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"It's Like Uprooting Trees": Responsive Treatment for a Case of Complex Post-Traumatic Stress Disorder Following Multiple Rapes

Francois van der Linde
David Edwards
Rhodes University

Address for correspondence to Professor David Edwards, Department of Psychology, Rhodes University, Grahamstown 6140 South Africa. E-mail: d.edwards@ru.ac.za

This systematic case study documents 27 sessions of assessment and treatment with cognitive therapy of Bongi (23) who presented with major depression, posttraumatic stress disorder and borderline traits. Bongi had been raised in a punitive environment, had been raped three times, the first time at age 9, and had been in a series of abusive relationships. The treatment illustrates the importance of therapist responsiveness in addressing this kind of complex presentation, the importance of drawing on case formulation to guide the course of treatment and the range of different interventions that need to be incorporated into an integrative treatment of a complex case. Self-report measures of depression, anxiety and posttraumatic stress indicators provided evidence that the therapy contributed to positive changes and the qualitative therapy narrative gives details of the nature of some of those changes. Although treatment was not complete when Bongi moved away, Bongi herself judged that the therapy had been a valuable experience which had resulted in her feeling more alive, more confident, and better able to take care of herself.

Keywords: cognitive therapy, complex posttraumatic stress disorder, integrative psychotherapy, posttraumatic stress disorder, systematic case study

Some cases of posttraumatic stress disorder (PTSD) can be assessed and treated in a few sessions of trauma-focused work. However, where there are multiple traumas, traumas going back to childhood, and/or a history of insecure or disorganized attachment, treatment is more challenging and likely to take longer. Such cases are referred to as complex PTSD (Courtois & Ford, 2009; Jackson, Nissenson & Cloitre, 2010) and treating them calls for responsiveness and collaborative engagement with the client with attention being given to crisis intervention, anxiety management, psychoeducation and relationship-building before attempting trauma-focused work. After reviewing trauma-focused treatments, their rationale, and how they can be adapted for more complex cases, Edwards (2013, this issue) presented a 5 level model for formulation and treatment planning. Concerns at the earlier levels need to be addressed before proceeding to the later levels. At Level 1 there is crisis intervention, risk management, and practical steps to ensure everyday functioning. At Level 2, there is building support, establishing motivation and building the therapeutic alliance. Trauma focused work is at Level 3. At Level 4 there is resource building and work with early maladaptive schemas as they come into focus during the trauma-focused work. At level 5 there is a focus the client building a new life and a new identity. The various components of this model are derived from the literature on case formulation in psychotherapy and on treating PTSD in particular.

This article is a systematic case study (Fishman, 2005) of Bongi, a 23-year-old woman with PTSD who had been raped three times. It documents how Edwards' model works in practice as treatment was shaped in response to Bongi's borderline traits, her longstanding comorbid major depression and the need to pay attention to establishing a strong therapeutic alliance. In such cases, therapists need to formulate on an ongoing basis between and even within sessions in order to meet the client in a compassionate manner and determine the appropriate focus of therapeutic work.

Research Methodology

Bongi was part of a series of South African cases (Edwards, 2009, 2010, 2013) treated with Ehlers and Clark's cognitive therapy (ECCT) (Clark & Ehlers, 2005; Ehlers & Clark, 2000; Ehlers, Hackmann, & Michael, 2004), a treatment shown to be efficacious in randomized controlled trials. Edwards attended some clinical supervision sessions of cases during the research trials and observed that considerable attention was paid to the timing of interventions and clients' readiness to respond to them. In the South African series, treatment of the more complex cases was also informed by the literature on schema therapy (Young, Klosko & Weishaar, 2003) and other approaches to complex trauma (Courtois & Ford, 2009).

Naturalistic case studies of the application of treatments to individuals in specific contexts, allow an evaluation of the clinical theories on which case formulation and treatment planning are based. Comprehensive qualitative data provide rich information on the process of therapy, events during and between sessions, at what stages change occurs, and which interventions the participant experienced as valuable. This is supplemented by quantitative data gathered from repeated administration of self-report measures (Dattilio, Edwards, & Fishman, 2010). The research aims were: to examine the treatment planning process in order to evaluate the transportability of ECCT to a South African setting, and to examine the ongoing process of case formulation and the kind of clinical decisions that determine the course of treatment.

Case Selection and Treatment Context

Participants in the case series had to meet DSM-IV-TR (American Psychiatric Association, 2000) criteria for PTSD. Having an African language as first language was preferred, as well as being reasonably fluent in English or Afrikaans. Exclusion criteria were current substance abuse, or psychosis. Following an assessment, participants were informed of the nature of the intervention and the rationale for treatment. Following ethical approval by Rhodes University, they gave written informed consent for the data to be used in research and publications where their privacy would be protected by use of pseudonyms and omission of identifying information. Bongi was treated by the first author, FvL, then, an intern clinical psychologist. The second author (DE) supervised the case as well as the writing of a research thesis based on it.

Data Collection

Voice recordings were made of all 27 assessment and treatment sessions.

Self-Report Scales were administered on a regular basis during assessment and therapy. The 21-item Beck Depression Inventory II (BDI-II) (Beck, Steer, & Brown, 1996) - 22 times. The 21-item Beck Anxiety Inventory (BAI) (Beck & Steer, 1993) - 23 times. The 17 items of Part 3 of the Posttraumatic Diagnostic Scale (PDS) (Foa, Cashman, Jaycox, & Perry, 1997) - seven times. The Posttraumatic Cognitions Inventory (33 Item Short Form: PTCI) measures negative cognitions about the self and the world, and cognitions related to self-blame (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999) - 6 times.

