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AN INCEST CASE STUDY: SUFFERING FROM PTSD

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People who suffer from childhood sexual abuse have a tendency to later develop post-traumatic stress disorder. They may re-experience the traumatic event and associated psychological distress, avoid talking about traumatic event, experience low self-worth, andinability to make healthy relationships. They mayfeel guilt about the trauma. This article illustrates how a survivor of childhood sexual abuse learned to manage her intrusive symptoms of post-traumatic stress and re-structured abuse related beliefs and schemas. The present case is an attempt to provide therapeutic intervention to a 20 years old girl who suffered from childhood sexual abuse. The patient came to Center for Clinical Psychology (CCP), University of the Punjab with the complaints of hyper-ventilation, vertigo, blindness and immobility of body upon recalling her childhood traumatic events from the last 2 months. It was hypothesized that method of Imagery Re-scripting(Smucker, Dancu, Foa, &Niederee, 1995) would alter patient's dysfunctional abuse related beliefs such as feelings of victimization and powerlessness into empowerment. In the present case study, ABA research design was used. At the first stage (A), psychological assessment was carried out and the patient was diagnosed according to DSM-Vwith Post-traumatic Stress Disorder (PTSD). In the treatment phase (B), the patient was treated withImagery Re-scripting which involves Imaginal exposure and Re-scripting process. A total of 8 sessions were conducted over a period of 2 months. Post assessment (Stage A) showed that technique of imagery re-scripting proved to bean effective method for the patientssuffering from PTSD.

*Keywords.*Imagery Re-scripting, Incest, Childhood Sexual Abuse, PTSD

Incest is defined as sexual contact between two persons whoare related bysome formal or informal bond of kinship which is culturally viewed as a bar to sexual relations (Kaplan & Sadock, 1998). Incestuous behavior primarily involves sexual intercourse between a father and his daughter, a mother and her son, or a brother and his sister (Lester, 1972). In Islamic context, a clear cut indication about the prohibited sexual relationships has already been established in Surah Nisah. Surah Nisah provides a complete guideline for marital relationships which clearly states that mothers, sisters and daughters are prohibited to you for

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marriage (Al Quran, 4:23). In Pakistan, a research conducted by Sahil NGOfound that a total of 194 cases of incest have been reported in the previous five years i.e., from 2007 to 2011. Incest cases have been increased by more than 100% by 2011.

Families in which incest occurs report multiple psychopathologies and dysfunctional lifestyle (Celbis, Ozkan, & Ozdemire, 2006). Several studies have indicated childhood sexual abuse associated with various psychological problems in adulthood, such as increased rates of chronic anxiety, depression, suicide and self-injurious behaviors, interpersonal and sexual problems, and posttraumatic stress disorder. Long term effects of sexual abuse include feelings of guilt, self-blame, self-disgust, self-hatred, inferiority, low self-esteem, powerlessness and mistrust of others are frequently seen (Ali, 2005; Briere & Runtz, 1992; Elliot & Briere, 1992; Jehu, 1991; Long,Burnett, & Thomas, 2006; Shahid & Amjad, 2016). Similar findings have been reported that females experience symptoms of depression and helplessness and use emotion focused coping which is considered an in- effective strategy to tackle life stressors (Ahmad & Mohsin, 2010)

Information-processing models which emphasize the role of emotional networks have gained considerable support as explanations of PTSD symptomatology. Such models provide explanations for the "state dependent" nature of traumatic memories and for the re-experiencingof trauma, which are the hallmark of PTSD (Chemtob, Roitblat, Hamada, Carlson, & Twentyman, 1988;Foa & Kozak, 1986; Foa, Steketee, & Rothbaum, 1989; Lang, 1986). According to theories of emotional processing and state-dependent recall, dysfunctional schemas related to childhood abuse can readily be accessed and modified when the patient is in an emotional state similar to that which occurred during the abuse experience or when the greatest number of elements of the experience is included in the imagery.

In the late 20thand early 21st centuries there has been a renewed interest in the use of imagery re-scripting with traumatic memories (Rusch, Grunert, Mendelsohn, & Smucker, 2000; Smucker *et al.,* 1995; Weertman & Arntz, 2007). Edwards (2007) elaborates further on the use of imagery techniques to facilitate restructuring of dysfunctional cognitions associated with childhood sexual abuse. The use of imagery techniquesis beneficial to alleviate post-traumatic stress andto facilitate restructuring of dysfunctional cognitions associated with childhood sexual abuse (Wittmann, Schredl, & Kramer, 2006).

