unaffected.

Research by Factor, Podskalny and Molho (1995) found that in a sample of 842 patients with movement disorders seen over 71 months, only 3.3% were found to have a psychogenic movement disorder. Tremor and dystonia are the most common psychogenic disorders. Psychogenic dystonia can often occur after a minor peripheral injury. This type of dystonia is often more painful than organic dystonias (Morgante, Edwards, & Espay, 2013).

Since the symptoms of psychogenic movement disorders often mimic the full range of involuntary movements of movement disorders of organic origin, diagnosis can be extremely difficult and physicians are often hesitant to diagnose a movement disorder as psychogenic. This can be seen from the low rate of 3.3% of movement disorders that were classified as psychogenic in the abovementioned study. When there are indications that a movement disorder may be psychogenic, psychiatric medication such as antidepressants is often prescribed. If these medicines are effective in reducing symptoms, the hypothesis of psychogenic origin can be considered more strongly than that of organic origin (Hinson & Haren, 2006).

At present, psychogenic neurological symptoms are most often formulated using psychodynamic concepts. The loss of motor function is seen to be the result of psychological conflict within an individual. The expression of physical symptoms is conceptualized as an attempt to resolve this inner conflict and constitutes the primary gain. The physical symptoms are seen as a communication of psychological distress. In addition, the individual may also benefit from advantages that accompany the “sick patient” status as a secondary gain (Nowak & Fink, 2009).

2.4 Treatment of Meige’s syndrome

At the time of writing various attempts have been made to treat Meige’s syndrome. The two most consistently effective treatments are deep brain stimulation (DBS) and botulinum toxin

injections. The section below contains a summary of the most prominent treatments and the reported efficacy thereof.

2.4.1 DBS

Bilateral pallidal deep brain stimulation (DBS) of the globus pallidus internus (Gpi) is known to be one of the more effective treatments for Meige's syndrome (Houser & Waltz, 2005; Blomstedt, Tisch, & Hariz, 2008). Several studies have reported more than a 50 percent improvement in symptoms after DBS (Wang et al., 2016). Reese et al. (2011) conducted an evaluation study of the long-term outcomes of DBS treatment for Meige symptoms in 12 patients. The results indicated an average improvement of 53 percent after a median follow-up time of 38.8 months. The conclusion of this study was that the benefits of DBS may last for up to six years. The average age of participants in the study was 64.5 years, making long-term follow-up at 10 or 15 years post-treatment more difficult.

The DBS process requires brain-stimulating electrodes to be implanted under local anaesthesia into the selected areas of the brain according to the specificity of the case. At the beginning of surgery, a head frame is placed on the patient's cranium. A magnetic resonance imaging scan is then administered to determine the coordinates of the target nuclei (Hu, Zhang, Meng, Ma, & Zhang, 2012). Tiny burr holes are drilled into the cranium and electrodes are implanted bilaterally. The electrodes are then activated to stimulate the selected areas (Markaki et al., 2010).

Among the complications of DBS listed by Bereznai, Steude, Seelos, and Bötzel (2002) were moderately reduced speech volume after DBS and meningitis (in this case the electrodes had to be removed and antibiotic treatment was necessary). There are serious anaesthetic challenges that complicate the process and a risk of intracerebral haemorrhage is present (Bhoyar, Gujjar, Shinde, & Kotak, 2012). DBS technology is currently expensive and treatment costs are therefore high (Hu et al., 2012). Foncke (2006) reported serious changes in mood in patients who underwent DBS for Parkinson's disease and cited a study in which two out of sixteen patients who received DBS for dystonia committed suicide. Serious changes in mood and suicide risk are therefore included as possible complications of DBS.

2.4.2 Botulinum toxin injections

Botulinum toxin injections are also a frequent choice of treatment as results provide rapid relief of symptoms. In 2008 this was listed as the treatment of choice for Meige's syndrome

(Sabesan, 2008). The clinical effect of this treatment can be noticed within 1–3 days and the peak effect occurs 2–6 weeks after the initial injections. Results are dependent on the correct targeting of affected muscles and the selection of a suitable amount of toxin (LeDoux, 2009). Repeated injections are typically needed to sustain the effect of this treatment (Sabesan, 2008). Findings show that reduction in spasms can be achieved after 48 injections into various areas of the face (Møller et al., 2003).

Drawbacks include several physical side effects such as dysphagia, facial weakness, dry mouth and flu-like symptoms (Markaki et al., 2010) as well as temporary efficacy of treatment as symptoms often return over time (Mauriello et al., 1997). In many cases, continuous treatment is necessary to sustain the effect thereof. A study by Czyz et al. (2013) showed good results for patients treated over a period of 19 years. Treatments were administered every 127 days on average and the total number of treatments administered over 19 years was 62. Although the results were positive, with few adverse effects, it should be noted that this treatment can often be extremely painful for the recipient and therefore the need for such long-term treatment can be seen as a drawback. Patients often find multiple injections to be too painful, causing them to discontinue treatment (Onguchi, Takano, Dogru, Ono, & Tsubota, 2004).

2.4.3 Oral medication

Oral medication is often used as a first-line treatment for Meige's syndrome. Benzodiazepines and other anticholinergic drugs are prescribed to decrease the monosynaptic and polysynaptic reflexes. Clozapine and risperidone act as dopamine receptor antagonists and may improve dystonia if administered in low doses. A range of other medicines also appear to have brought about a certain improvement in symptoms (Lee, 2007). The results attained with these drugs are modest and there may be a range of problematic side effects (LeDoux, 2009). Sabesan (2008) reports that oral medication is effective in 22 percent of Meige's syndrome patients.

2.4.4 Psychotherapy

A literature search for psychotherapy as a treatment for Meige's syndrome yielded few results as mentioned below.

The first such study was published by Wickramasekera in 1974 and it described a case in which blepharospasm (one of the constellation of Meige symptoms) that previously failed to

respond to analytic psychotherapy was successfully treated by means of a combination of hypnosis and behavioural therapy. Eight years later, Fielding and Gunary (1982) presented two cases of blepharospasm that were successfully managed by using massed practice and relaxation techniques. In contradiction to this, an article by Faulstich, Carnrike and Williamson (1985) stated that traditional psychotherapy has not been found to be a successful treatment for Meige syndrome. In rare cases, supportive group psychotherapy and hypnosis have been found to bring about some improvement in symptoms. They reported that behavioural approaches (like practising facial movements such as blinking) have been somewhat effective in reducing and managing the severity of symptoms. Jacome (2010) reported similar results regarding the efficacy of behavioural modifications to minimize or reduce symptoms.

No record could be found of a psychotherapeutic approach that conceptualises the symptoms as possibly resulting from unresolved trauma, as proposed by SHIP®.

Castelbuono and Miller (1998) examined 238 Meige patients in a clinical setting by means of a questionnaire. Over time, 11 percent of their sample reported being symptom-free without surgical intervention. The researchers were not able to account for the spontaneous remission of symptoms. This leaves room for the possibility that the improvement could have resulted from intrapsychic changes, which underlines the importance of investigating psychotherapy as a treatment. Further research has indicated that the onset of Meige's syndrome symptoms is often preceded by a major lifetime stressor and that persons who experience closely spaced stressful life events are at higher risk of developing Meige's symptoms (Johnson et al., 2007). This emphasizes the role of psychological trauma and stressors in the onset of Meige's symptoms.

Psychotherapy is generally recommended for psychogenic movement disorders. Psychotherapeutic treatments include cognitive psychotherapy with behavioural modifications focused on reducing or disabling the symptoms of Meige's syndrome and reducing perceived stress and disability (Jacome, 2010), and psychodynamic psychotherapy aimed at treating underlying depression (Hinson & Haren, 2006). Both psychodynamic psychotherapy and cognitive behavioural psychotherapy have shown positive results when working with conversion disorders and psychogenic movement disorders. More generalized studies about psychotherapy as a treatment for functional (psychogenic) movement disorders are available. The results are discussed below.

Cognitive behaviour therapy has been effective in decreasing the symptoms of patients with non-epileptic seizures by 50%. Eye movement desensitization and reprocessing were successfully used to totally eliminate non-epileptic seizures, with results that were found to have been maintained at a 12-month follow-up (Kelley & Benbadis, 2007). Hypnosis was attempted as part of a treatment programme for patients with a psychogenic movement disorder. The results showed no clear benefit from adding hypnosis to the programme (Ricciardi & Edwards, 2013). Sharma, Jones, and Factor (2017) report that brief (1–8 sessions) of psychodynamic psychotherapy produced good outcomes in 60% of the patients who were treated for psychogenic movement disorders. The authors were not specific as to what a “good” outcome was and the recommendation was made that further studies are necessary.

The researcher was unable to find studies that investigated psychotherapy as a treatment option for Meige’s syndrome of psychogenic origin, also referred to as psychogenic facial movement disorder. The website for the Dystonia Medical Research Foundation (DMRF) lists a variety of non-drug and surgical treatment options for dystonia. Psychotherapy is not among them. This indicates the general lack of interest in psychotherapy as a treatment option for dystonia ("DMRF | Treatments for Dystonia | Dystonia Medical Research Foundation | DMRF", 2017). The website of the National Spasmodic Torticollis Association (NSTA) lists treatments that are of a similar nature and psychotherapy is not included here either (National Spasmodic Torticollis Association, 2017).

In the following chapter, SHIP® will be discussed as a potential psychotherapeutic treatment modality for Meige’s syndrome.

Chapter 3

A Brief Introduction to SHIP®

3.1 The development of SHIP®

Steenkamp (1991) originally introduced SHIP® as a psycho-physiological psychotherapy method. The development of SHIP® originated from Steenkamp's exploration of autogenic training as an approach based on the concept of intrinsic self-regulation, believed to be present in all humans. Steenkamp (1991) later incorporated techniques from a plethora of existing modalities to aid and enhance the process of self-regulation. In time, these became part of the practice of SHIP®. A summary of the SHIP® concepts is provided later in this chapter.

SHIP® practitioners are constantly contributing to its evolution through their observations in private practice. This allows theory to develop from data, as described in the model of grounded theory. SHIP® has been redefined since its inception and remains part of a continuous process of evolution. "Over an extended period, which has covered more than 100,000 psychotherapy sessions, hypotheses have been formulated, tested, and integrated into a more efficient, practical SHIP® and descriptive SHIP® theory" (Steenkamp et al., 2012, p. 204).

Steenkamp et al (2012) introduced SHIP® to the psychological community. In a subsequent article, Steenkamp (2014) introduced the nine-constituent model of SHIP®. These articles and others by Steenkamp (2013, 2015) are the basis from which the researcher has formulated his understanding of SHIP®, its concepts and its location on the existing spectrum of psychological theory and psychotherapeutic models. For the purposes of this research, a basic overview of SHIP® is given and the concepts that are most relevant to the research are introduced. For a more comprehensive understanding of SHIP®, the researcher recommends visiting the website www.ship.org.za for access to the available literature on the subject.

3.2 The psycho-biodynamic model

Steenkamp et al, (2012), define SHIP® as a psycho-biodynamic oriented psychotherapy with the following focuses:

psycho – refers to the current psychological experiences (e.g. emotional dis-ease, such as anger, sadness, anxiety, in relation to all encounters)

bio – refers to *involuntary* sensory experiences and/or physical reactions (e.g. palpitations, dizziness, physical dis-ease such as spasms in the body)

dynamic – refers to the continuously suppressed, unresolved/uncompleted past experiences (trauma) projected onto and contaminating the perception of the present (e.g. the experience of childhood sexual molestation) (Steenkamp et al., 2012, p. 203).

3.3 Autonomic regulation

SHIP® is based on the concept of autonomic regulation – “a complex interaction between nerve centres, glands and chemicals that form the multiple self-correction interactive feedback systems” within an individual (Steenkamp et al., 2012, p.3). According to SHIP® theory, trauma inhibits the process of autonomic regulation and has an effect on several areas of functioning (Steenkamp, 2015). Spontaneous healing reactions (SHRs) are at the centre of autonomic regulation and are defined as the unfreezing of trauma. SHIP® psychotherapy aims to facilitate a healing space in which the abovementioned autonomic regulation can take place through SHRs (Steenkamp, 2013), thereby allowing the system to return to its healthy blueprint disposition (Steenkamp, 2014). It is hypothesized that any change in Meige’s syndrome symptoms is due to intrapsychic change as part of autonomic regulation. The data collection methods were selected in an attempt to document and map autonomic regulation processes, SHRs and intrapsychic change before, during and after the application of SHIP®.

3.4 Pathology as conceptualized from a SHIP® perspective

3.4.1 The trauma-spectrum model

In conceptualising dis-ease and dis-orders, SHIP® subscribes to a trauma-spectrum model. According to this model, the presenting symptoms are conceptualized as a manifestation of unresolved trauma. Whereas traditionally, a cluster of symptoms is diagnosed as a psychological disorder and treated by means of medication and other treatments (including psychotherapy), SHIP® conceptualizes these symptoms as trauma ramifications and misunderstood psycho-biodynamic healing reactions (Steenkamp, 2014). This understanding of trauma requires the definition of trauma to be expanded to enlarge its scope considerably. SHIP® moves away from labelling clusters of symptoms as pathology and instead regards them as normal reactions to abnormal circumstances.

In SHIP®, trauma is described as the experience and reaction of an individual to an overpowering event. As soon as a person perceives an event as overpowering (physically or psychologically), a fight or flight reaction occurs and the body enters a state of hyperarousal. When external circumstances do not allow this state of hyperarousal (fight or flight) to run its natural course, the event is perceived to have taken place at the person's expense and hence becomes an unresolved trauma memory. Traumatic events may be explicit (violence/assault/cruelty) or subtle and/or continuous, as is often the case in developmental trauma such as neglect, abuse, having a major illness, witnessing domestic violence and other incidents. According to the SHIP® model, certain reactions take place within a person's system when something is experienced as traumatic.

Steenkamp (2014) indicated that the comorbidity between post-traumatic stress disorder (PTSD) and other chronic disorders is significant in relation to the effect that trauma-induced stress may have on the brain. Recent research (De Carvalho, Pereira, Frozi, Bisol, Ottoni & Lara, 2015) have demonstrated the effect that childhood trauma may have on the development of maladaptive personality traits. Research by Glaser (2014) demonstrates the significant effect that trauma such as neglect and abuse can have on the developing brain.

Steenkamp (2014) supports the hypothesis advanced by other authors that a single inclusive trauma-spectrum model could be proposed as an alternative to the traditional diagnostic schema of separating clusters of symptoms into separate disorders. In the SHIP® framework, the idea of trauma-spectrum disorders is reframed as trauma-spectrum manifestations to support the understanding that spontaneous healing is a natural occurrence that is often interpreted as pathology when it is not correctly identified. SHIP® defines the psycho-biodynamic reactions to trauma and hyperarousal as spontaneous healing reactions (Steenkamp et al., 2012). This concept is clarified below.

SHIP® theory draws a clear distinction between trauma and the trauma-activating event. The trauma-activating event refers to the external event that catalyses a series of internal healing (fight/flight) responses. The inability to express and successfully integrate these spontaneous healing reactions is seen as the actual trauma. When there is trauma locked in the system, events that are in some way reminiscent of the trauma-activating event can re-activate the trauma in the system, often serving as a catalyst to activate deep emotions and/or feelings that are disproportionate to the objective magnitude of the event. These events are called associative activators. Terms such as trauma reminders, trauma-related cues and abuse-reminiscent stimuli

have been used to describe this in trauma literature (Steenkamp, 2014). These activators could be anything from a specific date, event or sensory experience to an illness etc.