Material written by Bongi providing information about her thoughts, emotions, and struggles, included poems, a seven page letter written to FvL and text messages.

Weekly supervision sessions with the therapy/research supervisor were documented.

A research interview, based on Elliott's (1999) Client Change Interview Protocol, was conducted with Bongi after session 25 by a counselling psychologist with experience in trauma work. This was voice recorded.

Data Reduction

This data were used to create the following data reductions: (1) An assessment summary, including a case history and a comprehensive account of presenting problems, (2) a diagnosis and case formulation, (3) an initial treatment plan, (4) a treatment narrative, (5) graphical representations of quantitative data, and (6) a thematic summary of the research interview. Abbreviated here, to fit the constraints of a journal article, these are presented more fully in van der Linde (2007).

Assessment Summary

Introduction and Presenting Symptoms

Born and raised in an adjoining African country, Bongi (23) moved to South Africa for a year of post-graduate study. After three months she approached the University clinic with disabling symptoms and was referred for psychological assessment. FvL suggested she come twice a week. As she had no time during the week, she was seen for a double session on Saturdays. A psychiatrist prescribed Fluoxetine which she discontinued after a month because of side effects.

Bongi experienced memory and concentration difficulties, headaches, migraines, pain in her spine and below her heart, a tight band across her chest and difficulty breathing. She felt sad, hopeless, helpless, had lost her appetite, withdrawn from recreational and social activities and was sleeping during the day. Since being raped two years previously, she felt she had lost her dignity, her belief in herself and her abilities, and her relationship with God. She felt emotionally detached, was hypervigilant, with an exaggerated startle response, seeing the world as a dangerous place where something bad could happen at any time, was mistrustful of men, believed no man could love her, and that her life was irretrievably ruined. Irritability and anger outbursts were frequent.

She tried to avoid situations that triggered re-experiencing symptoms: seeing a suspicious looking stranger, being alone in a dark place, hearing conversations, news reports on radio or TV, related to sex or rape. These evoked distressing images she could not describe. She recalled nightmares in which she was overpowered by someone stronger than herself, and re-experienced the emotional and physical pain she had felt at the time of the rape. Sometimes she woke scared and tearful and saw indistinct shapes in the dark. Sometimes her whole body would shake, her vision blurred, and she became disoriented. She thought she was going crazy. Reading the anxiety symptoms in the BAI triggered intense distress. She inflicted pain on herself by pressing the sides of her hands together hard, biting her hands, and violently shaking her head from side to side. She said that this helped her let out the pain by transferring it from the inside to the outside of her body. She was suicidal but deterred by not wanting to disappoint people that loved her. So she told herself the best way to cope was by ignoring what had happened in the past.

Bongi's History

Bongi grew up on a farm with two younger siblings and her mother who was caring, but easily influenced by and subjugated to her husband and regularly administered corporal punishment. Bongi never had a birthday party or received presents. She felt most loved by a paternal aunt who lived close by. Her father was away and she longed to be able to tell him about her activities and dreams. However, when she was twelve he returned to the farm, but focused on the success of his businesses, and rarely spent time with the family. He was strict, using the children as farm labourers, waking them at 4h00 so they could work before going to school, and beating them with a belt or stick if work was not done satisfactorily or they went to play with friends. Soon she hated and feared him and still gets scared at the sound of a diesel engine, a reminder of her father's car. From age 15 she was away at boarding school, then at University, though during holidays she had to work on the farm. While at University, aged 19, she started modelling and befriended local celebrities. On completing her degree, after further punitive treatment on the farm for a few months, she enrolled at a South African university hoping to change her life for the better.

Bongi had experienced three rapes and several abusive relationships. Aged 9, she was raped by a respected community member who lured her friends away with money for sweets and took her behind a church where he forced her to have sex. She knew nothing about sex, but felt this was wrong. Afraid of being accused of lying and being beaten, she told no-one. Afterwards, whenever she saw him she ran away, and, if asked why, said he had recently beaten her. After that she felt depressed, and, on a visit to her father, attempted suicide by running into a busy street. She was severely beaten. She described feeling envious when she saw photos of herself at an earlier age, where she

looked happy. On holiday, aged 18, she experienced "love at first sight" but next day the man asked for sex, saying that if she truly loved him she would agree. When she refused, he forced himself on her and subsequently never spoke to her again.

Aged 20, she and other models signed contracts at the home of a fashion show organizer. They were offered transport home but Bongi was left behind with the organizer's sister and another woman. The organizer went out and, on returning late, suggested she spend the night there and later that they have sex. She refused but he persisted. She told the man's sister what was happening and felt betrayed when she advised her to give into him. Later, the man entered the room where she was sleeping, overpowered and raped her. Bongi left early the next morning. He was a prominent public figure, and seeing pictures of him and reading stories about herself in the gossip columns evoked intense distress. She became depressed and quit modelling. Aged 21, a close female friend died while visiting another country, and a few months later her brother died of cancer. Bongi was now frequently tearful, drinking a lot of alcohol and partying frequently. Having been in emotionally abusive relationships at ages 19 and 21, she was now in another relationship for a year which she described as the most abusive of all.