Theliterature showed that therapeutic effectiveness with abuse survivors will be enhanced if both imagery and verbal modalities are employed in recall, desensitization and cognitive restructuring.This article will look into how a survivor of childhood sexual abuse learned to resolve intrusive symptoms of PTSD and altered abuse related beliefs and schemas by using the therapeutic technique of Imagery Re-scripting.

Objectives

- To assess the effectiveness of Imagery re-scripting in treatment outcome for incest survivors.

Hypotheses

- Imagery re-scripting is likely to reduce physiological arousal associated with the recall of childhood sexual abuse.
- Imagery re-scripting is likely to reduce maladaptive cognitions associated with the trauma of abuse.

Method

Research Design

In the present study A×B×A single case research design was used to determine the efficacy of Imagery re-scripting in treating patients who experience childhood sexual abuse and later suffer from Post-traumatic Stress Disorder (PTSD).

Sample

The sample comprised of a single case (N=1).

Case Description/Sample Characteristics

The patient was a 20 years old girl, single, last born among 3 siblings and was a student of M.Sc.(psychology). She came to CCP with the complaints of episodic state of heightened psychological distress manifested as hyper-ventilation, vertigo, blindness and immobility of body on recalling her childhood traumatic events. Thepatient has been experiencing this state of arousal from the last 2 months.During her psychology class she studied about psychoanalytic school of thought (Sigmund Freud) and recalled her memories of childhood sexual abuse

by her eldest brother. The patient has always avoided talking about and recalling her distressing memories of sexual trauma, however studying the theory of psycho-analysis triggered her sexual trauma. Recalling of traumamade the patient experience intense psychological distress which was exhibited in the form of hyper-ventilation, vertigo, visual problems and inability to move her body though she remained conscious. Moreover, she failed her courses. Shefound it difficult to continue her studiesdue to problems in attention and concentration. She was referred by her department to the clinical psychologist for seeking psychological treatment. Therefore, information shared by the patient was kept confidential and her anonymity was ensured.

History of Present Illness

The patient revealed her trauma of sexual abuse by her eldest brother in her childhood, approximately at the age of 7 years. Her brother initially assaulted her and she surrendered. In the later experiences of sexual abuse, he behaved more physically aggressively towards the patient. She developed anger against her perpetrator which eventually resulted in resentments towards him. The events of sexual assault happened only at home and when her mother was at her workplace. The patient attempted to inform her mother but she took no active practical steps for her to stop this abuse. However, the patient's mother advised her not to go near him in her absence. The patient's father is living abroad and mother being at her workplace became the facilitating factors of forced sexual interaction between patient's brother and her. The patient has always remained in guilt because of unwanted sexual interaction with her brother. She also suffered from memory problems as she was unable to recall many events of her life such as immediate effect of trauma on her mind, her performance at school, relationships with friends and so on.

The patient at the age of almost 12 years, made a strong determination to resist sexual interaction with her brother because she was going through the phase of pubertal changes and she feared from conceiving. She used many ways to rescue herself such as locking herself up in a roomand not responding to her brother. She continued to resist sexually abuse and one day she finally succeeded. The patient remains in conflicting relationship with her perpetrator that once she did not even talk to him for about one year.

She reported to have distant relations with her father because her father has been living abroad and is emotionally detached. She shares

moderately satisfactory relationship with her mother. On one side, her mother shows caring attitude towards her but on the other side, patient blames her childhood sexual abuse to parental non-supervision. It was revealed from her history that patient's mother gives more preference to her brothers and her choice is not valued. The patient has healthy relations with her second born brother. The patient finds her home environment very restricted and non-supportive for her whereas her brothers are given autonomy/independence in every aspect of life. She is not allowed to sit alone at home. She wasrestricted by her family to make friends thoughshe made and maintained healthy relations with others.These factors made the patient found herself worthless and inferior in the presence of her siblings.

Given the above mentioned history of patient's problems, she was referred by her university teacher with the complaints of hyper-ventilation, vertigo, loss of sight and immovability of body occurring from the last 2 months.