3.5 Spontaneous healing reactions (SHRs)

SHRs are the body's attempt to self-regulate and ultimately return to a state of flow and internal homeostasis. SHRs typically occur at the time of the trauma and usually external circumstances do not allow the person to fully experience and integrate these reactions. Unresolved SHRs are then placed "on-hold" and can become frozen or disconnected as part of an attempted self-preservation (Steenkamp, 2012). The frozen SHRs do not pass through the synapses and the neural functioning is affected. Several traumas of the same nature may occur, resulting in the development of a trauma-chain that may ultimately affect the individual's way of perceiving the self and interacting with the world. Frozen SHRs can manifest in symptoms such as cerebrovascular disease, cardiovascular disease, skin disease, somatisation disorder and psychosis (Steenkamp, 2014). During SHIP® psychotherapy, several different SHRs may be experienced, some of which are listed in the paragraph below.

Many of the reactions have previously been described in the terminology of PTSD. These reactions may include experiences such as "bodily distortions, spinning, palpitations, headaches, nausea, pain sensations, sadness, anger, frightening images, smells, sounds etc." (Steenkamp et al., 2012, p. 206). SHRs may fall into different categories such as auditory, visual, kinaesthetic, olfactory, proprioception (the body's sense of internal state and space) as well as vestibular responses. Children can experience trauma even before they acquire language. These trauma memories manifest as non-narrative, sensorimotor experiences. Steenkamp has identified 1860 variations of SHRs in his experience as a private practitioner (Steenkamp, 2014).

3.6 Coping style

Steenkamp (2013) states that a coping style is a specific way of functioning within the world and a compromised coping style forms in response to specific trauma-activating events. The impact of these events seems to be most significant between the ages of three and six years. Steenkamp hypothesises that the coping style is established within the first ten years of life. Through a process of trial and error, certain areas of the personality that are most effective become more prominent as energy is directed towards that which is effective in satisfying the physical and emotional needs of the individual. The function of the compromised coping style

is to guard against further developmental trauma and possible re-activation of unresolved developmental trauma. Coping styles can take the form of becoming the rescuer, pleaser, spectator, director, performer, explorer etc. The coping style of “no identity” can also occur when a person is subjected to excessive judgment as a child and thus becomes unable to fit into his or her own skin.

Persons with compromised coping styles are often unable to express themselves adequately and this inability to express themselves may result in underlying depression and anxiety. According to SHIP® theory, depression and anxiety are interrelated. Early trauma victims often develop depressive symptoms if the trauma remains unresolved. Unresolved trauma results in an inability to express oneself and live freely. The assertive self is de-pressed and the resulting feeling of powerlessness and loss of control results in anxiety. The internal anxiety is then projected unto the external world and the individual lives with the feeling of not being able to fit in or enjoy living in the world.

3.7 Intra-translators

Intra-translators refer to the manifestation of unresolved SHRs within an individual. The system is unable to restore homeostasis and this blocking of the natural flow of energy within the individual eventually manifests as somatic symptoms such as headache, stomach pain, or physical discomfort (Steenkamp, 2014). Somatization symptoms can be conceptualized as an intra-translator in the SHIP® framework. The retained trauma memory manifests as somatization. This somatization is metaphoric and the observant psychotherapist is able to interpret the metaphoric significance of somatic symptoms. In the presented case of Meige’s syndrome, the symptoms limited the participant’s ability to express herself – this had great metaphorical significance.

3.8 Inter-translators

As a result of unresolved trauma, the individual becomes trapped in the trauma memory, unable to distinguish the past from the present, and continues to live as if the danger is still present. The individual views the world through a lens that has become coloured by the trauma memory (Steenkamp, 2014) and is therefore unable to move into the future free of problems. The word “projection” is commonly used in psychology to describe how parts of the self are projected onto an object. Similarly, inter-translators can manifest as projections onto the world, negative schemas about the self and others or potential psychosis and paranoia (Steenkamp, 2014). The

inter-translator serves as a gateway to childhood trauma. The SHIP® practitioner uses this to access the trauma memory and facilitate the process of spontaneous healing. This allows the function of the inter-translator to be fulfilled – to bring the person into contact with the underlying trauma so that frozen SHRs can be released. When the purpose of the inter-translator has been fulfilled, there is no need for its continued existence.

3.9 Distractors

Some situations may render an individual's coping style ineffective – the coping style becomes flooded by stress and the individual seeks temporary relief or control through the use of a distractor. Distractors can be compared to what is referred to as defences in some paradigms. The focus of a distractor is short-term, with the goal of shutting off or avoiding the trauma that becomes exposed when the coping style is neutralized. This allows the person a temporary escape until the coping style is again able to handle the demands of the external environment (Steenkamp, 2014). Distractors can take the form of any avoidance behaviour that come to be practised excessively, such as using substances, physical activity, emotional outbursts and others. Distractors are often practised consciously even though the individual may be aware that temporary relief may be at the expense of traumatising, as is the case with substance abuse.

3.10 Genetic constitution

Genetic susceptibility to trauma is taken into account as a factor that may play a role in the development of PTSD. SHIP® theory also takes into account research in the field of epigenetics that has shown the tendency of genes to respond to the external activators of the environment. The following section contains a summary of the available practical research on SHIP®.

3.11 Literature review

There are few studies on SHIP® as a psychotherapy.

Steenkamp (1991) presented five case studies of clients with psychosomatic symptoms who underwent SHIP®. The results showed that SHIP® was successful in removing psychosomatic symptoms. This was the first appearance of such a study in the literature. Subsequently, Schoeman (2003) introduced SHIP® as part of a treatment model for hearing-impaired individuals who had received cochlear implants. The results showed positive changes when SHIP® was administered to a 33-year-old female who was congenitally deaf and had received

a hearing implant. In 2007, Sevenster examined the experiences of 12 individuals suffering from pathological pain who participated in SHIP® through an interpretive phenomenological analysis. The participants were mainly Caucasian women, the same population group as the participant in this study. Although this does place a limitation on the generalisation of these results towards the general population, it provides an opportunity to add to the growing knowledge of women who undergo SHIP® as a treatment for painful symptomology. The results indicated that SHIP® had a significant effect on the participants' experiences of pain and the meaning attributed to it. Participants gained a sense of ownership of their experiences and a feeling of empowerment through the process of SHIP® and they found more value in validating pain than in trying to control or contain it. Hoffman and Steyn (2010) investigated the effect of SHIP® on adolescent tennis players. This was the first instance in which SHIP® was evaluated in a sports psychology context. The results showed an increased ability to cope with competition stress, increased psychological wellbeing and improved mood states when an experimental group that received the intervention was compared to a control group that did not. The most recent research by Kieser-Muller (2016) presented a case of an ageing individual with complex PTSD who underwent SHIP® for seven years. The participant experienced relief of somatic distress, improvement in terms of regulating emotions and attention and cognition as well as enhanced relational regulation. The above summary of available research illustrates the need for more intensive and focused studies of SHIP® for different symptoms and in differing contexts.

Chapter 4

Methodology

4.1 Introducing the hermeneutic single-case efficacy design (HSCED)

The researcher conducted a literature search of the available approaches to single case studies and found the Hermeneutic Single-Case Efficacy Design (HSCED) as described by Elliott (2002) and modified by Wall, Kwee, Hu, & McDonald (2016) to be a good fit for the purposes of his research. This design has been identified as practical for graduate student research (Wall et al., 2016). The following section provides a brief summary of the development of the HSCED and its relevance as a research design.

The randomized clinical trial (RCT) design has served as a standard for measuring the efficacy of psychotherapeutic interventions. In recent years the RCT design has been criticized for inferring causal relationships without providing any mechanism for understanding the nature of those relationships (Haynes & O'Brien, 2000). A further problem is that RCTs are not suitable for inferences about single cases. Clinicians are often in a position to investigate individual clients' specific healing processes. In such cases a single case design or case study is indicated (Elliot, 2002). Kazdin (1981) proposed guidelines for increasing the validity of the single-case design. These include using quantitative and qualitative data and multiple change assessments over a period of time, as well as measuring the reduction in participants' previous chronic problems and immediate effects after completion of the intervention. In an effort to address these issues, Elliot (2002) outlined the HSCED as an approach for assessing treatment causality in single psychotherapy cases. The approach was based on the works of Kazdin (1981), Cook and Campbell (1979), Mohr (1993) and Bohart and Boyd (1997).

4.2 The HSCED structure

Elliot designed the initial structure of the HSCED in 2002. The structure allows for flexibility in the use of data collection instruments and other finer details to suit the uniqueness of specific cases. The macro structure and essentials of HSCED remain constant, as set out in the section below.

4.2.1 Rich case record

HSCED requires a rich case record to be compiled. Various data sources may be used here. The researcher conducted a literature review and data collection methods were selected to

match the method and theoretical underpinnings of SHIP® in accordance with the recommendations for HSCED as outlined by Elliot (2002) and enhanced by Wall et al. (2016).

Data collection procedures

1. *Basic information.* Idiographic case information was used to provide a context in which to understand the data collected. Identifying details, the history of the presenting problem and other clinically significant details were obtained from the case file, with the permission of the participant and her psychotherapist. These details were notated by the psychotherapist in his initial interview with the participant and recorded in the form of case notes as psychotherapy progressed. Central to the study are the physical symptoms of Meige's syndrome and the subjective experience of depression and anxiety that accompanied these symptoms. To this end, a self-report of the history of symptoms was collected in the clinical interview before the commencement of SHIP®. This report serves as a baseline against which symptoms are measured (Elliot, 2002).
2. *Quantitative outcome measures.* Elliot (2002) suggests that quantitative measures should be used to provide a description of how much a participant has changed after psychotherapy. It is therefore suggested that the measuring instrument should be a repeated-measures design: the same individual is measured for the same constructs before and after psychotherapy (Gravetter & Forzano, 2012). The Rorschach inkblot method (RIM) was selected as a quantitative measure. The following paragraph provides a brief description of and illustrates the reasoning behind the selection of the RIM.

The RIM is a performance-based measure in that it infers personality characteristics from the way participants respond to 10 ink blots that are printed on cards (Weiner & Greene, 2017). The internal mental processes and idiographic trauma memories (TSM) of the test taker are projected on the test (Huprich, 2006), making it an appropriate instrument of measurement. By 2004, selected studies had been using the Rorschach inkblot method (RIM) as a method of measuring changes before and after psychotherapy. A meta-analysis by Grønnerød (2004) of 38 studies on the topic supported the RIM as a valid method of measuring changes before and after

psychotherapy. Grønnerød's research showed that the time frame over which the pre- and post-tests are administered does not have an impact on the stability of the test. Multiple studies have investigated the suitability of the RIM for psychotherapy. The results have shown satisfactory consistency (Nygren, 2004). De Vos, Boyer and Borders (1989) have shown that many associative patterns and symbolisms measured by the RIM are universal across cultures. This makes the RIM suitable for the multicultural South African context. The RIM does not require any reading or writing skills from the participant. This eliminates any issues regarding English proficiency which might arise because the participant is not a mother-tongue English speaker.

The RIM was administered by the participant's psychotherapist (SHIP® practitioner) on 08/05/15 before the commencement of SHIP® and again on 24/06/16 after SHIP® had been completed. Although there were still additional sessions after this date, these were follow-up sessions to monitor her psychobiological state and phase out psychotherapy contact.

3. *Change interview.* Elliot, Slatick and Urman (2001) developed the change interview. This semi-structured interview captures the client's qualitative description of the changes experienced through the progression of psychotherapy, including the participant's attribution for these changes. It typically takes 30 to 45 minutes and may be conducted by the researcher or psychotherapist (Elliot, 2002). The change interview has become standard practice and has been used in all HSCED studies to date. A brief semi-structured change interview was conducted by the psychotherapist immediately after the completion of SHIP® and a full change interview was conducted by the researcher six months after the completion of SHIP®. The brief interview was recorded by hand and the full interview was recorded digitally and transcribed. In order to refresh their memory of SHIP® sessions, SHIP® participants are encouraged to diarize their experience of individual sessions. Fortunately, the selected participant had made daily diary entries throughout the process. She was asked to re-read diary entries before the full change interview was conducted to allow for possible memory fallibility. The change interview contained a Likert-scale rating of symptoms by the participant on a scale of 1 to 7 that captured her view of the effect of SHIP® as well her rating of her symptomology pre- and post-SHIP®.

4. *Weekly outcome measure.* Elliott (2002) suggests using a simplified personalized questionnaire (PQ) as a weekly outcome measure of the participant's main psychotherapy-related problems and goals. Wall et al. (2016) suggest several innovations for an HSCED. These include an expansion of the repertoire of assessment tools to cater for investigating new psychotherapies and new applications of existing psychotherapies. Accordingly, the simplified personalized questionnaire was modified to include a measurement of the observable Meige's syndrome symptoms to accommodate the physical nature of Meige's syndrome and a measurement of subjective anxiety and depression. Both these variables were measured on a seven-point scale.

The PQ questionnaire was completed by the psychotherapist in collaboration with the participant at the start of each new session. The psychotherapist would inquire about the severity of the Meige's symptoms and anxiety and depression between the current session and the previous one and ask the participant to rate her symptoms on a scale of one to seven. The psychotherapist would then ask the participant to reflect on her qualitative experience between the current session and the previous one. The psychotherapist recorded this response verbatim.

5. *Helpful Aspects of Therapy (HAT) form.* The HAT is a commonly used qualitative measure of the psychotherapist's or client's experience of major psychotherapy events. It is a seven-item open-ended questionnaire that aims to locate important psychotherapeutic processes that are associated with change (Llewelyn, 1988). It may also be used to validate important change processes mentioned in the change interview (Elliott, 2002). The HAT was adapted to include specific SHIP® terms and completed by the SHIP® practitioner after each session. After the completion of SHIP®, the researcher transferred the hand-written notes to typed electronic format.
6. *Records of psychotherapy sessions.* Process notes or videotapes are made by the psychotherapist and used to locate, substantiate or clarify contradictions elsewhere in the data, if necessary (Elliott, 2002). In this instance, video recordings of the participant pre- and post-SHIP® were viewed to note any observable changes in Meige's syndrome symptoms. Particular emphasis was placed on the manner in which the symptoms affected the speech of the participant.

7. *Additional measures.* An additional measure used was a pre- and post-SHIP® customized questionnaire. This self-report questionnaire designed by Dr JO Steenkamp measures perceived changes in coping styles of clients. It was selected in order to measure the concept of coping styles as, according to SHIP® theory, changes could occur in the coping styles of persons who have completed the psychotherapeutic process. The pre- and post- SHIP® questionnaire was administered by the SHIP® practitioner and analysed by the researcher.

4.2.2 HSCED literature review

Since HSCED is a new emerging research method, the literature contains few HSCED studies and a need for more such studies has been identified. The researcher was able to find the following published accounts of studies that used the HSCED design:

In Lisbon, Portugal, the HSCED was used to deepen our understanding of a case in which systematic psychotherapy was administered to a patient with paranoid personality disorder. Individual sessions were conducted by a psychotherapist and co-psychotherapist as part of the systemic approach (Carvalho, Faustino, Nascimento, & Sales, 2008). The HSCED results indicated that the psychotherapy had been effective in de-pathologizing the patient's condition. The HSCED has also been used in cases where person-centred therapy and emotion-focused therapy were applied as a treatment method for a person suffering from social anxiety. The HSCED was able to adequately indicate that the changes that occurred were due to psychotherapy (Stephen, Elliott, & Macleod, 2011; MacLeod, Elliott, & Rodgers, 2012; MacLeod & Elliott, 2014). Elliott et al. (2009) used the HSCED to evaluate the efficacy of process/experiential/emotion-focused psychotherapy as a treatment for a 61-year-old European-American male who was suffering from panic disorder and bridge phobia. These studies illustrate the applicability of HSCED as a design that investigates the efficacy of different psychotherapeutic modalities in treating a variety of symptoms. The relatively few HSCED design studies available also illustrate the need for more studies of this nature to be conducted.