Diagnosis, Case Formulation And Treatment Plan

Bongi met criteria for PTSD, chronic, major depressive disorder (recurrent, moderate), dysthymia (early onset) and had marked traits of borderline personality disorder (affective instability, difficulty controlling anger, impulsivity, unstable sense of self). Scores on the self-report scales (presented later in Figures 1-3 and Table 1) supported these diagnoses. PDS and PTCI scores were high, and BAI and BDI-II scores were variable, a feature of borderline personality where individuals switch into what in schema therapy is called detached protector mode and remain functional but cut off emotionally (Young, Klosko, & Weishaar, 2003). Her presentation fits accounts of complex PTSD (Courtois & Ford, 2009; Jackson, Nissenson & Cloitre, 2010).

Raised in an emotionally deprived and punitive family context, Bongi had no-one to turn to when she was raped at age nine. With a submissive mother as role model, Bongi learned to live in fear and subjugation, did not expect her needs to be recognized or met or feel protected in the face of the abuse directed at her routinely by family members and, on the occasion of the first rape, a respected community member. With limited emotional awareness, she suppressed her feelings much of the time. As a young adult, abusive relationships and further rapes, reinforced her fear, mistrust, subjugation and lack of agency. Her somatic symptoms confused and frightened her. Although she wanted to "have a normal romantic relationship with a guy who loves me for who I am," her sense of herself as worthless, unlovable and a regular target of abuse left her hopeless about having a meaningful life or ending her emotional pain. Two bereavements compounded this escalating unhappiness. Her friend, one of the few people she felt understood by, had been an important source of support. While a girl, she had helped look after her brother who was four years younger than her. Now, in South Africa, far from familiar contexts, instead of the hoped for new start in life, she experienced regular flashbacks and nightmares of the third rape, her intense symptoms scared her and her depression deepened by a cycle of negative thoughts and withdrawal.

A collaborative relationship was established during the eight assessment sessions, and Bongi was clearly committed to the process. However, when questioned about the rapes, she became very distressed and responded only briefly and vaguely. She had no understanding of PTSD and how the unprocessed traumas were contributing to her hypervigilance and irritability or how the avoidance of triggers and suppression of memories was preventing her from coming to terms with what had happened to her. Although an imaginal reliving of the trauma is recommended in the assessment phase of ECCT, Bongi's unwillingness to do this was respected. In the treatment plan, attention was to be given to: explaining and normalising the impact of the rapes and other abuse experiences, and giving her a perspective on the broader impact of the punitiveness and neglect that had characterised her childhood; increasing her social support; helping her with the challenges of everyday functioning; giving up her avoidances and increasing her assertiveness. It was hoped that Bongi would later be ready for trauma focused work that could impact on the PTSD symptoms themselves.

Treatment Narrative

Sessions 9-11: Crisis and Reaction

These sessions focused on crisis intervention as she had nowhere to stay during the University vacation. In session 9, Bongi cried softly, unable to speak for about ten minutes. FvL helped her phone a friend who agreed to help her. But Bongi had a conflictual relationship with her, and, at session 10, following several quarrels, felt such intense rage she feared she might lose control and physically attack her: "I want to kill her, chop her body up, cook it . . . feed it to the dogs." She had struggled to wake up and had a headache and chest and abdominal pain. When FvL asked about re-experiencing symptoms and tried to explain their role in exacerbating distress she withdrew and although her anger calmed somewhat she left the session early. At session 11, FvL, who was going away for two weeks, focused on rebuilding the relationship. Still feeling mistreated by her friend and visibly distressed, she reported suicidal impulses, although she reassured him she would not act on them. They discussed a hospital admission but, a few days later, she sent an SMS saying she would not need that.

Sessions 12-15: Formulation, triggering, Assertiveness

At session 12, Bongi spoke cheerfully about having moved in with a different friend, sorted out her finances and started smoking marijuana to help manage her stress. However, she hesitantly mentioned she had voluntarily had sex with two men, one of her own age, the other older than her father. She did not enjoy this and afterwards felt disgusted and guilty, and was reminded of the rapes. FvL gave her a chapter (Mandeville, 2003) by a female sexual abuse survivor who did not understand that the abuse lay behind her severe symptoms until she sought professional help years later. Bongi commented on similarities between herself and the author and felt encouraged by the therapeutic gains described. Bongi seemed to understand FvL explanation of how the rapes had been overwhelming experiences she could not process and how her avoidant coping had maintained her PTSD and depression.

At session 13 Bongi had unexpectedly met the perpetator of the third rape who was attending a conference at the university. After she chatted with him and gave him her phone number, he sent messages showing he had no idea of the harm he had done to her. This triggered such intense distress she could hardly speak. She was angry, hopeless, felt she was being punished for no reason. She was also confused about why she felt

so distressed, and thought she was going crazy. Later FvL spoke about how she could overcome the shame and, and learn to use the anger to behave more assertively. He suggested that as a step towards addressing the shame, she tell a trusted friend about having been raped, and expressed the hope that in future she would be able to speak about the content of her flashbacks.