AssessmentMeasures

Ratings of presenting complaints/symptoms on 0-10Scale. The ratings on presenting complaints and symptoms were taken from the patient on a scale of 0-10 (see Table 1).

Table 1
Ratings by the patient on 0-10 Scale (N=1)

Symptoms/ Complaints	SUDS Ratings (0-10)
Hyperventilation	8
Vertigo	8
Immobility of body (paralysis)	10
Lack of concentration	7

According to DSM-V, patient was diagnosed as suffering from child sexual abuse (V15.41) and post-traumatic stress disorder (309.81).

Procedure

Intervention

The technique of 'Imagery Re-scripting' developed by Smucker, *et al.*(1995) was used for the present case because thisis specifically designed to alleviate intrusive symptoms of PTSD and to alter abuse related beliefs and schemas (e.g., powerlessness and victimization into empowerment) of survivors of childhood sexual abuse. The theoretical model of imagery re-scripting suggests that the re-scripting process may produce change in pathological schemas associated with interpretation of the abusive event. The therapeutic package of Imagery Re-scripting involves step by step process of Imaginal Exposure, Mastery Imagery and Cognitive Restructuring/ Nurturing.Throughout this process of Imagery Re-scripting, the therapist's role is to provide a supportive and safe environment in which the patient can imagine and verbalize the traumatic event. The therapist remains non-directional and avoids suggesting patient what to do and what she is able to do.

The first step of "*Imaginal Exposure*" involves imaginal reenactment of the abusive scene completely,as vividly as possible. The patient is asked to close her eyes, re-experience the images of abuse scene and verbalizesaloud what she sees, feels and accompaniedthoughts,in the present tense (as it is happening now).In case the patient wants to quit the painful imagery, the therapist will facilitate the patient to stay with abusive imagery. Very often,the patient will rate her level of discomfort on a scale of 0 to10.

Followed by imaginal exposure to the sexual abuse scene, the next phase of "*re-scripting"*begins. The aim of re-scripting is to replace victimization imagery with mastery imagery, thus enabling the abuse victim to experience herself responding to the abuse scene as an empowered individual no longer "frozen" in a state of helplessness. In this phase, the patient again imagines the start of abuse memory. However, this time, when the abuse starts, the patient will develop mastery imagery by creating a new scenario in which she visualizes her 'adult' self today entering the abuse scene to rescue the child. The role of adult self is to rescue the child and protect her from any further abuse (by using any means), drive her out of the reach of perpetrator (may seek help from people), and nurture the child. The patient will decide on her own, what coping strategies to use in the mastery imagery.

Following completion of the mastery imagery, the therapist brings up the stage of *"cognitive restructuring*", in which the adult self is asked

to interact directly with the victimized child and re-structure her thoughts. The adult may hug the child, re-assures to protect the child from abuser, and promises not to leave the child. Once the patient indicated her readiness to terminate the imagery session, the therapist guides the patient to make the imagery fade away and open her eyes.

A total of eight sessions were conducted over a period of 2 months (once a week) to achieve goals. Each session lasted for 1 to 2 hours. The patient already had partial insight of her problems due to educational background of psychology. The therapist explained about the nature, causes, symptomatology, precipitating and maintaining factors of the illness to the patient. In the next session, the patient was explained treatment rationale and step by step process of imagery re-scripting. In the step 1 of imaginal exposure, the patient found it extremely difficult to verbalize her traumatic experience. She tried to verbalize many times but she failed. The patient was continuously in tears and took enough time to start verbalizing. The therapist motivated her, supported her and told her togather courage and verbalize her trauma. The patient rated herself on 10 points (SUDS scale). In the second step of mastery imagery when her adult-self entered the abuse scene to rescue the child, the adult took help of police in protecting the child. At this stage, SUDS decreased to 7 points. The patient found it difficult to verbalize the event as it was happening. The therapist motivated her throughout to go through this process and rescue the child. The patient succeeded in achieving this step. The last step of cognitive re-structuring was relatively difficult for the patient to achieve. In the imagery, the traumatized child was continuously in tears and the adult self was unable to nurture the child. This was the time when the therapist intervened and nurtured the child. The nurturance/cognitive restructuring by the therapist and the adult-self continued till the SUDS rating decreased to zero level.