4.2.3 Sampling method

Convenient and purposive sampling was used as the case was chosen on the basis of convenience and to fulfil a particular function (Gravetter & Forzano, 2012). In this instance, the function was to describe the case of a person suffering from Meige's syndrome who was undergoing SHIP®. The average time required for the completion of SHIP® when administered once a fortnight is about two years (JO Steenkamp, personal communication, August 23, 2015). In the selected case, the participant received sessions on a more frequent basis and completed her SHIP® process on 14 October, 2016. A recent case was selected to allow for the fact that SHIP® is an evolving method. It also makes it possible to conduct the interview shortly after the completion of SHIP® and again after a six-month period. Meige's syndrome is a rare condition and for this reason there were no other possible participants. Inclusion criteria were limited to a person who has Meige's syndrome and is approaching completion of SHIP®. All other persons were excluded.

4.2.4 Data analysis

The data gathered by the abovementioned methods had to be analysed and interpreted to yield both quantitative and qualitative results. The following section describes the process of data analysis and interpretation.

4.2.4.1 Basic information

The idiographic case information was used to corroborate and provide a context for the data collected through other methods. No specific method of analysis was required.

4.2.4.2 RIM data

The RIM protocols were scored by the researcher and independently scored by a proficient external scorer to ensure reliable scoring. The guidelines for administration, scoring and coding of the Comprehensive System were followed in using the RIM. The scores were then entered into a computer program called Rorschach Interpretation Assistance Program (RIAP). The RIAP delivers computer-generated qualitative and quantitative data and interpretations based on the Comprehensive System (CS) as set forth by Exner (2009) and Weiner (2001). The CS is widely accepted as valid (Wood, Nezworski, & Stejskal, 1996; Exner 2009) and provides quantitative measurements of several psychological constructs, in the form of descriptive statistics.

The researcher has, in consultation with Dr Steenkamp, selected certain areas of functioning that should experience a shift after the SHRs have taken place and SHIP® has been completed. Although the researcher's attention was focused on these areas, other significant results were also noted. The section below provides a theoretical exposition of the selected variables and explains why change was expected in these areas.

Coping Style: A coping style is defined as a part or parts of the individual's personality traits that become the dominant style of relating to the external environment (Steenkamp, 2002). Weiner (2014) classifies a coping style as part of a person's defences – a mechanism that allows people to reduce and deal with painful experiences. A coping style plays a large role in a person's ability to adjust to different experiences and situations. The coping style configuration is formed through a process of trial and error during the developmental years as energy is directed into that part of the personality potential which proves successful in dealing with external demands (Steenkamp, 2002), while denying that which fails to produce results. The coping style that guards against further vulnerability and trauma by maintaining a survival-relationship with external life (Steenkamp, 2013) can be measured by the structural variables EB (Erlebnistypus), EBPer (Erlebnistypus Pervasive) and L (Lambda) on the RIM (Exner, 2009). According to Steenkamp (2015), persons who are integrated have unrestricted access to all internal personality traits and potentialities and thus to a selection of coping styles. Trauma, on the other hand, can result in a rigid, unchanging coping style configuration and limited flexibility. This indicates that changes should occur in the coping styles of persons who have completed SHIP®.

Internal Resources: In the context of this study, internal resources are defined as the amount of psychological resources available to deal with stress management (Exner, 2009). Steenkamp (2015) states that persons who are subjected to trauma can experience a depletion of internal resources. Autonomic regulation through SHIP® facilitation would lead to a release of stuck trauma energy and to the replenishment of these resources and therefore a change in the measured internal resources is expected before and after SHIP® – in other words the denied potentialities have become open to the experience of expression and interaction (Steenkamp, 2013). Internal resources can be operationally measured by the EA (experience actual), D (the D score), and the Adj D (adjusted D score) on the RIM (Exner & Erdberg, 2005).

Self-perception: Self-perception is defined as how one sees oneself, the interior vocabulary of concepts that represent the characteristics of the self (Exner, 2009). SHIP® theory states that

trauma, the biology of disconnection, affects perception that results in projection (Steenkamp, 2013).

The SHIP® term ‘inter-translator’ describes this perceptual trauma-colouring:

This time perception corruption as a state of imprisonment results from the fact that the brain has lost its ability to distinguish past from present – stored procedural memory of the trauma-activating event continues to operate as if the danger is still imminent, resulting in an inability to move into the future free of issues (Steenkamp, 2014, p. 9).

Self-perception can be operationally measured by the structural variables $3r+(2)/R$ (Egocentricity Index) and FD (Form Dimension) on the RIM. FD relates to the ability to think and reflect about the self. The notion is that after SHIP®, the ego defences should be stronger and self-perception should have undergone change, due to the system’s automatic gravitation towards an integrated self.

Depression, anxiety and stress: In this dissertation depression refers to depressive dispositions and affective problems, not to a prevalent depressive disorder. According to SHIP® theory, depression and anxiety are related (Steenkamp, 2002). Depression can be operationally measured by the DEPI (Depression Index) on the RIM (Exner & Erdberg, 2005). Anxiety and stress can be operationally measured by the structural variables of FY, YF and Y (diffuse shading), m (inanimate movement) as well as the D Score and Adjusted D Score. The system’s return to homeostasis implies a re-integration of the sense of self and the resolution of depressive and anxiety symptoms (Steenkamp, 2015).

4.2.4.3 *The change interview*

In interpreting the change interview, a thematic analysis was used to identify prominent themes relating to changes that have taken place. The interview was conducted and analysed by the researcher. As suggested by Willig (2014), the researcher immersed himself in the data by transcribing the interview and then re-reading it. The researcher then read through the text line by line, labelling meaningful units with a code that represents a specific meaning. Clusters of codes were then organized into themes that relate to the research question. In the final stage themes were interpreted and conclusions were drawn.

4.2.4.4 *Weekly outcomes measure*

The PQ questionnaire data were interpreted to yield quantitative information in the form of mean scores against which individual ratings of symptoms before, after and during SHIP® could be plotted. A thematic analysis was used to analyse the qualitative descriptions of the experience of individual SHIP® sessions.

4.2.4.5 *HAT form*

The HAT forms were completed by the SHIP® practitioner and analysed by the researcher by means of thematic analysis. The data collected were used to locate significant SHIP® processes such as SHRs and to substantiate change processes mentioned in the change interview.

4.2.4.6 *Questionnaire*

Item-by-item pre-post comparisons were used to analyse the data for indications of shifts in coping styles. The pre-and post-SHIP® questionnaire was administered by the SHIP® practitioner. The questionnaire was used as collateral information and was not specifically analysed.

4.3 Direct evidence

After the collection and analysis of data, evidence of the change brought about by psychotherapy was considered. Elliott (2002) mentions five forms of evidence, two of which need to be clearly present if the analysis of the data is to proceed.

- 1) Retrospective attribution of change to SHIP® as recorded in the change interview.
- 2) Process outcome mapping which indicates that participant's post-psychotherapy changes correspond to specific SHIP® processes.
- 3) Correlation of within-psychotherapy process outcomes – week-by-week changes in symptoms co-vary with adherence to SHIP® principles. E.g., how well the practitioner was able to facilitate the activation of SHRs.
- 4) Change in chronic symptoms – if the SHIP® psychotherapy coincides with a change in Meige's syndrome symptoms against the reported baseline, a psychotherapeutic influence can be inferred.
- 5) Event-shift sequence – significant psychotherapeutic events precede a change in Meige's syndrome symptoms.

4.4 Indirect evidence and alternative explanations for measured client change

HSCED requires the researcher to assume the role of “detective” when he considers the eight alternative non-psychotherapy explanations prescribed by Elliot (2002). The section below lists and describes these possible alternative explanations.

4.4.1 Trivial or negative change

Trivial change. Qualitative changes may be described in ambiguous terms such as: “I think I am starting to realise that there could possibly have been changes that occurred”. Quantitative measurements also have to fall within the range of clinical significance in order to be considered. In the case of the participant, trivial change was disqualified as retributive attribution of change was clear and unambiguous.

Negative change. Negative changes in both quantitative and qualitative outcomes can cast doubt on the effectiveness of psychotherapy. The participant reported no negative changes after receiving SHIP®.

4.4.2 Statistical artefacts

Statistical errors may include factors like measurement errors, experimental errors or regression to the mean.

Measurement errors. Measurement errors account for inconsistencies in quantitative measurements. Questions could be misheard, misread or misunderstood. The researcher attempted to account for measurement error in the coding of the RIM protocols by obtaining a second independent scoring from his supervisor and corroborating the results.

Experimental errors. With the relaxed standard of significance (80 percent), there is a chance that multiple change measures may show some reliable differences as a result of change alone (Elliott, 2002). As is the case in this research, when three measures of change (RIM, PQ & Questionnaire) are used, there is a .49 percent chance that one of them may show change by chance. The proposed solution is that two of the three measurements should show reliable change. Fortunately, reliable change was present in all three measures.

Regression to the mean by outliers. Regression to the mean would be relevant if the initial RIM scores lay within the extreme values of the measure. The possibility would then arise that subsequent measures would show a drop in these scores (Elliott, 2002). The pre-SHIP® RIM results include some extremities and thus regression to the mean was considered to be

an issue. The participant's pre-SHIP® PQ scores were in the extreme range (maximum possible). As psychotherapy progressed these scores remained stable, only fluctuating after the participant had undergone sufficient sessions to effect change. Regression to the mean was therefore considered a factor.

4.4.3 Relational artefacts

The term relational artefacts refers to the idea that because of the interpersonal dynamics between the psychotherapist or researcher and the participant, it may be desirable for the participant to show improvement. The participant may express improvement out of gratitude towards the psychotherapist or as part of a desire to end psychotherapy. Relational artefacts were a possibility in this study as a good psychotherapeutic relationship was established between the psychotherapist and the participant.

The likelihood of conveyed psychotherapy attributions. Bohart and Boyd (1997) suggest several plausibility criteria. In relation to the change interview, elaboration and discrimination are considered vital. A reliable client account of the influence of psychotherapy is supplied. Specific details and attributions are provided regarding what has changed and how change came about. These include general descriptions and adequate support detail. In addition, one can expect not only positive but also negative or neutral descriptions. Excessively positive or very vague descriptions that lack detail and cannot be elaborated on when the participant is questioned are a likely indicator of interpersonal self-report artefacts. The participant attributed alleviation of Meige's syndrome symptoms and anxiety and depressive symptoms to SHIP®. She was able to explain details of the important themes that she had to work through and how she believes that previous unresolved trauma in her history manifested in Meige's syndrome symptoms. She also described psychotherapy as being extremely difficult at times and that she often felt that she did not have the strength to continue going to sessions. Her report is therefore seen to contain a mix of positive and negative experiences of psychotherapy.

Interview Strategy. Another factor is that the participant is aware that the researcher is the psychotherapist's son. This could also have served as a motivation to report improvement in the change interview. The change interview was extensive and was conducted in a manner that encouraged self-reflection and openness.

4.4.4 Expectancy artefacts

Another possible non-psychotherapy explanation for reported change could be that the participant had certain cultural expectations of psychotherapy. The client may have convinced herself that because she has undergone psychotherapy, she must have changed. Post-psychotherapy accounts such as the change interview are vulnerable to these artefacts. This is especially the case when the participant is reporting mood symptoms or other self-evaluations that may be somewhat ambiguous. To allow for this, the participant was encouraged to keep a diary and to read diary entries before the change interview to refresh her memory of her experience of her symptoms before, during and after the process. The fact that Meige's symptoms are physically observable and were drastically affecting the participant's speech, decreased the likelihood of expectancy artefacts, although some such artefacts could still have been present when the participant was reporting depressive and anxiety symptoms. The participant's account of how her depression lifted was idiosyncratic, unlike what could be expected if it were affected by cultural expectations. She also recalled that the depression got worse at times and that the change was a gradual process that occurred after a year. She was able to recall specific months during which symptoms worsened and then lifted again in others. This contributed to the authenticity of her account. Accordingly, the concept of expectancy artefacts was not considered to be significant, even if it could not be discounted altogether.

4.4.5 Self-correction processes: self-generated return to baseline and self-help

These non-psychotherapy explanations assume that change has occurred, but that it was caused by factors other than psychotherapy. For instance, the client may have been in a particular state of distress when she entered psychotherapy and change was a natural function of reverting to normal functioning or change could be the result of an ongoing developmental trend that was in process and occurred independently of the psychotherapeutic process.

4.4.5.1 Self-report strategies: direct and indirect

The term direct self-report strategy refers to asking the participant about her attribution of change. In the selected case study, the participant reported that change without SHIP® would have been highly unlikely and she ascribed the change she experienced as the result of "going to the root of the dis-ease...I had to work through it...emotionally and physically". The psychotherapist process notes and PQ scores provide a helpful indirect measure. The

fluctuation in these scores according to the intensity of the SHIP® sessions corresponded to the participant's account, as shown in the results section.

4.4.5.2 Baseline and pre-test strategies

In order to better evaluate the likelihood of change being due to a self-correction process, a measurement of the participant's baseline functioning is required. This was done during the first interview by asking the participant how long she had been experiencing the presenting problems. She reported that she had been struggling with depression for years and had been taking an antidepressant for about 15 years prior to SHIP®. She reported that she had been experiencing the Meige symptoms for about four months before starting psychotherapy. The duration of her central problem of Meige's syndrome was sufficient to qualify for a diagnosis of Meige's syndrome by a neurologist and the remission of her symptoms occurred within a time span that was significantly shorter than the time that spontaneous remission of symptoms is typically expected to take. The long duration of her symptoms and the physical nature of the Meige symptoms make it unlikely that the change was due to self-correction processes.

After this, the researcher summarized the findings in the form of an affirmative case that supports the notion that SHIP® was responsible for the changes in symptoms and a sceptical case that support the notion that changes may be due to other factors.

4.5 Extratherapy events

These events are, as the name indicates, any event that occurs outside psychotherapy and may cause changes in the participant's symptoms. Examples of such events are changing jobs, changes in health due to physical injuries or medical interventions, new relationships, births and deaths, substance abuse and other events. These events can contribute in a positive or negative manner to the psychotherapy outcome and could, in their most extreme form, cause the termination of psychotherapy or make an unsuccessful psychotherapy appear successful. The main method of evaluating the effect of extratherapy events is to ask the participant. This is done in the change interview – the participant was asked what she thought had brought about the changes. The client was then also prompted to describe extratherapy events and say whether she perceived these to have an influence on her outcome. The psychotherapist's process notes were also used to corroborate the influence of extratherapy events on the process.

The participant reported that there had been some interpersonal events between herself and her mother that activated her emotions and often made her more depressed. She indicated that these events were always brought into psychotherapy. In SHIP® terms, these events are perceived as associative activators that can be used to facilitate spontaneous healing. There were several indications in the psychotherapist's process notes of such events being used in the SHIP® sessions. Botox injections were reported as another significant extratherapy event. According to the participant, the botoxulin injections were incredibly painful and had the effect of traumatising her – it was a setback that caused additional trauma. She reported that her Meige symptoms and depression worsened after the Botox and that she had to work through the trauma of the injections during SHIP®. The PQ scores and the psychotherapist's process notes confirm this notion. Around the month of September when the injections were administered, a significant change in PQ scores was recorded. It was therefore concluded that extratherapy events did influence the process in a negative manner and could quite possibly have prolonged the duration of SHIP® owing to the additional trauma that they caused. Extratherapy events were not judged to be responsible for the positive changes in Meige's symptoms and depression and anxiety.