At session 14, a demanding week of studies had helped her avoid thinking about the rapes. FvL began by sharing a developmental perspective on her life. Growing up, she had lacked nurturance and loving understanding of her experiences, and had been abused emotionally, physically and sexually. Used to her needs being unmet and, having modelled on her mother's appeasing behaviour towards her father, she tolerated abuse in new relationships and tried to please others before they disappointed her. When she expressed doubt that she could change any of this, FvL affirmed that she could change by processing the past traumas and experimenting with ways of relating that would not lay her open to further abuse but lead her to feeling valued, respected, and cared for. When, in a role play, FvL modelled an alternative way of responding in her recent encounter with the rapist, she was surprised that such a firm, self-protective response was "allowed." Then she role-played responding to a man she had no interest in who approached her in a night club. After accepting a drink and engaging in extended conversation, she explained she did not want to hurt his feelings, FvL used Socratic questioning and cognitive restructuring to provide a framework for experimenting with new behaviour in similar situations. This motivated her to use therapy to get her life back on track and next day sent an SMS: "… thank you for yesterday's therapy. It was empowering and fun … You are the most understanding and caring person I never had but wish I did."

At session 15 Bongi said she had decided to feel "fabulous," but was actually tired from a busy week and a party the night before and wanted to cancel the next session. She had disclosed the rape to a friend, who had responded empathically and she felt proud of herself for doing it, noting that she had not felt ashamed. FvL gave further psychoeducation on assertiveness including reading to take home. As he gave examples of Bongi's inappropriate aggressiveness and non-assertive behaviours, she realized how this was maintained by early socialisation messages such as "Don't be selfish, think of others first." Returning to role play the nightclub scene, she could now refuse the drink, but recognized she felt pressure to talk to men because she did not want to hurt them and because "My friends always ask me why I don't have a guy and don't want to speak to one for any length of time." FvL modelled assertively telling her friend she was currently not interested in dating, but she remained sceptical about being able to be as direct as FvL had been.

Session 16-18: Reliving the Trauma, Anger and Repair

At session 16 FvL, gave Bongi a description of imaginal reliving by another rape survivor from the case series (Payne, 2006). She recognized many features of her own experiences, and the therapeutic gains that were described motivated her to try it. FvL described the process and they discussed how it would be managed. At session 17, Bongi jokingly said had she decided not to continue, indirectly expressing her ambivalence about the imaginal reliving. FvL demonstrated it with a neutral event and Bongi prepared to relive the third rape. She looked scared and was quiet for a long time. At first her eyes were open. As she got closer to the actual rape she closed them. Her breathing became deeper, and she cried at times. Throughout, she appeared to be calm, except at one point where, for a few moments she threw her head back, then leaned forward, opened her eyes and asked "Where am I?" She had felt as if she was back in his house. Hearing FvL remind her of where she was and that she was safe, she became reoriented and relaxed. There was a brief discussion during which she reflected on how the experience had fitted in with what she had been told about the process beforehand and, after some time she felt ready to leave.

The reliving provided important information about emotional hotspots and key appraisals. During the hours before the rape, Bongi had felt anxious, anticipating something bad would happen. As the rapist entered the bedroom she felt afraid and powerless. When she refused to have sex she felt misunderstood because the rapist could not see that she wanted care in relationships. Although there was a long struggle, and with his superior strength he had pushed her down on the bed and forced himself into her, she believed she did not resist enough and that "I gave up and let him rape me." She also felt mental defeat, as if she was being murdered, destroyed. She was also unable to integrate the event: "I can't believe this is happening". At one point her upper body fell off the bed, she hit her head on the ground and felt overwhelming pain as if her back was breaking. Afterwards, Bongi felt disgusted and contaminated: "scrubbing with soap and hot water cannot wash me clean." She continued to feel frightened until she was able to leave the house altogether. Subsequently she felt hopeless: "Will things always hurt and feel so bad inside me? I think it will." She would have been proud to be a virgin. An image of a doll with an arm broken off, incomplete and ugly, expressed her shame about how her friends would perceive her, and how she had been changed by the rape. During the reliving, she asked FvL not to look at her and after sessions she wanted to be where no-one could see her. Her anger terrified her. It was like having a devil inside her: "I often scream or try to hit and kick the person who angered me. Sometimes I want to kill them."

When FvL contacted Bongi to confirm the next session (18), she told him she was angry with him and did not want to come, though she reluctantly agreed to. Apprehensively, FvL prepared to face her anger. She said she was no longer angry and had been acting during the phone call. Though relieved, FvL doubted her honesty. Back in her room after the session, she had felt lonely, empty wanting to do something to "bring herself back." She stayed with a friend but felt no better. She had become increasingly aware of her anger as the week had progressed. FvL expressed concern that she might have felt he had forced her to do the reliving session, just as the rapist had forced her to have sex. He then contrasted therapy with the rape incident, explaining how the rapist ignored her refusal in order to satisfy his needs, while he had pushed for the reliving to help her find healing. Although both events caused the same emotions, he was motivated to do it because he cared about her. She started crying, more than in previous sessions. FvL commended her for her bravery that showed she was serious about the healing process. She seemed to want to say something, and, after some silence she explained how she had felt empty and lost for a long time, but she could see in FvL's face that he meant it when he said he cared about her. She cried again, then offered her own metaphor: "It is like uprooting trees, taking them out with roots and all; as they are pulled out some damage is done to the earth and a whole is left, but it is for the best." Later she sent an SMS thanking FvL for the session and for helping

her cry, adding that she felt drained and had been sleeping since it ended.