In the very next session, the patient was less distressed as her SUDS level started from 6 points at the step 1. In the second step of Imaginal re-scripting, this time she did not take help of the police and adult-self rescued the child. Her SUDS level did not decrease. The nurturing stage was easy to achieve this time as compared to the previous session. In the upcoming sessions, the patient was far less distressed as compared to previous sessions. She looked more empowered to deal with her problems and her SUDS level also started from 5 points. A homework was given in which she was asked to write down a letter to his perpetrator (eldest brother) in which she would express her thoughts and feelings about the abuse. The rationale behind this homework was to use

letter writing ascoping strategies that will help her digest the painful memories of trauma. In the next session, it was planned to review homework and practice imagery re-scripting. However, the patient reported that she is not given personal space at her home therefore she did not complete her homework. She was asked to do her homework during the session. The patient was excited to write a letter to his perpetrator because she had never expressed her emotions for him. She wrote the letter in an ironical/ sarcastic way of comic. The agenda of repeating imagery re-scripting was not achieved then.

In the last sessions, the entire focus of the imagery work was on "adult-nurturing-child". The abusive imagery was no longer repeated, but instead she was asked to close her eyes and to use her own imagery to check-in with the child. The therapist facilitated the self-nurturing imagery by asking questions such as: Where is the child now? What is she doing? How is she feeling? What are her needs? What do you see in child's eyes? What would you like to say to the child? How does the child respond to adult self?When the patient checked in the child, she was happy and playing with her friends. The child expressed her needs to live happily in the future. Then the patient nurtured the child. The patient was counseled regarding her mildly decreased self-concept. The last minutes of session were spent on reviewing progress made during treatment and prepare for termination. This included discussion of ways of coping with future stressful situations. A complete summary of sessions and therapeutic interventions that were used in treatment are discussed in the next section.

Table 2
Summary of Sessions and Therapeutic Interventions Used

Session 1	History Taking / Clinical interview
(1.5 hours)	Ratings of Presenting Complaints/Symptoms on a scale of 0-10
Session 2	Psycho-education
(1 hour)	Ratings of Presenting Complaints/Symptoms on a scale of 0-10

Table continued

Table 2
Summary of Sessions and Therapeutic Interventions Used

Session 3 (2 hours)	Explain rationale of 'imagery re-scripting' Imagining the traumatic event of sexual abuse (as if happening in the present) Create mastery imagery by re-scripting sexual abuse scene using various coping strategies to expel the perpetrator Foster cognitive restructuring Ratings of Presenting Complaints/Symptoms on a scale of 0-10
Session 4 (2 hours)	Repeat traumatic scene Repeat mastery imagery scene Repeat cognitive restructuring imagery Ratings of Presenting Complaints/Symptoms on a scale of 0-10
Session 5 (1.5 hours)	Repeat traumatic scene Repeat mastery imagery scene Repeat cognitive restructuring imagery Explain rationale of writing a letter to the perpetrator and given as a homework assignment
Session 6 (1.5 hours)	Letter writing Discuss letter
Session 7 (1.0 hour)	Adult check-in with the child Repeat cognitive restructuring imagery Counseling to enhance self-concept
Session 8 (1.0 hour)	Adult check-in with the child Repeat cognitive restructuring imagery Termination of therapy

Ethical Considerations

A written informed consent was signed by the patient that involved confidentiality of information and anonymity of participant. The patient was also informed that the information provided by her would only be used for educational and research purpose. The patient was educated regarding the procedure of therapy, no. and duration of sessions and audio recording of sessions. A verbal consent was also taken from the patient to get through the process of imagery re-scripting. Results were reported objectively.

Results

The patient subjectively reported marked improvement in her condition after 8 sessions of therapeutic intervention program. The patient was more comfortable in talking about her traumathan before because her sexual conflict was resolved. Her psychological tension regarding her trauma was decreased. Her feelings of anger towards her perpetrator were reduced. Her self-concept was improved. All of these improvements are evident from subjective ratings.