4.6 Psychobiological causes

This section describes any relevant hormonal or psychophysiological processes or herbal remedies. It includes medications taken for mood or anxiety problems. In the case of the participant, both herbal remedies and psychiatric medications were taken during the course of SHIP®. It should be noted that the participant had been taking psychiatric medication for years before the start of SHIP®. She was also prescribed psychiatric medication for the Meige's symptoms and had been taking these medicines for more than a month before the commencement of SHIP® without any significant improvement. During the course of SHIP®, she vacillated between different psychiatric medicines until ultimately discontinuing their use altogether several months into the process. The participant reported that she has discontinued the use of these medicines for several months without experiencing the return of any depressive symptoms. She also reported consulting a homeopath while she was in the initial stages of SHIP®. The medicines that were prescribed had no effect and were discontinued after one month of use. SHIP® theory states that although there may be a place for psychiatric medicines in certain instances, these medicines often repress the spontaneous healing messages that are attempting to surface. As such, the choice to discontinue the use of these medicines may have been conducive to the facilitation of spontaneous healing.

Psychobiological causes may be present in the case of this research but considering the above evidence, it seems improbable that they were sufficient to cause the measured change on their own.

4.7 Conclusion

After considering all the above mentioned alternative causes of change, the researcher was able to present of complete picture of the possible explanations for the measured change in the participant. A comprehensive discussion is given in the relevant chapter.

4.8 The context

The researcher approached Dr JO Steenkamp, the founder of SHIP®, and explained the nature of his proposed research. Steenkamp is a private practitioner in Pretoria, South Africa. He has given written consent for the use of this case from his practice. In anticipation of future research, an option is provided for SHIP® clients to agree to allow their case details to be used for research purposes. These include a pre- and post-SHIP® administration of the RIM and the coping styles questionnaire as well as weekly outcome measures. An information form is provided and participants are given time to read the form and ask questions before a consent form is signed.

4.9 Reflexivity

The researcher (Casper Steenkamp) is the son of Dr JO Steenkamp. A favourable outcome is thus desirable for both the researcher and the practitioner. Although the practitioner attempted to remain as neutral as possible when administering the RIM and completing the HAT, there is a possibility that researcher bias influenced the process. The psychotherapist and researcher had no prior knowledge of how changes in the raw RIM responses affect the variables that are identified for measurement on the CS, as the analytical process is complex. There is also a possibility that the participant may wish to give desirable answers in the change interview. The fact that Meige's syndrome symptoms are physical and easily observable makes it possible for the changes in symptoms to be corroborated by independent third parties.

4.10 Ethical considerations

The study was guided by the HPCSA ethical guidelines and principles for health research ("Professional Conduct & Ethics – HPCSA", 2016).

The participant was informed about the study both verbally, by her psychotherapist and the researcher, and in writing through an informational letter. She was given information about the purpose of the study, the data collection procedures, her right to withdraw from the study at any given time without any negative consequences as well as the confidentiality of the case. Information was also provided about the international publication of the study.

Written consent was obtained from the participant to allow the data to be collected, stored and published. The results of the data were made available to the participant after the completion of the research. The study commenced after the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria had approved the research proposal.

SHIP® as a psychotherapy is facilitated by qualified psychologists (qualified SHIP® practitioners), within their scope of practice. The following careful steps were taken to ensure that the participant was not put under any emotional strain through the administration of the testing procedures:

- The RIM was administered by Dr Steenkamp after rapport had been established through psychoeducation about the nature of SHIP® and the confidentiality of the psychotherapeutic process.
- Ship session notes and HAT forms were completed after the participant had been given an opportunity to speak about any significant events or insights that she experienced between sessions.
- Debriefing sessions were made available free of charge if the participant felt traumatized by the process. The participant did not express the need for any such sessions.
- The researcher requested that the change interview be conducted in a space where the participant would feel most comfortable. The participant suggested her living room as a comfortable space, hence the interview was conducted there.

All data obtained from the research were digitized and password-encrypted. The data will be securely stored in the Department of Psychology (11th floor, Humanities Building, University of Pretoria) for 15 years after publication.

Chapter 5

The Curious Case of Mrs M

5.1 Presenting complaint

Mrs M is a 42-year-old Afrikaans Caucasian female who was referred to SHIP® by her husband (Mr M). They have been married for 21 years and have two children (11 and 14).

She reported her reason for coming to psychotherapy as follows:

“The reason was absolute desperation to be free of that which was holding me back. If there was an unknown cause of my Meige’s syndrome then I wanted to be free of this.”

She described her physical symptoms as follows:

“There were acute facial spasms on both sides. My jaw was uncontrollable. My forehead contracted terribly. I struggled to swallow and because of the spasms I could not eat. It (talking) was incredibly painful to the point that I decided rather not to talk. At times, my lips became blue and I struggled to breathe.”

She presented with the following manifestations of Meige’s syndrome:

- blepharospasm - involuntary squinting
- oromandibular dystonia - facial grimacing, frowning, involuntary contraction of the jaw muscles, protruding lips when trying to speak, tongue writhing, and uncontrollable contraction of the platysma muscle, causing problems with swallowing and speaking.

5.2 History of presenting complaint

Mrs M experienced the first physical symptoms of Meige’s syndrome in December 2013 while on holiday. At the time, Mr M had just returned from an international business trip (a regular occurrence due to the nature of his career). She experienced minor contractions of the muscles in her cheeks. Mr M went on a subsequent business trip in January 2014. Upon his return, he showed her photographs of his trip. One of the photographs was of himself, his business partner and the partner’s wife. She recalls feeling rejected, left out and jealous that she could not accompany him on these trips. The spasms worsened after this event. She confronted her husband about her feelings and the spasms lessened for about a week, after which they resurfaced and worsened until they became as bad as at her initial presentation.

5.3 Daily functioning

Mrs M’s level of functioning before the onset of her current condition was good. She described her experience of Meige’s syndrome as follows:

Communication with the world around me changed severely. Talking to friends and family was too difficult and painful. I became badly isolated. On compulsory trips outside of the house I would avoid people at all costs because of the pain and embarrassment of the condition. When really necessary I would write notes to communicate my needs. In many situations my children (11 and 14) would become my voice and speak on my behalf. The spasms initially mostly affected my vision and speech. However slowly but surely the spasms also increased when attempting to eat. It became too painful and difficult to chew anything and swallowing was almost impossible because of the severe pain – somehow I gave up on eating, losing a lot of weight in the process which caused me to have little energy and I have become weak physically. I trained multiple times per week prior to this, but that stopped completely. The pain in my jaw was intense and I had severe headaches. The spasms also caused my eyes to close up, affecting my vision. Talking to my children, husband or any person was too painful and took so much effort that I kept it to the absolute minimum. Most of the time I physically could not speak because of the spasms and pain, I could not even smile. My and our family life changed completely.

Mrs M reported that she started to feel hopeless, alone and alienated and was unable to work. The idea of suicide entered her thoughts on numerous occasions and Mr M recounted that there were two occasions where he feared he would lose his wife to Meige's syndrome.

5.4 Medical and psychiatric history

Mrs M reported that she had been diagnosed with post-natal depression after the birth of her first child and had been using Cilift (20 mg once per day) for 15 years since her student days. After the onset of Meige's syndrome she saw a doctor at her local ER clinic who told her she was suffering from anxiety and gave her a prescription for Venlor and Ativan. She then visited a neurologist who requested MRI and EEG procedures. No abnormalities were found and her thyroid function tested normal. The neurologist prescribed Ritrovil and Urbanol but because of unwanted side effects, Mrs M returned to Venlor and would take Ativan before meals to ease the discomfort of swallowing food.

Mrs M's history of use of psychiatric medication is summarized below:

- Cilift – 20 mg once per day for 15 years. Stopped use completely in July 2016.
- Venlor – 20 mg once per day. January 2015 to June 2015.

- Urbanol – January 2015 to May 2015.
- Ativan – 20 mg once per day. January 2015 to May 2015. July 2015.

5.5 Alternative treatments

For a period of three months prior to starting SHIP® Mrs M visited a faith healer. She also consulted a homeopath, who told her that her condition was caused by micro-parasites that had infected her bile. The homeopath stated that the parasites would probably infect other areas if left untreated and a herbal remedy was prescribed that would provide relief after four days. The herbal remedy did not alleviate the symptoms.

5.6 Developmental history

Mrs M reported that she was born out of wedlock and her parents would often experience marital conflict. Her father was diagnosed with bipolar disorder and would engage in excessive drinking. She recounted traumatic memories of him that included pornography and incidents involving prostitutes. Her mother would verbally abuse her father and threaten to leave him. Mrs M felt powerless in the face of the conflict between her parents. She recounted an incident in which she went for a tonsillectomy. She emerged from the operating theatre with a bandage around her head – her mother had secretly scheduled her for cosmetic ear surgery along with the tonsillectomy. This was very traumatic for her.

At school her marks were poor and she experienced high school as overwhelming. In her relationships she felt as if boyfriends dated her mostly for her looks. Later in her life a man whom she was dating told her that she was overweight and after this she became bulimic for the three-month duration of the relationship.

Mrs M also reported other traumatic events in her life:

- She had previously been very ill with pancreatitis which resulted in severe weight loss.
- She suffered from post-natal depression after the birth of both her children.
- She experienced extreme work stress that resulted in hair loss.
- Her husband was involved in a major motor vehicle accident.
- There was an armed robbery at her home.
- Ulcerative colitis made her severely ill.

- Her father died after a long period of psychobiological decay.
- Meige's syndrome.

5.7 The SHIP® psychotherapy

Mrs M completed 75 sessions of SHIP®, totalling up to 114 hours. SHIP® sessions usually lasted for one hour and were administered once bi-weekly. Dr Steenkamp reported that owing to the severity of her dis-ease, more frequent sessions that were sometimes of longer duration were indicated. The average number of hours of SHIP® that Mrs M received amounted to 3 hours per week. The process started in May 2015 and currently she is not attending psychotherapy on a regular basis any more, her last session having taken place in February 2017. During the process of psychotherapy, she received continuous support from her husband and her church circle.

The psychotherapy notes indicate that Mrs M reported feeling extremely depressed upon entering the psychotherapist's office on several occasions during the process. There were also suicidal references that could be ascribed to the debilitating effect of Meige's syndrome on her life but there was no indication of a plan to put her intention into effect. Several traumas were uncovered during psychotherapy. SHIP® facilitated the space that allowed Mrs M to work through these traumas, allowing the SHRs to release and the autonomic regulation process to run its full course. The most prominent traumas are listed below:

- A lack of physical touch and nurturance as a child, resulting in feelings of being unloved and an insecure sense of self. This included being excluded by her mother.
- Feelings of anger towards her mother and the ambiguity of being told that she should not speak if she did not have anything good to say while her mother would continuously say demeaning things about her father. Not being able to voice her feelings in her mother's presence resulted in her feeling that she did not have a voice in her family. This is something that she also experienced when Meige's syndrome started – she could not physically speak any more and had lost her voice.
- Not being able to speak to her husband about not taking her along on his overseas trips for fear that this might cause conflict. This again resulted in feelings of not having a voice or being unable to express herself.
- Becoming extremely emotionally disturbed by the green uniforms of the nursing staff at the ER facility where she was admitted for Meige's syndrome for the first time.

This associative activator led to the opening up of multiple trauma memories. The first of these was a lame feeling in her throat caused by anaesthetic during her childhood. This occurred during an operation that her mother arranged without her consent. She fought the nurses in their green uniforms while they held her down on the operating table and forced the anaesthetic mask over her face. She felt powerless and angry towards her mother. The second trauma memory associated with the green uniforms was that of a childhood molestation by an uncle's girlfriend who was employed as a hospital nurse and used to wear a green uniform. Mrs M remembered how traumatic it was for her when this nurse took her to have her ears pierced and how she had hoped that her mother would refuse this and protect her. She felt unsafe and unprotected by her mother.

- A traumatic experience at the dentist as a child that resulted in not being able to breathe.
- Her feelings of anger towards herself for creating the illusion that she was living a perfect life while in actual fact she was not as calm as she pretended to be and lived with a feeling of being inhibited.

5.8 Summary

This chapter presented the case of Mrs M and her psychotherapeutic process. In the following chapter, the results of the additional data gathering methods are presented.

Chapter 6

Results

The purpose of this study was to investigate the efficacy of SHIP® as a treatment modality for Meige's syndrome. In this chapter, the findings of the study are presented. Descriptive statistics as yielded by the quantitative measures are presented first, followed by qualitative descriptions of change.

6.1 RIM data

The RIM results are divided into two sections. The first section displays the raw data as yielded by the comprehensive system. In this section, the researcher shows all the variables that were measured on the RIM. The pre- and post-SHIP® results are given. The second section contains any changes in the interpretive hypothesis as provided by the RIAP for the pre- and post-SHIP® administrations.

6.1.1 Quantitative RIM results

The table below contains the descriptive statistics yielded by the RIM pre- and post-SHIP®. The pre-SHIP® results placed Mrs M within the international norm group of outpatient ambulant. As such, both the pre- and post-scores are presented alongside the norms for the outpatient ambulant category. The standard deviation was added to the mean scores to obtain a range within which the scores would be expected to fall. Scores that are highlighted in yellow were considered significant for one of two reasons:

- 1) The pre-SHIP® score fell within the expected range but the post-SHIP® score did not.
- 2) The pre-SHIP® score did not fall into the expected range but the post-SHIP® score did.

In the discussion, hypotheses are advanced to explain the reasons for these changes in scores. The scores that are highlighted in green were considered significant by the researcher because they form part of a cluster of scores that influence a specific variable such as affect, mediation or processing or because the score has shifted from lying close to the expected range to lying much further from it, or vice versa.

Table 1: RIM Results

	Pre-SHIP®		Post-SHIP®
Variable	Score	Mean +/- SD	Score
R	15	14.47/23.35	17
W	9	5.61/11.99	9
D	3	3.14/10.92	4
Dd	3	1.08/5.08	4
S	0	.26/3.9	0
DQ+	7	4.57/9.25	4
DQo	5	6.85/14.41	12
DQv	3	-.06/2.44	1
DQv/+	0	-.03/.57	0
FQx+	1	-.32/1.28	0
FQxo	6	7.56/15.22	5
FQxu	1	1.49/5.53	6
FQx-	7	1.09/4.97	5
FQxNone	0	-.15/1.15	1
MQ+	0	-.26/.82	0
MQo	4	1.57/4.01	0
MQu	0	-.33/1.45	1
MQ-	0	-.23/.83	1
MQNone	0	0.00	0
S-	0	-.27/2.13	0
M	0	2.42/5.44	1
FM	0	2.19/5.67	1
m	1	.26/2.9	0
FM+m	1	3.59/7.43	1
FC	3	.32/3.64	4
CF	2	.26/3	0
C	0	-.23/1.31	1
Cn	0	0.00	0
Sum Color	5	2.05/6.23	6

WSumC	3.5	1.76/5.08	5.0
Sum C'	1	0.01/2.93	0
Sum T	0	-.22/1.9	3
Sum V	0	-.34/1.54	0
Sum Y	1	0.08/2.48	1
Sum Shading	?	.89/7.49	?
Fr+rF	0	-.27/.59	0
FD	1	-.14/2.5	1
F	6	3.11/7.95	7
(2)	2	4.11/9.51	3
3r+(2)/R	.13	.27/.49	.18
Lambda	.67	.23/.63	.70
EA	7.5	4.32/10.38	7.0
es	3	5.57/13.83	5
D score	+1	-2.04/.72	0
AdjD	+1	-1.42/1.2	0
a (active)	3	3.56/8.42	0
p (passive)	2	1.27/5.63	3
Ma	3	.85/4.27	0
Mp	1	.24/2.48	2
Intellect	?	-.23/3.71	?
Zf	11	8.95/15.57	9
Zd	+6.0	-3.99/5.05	+2.5
Blends	4	1.83/6.77	4
Blends/R	4:15?	0.1/.36	4:17?
Col-Shd Bl	?	-.16/1.54	?
Afr	.36	.35/.77	.89
Populars	1	2.64/7.64	3
XA%	.53	.69/.93	.65
WDA%	.50	.76/.94	.69
X+%	.47	.48/.78	.29
X-%	.47	.05/.27	.29