Sessions 19-22: Processing and Some Resolution

At session 19, Bongi reported the familiar somatic symptoms and was particularly concerned about the appraisal that she had lost her soul. Her soul had been under attack for a long time, FvL suggested: an absent father in early childhood, being raped at age 9, harshness and punitiveness during adolescence, abusive romantic relationships, losing her close friend and brother, and being raped twice more. He asserted that although her soul had been damaged and its growth marginalised, it was still very much alive. As they discussed this she realized that her soul needed time to heal. This would involve stopping the abuse, nurturing herself, supporting its growth so that in due course she could allow others close to her again. After this they focused on her shame and associated worthlessness. FvL gave some psycho-education about shame and worked with cognitive restructuring. He praised her when she mentioned she had assertively told a man on the phone that she would not go out with him and he had not bothered her since.

The next three sessions focused on her responses to teaching practice in a township school. She was mistreated by a fellow student; learners were disruptive and some threatened to harm her. She was also moving out of residence for the vacation. She felt, tired, demotivated, numb, unable to relax at school or after hours. They did some assertiveness work but when FvL started to explore the possibility of triggering, Bongi became quiet and, staring out the window, said very slowly, "I don't need help anymore. I must just accept that this is how my life will be." Taken aback, FvL sat in silence for some time, then empathised with her and encouraged her to express what she felt. She did so hesitantly and FvL focused on responding empathically.

Although, at session 21, she had received unexpectedly good academic results, she felt drained, like a body without a soul and said, "I have no space for happiness because there is too much sadness." However now she responded positively when FvL educated her about triggers and, using examples unrelated to her own experiences, explained how the brain could treat these as signals warning of possible current threat. She looked pleased, recognizing how this happened in her own life when, for example, she was threatened, saw sex scenes on TV, encountered the word "rape," or was alone in her room. At session 22, she had more good academic results and at the end of her teaching practice the learners had written her poems containing phrases such as: "You were friendly, kind, never in a bad mood… never despondent… your existence impacted upon us… we will miss you… you touched our hearts." She was cheerful and FvL used this to challenge her negative appraisals of herself. She had also identified that being unexpectedly touched by a male or female was a trigger that usually evoked an outburst of anger. FvL educated her about how emotional hotspots in the trauma memory lay behind the intense emotions she experienced when flashbacks were triggered., The memory of the rapist pushing her down on the bed and forcing himself into her evoked overwhelming emotions: feeling shaky, terrified she was being murdered, and helpless and angry. Now, helped by FvL's assurance that she was safe with him in the office, she could tolerate this experience. As she felt calmer, they were able to discuss these emotions as well as the physical pain and mental defeat and FvL helped her challenge the overgeneralization of these feelings to other parts of her life.

Recent nightmares seemed to represent her feeling disgusted and contaminated by the rapes and the damage to her capacity to love. In one, something was melting her body from the inside, killing her; in another, worms inside her chest were eating her, in the third, she put her arm down her throat and pulled something out. While awake, she felt she wanted to vomit something up that was causing nausea, dizziness, and pain in her chest. FvL commented that the last image suggested that healing was taking place through the therapeutic process. At the end, she took out a marble-based pen-stand given to her at the school, and put it on FvL's desk, and asked him to keep it for her. HeI left it where it would be easy for her to see.

Sessions 23-27: Positive Imagery and More Processing

Before session 23, Bongi had been prescribed the antidepressant imipramine which she took regularly. FvL used an imagery technique in which Bongi was guided to see and describe a perfect mother or nurturer (Lee, 2005). Bongi soon described:

> *… a confident and proud Black woman, wearing a comfortable long red dress with flowers on it… She is smiling, has loving eyes, and the way she smells has a calming effect on me… as if I want to breathe in deeply. She is concerned about my life… She communicates with me telling me that she loves me and cares for me… that she is proud of me… now she is hugging me… I feel secure, calm, happy.*

This had connected her to inner resources that would strengthen her, and she was deeply moved.

FvL then guided her to work with the dream images from last time. First Bongi saw evil worms tossing and turning in a small space inside her, saying, "We want to get out … We'll start eating you." She recalled painful burning and tingling that she had experienced during the dream in which she had beaten her chest repeatedly, drunk boiling water, and tried to vomit, but without experiencing relief. During the guided imagery, she put her hand and arm down her throat, removed something hard and shapeless with worms clustered on it, threw it away and then saw herself lying unconscious. FvL suggested she imagine her perfect nurturer being with her as she awoke, taking care of her and healing her. At the end, she saw herself healed physically and emotionally, feeling relaxed and assured. The object taken from inside her was being burnt in a fireplace.

After a break, they addressed Bongi's thought, "I gave up and let him rape me." She described how the rapist became angry with her repeated attempts to push him off to escape. Bongi did not experience the intense emotions she usually did when speaking about the rape, and said, "it feels like I've done this before so the emotions are not so intense now." FvL was pleased to see this reduced emotional reactivation and reframed her "giving up" not as being helpless or as permission giving, but rather as intelligent survival behaviour. She agreed and said that she had also come to think of it in this way.

Bongi also mentioned she had felt lonely and dated a boyfriend. One day they were alone kissing and she realized he was getting ready to have sex. She stopped him, and assertively (her word) told him that she was not ready to go any further and would like to end the relationship. He respected her decision. FvL then explained that another focus of the therapy was to help her restore activities she had enjoyed before and stopped doing. She smiled and said that she had accepted an invitation from some friends to go to gym tomorrow.