Table 3
Ratings by the patient on 0-10 Scale at Pre and Post Level (N=1)

Symptoms/ Complaints	Pre SUDS Ratings (0-10)	Post SUDS Ratings (0-10)
Hyperventilation	8	2
Vertigo	8	2
Immobility of body (paralysis)	10	0
Lack of concentration	7	2

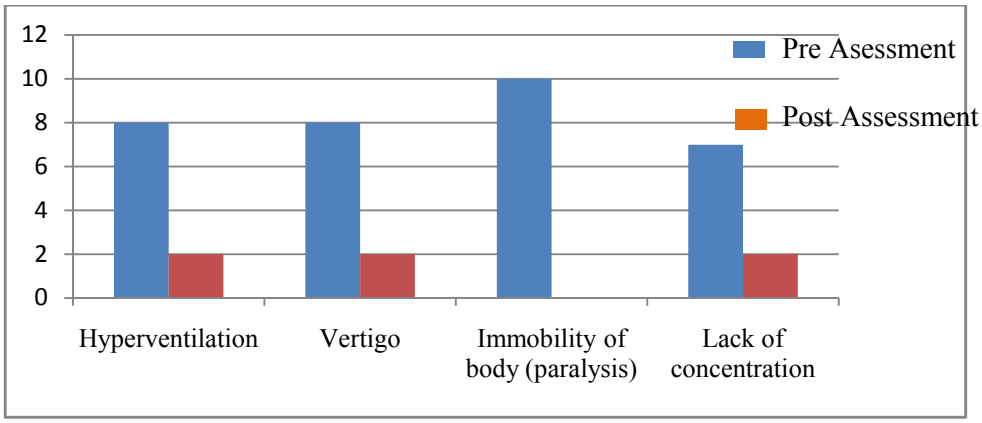

Figure1. Pre and Post Assessment SUDS Ratings (0-10)

The analysis of pre and post assessment showed progress in patient's overall condition. The technique of Imagery Re-scripting proved to be an effective method for the patient in alleviating her symptoms of PTSD.

Discussion

Certain childhood experiences such as abuse, assault, separation or divorce between parents seem to leave some people at risk for later posttraumatic stress disorder (Koopman *et al.*, 2004; Shephard, 2004). In present case the patient experienced sexual abuse in her childhood and later on she developed posttraumatic stress disorder. It has been found that people whose social and family support is weak are also more likely to develop a stress disorder after a traumatic event (Ozer, 2005; Simon, Gaher, Jacobs, Meyer, & Jimenez,2005). In the present case, lack of concern is exhibited by her mother that indicates weak familial support. Shahid and Amjad (2016) also asserted that the reaction of parents is mostly non-supportive. The severity and nature of traumatic events help to determine whether one will develop a stress disorder or not. Generally, the more severe the trauma and the more direct one's exposure to it, the greater the likelihood of developing a stress disorder (Chung, Dennis, Easthope, Werrett, & Farmer, 2005). The patient herself experienced the trauma of sexual abuse and continued to experience for almost 5 years.

In Wiehe's (1990) study of adults who have experienced sibling abuse, a majority of sibling incest victims also experience some form of physical and/or emotional abuse by their siblings. These other types of abuse are likely to further impact and contribute to the effects suffered because of the sibling incest. The patients' perpetrator (her eldest brother) also physically abused her during the acts of sexual abuse.

Ishtiaq and Bokharey (2012) asserted that absence of mothers in family leave the individual to be vulnerable for intra-familial sexual abuse. Helplessness has significant impact coupled with anger and crying behavior among incest survivors. This relates with the patient's history in a way that she was also sexually abused when her mother was outside home and her eldest brother took advantage of it. She found her helpless at the time of sexual abuse. She cried a lot but his brother continued to sexually abuse her. She also developed anger against his eldest brother which is reflected till now.

It has been reported that survivors of sibling incest are likely to be unsupported when they disclosed their abuse to family members as adults, especially if the victimized individual is a female (Owen, 1998). Fitzgerald, Shipman, Jackson, Mc Mahon, and Hanley (2005) asserted that incest survivors themselves reported to have distant relationship with their mothers in childhood and poorer current psychological adjustment. The patient was also not supported when she disclosed her sexual abuse

to her mother. She also reported to have unhealthy and distant relations with her mother.

Conclusion

The technique of imagery re-scripting proved to be highly effective for the present incest case. This technique is a full fledge package because it involved imaginal exposure, empowerment of survivors and cognitive restructuring. This technique helped the patient to alleviate her problems and it may be used for other survivors of sexual abuse.

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