Xu%	0.07	.09/.27	.35
Isolate/R	.07	.03/.21	.12
H	3	.96/3.76	0
(H)	2	.2/2.68	1
Hd	0	.53/2.29	0
(Hd)	0	-.27/1.39	1
Hx	3	-.09/.11	1
All H Cont	8?	3.06/8.48	3?
A	1	4.39/9.31	3
(A)	1	-.21/.53	0
Ad	1	.35/3.51	3
(Ad)	0	-.19/.31	0
An	5	-.22/1.7	9
Art	0	-.07/2.11	1
Ay	0	-.2/.52	0
Bl	0	-.21/.69	0
Bt	1	-.01/1.79	0
Cg	0	-.01/2.79	0
Cl	0	-.2/.52	0
Ex	0	-.32/.74	0
Fi	0	-.19/.87	0
Food	0	-.19/.65	0
Ge	0	-.54/.82	2
Hh	0	-.25/1.17	0
Ls	0	-.17/1.65	0
Na	0	-.28/.58	0
Sc	0	-.35/.57	0
Sx	0	-.28/1.52	0
Xy	0	-.16/.26	0
Idio	3	.24/2.26	1
DV	0	-.34/1.74	0
INCOM	1	-.19/1.51	1

DR	0	-.59/1.17	1
FABCOM	0	-.24/1.16	0
DV2	0	-.26/.5	0
INC2	0	-.28/.54	0
DR2	0	-.09/.11	0
FAB2	0	-.34/.6	0
ALOG	1	-.15/.23	0
CONTAM	0	0.00	0
Sum 6 Sp Sc	?	-.31/5.35	?
Lvl 2 Sp Sc	?	-.47/1.23	?
WSum6	7	-3.15/16.29	5
AB	4	-.19/.75	5
AG	1	-.16/2.44	0
COP	1	.12/2.78	0
CP	0	0.00	0
GOODHR	3	2.31/5.55	1
POORHR	4	.61/4.51	3
MOR	1	-.2/2.56	0
PER	0	-1.46/2.16	3
PSV	0	-.03/.56	0
EB	4:3.5		2:2:50
EBPer	N/A		2.5

As mentioned in the methodology section, the following variables were identified for expected change before commencement of the research:

EB; EBPer; L; EA; D; Adj D; 3r+(2)/R; FD; DEPI; FY; YF

Although change occurred across most of these variables, only the following showed significant change:

Table 2: Identified variables for expected change

D score	+1	-2.04/.72	0
EB	4:3.5		2:2:5
EBPer	N/A		2.5

These results indicate that the EA is a reliable indication of Mrs M’s capacity to cope with demands. As Mrs M’s EA falls within the average range she potentially has the natural capacity to deal with the emotional and ideational demands of everyday life. This hypothesis is based on the finding that both sides of the EB are greater than zero and result in an EA greater than 3.5 with a Lambda of less than 1.0 (Exner, 2009).

6.1.2 Interpretive hypotheses (RIAP)

This section mentions only interpretive hypotheses that presented differently in the two administrations. These interpretations are provided as additional information to corroborate similar findings from the other data sources. That being said, these hypotheses should, as the term indicates, be seen as possibilities, not facts.

6.1.2.1 Affect

Significant changes in variables relating to affect are:

Table 3: Affect variables

Afr	.36	.35/.77	.89
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Pre-SHIP®

Mrs M “appears to be much less willing than most people to process emotional stimulation. Because of her aversion to becoming engaged in affectionately charged situations, she is at risk for being socially and emotionally withdrawn...However, the emergence of strong feelings often leads people like her to break off an interpersonal interaction and their aversion of emotionality may limit their social attractiveness.”

Post-SHIP®

Mrs M “appears to be as willing as most people to process emotional stimulation, whether or not she chooses to make her feelings known...However, her openness to becoming engaged in affectively charged situations should contribute to her being reasonably comfortable in social situations, even when strong feelings are being expressed by herself or others.”

The results show a general improvement in Mrs M’s capacity and willingness to engage with emotional content. Given that undergoing SHIP® is often an emotional process, it follows that

the completion of the process, the integration of trauma that caused previous unconscious projections onto the external world, would cause the participant to be better able to understand the psychobiological role of emotions and become more emotionally receptive as a result.

6.1.2.2 Interpersonal perception

Significant changes in variables relating to interpersonal perception are:

Table 4: Interpersonal perception variables

COP	1	.12/2.78	0
GOODHR	3	2.31/5.55	1
a (active)	3	3.56/8.42	0
Sum T	0	-.22/1.9	3
All H Cont	8?	3.06/8.48	3?
H	3	.96/3.76	0
PER	0	-1.46/2.16	3

Pre-SHIP®

Mrs M “gives evidence of limited capacity to form close attachments to other people. Although she may not necessarily avoid interpersonal relationships, these relationships will tend to be distant and detached, rather than close and intimate; her friendship and love relationships are likely to be psychologically at arm’s length rather than close and intimate.”

Mrs M “shows about as much interest in other people as most adults do. This apparent interest in being around other people and paying attention to what they say and do is a personality asset that ordinarily contributes to good social adjustment.”

Post-SHIP®

Mrs M “gives evidence of adaptive capacity to anticipate and establish close, intimate, and mutually supportive relationships with other people...She appears to be experiencing more needs for closeness to other people than are being met by her present circumstances.”

Mrs M “shows less interest in other people than most adults do. As a consequence, she may be indifferent to being around people and inattentive to what they are saying and doing.”

These results indicate that previously Mrs M avoided forming close attachments to others due to her possible traumatic experiences of intimate relationships in the past. Integrating these past experiences through SHIP® has resulted in a renewed desire for close attachments and a willingness to be more open about her need for closeness. The results also show that Mrs M has become less pre-occupied with how others view her; her decreased need for social validation indicates that she is comfortable with being by herself.

6.1.2.3 Information processing

Significant changes in variables relating to information processing are:

Table 5: Information processing variables

Zd	+6.0	-3.99/5.05	+2.5
DQ+	7	4.57/9.25	4
DQv	3	-.06/2.44	1

Pre-SHIP®

“In attending to her experience, she tends to take in more information than she can organize efficiently and to examine situations more thoroughly than serves any reasonable purpose.”

“The quality of her efforts to focus her attention with precision and to synthesize aspects of her experience largely resembles that of most people.”

Post-SHIP®

Mrs M “appears capable of attending to her experience in a reasonably open and flexible manner that constitutes a personality asset. The client shows an adaptive balance between being able to deal with situations sometimes in a detached and uninvolved manner, taking them at their face value and not forming any thoughts or feelings about them and, at times in a concerned and engaged manner, pondering their significance or resonating to their affective tone.”

“The quality of her efforts to focus her attention with precision and to synthesize aspects of her experience falls below that of most people.”

The results indicate more flexibility in Mrs M’s coping styles. Such a result was expected as according to SHIP theory, developmental trauma often results in rigid coping styles and through spontaneous healing, the need for a rigid coping style decreases. The participant

accordingly becomes more flexible and more ways of coping configurations of the inherent personality potentials become available.

6.1.2.4 Mediation

Significant changes in variables relating to mediation are:

Table 6: Mediation variables

XA%	.53	.69/.93	.65
WDA%	.50	.76/.94	.69
X+%	.47	.48/.78	.29
X-%	.47	.05/.27	.29
Xu%	0.07	.09/.27	.35
Populars	1	2.64/7.64	3

The XA% and WDA% are two variables that provide information about the extent to which mediational activities have yielded behaviours appropriate to the situation. When the XA% is less than .70 and the WDA% is less than .75, this signifies a significant mediational impairment (Exner, 2009). Mediational impairment appears to remain consistent in both protocols, although there seems to be an improvement in mediational capacity in the post-SHIP® protocol. Results still indicate mediational dysfunction and it can be assumed that the dysfunction tends to recur regardless of how obvious distal cues may be. This assumption is based on the minimal difference between XA% and WDA% scores.

When considering the X-%, generally in both protocols, there seems to be a likelihood of a serious mediational impairment. The post-SHIP® values for X-% appears to indicate a significant improvement in mediation.

Another interesting finding is the difference between the scores of the Xu%. The post-SHIP® protocol has a significantly elevated score of .35, indicating an individualistic approach to the world and interpretation of the world, but without distorting reality.

The production of popular responses increased slightly in the post-SHIP® protocol, but remains lower than expected. If the number of popular responses is below average (between 5 and 7), more individualistic responses will occur even in situations that are simple if precisely

defined. Exner (2009) explains that this may not be a liability, but does raise a question about whether the person has a persistent tendency to disregard social convention.

With regard to mediation, there seems to be an improvement in the post-SHIP® protocol, but there is also a persistent indication that Mrs M has an individualistic style when approaching her world that may at times disregard social norms or conventions.

6.2 PQ questionnaire results

6.2.1 Meige's symptoms; symptoms of anxiety and depression

PQ scores were measured for all 77 SHIP® sessions over a period of 12 months. Both the severity of Meige's symptoms and the severity of subjective anxiety and depression were measured. Monthly mean scores were then calculated and plotted on a graph versus the mean score in the first month of SHIP® and the mean score in the last month of SHIP®. The results are presented in the table below.

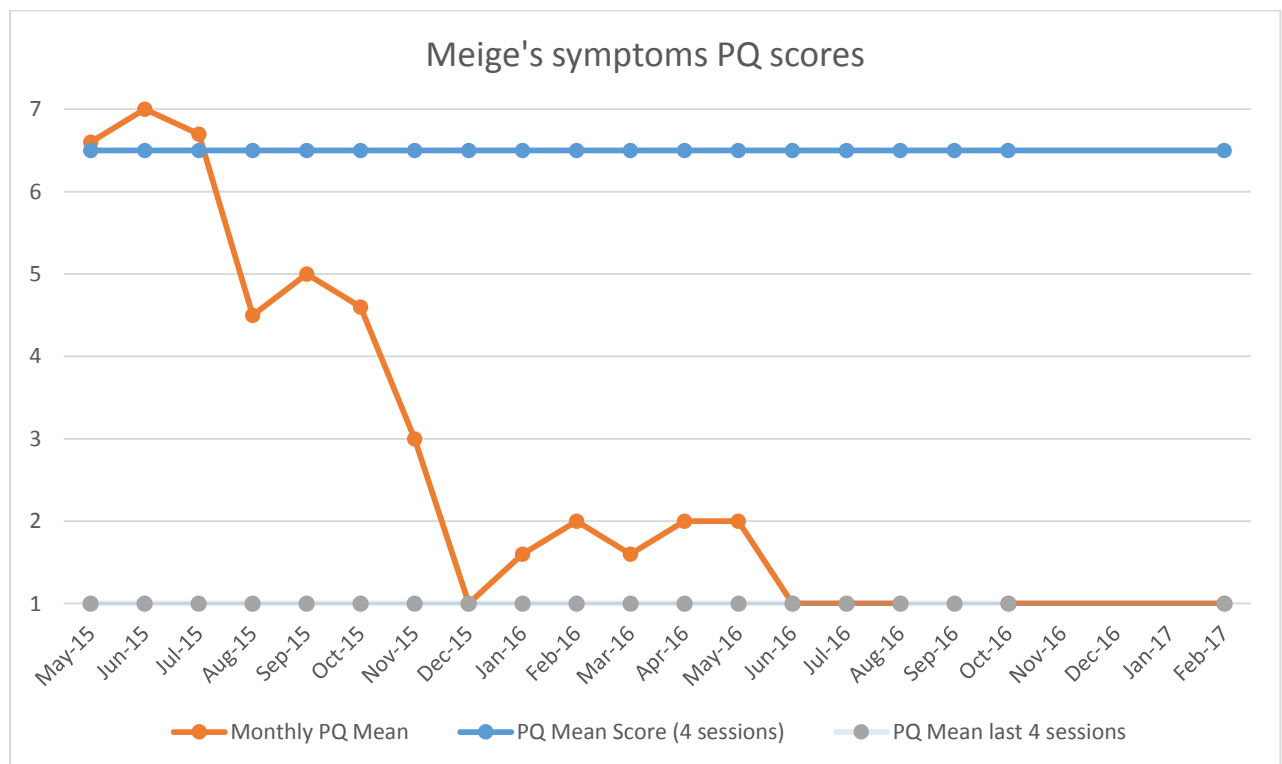


Figure 1: Meige's symptoms PQ scores

*Although the participant indicated that she had experienced Meige's symptoms at an intensity level of 7 (max) for four months before undergoing SHIP®, the researcher chose to

use the measurements of the first four sessions in order to take possible fallacy of memory into account. The results of the PQ scores for anxiety and depression are presented in the graph below. Calculations were similar to those mentioned above.

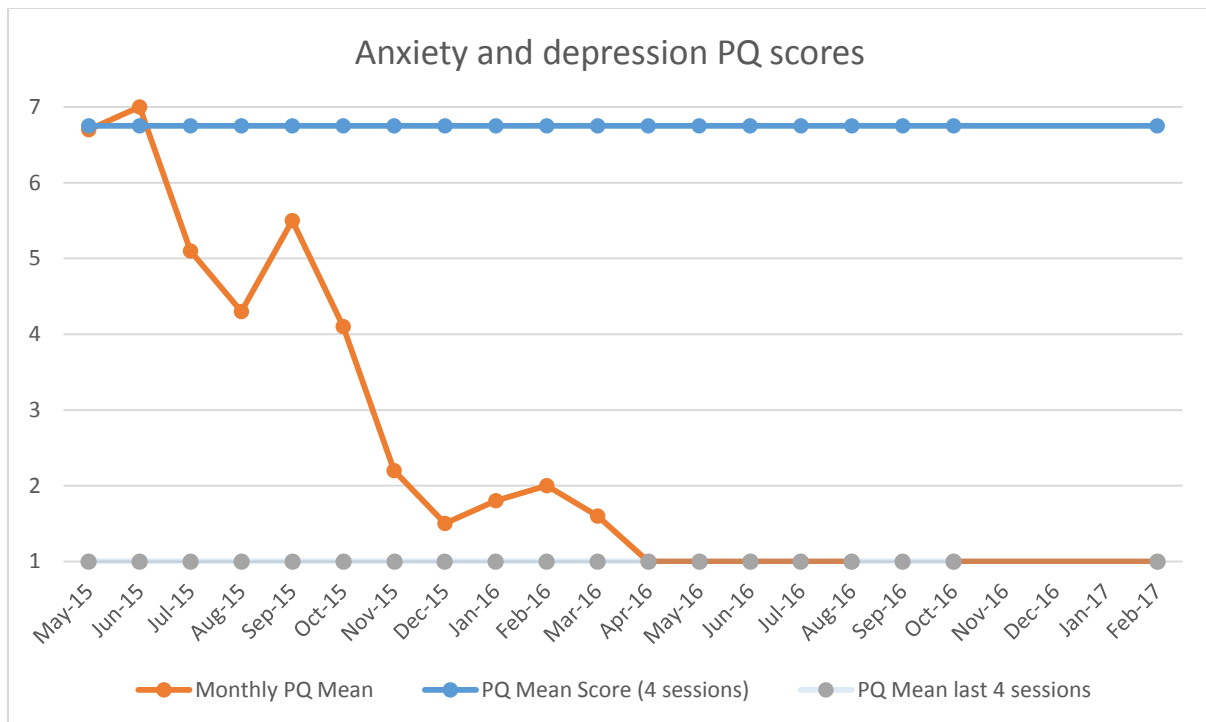


Figure 2: Anxiety and depression PQ scores

*Although the participant indicated that she had previously been diagnosed with depression and had been taking antidepressants for many years, the mean score of the first four SHIP® sessions was used as a baseline as the previous intensity level of the symptoms was not known.