At Session 24 Bongi had been feeling dizzy, numb, fatigued, and empty for two days. Exploration yielded no clear trigger. Today she had been missing home but her mother, whom she

phoned, spoke about the weather and herself and Bongi could not share with her meaningfully. Although she denied it, Bongi was angry and called her a "swine." FvL pointed out how the anger was a consequence of having subjugated her needs, but found it hard to engage her collaboratively. He persevered with asking her what she wanted until she suddenly blurted out, "I'd like to scream." She acknowledged being very angry but refused suggestions about how to express it. In the family, anger was always viewed as negative and unacceptable, and she was never encouraged to express it. Now she acknowledged that it was good to express one's anger to prevent intense feelings building up.

At session 25, Bongi was animated and smiling, having finalized plans to travel overseas and secured a teaching position in England. There was a discussion of triggers in which Bongi showed she had understood the process as previously explained to her. FvL pointed out that her anger was triggered by feeling misunderstood or not having her needs met, and how she would either become verbally and/or physically aggressive, or switch into detached protector mode and cut off feeling altogether. Then he experienced an intense headache, felt as if he was suffocating and wanted to open the door. Bongi also reported a sudden headache and asked to lie down on the floor as she felt pulled down, as if by gravity. She lay down, made small talk then lapsed into silence. After a break they discussed how many past incidents had created a reservoir of unexpressed anger. At FvL's suggestion she wrote the names of those she was angry with and a sentence under each expressing what she wanted to say. She resisted invitations to go further as she did not want to feel the emotions related to each person.

At session 26 Bongi reported two nightmares, being attacked by a snake and being surrounded by a raging fire. She also told how using her old perfume had triggered intense negative emotions associated with bad experiences during the last two years. FvL commented on the value of recognising triggers in this way. He shared his experience in the last session of headache and feeling suffocated, and pointed out how emotions related to past events are still active in the present - indeed so strongly that he had felt them himself. He gave her Kennerley's (2000) chapter on anger which she read and found insightful. Drawing on this, FvL spoke of anger as a reservoir of untreated toxic waste that is activated by triggers. They discussed ways of addressing this, and the possibility of her continuing therapy in the future. Bongi started crying. She had been crying during the week too at the thought of ending therapy. Despite this, she concluded that this had been a good year for her in which therapy had benefited her personally and academically.

Bongi arrived more than an hour late for the final session, 27. Her transport had fallen through and she was so angry it was hard for her to focus at first. After a while, FvL handed her a sheet of paper containing a mini emergency plan, details of Kennerley's (2000) book, and his email address. She became calmer but after, a break, expressed resignation and hopelessness about getting her life back on track. FvL pointed out the scale of what she had to deal with given her 23-year life characterised by neglect, emotional and physical abuse, and three rapes. He encouraged her by reminding her of the evidence that through therapy she had initiated a process of healing, which she could find ways to continue with. Finally, he asked her to draw a timeline of her life, and future paths she might choose to take. This seemed to instil hope and she said that she would like find a therapist to enable her to continue this process in future.

Treatment Monitoring

Research Interview

During this interview, Bongi became tearful about the approaching end to therapy and acknowledged her need for future therapy. But she expressed doubt about finding another therapist who would be as interested, understanding, and caring. Although uncomfortable at first with a male therapist, she identified his understanding and care, as well as the focus on emotions, as the most important aspects of therapy. She had a good understanding of what she learned in therapy and could not think of anything to improve the treatment model. Although she found the reliving so distressing that she would not engage in it again, she also understood and believed in the rationale for it and its contribution to change. She recognized that loneliness had been a significant problem, being far away from home and because she was irritated by other females getting excited about boyfriends, while she wanted to avoid men (including talking about them). Before therapy, she said, she had felt crushed, not yet knowing who she was and feeling as if she did not have a life. With the help of therapy, she began to feel alive, more confident, better able to take care of herself, but realized she needed more work on accepting herself, sharing her experiences with others, and being more assertive.

Self-Report Scales

Bongi's scores on the PDS, BDI-II and BAI, displayed in Figure 1-3, show that Bongi's progress was not smooth or steady. But they also provide evidence for therapeutic gains. Initially PDS scores remained in the moderate to severe range. There was some drop at the time of the reliving session which, if anything, exacerbated symptoms. However there was a steady decline thereafter so that at the end she was in the mild range. Table 1 shows that for much of the therapy Bongi was in the clinical range on the PTCI which measures negative beliefs associated with trauma. Normative data from PTSD patients is displayed that shows that by the end there were shifts of one standard deviation or more on two of the subscales. The progress on self-blame parallels the data from pie charts she did during sessions: in session 18 she gave herself 20% of the responsibility for the third rape, 15% at session 21, but 0% by session 22. The reduction in negative cognitions about the self also accords with data on cognitive restructuring in the treatment narrative. The limited shift in her negative cognitions about the world, which she still viewed as dangerous and threatening, accords with the fact that she still had many traumatic memories to process.

The inconsistency in the BDI-II scores reflects Bongi's capacity to go into detached protector mode from where she could cope and function despite her lack of resolution. The feedback from her teaching practice and good academic results showed that despite her depression and chronic PTSD she functioned effectively much of the time. There is also evidence that her depression was much less in the last few weeks which probably reflects the impact of having been consistently respected and cared for by the therapist, being able to assert herself, a sense of having returned to herself, the affirmation she had received from the learners she had been teaching, her good academic results, and the fact that she had exciting plans for the following year. The BAI scores show a similar inconsistency. Since anger and anxiety both give rise to the symptoms measured by the BAI these scores indicate the intensity of symptoms on the frequent occasions when re-experiencing was triggered and/or events happened that angered her.

Table 1

Bongi's Mean Scores on the PTCI Subscales Compared to Normative Data

							Normative data			
	Sessions						Controls		PTSD Patients	
PTCI Scale	S4	S7	S13	S16	S24	S26	Mean	SD	Mean	SD
Self-blame	2.4	2.8	2.6	4.0	2.2	1.2	1.0	1.5	3.2	1.7
Negative cognitions: World	5.7	4.9	6.3	4.9	5.9	4.7	2.1	1.4	5.0	1.3
Negative cognitions: Self	4.2	3.5	3.3	3.8	2.8	1.1	1.1	0.8	3.6	1.5
PTCI –full scale	140	123	126	130	111	63	35.5	34.8	133	44.2

Discussion And Conclusions

This case study speaks for itself in presenting a human story behind the statistics on child abuse and rape, reminding readers of the severe harm done to children and young people by abuse. It documents how current approaches to therapy can address and reverse the damage, the complexity and range of experiences evoked in the process, and the challenges and intensity of the process both for client and therapist (extending to the therapist's direct experience of Bongi's headache). It provides evidence that the work on reliving the trauma, and the systematic work that followed on specific hotspots and their associated cognitions made a difference to the PTSD itself. Despite the distress it caused, the reliving contributed to her finding it increasingly less distressing to share about the rapes while shifts in beliefs resulting from the systematic work on appraisals are tapped by the changes on the PTCI.

Generalization from clinical cases studies takes the form of building and refining the theory that informs assessment and treatment (Dattilio et al., 2010). Such theory, built on the experience of previous cases, can be continually evaluated and refined in light of data from new cases. This study, which contributed to the development of Edwards' (2013, this issue) clinical focus model summarized above, highlights the importance of flexibility and responsiveness in treatment planning. During assessment and treatment, attention had to be given to personal crises (Level 1). At Level 2, the quality of the relationship with the therapist was central, particularly with respect to Bongi's experience of his care and understanding. Regular attention needed to be given to on-going case formulation, to motivating her, and to addressing difficulties in the therapeutic alliance. Decisions often had to be made within sessions in response to Bongi's emotional state.

Work on resource building by means of awareness training and cognitive and behavioural skills building was balanced by the considerable attention given to implementing the trauma focused features of ECCT including the use of reliving and imagery rescripting (Level 3). This balance is reflected in Levitt and Cloitre's (2005) treatment for survivors of child abuse which begins with 8 sessions of STAIR (Skills Training in Affective and Interpersonal Regulation) before proceeding to the trauma-focused work of MPE (Modified Prolonged Exposure). Only limited work was done to address early maladaptive schemas (Level 4) but there is evidence of a significant shift in Bongi's identity and a vision of a different and better life (Level 5).