6.2.2 Distractors

Distractors used by Mrs M in sessions were measured for all 77 SHIP® sessions over a period of 12 months. The number of sessions in which distractors were used was divided by the number of sessions held in a specific month to determine the average frequency percentage of distractors used in that particular month.

Monthly mean scores were plotted on a graph versus the mean monthly score over the entire period. The results are presented in the table below.

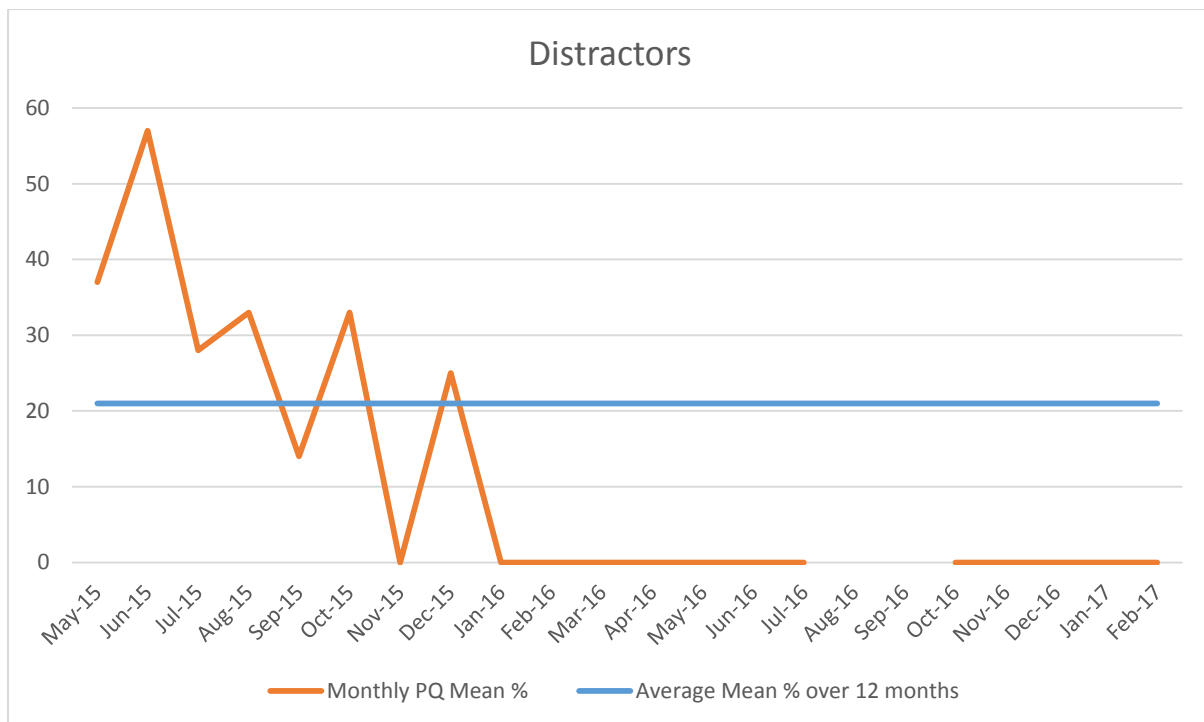


Figure 3: Distractors

The most prevalent distractor used by Mrs M was the feeling of wanting to run away. She made use of distractors in 15 different sessions. Of these, wanting to run away was mentioned on 8 occasions. This accounts for 53% of her distractors. Other distractors included a need to keep quiet, not wanting to engage some of the images that are used as activators in SHIP® and wanting to build a “wall” around herself to keep engaging emotional material away.

6.2.3 Associative activators

Whenever Mrs M experienced associative activators, they were noted for all 77 SHIP® sessions over a period of 12 months. The number of sessions in which associative activators were present was divided by the number of sessions held in a specific month to determine the average frequency percentage of associative activators present in that particular month. Monthly mean scores were plotted on a graph versus the mean monthly score over the entire period. The results are presented in the table below.

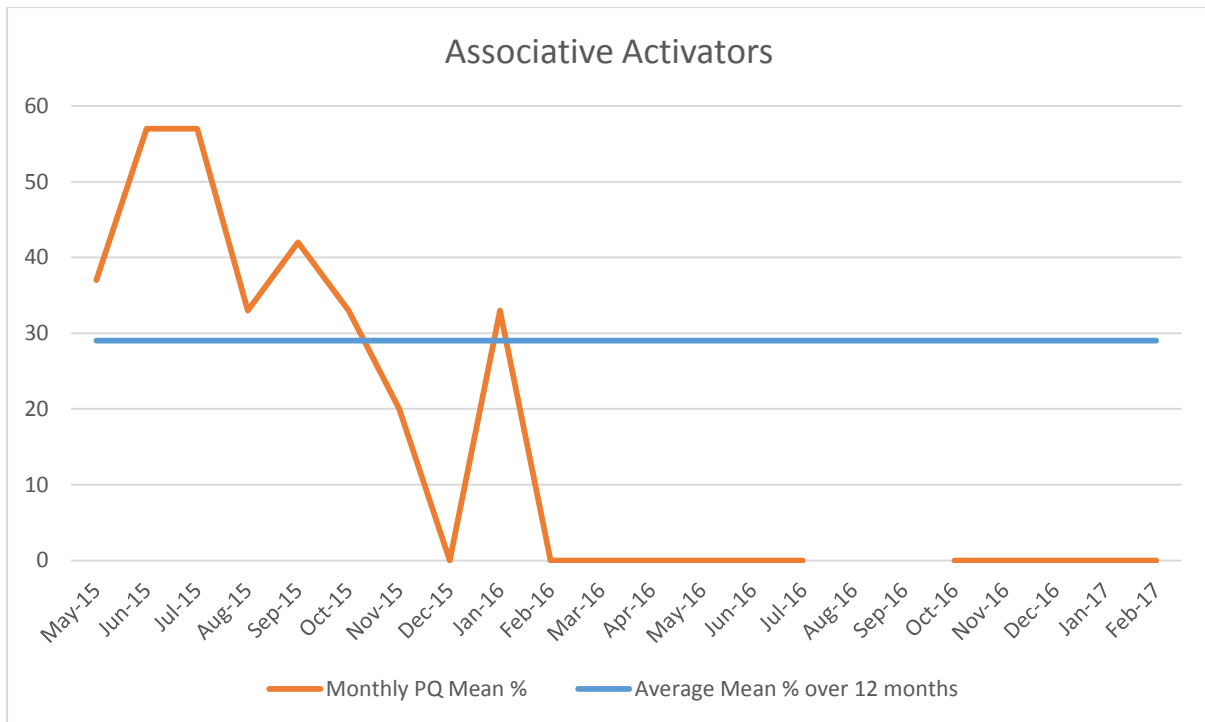


Figure 4: Associative activators

6.2.4 SHRs

A person could experience multiple SHRs in the course of a single SHIP® session and these could range over a variety of locations. SHRs were documented according to category and location. Five categories of SHRs were identified:

1. Proprioceptive: 143 occasions
2. Vestibular: 5 occasions
3. Emotional: 53 occasions
4. Depersonalisation: 6 occasions
5. Olfactory: 1 occasion

SHRs were recorded across 23 categories. The total number of SHRs that occurred in the course of SHIP® are listed below as per location:

1. Arms: 10
2. Stomach: 23
3. Head (headache): 6
4. Shoulders: 12
5. Whole body: 7
6. Muscles in face: 21

7. Throat: 17
8. Jaw: 3
9. Neck: 6
10. Heart: 10
11. Hands: 4
12. Mouth: 3
13. Legs: 9
14. Eyes: 54 (includes emotional crying)
15. Buttocks: 1
16. Hips: 1
17. Lungs: 2
18. Nose: 1
19. Solar plexus: 2
20. Coccyx: 1
21. Back: 1
22. Feet: 1
23. Sexual organs: 1

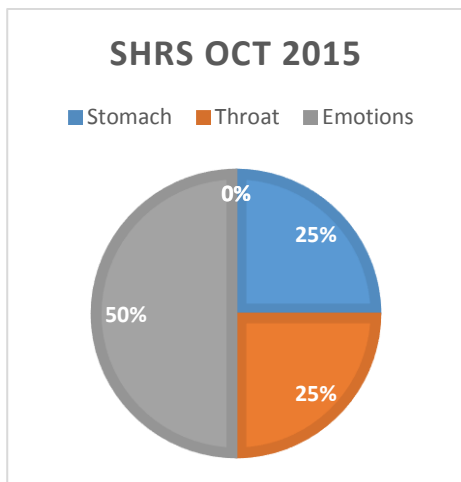
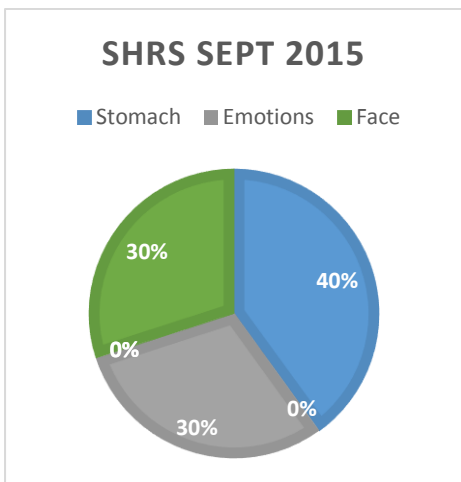
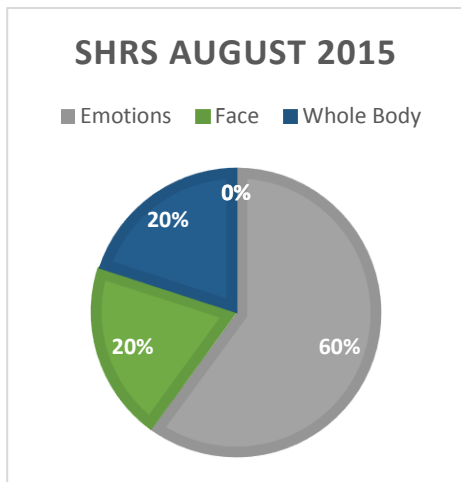
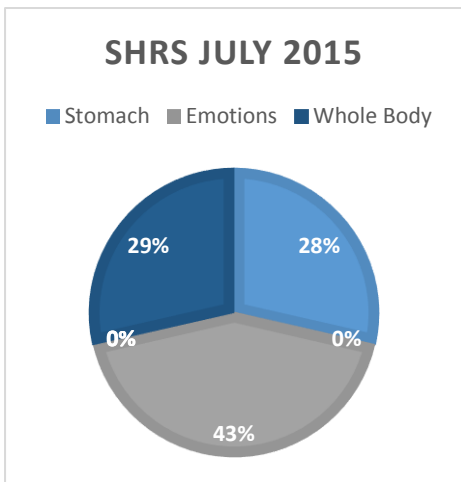
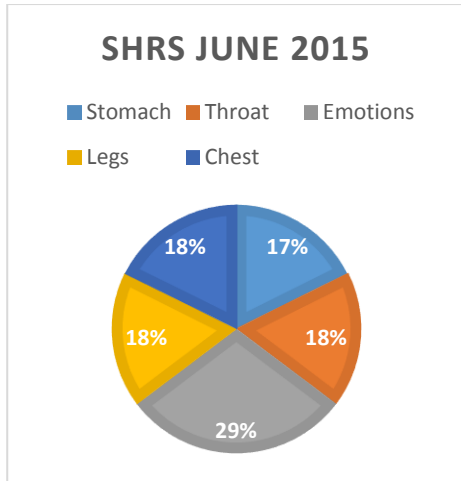
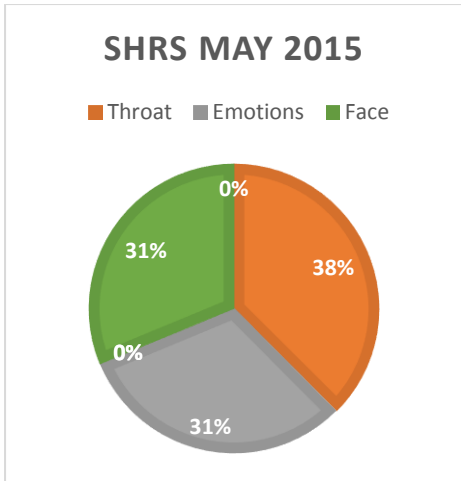
As previously discussed, literature indicates that bodily areas in which Meige's syndrome symptoms occur range mostly from the shoulders upwards through the neck to the entire face. The statistics below indicate the number of SHRs that occurred in these areas compared to the rest of the body.

Shoulders upwards: 123 (including emotional expressions in face, e.g. crying)

Rest of the body: 73

No specific location (depersonalisation; vestibular): 11

The three most prominent SHR locations are shown in the graphs below for each month of the SHIP® process from May to December 2015 (more may be shown if percentages are equal for more than three locations). After December 2015, SHRs became less prominent and sessions became less frequent. Meige's syndrome symptoms and anxiety and depression reached PQ scores well below the baseline on a consistent basis.



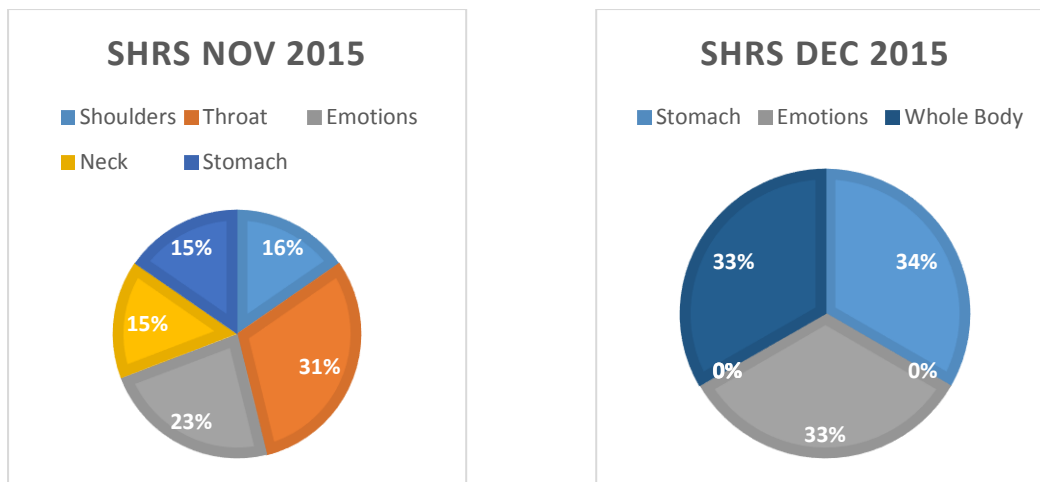


Figure 5: SHRs

6.3 Coping styles questionnaire results pre- and post-SHIP®

The coping styles questionnaire gives a brief exposition of 12 possible coping styles and the participant rates hers coping style according to the following scale:

- 1- *never*
- 2- *sometimes*
- 3- *mostly*

The results are given below.

Table 7: Coping styles

Coping Style	Pre-SHIP®	Post-SHIP®	d
Pioneer	2	3	1
Director	3	3	
Mentor	3	3	
Fixer	1	2	1
Manager	3	2	1
Survivor	3	3	0
Performer	3	3	0
Chameleon	2	2	
Sensitive	2	1	1
Avoider	3	1	2
Outsider	3	2	1
Protector	2	1	1

6.4 Change interview data

As mentioned earlier, the change interview was interpreted through a thematic analysis. The change interview format as prescribed by Elliott (1996) was used. This format includes questions that require an answer on a rating scale of one to five. The results are listed below:

Regarding change, the participant was asked to locate herself on the following rating scale:

- 1- *very much expected it*
- 2- *somewhat expected it*
- 3- *neither expected nor surprised by change*
- 4- *somewhat surprised by it*
- 5- *very much surprised by it*

The participant rated change in her anxiety, depression and Meige's symptoms as a 2 on this scale, indicating that change was somewhat expected.