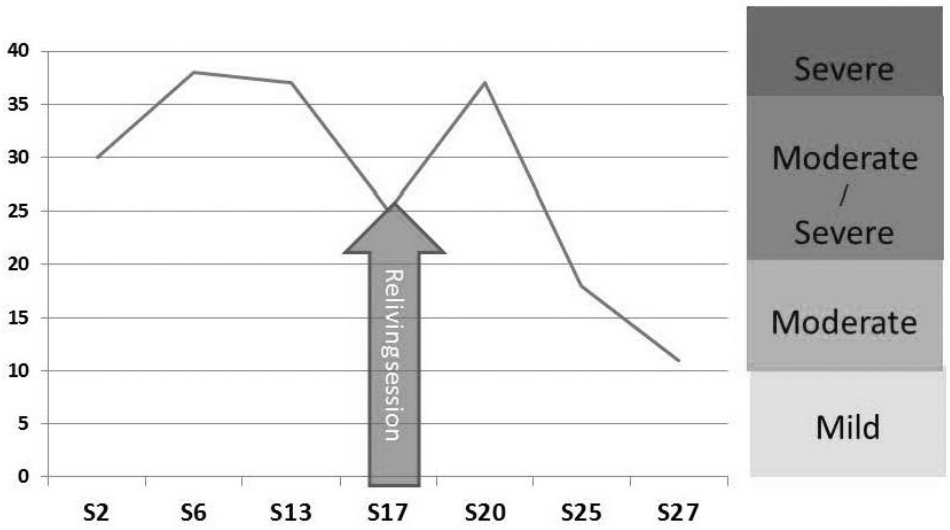

Figure 1. Bongi's PDS Scores

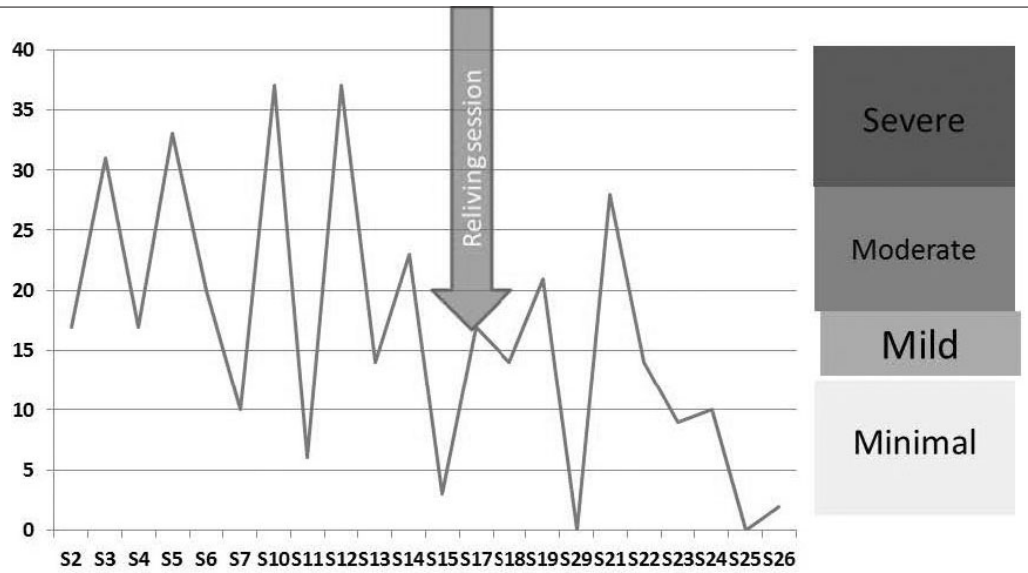

Figure 2. Bongi's BDI-II Scores

Fishman (2011) has argued for the value of comparing the process of two cases treated with the same model. Although his emphasis is on comparing good outcome and poor outcome cases, it can equally be adapted to comparing cases which pose different challenges with respect to case formulation and clinical decision making since it is such cross-case comparisons that are the foundation of clinically usable theory. Readers might therefore find it of interest to compare Bongi's case with that of a simpler case of PTSD described by Drake and Edwards (2012) where, because of the client's greater resourcefulness, therapist responsiveness was focused within a much narrower range. Although the two treatments differ in detail, they can both be accommodated within the general theory of Edwards' clinical focus model.

Although some of Bongi's symptom remission at the end may have been due to the prescription of an antidepressant, the narrative demonstrates changes in attitudes and values that would not have been achieved by medication alone and Bongi's own evaluation was that the process of therapy made a significant impact on her life. Although there is room to debate specific decisions made by therapist and supervisor in determining the timing and sequencing of interventions, Eells (2010, p. 287), an expert in case formulation, commented favourably on the full

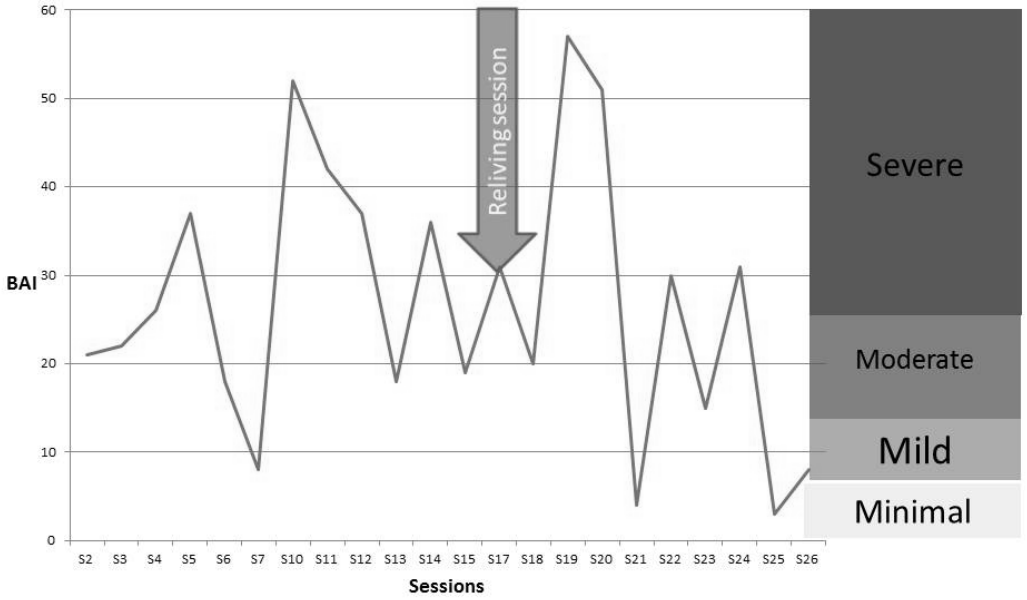

Figure 3. Bongi's BAI Scores

version of this case (van der Linde, 2007) and highlighted the responsiveness of the therapist who:

> *thereby guided Bongi to a point where she was willing to relive one of the rapes. Her tolerance for these reliving experiences was also managed in a metacompetent fashion, to the extent that Bongi was eventually able to use the experience productively. . . . the therapist [was able] to join with her appropriately while also remaining within the broad framework of a manualized therapy that has demonstrated strong efficacy.*

This serves as an independent evaluation of the appropriateness and the clinical decisions made and of the value of Edwards' clinical focus model for guiding responsive selection of the appropriate clinical focus as therapy proceeds.

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Author Notes

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