Regarding the question of the likelihood of change in these symptoms without undergoing SHIP®, the participant was asked to give a rating on the following scale:

- 1- *very unlikely*
- 2- *somewhat unlikely*
- 3- *neither likely nor unlikely*
- 4- *somewhat likely*
- 5- *very likely*

The participant rated the likelihood of change without undergoing SHIP® as 2 on this scale for all her symptoms, indicating that it was somewhat unlikely.

Lastly, the participant was asked to rate the importance of the perceived changes on the following scale:

- 1- *not at all*
- 2- *slightly important*
- 3- *moderately important*
- 4- *very important*
- 5- *extremely important*

She rated the importance of change as 5 on this scale, indicating that the perceived changes were extremely important to her.

6.4.1 11 Significant theme clusters

Several themes were identified in the change interview. The researcher has grouped these themes into the clusters that are set out below:

6.4.1.1 *Desperation and hopelessness*

The theme of desperation surfaced several times in the change interview. By the time she initially contacted Dr Steenkamp for SHIP®, Mrs M was utterly desperate to find relief for the debilitating symptoms of Meige's syndrome. She had already tried numerous other treatments, none of which had yielded any lasting relief. This left her feeling hopeless. Her hopelessness started to lift after about three months of psychotherapy, when her symptoms improved for a brief period. Coming from a place of desperation, Mrs M was willing to “*try anything*”. This made her a good candidate for psychotherapy as she was willing to immerse herself fully in the process and to engage with difficult material out of desperation for change. It must be noted that even though Mrs M felt hopeless several times, she never completely lost hope and she had confidence in SHIP®. The continuous reframing in SHIP® which told her that her psycho-biodynamic system was providing her with spontaneous healing clues and the reframing of the SHIP® facilitator to the effect that this is the nature of the spontaneous healing process are part of the process of psycho-education that takes place during SHIP®. This motivates clients to keep going.

6.4.1.2 *Medication*

Mrs M described a long-standing use of psychiatric medication. Her frame of reference was to turn to medication as a first option to treat physical and emotional difficulties. This ties in with the abovementioned idea that she came to psychotherapy out of desperation when other options did not work. The narrative regarding medication changed quite clearly and drastically as Mrs M progressed in psychotherapy. She progressed from being dependent and in her own words “*addicted*” to certain psychiatric medicines to not taking any medication or experiencing any need to do so for more than six months. Concurrent with this process was the increasing awareness that there is a link between her unresolved past trauma and her present psychological and physical discomfort. It must be noted that Mrs M found the prescribed medicines beneficial in providing temporary relief from pain and debilitating spasms.

6.4.1.3 Not being good enough; worthlessness; guilt and shame

Because they are interlinked, these themes are grouped in a cluster. During SHIP®, Mrs M became aware that these feelings stem from her childhood experiences of her primary caregivers. She realised that the pain of feeling rejected and not being comforted by her caregivers had manifested in feelings of worthlessness and a fear of rejection or being left out. In the course of the SHIP® sessions, Mrs M also became aware that she had been molested as a child and that she had not been conscious of this or of how it was affecting her sense of self-worth. Mrs M mentioned the words “*guilt*” and “*shame*” several times in the change interview. She recounted that the debilitating Meige’s syndrome symptoms accentuated her feelings of shame and that SHIP® had brought her into contact with these feelings in order for healing to take place.

6.4.1.4 Faith

Mrs M regards her faith as an important factor in her recovery. She believes that without her faith to ground her, she would not have been able to make it to this point. She believes that SHIP® was used as an instrument of God to allow her to heal.

6.4.1.5 The safe space

During the interview, Mrs M highlighted the safe space created by her psychotherapist as one of the most important factors that allowed her to engage fully in the healing journey. She recounted that she never felt judged and her psychotherapist never dictated to her how she should feel. She stated that even though she was struggling with feelings of worthlessness and rejection, her psychotherapist never made her feel this way. This non-judgment was the direct opposite of what she experienced during childhood.

She emphasized the importance of her psychotherapist’s reassurance and his faith in the process of spontaneous healing. She said she believed that his unfaltering belief in the process was infectious and had helped her to believe that it was necessary to engage with the unresolved trauma in order to be free of it.

6.4.1.6 The intense, difficult process

Another prominent theme was the intensity of SHIP®. Mrs M reiterated several times how difficult it was to “*pick myself up and go back for another session*”. Even though she knew it was beneficial, the process was extremely difficult and painful. She recounted that many of

the double sessions (sessions that were scheduled for two hours' duration) were incredibly intense and tiring. She quoted the following words from one of her diary entries: *“I am not up to it today, can't. I can't do it now. I don't even know if I will be able to say a word. And after the session I would cry for hours. I couldn't even see when I drove home (too tearful). So yes, it was very difficult, there were very, very difficult times.”*

6.4.1.7 Debilitating physical symptoms

A strong theme that emerged during the change interview was the debilitating effect of the Meige's syndrome symptoms. Mrs M reported that she could not speak or eat properly. The pain was often overwhelming and tiring. Her work, her familial and social life were severely affected and her psychological state started deteriorating. She became increasingly aware of how people around her would feel sorry for her and how they would try to assist her. This again contributed to her feelings of guilt and shame. Mrs M described how she experienced a flicker of hope when the symptoms subsided briefly after a particular SHIP® session.

Mrs M gave a rough timeline showing the severity of the Meige's symptoms during SHIP®: *“When I started with SHIP® it took about two months and there was sudden improvement. And my hopes were up, it was extremely quick. But then we started to address very deep things and the symptoms returned and it started to get very difficult again. Then it became acute in the middle of 2015 but this was also when I went off the medication. And then there was definite improvement in August...it was bad in the beginning and it was worse after three months and then it became worse because I stopped the medication. It was the worst until August when it lifted again. And then it was the Botox in September...and that caused so much trauma that it put us back again some months with SHIP® treatment, we had to work through that again to continue...Then there was improvement again in December. There was definite improvement in January to March and it was as if it just lifted after April.”*

6.4.1.8 Anxiety and depression

According to SHIP® theory, depression and anxiety go hand in hand. Depression had been a theme in Mrs M's life for many years. It emerged in the change interview that she had been diagnosed with depression after the birth of her first child. She suffered post-natal depression again after the birth of her second child. Mrs M stated that she had to deal with an underlying anxiety relating to her low self-worth several times in SHIP®. She also dealt with feelings of depression and she recounted *“sinking into a dark hole”* and *“this feeling as if I was lying on a glass floor, my legs broken, unable to move. That darkness, that total nothing, there was*

nothing. Those were very difficult sessions.” Mrs M was of the opinion that her anxiety was present even before she started feeling depressed – she had carried it with her for most of her life before confronting it in SHIP®. She would often have this anxious feeling in her stomach before coming to SHIP®. She stated that during SHIP® her feelings of depression and anxiety followed a similar pattern to that of the Meige’s syndrome symptoms. She believes that the two were linked, that Meige’s forced her to “*face*” her unconscious psychological discomfort.

6.4.1.9 Facing and expressing emotions

A prominent theme for Mrs M is the metaphor of the face. The manifestation of debilitating symptoms in her face forced her to face up to her underlying psychological discomfort – something which she had avoided facing for a very long time. Speaking up and expressing herself was seen in a similar fashion. Mrs M’s most prominent coping style was to avoid her emotions and to suppress them into depression. She recounted several incidents from her childhood where she was told not to tell people how she felt. She never spoke up or told people about how she felt. When the spasms started limiting her expression and taking away her voice, she eventually realized the significance of the message being conveyed to her – she had to learn to express herself, to speak up. She recounted that she was not a person who told people how she felt, something that she now does more easily. She was also not someone who cries much but recounts crying in many sessions and then sometimes crying for hours afterwards.

6.4.1.10 Childhood trauma

Mrs M stated that there were many “*childhood hurts*” that she had to confront through SHIP®. Many of her feelings of guilt and shame as well as her feelings of not being good enough were traced back to her primary caregivers and the trauma and hurt that was present in these relationships.

6.5.1.11 Self-worth, peacefulness and freedom

The final theme identified from the change interview relates to how Mrs M experiences herself now. She mentioned that after SHIP® she has a renewed sense of self-worth. She recounted that her sense of self-worth is internalized now – she does not have to do anything to feel worthy, she can just “*be*”, knowing that she is good enough and that she has worth. She does not feel the need to be in control of everything – “*you can just leave some things and they work out, it doesn’t make me anxious any more*”

”

Mrs M stated that she is now able to be a mother, wife, sister, friend and daughter and that in itself is enough for her. She stated that her previous serenity had been assumed but that she now lives with an unbelievable sense of freedom and peace. Mrs M’s husband also described her as less affected by happenings in her life and more content.

6.5 HAT data

Data from the HAT forms fall into the spheres of descriptive quantitative data and descriptive qualitative data. Descriptive data are listed first and subsequently some sessions that were considered to be especially significant are described.

The modified HAT form contains a section in which the SHIP® psychotherapist is able to rate the usefulness of the events that occurred in the session. The options are as follows:

- 1- Greatly hindering*
- 2- Moderately hindering*
- 3- Neutral*
- 4- Moderately helpful*
- 5- Greatly helpful*

In this case the psychotherapist rated most of the sessions as 5 since all sessions are considered useful in the SHIP® framework. Some sessions were marked as 4 (moderately useful) and some were given a rating of 5** to indicate that they were especially useful. For statistical purposes, the researcher downgraded all ratings by one point so that 5** were down-rated to 5; 5 downrated to 4 etc. Since the purpose of the statistic is to identify periods of more/less helpful sessions, this downrating did not affect the reliability of the statistics. The graph below reflects the monthly ratings of helpful events in sessions against the overall median helpfulness rating.

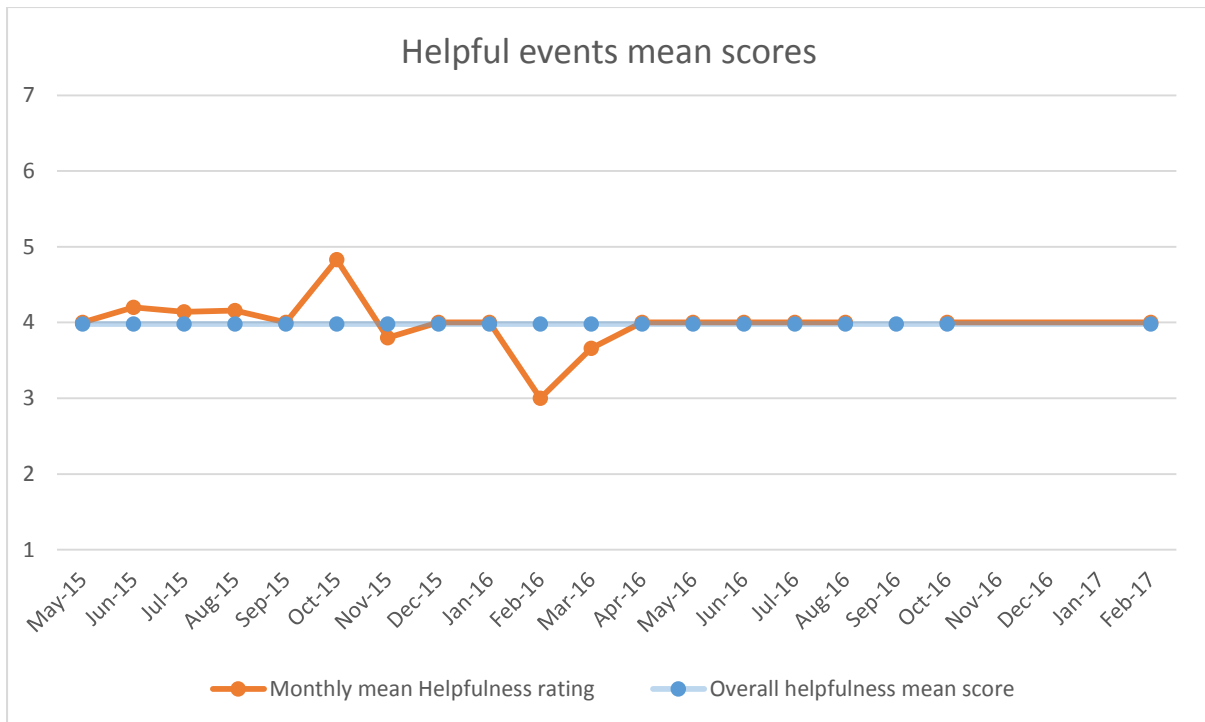


Figure 6: Helpful events

6.6 Summary

In this chapter, the results of all the different data collection methods were listed and displayed in the form of graphs and charts. In the following chapter, the results are discussed and the affirmative and sceptical cases are presented.

Chapter 7

Discussion

The sections below contain a discussion of the results of the research. The evidence for change is discussed first. After this the affirmative and sceptical cases are presented. The researcher has made every attempt to present both cases in an unbiased manner.

7.1 Change analysis

The HSCED requires the researcher to determine whether sufficient evidence for change is available in order to continue with the analysis of the data. The researcher considered the direct evidence for change that was mentioned in the methodology chapter. The evidence was considered to be sufficient to satisfy the criteria for direct change. The following section presents:

- a) Direct evidence for change – a discussion of the ways in which the direct evidence was present.
- b) The affirmative case – a case that discusses the attribution of this change to the administration of SHIP®.
- c) The sceptical case – a case that discusses possible alternative explanations for the measured client change.
- d) Limitations of the research and recommendations for future research.
- e) Conclusion.

7.2 Direct evidence for change

The following direct evidence for change was considered to be present as per the requirements stated in chapter 4:

7.2.1 Retrospective attribution of change to SHIP® as recorded in the change interview

Mrs M's ratings on the Likert scales in the change interview indicate that she perceived the change in symptoms to be somewhat unlikely without SHIP® and that the changes that occurred were somewhat expected and extremely significant.

Several of the themes identified in the thematic analysis showcase the significant changes that Mrs M experienced after the completion of SHIP®. The most significant changes are listed below:

- a) The discontinuation of psychiatric medication taken to suppress the symptoms of Meige's syndrome and depression and anxiety. Mrs M was able to discontinue the use of this medication because of a reduction in her symptoms and a consequent need to be free of the influence of drugs on her spontaneous self.
- b) Gradual relief of debilitating physical symptoms. Mrs M reported that the symptoms of Meige's syndrome diminished over the course of SHIP® and were virtually non-existent by the end of the process.
- c) Relief of anxiety and depression. Mrs M had experienced depression and anxiety for several years prior to engaging in SHIP®. After SHIP® she is able to experience life with its ups and downs without becoming significantly depressed or anxious.
- d) Sense of self-worth and freedom. Mrs M reported that SHIP® has given her a renewed sense of self-worth and has allowed her to be less affected by external events owing to her internal sense of self-worth.

7.2.2 Process outcome mapping which indicates that participant's post-therapy changes correspond to specific SHIP® processes

At the core of SHIP® as a psychotherapeutic method lies the ability of the psychotherapist to facilitate the spontaneous release of SHRs. The notation of a total of 207 SHRs throughout the process indicates that SHIP® was facilitated successfully. A total of 123 SHRs (59%) were located in 9 areas that are associated with Meige's syndrome symptoms and the remaining 73 were mapped to 14 other locations in the rest of the body, while 11 had no specific location. This indicates that a significant number of SHRs occurred in areas associated with Meige's syndrome, as would be expected in order for symptoms to be alleviated.

7.2.3 Correlation of within-therapy process outcomes

What is most notable from the graphic representation of Meige's syndrome symptoms, anxiety and depression, use of distractors and prevalence of associative activators is that the graphs all follow a very similar curvature. Month-by-month changes in symptoms were found to co-vary with adherence to SHIP® principles. Symptoms increased in the first two months and then decreased quite significantly, with an increase in September 2015. It is generally expected that as an effective intervention progresses, symptoms start decreasing. In the case of SHIP®, it is expected that as unresolved trauma is allowed to

resolve, associative activators and SHRs will start becoming less prevalent and intense. This is clearly reflected in the results as SHIP® progressed.

7.2.4 Change in chronic symptoms

If the SHIP® process coincides with a change in Meige syndrome symptoms against the reported baseline, a psychotherapeutic influence can be inferred. Mrs M's reported baseline of Meige symptoms decreased from 6.5 to 1 (7 being the highest rating) whereas the depression and anxiety PQ score baseline decreased from 6.75 to 1 (7 being the highest rating) after the completion of SHIP®. When looking at the PQ scores for helpful events, the scores were above the mean for the months of May to October 2015. The PQ scores for Meige's symptoms and anxiety and depression show considerable improvement during these months, compared to less improvement and a more stable level of symptoms from December 2015 to February 2017. This serves as evidence of a reduction of chronic symptoms that coincides with the SHIP® process.

7.2.5 Event-shift sequence

An event-shift sequence is indicated when significant psychotherapeutic events precede a change in Meige's syndrome symptoms. On the HAT form, the most helpful sessions were reported during October 2015 (4.83 out of 5). This indicates that the SHIP® psychotherapist experienced October as an important month in which the release of significant past trauma was successfully facilitated. The PQ scores for anxiety and depression dropped from 4.1 in October to 2.2 in November whereas PQ scores for Meige's syndrome symptoms dropped from 4.6 in October to 3 in November and then to 1 in December. The number of associative activators present also dropped from 33% to 20%. These correlations indicate that an event-shift sequence was present.

7.3 The affirmative case – a SHIP® formulation

Disclaimer: not all of the arguments presented in this motion are the direct views of the author. Some arguments are made to help facilitate the analysis of change, in this case through the presentation of contrasting views.

The affirmative case presents the results of the research in a SHIP® framework that conceptualizes the measured changes as being due to the successful facilitation of SHRs and

the resolution of trauma that was frozen within the client. In the case of Mrs M, the Meige's syndrome symptoms are presented as trauma spectrum manifestations.

7.3.1 Associative activators – the link to frozen trauma

As mentioned in chapter 5, Mrs M experienced developmental trauma when growing up. The fact that Mrs M experienced specific triggers (associative activators) that led to the onset of feelings of depression and Meige's symptoms indicates that the developmental trauma she experienced as a child was still unresolved and became re-activated through the associative activators. The anxiety, depression and Meige's symptoms are manifestations of the unresolved developmental trauma. The symptoms indicate that the psycho-bio-dynamic system is out of balance (Steenkamp, 2013). Of the events mentioned in Mrs M's history, the following were identified as associative activators that were used in SHIP® to access trauma memories:

- The birth of her children was an associative activator that activated her memories of being a young baby who did not receive the nurture and caring that she needed from her primary caregivers.
- The onset of Meige's symptoms after Mrs M's husband returned from his overseas trip. This activated the childhood feeling of being excluded and left out in her own family.
- The green nurses' uniforms at the ER facility. This activated the memory of a traumatic operation that she was forced to undergo as a child as well as the memory of childhood molestation.

As Mrs M progressed through SHIP®, associative activators diminished, as indicated in the results section. This was due to the successful facilitation of SHRs and the resolution and integration of unresolved trauma within her system. The result of the resolution of underlying trauma is indicated when situations or circumstances that would previously have triggered (associative activators) PTSD symptoms (TSMs) no longer have the same effect. It can therefore be expected that successful SHIP® would reduce the number of associative activators in a person's life and the effect thereof.

7.3.2 The metaphor of Meige and underlying dynamics

The researcher considered Mrs M's statement regarding having to "face" up to the underlying psychological discomfort that had prevented her from being able to express herself fully as a

being of significance. Meige's symptoms manifested in an area of the body that is clearly visible and cannot be hidden from the world, although Mrs M's tendency all her life had been to hide. The Meige's symptoms forced her to come into contact with the unexpressed pain of childhood and rendered her previous coping style of avoiding issues ineffective. Her speech was affected – she experienced difficulty “speaking up”. A feeling that she had experienced throughout her life had now manifested in the physical sphere. Her difficulties in swallowing represented her difficulty in “swallowing” her life as it was at the time. She literally could not take in any more. The paradox inherent in human dynamics becomes clear – there is an unconscious drive towards healing that is expressed through the perpetuation of the same way of functioning in the world. The attempt to escape from unresolved trauma often leads to additional traumatising circumstances. Interpersonal dynamics are established early in life and repeated in subsequent relationships. The conscious mind is unaware of these dynamics and is therefore unable to alter the process. Only when the unconscious is made conscious, can the interpersonal dynamics of an individual begin to change (Cabaniss, Cherry, Douglas, & Schwartz, 2016).

It is the opinion of the researcher that Mrs M's depressive symptoms were the result of early unresolved early trauma, of living an incomplete, inexpressive life. In SHIP® terminology, this is referred to as an inter-translator. The depressive symptoms were not identified as such and were therefore never treated as a psycho-biodynamic healing opportunity. The suppression of these symptoms through the use of psychiatric medication was successful for some time. The suppression of and disregard of the inter-translator resulted in the manifestation of Meige's symptoms as an intra-translator. These symptoms in turn reinforced the inter-translator of depression, resulting in a combination of psycho-biodynamic symptoms that became overwhelming to the point where Mrs M became desperate enough to engage with the underlying unresolved painful experiences of the past if it would provide emancipation from her condition through SHIP®.

7.3.3 The resolution of symptoms through SHIP®

It is important to be aware that, according to SHIP® philosophy, change is a result of autonomic regulation that is made possible through spontaneous healing facilitation. Thus, it can be said that the change was in fact due to self-correction processes but that SHIP® was needed to facilitate the space in which these processes could occur and that although these

processes are spontaneous, they were only able to occur because the psychotherapist facilitated the process according to the SHIP® framework.

Depression is characterized by overwhelming feelings of sadness, despair and isolation for a period of longer than two weeks (American Psychiatric Association, 2013). It is by nature an overwhelming emotional experience. As such, it is expected that confronting these emotions and accessing the underlying trauma at their root would be an emotionally difficult and painful experience.

The SHR pie charts in Chapter 6 list the three most prominent SHRs for each month from May 2015 to December 2015. Emotions are coded as grey. It is evident that emotions were present in all of these months and in the months of June, July, August and October, emotions were the most prominent SHR. Further evidence of the difficult emotional process that Mrs M experienced in SHIP® is to be found in her responses in the change interview. In the theme cluster entitled “the intense, difficult process”, there are several references to how emotional the experience was for her. It is therefore concluded that through SHIP®, Mrs M was able to access the unresolved emotional pain of the past and thus experienced a relief from her depressive symptoms and regained hope for the present. Since Meige’s symptoms and depression are both seen as TSMs that are a result of an inhibition of the process of autonomic regulation, the conclusion is drawn that SHIP® facilitated the release of SHRs and this affected the resolution of Meige’s symptoms.

In order to facilitate healing successfully, the psychotherapist has to be able to identify and neutralize distractors.

7.3.4 Neutralizing distractors

Distractors serve as a defence mechanism when the coping style is rendered ineffective. Although distractors have a necessary function, they need to be identified and neutralized in psychotherapy as they provide a temporary escape from the overwhelming effect of SHRs. In SHIP®, a safe space is created in which to experience the overwhelming nature of these SHRs. Distractors hamper this process. The distractor graph in Chapter 6 indicates that initially Mrs M presented with frequent distractors in sessions. As she became socialized into SHIP® and the safe psychotherapeutic space, she was able to engage better in the process without making use of distractors. The decline in the use of distractors can be viewed in terms of the engagement of deep and difficult trauma memories. As psychotherapy continued

and trauma was resolved, distractors also decreased because there was less unresolved pain and trauma to distract from. October was listed as an especially important month on the HAT scores in terms of the trauma memories that were accessed in this month. The spike in the use of distractors in this month indicates that the material that was accessed was so painful and difficult that the distractors would often surface as a defence mechanism. The SHR graph also indicates that it was a very emotional month for Mrs M.

7.3.5 The shift in coping style and interpersonal dynamics

SHIP® opened up channels for expression to occur freely again and this was confirmed by Mrs M's indication on the coping styles questionnaire that her coping style had shifted away from being an "avoider" (from mostly to never). The results on the RIM are a further illustration of the shift in coping style and interpersonal functioning. The significant change in affect ratio shows Mrs M's new-found willingness to engage with emotions and express herself in emotionally charged situations instead of using avoidance and withdrawal, as in the past.

The significant changes in Mrs M's scores in the category of interpersonal perception indicate that changes occurred in this area. Mrs M's tendency to be distant in interpersonal relationships pre-SHIP® can be understood in terms of her own experience of not having a secure attachment relationship with her primary caregivers. Working through this experience in SHIP® has opened up her awareness of her need for closeness as well as her new-found capacity to be in close, intimate and mutually supportive relationships. Mrs M's scores on the coping style questionnaire shifted by one point in the areas of pioneer, fixer, manager, sensitivity, outsider and protector. This once again indicates the shift in how she experiences social situations.

The experience of being free of trauma opens up new possibilities of functioning in the world (Steenkamp, 2013). The changes in the variables relating to information processing on Mrs M's RIM scores are indicative of this. She has become more flexible in the way she receives and interprets information and she is less affected by the information that she takes in. This finding is similar to the decline in associative activators that Mrs M experienced as SHIP® progressed.

7.3.6 Concluding statement

When considering the abovementioned formulation and supporting evidence, a strong case can be made for a finding that the changes measured post-psychotherapy were the result of and specific to the SHIP® process.

7.4 The sceptical case – alternative explanations

Disclaimer: not all of the arguments presented here are the direct views of the author but are instead made to help facilitate the analysis of change – in this case through the presentation of contrasting views.

The sceptical case presents alternative explanations for the observed change in symptoms.

7.4.1 Spontaneous remission and regression to the mean

The literature review on the course of Meige's syndrome indicates that spontaneous remission of symptoms did occur in 11% of cases (Castelbuono & Miller, 1998). As there is no clear proof of a link between the involuntary contractions of muscles in the face and previous psychological trauma, it is possible that spontaneous remission of symptoms would have occurred over time and that time is the variable responsible for change, not psychotherapy. Additionally, regression to the mean could account for the changes measured on the RIM as many of the pre-SHIP® scores fell outside the expected norms while some post-SHIP® scores seem to have regressed to the point where they fall within the norms. Examples of these are the DQ+, DQo, DQv, es, D score, Zd and popular scores. As such, all the possible changes could have occurred naturally over time and are not necessarily due to SHIP®.

7.4.2 Misdiagnosis and relational artefacts

Mrs M's age does not fall into the expected range for the onset of Meige's syndrome. She is younger than the typical age. Prior to the onset of the symptoms it appears Mrs M was appears to have been experiencing several stressors in her life. Her work life was stressful and her husband was away from home on some occasions due to the nature of his work. The symptoms could therefore have been a somatic reaction to psychosocial stressors. It is possible that Mrs M's circumstances changed over time and her symptoms diminished accordingly. These symptoms could have been misdiagnosed as Meige's syndrome when in fact they were a somaticized stress reaction.

The reported changes in symptoms could have resulted from relational artefacts. Because of the establishment of a good psychotherapeutic relationship and the spontaneous alleviation of Meige's symptoms, it is possible that Mrs M was eager to ascribe this alleviation of her symptoms to SHIP® as part of a desire to express gratitude towards the psychotherapist. Given the fact that Mrs M devoted many hours and thousands of rands to the SHIP® process, she may have desired to ascribe the alleviation of symptoms as well as other perceived changes to SHIP® in order to justify the money and time that was devoted to the process.

7.4.3 Botox, homeopathy and other treatments

During the period when Mrs M was participating in SHIP®, she also engaged briefly in other treatments such as Botox injections. It is possible that any one of these treatments could have effected or played a role in the resolution of her symptoms.

7.4.4 Concluding statement

Both misdiagnosis and spontaneous remission are likely in the case of Mrs M, given the evidence in literature of cases of spontaneous remission. There is also limited evidence to discount the effect of Botox and homeopathic treatments on the resolution of symptoms. The case can also be made that if SHIP® did play a role in effecting change, this may not have been effective without the simultaneous application of the other treatments mentioned previously.

7.5 Limitations and recommendations relating to current findings

Given the fact that the study is the first of its kind in terms of psychotherapy and Meige's syndrome, the researcher found several limitations that could be addressed in future research.

The first limitation lies in the diagnosis of Meige's syndrome. Although the diagnosis was formally made by a neurologist, details are unclear about what the process was (what tests and measurements were taken, etc.) to arrive at such a diagnosis. In terms of Meige's symptoms, the baseline was obtained by asking the participant about the duration and severity of these symptoms prior to admission. The limitation herein is that there are no objective measurements to confirm the facts provided. The pre-SHIP® baseline is thus based entirely on the report of the participant. Similarly, no official rating system was used to rate Meige's symptoms. Such rating systems are available and are often used by medical practitioners to measure dystonia. It is recommended that such measurement instruments be utilized in future

research to give a more objective measurement of symptoms. Future research could make use of video recordings to measure the debilitating effect of Meige's symptoms before and after the intervention and, with permission from the relevant parties, these could be made available to academics who review the study.

In the case of the RIM results, baseline testing some months before the application of SHIP® and again some months after would have provided indications of changes that occur between testing irrespective of SHIP®. A six-month follow-up testing after the completion of psychotherapy is thus recommended for future research as testing six months prior to psychotherapy may prove logistically difficult. The same can be done for any other data collection measures used.

Some of the data collection procedures were conducted by the participant's psychotherapist. The fact that the researcher is the son of this psychotherapist opens up the possibility that observer bias and subjective opinions on the part of both researcher and psychotherapist influenced the collection and interpretation of qualitative data.

Case studies are inherently limited in terms of sample size and generalisations from the sample. Although the results are encouraging, the sample is too small to make generalisations in terms of the efficacy of SHIP® as a treatment for Meige's syndrome beyond this specific case. It is recommended that similar studies be conducted that include bigger samples and different populations.

Owing to the nature of the study, the research was unable to limit the influences of external variables. It is therefore impossible to truly account for the influence of external interventions such as those mentioned in the sceptical case. More research of a similar nature would have to provide similar results in order for conclusive claims to be made that SHIP® is the agent of change. If future studies yield similar results, SHIP® can be recommended as a primary intervention for Meige's syndrome. Given the success of SHIP as a treatment modality in this case, it is recommended that future studies investigate its application as a treatment option for other illnesses with unclear aetiologies where possible psychogenic origins are considered a possibility.

7.6 Conclusion

For the most neutral verdict, an independent panel of three judges is recommended. At the time of research, such resources were not available to the researcher. The following section

contains the judgment made by the researcher after careful consideration of the findings. The reader is encouraged to think critically about possible explanations for the findings and to take into account that the researcher's conclusion is not considered to be objective.

The researcher has considered both the affirmative and the sceptical cases and the affirmative case was considered to carry more weight and to contain conclusive evidence of the following:

- Sufficient evidence that links significant psychotherapeutic processes to measured change throughout the course of SHIP®.
- Additional changes in the participant's interpersonal functioning due to the completion of SHIP®.

The three research questions can thus be answered as follows:

- 1) The symptoms of Meige's syndrome did change significantly over the course of SHIP®.
- 2) The change was found to be due to the effect of SHIP®.
- 3) The main factor accountable for the change is the successful facilitation of SHRs through SHIP®.

The results of this HSCED study are encouraging and support the hypothesis that Meige's syndrome may have a psychogenic aetiology. These results document the successful treatment of Mrs M's symptoms through SHIP® and encourage future research regarding SHIP® as a treatment option for Meige's syndrome.

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